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

February 21, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Marcia E. Kaplan, Esq.
NYS Dept. of Health
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 11790

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

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

EFFECTIVE DATE 2/28/96

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

Enclosed please find the Determination and Order (No. 95-271) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. The Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER

OF

STANLEY BROWN

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 95-271

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on January 10 and January 12, 1996[1], to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) November 17, 1995 Determination finding Dr. Stanley Brown (Respondent) guilty of professional misconduct. The Respondent requested the Review through a Notice which the Board received on November 12, 1995. James F. Horan served as Administrative Officer to the Review Board. Leland Stuart Beck, Esq. filed a brief for the Respondent on December 13, 1995. Marcia Kaplan, Esq. filed a reply brief for the Office of Professional Medical Conduct.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

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

[1]The Board conducted the January 12, 1996 deliberations by conference call.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with practicing medicine with negligence on more than one occasion in the treatment of four persons, whom the record refers to as Patients A through D. The Petitioner charged further that the Respondent practiced medicine fraudulently arising in relation to records the Respondent prepared relating to Patient A.

The Committee did not sustain any charges relating to Patients B and C. The Committee found the Respondent guilty of negligence on more than one occasion, for treating Patients A and C, failure to maintain accurate records for Patient A and fraud arising from the record the Respondent maintained for Patient A.

The Committee found that the Respondent failed to evaluate and treat Patient C for an early unruptured ectopic pregnancy on April 18, 1985. The Committee found that the Respondent failed to perform appropriate diagnostic tests to establish a diagnosis for the Patient when she remained symptomatic after a week of antibiotic therapy. The Committee found that, based on the Patient's symptoms, the Respondent should have done a cervical culture for gonorrhea and chlamydia, a pregnancy test and a pelvic sonogram. The Committee found further that, depending on the test results, the Respondent should have admitted the Patient for a laparoscopy.

The Committee found further that the Respondent had failed to evaluate and treat an ectopic pregnancy in Patient A. The Committee found that the Respondent performed a termination of pregnancy on Patient A on August 3, 1990. The Committee found that following such a procedure, the physician must determine whether villi are present either first by visual inspection, or if unable to find villi in that manner, then by sending tissue to a pathologist. The Committee found that after the August 3, 1990 termination, a pathology report indicated no villi were present. The Committee

found that if not diagnosed in time, an ectopic pregnancy may rupture, causing intra-abdominal bleeding, and even death. The Committee found further that the Respondent should have considered an ectopic pregnancy following a report showing an empty uterus. The Committee found that blood work indicated the Patient was still pregnant. The Committee found that the blood tests should have led the Respondent to suspect and test for ectopic pregnancy. The Committee found that as of August 15, 1990, the Respondent told the Patient that the abortion had been successful and that the Respondent did not mention the possibility of an ectopic pregnancy at that time. The Committee found that the Respondent did not discuss the possibility of ectopic pregnancy with the patient until September 6, 1990, after the Respondent had already performed an initial surgical procedure on the patient to "rule out an ovarian mass".

The Committee found that the Respondent should have suspected and tested for ectopic pregnancy from the time he obtained the pathology report from the August 3, 1990 abortion, until the time that the ectopic pregnancy was removed during a second surgical procedure on September 6, 1990. The Committee found that the Respondent failed to do so.

As to the fraud charge, the Committee found that the Respondent knowingly and intentionally fabricated a record (DOH Ex. 3, page 9) designed to cover up the Respondent's failure to diagnose the ectopic pregnancy. The Committee also found that notes in Patient A's August 22, 1990 record were false.

As to medical records, the Committee found the Respondent's record for Patient A was kept in haphazard fashion at best and was knowingly and intentionally altered.

The Committee made their findings in Patient A's case, in part based on Patient A's testimony. The Committee found Patient A to be a credible witness. The Committee found that the Respondent was not a credible witness, particularly in regard to his testimony concerning Patient A and in his testimony concerning DOH Ex. 3, page 9. The Committee also found the Respondent's nurse, Eileen Garfen, LPN, was not a credible witness, concerning her testimony about Patient A.

