New York State Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

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

Charles J. Vacanti, M.D.
Chair

June 21, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Martino Bernard, M.D.
60 Shawnee Avenue
Yonkers, New York 10710

License No. 136075

Dear Dr. Bernard:

Effective Date: 06/28/96

Enclosed please find Order #BPMC 96-149 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

Sincerely,

Charles Vacanti

Charles Vacanti, M.D.
Chair
Board for Professional Medical Conduct

Enclosure

cc: James Eberz, Esq.
118 North Bedford Road
P.O. Box 151
Mount Kisco, New York 10549

Terrence Sheehan, Esq.

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

IN THE MATTER

OF

MARTINO BERNARD, M.D.

SURRENDER

ORDER

BPMC #96-149

Upon the Application of MARTINO BERNARD, M.D. (Respondent) to Surrender his/her license as a physician in the State of New York, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted; it is further

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order via certified mail, whichever is earliest.

SO ORDERED.

DATED: 19 June 1996

Charles J. Vacanti

CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

MARTINO BERNARD, M.D.

APPLICATION TO SURRENDER LICENSE

STATE OF NEW YORK)
ss.:
COUNTY OF)

MARTINO BERNARD, M.D., being duly sworn, deposes and says:

In or about 1978, I was licensed to practice medicine as a physician in the State of New York having been issued License No. 136075 by the New York State Education Department.

My current address is 60 Shawnee Avenue, Yonkers, NY 10710, and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that I have been charged with FIFTEEN (15) specifications of professional misconduct as set forth in the Statement of Charges, annexed hereto, made a part hereof, and marked as Exhibit "A".

I am applying to the State Board for Professional Medical Conduct for permission to surrender my license as a physician in the State of New York on the grounds that I am guilty of the Thirteenth Specification insofar as it pertains to Patient C (paragraphs C and C.1 through C.7) and I do not contest the Thirteenth Specification insofar as it pertains to Patient F (paragraphs F and F.1 through F.7) in full satisfaction of the Statement of Charges.

It is agreed that, if the Board grants this application, the effective date of the

surrender of my medical license will be June 30, 1996.

I further agree that I will not treat patients with high risk pregnancies between the date I execute this application and June 30, 1996, the date my license surrender becomes effective.

I hereby make this application to the State Board for Professional Medical Conduct and request that it be granted.

I understand that, in the event that the application is not granted by the State Board for Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such application shall not be used against me in any way, and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the State Board for Professional Medical Conduct shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by a Committee on Professional Medical Conduct pursuant to the provisions of the Public Health Law.

I agree that, in the event the State Board for Professional Medical Conduct grants my application, an order shall be issued striking my name from the roster of physicians in the State of New York without further notice to me.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

Martino Bernard

MARTINO BERNARD, M.D.
Respondent

Sworn to before me this
4th day of June, 1996

Yvonne Rios Pace

NOTARY PUBLIC

YVONNE RIOS PACE
Notary Public, State of New York
Qualified in Dutchess County
Commission Expires 10/31/97

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

IN THE MATTER

OF

MARTINO BERNARD, M.D.

APPLICATION TO SURRENDER LICENSE

The undersigned agree to the attached application of the Respondent to surrender his license.

Date: 6/4, 1996

Martino Bernard

MARTINO BERNARD, M.D.
Respondent

Date: June 4, 1996

James G. Eberz

JAMES G. EBERZ, Esq.
Attorney for Respondent

Date: 6/12, 1996

TERRENCE SHEEHAN
Associate Counsel
Bureau of Professional
Medical Conduct

Date: June 17, 1996

ANNE F. SAILE
Acting Director
Office of Professional Medical Conduct

Date: 19 June, 1996

CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional Medical Conduct

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

IN THE MATTER OF MARTINO BERNARD, M.D.	STATEMENT OF CHARGES

MARTINO BERNARD, M.D., the Respondent, was authorized to practice medicine in New York State on or about 1978, by the issuance of license number 136075 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between on or about March 15, 1988 and on or about November 20, 1988 Respondent provided prenatal and in-hospital care to Patient A at his office located at 251 East Tremont Avenue, Bronx, N.Y. and at Bronx-Lebanon Hospital, Bronx, N.Y. (The names of patients are contained in the attached appendix):

1. Respondent failed to obtain and note an adequate history.
2. Respondent failed to perform and note an adequate physical examination.
3. Laboratory tests revealed a positive sickle cell screen. Respondent failed to adequately follow-up this finding.
4. While in the hospital Patient A received RHO Gam on November 13, 1988. Respondent failed to obtain a history of previous RHO Gam administration and a history of RH sensitization.
5. Respondent failed to order the following indicated tests: RH antibody, Rubella titres, hepatitis B screen, and hemoglobin

electrophoresis for sickle cell disease.

6. Given the history of a previous classical c/section and possible spontaneous uterine rupture before labor, Respondent should have ordered a early sonogram at 18 to 20 weeks, but failed to do so.

7. Respondent failed to make a diagnosis of intrauterine growth retardation.

8. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient's history, examination laboratory tests, interval notes and the transmission of pertinent information to the physicians treating the patient.

B. Respondent provided prenatal and obstetrical care to Patient B for pregnancies in 1986 and 1989 at his office and at Union Hospital, Bronx, N.Y. Regarding the treatment rendered in 1986:

1. Respondent failed to obtain and note an adequate history.

2. Respondent failed to perform and note an adequate examination.

3. Respondent failed to order the following indicated tests: Hepatitis B screen, blood type and Rh factor, blood glucose, Rubella titres, a CBC and urinanalysis.

4. On July 28 1986 and August 11, 1986, Respondent's office records note two fetal hearts. On August 25, 1986 only one fetal heart is noted. Respondent failed to follow-up on this new finding of one fetal heart in a twin gestation.

5. Respondent assisted in the performance of a C/section on

September 28, 1986. This surgery was not indicated. The patient should have been allowed to deliver vaginally.

6. Respondent failed in 1986 to maintain a medical record for Patient B which accurately reflects the patient's history, examination, interval notes and laboratory tests.

7. Regarding the prenatal and obstetrical care Respondent rendered in 1989: Respondent failed to obtain and note an adequate history.

8. Respondent failed to perform and note an adequate physical examination, including documentation of intrauterine growth and fetal assessment in a hypertensive patient.

9. Respondent failed to order the following indicated tests: Hepatitis B screen, early blood glucose, Rubella titres and repeat sonograms.

10. Patient B was a high risk obstetrical patient. A consultation with a high risk obstetrical specialist was indicated. Respondent failed to obtain one.

11. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient's history, examination, interval notes and laboratory tests.

C. Between on or about June 29, 1993 and on or about September 3, 1993 Respondent treated Patient C for a termination of pregnancy at Flushing Women's Center, Flushing, New York.

1. Prior to performing a suction curettage on June 29, 1993, Respondent failed to perform and note the findings of an adequate medical history and physical examination.

2. Respondent failed to obtain the following laboratory tests prior to performing the abortion: urine pregnancy test, hematocrit, blood type and Rh factor.

3. No products of conception were obtained. Respondent failed to inform Patient C that he had failed to terminate her pregnancy.

4. Respondent prescribed methergine which was not indicated.

5. On July 13, 1993, Patient C returned to Respondent. Respondent performed a second suction curettage, obtaining only minimal tissue. Respondent failed to inform Patient C that he had failed to terminate her pregnancy.

6. Respondent's repeated failure to terminate the patient's pregnancy subjected Patient C to an otherwise preventable midtrimester abortion, a procedure with a higher risk of morbidity and other adverse consequences.

7. Respondent failed to maintain a medical record for Patient C which accurately reflects the patient's history, examination and laboratory tests.

D. Between on or about September 15, 1993 and on or about March 9, 1994 Respondent provide prenatal care to Patient D at his office located at 251 East Tremont Avenue, Bronx, N.Y.

1. Respondent failed to perform and note an adequate physical examination.

2. Respondent failed to obtain and note an adequate history.

3. Respondent failed to inform Patient D that Respondent would be providing only prenatal care and that another physician would

have to perform the delivery and provide post-partum care. Respondent also failed to inform Patient D that it would be in her best medical interest to obtain a physician who would provide continuous care i.e., prenatal, delivery and post-partum care.

4. Respondent failed to order the following indicated tests: Hepatitis B screen, blood type and Rh factor, blood sugars, sonogram and serum alpha-feto proteins.

5. Respondent failed to consider this patient as a high risk obstetrical case due to, inter alia, a history of four premature births. Respondent failed to obtain a consultation with, or refer this patient to, a maternal - fetal medicine specialist.

6. Respondent failed to make an arrangement with another physician or hospital staff for her delivery and post-partum care.

7. Respondent failed to maintain a medical record for Patient D which accurately reflects the patient's history, examination and laboratory tests. Also missing are notes indicating that the patient was informed that Respondent intended to provide only prenatal care and that it would be preferable for her to receive continuous rather than fragmented pregnancy care; and a description of the nature of an arrangement with another physician for the patient's delivery and post-partum care.

E. Between on or about January 16, 1987 and on or about August 5, 1987 Respondent provided obstetrical care to Patient E at his office.

1. Respondent failed to obtain and note an adequate history.

2. Respondent failed to perform and note an adequate physical examination.

3. Because of history of three previous immature births, Patient E required very close monitoring, including repeat sonograms and pelvic exams to evaluate cervical condition. Respondent improperly failed to provide such monitoring and to recognize this patient as being a high risk patient.

4. On June 30, 1987 Patient E had a premature delivery, the infant weighing 1355 grams with an apgar of 4/7. Respondent failed to provide adequate monitoring, which would have prevented this premature birth.

5. Respondent failed to maintain a medical record for Patient E which accurately reflects the patient's history, examination and laboratory tests.

F. Between on or about December 12, 1991 and on or about January 29, 1992 Respondent provided prenatal care to Patient F at his office.

1. Respondent failed to obtain and note an adequate history.

2. Respondent failed to perform and note an adequate physical examination.

3. Respondent failed to inform Patient F that Respondent would be providing only prenatal care and that another physician would have to perform the delivery and provide post-partum care. Respondent also failed to inform Patient F that it would be in her best medical interest to obtain a physician who would provide continuous care i.e., prenatal, delivery and post-partum care.

4. Respondent failed to order the following indicated tests: Hepatitis B screen, blood type and Rh factor, serology, a CBC and urinanalysis.

5. Respondent failed to provide prenatal care to Patient F during her last eight weeks of pregnancy. Respondent failed to schedule an appointment for Patient F during this period of time or attempt to contact her.

6. Respondent failed to make an arrangement with another physician or hospital staff for her delivery and post-partum care.

7. Respondent failed to maintain a medical record for Patient F which accurately reflects the patient's history, examination and laboratory tests. Also missing are notes indicating that the patient was informed that Respondent intended to provide only prenatal care and that it would be preferable for her to receive continuous rather than fragmented, pregnancy care; and the nature of the arrangement with another physician for the patient's delivery and post-partum care.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATION
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in

N.Y. Educ. Law §6530(4)(McKinney Supp. 1996) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A1-A8.
2. Paragraphs B and B1-B11.
3. Paragraphs C and C1-C7.
4. Paragraphs D and D1-D7.
5. Paragraphs E and E1-E5
6. Paragraphs F and F1-F7.

SEVENTH THROUGH TWELFTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1996) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

7. Paragraphs A and A1-A8.
8. Paragraphs B and B1-B11.
9. Paragraphs C and C1-C7.
10. 1Paragraphs D and D1-D7.
11. Paragraphs E and E1-E5
12. Paragraphs F and F1-F7.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1996) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two

or more of the following:

13. Paragraphs A and A1-A8; B and B1-B11; C and C.1-C7; D and D1-D7; E and E1-E5 and/or F and F1-F7.

FOURTEENTH 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. 1996) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

14. Paragraphs A and A1-A8; B and B1-B11; C and C.1-C7; D and D1-D7; E and E1-E5 and/or F and F1-F7.

FIFTEENTH SPECIFICATION

FAILURE TO MAINTAIN ADEQUATE MEDICAL RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1996) by failing to maintain adequate medical records, as alleged in the facts of:

15. Paragraphs A and A8.
16. Paragraphs B and B11.
17. Paragraphs C and C7.

18. Paragraphs D and D7.

19. Paragraphs E and E5

20. Paragraphs F and F7.

DATED: February , 1996
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct