STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

September 23, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Sylvia Finkelstein, Esq.
NYS Department of Health
5 Penn Plaza - 6th Floor
New York, NY 10001

Herbert Schwarz, M.D.
186 Grand View Boulevard
Yonkers, NY 10710

Donald J. Yannella, Esq.
Iannuzzi and Iannuzzi
233 Broadway
New York, NY 10279

Effective Date: 09/30/96

RE: In the Matter of Herbert Schwarz, M.D.

Dear Ms. Finkelstein, Dr. Schwarz and Mr. Yannella:

Enclosed please find the Determination and Order (No. ARB-96-61) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw

Enclosure

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

COPY

IN THE MATTER

OF

HERBERT SCHWARZ, M.D.

ADMINISTRATIVE
REVIEW BOARD
DETERMINATION
AND ORDER
ARB NO. 96-61

The Respondent **HERBERT SCHWARZ, M.D.** (Respondent) requests, pursuant to Public Health Law (PUB.H.L.) §230-c(4)(a) (McKinney's Supp. 1996), that the Administrative Review Board for Professional Medical Conduct (Board) review and vacate a March 21, 1996 Determination by a Hearing Committee on Professional Medical Conduct (Committee), which found that the Respondent had committed professional misconduct in practicing medicine and which revoked the Respondent's New York medical license. After reviewing the record in this matter and conducting deliberations on August 23, 1996, Board Members **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** vote unanimously to sustain the Hearing Committee's Determination and Penalty.

Administrative Law Judge **JAMES F. HORAN** served as the Board's Administrative Officer and drafted this Determination.

DONALD J. YANNELLA, ESQ., Ianuzzi and Ianuzzi, represented the Respondent.

SYLVIA P. FINKELSTEIN, ESQ. (Associate Counsel), represented the New York State Health Department (Petitioner).

COMMITTEE DETERMINATION ON THE CHARGES

PUB.H.L. §230(7) authorizes three member Committees from the State Board for Professional Medical Conduct (BPMC) to conduct disciplinary proceedings to determine whether physicians have committed professional misconduct by violating New York Education Law (EDUC. L.) §6530 (McKinney's Supp. 1996). The Petitioner filed charges with BPMC alleging that the Respondent, an obstetrician/gynecologist, committed professional misconduct under the following categories:

- practicing with negligence on more than one occasion, in violation of EDUC. L. §6530(3);
- practicing with gross negligence, in violation of EDUC. L. §6530(4);
- practicing with incompetence on more than one occasion, in violation of EDUC. L. §6530(5);
- failing to maintain accurate records, in violation of EDUC. L. §6530(32);
- performing a procedure not duly authorized, in violation of EDUC. L. §6530(26); and
- willful or grossly negligent failure to comply with state law governing the practice of medicine, in violation of EDUC. L. §6530(16).

The allegations related to abortions which the Respondent performed on eleven patients. The records refers to the patients by the initials A through K, to protect their privacy.

This proceeding began on August 16, 1995 through an Order by the Commissioner of Health pursuant to her authority under PUB.H.L. §230(12). The Order suspended the Respondent's medical license summarily, upon the Commissioner's finding that the Respondent's continued medical practice constituted an imminent danger to the Public Health.

Three BPMC Members, **STEPHEN A. GETTINGER, M.D. (Chair), SHARON C.H. MEAD, M.D.** and **ANTHONY SANTIAGO** comprised the Committee which conducted a hearing into the charges, pursuant to PUB.H.L. §230(10)(e), and which rendered the determination which the Board now reviews. Administrative Law Judge **LARRY G. STORCH** served as the Committee's Administrative Officer. When testimony concluded at the hearing, the Committee issued an Interim Determination to continue the Commissioner's Summary Order in effect pending the final resolution in this case.

In their Determination on the charges, the Committee found that the Respondent had committed negligence:

- by using the drug Ketamine inappropriately as the sole anesthesia agent for procedures on Patients B, C, F, G, I and J;
- by using Ketamine without training in the anesthetic or respiratory support, that is necessary when using Ketamine;
- by failing to have appropriate monitoring or resuscitative equipment that is necessary when administering general anesthesia;
- by failing to record patient vital signs during general anesthesia;

- by failing to obtain a hemoglobin or hematocrit for each named patient; and
- by failing to follow-up adequately when a pathology report for Patient C revealed an absence of products of conception, raising the possibility that Patient C had an ectopic pregnancy, which can result in hemorrhage or death. (Committee Findings of Fact 13 and 62)

The Committee found that the Respondent practiced with gross negligence in treating Patient A, and placed Patient A in grave danger by:

- failing to date the Patient's pregnancy accurately;
- inducing the abortion with a homemade saline solution in an uncertain quantity; and
- performing the abortion despite his diagnosis of placenta previa, creating a risk for hemorrhage or death. (Committee Finding of Fact 14 and 38)

The Committee found that the Respondent practiced with gross negligence in treating Patient B by:

- performing an abortion under general anesthesia, using Ketamine;
- despite Patient B's history of asthma; and
- without adequate resuscitative equipment available or personnel to use the equipment

The Committee found that the Respondent demonstrated gross negligence in treating Patient K, by inducing abortion by a saline solution, that the Respondent believed to be 12-14% in concentration, approximately 4-5 times greater than accepted concentrations, which presented an unacceptable risk to the patient.

The Committee found that the Respondent practiced with incompetence on more than one occasion and demonstrated a lack of knowledge and skills necessary to practice medicine by:

- using Ketamine as a general anesthetic, when he lacked fundamental knowledge of the drug's effect;
- failing to recognize his error in estimating the size for Patient A's fetus; and
- using homemade saline for saline induced abortions.

The Committee concluded that the Respondent failed to maintain accurate records for each Patient A through K, that the Respondent failed to record results from fetal tissue examinations in several cases, failed to note vital signs on virtually all patient records and acknowledged recording negative breast examinations, when the Respondent performed no examination. The Committee also found that the Respondent admitted to altering the record for Patient A, after Patient A was admitted to Long Island Beach Memorial Hospital hemorrhaging from her vagina.

The Committee found no cause to sustain charges that the Respondent had failed to obtain consent for procedures from Patients B and C.

The Committee concluded that the Respondent willfully or with gross negligence failed to comply with PUB.H.L. §4164(1) by performing abortions past the twentieth week of pregnancy on Patients A, E and H, without another physician present to take control of and provide immediate medical care to any live birth that resulted from the abortion. Following the Respondent's Notice of Review, the Petitioner withdrew the charges under this category relating Patients E and H. (Petitioner's Brief Exhibit A)

The Committee voted to revoke the Respondent's New York medical license, because:

- the Respondent demonstrated a pattern of negligent and incompetent practice which he was unable or unwilling to correct;
- the Respondent is an inappropriate candidate for re-education;
- the Respondent served an especially vulnerable population; and
- the Respondent's practice method placed his patients' welfare on a razor's edge.

REVIEW HISTORY AND ISSUES

The Review Board received the Respondent's notice requesting an administrative review on April 9, 1996. Pursuant to PUB.H.L. §230-c(4)(a), the Notice stayed the Committee's penalty pending this Determination from the Board, but the Notice did not stay the Commissioner's Summary Order, which has remained in effect throughout this review.

By letters dated April 18, 1996, May 31, 1996 and June 21, 1996, the Respondent requested extensions in time for filing briefs with the Board. The Petitioner did not object nor consent to the extension requests. The Board granted the Respondent extensions on each occasion, so that the final date for filing briefs became August 9, 1996. The Board granted the extensions because the Summary Suspension Order remained in effect through the review period.

The record on review consisted of the hearing transcript and exhibits, the Committee's Determination, the Respondent's brief and the Petitioner's reply brief. The Board received the Respondent's brief on August 13, 1996 and the Petitioner's reply on August 21, 1996.

The Respondent's brief argues that he poses no risk to his patients and that license revocation is an unduly harsh penalty. The Respondent challenges the investigation into his practice and the grounds for his Summary Suspension. The Petitioner alleges that bias on the Hearing Committee's part and errors at the hearing denied him due process. The Respondent also challenges the Committee's findings on factual issues and he argues that the facts in the case warrant a less severe penalty than revocation.

The Petitioner argues that the Respondent's allegations concerning the Summary Suspension are beyond the Board's review authority. The Petitioner also contends that the Respondent's challenge to the Committee's factual findings are improper attempts to relitigate matters which the Committee addressed. The Petitioner urges the Board to sustain the Committee's Determination.

THE BOARD'S REVIEW AUTHORITY

PUB.H.L. §230(10)(i), §230-c(1) and §230-c(4)(b) authorize the Board to review determinations by hearing committees for professional medical conduct and to decide:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

PUB.H.L. §230-c(4)(b) permits the Board to remand a case to the Committee for further consideration. PUB.H.L. §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board. PUB.H.L. §230-c(1) bars the Board from reviewing a Commissioner's Summary Order.

The Board has the authority to substitute our judgement for that of the Hearing Committee, in deciding upon a penalty Matter of Bogdan 195 AD 2d 86, 606 NYS 2d 381 (Third Dept. 1993), in determining guilt on the charges, Matter of Spartalis 205 AD 2d 940, 613 NYS 2d 759 (Third Dept. 1994), and in deciding credibility issues, Matter of Minielly __AD 2d__, 634 NYS 2d 856, 1995 N.Y. App. Div. LEXIS 12692 (Third Dept. 1995).

THE BOARD'S DETERMINATION

The Board has considered the record below and the party's submission. We find that the Committee's findings and conclusions support their Determination that the Respondent:

- practiced medicine with gross negligence;
- practiced with negligence on more than one occasion;
- practiced with incompetence on more than one occasion;
- failed to maintain accurate records; and
- willfully or with gross negligence, failed to comply with Public Health Law §4164(1).

The Board votes 5-0 to sustain the Committee's penalty revoking the Respondent's license. The penalty is consistent with the Committee's findings concerning the Respondent's dangerous, sub-standard practice and with the Committee's conclusion that the Respondent is unable or unwilling to alter his practice to meet acceptable practice standards. We discuss our Determination in more detail below, with emphasis on the Respondent's challenges on procedural matters, the Committee's factual findings and the penalty.

PROCEDURAL ISSUES: At pages 3 and 4 in his brief, the Respondent challenges the grounds for the Commissioner's Summary Order. The Board will not consider those arguments, because PUB.H.L. §230-c(1) bars the Board from reviewing Summary Orders.

As to the due process arguments which the Respondent raises at pages 2, 5, 6, 10, 16, 18 and 19 in his brief, concerning the investigation, charges and hearing in this matter, the Board finds that these arguments raise legal issues which are beyond the Board's review authority. The Respondent should raise those issues with the Courts.

FACTUAL FINDINGS: At pages 7 through 17 in his brief, the Respondent argues that the Committee made erroneous conclusions about the way the Respondent used Ketamine and Saline, about the Respondent's treatment for Patients A, B and K and about the gestation age for Patients A's fetus. The Respondent based his allegations on contradictory testimony from the record. The Board finds no merit in the Respondent's argument. Contradictory evidence in the record does not invalidate the Committee's findings. Contradictory evidence creates a credibility issue, which the Committee

as fact finder has the authority to resolve. The Committee's Determination indicates which evidence they found credible. The question for the Board is whether that evidence supports the Committee's Determination.

The findings by the Committee concerning the Respondent's care for Patients A, B and K support the Committee's Determination that the Respondent practiced with gross negligence in treating those Patients. The findings also support the Committee's conclusion that the Respondent used Ketamine inappropriately for general anesthesia, that the Respondent failed to have adequate resuscitative equipment or trained personnel available and that this situation presented an especially dangerous situation for Patient B. The record also supports the Committee conclusions that the Respondent placed Patients' A and K's lives in danger by inducing abortions in those Patients through a homemade saline solution of undetermined concentration and that the Respondent placed Patient A's life in danger by performing an abortion on Patient A despite the placenta previa diagnosis.

