STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

July 22, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
NYS Dept. of Health
5 Penn Plaa-6th Floor
New York, New York 10001

Kevin D. Porter, Esq.
c/o Thurn and Heller, LLP
261 Madison Avenue
New York, New York 1016

Phillip Whitelaw, M.D.
569 Woodbury Road
Plainview, New York 11803

Effective Date: 07/29/96

RE: In the Matter of Phillip Whitelaw, M.D.

Dear Mr. Sheehan, Mr. Porter and Dr. Whitelaw:

Enclosed please find the Determination and Order (No. 96-171) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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 all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

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

COPY

IN THE MATTER

OF

PHILLIP WHITELAW, M.D.

DETERMINATION

AND

ORDER

BPMC-96-171

THEA GRAVES PELLMAN, Chairperson, **DAVID HARRIS, M.D.** and **DANIEL A. SHERBER, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ESQ.** served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Notice of Hearing:	November 13, 1995
Statement of Charges:	October 20, 1995
Prehearing Conference:	December 27, 1995
Dates of Hearing:	January 3, 1996 January 18, 1996 January 26, 1996 February 8, 1996 February 20, 1996 March 4, 1996

Department of Health appeared by:		Henry M. Greenberg, General Counsel New York State Department of Health
	BY	Terrence Sheehan, Esq. Associate Counsel NYS Department of Health 5 Penn Plaza New York, New York 10001
Respondent appeared by:		Kevin D. Porter, Esq. 1211 Avenue of the Americas New York, New York 10036
Witnesses for the Department of Health:		Aaron G. Meislin , M.D. Mother of Patient E
Witnesses for the Respondent:		Agnes Nagy, M.D. Peter A.M. Auld (by affidavit) Phillip Whitelaw (Respondent)
Deliberations held:		April 25, 1996

AMENDMENTS TO THE STATEMENT OF CHARGES

On January 3, 1996, the Department made the following amendments to the Statement of Charges (Ex. 1):

Factual Allegation A.1.e.: date amended to read October 31, 1992;

Factual Allegation B.1.f.: date amended to read May 24, 1993.

In its proposed findings of fact dated April 22, 1996, the Department determined to withdraw three allegations: 1) Factual Allegation B(1)(g) relating to Respondent's treatment of Patient B on February 2, 1991 (Petitioner's proposed finding #19); 2) Factual Allegation D(1)(e) relating to Respondent's treatment of Patient D on April 28, 1987 (Petitioner's proposed finding #31); and Factual Allegation F(1) relating to Respondent's administration of measles vaccine to Patient F (Petitioner's proposed finding #47).

A copy of Exhibit 1 is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

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

NOTE: Petitioner's Exhibits are designated by Numbers.

Respondent's Exhibits are designated by Letters.

T = Transcript

The affidavit of Dr. Auld, was received in evidence as Respondent's Exhibit "B".

GENERAL FINDINGS

A. The Respondent was authorized to practice medicine in New York State in 1953 by the issuance of license number 073608 by the New York Education Department.

B. On or about June 1, 1994, Respondent entered into a Consent Order with the New York State Department of Health in which he admitted violating Article 33 of the Public Health Law in that he prescribed controlled substances inappropriately and failed to maintain proper records of his controlled drug prescribing practices. The Commissioner of Health fined Respondent Two Thousand Five Hundred Dollars ($2,500.00) of which One Thousand Five Hundred Dollars ($1,500.00) was suspended upon Respondent's compliance with certain conditions.

FINDINGS OF FACT RELATED TO PATIENT A

1 Respondent treated Patient A, a male born in October, 1988, from October, 1988, through in or about June, 1993. (Ex. 2)

2. On or about November 21 and December 2, 1988, Respondent administered injections of gamma globulin to Patient A. (Ex. 2, p. 1)

3. Gamma globulin is generally administered to infants to treat specific diseases and is not used as a prophylactic. (Ex. B, p. 3; T. 22)

4 On or about January 6, February 1 and March 1, 1989, Respondent administered doses of flu vaccine to Patient A. (Ex 2, p. 1)

5. The administration of three (3) doses of flu vaccine to a child of less than six (6) months of age was inappropriate. Providing a flu vaccine to an otherwise healthy small child is not a routine, preventative procedure and is not part of routine well-baby care. (T. 24, 63-6, 208-9)

6. Respondent administered six (6) half-dose injections of DPT vaccine to Patient A between on or about January 6, and May 24, 1989. (Ex. 2, p. 1)

7 The American Academy of Pediatrics does not recommend half-dose administration of DPT vaccine. (Ex. B, p. 4, T. 24-6)

8. Respondent prescribed antibiotics on numerous occasions during his treatment of Patient A. He also performed numerous hemoglobin and white blood counts on the Patient at many well-baby visits. (Ex. 2)

9 The frequent antibiotic treatments were excessive and inappropriate based on the results of blood tests which often did not indicate the presence of bacterial infections which could respond to antibiotic treatments. (T. 26-7)

10 Respondent prescribed Decadron, 5 milligrams, three (3) times per day for Patient A on or about October 31, 1992. He recorded notes in the patient's medical record indicating complaints of cough, red eyes, general glandular enlargement and hoarseness. He noted an impression of "upper respiratory infection, allergic laryngitis." (Ex. 2, p. 1; T. 472)

11 The administration of Decadron to treat "croup" or "croup-like" symptoms was not a significant deviation from acceptable standards of practice. (Ex. B, p. 5)

12. Respondent performed HEAF tuberculin testing every three (3) months within Patient A's first year and thereafter at six (6) month intervals. (Ex. 2; T. 28-9, 475)

13 Unless there is a specific exposure, administration of a tuberculin test is probably ineffective in the first year of a child's life and giving such a test three or four times in the first year of life is totally inappropriate. (T. 99-100)

14. Respondent performed twelve blood counts during Patient A's first year of life. (Ex. 2)

15 Absent some underlying blood difficulty, there is no indication to perform routine blood counts at well-baby visits The number of blood counts performed by Respondent during Patient A's first year was grossly excessive (T 29-30, 70-1)

16. Respondent performed six (6) urinalysis and five (5) throat cultures on Patient A during his first year of life. (Ex. 2)

17 The performance of six (6) urinalysis and five (5) throat cultures was not justified by Patient A's medical record and were unnecessary. (T. 30-1)

18. The medical record of Patient A maintained by Respondent did not adequately meet the accepted standards of medical practice. (T. 89-91)

FINDINGS OF FACT RELATED TO PATIENT B

19 Respondent treated Patient B, a female born in June, 1984, from June, 1984, through in or about August, 1993. (Ex. 3)

20. Respondent prescribed a diet of rice, apples, pears and barley for Patient B at the age of 19 days. (Ex. 3, p. 1)

21. If a child is excessively hungry, it will usually be able to tolerate solid foods at an age of less than four (4) months. (T. 109)

22 On or about July 16, 1984, Respon lent prescribed zinc sulfate as treatment for Patient B's condition of seborrhea. (Ex. 3, p. 1)

23 Zinc sulfate is not a harmful treatment (T. 109, 120)

24. Respondent testified that the seborrhea would have to be a significant condition before he would prescribe zinc as treatment.

