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

Karen Schimke
Executive Deputy Commissioner

March 21, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Silvia P. Finkelstein, Esq.
Associate Counsel
NYS Dept. of Health
5 Penn Plaza-6th Floor
New York, New York 10001

Nathan L. Dembin, Esq.
Nathan L. Dembin & Assoc., P.C.
225 Broadway-Suite 1905
New York, New York 10007

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

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

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

Enclosed please find the Determination and Order (No. 96-61) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

COPY

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

IN THE MATTER	DETERMINATION
OF	AND
HERBERT SCHWARZ, M.D.	ORDER

BPMC-96-61

A Commissioner's Order and Notice of Hearing, dated August 16, 1995 and a Statement of Charges, dated August 15, 1995, were served upon the Respondent, Herbert Schwarz, M.D. **STEPHEN A. GETTINGER, M.D. (Chair), SHARON C.H. MEAD, M.D., and ANTHONY SANTIAGO,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Silvia P. Finkelstein, Esq., Associate Counsel. The Respondent appeared by Nathan L. Dembin, Esq. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	August 16, 1995
Answer to Statement of Charges:	None
Pre-Hearing Conference:	August 24, 1995
Dates of Hearings:	
Received Petitioner's Proposed	

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Findings of Fact, Conclusions of Law and Recommendation:	November 29, 1995
Received Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendation:	November 30, 1995
Witnesses for Department of Health:	Richard Hausknecht, M.D. Michael Block, M.D. Howard Bernstein, M.D. Patient A Patient G Marion Norman, R.N.
Witnesses for Respondent:	Anthony Mustalish, M.D. Vincent Merendino, M.D. Herbert Schwarz, M.D. Ivette Ortiz
Deliberations Held:	December 8, 1995 January 18, 1996

STATEMENT OF CASE

By an Order dated August 16, 1995, the Commissioner of Health summarily suspended the medical license of Respondent, Herbert Schwarz, M.D. upon a finding that Respondent's continued practice of medicine constituted an imminent danger to the health of the people of this state. Following the conclusion of testimony, the Hearing Committee unanimously determined that the summary suspension should remain in effect pending the final resolution of this matter.

Respondent is an obstetrician/gynecologist. The Department charged Respondent with twenty-seven specifications of professional misconduct, relating to Respondent's performance of abortions upon eleven patients. The charges include allegations of negligence on more than one occasion, gross negligence, incompetence on more than one occasion, failure to maintain

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accurate records, performing professional services not duly authorized by the patient, and willful or grossly negligent failure to comply with state law governing the practice of medicine.

Copies of the Commissioner's Order and Notice of Hearing and the Statement of Charges are attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Herbert Schwarz, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State on or about September 14, 1963, by the issuance of license number 091304 by the New York State Education Department. Respondent's license was suspended by action of the Board of Regents from September 24, 1982 through March 23, 1983, and was thereafter placed on probation for a period of eighteen months. The period of probation ended on September 23, 1984. Respondent is currently registered with the New York State Education Department to practice medicine. (Dept. Ex. #2).

2. At all times mentioned, Respondent was an obstetrician/gynecologist and maintained a private practice at 65

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East 96th Street, New York, New York. (T623).

3. The basic standards of care relevant to the performance of abortions are the same regardless of the setting where the procedure is performed. The setting does not determine the standards of care. (T142-143).

4. A diagnosis of pregnancy is established through a detailed history and appropriate physical examination, laboratory tests and/or sonography when necessary. (T21-22). A diagnosis of pregnancy may be confirmed by the presence of a fetal heart or sonographic visualization of the embryo. (T22).

5. The age of a pregnancy is generally calculated in weeks from the date of the last menstrual period. There is a direct correlation between uterine size and the duration of the pregnancy. At 22 weeks or more of gestation, it is the standard of care to determine the age of the gestation by sonographic examination in which the biparietal diameter and femur length are measured. (T24, 57-58, 505-506).

6. An adequate physical examination for a physician contemplating the performance of an abortion would include, at a minimum, an abdominal examination and a bimanual pelvic examination to ascertain the size and orientation of the uterus. (T23-24).

7. Prior to the performance of a termination of pregnancy, certain diagnostic and laboratory tests must be performed. The Rh factor of the patient must be determined. The patient's hemoglobin and/or hematocrit must also be ascertained by means of a blood test. (T25-26, 37, 508-510).

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8. Respondent testified that he never did a hematocrit or a hemoglobin test on a patient coming in for an abortion, relying on the Model Standards of the National Abortion Federation. (T1309, 1772-1773; Ex. 20).

9. The standard of care for the performance of termination of pregnancy requires that the patient be properly counselled. At a minimum, adequate counselling would include ensuring that the patient understands the procedure being contemplated, and that the patient understands the risks and complications associated with the procedure. In addition, family planning, which may be done after the procedure, should include a discussion about contraceptive methods and the prevention of unwanted pregnancies in the future. (T20-21, 496).

10. The standard of care for the performance of the termination of pregnancy requires that the physician obtain consent from the patient before performing the procedure. (T41-42).

11. It is the standard of care in the performance of abortions that all tissue removed be examined to verify that villi or fetal parts are present. If villi or fetal parts cannot be identified with certainty, the tissue specimen should be sent for further pathologic examination. In a second trimester, abortion, if all body parts and placenta are found on examination, it would not be considered substandard to omit an outside pathology report. The person performing the gross examination should document the findings in the patient's chart. Products of conception should be disposed of in compliance with

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federal, state and local requirements. (T502; Dept. Ex. #19; Dept. Ex. #20).

12. The standard of care in the performance of abortions requires that the physician follow up on any patient upon whom he has performed an abortion. The follow-up consists of a review of the pathology report, if any; review of post-abortion symptoms and discussion of contraceptive methods. (T45-46).

13. An ectopic pregnancy is a pregnancy that is in some location other than the uterine cavity. The major risks associated with ectopic pregnancy are hemorrhage and death. When a patient has a positive pregnancy test and there is an absence of chorionic villi in the tissue removed, an ectopic pregnancy can be strongly suspected. A suspicion of ectopic pregnancy calls for immediate action on the part of the physician. This action may include sonographic examination to locate the pregnancy and/or laparoscopy. It is a deviation from acceptable standards of medical practice not to follow up on a suspected ectopic pregnancy. (T48-49).

14. The condition known as placenta previa exists when the placenta overlies the internal os of the uterus. A "central" placenta previa totally covers the opening of the uterine cavity. Placenta previa can diagnosed by ultrasound or by feeling it on pelvic examination. It is a serious deviation from acceptable standards of medical practice to attempt a termination of pregnancy on a patient suffering from placenta previa, in an office setting; the patient would be exposed to an enormous risk

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of hemorrhage. (T50, 65-66, 74, 350, 506-507).

15. A reasonably prudent physician who performs an abortion keeps accurate medical records reflecting the treatment rendered. At minimum, the medical record should contain the patient's history, findings of physical examination, results of laboratory tests, and consent forms. In addition, the record should contain an operative note which should include confirmation of gestational age, the instruments used to dilate the cervix (if any), the size of the cervical dilators, the size of the cannula, the instruments used to remove the pregnancy, the type and amount of tissue removed, and the amount of estimated blood loss. If local anesthesia is used, the chart should indicate the type of anesthetic agent used, as well as the amount and method of administration. If general anesthesia is used, a formal anesthesia chart should be kept, reflecting the patient's vital signs (blood pressure, pulse and respiration) before the administration of anesthesia. The same vital signs would be recorded during the procedure and once the anesthesia has concluded. (T42-45; 1739-1740).

16. The only vital signs recorded in any of the patient records at issue in this hearing were blood pressures. No findings regarding pulse, temperature, or respiration were noted in any of the charts. (Pet. Ex. ## 3, 5-14).

17. The standards of care relevant to the administration of anesthesia are dependent on the drug that is being administered and the purpose for its administration. The setting does not determine the standard of care. There is no

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distinction between anesthesia given in an ambulatory surgical unit and a physician's private office. The risks associated with a substance are identical regardless of the location of administration. Consequently, the standards of care are identical. (T1580).

18. It is acceptable medical practice to perform a first trimester abortion under local anesthesia. The administration of general anesthesia inherently carries more risks than the administration of local anesthesia. Those risks include, but are not limited to, respiratory depression or respiratory complication, sudden drop in blood pressure, and aspiration of stomach contents. If the patient prefers general anesthesia, it should be administered by an anesthesiologist or a certified registered nurse anesthetist trained to monitor the patient's vital signs during the procedure and to attend to respiratory complications. (T27, 36-37, 41, 1289-1290, 1591-1592, 1594-1595, 1656).

19. Prior to the administration of general anesthesia, acceptable standards of practice require that the physician obtain a history from the patient including, but not limited to, existing medical conditions that would increase the risks associated with general anesthesia. These conditions include cardiac illness, history of past anesthesia, and previous pulmonary disease. In addition, in patients over the age of 35, certain laboratory tests would be necessary, including a complete blood count, chest x-ray, and electrocardiogram. (T37-38).

20. Ketamine (Ketelar) is an anesthetic agent with

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very potent analgesic properties. It is generally used for the induction of general anesthesia. Ketamine may also be used as a sole anesthetic agent for short procedures not requiring skeletal relaxation. The risks associated with Ketamine include loss of airway reflexes, loss of consciousness, apnea, hallucinations, and aspiration of stomach contents. Ketamine may affect the patient's gag and swallow reflexes. (T39-40, 930, 1556, 1582-1583, 1585, 1588, 1594-1594, 1632-1634, 1653-1654, 1657-1658).

21. Pregnant patients must be considered a "full stomach" for purposes of administration. Pregnant women have delayed emptying of their stomachs. This increases the risk for passive regurgitation and aspiration. (T1591).

22. The proper dosage of Ketamine varies depending on the patient's individual response. The drug should be titrated against the patient's requirements. The initial dose to produce anesthesia ranges between 1-2 mg/kg of body weight (0.5-1 mg/lb). The dosage range for conscious sedation is 0.125-0.250 mg/lb. (T1583-1584, 1587; Pet. Ex. #16).

23. Ketamine should be used by medical personnel trained in the ability to handle airway obstruction and to control respiration. While using Ketamine, blood pressure, pulse and respiration should be monitored. Oxygen saturation should be monitored with a pulse oximeter. (T1594, 1654).

24. Respondent maintains that he uses a very small dose of Ketamine (30-50 mg) which is not enough to induce anesthesia, but which produces a state called conscious sedation. Respondent states that this dose is so small, that he can use it

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with great safety. Respondent does not have medically trained personnel monitoring the patient during the abortion procedures, but has personnel trained "on the job" in the room with him. (T982, 1158).

25. The safety of Respondent's technique has not been documented in the medical literature. (T1371).

26. Respondent has had no training in anesthesia or respiratory support. It is a deviation from accepted standards of medical practice for the surgeon to administer a general anesthetic, monitor the patient and perform the surgery. (T1272-1273, 1595, 1659).

27. A reasonably prudent physician performing second trimester abortions in an out-patient facility must have means of maintaining the cardiovascular status of the patient by monitoring pulse and blood pressure continuously and must have the means of maintaining blood volume either by crystalloid or a combination of crystalloid and albumin. (T498-499, 915).

28. Adequate resuscitative and monitoring equipment must be available when general anesthesia is being administered, including oxygen, endotracheal tubing, and pulse oximetry. In addition, intravenous equipment and fluids must be maintained and crystalloid and/or albumin for emergency maintenance of cardiovascular status in the event of very heavy bleeding. (T40-41, 498-499, 1594-1595).

29. The record indicates that Respondent had a cardiac monitor, a defibrillator and oxygen equipment. The defibrillator paddles were kept separate from the actual defibrillator.

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Photographs of Respondent's "crash cart", taken by Department of Social Services (DSS) investigators demonstrate that the equipment was in such disarray as to render it unavailable in an emergency. Moreover, none of Respondent's staff had any training in operating any of the emergency equipment. (T862-863, 878-880, 990, 1524; Pet. Ex.#15A).

30. When the method of termination of pregnancy is saline infusion, a 3% concentration of saline is injected in the amniotic cavity. The standard of medical practice requires that the concentration of saline and the total volume injected be noted in the chart. There are severe risks associated with injection of saline concentration into the muscular wall or the peritoneal cavity. These risks include chemical peritonitis; rapid rise of sodium levels in the patient's blood (hypernatremia); or a sudden drop in potassium which can result in severe arrhythmia. (T134-136).

31. Respondent prepares his own saline concentration in a pressure cooker in his office. He makes what he believes to be a 12-14% salt concentration solution which he uses for intrauterine saline infusions. Respondent's concentration of saline appears to be 4-5 times greater than the standard 3% concentration. (T1070-1071).

32. When performing a termination by means of a saline infusion, it is the standard of practice to note the patient's vital signs, the concentration of the saline solution, and the total volume injected. (T134-135).

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Patient A

33. Respondent treated Patient A, age 36, on or about March 16, 1995, March 17, 1995, March 19, 1995, and/or March 20, 1995 at his office located at 65 East 96th Street, New York 10128. (Pet. Ex. #3).

34. Respondent obtained and documented a complete medical history for this patient. (T56).

35. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as Respondent failed to obtain a hemoglobin and/or hematocrit. (T37, 1508).

36. The informed consent form (available in English or Spanish, as needed), contained all of the minimum requirements of appropriate counselling with respect to the termination of pregnancy. The form contained in Patient A's medical record indicates that it was initialled and signed by Patient A and countersigned by Respondent. Respondent discussed the various options with the patient. (T57, 183; Pet. Ex. #3).

37. Respondent failed to correctly evaluate the fetal age prior to attempting to terminate Patient A's pregnancy. Respondent recorded the diagnosis of a 22 week gestation. He told Patient A that it was a 21 week gestation. He testified at the hearing that he considered it to be a 24.5 week gestation, although that is not what he recorded on the chart. Despite the discrepancy between the estimated period of gestation (22 weeks) and the weight of the fetus subsequently delivered (890 grams), Respondent still maintained that with his expertise, his estimate could only be several days to one week off. Copies of the

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sonogram attached to the chart and admitted into evidence, cannot be interpreted. (T56, 58, 156, 1034, 1095; Pet. Ex. #3).

38. Despite the fact that Patient A evidenced placenta previa, Respondent failed to adequately address said condition. Although Respondent had diagnosed placenta previa and noted it in the patient's chart, he nevertheless proceeded to perform a termination of pregnancy. This exposed Patient A to grave risk of hemorrhage and death. (T55-56, 64, 65-66, 74-76, 350-351, 477-478).

39. Public Health Law §4164(1) mandates that when an abortion is to be performed after the 20th week of pregnancy, a physician other than the physician performing the abortion shall be in attendance to take control of and to provide immediate medical care for any live birth that is the result of the abortion.

40. On or about March 16, March 17 through March 19, and/or March 20, 1995, Respondent attempted to terminate a second trimester pregnancy, in his office. Respondent acted without adequate resuscitative equipment available and in the absence of clinical support personnel, including another physician, as mandated by P.H.L. §4164(1). (T158-164, 810-811, 878-879, 880-881, 888-889; Pet. Ex. #3; Pet. Ex. #15-A(1)).

41. Respondent failed to take or note in the chart Patient A's vital signs prior, or during the attempts to terminate Patient A's pregnancy. (T1739-1740; Pet. Ex. #3).

42. On or about March 16, 1995 Respondent inserted three laminaria and sent the patient home. On or about March 17,

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1995, Respondent inserted another laminaria and gave the patient a Prostin suppository with instructions to self-insert it at bedtime. On or about March 18, 1995, the patient returned to Respondent's office and was given another Prostin suppository to be self-inserted at bedtime. The patient was sent home with instructions that if the abortion happened she should bring the conception material back to Respondent's office in two plastic bags. On or about March 20, 1995, Patient A returned to Respondent's office at which time Respondent made several attempts to place a needle in the amniotic sac before he succeeded in injecting an unknown amount of saline. Respondent noted some bleeding during these attempts; he sent the patient home. The chart reflects that the substance injected was prostaglandin. (T55, 158-165, 890-891, 1070, 1271-1272; Pet. Ex. #3).

43. On or about March 21, 1995, Patient A was admitted at Long Beach Memorial Hospital's Emergency Department, hemorrhaging from her vagina. Respondent confirmed on the telephone to Dr. Michael Block, the treating physician at Long Beach, that Patient A was suffering from placenta previa. Patient A was transfused during the performance of an emergency hysterotomy. Dr. Block found a complete placental abruption and fetal demise of a 26-28 week-size fetus. (T44, 62-64, 549-550, 566, 568-571, 1380-1381, 1452-1454, 1505-1506, 1522, 1536-1537, 1685; Pet. Ex. #4, pp. 7, 13-14, 51-52).

44. Respondent testified that he changed the medical record he kept for Patient A. Respondent testified that he

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"backdated" progress notes in Patient A's chart and that he had not made a diagnosis of placenta previa prior to this discussion with Dr. Block. Respondent testified that he dated Patient A's pregnancy at 24 weeks, yet he knowingly wrote 22 weeks in the medical record. Respondent testified that Patient A's chart is inaccurate. (T1388-1392, 1787-1794).

45. Respondent deviated from acceptable standards of medical practice in the care he rendered to Patient A in that he failed to correctly determine the age of the pregnancy prior to performing an abortion. On the first date of treatment, March 16, 1995, Respondent noted the need to rule out placenta previa, yet he proceeded with the clinical steps to bring on an abortion. Respondent failed to correctly interpret a sonogram to ascertain the patient's condition prior to commencing the abortional process. On March 20, 1995, Respondent noted confirmation of the diagnosis of placenta previa in Patient A's chart. Respondent failed to take immediate steps to address the patient's condition. Instead, Respondent continued the abortion process by injecting into her amniotic sac what he believed to be a 12-14% concentrated saline solution prepared in a pressure cooker in his office. Respondent failed to admit Patient A to a hospital for immediate care. (T75-76, 895-898, 1071-1072, 1271-1272).

Patient B

46. Respondent treated Patient B, age 14, on or about February 6 and/or February 7, 1995, at his office located at 65 East 96th Street, New York. Respondent dated Patient B's pregnancy at 14.2 weeks. (T78; Pet. Ex. #5).

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47. At all the dates above mentioned, Respondent failed to obtain and note an adequate medical history. (T79-80; Pet. Ex. #5).

48. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as Respondent failed to obtain a hemoglobin and/or hematocrit. (T80-81).

49. The record does not contain a signed consent form. However, Respondent testified that the patient was counselled and gave informed consent for the procedure. (T1140; Pet. Ex.#5).

50. On or about February 7, 1995, Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the abortion. (T1180-1182, 1740; Pet. Ex. #5).

51. Although Respondent knew that Patient B had a history of asthma, he administered general anesthesia by injecting Ketalar *via* IV push, in the absence of adequate resuscitative equipment. (T40-41, 81-82, 86, 498, 1594-1595).

52. Respondent noted the timing (12:55 p.m.) and amount of anesthetic agent (50 mg IV Ketalar) administered to this patient. (T1146; Pet. Ex. #5).

53. Respondent deviated from acceptable standards of medical practice in that he failed to document an examination of the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about February 7, 1995. Respondent testified that he confirmed the existence of products of conception. However, the chart contains no description of the products of conception obtained.

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(T83, 1146; Pet. Ex. #5-A).

54. Respondent deviated from acceptable standards of medical practice with respect to the treatment rendered to Patient B in that he administered general anesthesia to a 14 year-old child with a history of asthma without monitoring her oxygen saturation. (T86).

Patient C

55. Respondent treated Patient C, age 18, on or about November 17, 1994 at his office located at 65 East 96th Street, New York. (T89; Pet. Ex. #6).

56. Respondent obtained a minimally adequate medical history. (T90, 399-401).

57. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as he failed to obtain a hemoglobin and/or hematocrit. (T90-91).

58. The informed consent form contained all of the minimum requirements of appropriate counselling with respect to the termination of pregnancy. The form contained in Patient C's medical record indicates that it was initialled and signed by the patient and countersigned by Respondent. (Pet. Ex.#6).

59. On or about November 17, 1994, Respondent failed to take or note in the chart vital signs of the patient prior, during and subsequent to the termination of pregnancy. (T1180-1182, 1739-1740; Pet. Ex. #6).

60. Respondent administered general anesthesia to this patient by injecting Ketalar *via* IV push, in the absence of adequate resuscitative equipment. (T40-41, 90, 498, 1594-1595).

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61. Respondent referred the tissue to a pathology laboratory for gross and microscopic evaluation to determine that all of the necessary products of conception were removed during the termination of pregnancy. (T92-93, 402-403; Pet. Ex. #6).

62. The pathology report indicated that Patient C was at risk for an ectopic pregnancy. Although he notified the patient of her condition, Respondent failed to adequately treat and/or follow-up on this potentially life-threatening condition. ((T92-94, 1164, 1179, 1539-1540, 1742; Pet. Ex. #6; ALJ Ex. #1).

Patient D

63. Respondent treated Patient D, age 16, on or about December 5, 1994, at his office located at 65 East 96th Street, New York. (T95; Pet. Ex. #7).

64. Respondent obtained a minimally acceptable medical history. (T448, 513; Pet. Ex. #7).

65. There is a discrepancy between the patient's date of her last menstrual period (LMP) and the gestational age by sonography. The chart maintained by Respondent indicates that Patient D's last menstrual period occurred on July 17, 1994. By dates, Patient D's gestation would be at 21 weeks. Respondent dated the pregnancy at 18 weeks by sonography. Sonography is considered a more reliable measure of gestational age than menstrual history. ((T25, 102; Pet. Ex.#7).

66. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as he failed to obtain a hemoglobin and/or hematocrit. (T96, 100-101).

67. The informed consent form contained all of the

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minimum requirements of appropriate counselling with respect to the termination of pregnancy. The form contained in Patient D's medical record indicates that it was initialled and signed by the patient and countersigned by Respondent. (Pet. Ex.#7).

68. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy. (T100-101, 1180-1182).

69. The medical record indicates that laminaria were inserted and that the abortion procedure was completed by "mechanical help". Respondent testified that the phrase "mechanical help" indicates that forceps were used to remove fetal tissue. (T1374-1375; Pet. Ex. #7).

70. Respondent testified that he did not administer an anesthetic to Patient D, nor is there any evidence in the chart that indicates that any anesthetic was administered to the patient. (T1209; Pet. Ex. #7).

71. Respondent testified that he examined the tissue to determine that all of the necessary products of conception were removed during the abortion. The Department's expert, Dr. Hausknecht, testified that there is no evidence that Respondent failed to evaluate the tissue. However, Respondent failed to document the evaluation of tissue. (T99, 452, 1214; Pet. Ex.#7).

Patient E

72. Respondent treated Patient E, age 16, on or about December 4, 1994, December 5, 1994, December 6, 1994 and/or December 20, 1994, at his office located at East 96th Street, New York. (T101; Pet. Ex. #8).

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73. Respondent obtained a minimally acceptable medical history. (T453, 513; Pet. Ex. #8).

74. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as he failed to obtain a hemoglobin and/or hematocrit. (T107).

75. On or about December 6, 1994, Respondent terminated Patient E's 21 week pregnancy with the aid of "mechanical help", in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel, within the meaning of P.H.L. §4164(1). (T104, 805-806, 878-879; Pet. Ex. #8).

76. Respondent noted in the chart that laminaria and mechanical help were used in the termination of the patient's pregnancy on or about December 6, 1994. Respondent previously testified that the entry "mechanical help" indicated that forceps were used to remove fetal tissue.(T1374-1375; Pet. Ex. #8).

77. Respondent failed to take or note in the chart vital signs of the patient prior, during and subsequent to the termination of Patient E's pregnancy. (T105-106, 1180-1182).

78. No anesthesia was administered to Patient E in conjunction with the abortion procedure. (T1223; Pet. Ex. #8).

79. Respondent failed to document that he evaluated the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy. Respondent testified that he did evaluate the tissue, but did not document the results of the examination. (T106, 1225; Pet. Ex. #8).

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Patient F

80. Respondent treated Patient F, age 23, on or about May 17, 1995 and May 18, 1995, at his office located at 65 East 96th Street, New York. (T107; Pet. Ex. #9).

81. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as he failed to obtain a hemoglobin and/or hematocrit. (T110; Pet. Ex. #9).

82. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of Patient F's pregnancy. (T1180-1182; Pet. Ex.#9).

83. Respondent administered general anesthesia to this patient by injecting Ketalar *via* IV push, in the absence of adequate resuscitative equipment. (T40-41, 109-110, 498, 1594-1595).

84. Respondent failed to note the timing and amount of anesthetic agent administered to the patient. (T111, 1401-1402; Pet. Ex. #9).

85. Respondent failed to document an evaluation of the tissue to determine that all necessary products of conception were removed during the termination of pregnancy on or about May 18, 1995. Respondent testified that he did evaluate the tissue, but did not document it. (T110, 452, 1234; Pet. Ex. #9).

Patient G

86. Respondent treated Patient G, age 30, on or about May 10, 1995, at his office located at 65 East 96th Street, New York. (T111; Pet. Ex. #10).

87. Respondent failed to perform necessary laboratory

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and/or diagnostic tests upon this patient, insofar as he failed to obtain a hemoglobin and/or hematocrit. (T113, 232-244; Pet. Ex. #10).

88. There is a discrepancy between the patient's date of LMP and the gestational age by sonography. The chart indicates that Patient G's last menstrual period occurred on or about April 14, 1995. By dates, the pregnancy would have been 5 weeks old on May 10, 1995. Respondent dated the pregnancy by sonography at 14.5 weeks. (T112, 462-463, 1236; Pet. Ex. #10).

89. The informed consent form contained all of the minimum requirements of appropriate counselling with respect to the termination of pregnancy. The form contained in Patient G's medical record indicates that it was initialled and signed by the patient and countersigned by Respondent. (Pet. Ex. #10).

90. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy. (T114, 1180-1182; Pet. Ex. #10).

91. Respondent administered general anesthesia to the patient by injecting 50 mg of Ketalar *via* IV push, in the absence of adequate resuscitative equipment. (T113; Pet. Ex. #10).

92. Respondent failed to document an evaluation of the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about May 10, 1995. Respondent testified that he did evaluate the tissue, but did not document the results of the evaluation. (T452, 1242; Pet. Ex. #10).

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Patient H

93. Respondent treated Patient H, age 17, on or about November 26, 1994, December 5, 1994 and/or December 6, 1994, at his office located at 65 East 96th Street, New York. (T115; Pet. Ex. #11).

94. Respondent dated this pregnancy by sonography as being 21.3 weeks. The sonogram contained in the patient's chart cannot be identified as belonging to Patient H. (T117-118; Pet. Ex. #11).

95. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as Respondent failed to obtain a hemoglobin and/or hematocrit. (T118).

96. On or about December 6, 1994, Respondent terminated the patient's 21 week pregnancy in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel within the meaning of P.H.L. §4164(1). (T805-806, 887).

97. The record indicates that laminaria were inserted to dilate the patient's cervix and that the patient aborted. However, Respondent failed to document the procedure performed on the patient on or about December 6, 1994. (T466-467; Pet. Ex.#11).

98. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy. (T119).

99. There is no indication in the patient's chart as to the timing, type and amount of anesthetic agent administered

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to the patient. However, Respondent testified that no anesthetic was used. (T1245; Pet. Ex. #11).

100. According to a pathology report dated February 21, 1995, Respondent submitted endometrial curettings and fetal parts for analysis. However, Department of Social Services (DSS) investigators inspected Respondent's office in March, 1995. They found a jar containing fetal parts with Patient H's name on the jar. Respondent testified that he evaluated the tissue but failed to document the results of that evaluation. (T452, 662, 1246; Pet. Ex. #11).

Patient I

101. Respondent treated Patient I, age 18, on or about April 6, 1995 and April 7, 1995, at his office located at 65 East 96th Street, New York. (T120; Pet. Ex.#12).

102. Respondent failed to perform necessary laboratory and/or diagnostic tests upon the patient, insofar as Respondent failed to obtain a hemoglobin and/or hematocrit. The sonogram contained in the patient's medical record cannot be identified as belonging to Patient I; it contains no date, no name, and no measurement is noted. The date of Patient I's last menstrual period is not noted in the chart. Respondent dated the pregnancy as being 16-17 weeks. (T122-124; Pet. Ex. #12).

103. On or about April 6 or April 7, 1995, Respondent terminated the patient's 17 week pregnancy under general anesthesia in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel. (T499, 774-775, 805-806, 887).

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104. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy. (T124, 126, 1180-1182, 1739-1740).

105. Respondent administered general anesthesia to this patient by injecting 30 mg of Ketalar *via* IV push, in the absence of adequate resuscitative equipment. (T498, 805-806, 878-879, 887, 1594-1595).

106. Respondent testified that he evaluated the tissue to determined that all of the necessary products of conception were removed during the termination of pregnancy on or about April 6 or April 7, 1995. Respondent did not document the results of his evaluation. Respondent kept the fetal parts obtained from this abortion in a jar in his office. (T452, 662, 1251; Pet. Ex. #12).

Patient J

107. Respondent treated Patient J, age 36, on or about May 3 or May 9, May 10 and May 11, 1995, at his office located at East 96th Street, New York. (T126; Pet. Ex. #13).

108. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as he failed to obtain a hemoglobin and/or hematocrit. Respondent dated the pregnancy as 16.5 weeks. (T132; Pet. Ex. #13).

109. Respondent was aware that Patient J was Rh negative, and administered Rhogam before terminating the patient's pregnancy. (T131, 1251; Pet. Ex. #13).

110. Respondent terminated the patient's 18 week pregnancy under general anesthesia in his office, without

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adequate resuscitative equipment available and in the absence of clinical support personnel. (T498, 805-806, 878-879, 887, 1594-1595).

111. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy. (T132, 1180-1182, 1739-1740; Pet. Ex. #13).

112. Respondent administered general anesthesia to this patient by injecting Ketalar *via* IV push, in the absence of adequate resuscitative equipment. (T498, 805-806, 878-879, 887, 1594-15950.

113. Respondent testified that he evaluated the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy. He further testified that he did not document the results of his evaluation. Respondent kept the fetal parts obtained from this abortion in a jar in his office. (T452, 662, 1257; Pet. Ex. #13).

Patient K

114. Respondent treated Patient K, age 20, on or about May 22 and May 23, 1995, at his office located at 65 East 96th Street, New York. (T133; Pet. Ex. #14).

115. Respondent obtained a minimally acceptable medical history. (T453, 513; Pet. Ex. #14).

116. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient, insofar as he failed to obtain a hemoglobin and/or hematocrit. (T139; Pet. Ex. #14).

117. On or about May 22 and/or May 23, 1995, Respondent

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terminated an approximately 18 week pregnancy in his office, by infusion of what Respondent believed to be a 12-14% saline solution prepared by Respondent in a pressure cooker in his office. The pregnancy was terminated without adequate resuscitative equipment available to treat excessive hypernatremia which may result from such infusion. (T133-139).

118. Respondent failed to document the saline concentration and the volume infused into Patient K. (T133-135; Pet. Ex. #14).

119. Respondent failed to take or note in the chart vital signs of the patient prior, during and subsequent to the termination of pregnancy. (T138; Pet. Ex. #14).

120. The patient's medical record does not contain documentation concerning the timing, type and amount of anesthetic agent administered to the patient, if any. Respondent testified that he did not administer any anesthetic to the patient. (T1259; Pet. Ex. #14).

121. Respondent testified that he evaluated the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy. Respondent failed to document the results of the evaluation. He kept the fetal parts obtained from this abortion in a jar in his office. (T452, 662, 1263; Pet. Ex. #14).

Medical Records

122. Respondent failed to keep medical records which accurately represent the conditions of his patients and the care rendered to them. (Pet. Ex. ##3, 5-14).

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CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A: (33-45);

Paragraph A.2: (7,35);

Paragraph A.4: (37);

Paragraph A.5: (14, 38);

Paragraph A.6: (23, 26-29, 40);

Paragraph A.7: (41);

Paragraph A.8, except for the allegations that the patient was inappropriately sent home, and that the patient was admitted to Long Beach Memorial Hospital's Emergency Department, febrile and in shock, which are not sustained: (42-45);

Paragraph B: (46-54);

Paragraph B.1: (47);

Paragraph B.2: (48);

Paragraph B.5: (15-16, 50);

Paragraph B.6: (23, 26-29, 51);

Paragraph C: (55-62);

Paragraph C.2: (57);

Paragraph C.5. (15-16, 59);

Paragraph C.6: (13, 61-62);

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Paragraph C.7: (23, 26-29, 60);

Paragraph D: (63-71);

Paragraph D.2: (66);

Paragraph D.4: (16, 68);

Paragraph E: (72-79);

Paragraph E.2: (74);

Paragraph E.3: (23, 26-29, 75);

Paragraph E.5: (77);

Paragraph F: (80-85);

Paragraph F.1: (81);

Paragraph F.2: (82);

Paragraph F.3: (23, 26-29, 83);

Paragraph F.4: (84);

Paragraph G: (86-92);

Paragraph G.1: (87);

Paragraph G.4: (15-16, 90);

Paragraph G.5: (23, 26-29, 91);

Paragraph H: (93-100);

Paragraph H.1: (95);

Paragraph H.2: (23, 26-29, 96);

Paragraph H.3: (97);

Paragraph H.4: (98);

Paragraph I: (101-106);

Paragraph I.1: (102);

Paragraph I.2: (23, 26-29, 103-105);

Paragraph I.3: (15-16, 104);

Paragraph I.4: (23, 26-29, 105);

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Paragraph J: (107-113);

Paragraph J.1: (108);

Paragraph J.3: (15-16, 111);

Paragraph J.4: (23, 26-29, 112);

Paragraph K: (114-121);

Paragraph K.2: (116);

Paragraph K.3: (29-32, 117-118);

Paragraph K.4: (15-16, 119).

The Hearing Committee further concluded that the following Factual Allegations should not be sustained:

Paragraph A.1;

Paragraph A.3;

Paragraph B.3;

Paragraph B.4;

Paragraph B.7;

Paragraph B.8;

Paragraph C.1;

Paragraph C.3;

Paragraph C.8;

Paragraph D.1;

Paragraph D.3;

Paragraph D.5;

Paragraph D.6;

Paragraph D.7;

Paragraph D.8;

Paragraph E.1;

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Paragraph E.4;

Paragraph E.6;

Paragraph E.7;

Paragraph F.5;

Paragraph G.2;

Paragraph G.3;

Paragraph G.6;

Paragraph H.5;

Paragraph H.6;

Paragraph I.5;

Paragraph J.2;

Paragraph J.5;

Paragraph K.1;

Paragraph K.5;

Paragraph K.6.[1]

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each Specification:

First Specification: (Paragraphs A, A.2, A.4, A.5, A.6, A.7, A.8, B, B.1, B.2, B.5, B.6, C, C.2, C.5, C.6, C.7, D, D.2, D.4, E, E.2, E.3, E.5, F, F.1, F.2, F.3, F.4, G, G.1, G.4, G.5, H, H.1, H.2, H.3, H.4, I, I.1,

[1]Factual Allegation C.4 was withdrawn by Petitioner during the course of the proceedings, and was not considered by the Hearing Committee in its deliberations on this matter.

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I.2, I.3, I.4, J, J.1, J.3, J.4, K, K.2, K.3, and K.4);

Second Specification: (Paragraphs A, A.4, A.5, and A.8);

Third Specification: (Paragraphs B, B.1, and B.6);

Twelfth Specification: (Paragraphs K and K.3);

Thirteenth Specification: (Paragraphs A, A.4, A.7, A.8, B, B.5, B.6, B.7, C, C.5, C.7, D, D.4, E, E.5, F, F.2, F.3, F.4, G, G.4, G.5, H, H.4, I, I.3, I.4, J, J.3, J.4, K, K.3, and K.4);

Fourteenth Specification: (Paragraphs A, A.4, and A.7);

Fifteenth Specification: (Paragraphs A, A.4, and A.7);

Sixteenth Specification: (Paragraphs B, B.1 and B.5);

Seventeenth Specification: (Paragraphs C, C.5 and C.6);

Eighteenth Specification: (Paragraphs D and D.4)

Nineteenth Specification: (Paragraphs E and E.5);

Twentieth Specification: (Paragraphs F, F.2, and F.4);

Twenty-First Specification: (Paragraphs G and G.4);

Twenty-Second Specification: (Paragraphs H, H.3, and H.4);

Twenty-Third Specification: (Paragraphs I and I.3);

Twenty-Fourth Specification: (Paragraphs J and J.3);

Twenty-Seventh Specification: (Paragraphs A and A.6);

Twenty-Eighth Specification: (Paragraphs E and E.3);

Twenty-Ninth Specification: (Paragraphs H and H.2).

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The Hearing Committee further concluded that the following Specifications should not be sustained:

Fourth Specification;

Fifth Specification;

Sixth Specification;

Seventh Specification;

Eighth Specification;

Ninth Specification;

Tenth Specification;

Eleventh Specification;

Twenty-Fifth Specification;

Twenty-Sixth Specification.

DISCUSSION

Respondent is charged with twenty-nine 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 Peter J. Millock, Esq., former General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

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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 licensee 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.

At the outset, the Hearing Committee assessed the credibility of the various witnesses presented by both parties.

Witnesses for the Department

Richard U. Hausknecht, M.D. was the principal expert witness presented by the Department. Dr. Hausknecht is a board certified obstetrician/gynecologist, and an associate clinical professor of obstetrics & gynecology at the Mount Sinai School of Medicine. The Hearing Committee found Dr. Hausknecht's testimony to be credible and comporting with generally accepted standards of medical practice.

Michael Block, M.D., is the obstetrician/gynecologist who treated Patient A when she came to the emergency room at Long Beach Memorial Hospital. The Committee found Dr. Block to be generally credible. However, there were several factual errors in Dr. Block's discharge summary, which was prepared several weeks after the patient's discharge from the hospital. Where Dr.

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Block's testimony differed from the contemporaneous records kept by the hospital, the Committee gave greater weight to the hospital chart.

The Department also presented testimony of Patient A and Patient G. The Committee found Patient A to be a credible witness. Her account of events was consistent and corroborated by the medical records and the testimony of Dr. Block. However, the Hearing Committee did not consider Patient G's testimony to be credible, and did not give it any weight.

The Department also presented the testimony of Marion Norman, R.N. Ms. Norman is an investigator for the New York State Department of Social Services (DSS). She testified as to the findings of a DSS inspection of Respondent's office. There were severe defects in Ms. Norman's testimony. She testified that certain medical equipment was not present. However, photographs taken by other DSS investigators on the survey team clearly show the equipment was there, albeit in unusable disarray. Ms. Norman further testified that Medicaid had strict requirements for patient counselling regarding abortions, yet was unable to produce such guidelines for examination. The Hearing Committee unanimously concluded that Ms. Norman was not a credible witness.

The Department presented the testimony of Howard H. Bernstein, M.D. on its rebuttal case. Dr. Bernstein is board certified in anesthesiology and obstetrics/gynecology. He has considerable expertise in the use of Ketamine. The Hearing Committee found Dr. Bernstein's testimony regarding the

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appropriate standards for the use of Ketamine to be highly persuasive. Consequently, the Committee gave great weight to his testimony.

Witnesses for Respondent

Respondent presented testimony by two experts. Anthony Mustalish, M.D., an emergency medicine specialist, testified regarding the care received by Patient A at Long Beach Memorial Hospital. The Hearing Committee considered Dr. Mustalish to be credible with regard to issues of emergency medicine, but less credible concerning matters of obstetrics and gynecology, and the appropriate standards for the performance of abortions. Consequently, the Committee determined that much of Dr. Mustalish's testimony was collateral to the issues in this case. As a result, Dr. Mustalish's testimony was not given much weight.

Respondent also presented the testimony of Vincent Merendino, M.D. Dr. Merendino, a retired OB/GYN, testified that he performed his last abortion in 1988, and that he had never used Ketamine, nor had he ever administered general anesthesia in his office. Nevertheless, Dr. Merendino rendered opinions regarding Respondent's use of the drug and indicated that he was very familiar with Ketamine. Upon cross-examination, however, it became apparent that Dr. Merendino's "knowledge" on the use of Ketamine was based primarily upon his conversations with Respondent. Dr. Merendino indicated that he has known Respondent for 25 years and that he testified because the proceedings were a "witch hunt, like the O.J. case, and everybody is involved in the conspiracy against Respondent." (See, Tr., p. 1745). Dr.

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Merendino's opinions were not supported by the record and were inconsistent with the evidence. The Hearing Committee gave no credence to his testimony.

Respondent also produced the testimony of Ivette Ortiz. Ms. Ortiz was employed by Respondent during the period of time in which Respondent treated Patient A. Ms. Ortiz testified regarding her recollections of Respondent's interactions with Patient A. The Hearing Committee considered Ms. Ortiz to be a generally credible witness.

Respondent also testified on his own behalf. The Hearing Committee found much of Respondent's testimony to be troubling. Respondent's testimony was rambling and evasive. Many of his answers were unresponsive, and he answered questions which were not asked in an obvious attempt to avoid the questions which were asked. (*See*, e.g., Tr., pp. 1344-1347, 1355-1358, 1360-1362, 1370-1371, 1376-1379, 1382-1385, 1387, 1391, 1396-1397). Consequently, with some exceptions, the Committee did not give great weight to Respondent's testimony.

Equally troubling was Respondent's testimony regarding his medical records. Respondent admitted that he recorded negative findings for breast examinations which were, in fact, never done. (Tr., p. 1379). In addition, Respondent admitting altering the medical records for Patient A. He also stated that he recorded a gestational age of 22 weeks for Patient A's pregnancy, even though he considered the correct age to be 24.5 weeks. Respondent's acknowledged willingness to alter and falsify his records calls into question the credibility of all of

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Respondent's records.

Negligence on More Than One Occasion

The Hearing Committee concluded that several aspects of Respondent's medical care and treatment of the cited cases demonstrated negligence. Respondent used Ketamine as the sole anesthetic agent on a number of the cases (Patients B, C, F, G, I and J). Ketamine is generally used for the induction of anesthesia. It may also be used as a sole anesthetic agent for short procedures not requiring skeletal relaxation. The risks associated with Ketamine include loss of airway reflexes, loss of consciousness, apnea, hallucinations, and aspiration of stomach contents. Respondent claimed that he has used Ketamine safely during thousands of abortions, and that he used a very low dosage (30-50 mg). Respondent stated that the dose is so small, that he can use it with great safety. He further claimed that these low dosages result in "conscious sedation". However, Dr. Bernstein, a board-certified anesthesiologist, disputed Respondent's characterization of the level of anesthesia induced by the Ketamine. Dr. Bernstein expressed the opinion that Respondent was, indeed, inducing general anesthesia in his patients. As noted previously, the Hearing Committee gave great weight to Dr. Bernstein's testimony.

Generally accepted standards of medical practice require that Ketamine be used by medical personnel trained in the ability to handle airway obstruction and to control respiration. Blood pressure, pulse, respiration and oxygen saturation should be monitored. However, Respondent has no training in anesthesia

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or respiratory support. The Hearing Committee concluded that Respondent's inappropriate use of Ketamine constituted repeated acts of negligence, as defined above.

Generally accepted standards of medical practice also require that adequate resuscitative and monitoring equipment be available when general anesthesia is being administered. The record indicates that Respondent had a cardiac monitor, a defibrillator and oxygen equipment. The defibrillator paddles were kept separate from the actual defibrillator. However, photographs of Respondent's "crash cart" taken by the DSS investigators clearly demonstrate that the equipment was in such disarray as to render it unavailable in an emergency. Moreover, none of Respondent's staff had any training in operating any of the emergency equipment. The Hearing Committee unanimously concluded that Respondent's failure to have appropriate resuscitative and monitoring equipment, and trained personnel available to operate the equipment also constituted negligence.

Generally accepted standards of medical practice require that vital signs, including blood pressure, pulse and respiration, be recorded before, during and after operative procedures involving general anesthesia. None of the records for Patients A through K contained notations for any vital signs except for blood pressure. The Hearing Committee concluded that the failure to record such vital signs was negligence.

The record established that Respondent performed pregnancy and Rh factor tests, as well as sonograms for each of the named patients. However, Dr. Hausknecht testified that a

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prudent practitioner would also obtain a hematocrit and/or hemoglobin prior to performing an abortion. To the extent that Respondent failed to obtain a hemoglobin and/or hematocrit for each of the named patients, the Hearing Committee concluded that Respondent negligently failed to obtain or perform appropriate laboratory and/or diagnostic procedures.

Following the abortion of Patient C's fetus, Respondent received a pathology report indicating the absence of products of conception. This raised the possibility of an ectopic pregnancy. The major risks associated with an ectopic pregnancy are hemorrhage and death. This required immediate action by Respondent, including sonographic examination to locate the pregnancy and/or laparoscopy. The record indicates that Respondent did make one attempt to contact Patient C following his receipt of the pathology report. He discussed the options for follow-up evaluation, and the patient agreed to see him. She did not return to his office and he did nothing further to investigate her status. The Committee concluded that Respondent's failure to adequately follow-up with the patient constituted negligence.

Gross Negligence

The Department also charged Respondent with gross negligence with regard to each of the named patients. The Hearing Committee concluded that certain aspects of the care provided to Patients A, B and K demonstrated gross negligence. The Committee further concluded that Respondent's conduct with regard to the remaining patients was negligent, but was not so

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egregious as to warrant further findings of gross negligence.

Respondent failed to accurately date the age of Patient A's pregnancy. He then induced Patient A's abortion through the use of a homemade saline solution of uncertain concentration. Moreover, he performed the abortion despite his diagnosis of placenta previa. These actions placed Patient A's life in grave danger. The Hearing Committee unanimously concluded that this conduct was so egregious as to support a finding of gross negligence, as well as ordinary negligence. Consequently, the Committee sustained the Second Specification.

The Hearing Committee also concluded that Respondent's treatment of Patient B demonstrated gross negligence. Despite a history of asthma, Respondent performed an abortion under general anesthesia induced by Ketamine. As was previously discussed above, Respondent did not have adequate resuscitative equipment available, nor the personnel to use it. This presented an especially dangerous situation for an asthmatic patient such as Patient B. As a result, the Committee sustained the Second Specification.

Respondent performed Patient K's abortion *via* saline infusion. As noted previously, Respondent used a homemade saline solution of uncertain concentration. Respondent testified that he used what he believed to be a 12-14% concentration. This would be 4-5 times greater than the accepted 3% saline concentration and would present an unacceptable risk to the patient. The Hearing Committee unanimously concluded that Respondent's use of his homemade saline solution to perform

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Patient K's abortion was so egregious as to constitute gross negligence. Therefore, the Committee sustained the Twelfth Specification.

The Hearing Committee further concluded that Respondent's conduct with the remaining eight patients, although negligent, did not rise to the level of gross negligence. Accordingly, the Committee did not sustain the Fourth through Eleventh Specifications.

Incompetence on More Than One Occasion

The Hearing Committee further concluded that several aspects of Respondent's treatment of these eleven patients demonstrated incompetence. Respondent's use of Ketamine for general anesthesia was based on a lack of fundamental knowledge of the drug's effects. In addition, Respondent's failure to recognize his error in estimating the size of Patient A's fetus, the failure to take and record vital signs, and the use of a homemade saline solution for saline induced abortions all demonstrate a lack of the basic knowledge and skills necessary to practice the profession. As a result, the Hearing Committee voted to sustain the Thirteenth Specification.

Failing to Maintain Accurate Records

Respondent is charged with eleven specifications of failing to maintain accurate medical records. The record of these proceedings is replete with evidence supporting the charges. Respondent acknowledged that he recorded negative breast examinations when, in fact, no examination was performed. He admitted altering the records of Patient A. He failed to note

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basic vital signs on virtually all of the patients' records. In addition, Respondent stated that he altered Patient A's record after she was admitted to Long Beach Memorial Hospital. In addition, Respondent failed to record the results of his examination of fetal tissue obtained in several of the cited cases. The Hearing Committee unanimously concluded that Respondent failed to maintain accurate records with respect to each of the charged patients. Accordingly, the Committee voted to sustain the Fourteenth through Twenty-Fourth Specifications.

Performing a Procedure Not Duly Authorized

The Department charged Respondent with performing abortions on Patient's B and C without obtaining prior consent from the patients. During the course of the proceedings, the Department withdrew its allegation concerning Patient C, as a signed consent form was found to be in the patient's record. Consequently, the Hearing Committee did not sustain the Twenty-Sixth Specification. No consent form was contained in Patient B's medical record. Respondent testified that the patient did complete a consent form, but the form was not placed into the record.

Ordinarily, claims by a Respondent that something was done but not charted are not given great weight. However, the Hearing Committee takes note of the fact that each of the other patient records in this case contained a signed consent form. Accordingly, the Hearing Committee gave the benefit of the doubt to Respondent's claim that the absence of the consent form was a clerical oversight. As a result, the Hearing Committee did not

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sustain the Twenty-Fifth Specification.

Willful or Grossly Negligent Failure to Comply With State Law Governing the Practice of Medicine

Public Health Law §4164(1) provides, *inter alia*, that "When an abortion is to be performed after the twentieth week of pregnancy, a physician other than the physician performing the abortion shall be in attendance to take control of and to provide immediate medical care for any live birth that is the result of the abortion...." The Department has established that Respondent performed abortions beyond the twentieth week of pregnancy for Patients A, E and H. There was no physician in attendance to provide medical care for any resulting live births in any of these cases. Respondent is held responsible for conforming his medical practice to the requirements set forth in the Public Health Law. Consequently, the Hearing Committee concluded that Respondent is guilty of the willful or grossly negligent failure to comply with state law governing the practice of medicine with regard to Patients A, E and H. Therefore, the Committee voted to sustain the Twenty-Seventh, Twenty-Eighth and Twenty-Ninth Specifications.

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 as a physician in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension

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and/or probation, censure and reprimand, and the imposition of monetary penalties.

There were several aspects of this case which led the Hearing Committee to the decision to revoke Respondent's license to practice medicine. The evidence documented a pattern of negligent and incompetent practice which Respondent was not inclined to correct. Respondent's testimony revealed an inability to learn from experience or to learn from acknowledged errors. Respondent was previously disciplined by the Board of Regents for poor record-keeping. Nevertheless, the record clearly established that Respondent's records, which he claimed were revamped as a result of the Regents' action, were grossly inadequate. Thus, it was clear that Respondent is either unable or unwilling to conform his practice to the standards of the profession. The Hearing Committee therefore determined that Respondent was not a suitable candidate for re-training or supervised practice.

Respondent served an especially vulnerable patient population. Therefore it is incumbent upon this Board to be especially vigilant in protecting their interests. Of the eleven patients named in the Statement of Charges, only Patient A was seriously adversely affected by Respondent's poor practice. Nevertheless, Respondent's method of practice placed the welfare of his patients on a razor's edge. The Hearing Committee strongly believes that revocation of Respondent's medical license is the only sanction which will adequately protect the people of this state.

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ORDER

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

1. The First, Second, Third, Twelfth, Thirteenth, Fourteenth, Fifteenth, Sixteenth, Seventeenth, Eighteenth, Nineteenth, Twentieth, Twenty-First, Twenty-Second, Twenty-Third, Twenty-Fourth, Twenty-Seventh, Twenty-Eighth and Twenty-Ninth Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;

2. The Fourth, Fifth, Sixth, Seventh, Eighth, Ninth Tenth, Eleventh, Twenty-Fifth, Twenty-Sixth Specifications are **NOT SUSTAINED**;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order.

DATED: Albany, New York
March 20 , **1996**

STEPHEN A. GETTINGER, M.D. (CHAIR)

SHARON C.H. MEAD, M.D.
ANTHONY SANTIAGO

NEW YORK STATE DEPARTMENT OF HEALTH 19

TO: Silvia P. Finkelstein, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

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

Nathan L. Dembin, Esq.
Nathan L. Dembin & Associates, P.C.
225 Broadway - Suite 1905
New York, New York 10007

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APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH

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

IN THE MATTER

OF

HERBERT SCHWARZ, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: Herbert Schwarz, M.D.
186 Grand View Blvd.
Yonkers, New York 10710

The undersigned, Barbara A. DeBuono, M.D., M.P.H., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by HERBERT SCHWARZ, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 1995), that effective immediately HERBERT SCHWARZ, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 1995).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995), and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on August 24, 1995, at 10:00 a.m., at the offices of the New York State Health Department, 5 Penn Plaza, Sixth Floor, New

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York, NY 10001, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

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THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
August 16, 1995

Barbara A. DeBuono MD

BARBARA A. DeBUONO, M.D., M.P.H.
Commissioner of Health

Inquiries should be directed to:

Silvia P. Finkelstein
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
5 Penn Plaza
Suite 601
New York, New York 10001
(212) - 613-2615

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

IN THE MATTER
OF
HERBERT SCHWARZ, M.D.

STATEMENT
OF
CHARGES

HERBERT SCHWARZ, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 14, 1963, by the issuance of license number 091304 by the New York State Education Department. Said license was suspended by action of the Board of Regents from September 24, 1982 through March 23, 1983, and was thereafter placed on probation for 18 months. The period of probation ended on September 23, 1984.

FACTUAL ALLEGATIONS

A. Respondent, treated Patient A, age 36, on or about March 16, 1995, March 17, 1995, March 19, 1995, and/or March 20, 1995, at his office located at 65 East 96th Street, New York, New York 10128. (The identities of Patient A and the other patients are disclosed in the attached Appendix).

1. At all the dates above mentioned, Respondent failed to obtain and note an adequate medical history.
2. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
3. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy.

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4. Respondent failed to adequately evaluate fetal size and/or age, prior to attempting to terminate the pregnancy.

5. Despite the fact that Patient A evidenced placenta previa, Respondent failed to adequately address said condition.

6. On or about March 16, March 17 through March 19, and/or March 20, Respondent attempted to terminate a third trimester pregnancy, in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel.

7. Respondent failed to take or note in the chart vital signs of the Patient prior, during, and subsequent to the attempts to terminate Patient A's pregnancy.

8. On or about March 16, 1995 Respondent inserted 3 Laminaria and sent the Patient home. On or about March 17, 1995, Respondent inserted another Laminaria and gave the patient a Prostin suppository with instructions to self-inset it at bedtime, at home. On or about March 18, 1995, the patient returned to Respondent's office and was given another Prostin suppository to be self-inserted at bedtime, at home. The patient was inappropriately sent home with instructions that if the abortion happened she should bring the conception material back to Respondent's office in two plastic bags. On or about March 20, 1995, Patient A returned to Respondent's office at which time Respondent injected her abdomen several times, noted the presence of bleeding and nevertheless inappropriately sent the patient home. On or about March 21, 1995, Patient A was admitted at Long Beach Memorial Hospital's Emergency

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Department, hemorrhaging, febrile and in shock. Patient A was transfused and an emergency hysterotomy was performed with findings of a complete placental abruption and fetal demise of a 28 week size fetus.

B. Respondent treated Patient B, age 14, on or about February 6 and/or February 7, 1995, at his office located at 65 East 96th Street, New York, New York 10128.

1. At all the dates above mentioned, Respondent failed to obtain and note and adequate medical history.
2. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
3. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy.
4. Respondent failed to obtain consent from the Patient for said termination of pregnancy.
5. On or about February 7, 1995, Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
6. Although Respondent knew that Patient B had a history of asthma he inappropriately administered general anesthesia by injecting Ketalar IV push, in the absence of adequate resuscitative equipment.
7. Respondent failed to note the timing and amount of anesthetic agent (Ketalar) administered to this patient.

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8. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about February 7, 1995.

C. Respondent treated Patient C, age 18, on or about November 17, 1994, at his office located at 65 East 96th Street, New York, New York 10128.

1. Respondent failed to obtain and note an adequate medical history.
2. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient to properly diagnose her condition.
3. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about November 17, 1995.
4. ~~Respondent failed to obtain consent from the Patient for said termination of pregnancy.~~ withdrawn by Petitioner mlnks fff
5. On or about November 17, 1994, Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
6. Despite the fact that Patient C evidenced a risk for ectopic pregnancy, Respondent failed to adequately follow-up on the condition of the patient and failed to note any such follow-up.
7. Respondent inappropriately administered general anesthesia to this patient by injecting Ketalar IV push, in the absence of adequate resuscitative equipment.
8. Respondent failed to evaluate the tissue to determine that all of

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the necessary products of conception were removed during the termination of pregnancy on or about November 17, 1995.

D. Respondent treated Patient D, age 16, on or about December 5, 1994, at his office located at 65 East 96th Street, New York, New York 10128.

1. Respondent failed to obtain and note an adequate medical history.
2. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
3. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy.
4. On or about December 5, 1994, Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
5. Respondent failed to note in the chart what procedure was performed upon this patient on or about December 6, 1994, to terminate an 18 week pregnancy.
6. On or about December 6, 1994, Respondent inappropriately terminated an 18 week pregnancy in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel.
7. Respondent failed to note the timing, type and amount of anesthetic agent administered to this patient, if any.
8. Respondent failed to evaluate the tissue to determine that all of

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the necessary products of conception were removed during the termination of pregnancy on or about December 6, 1994.

E. Respondent treated Patient E, age 16, on or about December 4, 1994, December 5, 1994, December 6, 1994 and/or December 20, 1994, at his office located at 65 East 96th Street, New York, New York 10128.

1. At all the dates above mentioned, Respondent failed to obtain and note an adequate medical history.
2. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
3. On or about December 6, 1994, Respondent inappropriately terminated a 21 week pregnancy with the aid of "mechanical help", in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel.
4. Respondent failed to note in the chart what procedure was performed upon this patient on or about December 6, 1994.
5. Respondent failed to take or note in the chart vital signs of the Patient prior, during, and subsequent to the termination of Patient E's pregnancy.
6. Respondent failed to note the timing, type and amount of anesthetic agent administered to this patient.
7. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about December 6, 1994.

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F. Respondent treated Patient F, age 23, on or about May 17, 1995 and May 18, 1995, at his office located at 65 East 96th Street, New York, New York 10128.

1. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
2. Respondent failed to take or note in the chart vital signs of the Patient prior, during, and subsequent to the termination of Patient F's pregnancy.
3. Respondent inappropriately administered general anesthesia to this patient by injecting Ketalar IV push, in the absence of adequate resuscitative equipment.
4. Respondent failed to note the timing and amount of anesthetic agent administered to this patient.
5. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about May 18, 1995.

G. Respondent treated Patient G, age 30, on or about May 10, 1995, at his office located at 65 East 96th Street, New York, New York 10128.

1. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
2. Respondent failed to adequately evaluate fetal size and/or age, prior to attempting to terminate the pregnancy.
3. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy.

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amended by Pet. 8/24/95 gfj

4. On or about ~~December 5, 1994~~ MAY 10, 1995, Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
5. Respondent inappropriately administered general anesthesia to this patient by injecting Ketalar IV push, in the absence of adequate resuscitative equipment.
6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about May 10, 1995.

H. Respondent treated Patient H, age 17, on or about November 26, 1994, December 5, 1994 and/or December 6, 1994, at his office located at 65 East 96th Street, New York, New York 10128.

1. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
2. On or about December 6, 1994, Respondent inappropriately terminated a 21 week pregnancy in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel.
3. Respondent failed to note in the chart what procedure was performed upon this patient on or about December 6, 1994.
4. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
5. Respondent failed to note the timing, type and amount of anesthetic agent administered to this patient.

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6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about December 6, 1994.

I. Respondent treated Patient I, age 18, on or about April 6, 1995 and April 7, 1995, at his office located at 65 East 96th Street, New York, New York 10128.

1. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
2. On or about April 6 or April 7, 1995, Respondent inappropriately terminated a 17 week pregnancy in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel.
3. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
4. Respondent inappropriately administered general anesthesia to this patient by injecting Ketalar IV push, in the absence of adequate resuscitative equipment.
5. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about April 6 or April 7, 1995.

J. Respondent treated Patient J, age 36, on or about May 3 or May 9, May 10 and May 11, 1995 , at his office located at 65 East 96th Street, New York, New York 10128.

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1. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
2. On or about May 3 and/or May 11, 1995, despite the fact that Respondent knew Patient J was Rh negative and the risks inherent therein, Respondent inappropriately terminated an approximately 18 week pregnancy in his office, without adequate resuscitative equipment available and in the absence of clinical support personnel.
3. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
4. Respondent administered general anesthesia to this patient by injecting Ketalar IV push, in the absence of adequate resuscitative equipment.
5. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about May 3 and/or May 11, 1995.

K. Respondent treated Patient K, age 20, on or about May 22 and May 23, 1995, at his office located at 65 East 96th Street, New York, New York 10128.

1. Respondent failed to obtain and note an adequate medical history.
2. Respondent failed to perform necessary laboratory and/or diagnostic tests upon this patient.
3. On or about May 22 and/or May 23, 1995, Respondent innapropriately terminated an approximately 18 week pregnancy

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in his office, by saline infusion, without adequate resuscitative equipment available and in the absence of clinical support personnel.

4. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.

5. Respondent failed to note the timing, type and amount of anesthetic agent administered to this patient, if any.

6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about May 22 and/or May 23, 1995.

SPECIFICATION OF CHARGES

FIRST 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 § 6530(3) (McKinney Supp. 1995), in that Petitioner charges Respondent with having committed at least two of the following:

1. The facts contained in paragraphs A, A1, 2, 3, 4, 5, 6, 7, and/or 8, B, B1, 2, 3, 4, 5, 6, 7, and/or 8, C, C1, 2, 3, 4, 5, 6, 7, and/or 8, D, D1, 2, 3, 4, 5, 6, 7, and/or 8, E, E1, 2, 3, 4, 5, 6, and/or 7, F, F1, 2, 3, 4, and/or 5, G, G1, 2, 3, 4, 5, and/or 6, H, H1, 2, 3, 4, 5, and/or 6, I, I1, 2, 3, 4, and/or 5, J, J1, 2, 3, 4, and/or 5, K, K1, 2, 3,

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4, 5, and/or 6.

SECOND THROUGH TWELFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1995) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

2. Paragraph A, A1, 2, 3, 4, 5, 6, 7, and/or 8.
3. Paragraph B, B1, 2, 3, 4, 5, 6, 7, and/or 8.
4. Paragraph C, C1, 2, 3, 4, 5, 6, 7, and/or 8.
5. Paragraph D, D1, 2, 3, 4, 5, 6, 7, and/or 8.
6. Paragraph E, E1, 2, 3, 4, 5, 6, and/or 7.
7. Paragraph F, F1, 2, 3, 4, and/or 5.
8. Paragraph G, G1, 2, 3, 4, 5, and/or 6.
9. Paragraph H, H1, 2, 3, 4, 5, and/or 6.
10. Paragraph I, I1, 2, 3, 4, and/or 5.
11. Paragraph J, J1, 2, 3, 4, and/or 5.
12. Paragraph K, K1, 2, 3, 4, 5, and/or 6.

THIRTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1995) by practicing the profession of

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medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

13. The facts contained in paragraphs A, A1, 2, 3, 4, 5, 6, 7, and/or 8, B, B1, 2, 3, 4, 5, 6, 7, and/or 8, C, C1, 2, 3, 4, 5, 6, 7, and/or 8, D, D1, 2, 3, 4, 5, 6, 7, and/or 8, E, E1, 2, 3, 4, 5, 6, and/or 7, F, F1, 2, 3, 4, and/or 5, G, G1, 2, 3, 4, 5, and/or 6, H, H1, 2, 3, 4, 5, and/or 6, I, I1, 2, 3, 4, and/or 5, J, J1, 2, 3, 4, and/or 5, K, K1, 2, 3, 4, 5, and/or 6.

FOURTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS
FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) (McKinney Supp. 1995) in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, as alleged in the facts of:

14. Paragraph A, A1, 2, 3, 4, 5, 6, 7, and/or 8.
15. Paragraph B, B1, 2, 3, 4, 5, 6, 7, and/or 8.
16. Paragraph C, C1, 2, 3, 4, 5, 6, 7, and/or 8.
17. Paragraph D, D1, 2, 3, 4, 5, 6, 7, and/or 8.
18. Paragraph E, E1, 2, 3, 4, 5, 6, and/or 7.
19. Paragraph F, F1, 2, 3, 4, and/or 5.
20. Paragraph G, G1, 2, 3, 4, 5, and/or 6.
21. Paragraph H, H1, 2, 3, 4, 5, and/or 6.
22. Paragraph I, I1, 2, 3, 4, and/or 5.

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23. Paragraph J, J1, 2, 3, 4, and/or 5.

24. Paragraph K, K1, 2, 3, 4, 5, and/or 6.

TWENTY-FIFTH AND TWENTY-SIXTH SPECIFICATIONS

PERFORMING A PROCEDURE NOT DULY AUTHORIZED

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(26) (McKinney Supp. 1995) by performing professional services which had not been duly authorized by the patient, as alleged in the facts of:

25. Paragraph B and B4.

26. Paragraph C and C4.

TWENTY-SEVENTH THROUGH TWENTY-NINTH SPECIFICATION

WILLFUL OR GROSSLY NEGLIGENT FAILURE TO COMPLY WITH STATE LAW GOVERNING THE PRACTICE OF MEDICINE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(16) (McKinney Supp. 1995) by engaging in willful or grossly negligent failure to comply with substantial provisions of state law governing the practice of medicine, to wit, N.Y. Public Health Law § 4164(1), as alleged in the facts of:

27. Paragraph A, A4, 6, and/or 8

28. Paragraph E and/or E3.

29. Paragraph H and/or H2.

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DATED: August 13, 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

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