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*

November 13, 1995



**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Marcia E. Kaplan, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

Leland Beck, Esq.
Beck, Salvi & Gewurz, P.L.L.C.
600 Old Country Road
Garden City, New York 11530

Stanley Brown, M.D.
2500 Route 347
Suite 8C
Stony Brook, New York 11790

**RE: In the Matter of Stanley Brown, M.D.**

Dear Ms. Kaplan, Mr. Beck and Dr. Brown:

Enclosed please find the Determination and Order (No. 95-271) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:nm
Enclosure

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

**IN THE MATTER**

**OF**

**STANLEY BROWN, M.D.**

**DETERMINATION**

**AND**

**ORDER**

BPMC-95-271

**Ms. PRISCILLA R. LESLIE,** Chairperson, **RUFUS NICHOLS, M.D.** and **NAOMI GOLDSTEIN, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **MICHAEL P. MCDERMOTT, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee except for the hearings held on June 29, 1995 and July 6, 1995, when Jeffrey Kimmer, Esq. served as the Administrative Officer.

After consideration of the entire record, the Hearing Committee submits this DETERMINATION AND ORDER.

## SUMMARY OF PROCEEDINGS

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| Notice of Hearing and Statement of Charges: | May 3, 1995 |
| Pre-Hearing Conference; | May 26, 1995 |
| Hearing Dates: | June 12, 1995<br>June 29, 1995<br>July 6, 1995<br>September 14, 1995<br>September 20, 1995 |

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|---|---|
| Place of Hearing: | NYS Department of Health<br>5 Penn Plaza<br>New York, New York |
| Date of Deliberations: | October 12, 1995 |
| Petitioner Appeared By: | Jerome Jasinski, Esq.,<br>Acting General Counsel<br>NYS Department of Health |
| BY: | Marcia E. Kaplan, Esq. |
| Respondent Appeared By: | Beck, Salvi & Gewurz, P.L.L.C.<br>600 Old Country Road<br>Garden City, New York 11530 |
| BY: | Leland Beck, Esq. |

## STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with practicing with negligence on more than one occasion, practicing fraudulently and failing to keep records.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this DETERMINATION AND ORDER.

## WITNESSES

| | |
|---|---|
| For the Petitioner: | Patient A<br>Enayat Hakim-Elahi, M.D. |
| For the Respondent: | Sandra Brown, Respondent's wife<br>Giuseppe Basile, M.D.<br>Eileen Garfen, L.P.N.<br>Stanley Brown, M.D. the Respondent<br>Milind Mondkar, M.D.<br>Leonard Roberts, M.D. |

## FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages 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 evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

## GENERAL FINDINGS

1. The Respondent was authorized to practice medicine in New York State on July 1, 1977 by the issuance of license number 131011 by the New York State Education Department (Pet's. Ex. 2).

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through September 30, 1996 from 2500 Route 347, Suite 8C, Stony Brook, New York 11790 (Pet's. Ex. 2).

## FINDINGS AS TO PATIENT A

3. The Respondent treated Patient A, a 32 year old female, at Stony Brook Women's Health Services, 2500 Route 347, Stony Brook, New York, (hereinafter "office") from August 3, 1990 through August 22, 1990, and at Community Hospital of Western Suffolk, 498 Smithtown Bypass, Smithtown, New York, from September 6, 1990 through September 10, 1990. The Respondent's records indicate that he also treated Patient A thereafter at his office on October 8, 1990; however, Patient A denies seeing him on that date (Pet's. Ex. 3)

4. On August 3, 1990, the Respondent performed an attempted abortion by suction curettage under general anesthesia on Patient A at his office. Patient A's last menstrual period was on or about June 15, 1990. She reported a positive home pregnancy test when she made the appointment and had a positive urine pregnancy test at the Respondent's office on the date of the abortion procedure (Pet's. Ex. 3, pp. 2-7; Tr. 17-19, 43, 79).

5. It is important for the physician who performs an abortion to look at the tissue and determine whether villi are present. He can do this by floating the tissue in saline and looking at it with a magnifying glass. If he is not able to determine if villi are present he should immediately send the tissue to the pathologist, who should call him as soon as possible to report whether or not villi were found. If villi are not present, the physician must rule out ectopic pregnancy (Tr. 180, 185, 187).