The Committee concluded that the Respondent was a sloppy, indifferent practitioner, who does not provide quality care to his patients. The Committee stated that following their votes sustaining the charges in Patient A's case and Patient C's case, the Administrative Officer submitted to each member a copy of documents relating to disciplinary action the State Education Department took against the Respondent in 1988 (Board of Regents No. 7372)[2]. After reviewing that material, the Committee concluded that the Respondent had no insight into his failings or his need to change his practice and that prior discipline had only left the Respondent bitter. The Committee concluded that the Respondent is uneducable, and if permitted to practice, would continue to practice in the same negligent and sloppy manner.

The Committee stated that, considering only the violations in the present case, the Committee voted 2-1 to revoke the Respondent's license. When the Committee considered the present case and the 1988 findings of misconduct, the Committee voted unanimously to revoke the Respondent's license.

REQUESTS FOR REVIEW

RESPONDENT: The Respondent argues that the record does not support the Committee's findings with respect to Patients A and C. The Respondent argues that the Committee's findings ignore uncontradicted testimony, testimony by the Petitioner's expert and exhibits created contemporaneously with the events. The Respondent argues that the Committee's findings are self contradictory upon vital matters and unsubstantiated by the Committee's references. The Respondent asks that the Committee's Determination be reversed.

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[2]In the earlier action, the Board of Regents found the Respondent was guilty of negligence on more than one occasion and failure to maintain adequate records. They found that the Respondent failed to diagnose an ectopic pregnancy in 1981, and that the Respondent had performed an incomplete abortion and failed to examine fetal tissue in a case in 1983. The Regents also found that the Respondent's records omitted significant information and showed numerous blanks and gaps in information called for on printed forms. The Commissioner of Education suspended the Respondent's license for two years, stayed the suspension and placed the Respondent on probation for two years.

The Respondent challenges the Committee's findings that are based on testimony by Patient A and which rejected testimony by the Respondent and his nurse, Ms. Garfen. The Respondent alleges that the Committee's findings are haphazard and indicate that the Committee did not seriously consider the evidence in this case. The Respondent argues that the record does not contain evidence of the essential elements of fraud and that there was no evidence in the record to support a finding that the records were intentionally altered. As to Patient C, the Respondent argued that the only basis for the conclusions reached by the Committee is a review of the Patient's record by the Petitioner's expert. The Respondent argues that in reaching its conclusions, the Committee dealt with matters outside the charges presented and based their determination on selections from the record taken out of context, without giving consideration to the entire record. As to the records finding, the Respondent contends that there was no basis for considering that the Respondent's record was haphazard or altered. The Respondent contends that his records are as complete as any the Review Board will examine. The Respondent argues that the Committee's Determination failed to list the name of one of the Respondent's expert witnesses, that the Committee completely ignored the Respondent's proposed findings of fact and that the Determination is based largely on guess or surmise.

The Respondent argues that, if the charges are sustained, the penalty of revocation is an outrageous abuse of administrative power, because the Respondent did not harm any patient, did not steal money, did not violate any Narcotics Laws and provided good, acceptable, legal medical services to a vast range of patients, at a fair and reasonable charge. The Respondent argues that the excessive punishment supports the conclusion that the Committee entered the proceeding with a pre-determined agenda.

In a letter dated December 19, 1995, the Respondent's counsel argued that the Petitioner's failure to file a brief constituted a default and meant that the matter was being submitted to the Review Board without opposition. In a January 2, 1996 letter, the Respondent's counsel argued that he Petitioner's reply brief was improperly served and that the Petitioner's arguments failed to counter the Respondent's strong and detailed condemnation of the Committee's Determination. The Respondent contended that there was no answer to the Respondent's position before the Review Board.

PETITIONER: The Petitioner argues that the Board should reject the Respondent's repeated and inappropriate invitation for the Board to go beyond our authority and to change findings of fact and determinations as to credibility. The Petitioner also asks that the Board reject the Respondent's attacks on the impartiality of the Hearing Committee. The Petitioner contends that the Hearing Committee's conclusions are supported by their detailed findings and their penalty is appropriate.

REVIEW BOARD DETERMINATION

The Review Board has considered the record below and the briefs which counsel have submitted. The Review Board rejects the Respondent's request that we find the Petitioner in default. The Petitioner filed a reply which the Respondent and the Board received. There are no rules of pleading in these reviews that require an opposing party to answer the appealing party point for point. The appealing party, rather, must raise issues that will convince the Review Board to modify or overrule a Hearing Committee's Determination. The Review Board finds no merit in the Respondent's contentions concerning either the Committee's Determination that the Respondent was guilty of negligence on more than one occasion, fraud or failure to maintain adequate records, and, no merit in the Respondent's contentions concerning the Committee's Determination to revoke the Respondent's license to practice medicine in New York State.

FRAUD IN PRACTICING MEDICINE: The Review Board votes 5-0 to sustain the Hearing Committee's Determination that the Respondent committed fraud in the practice of medicine 1) by causing a page to be placed in Patient A's medical record dated 8/13-14/91, that purportedly memorialized events of 8/13-14/90 and, 2) for making false entries in Patient A's record for August 22, 1990. The Committee's Determination is consistent with their conclusions that Page 9 of DOH Exhibit 3 is a knowing and intentional fabrication designed to cover up the Respondent's failure to diagnose Patient A's ectopic pregnancy, and, is consistent with the Committee's conclusion that the August 22, 1990 notes, stating that Patient A offered no complaints and stating that she indicated that she could not afford more blood tests, were false.

The Respondent contends that the record does not contain evidence of essential elements of fraud: intent, misrepresentation, reliance and detriment. Fraud as defined by Education Law §6530(2), however, requires only a showing that the Respondent misrepresented or concealed a known fact, Matter of Adler, 211 AD2d 990, 622 NYS2d 609 (Third Dept. 1995). The record in this case demonstrates clearly that the Respondent provided a photocopy of documents to the Health Department, which the Respondent, on December 23, 1991, certified to be the complete, true and exact copies of Patient A's record (DOH Ex. 3, page 9; Tr. p. 764). The packet contained a page 9, dated August 13-14, 1991, which the Respondent's nurse Ms. Garfen prepared, at the Respondent's direction, the year after the treatment of Patient A (Tr. pp. 474, 491, 734, 763-764, 779) and which the Respondent and Ms. Garfen claim was a narrative that Ms. Garfen prepared so that the Respondent could discuss the care with his malpractice carrier, after Patient A wrote to the Respondent threatening a malpractice action (Tr. pp. 491, 734). Such testimony, however, is merely a credibility issue for the Committee to resolve and the Committee is not required to accept the Respondent and Nurse Garfen's explanations, Matter of Hachmovitch, 206 AD2d 637, 614 NYS2d 608 (Third Dept. 1994); Matter of Van Gaasbeek, 198 AD2d 572, 603 NYS2d 223 (Third Dept. 1993). The Committee may infer fraud from the surrounding circumstances (Matter of Hachmovitch, supra; Matter of Van Gaasbeek, supra).

Concerning Exhibit 3, page 9, the Committee could clearly infer from the record that Nurse Garfen prepared that page at the Respondent's direction to cover up his failure to diagnose Patient A's ectopic pregnancy. Page 9 is not written in a letter or memorandum form. It is handwritten by Nurse Garfen in the same style as other pages of the record, with Ms. Garfen's name at the end of each entry, in the style that a health care practitioner would sign an entry in a medical record, and in the style Ms. Garfen and the Respondent signed entries in other pages in the record. Also, although Ms. Garfen and the Respondent testified that it was written the year following Patient A's treatment, the passages in the record are written in the present tense, such as "she wishes to use L.I. Diag since it is closer to home" and "will await results". The Respondent was aware as of June, 1991 that patient A was contemplating a malpractice suit and the Hearing Committee could assume that the Respondent was aware, at the time that he sent the copy of Patient A's records to the Health Department in December,

1991, that the Health Department was looking into Patient A's case.

The Committee's conclusion that the Respondent's entry for August 22, 1995 is false (DOH Ex. 3, p. 15) is supported by the Committee's Finding of fact 37, and that Finding is supported by the Committee's citations to the record. Patient A testified that she never made the statement that she was unable to afford further tests and Patient A testified that she told the Respondent that she had pain in her side and bleeding. Based on that testimony and the conflicting information in the record, the Committee could infer that the Respondent made false entries in the August 27, 1990 note to cover up the Respondent's failure to follow up on the Patient's complaint of bleeding and pain. The Committee's conclusion concerning the August 22, 1990 note supports a separate finding that the Respondent committed fraud in the practice of medicine.

NEGLIGENCE-PATIENT A: The Committee's Findings and Conclusions are consistent with their Determination that the Respondent was negligent in failing to suspect and test Patient A for ectopic pregnancy, despite a pathology report that indicated no villi following the termination of pregnancy, despite no evidence of pregnancy in the Patient's uterus and despite a positive pregnancy test following the procedure. Patient A testified that the Respondent did not mention to her the possibility of ectopic pregnancy and that the Respondent told her that the termination of pregnancy was successful. The notes in the Respondent's record for Patient A do not contain any mention of the possibility of ectopic pregnancy and at the time the Respondent completed an emergency laparoscopy on the Patient at 6:00 P.M. on September 8, 1990, the Respondent made no mention in the Operative Report of ectopic pregnancy (DOH Ex. 3B, 7). The Respondent did not obtain the results of a blood pregnancy test before beginning the laparoscopy (FF 29) and the operative report for the first procedure had a diagnosis of "rule out ovarian mass". (FF 30) The failure to obtain the pregnancy report and the contents of the first operative report support a conclusion that the Respondent still did not suspect ectopic pregnancy at the time he concluded the first laparoscopy. The failure to suspect and test for ectopic pregnancy given the factors present in Patient A's case constituted negligence on the Respondent's part (FF 7, 8, 17, 18; Committee Conclusions, p. 18).

The Respondent argued that there was not substantial evidence to support the Committee's conclusions concerning the care for Patient A. This argument was based mainly on the Respondent's

contention that patient A was not a credible witness and that the Committee erred in rejecting testimony by the Respondent and Nurse Garfen, including testimony that the Respondent did suspect an ectopic pregnancy and told the Patient, but did not indicate this in the record. The issues the Respondent raised on this point go to credibility and to the weight which the Committee gave to conflicting testimony and evidence. Those decisions are the responsibility of the Hearing Committee, Matter of Nenno, 210 AD2d 827, 620 NYS2d 589 (Third Dept. 1994). The Committee determined that Patient A was a credible witness. The Committee found that the Respondent was not credible, especially with regard to Patient A and with regard to the page 9 in DOH Ex. 3. The Committee found that Nurse Garfen was not credible as a result of certain answers she made to questions by Dr. Goldstein of the Hearing Committee. The Review Board finds no reason to reject the Hearing Committee's conclusions on credibility. As we noted, the Board found sufficient grounds in the record to find that the Respondent fabricated page 9 of DOH Ex. 3 and that entries on page 15 of DOH Ex 3 were false. We further feel that the Committee acted properly in rejecting the Respondent's claim he suspected an ectopic pregnancy, but merely failed to note that in the record. A physician's records must contain sufficient information to assist a subsequent treating physician in reviewing patient history. A failure to record diagnosis or treatment in a record justifies a finding that no such diagnosis or treatment was made.

INADEQUATE RECORDS: The Review Board sustains the Hearing Committee's Determination finding that the Respondent failed to maintain adequate records for Patient A. As the Committee noted, the records were haphazard at best and were knowingly altered in Patient A's case. The Respondent argued that the Respondent's records were as complete as any the Board will examine. That contention by the Respondent, however, is inconsistent with even the Respondent's own testimony. The Respondent testified that documentation in Patient A's chart was not complete or was lacking (Tr. pp. 737, 795), or not what it should be (Tr. pp. 791, 803), and the Respondent stated that another obstetrician could conclude rightly that there was poor documentation in Patient A's chart (Tr. p. 738). The Respondent's own admissions about the poor documentation in his records

alone would support the Committee's Determination. Clearly, the finding that the Respondent fabricated a portion of patient A's chart also supports a finding that the Respondent failed to maintain an accurate record for Patient A.

NEGLIGENCE-PATIENT C: The Review Board sustains the hearing Committee's Determination that the Respondent was negligent for failing to evaluate and/or treat Patient C for an early unruptured ectopic pregnancy on April 18, 1985, and for failing to establish a diagnosis when the patient remained symptomatic after a week of antibiotic therapy. The Respondent contends that the entire basis for the Committee's findings was the testimony by an expert who reviewed the Respondent's records and a hospital record for Patient C[3]. The Respondent faults the Committee for rejecting testimony by the Respondent's experts. These arguments by the Respondent again center on issues going to credibility and weight of conflicting evidence. The Committee credited testimony by the petitioner's witness, based on Dr. Elahi's review of Patient C's records. That testimony and the records are sufficient to support the Committee's Determination as to Patient C.

The Respondent argued that the Committee's Finding of Fact 47 dealt with issues outside the record, because the charges made no mention of the April 11, 1985 office visit, which the Finding of Fact discusses. The Board finds, however, that the charge involving Patient C referred to an April 18, 1985 office visit and that all the findings supporting the Determination of negligence in treating Patient C arose from the April 18, 1985 office visit.

The Respondent alleged that there was no basis in the record for the Committee to find that the Respondent thought that Patient C's symptoms resulted from the Patient having a "bad" period (FF 51). In the testimony which the Committee cites (Tr. pp. 861, 867-870) to support their finding, the Respondent stated that he thought bleeding by the Patient might be the start of her period (Tr. 861, 870), but be he did use the phrase "bad" period. Whether or not the Respondent felt that the Patient's bleeding might be the beginning of the Patient's period or a "bad" period, however, does not matter. The charge involved the Respondent's failure to perform pregnancy and other tests on August 18,

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[3]The Respondent's brief at page 23, in the first sentence of the first full paragraph states that conclusions drawn by the Committee were based on a review of records "by their expert." The Board assumes that this reference was to the Petitioner's expert Dr. Elahi, as the findings relating to Patient C are based on Dr. Elahi's testimony.

1985. At Finding of Fact 51, the Committee found that the Respondent did not test for pregnancy on April 18, 1985 and did not suspect pregnancy on April 18, 1985. The Respondent's testimony (Tr. pp. 861, 867-870) supports that Finding.

OTHER ISSUES REGARDING MISCONDUCT DETERMINATION: The Respondent made other allegations attacking the Committee's Report, such as that the Committee failed to refer to any testimony by the Respondent's experts, that the Report failed to even list that the Respondent's expert David Sherman, M.D., that the Committee did not adopt even the Respondent's uncontradicted findings of fact, that the Committee's work was haphazard, that the Committee's findings were inconsistent and that the Committee did not carefully review the evidence. The Board has already noted that the Committee as finder of fact may consider and reject evidence. The Committee accepted credible evidence which supports their findings and conclusions. Their findings and conclusions support their Determination that the Respondent was guilty of negligence on more than one occasion, fraud and failure to maintain accurate records. The Committee was within their authority to reject testimony by the Respondent's experts and to reject the Respondent's proposed findings of fact. We note that although Dr. Sherman was not listed as a witness on Page 2 of the Committee's Determination, the Committee did accept Dr. Sherman's testimony in adopting Findings of Fact 44, 47 and 49. They also accepted testimony by the Petitioner's witness Dr. Leonard Roberts in support for Finding 44.

Finally, the Review Board finds nothing in the record to support the Respondent's other contentions concerning the Committee's Determination that the Respondent was guilty of misconduct.

PENALTY: The Review Board sustains the Committee's Determination revoking the Respondent's license to practice medicine in New York State. Revocation would be the appropriate penalty based only on the Committee's finding that the Respondent committed fraud in the practice of medicine. Revocation would also be the appropriate penalty based only on the Committee's finding that the Respondent was guilty of repeated acts of negligent conduct, for failure to suspect and test for ectopic pregnancy, and that the Respondent had no insight into his failings or the need to change

his practice.

Committing fraud in the practice of medicine is grounds to revoke a physician's license. Integrity is essential in the practice of medicine and the Respondent demonstrated that he lacks such integrity, by fabricating a record to cover up his failure to diagnose Patient A's ectopic pregnancy.

The Respondent's failure to diagnose ectopic pregnancies in Patients A and C placed both at risks of ruptured ectopic pregnancies, which can cause death. We reject the Respondent's contention that the Respondent caused no harm. In addition to the danger to which the Respondent exposed both Patients A and C, Patient A suffered harm through the pain she endured and the blood loss, during the time the Respondent failed to suspect or test her for ectopic pregnancy. The Patient also had to undergo two operations on September 6, 1990, because even at the completion of the first operation, the Respondent still did not suspect ectopic pregnancy.

The Education Department documents, which the Committee viewed following their Determination on the Specifications of Misconduct, demonstrate that the Respondent was disciplined in 1988, for failing to treat an ectopic pregnancy in 1981, for performing an incomplete abortion in 1983 and for failing to maintain adequate records. The prior disciplinary findings, combined with the Hearing Committee's Determination on Specifications in the present case, demonstrate a repeated a pattern of substandard care that exposed the Respondent's patients to danger. At the time of Patient A's treatment in 1990, the Respondent should have recently completed his probation from the earlier disciplinary proceeding. The Respondent's mistakes in Patient A's case demonstrate that, despite the earlier findings that the Respondent had failed to treat an ectopic pregnancy and that the Respondent had performed an incomplete abortion, the Respondent still had no insight into his failings or does not recognize the need to change his practice. The Respondent's testimony at the hearing further demonstrates that he lacks insight and recognition to correct his deficiencies. On several occasions the Respondent testified that his record keeping was poor (Tr. pp. 738, 791, 795, 803). The Respondent also stated that, in hindsight, he would keep better records (Tr. p. 737, 758) and that he would have proceeded differently in the cases of Patients A and C (Tr. pp. 765, 869). Hindsight from the Respondent's mishandling of similar cases that resulted in the earlier proceeding, however, provided the Respondent with no insight in treating Patient A in 1990 and no insight into correcting

his poor record keeping. The only motivation that may have resulted from the prior disciplinary action may have been the Respondent's motivation to fabricate the information in Patient A's record to cover up his failure to suspect and treat an ectopic pregnancy.

The Respondent has committed repeated acts of negligence which placed his patients in danger. He failed to correct those deficiencies after one disciplinary proceeding and he demonstrated in his testimony at the hearing that he still has no insight or motivation to correct his pattern of practice. This evidence demonstrates he is not educable, and, if permitted to practice, would continue in the same negligent and sloppy manner.

The Respondent's pattern of negligent practice constitutes a danger to his patients. Since the Respondent is not willing and/or capable of correcting his deficiencies, revocation is the only penalty that is appropriate to protect the public. The Board finds that a limitation of the Respondent's license would not be a sufficient penalty, because the Respondent's repeated acts of negligence reflect on his general competence to practice medicine.

The Respondent contended that the Hearing Committee's Determination was evidence of their bias against the Respondent and that the Committee had predetermined the penalty in the Respondent's case. The Respondent offered no proof of bias, other than the assertion that the Committee's Determination of guilt was unsupported by the evidence and that the penalty was unduly harsh. The Board concludes that the record in this case shows no bias on the Committee's part. The Committee made no findings of guilt in the cases of Patients B and D, and one Committee member dissented from the vote to revoke the Respondent's license, until learning of the Respondent's disciplinary history. Having found that the Committee's Determination is supported by the record and that the Committee's penalty is appropriate, there is no ground left to support the Respondent's claim of bias.

ORDER

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

1. The Review Board **SUSTAINS** the Hearing Committee's November 17, 1995 Determination finding Dr. Stanley Brown guilty of professional misconduct.

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

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

IN THE MATTER OF STANLEY BROWN, M.D.

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

DATED: Schenectady, New York
2/16, 1996

ROBERT M. BRIBER

IN THE MATTER OF STANLEY BROWN, M.D.

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

DATED: Delmar, New York

FEB. 14, 1996

SUMNER SHAPIRO

IN THE MATTER OF STANLEY BROWN, M.D.

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

DATED: Brooklyn, New York

2/13/96, **1995**

WINSTON S. PRICE, M.D.

IN THE MATTER OF STANLEY BROWN, M.D.

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

DATED: Roslyn, New York
Feb 14, 1996

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF STANLEY BROWN, M.D.

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

DATED: Syracuse, New York
14 Feb, **1995**

William A Stewart

WILLIAM A. STEWART, M.D.