At page 11, the Respondent's brief argues that a Pathology Report erroneously estimated the fetus in Patient A's case at twenty-eight weeks gestation. The Committee, however, made no finding in their Determination that the fetus was at twenty-eight weeks gestation. The Committee concluded on Page 44 in their Determination that the Respondent performed an abortion on Patient A after twenty weeks gestation, with no other physician in attendance to provide medical care for a resulting live birth. The evidence in the record supported that finding, and the finding provided the basis for the Committee's Determination that the Respondent willfully, or with gross negligence, violated PUB.H.L. §4164(1).

The Respondent's brief at page 12 contends that the Hearing Committee erred in concluding that the Respondent falsified medical records. The Board sees no error. The Respondent's testimony admitted that he backdated progress notes in Patient A's chart and that Patient A's chart was inaccurate. (Committee Finding of Fact 44) That testimony justifies the Committee's Determination that the Respondent failed to maintain an accurate record for Patient A. The Petitioner did not charge that the Respondent committed fraud in backdating the record and the Committee made no finding relating to fraud and made no mention about fraud in discussing their penalty.

The Respondent argued, at page 17 in his brief, that the Committee erred when they found that the Respondent acted negligently by failing to record vital signs for the abortion procedures. The Respondent argued that such a requirement is unreasonable given the short duration for the procedures. The Board agrees with the Committee that accepted medical practice requires a physician to record vital signs before, during and after procedures and that failing to so record the signs constitutes negligence.

PENALTY: The Respondent argued that revocation was an excessive and harsh penalty in his case and asked that the Board impose a less severe penalty. The Board finds that the Respondent's misconduct warrants a severe sanction and that no penalty authorized under Public Health Law §230-a, other than revocation, would provide adequate public protection.

The Committee found that the Respondent placed his patient's lives at risk. The Committee and the Board are responsible to protect the public from substandard medical practice and we can not allow a physician to remain in practice, who constitutes a danger to his patients. The Board agrees with the Committee that the Respondent is an unacceptable candidate for retraining. Retraining can correct only limited deficiencies in practice. The evidence demonstrated that the Respondent practiced at a level dangerously below acceptable medical practice. The Respondent also demonstrated that he was unwilling to admit mistakes and unable to meet acceptable standards for practice. The Respondent failed or refused to correct deficiencies in his practice after an earlier disciplinary proceeding against him. The Board has no reason to believe that the Respondent would not return to his same substandard practice pattern, if we allowed him to return to practice. The Board votes 5-0 to sustain the Committee's Determination revoking the Respondent's license to practice medicine in New York State.

ORDER

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

1. The Board **SUSTAINS** the Hearing Committee's March 21, 1996 Determination finding the Respondent guilty for professional misconduct.

2. The Board **SUSTAINS** the Committee's Determination to revoke the Respondent's license to practice medicine in New York State.

ROBERT M. BRIBER
SUMNER SHAPIRO
WINSTON S. PRICE, M.D.
EDWARD SINNOTT, M.D.
WILLIAM A. STEWART, M.D.

IN THE MATTER OF HERBERT SCHWARZ, M.D.

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

DATED: Schenectady, New York
Sept 20 , **1996**

ROBERT M. BRIBER

IN THE MATTER OF HERBERT SCHWARZ, M.D.

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

DATED: Delmar, New York

Sept. 20, **1996**

SUMNER SHAPIRO

IN THE MATTER OF HERBERT SCHWARZ, M.D.

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

DATED: Brooklyn, New York

SEPT 20, **1996**

WINSTON S. PRICE, M.D.

IN THE MATTER OF HERBERT SCHWARZ, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Schwarz.

DATED: Roslyn, New York
9/20, **1996**

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF HERBERT SCHWARZ, M.D.

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

DATED: Syracuse, New York
20 Sept., **1996**

William A Stewart

WILLIAM A. STEWART, M.D.