6. On August 3, 1990, the Respondent noted, that after macroscopic examination, he had sent "macerated tissue" to pathology. The pathology report indicates that the tissue was received by the pathologist on August 6, 1990 (Pet's. Ex. 3, pp. 6, 8).

7. On or after August 11, 1990, the pathologist reported that the microscopic examination of the abortion tissue showed "hypersecretory endometrium" and "no villi." The Respondent's record does not indicate the date that the pathology laboratory called his office with the report.

The significance of this particular pathology report is that the specimen contained no fetal tissue or placenta tissue which indicates that Patient A either had a failed abortion or an ectopic pregnancy, or both. (Pet's. Ex. 3, p. 8; Tr. 103-106, 714-715).

8. The Respondent should have considered ectopic pregnancy at this point. An ectopic pregnancy is a pregnancy which occurs outside the uterus, and can be in the fallopian tube, the ovary, a corner of the uterus, or in the abdomen. If it is not diagnosed in time, it may rupture, causing intra-abdominal bleeding, and even death (Tr. 103-106, 178, 185).

9. On August 13, 1990, Patient A received a phone call from the Respondent's office. She was told that the pathology was "questionable" and that she needed to have a blood pregnancy test and a sonogram performed. She was also instructed to return to the office to see the Respondent after having the tests. (Tr. 20-22, 27-28, 44, 80, 188).

10. Eileen Garfen, LPN, the Respondent's nurse, testified that she wrote a note on an ad pad contemporaneous with the events. The note reads "8/13/90 PT notified to have beta sub & sonogram done- Dr. Heimowitz # given App't given Wed 8/15/90 for fup" In another unidentified handwriting in red ink the note reads, "8/14/90-beta sub-8310 Pt notified NPO 12 mid Tues Poss D&C Wed @ 4:30" (Pet's. Ex. 3B).

11. This note, (Pet's. Ex. 3B), does not contain any reference to Patient A being advised that she might have an ectopic pregnancy or that a test was important in view of the pathology report to rule out a continuing intrauterine pregnancy. These details appear for the first time in another note dated "8/13/91."

The "8/13/91" note, (Pet's. Ex. 3, p. 9), was allegedly written by nurse Garfen at the Respondent's request after he had received a letter from Patient A discussing the possibility of her pursuing a medical malpractice claim against him (Pet's. Ex. 3, p.9, Pet's. Ex. 3B, Resp's. Ex. E).

12. The purported contemporaneous note, dated 8/13/90, (Pet's. Ex. 3B), was not part of the medical record submitted to the Office of Professional Medical Conduct and certified to by the Respondent as a complete and accurate copy of Patient A's medical record (Pet's. Ex. 3; Pet's. Ex. 3B).

13. The note dated "8/13/91", (Pet's. Ex. 3, p. 9), was placed in Patient A's medical chart as if in sequence for August 1990 (Pet's. Ex. 3, p.9; Tr. 489-492, 801).

14. Patient A had a beta sub unit done on August 13, 1990. The Respondent received the results the following day, August 14, 1990. The results were 8310, a level which is consistent with a pregnancy of eight weeks or more (Pet's. Ex. 3, p. 9; Pet's. Ex. 3A; Pet's. Ex. 4, p.2; Tr. 21, 44, 111).

15. On August 14, 1990, Patient A had a sonogram done at LI Diagnostic Imaging PC (Pet's. Ex. 5; Tr. 21, 44).

16. The referring OB/GYN should give the patient's history to the sonographer and direct the sonographer to the area of inquiry. If the Respondent had suspected the possibility of an ectopic, he should have sent specific instructions to the sonographer to look at the fallopian tubes and rule out ectopic pregnancy. The Respondent did not give any such instructions in this case (Pet's. Ex. 3; Tr. 119, 179-180).

17. A pelvic sonogram is intended to demonstrate what is in the uterus and in the fallopian tubes and the condition of the ovary.

The results of the sonogram performed on Patient A on August 14, 1990 were reported as negative: the uterus and ovaries were normal, there was no evidence of intrauterine pregnancy or retained products of conception or a mass that would suggest intrauterine

hematoma. The sonogram was not sufficient to permit the Respondent to rule out the possibility of the existence of an ectopic pregnancy. Furthermore, a negative pelvic sonogram does not rule out the possibility of an ectopic pregnancy; it could be in the abdomen (Pet's. Ex. 3, pp. 10, 13; Pet's. Ex. 5, p. 2; Tr. 113, 117, 155, 167-168, 177, 181).

18. Given the pathology report showing an empty uterus, and the fact that Patient A had an elevated Beta HCG, a diagnosis of ectopic pregnancy should have been considered. However, the Respondent did not suspect an ectopic. Also, he did not make any effort to obtain the sonogram results before he saw the patient on August 15, 1990 to make sure that both fallopian tubes were screened (Pet's. Ex. 3; Tr. 113-114, 116, 118-119, 152, 157).

19. Patient A saw the Respondent at his office on August 15, 1990. She did not complain of any symptoms. She felt well and had come to the office in response to the August 13, 1990 phone call requesting her to do so. The Respondent told Patient A that the blood work showed that she was still pregnant, but that was because her hormone levels were still high. He also told her that the sonogram indicated that she was not pregnant; and that the abortion was successful. He did not mention the possibility that she might have an ectopic pregnancy (Tr. 22, 27-30, 45-46, 67, 81-83, 109, 118-119, 152, 166).

20. At the time of the August 15, 1990 visit, Patient A was not told to make any follow-up arrangements and was not advised to have any additional testing.
(Contradictory notations appear in the Respondent's record for August 15, 1990. There is a notation inserted by the Respondent that Patient A was asked to return to the office in one week to be checked again. There is another note by Nurse Garfen, recorded even before the patient was examined, that Patient A was advised to come to the office in two weeks if no menses occurred.) In fact, no return visit was scheduled (Pet's. Ex. 3, p. 12).

21. On August 22, 1990 Patient A called the office because she was having a problem and was given an appointment to come in that same day. This was not a scheduled appointment (Pet's. Ex. 3, p. 12, 15; Tr. 30-31, 46, 63, 65-67, 81-83, 86, 468).

22. On August 22, 1990, the Respondent did not suspect a possible ectopic pregnancy. He did not tell Patient A to have any further testing and she did not refuse additional tests on the basis that she could not afford them (Pet's. Ex. 3; Tr. 32, 86-87, 168-169).

23. Between August 22 and September 5, 1990, Patient A's bleeding continued, at times it was intermittent but eventually it became constant. The pain in her left side increased.
She believed she had a stomach problem and went to see an internist. The internist advised her that it did not appear to be a stomach or intestinal related problem; that he did not know why she was bleeding but that she should find out. Patient A continued to believe it was an abdominal type of pain and took Mylanta (Tr. 32-33, 47-48, 64, 68-69, 74, 81-82).

24. On September 5, 1990, after 8 p.m., Patient A presented at the emergency room of Brookhaven Hospital and was seen by Dr. Ser, a partner of her regular OB/GYN.
Patient A gave a history of intermittent vaginal bleeding for 5 weeks and complained of LLQ abdominal pain. She had experienced a gush of blood and passed a large clot.
Dr. Ser discharged her home that evening with instructions to have an intra-vaginal sonogram the next day (Pet's. Ex. 6, p. 3-4; Tr. 34-35, 49-50, 64).

25. On September 6, 1990, Patient A had the sonogram performed at Reiter and Parkes. She was asked to remain there while the results were phoned to her OB/GYN, Dr. Molinoff. Dr. Molinoff asked her to come to his office immediately.
The pelvic sonogram lists a finding of a mass high in the left adnexa and differential

diagnoses of "ovarian neoplasm, abscess or possibly an ectopic gestation (considered less likely)."

Dr. Molinoff told Patient A that she had a mass outside the uterus but that he could not tell her what it was. He told her that he would not touch her, and that she would have to return to the Respondent. Dr. Molinoff called the Respondent who told him to have Patient A meet him at Community Hospital of Western Suffolk (Resp's. Ex. C; Tr. 35-36, 49-50).

26. Patient A went to the emergency room of Community Hospital of Western Suffolk. She gave a medical history of termination of pregnancy, bleeding for 5 weeks, pelvic pain for 2 weeks, and complained of right lower quadrant pain and vaginal bleeding. She reported she was staining and had passed a large clot the night before (Pet's. Ex. 7, pp. 7, 9, 48; Tr. 37, 51).

27. The Respondent was already at the hospital delivering a child and met Patient A in the ER. He palpated her abdomen and told her he did not detect any tenderness. He felt her skin and told her that she did not appear to have a fever. A nurse subsequently told her that she would have a diagnostic procedure (Pet's. Ex. 7, p. 7; Tr. 37, 57).

28. The physical examination note and the OR progress note, both written by the Respondent read "R/o TOA, ovarian cyst." TOA is a tubal ovarian abscess, an infection in the fallopian tube or ovary or both. At this point, the Respondent still did not suspect an ectopic pregnancy (Pet's. Ex. 7, pp. 8-11; Tr. 131-132, 136).

29. A blood pregnancy test was reported as positive at 4:30 p.m. The Respondent did not obtain the results of this test before starting his first procedure (Pet's. Ex. 7, p. 33; Tr. 135, 727-728).

30. The Respondent performed a laparoscopy between 5:15 p.m. and 6:30 p.m. The operative report of this first procedure has a pre-operative diagnosis of "rule out ovarian mass" and a post-operative diagnosis of "large mass of adhesions consisting of small and large intestines and omentum to the left pelvis area." (Pet's. Ex. 7, pp. 18, 20, 22; Tr. 133-134).

31. At some point after the laparoscopy, a nurse told Patient A that she could go home. However, after the blood pregnancy test was reported as positive, she was taken back into the OR for a second procedure (Pet's. Ex. 7, p. 33; Tr. 38).

32. At about 7:30 p.m., Patient A was informed that she would need an exploratory laparotomy. This was the first time that the Respondent ever discussed with Patient A the possibility that she might have an ectopic pregnancy (Pet's. Ex. 7, p. 12; Tr. 39).

33. The second procedure operative report has a pre-operative diagnosis of "possible ectopic; large pelvic adhesions" and a post-operative diagnosis of "left ectopic." (Pet's. Ex. 7, p. 28).

34. At or about 7:40 p.m., Respondent performed a left salpingo-oophorectomy for ectopic pregnancy. The pathology report confirms the ectopic pregnancy in the left fallopian tube (Pet's. Ex. 7, pp. 24-30).

## FINDINGS AS TO PATIENT A'S MEDICAL RECORDS

35. The records in Respondent's office were kept in haphazard fashion at best and were knowingly and intentionally altered in the case of Patient A (Pet's. Ex. 3, pp. 9, 15; Pet's. Ex. 3B; Tr. 185, 381, 396-398, 400, 409-412, 499, 515, 791, 795, 803).

36. Page 9 of Pet's. Ex. 3 contains entries dated "8/13/91" and "8/14/91" which purportedly memorialize events of August 13-14, 1990. The entry for "8/13/91" indicates that the patient was given an appointment for "Wed 8/15/91," when in fact 8/15/91 was a Thursday. The entry for "8/14/91" indicates that Patient A was notified of a possible D&C on Wednesday and told not to eat or drink after midnight Tuesday, when in fact Patient A was not so notified. Also, this page was inserted in the medical chart as if in sequence for August 1990 (Pet's. Ex. 3, p. 9; Tr. 27-28, 142).

37. The Respondent's medical record for Patient A on August 22, 1990, notes that Patient A offered "no complaints," although Patient A had complained of continued bleeding and a pain on her left side. The patient record further notes that in answer to the Respondent's recommendation that she have a repeat beta subunit, the patient said that she could not afford any more blood tests. Patient A made no such statement (Pet's. Ex. 3, p. 15; Tr. 30-32, 46-47, 67-69, 72-73, 86-87).

## CONCLUSIONS AS TO PATIENT A AND PATIENT A'S RECORDS

In this case (1) the pathology report indicates that there are no villi, (2) there is no evidence of pregnancy in the uterus, (3) the pregnancy test is still positive.

Given these circumstances, the Respondent should have suspected and tested for an ectopic pregnancy from the time the pathology report on the tissue obtained at the August 3, 1990 abortion showed "no chronic villi," until the ectopic was removed on September 6, 1990. He failed to do so.

The Hearing Committee concludes that page 9 of Exhibit 3 and Exhibit 3B are knowing and intentional fabrications designed to cover up the Respondent's failure to diagnose the ectopic pregnancy.

The Hearing Committee also concludes that the Respondent's note of August 22, 1990, "no complaints" and "Pt states she could not afford any more blood tests," are false.

## FINDINGS AS TO PATIENT B

38. The Respondent treated Patient B, a 32 year old female, at St. John's Episcopal hospital, Smithtown Division, Smithtown, New York from February 25, 1989 through March 1, 1989 (Pet's. Ex. 8).

39. On February 25, Patient B was admitted to the hospital in shock. Her complaints and condition on admission were consistent with an ectopic pregnancy.
The Respondent's plan was a laparotomy (Pet's. Ex. 8; Tr. 203-206).

40. Patient B had suffered a ruptured ectopic in the mid portion of the left tube (Pet's. Ex. 8; Tr. 821).

41. The Respondent performed a partial salpingectomy (Tr. 207).

42. Patient B was bleeding before, during and after her partial salpingectomy (Pet's. Ex. 8; Tr. 417).

43. It was then decided by Dr. Basile and the Respondent to cross clamp the infundibulopelvic ligament to obtain hemostasis and this was done successfully. The clamping of the infundibulopelvic ligament and ovarian ligament stopped the bleeding (Tr. 418, 822).

44. Once the infundibulopelvic ligament is clamped and the blood supply to the ovary is compromised there is the possibility that the ovary may become necrotic and be the source of complications. Under the circumstances it is appropriate to remove the ovary (Tr. 625-626, 822-823, 842-844, 1015).

## CONCLUSIONS

The removal of Patient B's left ovary was appropriate given the circumstances of this case.

## FINDINGS AS TO PATIENT C

45. The Respondent treated Patient C, a 23 year old female, at his office from April 11, 1985 through April 18, 1985 (Pet's. Ex. 9).

46. On April 11, 1985, Patient C presented with complaints of irregular bleeding and some cramping. Her last menstrual period is noted as having begun on March 17, 1985. Her past history included irregular bleeding, cramping and chronic pelvic inflammatory disease (PID). A urine pregnancy test and urinalysis are recorded as negative. Pelvic examination showed a mildly tender cervix, no adnexal masses, and a vaginal odor. The Respondent's impression was noted as "Recurrent chronic pid." A pap smear was obtained and the Respondent prescribed Amoxicillin 500 mg po qid. He did not do cultures for chlamydia or gonorrhea (Pet's. Ex. 9, pp. 4-5; Tr. 248-251, 258-260, 335, 856-858).

47. There was no primary reason for the Respondent to suspect that Patient C was pregnant on April 11, 1985. However, this Patient presented with no bleeding, an odor, a previous history of PID, a negative pregnancy test and she had not missed a period. Under these circumstances it was improper for the Respondent to have limited his diagnosis solely to PID (Tr. 260-262, 1031).

48. A patient with a history of PID is more prone to ectopic pregnancy (Tr. 251, 284-285).

49. On April 18, 1985, Patient C returned, still symptomatic, complaining of mild cramping and bleeding. The Respondent noted that the patient 's pelvic examination was unchanged. This means that the adnexa was still negative for masses and non tender, and the cervix continued to be mildly tender.

The Respondent advised Patient C to continue the antibiotics and gave her Anaprox for pain (Pet's. Ex. 9, p.5; Tr. 252, 264, 287-289, 859, 1031-1032).

50. April 18, 1985 was approximately one month since the onset of Patient C's last reported period (Tr. 263).

51. The Respondent did not perform a pregnancy test on April 18, 1985. He admitted that he did not suspect that the Patient was pregnant on either April 11th or April 18th and that he did not think that her symptoms on April 18th warranted further tests or examination. He considered this problem to be continuation of PID or a bad period and he advised the Patient to call him if her symptoms persisted (Tr. 263, 861, 867-870).

52. On April 27, 1985, Patient C was hospitalized at Brookhaven Memorial Hospital Medical Center, Patchogtue, New York, where she underwent a left salpingectomy for a ruptured left tubal pregnancy. She received three units of packed cells (Pet's. Ex. 10, pp. 5-6, 14, 17; Tr. 255).

## CONCLUSIONS AS TO PATIENT C

The Respondent failed to evaluate and/or treat Patient C for an early unruptured ectopic pregnancy on April 18, 1985. He failed to perform appropriate diagnostic tests to establish a diagnosis for the patient when she remained symptomatic after a week of antibiotic therapy. He

should have done a cervical culture for gonorrhea and chlamydia, a pregnancy test and a pelvic sonogram. Depending on the results, the Respondent should have admitted the Patient for a laparoscopy.

## FINDINGS AS TO PATIENT D

53. Patient D's blood type is AB Rh negative, Du negative. Her Rh negative status was correctly determined in January 1991, when she delivered her first child at University Hospital, Health Sciences Center, State University of New York at Stony Brook. Patient D's private obstetrician's records also reflect that she was Rh negative, Du negative. (Pet's. Ex. 12, p. 10-13, 37, Pet. 13, p. 13-14, 29-30; Tr. 296-297, 294, 300, 302).

54. The circling of the printed notation RH Negative. 15- on the Respondent's appointment sheet does not mean that the Patient has indicated that she was RH Negative. It is merely an indication that the Patient was advised that if she is tested to be RH Negative, there will be an additional $15.00 charge (Tr. 327-328, 346, 360-361, 459-460).

55. Patient D was tested twice at the Respondent's office for RH Factor and was determined to be RH Positive by two different nurses (Resp's. Ex. D; Tr. 332).

56. On November 28, 1988, the Respondent performed a termination of pregnancy by suction curettage on Patient D at his office (Pet's. Ex. 11; Tr. 291).

57. Rhogam or MicRhogam should be administered to an RH Negative patient at the time of the abortion. Neither was administered in this case (Tr. 291-296, 302-308, 315, 898-902).

## CONCLUSIONS AS TO PATIENT D

Patient D was RH Negative and the Respondent should have administered Rhogam or MicRhogam at the time of the abortion. However, the Respondent's failure to prescribe Rhogam or MicRhogam was occasioned by the fact that the patient had tested twice erroneously as RH Positive by two different nurses in his office.

The Hearing Committee concludes that the Respondent's care of Patient D was not unreasonable and did not deviate from accepted medical standards given the circumstances of this case.

## CONCLUSIONS OF THE HEARING COMMITTEE REGARDING CREDIBILITY

Patient A was a credible witness. She was candid and direct and her testimony was consistent during direct examination, cross-examination and the Hearing Committee's questioning.

The Respondent was not a credible witness particularly with regard to his testimony concerning his treatment of Patient A. The Hearing Committee rejects the Respondent's claims that he provided appropriate care to Patient A even where it is not recorded.

The Hearing Committee also rejects the Respondent's contention that page 9 of Exhibit 3, (Patient A's medical record) was not intended as part of the patient 's medical record but merely a narrative prepared to assist him in reporting to his medical malpractice carrier. Also, a copy of Patient A's medical records, without the page marked as Exhibit 3B in evidence, was certified as complete, when forwarded to the Office of Professional Medical Conduct. The Hearing Committee has concluded that Page 9 of Exhibit 3 and Exhibit 3B are knowing and intentional fabrications designed to cover up the Respondents failure to diagnose the ectopic pregnancy.

Eileen Garfen, an LPN who worked for the Respondent since 1988, was not a credible witness. She testified that on August 22, 1990 she heard the Respondent tell Patient A that he wanted a second beta sub unit to rule out a possible ectopic and that the patient refused to have any

additional tests. However, she admitted under questioning by Dr. Goldstein that she was not sure that she was even in the room when the patient was examined or on what dates she spoke to the patient. Also there are no notes of the conversations she claims to have had with the patients.

## VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

**FIRST SPECIFICATION:** (Practicing With Negligence On More Than One Occasion)

**SUSTAINED** As to the charges specified in paragraphs A, A(1), C, C(1) & (2) of the Statement of Charges.

**NOT SUSTAINED** As to the charges specified in paragraphs B, B(1), D, D(1) & (2) of the Statement of Charges.

**SECOND SPECIFICATION:** (Practicing Fraudulently)

**SUSTAINED** As to the charges specified in paragraphs A, A(2)(a) & (b) of the Statement of Charges.

**THIRD SPECIFICATION:** (Failing To Keep Accurate Records)

**SUSTAINED** As to the charges specified in paragraphs A, A(2)(a) & (b) of the Statement of Charges.

## DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee has concluded that the Respondent failed to properly diagnose ectopic pregnancies in two cases, Patient A and Patient C. The Hearing Committee has also concluded that the Respondent knowingly and intentionally falsified portions of Patient A's medical record to cover up his failure to diagnose the ectoopic pregnancy. Such action constitutes fraud in the practice of medicine.

In addition, the Hearing Committee also concludes that the Respondent is a sloppy, indifferent practitioner who does not provide quality care to his patients.

After the Hearing Committee had voted on the charges, SUSTAINING those charges relative to Patient A and C and NOT SUSTAINING those charges relative to Patient B and D, the Administrative Officer submitted to each member of the Hearing Committee a copy of the documents relative to the disciplinary action by the State Education Department against the Respondent in May 1988.

After a review of these documents, the Hearing Committee concludes that the Respondent has no insights into his own failings or the need to change his practice. Prior discipline has only left him bitter.

The Hearing Committee further concludes that the Respondent is uneducable and, if permitted to practice, would continue to in the same negligent and sloppy manner.

Considering only those violations found in the present case, a majority of the Hearing Committee voted to REVOKE the Respondent's license to practice medicine. However, when the Hearing Committee considered the violation in the present case and the record of the 1988 disciplinary action, the vote to REVOKE was UNANIMOUS.

## ORDER

**IT IS HEREBY ORDERED THAT:**

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

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

**DATED: New York, New York**
11/10/95 **1995**

Priscilla R. Leslie

**PRISCILLA R. LESLIE, Chairperson**

**RUFUS NICHOLS, M.D.**
**NAOMI GOLDSTEIN, M.D.**

# APPENDIX I

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

| | |
|---|---|
| IN THE MATTER OF STANLEY BROWN, M.D. | NOTICE OF HEARING |

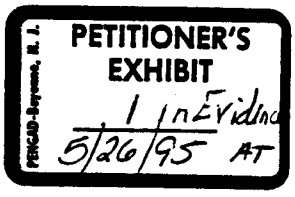
TO: STANLEY BROWN, M.D.
2500 Route 347, Suite 8C
Stony Brook, N.Y. 11790

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act Sections 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 the 12th day of June, 1995 at 10:00 in the forenoon of that day at 5 Penn Plaza, Sixth Floor, New York, New York 10001 and at such other adjourned dates, times and places as the committee may direct.

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. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce





witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (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. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1995), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 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.

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 to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

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 THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York

May 3, 1995

ROY NEMERSON
Deputy Counsel

Inquiries should be directed to: Marcia E. Kaplan
Bureau of Professional
Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001
Telephone No.: 212-613-2615

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

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| IN THE MATTER | : | STATEMENT |
| OF | : | OF |
| STANLEY BROWN, M.D | : | CHARGES |

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STANLEY BROWN, M.D., the Respondent, was authorized to practice medicine in New York State on July 1, 1977 by the issuance of license number 131011 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through September 30, 1996 from 2500 Route 347, Suite 8C, Stony Brook, N.Y. 11790.

## FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a 32 year old female, at Stony Brook Women's Health Services, 2500 Route 347, Stony Brook, N.Y., (hereafter "office") from on or about August 3, 1990 through on or about August 22, 1990, and at Community Hospital of Western Suffolk, 498 Smithtown Bypass, Smithtown, N.Y., from on or about September 6, 1990 through on or about ~~October 8, 1990~~. (The identity of Patient A, and all other patients, is disclosed in the attached Appendix.) On or about August 3, 1990,

Respondent performed a suction curettage on Patient A at the office. On or about August 3, 1990, Respondent noted, upon macroscopic examination, that he sent "macerated tissue" to pathology; however, on or about August 11, 1990, the pathologist reported that the microscopic examination of the abortion tissue showed "hypersecretory endometrium" and "no villi." A Beta HcG performed on or about August 13, 1990 was 8310. A sonogram performed on or about August 14, 1990 was reported as negative. Patient A was seen by Respondent on or about August 15, 1990, and advised to return in two weeks if no menses occurred. On or about August 22, 1990, Patient A returned. Respondent noted normal findings upon physical examination.

On or about September 6, 1990, Patient A presented to the emergency room at Community Hospital of Western Suffolk with right lower quadrant pain and vaginal bleeding. She was admitted and Respondent performed a left salpingo-oophorectomy for ectopic pregnancy.

1. Respondent failed to rule out ectopic pregnancy in a timely manner during the period after the pathology report of the tissue obtained at the August 3, ~~1993~~ abortion showed "no chorionic villi" and continuing until the ectopic ~~ruptured~~ on or about September 6, 1990.

2. Respondent knowingly failed to keep accurate records concerning his evaluation and treatment of Patient A, as follows:

a. A page in the record contains entries dated "8/13/91" and "8/14/91" which purportedly memorialize events of August 13-14, 1990. The entry for "8/13/91" states that the patient was given an appointment for "Wed 8/15/91," when in fact 8/15/91 occurred on a Thursday, and the entry for "8/14/91" states falsely that the patient was notified of a possible D&C on Wednesday and told not to eat or drink after midnight Tuesday.

b. The patient record for August 22, 1990 states falsely that Patient A offered "no complaints," when in fact, Patient A complained of continued bleeding, and further states falsely that in response to Respondent's recommendation that she have a repeat beta subunit (blood pregnancy test), the patient said that she could not afford any more blood tests.

B. Respondent treated Patient B, a 32 year old female, at St. John's Episcopal Hospital, Smithtown Division, Smithtown, N.Y., from on or about February 25, 1989 through on or about March 1, 1989. On or about February 25, 1989, Respondent performed a left salpingo-oophorectomy. The left tube contained a 1.0 cm. ruptured ectopic pregnancy (which Respondent estimated as 1.5 cm) without ovarian involvement. The pathology report showed a normal left ovary.

1. Respondent performed a left oophorectomy without appropriate medical indication.

C. Respondent treated Patient C, a 23 year old female, at his office (address unrecorded) from on or about April 11, 1985 through April 18, 1985. On or about April 11, 1985, Patient C presented with complaints of irregular bleeding and some cramping. Her LMP is noted as March 17, 1985. Her past history included P.I.D. and irregular bleeding. She used no contraceptives. A urine pregnancy test and urinalysis are recorded as negative. Pelvic examination showed a mildly tender cervix, no adnexal masses, and a vaginal odor. Patient C's impression is listed as "Recurrent chronic pid (pelvic inflammatory disease.)" Respondent prescribed Amoxicillin 500 mg po qid. On or about April 18, 1985, Patient C returned complaining of mild cramping and bleeding. Pelvic examination was unchanged. She was advised to continue antibiotics. On or about April 27, 1985, Patient C was hospitalized at Brookhaven Memorial Hospital Medical Center, Patchogue, N.Y., where she underwent a left salpingectomy for a ruptured left tubal pregnancy. She received three units of packed cells.

1. Respondent failed to evaluate and/or treat Patient C for an early unruptured ectopic pregnancy on or about April 18, 1985.

2. On or about April 18, 1985, after Patient C remained symptomatic after a week of antibiotic therapy, Respondent failed to perform appropriate diagnostic tests to establish a diagnosis.

D. On or about November 28, 1988, Respondent performed a termination of pregnancy by suction curettage for an eight week

size pregnancy on Patient D, a 25 year old female, at Stony Brook Women's Health Services (hereafter "office"), The Appointment Sheet indicates "RH Neg. 15-. " In the the Nurse's notes in the office record, Patient D's blood type is noted as "Rh Positive." Patient D was not given MicRhogam. Patient D was subsequently admitted to University Hospital, Health Sciences Center, State University of New York at Stony Brook, Stony Brook, N.Y., in on or about December, 1988 and in or about January, 1991. During the January, 1991 hospitalization, when Patient D delivered her first child, Patient D's blood type was recorded as AB Rh negative, Du negative.

1. Respondent failed to ascertain that Patient D's blood type was Rh Negative, Du negative, prior to performing a termination of pregnancy by suction curettage on or about November 28, 1988.

2. Respondent failed to prescribe MicRhogam for Patient D after the abortion which he performed on or about November 28, 1988.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

1. Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law

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

The facts in paragraphs A and A.1, B and B.1, C and C.1 and/or C.2, D and D.1 and/or D.2.

SECOND SPECIFICATION

PRACTICING FRAUDULENTLY

2. Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Sec. 6530(2) (McKinney Supp. 1995), as follows:

The facts in paragraphs A and A.2(a) and/or A.2(b).

THIRD SPECIFICATION

FAILING TO KEEP ACCURATE RECORDS

3. Respondent is charged with failing to maintain a record for Patient A which accurately reflects the evaluation and treatment of the patient under N.Y. Educ. Law Sec. 6530(32) (McKinney Supp. 1995), as follows:

The facts in paragraphs A and A.2(a) and/or A.2(b).

DATED: May 3, 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical
Conduct