25 Respondent noted in the patients' medical record on or about August 6, 1984 that Patient B's seborrhea had improved. (Ex. 3, p. 1)

26 Respondent administered four (4) doses of flu vaccine to Patient B during her first two (2) years of life (Ex. 3, p. 1)

27 Between on or about September 7, 1984 and January 11, 1985, Respondent administered half doses of DPT vaccine followed by a fifth full dose. (Ex. 3)

28. There is no reason to give half-doses of DPT as part of the primary immunization schedule. (T. 110)

29. In a note in Patient B's medical chart dated May 12, 1989, Respondent noted complaints of vomiting and diarrhea throughout the previous day. The patients' temperature was recorded as 102 degrees. Additional complaints of red eyes and throat, glandular enlargement and tender submandibular glands. A throat culture was taken and an impression of a bacterial throat was noted. Respondent administered a penicillin injection and prescribed Chlortrimetron 5mg., Tigan 50mg. and Atropine .2cc. as treatment. (Ex. 3, p. 2; T. 598)

30 The injection of penicillin and treatment of Patient B's condition with antibiotics and an antiemetic was indicated and appropriate. (T. 126-7, 130)

31 A note in Patient B's medical record dated May 24, 1993, indicates complaints of a sore throat for two (2) days and an earache on that date. Respondent noted an impression of a PC virus and bacterial throat and prescribed Penicillin VK 250 milligrams every three (3) hours. (Ex. 3, p. 4; T. 603)

32 Respondent noted in the medical record on the following day, May 25, 1993, that a culture grew beta hemolytic strep A. Respondent prescribed Penicillin VK 500 milligrams four (4) times per day for ten days. (Ex. 3, p. 4; T. 603)

33 The treatment of Patient B's condition with penicillin was appropriate. (T. 112-3, 136-7)

34 Respondent performed eleven blood counts during the first fifteen months of Patient B's care. (Ex. 3)

35 The number of blood counts performed on Patient B was excessive. (T. 116)

36 The medical record maintained by Respondent for Patient B did not constitute a minimally acceptable medical record. (T. 116)

FINDINGS OF FACT RELATED TO PATIENT C

37 Respondent treated Patient C, a male born in July, 1966, from July, 1966, through in or about September, 1981. (Ex. 4)

38 Respondent prescribed prednisone, a synthetic cortisone preparation, as treatment for Patient C on three (3) separate occasions; on or about October 19, 1971, February 5, 1974, and February 6, 1976. (Ex. 4; T. 173)

39 Respondent noted the following complaints on each of those three (3) dates: October 19, 1971, hoarse cough, sniffle and 100 degree temperature; February 5, 1974, red eyes, coated tongue, sniffles, indications of allergy; February 6, 1976, cough, red left eardrum, indications of allergy and elevated temperature. (Ex. 4; T. 179, 181, 183)

40 Respondent testified that each prescription of prednisone was for 5 milligrams three (3) times a day for one or two days. (T. 672)

41 Respondent recorded in Patient C's medical record, in a note dated December 14, 1971, that the patient had been exposed to chicken pox. Respondent administered gamma globulin 1cc. (Ex. 4, p. 2, T 661)

42 At the time of the treatment, gamma globulin had never been demonstrated to have any preventative effect on the development of chicken pox. (T. 175)

43 On or about August 13, 1966, Respondent administered a fluoroscope test to Patient C A fluoroscope is a machine with a screen which is held over a patient's body. The screen displays X-rays which are passed through a patient's body. (Ex. 4, p. 1; T. 173)

44. Exposing an infant to fluoroscopy is potentially harmful in that such exposure is associated with cell damage and future cancer or leukemia. (T. 174-5)

FINDINGS OF FACT RELATED TO PATIENT D

45 Respondent treated Patient D. a female born in May, 1983, from June, 1983, through in or about June, 1993. (Ex. 5)

46 Respondent administered gamma globulin, 1cc., to Patient D at 19 days, six (6) weeks, 10 weeks and 10 1/2 months of age. (Ex. 5, p. 1)

47 Gamma globulin is not used in the routine care of a well infant and its' use is inappropriate except under specific circumstances such as to prevent or attenuate measles or to prevent hepatitis A. (T 207)

48 Respondent recorded in Patient D's medical record in an entry dated June 10, 1983 to "add solids" to her diet. (Ex. 5, p. 1; T. 675)

49 Respondents' reason for adding solids to the patient's diet was because she was probably hungry (T 676)

50 Respondent administered flu vaccine injections to Patient D at three, four and five months of age. (Ex. 5, p. 1)

51 Flu immunization to a child less than six months of age was inappropriate treatment. (T. 208-9)

52. Respondent noted in Patient D's medical record in entries dated August 29, and September 26, 1983, that DPT immunization shots in half-doses were administered to the patient. (Ex. 5, p. 1)

53 Half-dose immunizations with the DPT vaccine were considered unnecessary and inappropriate in 1983 (T 209)

54 Respondent frequently provided antibiotic therapy to Patient D despite normal findings on throat cultures (Ex 5, T 210)

55 The practice of providing antibiotics following negative throat culture results was inappropriate (T 210-11)

56 Respondent performed HEAF tuberculin tests on Patient D at three (3), six (6), nine (9) and thirteen months of age (Ex. 5, p. 1; T. 211)

57 Respondent performed ten blood counts on Patient D during her first year of life (Ex. 5, p. 1)

58 Performing ten blood counts during the first year of Patient D's life was not good medical practice. (T. 212)

59 Respondent performed numerous throat cultures on Patient D at well-baby visits. (Ex. 5; T. 212)

60 The performance of throat cultures at numerous well-baby visits was not an acceptable medical practice. (T. 212)

61 The medical records of Patient D as maintained by the Respondent did not meet the minimally accepted standards of medical practice. (T. 214-5)

FINDINGS OF FACT RELATED TO PATIENT E

62 Respondent treated Patient E, a female born in March, 1977, on one occasion in June, 1988, and subsequently during the period of December, 1990 through February, 1991. (Ex. 6A)

63 On December 12, 1990, Patient E was brought by her mother to Respondent's office with complaints of night sweats, fever, chest pains, fatigue, cough and a lump on the lower left side of her neck, half the size of a golf ball. (Ex. 6; T. 369-70)

64 The entry of December 12, 1990, in Respondent's medical record of Patient E fails to note a chief complaint, including any presence of a mass or lump in her neck. (Ex. 6A, p. 3, Ex 6E, p 1; T 247-8)

65 Respondent recorded an impression of hypothyroidism in Patient E and prescribed l-thyroxin at 05 milligrams to gradually increase to .2 milligrams daily. Respondent did not order any laboratory tests of the patient's thyroid before noting his impression. (Ex. 6A, p. 3, T. 705, 711, 746-7)

66 Respondent prepared an instruction sheet for Patient E for the use of the medication. He noted "return one year" at the end of the instructions. (Ex. 13A; T. 712)

67 Patient E was subsequently seen by Respondent on or about January 29, 1991. He noted in the medical record that the patient was to continue on l-thyroxin 0.2 milligrams per day. There is no record of Respondent observing a mass in Patient E's neck at this office visit. (Ex 6A, p 3)

68 Respondent's failure to perform laboratory tests of Patient E's thyroid before prescribing medication to treat her hypothyroidism precluded the establishment of a baseline value and prevented monitoring the subsequent effects of the medication on the patient's thyroid levels. (T. 256)

69 Patient E was seen by Respondent at his office on or about February 18, 1991, when accompanied by her mother. Respondent wrote a prescription for one hundred tablets of Synthroid 0.2 milligrams for Patient E. He did not note this prescription in the patient's medical record. (Ex. 3A, p. 3, Ex. 14; T. 380-3, 715-6)

70 In April, 1991, Patient E was diagnosed by an endocrinologist as having Hodgkin's disease (Ex. 6C; T. 385-6)

71 The medical record maintained by Respondent for Patient E did not constitute a minimally acceptable record. (T. 259)

FINDINGS OF FACT RELATED TO PATIENT F

72. Respondent treated Patient F, a female born in February, 1953, on a regular basis from January, 1956, through December, 1993. (Ex. 7)

73 Respondent prescribed prednisone on several occasions as treatment for Patient F's viral infections. (Ex. 7)

74 Patient F had a history of allergies and asthma. Prednisone was given to suppress Patient F's allergic reaction, to shorten the course of the patient's viral illnesses and to speed her recovery. (T. 812-3)

75 Respondent noted in Patient F's medical record in an entry dated April 19, 1977, that the patient had been taking heroin. There is no indication in the medical record that Respondent referred the patient for treatment or took any other action to address her drug usage. (Ex. 7, T. 295-6)

76 Respondent prescribed controlled substances, including Valium, Codeine, Percodan, Percocet and Dalmane, on several occasions for Patient F, notwithstanding her history of substance abuse. (Ex. 7, T. 298-9)

77 Respondent administered several series of poison ivy desensitization shots in April, 1981, March, 1984, and February, 1985. (Ex. 7, pp. 4-6)

78 Respondent administered the poison ivy shots to modify or attenuate poison ivy rashes from which the patient often suffered. (T. 820)

79 Respondent prescribed tetracycline for Patient F for an inflamed red nare on or about May 17, 1985. (Ex. 7, p. 6)

80. Patient F's child may have been born in January, 1985 and she may have not been pregnant in May, 1985. (T. 821)

81. In November, 1987, Respondent recorded a diagnosis of a condition of pitting edema in Patient F's medical record. (Ex. 7, p. 7)

82. Respondent's medical record for Patient F for the period of November and December, 1987, indicates he referred the patient to a hospital for an evaluation of the pitting edema. An entry dated December 28, 1987, notes that the edema was gone. (Ex. 7, p. 8; T. 323-5, 821-2)

83 The medical record of Patient F maintained by Respondent did not meet the accepted standards of medial practice (T 312-3)

FINDINGS OF FACT RELATED TO PATIENT G

84 Respondent treated Patient G, the husband of Patient F, between October, 1985, and July, 1992. Patient G had chronic hepatitis and cirrhosis for which he was receiving Interferon treatment at Stony Brook Medical Center. (Ex. 8; T. 874)

85 On multiple occasions, Respondent prescribed controlled substances including Percocet, Percodan, Valium and Prednisone for Patient G as treatment for his complaints of pain, despite the presence of his liver disease. (Ex. 8; T. 875-6)

86. Respondent displayed poor clinical judgment and inappropriate usage of medication in his treatment of Patient G. (T. 343)

87 There is no evidence in the medical record of Patient G that Respondent coordinated his treatment of the patient with any hospital physician who was treating his liver condition. (Ex. 8; T. 337, 885)

88 The medial record of Patient G maintained by Respondent was very inadequate due to the absence of any mention of consultation and cooperation with the specialists treating the patient's liver condition. (T. 338)

CONCLUSIONS OF LAW

The following Conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from an unanimous vote of the Hearing Committee.

The Hearing Committee concluded that the following Factual Allegations set forth in the Department's Notice of Hearing and Statement of Charges (Ex. 1) should be **SUSTAINED** The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A.1.a.	(2-3);
Paragraph A.1.b.	(4-5);
Paragraph A.1.c.	(6-7, 28);
Paragraph A.1.d.	(8-9);
Paragraph A.2.a.	(12-13);
Paragraph A.2.b	(14-15);
Paragraph A.2.c.	(16-17);
Paragraph A.3.	(18);
Paragraph B.1.c.	(5, 26);
Paragraph B.1.d.	(7, 27-28);
Paragraph B.2.a.	(15, 34-35);
Paragraph B.3.	(36);
Paragraph C.1.b.	(41-42);
Paragraph D.1.a.	(3, 46-47);
Paragraph D.1.c.	(5, 50-51);
Paragraph D.1.d.	(7, 28, 52-53);
Paragraph D.1.f.	(9, 54-55);
Paragraph D.2.a.	(13, 56);
Paragraph D.2.b.	(15, 57-58);
Paragraph D.2.c.	(59-60);
Paragraph D.3.	(61);
Paragraphs E.1 and E.2	(62-63, 65, 67, 70);
Paragraph E.3	(63, 65, 68);
Paragraph E.4.	(63, 65, 67, 70);

Paragraph E.5	(68);
Paragraph E.6	(64, 67, 69, 71);
Paragraph F.3.	(75),
Paragraph F.4	(76),
Paragraph F.8.	(83);
Paragraph G.2.	(85-86);
Paragraph G.3.	(87);
Paragraph G.4.	(88);
Paragraph H.	(General Finding B)

The Hearing Committee concluded that the following Factual Allegations should **NOT BE SUSTAINED:**

Paragraph A.1.e.;

Paragraphs B.1.a., B.1.b. B.1.e. and B.1.f.,

Paragraph C.1.a.;

Paragraph D.1.b.;

Paragraphs F.2., F.5., F.6., F.7.

The Hearing Committee concluded that the following Specifications of Charges should be **SUSTAINED** based upon the Factual Allegations which were sustained:

Fifth Specification;

Sixth Specification as it relates to the facts in Paragraphs F.3., F.4. and F.8.,

Seventh Specification as it relates to the facts in Paragraphs G.2., G.3. and G.4.,

Twelfth Specification;

Thirteenth Specification as it relates to the facts in Paragraphs F.3., F.4 and F.8.;
Fourteenth Specification as it relates to the facts in Paragraphs G.2., G.3. and G.4.;

Fifteenth Specification as it relates to the facts in Paragraphs A.1.a. through A.1.d., A.2.a. through A.2.c., A.3., B.1.c., B.1.d., B.2.a., B.3., D.1.a., D.1.c., D.1.d., D.1.f., D.2.a. through D.2.c., D.3., E.1. through E.6., F.3., F.4., F.8., G.2. through G.4;

Sixteenth Specification as it relates to the facts in Paragraphs A.1.a. through A.1.d., A.2.a. through A.2.c., A.3., B.1.c., B.1.d., B.2.a., B.3., D.1.a., D.1.c., D.1.d., D.1.f., D.2.a. through D.2.c., D.3., E.1. through E.6., F.3., F.4., F.8., G.2. through G.4;

Seventeenth Specification except those facts relating to Paragraph A.1.e.;
Eighteenth Specification as it relates to the facts in Paragraphs B.1.c., B.1.d. and B.2.a.,

Nineteenth Specification as it relates to the facts in Paragraphs D.1.a., D.1.c., D.1.d., D.1.f. and D.2.a. through D.2.c.,

Twentieth through Twenty-Sixth Specification.

The Hearing Committee concluded that all other Specifications of Charges should **NOT BE SUSTAINED.**

DISCUSSION

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

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

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

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

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

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

Using the above definitions as a framework for its deliberations, the Hearing Committee determined that the Department had established, by a preponderance of the evidence, certain Factual Allegations and Specifications of Charges as set out above.

The Hearing Committee recognized that it was essential to establish what was the appropriate standard of medical care for each of the cases at issue. It was therefore necessary to closely evaluate the credentials and testimony of the expert witnesses to determine the appropriate weight to be

accorded to each. Dr. Meislin stated that he has been in practice as a primary care pediatrician for over 35 years and that he also holds the title of Professor of Clinical Pediatrics at the New York University School of Medicine The Committee considered him to be most knowledgeable about the specialty of pediatric medicine His testimony was viewed as objective and authoritative and his opinions were seen as being rational and based on solid reasoning. Accordingly, his testimony was accorded great weight. The expertise of Drs. Nagy and Auld in the practice of pediatrics was noted by the Hearing Committee. However, the opinions expressed in the testimony of Dr. Nagy and the affidavit submitted by Dr. Auld were seen as less objective and often were less than unqualified endorsements of the practices of the Respondent. In fact, Dr. Auld suggests that Respondent's testing frequencies and treatment methodologies may be too aggressive and, with modification, would be consistent with acceptable community standards. Their testimony was not relied upon as greatly by the Committee in its' determinations.

CONCLUSIONS RELATED TO PATIENTS A, B, C AND D

The Committee sustained Factual Allegations related to Patients A, B, C and D which it considered to be indicative of inappropriately managed well baby care and unnecessary and excessive treatment. The Committee chose to consider the treatment provided to the four patients as evidence of a general pattern of nonconformity with generally accepted standards of preventive pediatric care in existence at the time treatment was rendered. The Committee fully agreed with the opinion rendered by Dr. Meislin that:

> ***"What appears here is a pattern of overtreatment and overmanagement. Any individual situation. . . that at any one time it might be justified to treat with antibiotics, or to take an extra blood count or an extra urine, at any one time is defensible; but the overall pattern of care here is what I feel is inappropriate. . . " (T. 116-7)***

The Hearing Committee concluded that the seven practices of Respondent, discussed below, which were repeatedly performed constituted a pattern of overtesting and overtreating which deviated from accepted standards of practice. It was also the opinion of the Committee that the fact that there was no potential harm to the patients posed by the various tests did not justify or excuse their performance. The absence of injury did not alter what would have been the acceptable standard of practice and was considered to be an irrelevant factor.

The Factual Allegations related to these four patients may be grouped into seven separate practices as follows:

1. **Administration of gamma globulin injections (A.1.a., C.1.b., D.1.a.):**

The Committee agreed with Dr. Meislin's testimony that the administration of gamma globulin injections for general preventive treatment of healthy infants is inappropriate. It noted that Dr Auld indicated such a treatment is usually provided to address a specific condition and offered a qualified statement that it "theoretically could" modify childhood diseases. The Committee also accepted Dr. Meislin's statement that gamma globulin had never been shown to be effective in preventing chicken pox.

2. **Multiple administration of flu vaccine (A.1.b., B.1.c., D.1.c.):**

The Hearing Committee determined that there was no justification for repeated administrations of flu vaccines to Patients A, B and D when they were otherwise healthy and that such practice was a deviation from acceptable standards of pediatric care and was not a part of routine well-baby care. Respondent could offer no serious rationale for this practice other than asserting that influenza is "not a nice disease to have."

3. **Multiple administrations of half doses of DPT immunizations (A.1.c., B.1.d., D.1.d.):**

Both Dr Meislin and Dr Auld stated that the American Academy of Pediatrics does not recommend half-dose administration of DPT vaccine. The Committee considered the testimony by Dr Meislin that the administration of half-doses of DPT was an outdated practice which had been discontinued well before the 1980's. There was nothing in the medical records of Patients A, B or D to support the contention that Respondent provided half-doses due to parental objections to the administration of a full dose of the immunization.

4. **Frequent administration of antibiotics (A.1.d., D.1.f.):**

The Committee concluded that antibiotics were often prescribed for Patients A and D even though blood test and throat culture results indicated such treatments were contraindicated or not indicated at all. Dr Meislin testified that Patient A's blood counts, as noted in an entry dated September 16, 1991, indicated the presence of a common virus for which an antibiotic would not be an accepted treatment. Respondent prescribed an antibiotic as treatment, notwithstanding his diagnosis. The Committee determined these practices were a deviation from accepted standards of practice.

5. **Frequent tuberculin testing during patient's first year of life (A.2.a., D.2.a.):**

The Committee supported the testimony of Dr. Meislin that, absent a specific exposure, frequent HEAF testing at infancy is both ineffective and inappropriate. Respondent's own expert states that "Respondent did tuberculin testing on a more frequent basis than is generally recommended. . . this is certainly not the practice of most pediatricians. . . ". Respondent noted in Patient D's medical record, in an entry dated October 6, 1987, that the patient may have been exposed to the disease; however, the patient was tested for tuberculosis four times between August, 1983, and May, 1984, over three years before the reported exposure. The Committee considered the repeated testing to be unnecessary and excessive.

6. **Repeated blood counts at infancy (A.2.b., B.2.a., D.2.b.):**

The Hearing Committee could find no support in the medical records of the four patients to justify the repeated blood testing by the Respondent for otherwise healthy patients. Any concerns with anemia and infections during the first year of life were not considered to provide the basis for blood testing at virtually every well-baby visit. The contention that no harm to the patient was presented by this practice was dismissed as irrelevant in determining whether there was a deviation from accepted standards of practice.

7. **Repeated urinalysis and throat cultures (A.2.c., D.2.c.):**

As with the repeated blood testing, the Hearing Committee considered the frequent urinalysis performed on Patient A and the repeated throat cultures performed on Patients A and D to be completely unjustified by their medical condition. The medical record of Patient A does not contain a history of urinary tract infections and the records of Patients A and D lacked documentation to support the frequent throat cultures.

The Committee concluded that Respondent's pattern of practice represented an overall non-compliance with generally accepted standards of pediatric practices. It felt that Respondent relied on outmoded treatment and testing regimens which demonstrated a failure to remain familiar with current developments in his specialty. The Committee also believed some of Respondent's practices may have been harmful to his patients. It was particularly concerned with his administration of a fluoroscope test to Patient C. The Hearing Committee believed such testing to be clearly inappropriate. The testing of an infant with a fluoroscope was also viewed as a further indication of Respondent's failure to maintain an acceptable level of skill and knowledge in his practice.

The Hearing Committee determined that the Factual Allegations related to Patients A, B, C and D which were sustained constituted the practice of the profession with negligence and incompetence on more than one occasion. It did not conclude that Respondent's negligent treatment of those four patients was so egregious as to constitute gross negligence on a particular occasion

nor did it conclude that the incompetent treatment was so unmitigated as to rise to the level of gross incompetence. It was also determined that the Respondent's practices constituted the ordering of excessive tests and treatments which were not warranted by the conditions of Patients A, B and D. Specifications which related to these acts of professional misconduct were sustained, as set out, above

Certain Factual Allegations related to Patients A, B, C and D were not sustained by the Hearing Committee. The prescription for Decadron on October 31, 1992 for Patient A was considered to be indicated based on the patient's complaints and was seen as being appropriate to reduce inflammation. Allegation A.1.e. was not sustained. Providing solid foods to an infant of less than four months was not considered to be a deviation from accepted standards of practice and was seen as being fairly common among practitioners. Allegations B.1.a. and D.1.b. were not sustained. Similarly, the Committee considered the treatment of Patient B's seborrhea with zinc sulfate to not be uncommon and to not be a deviation from accepted standards of practice. Factual Allegation B.1.b. was not sustained.

Factual Allegations B.1.e. and B.1.f. were also not sustained. The Committee believed Respondent's professional judgement in treating a specific complaint on a specific date needed to be accorded some measure of respect. Dr Meislin agreed that there may have been a basis for Respondent's treatment and that "one would have to depend on the doctor's judgement to a great extent." The Committee determined that treating Patient B with penicillin on May 12, 1989, may have been appropriate to address complaints of vomiting.

The Committee felt that treatments of prednisone prescribed to Patient C were within acceptable standards of care. It noted that the patient's medical chart recorded complaints, including indications of allergies, for which prednisone may have been indicated. Allegation C.1.a. was not sustained.

CONCLUSIONS RELATED TO PATIENT E

Respondent and the mother of Patient E provided diametrically opposed testimony regarding the treatment of the patient. The Hearing Committee closely evaluated their testimony to determine their credibility. The Committee believed the mother's testimony to be consistent and felt she had a clear, detailed recollection of the events of several years previous. She was considered to be a highly credible witness.

The conflicting information in the various copies of Respondent's medical records for Patient E made it difficult to verify certain information testified to by him. Exhibits 6A, 6B and 6E each purported to be copies of all, or in the case of Exhibit 6A a portion of, the medical chart for the patient. Exhibit 6E was expressly prepared to assist the Committee in reading illegible parts of the other two Exhibits and was intended to be an exact transcription of the original chart. However, differences in the three documents were considered to be so great so as to diminish Respondent's credibility and to call his veracity concerning Patient E into question.

The entry in the medical record for Patient E's December 12, 1990, office visit makes no mention of any complaints. There is no report of a mass on the patient's neck. Respondent could not recall if he recorded the patient's history at her June, 1988 visit or her December, 1990 visit and it was not clear when the entry for the December visit was actually written. The Committee believed the records to be so deficient that Respondent's contention that he observed no mass was not believed.

It was considered significant that no notation related to her nodes was ever recorded in Patient E's chart. Respondent's custom, as seen in the records of Patients A, B, C and D, was to routinely record "GGE" as a general impression at virtually every office visit regardless of the relevancy of such finding. The absence of such a reference at each of Patient E's visits was viewed as being significant by the Committee and detracted from Respondent's credibility.

It was also noted that the records maintained by the subsequent treating endocrinologist's practice in Exhibit 6C and 6E verified the patient's complaints and the fact that such complaints had persisted for a period of time prior to April, 1991.

The Committee concluded that Respondent's examination and treatment of Patient E on December 12, 1990, was inadequate, even if he saw no mass on her neck. The diagnosis of hypothyroidism without performing any diagnostic tests was considered to be improper. It agreed with Dr Meislin's opinion that the patient's complaints may have suggested a diagnosis of hypothyroidism, but no treatment should have followed until confirming laboratory data was received.

It was also considered inappropriate for Respondent to prescribe L-thyroxine .05 milligrams to be increased to .2 milligrams daily starting on December 12, 1990, and to not schedule a follow-up appointment to monitor the patient's progress. The Committee noted that Respondent only instructed the patient's mother to call and advise of the patient's progress and further wrote instructions to return one year later. The absence of any initial testing of the thyroid prevented subsequent testing that could be meaningful to measure the effects of the treatment. This was viewed as evidence of Respondent's failure to monitor the impact of the medication on the patient.

Respondent's treatment of Patient E was considered to be an egregious failure to exercise the care expected to be provided by a physician under the circumstances. The failures to document patient complaints, to perform appropriate tests prior to diagnosis and treatment of a medical condition and to monitor the effects of a prescribed medication were determined to be negligence and gross negligencein the practice of the profession. The Hearing Committee concluded that the treatment of Patient E also constituted gross incompetent and incompetence on the part of the Respondent. His inaccurate diagnosis and treatment of hypothyroidism without appropriate testing and monitoring was believed to be a demonstration of an unmitigated lack of the skill necessary to treat this patient under the circumstances.

CONCLUSIONS RELATED TO PATIENT F

The Hearing Committee concluded that Respondent clearly mismanaged the care of Patient F It was felt that the patient exhibited obvious drug-seeking behavior for many years and that Respondent failed to take affirmative action to obtain appropriate therapy for her The contention that he continued to provide pain medication, even with his knowledge that she had been taking heroin, in order to maintain the family unit for the sake of her child was considered to be no justification for his prescribing practices. It was noted that the frequent prescribing of pain medications began well before the birth of the child in 1985. The medical records of Patient F lack any verification of Respondent's alleged attempts to secure the patient's treatment records. From at least 1981 through 1993, Respondent frequently prescribed controlled substances for the patient's pain. There is no mention of any program of treatment that the patient participated in or to which Respondent referred her.

The Committee believed that Respondent's continued treatment of an adult with controlled substances over a period of many years with no record of treatments received elsewhere constituted gross negligence and gross incompetence. Respondent's emotional connection with the patient and her family resulting in the continued supply of controlled substances to her detriment was considered to clearly be an egregious level of negligence. His professional duty in the face of alleged noncompliance with treatment plans and referrals was to cease treatment. The continued treatment of the patient with controlled substances for well over ten years was inexcusable. It was also noted that Respondent was not qualified to treat the patient as an adult, yet he continued doing so. This was determined to be gross incompetence.

The Hearing Committee did not sustain Factual Allegations F.2., F.5., F.6. and F.7. As with Allegation C.1 a., the treatment of Patient F with prednisone was considered to be appropriate based on the patient's history of asthma and her symptomatology. The poison ivy desensitization shots were considered appropriate based on the patient's history. The record is not clear that Patient F was pregnant when Respondent prescribed Tetracycline for an inflamed red nare in May, 1985.

Dr. Meislin testified only that he assumed the patient was pregnant at that time, while Respondent testified that the baby was born in January, 1985. Patient F's medical record notes that Respondent referred her to a hospital in November and December, 1987 to evaluate his diagnosis of pitting edema. An entry dated December, 1987, records that the condition was no longer present.

CONCLUSIONS RELATED TO PATIENT G

The Committee determined that Respondent mistreated Patient G in a manner similar to his wife, Patient F. Respondent was aware that Patient G was being treated at Stony Brook Medical Center for hepatitis and cirrhosis of the liver. There is no evidence in the medical chart to indicate Respondent ever consulted with, or attempted to contact, those medical specialists who were providing treatment elsewhere. There is nothing in the record to confirm Respondent's allegation that he attempted unsuccessfully to make such a contact. Respondent treated the patient on a frequent basis for over five years with controlled substances to address complaints of pain without any knowledge of what medications the patient was receiving elsewhere. The Committee considered this to be a gross deviation from accepted standards of practice. It was felt he should have aggressively sought information from the hospital or should have ceased his own treatment of the patient. Any concerns of stabilizing the family structure should have been viewed as less significant than ensuring safe and appropriate treatment of the patient.

The Hearing Committee determined that Respondent practiced medicine with gross negligence and gross incompetence in his treatment of Patient G. It believed his continued prescribing of pain medications to a patient with severe liver disease without confirming what other treatments were being received by the patient to be especially egregious. As with Patient F, Respondent was not competent to treat an adult such as Patient G on a long-term basis. This was particularly true for a patient with a serious liver condition.

VIOLATIONS OF PUBLIC HEALTH LAW ARTICLE 33

Exhibit 9 in evidence was a copy of the Consent Order Respondent entered into on or about June 1, 1994, in which he admitted violating Public Health Law Article 33 in that he prescribed controlled substances inappropriately and failed to maintain proper records related to his controlled substances prescribing practices. It was observed by the Committee that these charges were based upon his treatment of Patients F and G. Factual Allegation H and Specification Twenty-Six were sustained by the Hearing Committee.

FAILURE TO MAINTAIN ADEQUATE RECORDS

The Committee sustained Factual Allegations related to the inadequacy of the medical records maintained by the Respondent for each of the seven patients. All members agreed that the records of each patient were almost totally illegible. This in and of itself did not make the records inadequate; however, it was felt that the records would be of no use to any subsequent treating physician who may have assumed the care of any of the patients. The absence of any clarity of the records contributed to a determination that they were not adequate.

What particularly troubled the Committee were the frequent discrepancies between copies of the original records and what were purported to be exact transcriptions which were compiled to assist in making it easier to read those records. Certain words were given emphasis or punctuation was changed in some instances so as to give a different meaning to a written entry. Entries in one copy, such as the office visit of Patient E's mother set out in Exhibit 6A, were not found in Exhibit 6B or 6E. The Committee concluded that the transcriptions were not exact and true copies of the originals in all instances.

It was also observed that Respondent often failed to record dosages or frequencies of the medications he prescribed. Developmental and growth factors of the pediatric patients were rarely recorded which the Committee believed to reflect a serious inadequacy in Respondent's record-keeping. The records of Patient E were considered to be grossly inadequate in that Respondent could not even recall when her history was recorded. The failure to record the mass on Patient E's neck was also deemed a gross deviation from acceptable standards of practice.

Another gross deviation from accepted standards of record-keeping was Respondent's practice of combining the records of several persons in one document. The Committee considered it essential for each patient to have a separate medical record. Treatment provided to Patient E's mother was contained in the daughter's chart. Treatments for Patient G were noted in his wife's chart. There were indications in Patient F's record that Respondent may have prescribed controlled substances to friends of the patient in 1993. Combining treatments of several persons in one record was considered to be highly improper.

The Committee determined that Respondent failed to maintain records for each of the seven patients which accurately reflected the evaluation and treatment of each patient. This was also considered to the practice of the profession with negligence on more than one occasion and with incompetence on more than one occasion. The deviations from accepted standards were so egregious and unmitigated in the cases of the records maintained for Patients E, F and G that the Committee determined such inadequate record-keeping to constitute practicing with gross negligence and with gross incompetence.

DETERMINATION AS TO PENALTY

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

The Committee believed that the treatment of Patients E, F and G justified license revocation even without the addition of the acts of misconduct found in Respondent's treatment of Patients A, B, C and D. The failure to note or treat the mass on Patient E's neck in an appropriate manner was viewed as so serious that no other penalty could be considered adequate. The encouragement of the drug-seeking behavior of Patients F and G by the continued prescription of controlled substances for many years was considered to be inexcusable. Respondent exhibited no insight through his testimony that his pattern of treatment of those two patients was improper and that it may have been detrimental to their well-being. The Committee also considered Respondent's admission that he had violated provisions of Article 33 of the Public Health Law in determining that license revocation was the only appropriate penalty.

ORDER

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

1 The following Specifications of Charges, as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED:**

a Fifth Specification;

b Sixth Specification as it relates to the facts in Paragraphs F.3., F.4. and F.8.;

c Seventh Specification as it relates to the facts in Paragraphs G.2., G.3 and G.4.,

d Twelfth Specification;

e. Thirteenth Specification as it relates to the facts in paragraphs F.3., F.4. and F.8.;

f. Fourteenth Specification as it relates to the facts in Paragraphs G.2., G.3. and G.4.;

g. Fifteenth Specification as it relates to the facts in Paragraphs A.1.a. through A.1.d., A.2.a. through A.2.c., A.3., B.1.c., B.1.d., B.2.a., B.3., D.1.a., D.1.c., D.1.d., D.1.f., D.2.a. through D.2.c., D.3., E.1. through E.6., F.3., F.4., F.8., G.2. through G.4.,

h. Sixteenth Specification as it relates to the facts in Paragraphs A.1.a. through A.1.d., A.2.a. through A.2.c., A.3., B.1.c., B.1.d., B.2.a., B.3., D.1.a., D.1.c., D.1.d., D.1.f., D.2.a. through D.2.c., D.3., E.1. through E.6., F.3.,F.4., F.8., G.2. through G.4.,

i. Seventeenth Specification except those facts relating to Paragraphs A.1.e.;

j. Eighteenth Specification as it relates to the facts in Paragraphs B.1.c., B.1.d. and B.2.a.;

k. Nineteenth Specification as it relates to the facts in Paragraphs D.1.a., D.1.c., D.1.d., D.1.f. and D.2.a. through D.2.c.;

l. Twentieth through Twenty-Sixth Specifications.

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

DATED: Albany, New York
July 19, **1996**

THEA GRAVES PELLMAN, Chairperson

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APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
PHILLIP WHITELAW, M.D.	:	CHARGES

----------X

PHILLIP WHITELAW, M.D., the Respondent, was authorized to practice medicine in New York State on 1953 by the issuance of license number 073608 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between in or about October, 1988 and in or about June 1993, Respondent treated Patient A, an infant, (whose name is contained in the attached Appendix) at Respondent's private office located at 569 Woodbury Road, Plainview, NY 11803.

1. Respondent inappropriately managed well baby care and administered unnecessary and excessive treatment, including:

a. Two injections of gamma globulin, one at age 6 weeks, the other at age 8 weeks.

b. Three doses of flu vaccine.

c. Six half-dose injections of DPT vaccine.

d. Numerous prescriptions for antibiotics.

e. A prescription for Decadron on [December] October 31, 1992.

2. Respondent ordered unnecessary and excessive testing of Patient A, including:

a. Tuberculin testing every three months within Patient A's first year, and thereafter at 6 month intervals.

b. Hemoglobin and white blood counts performed at each well baby visit, including 12 blood counts over the baby's first year of life.

c. Numerous urinalyses and throat cultures, including 6 urinalyses and 5 throat cultures during the first year of life.

3. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient complaints, history, physical examination, diagnoses, progress notes and treatment plan.

B. Between in or about June, 1984 and in or about August, 1993, Respondent treated Patient B.

1. Respondent inappropriately managed well baby care and administered unnecessary and excessive treatment including:

a. The prescription of a diet of rice, apple, pears and barley at 19 days of age for seborrhea.

b. Treatment of seborrhea with zinc sulphate at 7 weeks of age.

c. Four doses of flu vaccine.

d. Four half doses of DTP vaccine followed by a fifth full dose.

e. 600,000 unit injection of aqueous procaine penicillin, Chlor-Trimeton 5mg., Tigan 50 mg. and atropine .2cc for a febrile illness on May 12, 1989.

f. Prescription of penicillin, 250 mg. 3h, for 1 day, then 500 mg. qid for 10 days, for strep throat on [June 12, 1991.] May 24, 1993

JA 1/3/96

g. Treatment of a febrile illness and GI upset on February 2, 1991 with Ceclor before throat culture results were read, followed by a prescription for penicillin despite negative throat culture findings.

2. Respondent ordered unnecessary and excessive testing of Patient B including:

a. 11 blood counts over the patient's first 15 months of care.

3. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient complaints, history, physical examination, diagnoses, progress notes and treatment plan.

C. Between in or about July, 1966 and in or about September 1981, Respondent treated Patient C.

1. Respondent administered unnecessary and excessive and inappropriate treatment, including:

a. Treatment with prednisone on three occasions between 5 and 9 years of age.

b. Gamma globulin, 1cc, IM, to prevent chicken pox on December 14, 1971.

D. Between in or about June, 1983 and in or about June, 1993, Respondent treated Patient D.

1. Respondent inappropriately managed well baby care and administered unnecessary and excessive treatment, including:

a. Gamma globulin, 1cc, given at 19 days, 6 weeks, 10 weeks and at 10 1/2 months of age.

b. Solids added to the infant's diet at 19 days.

c. Flu vaccine injections at three, four and five months of age.

d. DPT immunization shots given in half doses on August 29, 1983 and September 26, 1983.

e. Erythromycin and Teldrin prescribed for fifth disease on April 28, 1987.

f. Frequent antibiotic therapy despite normal findings on throat cultures.

2. Respondent ordered unnecessary and excessive testing of Patient D, including:

a. Tuberculin testing at 3, 6, 9, and 13 months.

b. 10 blood counts during the first year of life.

c. Numerous throat cultures on well baby visits.

3. Respondent failed to maintain a medical record for Patient D which accurately reflects the patient complaints, history, physical examination, diagnoses, progress notes and treatment plan.

E. Between in or about June, 1988 and in or about April 12, 1991 Respondent treated Patient E.

1. Respondent failed to make a diagnosis of Hodgkin's disease.

2. Respondent made a diagnosis of mild hypothyroidism which was not indicated.

3. Respondent failed to order laboratory tests to evaluate Patient E's thyroid.

4. Respondent prescribed L-thyroxine which was not indicated.

5. Respondent failed to order tests to monitor the Patient's L-thyroxine levels.

6. Respondent failed to maintain a medical record for Patient E which accurately reflects the patient complaints, history, physical examination, diagnoses, progress notes and treatment plan.

F. Between in or about January, 1956 and in or about December, 1993, Respondent treated Patient F.

1. Respondent improperly administered measles vaccine for the third time at patient age of 22 years.

2. Respondent repeatedly treated viral infections with prednisone which was not indicated.

3. In or about 1977 Respondent noted that Patient F was taking heroin. Respondent failed to make an appropriate referral for management of this condition.

4. Respondent frequently prescribed controlled drugs including Valium, codeine, Percodan,

Percocet and Dalmane which was not indicated in a patient with an admitted drug abuse problem.

5. Respondent administered several series of poison ivy desensitization shots which were not indicated.

6. In or about May, 1985, Respondent prescribed tetracycline for an inflamed red nare while Patient F was pregnant, which was contraindicated.

7. In or about November, 1987 Respondent recorded a diagnosis of pitting edema. Respondent failed to properly evaluate this condition.

8. Respondent failed to maintain a medical record for Patient F which accurately reflects the patient complaints, history, physical examination, diagnoses, progress notes and treatment plan.

G. Between in or about October, 1985 and in or about July, 1992, Respondent treated Patient G.

1. Patient G had chronic hepatitis and cirrhosis for which he was receiving interferon treatment

at Stony Brook Medical Center in Stony Brook, New York.

2. Respondent routinely prescribed prednisone, Valium, Percocet and Percodan which was not indicated in the presence of severe liver disease.

3. Respondent failed to coordinate his treatment of Patient G with the Stony Brook internist or hepatologist managing the patient's hepatitis.

4. Respondent failed to maintain a medical record for Patient G which accurately reflects the patient complaints, history, physical examination, diagnoses, progress notes and treatment plan.

H. On or about June 1, 1994 Respondent entered into a Consent Order with the New York State Department of Health in which he admitted violating Article 33 of the Public Health Law in that he prescribed controlled substances inappropriately and failed to maintain proper records of his controlled drug prescribing practices. The Commissioner of Health fined Respondent $2,500, of which $1,500 was

suspended upon Respondent's compliance with certain conditions.

SPECIFICATIONS OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1995), in that Petitioner charges:

1. The facts in paragraphs A and A(1)(a) through A(1)(e), A(2)(a) through A(2)(c) and A(3).

2. The facts in paragraphs B and B(1)(a) through B(1)(g), B(2)(a) and B(3).

3. The facts in paragraphs C and C(1)(a) and C(1)(b).

4. The facts in paragraphs D and D(1)(a) through D(1)(c), D(2)(a) through D(2)(c) and D(3).

5. The facts in paragraphs E and E(1) through E(6).

6. The facts in paragraphs F and F(1) through F(8).

7. The facts in paragraphs G and G(1) through G(4).

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1995), in that Petitioner charges:

8. The facts in paragraphs A and A(1)(a) through A(1)(e), A(2)(a) through A(2)(c) and A(3).

9. The facts in paragraphs B and B(1)(a) through B(1)(g), B(2)(a) and B(3).

10. The facts in paragraphs C and C(1)(a) and C(1)(b).

11. The facts in paragraphs D and D(1)(a) through D(1)(f), D(2)(a) through D(2)(c) and D(3).

12. The facts in paragraphs E and E(1) through E(6).

13. The facts in paragraphs F and F(1) through F(8).

14. The facts in paragraphs G and G(1) through G(4).

FIFTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1995) in that Petitioner charges at least two of the following:

15. The facts in paragraphs A and A(1)(a) through A(1)(e), A(2)(a) through A(2)(c) and A(3); B and B(1)(a) through B(1)(g), B(2)(a) and B(3). D and D(1)(a) through

D(1)(f), D(2)(a) through D(2)(c) and D(3); E and E(1) through E(6); F and F(1) through F(8); and G and G(1) through G(4).

SIXTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1995) by practicing the profession with negligence on more than one occasion in that Petitioner charges at least two of the following:

16. The facts in paragraphs A and A(1)(a) through A(1)(e), A(2)(a) through A(2)(c) and A(3); B and B(1)(a) through B(1)(g), B(2)(a) and B(3); D and D(1)(a) through D(1)(f), D(2)(a) through D(2)(c) and D(3); E and E(1) through E(6); F and F(1) through F(8); and G and G(1) through G(4).

SEVENTEENTH THROUGH NINTEENTH SPECIFICATIONS

ORDERING EXCESSIVE TESTS AND TREATMENT

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1995), in that he ordered escessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient. Petitioner charges:

17. The facts in paragraphs A, A(1)(a) through A(1)(e) and A(2)(a) through A(2)(c).

18. The facts in paragraphs B, B(1)(a) through B(1)(g) and B(2)(a).

19. The facts in paragraphs D, D(1)(a) through D(1)(f) and D(2)(a) through D(2)(c).

TWENTIETH THROUGH TWENTY-FIFTH SPECIFICATIONS

FAILURE TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1995), in that he failed to maintain records for patients which accurately reflect the evaluation and treatment of the patients. Petitioner charges:

20. The facts in paragraphs A and A(3).

21. The facts in paragraphs B and B(3).

22. The facts in paragraphs D and D(3).

23. The facts in paragraphs E and E(6).

24. The facts in paragraphs F and F(8).

25. The facts in paragraphs G and G(4).

TWENTY-SIXTH SPECIFICATION

HAVING BEEN FOUND IN VIOLATION OF

PUBLIC HEALTH LAW ARTICLE 33

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law Section 6530(9)(e) (McKinney Supp. 1995) in that Respondent was found by the Commissioner of Health to be in violation of Article 33 of the Public Health Law. Petitioner charges:

26. The facts in paragraphs H.

DATED: New York, New York
10/20/95

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct