STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

October 27, 1992

NOT APPEALED

CERTIFIED MAIL - RETURN RECEIPT REQUESTED EFFECTIVE DATE 11/03/92

Ralph J. Bavaro, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Allan J. Greenberg, Esq.
2610 East 16th Street
Brooklyn, New York 11235

Clyde H. Springer, M.D.
c/o Medical Staff Office
Lindsey Hospital Medical Center
740 North Sequoia Avenue
Lindsey, Ca. 93247

Clyde H. Springer, M.D.
c/o Hillman Health Center
1062 South K Street
Tulare, Ca. 93274

RE: In the Matter of Clyde H. Springer, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. BPMC-92-91) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
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 than 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), "(t)he 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
Corning Tower - Room 2503
Empire State Plaza
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.

Very truly yours,

Tyrone T. Butler/crc

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	HEARING COMMITTEE'S FINDINGS OF FACT, CONCLUSIONS,
OF	:	DETERMINATION AND
CLYDE H. SPRINGER, M.D.	:	ORDER

ORDER NO. BPMC-92-91

JANE C. McCONNELL, CHAIRPERSON, GEORGE T. C. WAY, M.D., and ARTHUR J. WISE, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed pursuant to Section 230(1) of the Public Health Law of the State of New York, served as the hearing committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **GERALD H. LIEPSHUTZ, ESQ.,** served as administrative officer for the hearing committee.

After consideration of the entire record, the hearing committee issues its Findings of Fact, Conclusions, Determination, and Order.

SUMMARY OF CHARGES

Respondent was charged with the following acts of professional misconduct as more fully set forth in a copy of the STATEMENT OF CHARGES attached hereto:

1. Practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (FIRST SPECIFICATION)

2. Practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (SECOND SPECIFICATION)

3. Practicing the profession with incompetence on more than

one occasion under N.Y. Educ. Law Section 6530(5) (THIRD SPECIFICATION)

4. Practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (FOURTH SPECIFICATION)

5. Abandoning or neglecting a patient under and in need of immediate professional care without making reasonable arrangements for the continuation of such care under N.Y. Educ. Law Section (30) (FIFTH SPECIFICATION)

RECORD OF PROCEEDINGS

Service of NOTICE OF HEARING and STATEMENT OF CHARGES:	June 19, 1992
Department of Health (Petitioner) appeared by:	Ralph J. Bavaro Associate Counsel NYS Department of Health
Respondent appeared by:	Respondent did not appear on the initial hearing day in this matter. Subsequent to that hearing day and prior to the hearing committee's scheduled deliberations, Petitioner gratuitously made further efforts to locate Respondent. Respondent, by telephone, then provided Petitioner with the name of his attorney, Allen J. Greenberg, Esq., 2610 East 16th Street, Brooklyn, New York 11235. Respondent was offered the opportunity to present his case. That offer was declined. (See transcript pp. 121-133; Petitioner's Exhibit 11)

Hearing dates:	July 16, 1992 August 13, 1992
Adjournments:	None
Hearing Committee absences:	Arthur J. Wise, M.D., was not present for the initial ten minutes on the hearing day of July 16, 1992. (See Transcript pp. 8-10, 15-16) Dr. Wise affirms that he has read and considered evidence introduced at and the transcript of that time.
Witnesses for Petitioner:	1. Mitchell J. Scher, Department of Health investigator 2. Patient H 3. Elizabeth C. Muss, M.D.
Witnesses for Respondent:	None
Petitioner's Proposed Findings of Fact and Conclusions of Law received:	August 13, 1992

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record in this matter. Numbers in parentheses preceded by "T." refer to transcript pages, while those preceded by "Ex." refer to an exhibit in evidence. These citations represent evidence found persuasive by the hearing committee while arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All findings of fact were made by a unanimous vote of the hearing committee. Many findings were adopted by the hearing committee as proposed by Petitioner.

1. Clyde H. Springer, M.D., Respondent, was authorized to

practice medicine in New York State on October 24, 1980 by the issuance of license number 144271 by the State Education Department, and he is currently registered to practice medicine for the period January 1991 through December 1992 from 3317 Farragut Road, Apt. A, Brooklyn, New York 11210. (Ex. 2)

Service of Process

2. At all times relevant herein, Respondent was registered to practice medicine in New York from 3317 Farragut Avenue, Brooklyn, New York 11210. All attempts by the Department of Health to contact and serve Respondent with process prior to the hearing on July 16, 1992 were unsuccessful. (T. 15-30)

3. During the investigatory phase of the present case in approximately November to December 1990, Senior Professional Medical Conduct Investigator Mitchell Scher attempted to contact Respondent several times. Mr. Scher visited Respondent's previous office on Church Avenue in Brooklyn, New York. However, the office was closed. Mr. Scher visited Respondent's current registration address, but he was informed by an acquaintance of Respondent that Respondent was away on vacation and would return in approximately one month. Mr. Scher sent a letter to Respondent to contact him. That letter was returned unclaimed. Mr. Scher visited Brooklyn Hospital where Respondent once had privileges and was informed that Respondent was no longer on staff. Mr. Scher reviewed Respondent's personnel credential file at Brooklyn Hospital and could find no other address or relatives through

which to contact Respondent. Mr. Scher also learned that Respondent's medical malpractice insurance had been terminated. (T. 15-18)

4. On or about April 9, 1992, Mr. Scher checked with the appropriate U.S. Post Office station, and he was informed that mail was still being delivered to Respondent at 3317 Farragut Avenue. On that date Mr. Scher again visited 3317 Farragut Avenue, and he was informed by an acquaintance of Respondent that Respondent had gone to the "islands". On that date Mr. Scher again visited Church Avenue and he discovered that Respondent's old office was now a department and an electronic store. (T. 18-21)

5. Mr. Scher attempted to personally serve Respondent at his registration address with the Notice of Hearing and Statement of Charges (Ex. 1) on three separate occasions: May 22, 1992--11:00 a.m., June 1, 1992--5:00 p.m., June 17, 1992--3:00 p.m. After the last attempt on June 17th, Mr. Scher secured a copy of the Notice of Hearing and Statement of Charges to the front door. On June 19th, Mr. Scher mailed a copy of the Notice of Hearing and Statement of Charges to Respondent's registration address, which was also Respondent's last known address. (T. 21-22)

6. A copy of the Notice of Hearing and Statement of Charges was also sent by certified mail to 825 Franklin Avenue, Brooklyn, New York, where Respondent is believed to have practiced in September 1991. The phone number at that location had been disconnected. (T. 23-24) That mailing was returned unclaimed.

(T. 128-129)

7. Subsequent to the July 16th hearing in this matter, the Department of Health learned that Respondent had been practicing medicine in the State of California. He was employed by the Tulare County Health Department and he was working at the Hillman Health Center, 1062 South K Street, Tulare, California 93274. Respondent also had temporary privileges at Lindsey Hospital Medical Center, 740 North Sequoia Avenue, Lindsey, California 93247. The Notice of Hearing and Statement of Charges along with a cover letter affording Respondent the opportunity to contact the Department of Health was sent by express mail to both of those addresses on July 21, 1992. (Ex. 11) On July 23, 1992, Respondent telephoned the N.Y. State Health Department's Office of Counsel in New York City and provided the name of his attorney, Mr. Alan Greenberg, Esq. For more than two weeks thereafter, efforts on the part of Administrative Officer Gerald Liepshutz and Associate Counsel Ralph J. Bavaro to communicate with Mr. Greenberg by letter and telephone were unsuccessful. (Ex. 11) On July 27, 1992, Mr. Bavaro sent a letter by express mail to Mr. Greenberg, providing him with copies of all hearing exhibits and the name of the reporting service. In that letter, Mr. Bavaro advised Mr. Greenberg about the possibility of converting the pre-scheduled deliberation date of August 13, 1992 into a hearing date, and he invited a prompt response. (Ex. 11) On July 27, 1992, Respondent telephoned and spoke to Mr. Bavaro. In that conversation Respondent stated that he was being represented by

Mr. Greenberg concerning the Notice of Hearing and Statement of Charges in this matter. Respondent was instructed by Mr. Bavaro to have Mr. Greenberg contact the Department of Health to make arrangements for the Respondent to be heard. Respondent was further instructed that he should himself make arrangements to be heard in the event that Mr. Greenberg was not representing him. On August 3, 1992, Mr. Liepshutz sent an express letter to Mr. Greenberg requesting a prompt response with respect to Respondent's appearance in this matter. (Ex. 11) On August 10, 1992, a telephone conference took place among Mr. Liepshutz, Mr. Greenberg, and Mr. Bavaro to discuss arrangements for August 13th. (T. 121-127)

8. Respondent subsequently withdrew his request to appear at the hearing. (T. 132-133; Administrative Officer Ex. 1)

REGARDING PATIENT A - FIRST THROUGH FOURTH SPECIFICATIONS

9. Patient A presented to Respondent on or about January 29, 1988 complaining of nervousness, sleeplessness, shortness of breath with history of asthma, and muscle spasm. Apart from the reference to asthma there was no medical history or history of present illness taken. There was no physical examination nor diagnosis. Respondent prescribed zanax, sinequan, proventil, calcium gluconate and flexeril. A laboratory test revealed abnormal hematology and liver function. However, the chart contains no evidence of treatment or follow-up investigation directed at those abnormal results. (Ex. 3; T. 62-63)

10. On May 5, 1988, the recording of Patient A's complaints are largely illegible. However, there appears to be reference to anemia and complaint of being easily bruised. Respondent noted the need for PT/PTT to be completed. However, the chart contains no such test results. (Ex. 3)

11. On May 19, Patient A complained of severe cough and cold. Apart from the notation "allergies: none," there is no history. There is also no evidence of physical examination or diagnostic workup. Respondent prescribed zanax, sinequan, keflex 250, robitussin DM and proventil. (Ex. 3)

12. On June 2, 1988, Patient A complained of pain in both heels due to open wounds. A history of IV drug abuse fifteen years ago is noted. It is noted that Patient A is on methadone 30 mg., and is allergic to Talwin. There is no evidence of a comprehensive history, history of present illness, description of open wounds, physical examination or diagnosis. Respondent prescribed zanax, sinequan, peroxide and proventil. There is no evidence of adequate treatment directed toward Patient A's open wounds. (Ex. 3; T. 60)

13. None of the entries of medications given indicate the dosages prescribed. (Ex. 3; T. 69) None of the office visit entries indicate how Patient A responded to the medications. (Ex. 3)

14. On an initial visit, a physician has an obligation to perform an adequate history, a history of present illness, and a physical examination including at a minimum the examination of

vital signs, heart, lungs and abdomen as well as an examination directed at the present complaint. (T. 66-67)

15. On follow up visits, a physician has an obligation to physically monitor and discuss the effects of prior medications and to evaluate new complaints such as a discussion and physical examination of symptoms. Abnormal laboratory results should be addressed either through treatment or further investigation and recorded in the chart. (T. 62, 65-68) There is no evidence that Respondent met those obligations in his care of Patient A. (Ex. 3)

16. The medications noted above were prescribed without a clear indication or justification. In particular, zanax and sinequan should not be prescribed together, especially in conjunction with methadone because of their incompatibility and interactions which can cause adverse side effects. (T. 58-59, 63-65, 68-69)

REGARDING PATIENT B - FIRST THROUGH FOURTH SPECIFICATIONS

17. Patient B presented to Respondent on or about February 2, 1988. Most of the office visit entry for that date is illegible. However, there appear to be complaints of back pain, infection and asthma. Respondent prescribed Valium 10 milligrams,[1] zantac, proventil, naprosyn 500, keflex 500, valisone cream,

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[1] Respondent's entry "V10" refers to Valium 10 mgs., (see Exhibit 10, Department of Social Services, Medicaid Management Information System, Recipient Claim Detail Reports for Patients A-G. See also T. 35-37).

condoms and maalox. There is no comprehensive history, physical examination or diagnosis. A laboratory test revealed abnormal results: low WBC; elevated MCH, glucose, sodium, chloride, SGOT and SGPT. None of the abnormal results were addressed except for the elevated glucose which was mentioned on the next office visit of February 24, 1988. (Ex. 4, T. 71)

18. On February 24, 1988, Respondent mentioned the need for a glucose tolerance test as soon as possible, but there is no evidence that it was ever done. On February 24th, Respondent prescribed valium 10, elavil, zantac, proventil, naprosyn 500, valisone, condoms and maalox. There is no evidence of medication monitoring, discussion of symptoms, or physical evaluation. (Ex. 4, T. 71-72)

19. The office visit entry for May 21, 1988 is largely illegible. There is no evidence of adequate evaluation or a justification for medications. Respondent prescribed zanax and other medications. (Ex. 4)

20. Respondent's evaluation of Patient B failed to include an adequate history, physical examination and diagnostic workup. (T. 71-74) The medications prescribed such as keflex, zantac, valium and zanax were prescribed without justification or clear indication. Valium 10 and zanax are both addictive and they are not appropriate in combination. (T. 71-75)

REGARDING PATIENT C - FIRST THROUGH FOURTH SPECIFICATIONS

21. Patient C presented to Respondent on or about January

26, 1988 complaining of anxiety and insomnia. Respondent prescribed valium 10 with no indication of amount prescribed. There was no history taken except for reference to Patient C having seen a psychiatrist. There was no indication regarding treatment or prescriptions rendered by that psychiatrist. There was no physical examination. (Ex. 5; T. 76-77)

22. On May 23, 1988 Patient C complained of cold and cough. The indicated evaluation for such a complaint should include listening to chest, ascertaining whether sputum was present, taking temperature and vital signs. None of those were done. (T. 77) Respondent prescribed ampicillin, benylin, and valium 10. There is no evidence of history, physical examination, monitoring of prior medications or diagnosis. (Ex. 5; T. 76-77)

23. On June 3, 1988 Patient C complained of diarrhea for three to four days and abdominal pain since eating cookies and ice cream. There is no evidence of a physical examination except for blood pressure. For the first time there is a history of hepatitis 1979, migraines, "IV drug abuse (cocaine) x yesterday", and an allergy to talwin. Past medications include: methadone 60 mgs., benylin, ampicillin, valium 10. The blood pressure, history, and patient complaints all appear to be written by R. Corvagal R.N. There is no evidence that Respondent took a temperature or examined Patient C's abdomen as would be indicated. (T. 78) Respondent listed four impressions. However, only one - acute anxiety- is legible. There is no evidence of a basis for a diagnosis of anxiety. (Ex. 5, T. 78)

24. Respondent did not adequately investigate Patient C's complaints by means of history, physical examination or other diagnostic work-up. (T. 76-78)

REGARDING PATIENT D - FIRST THROUGH FOURTH SPECIFICATIONS

25. Patient D presented to Respondent on January 14, 1988 complaining of peptic ulcer disease ("PUD"), a history of asthma, and arthritis in leg and hands. There was no history taken, physical examination, diagnostic workup or diagnostic impression. Respondent prescribed catapres, zantac, valium 5, naprosyn, proventil and theodur. Dosages are not noted. (Ex. 6) Although catapress is a drug given for hypertension, no blood pressure was taken. (T. 79-80)

26. On January 27, 1988 Patient D complained of cold and cough. There is no evidence of physical examination, particularly blood pressure, history of complaint or diagnosis. Respondent "refilled meds" but did not note which ones. (Ex. 6; T. 81)

27. On April 21, 1988, Patient D complained of increased shortness of breath and history of asthma. There is no evidence of an investigation of Patient D's complaints including, at a minimum, blood pressure. Respondent prescribed catapres, proventil, valium 10, zantac 50, theodur, lotrimin, alcohol, vaseline and Q-tips. Dosages are not noted. (Ex. 6)

28. Respondent failed to investigate Patient D's complaints, especially with respect to hypertension. In addition, Respondent prescribed medications such as zantac, naprosyn and theodur

without indication or justification. (T. 79-82)

REGARDING PATIENT E - FIRST THROUGH FOURTH SPECIFICATIONS

29. Patient E presented to Respondent on February 5, 1988, complaining of nervousness and a history of asthma. Other complaints are illegible. There is no evidence of history, discussion of symptoms, physical examination or diagnosis. Respondent prescribed zanax, alupent spray and theodur. Dosages are not noted. (Ex. 7) A February 5th laboratory test revealed abnormal hematology and liver function (SGPT) results. There is no evidence that Respondent ever noted the abnormal results or addressed them with any treatment of further investigation. (Ex. 7; T. 84-85)

30. On February 22, 1988 Patient E complained of anxiety. Respondent "refilled medications" but did not note which ones. There is no history in terms of the specific symptoms of anxiety Patient E was suffering. There is no physical examination. There is no diagnosis. (Ex. 7)

31. On March 7, 1988, Patient E complained of shortness of breath and asthma. Once again, there is no past history, history of present illness, physical examination or diagnosis. Respondent prescribed alupent, theodur, zanax and elavil. No dosages were noted. (Ex. 7)

32. On or about March 12, 1988, Patient E complained of shortness of breath and asthma. A "refill" is given. There is no evidence of any evaluation or investigation of complaints. (Ex.

7)

33. Despite Patient E's continued complaints of shortness of breath, there is no adequate treatment rendered, or referral to another physician, such as a pulmonologist, for treatment. (Ex. 7)

34. Theodur is inappropriate as an initial prescription for asthma. If theodur is given, it should be accompanied by blood level tests to insure that the patient is not being over or under dosed. In addition, theodur causes nervous anxiety. A question is raised as to whether the zanax was prescribed to offset the effects of the theodur. (T. 83, 88-90) There is no evidence for any of the office visits that Respondent monitored Patient E's medications. (Ex. 7)

35. Respondent's care of Patient E was substandard because he failed to investigate complaints through history, physical examination or other diagnostic workup; failed to adequately address persistent complaints of shortness of breath and asthma; failed to address the abnormal laboratory results of February 5; prescribed and refilled medications without indication or justification; and failed to monitor medications. (T. 82-90)

REGARDING PATIENT F - FIRST THROUGH FOURTH SPECIFICATIONS

36. On January 28, 1988 Patient F presented to Respondent complaining of muscle spasm, nervousness, and pain in the chest wall. She was noted as having no allergies. There was no history, physical examination or other investigation of

complaints. In particular, no electrocardiogram was done, which would be indicated for the patient's complaint of chest pain. (T. 95-96) There was no diagnosis. Respondent prescribed zanax, sinequan and naprosyn. (Ex. 8)

37. On February 24, 1988 Patient F complained of chest pain and a skin rash. There is no evidence of a history, physical examination or diagnosis. An echocardiogram of February 24th was within normal limits. Respondent gave a prescription for skin rash and refilled medications. (Ex. 8)

38. On March 30, 1988, Patient F complained of a welt on her head. Other complaints are illegible. Respondent prescribed zanax, sinequan, motrin, and calcium gluconate. (Ex. 8)

39. On June 1, 1988 Patient F complained of spasm of jaws and severe back pain. An entry, apparently written by a nurse, notes a blood pressure, and it states that Patient F had a history of IV drug use for eleven years, was on methadone 40 mgs., had a history of epileptic seizures and nervousness, and an allergy to talwin. (Ex. 8) Respondent prescribed zanax and zinequan. (Ex. 8)

40. Prescriptions for zanax and sinequan were contraindicated for a patient on methadone. (T. 96-97)

41. Respondent did not adequately investigate Patient F's complaints or monitor her medications. (T. 92-94)

REGARDING PATIENT G - FIRST THROUGH FOURTH SPECIFICATIONS

42. On January 28, 1988 Patient G presented to Respondent

complaining of history of asthma, polyuria at night, sleeplessness and nervousness. There was no comprehensive history or physical examination. Respondent prescribed valium 10, isuprel and theodur 200. Laboratory tests revealed abnormal hematology and liver function results. There is no evidence that those results were ever addressed, which especially for the liver function test was indicated. (T. 105-106; Ex. 9)

43. On February 11, 1988, Patient G was "in for follow-up, denies any new problem...and complains of dizziness". There is no evidence of a physical examination or investigation of complaints. Respondent prescribed fioricet, antivert, and valium 10. (Ex. 9; T. 99-100)

44. On February 25, 1988, Patient G complained of cough and cold. Respondent prescribed valium 10 and other medication without evaluating Patient G's complaints. (Ex. 9)

45. On March 8, 1988 Patient G's complaints were not evaluated and Respondent prescribed valium 10 and other medications. (Ex. 9; T. 102-103)

46. On March 30th, Patient G complained of insomnia. Without any evaluation, Respondent prescribed valium 10, sinequan 100 and other medications. (Ex. 9; T. 103)

47. On May 3, 1988, Patient G complained of splitting nails. Without evaluation, Respondent prescribed valium 10, sinequan 100,bandaids and vaseline. (Ex. 9; T. 104-105)

48. Respondent failed to adequately investigate Patient G's complaints. (T. 99-100, 102-104) Respondent prescribed

medications such as fioricet, antivert and valium without clear indication or justification. (T. 99-100, 103-104)

REGARDING PATIENT H - FIRST THROUGH FIFTH SPECIFICATIONS

49. Patient H first sought medical care from Respondent in November 1989 at Respondent's office on Church Avenue in Brooklyn. On her first visit she tested positive for pregnancy and Respondent informed her that she was eight weeks pregnant. Patient H then began to see Respondent on a monthly basis for obstetric care until March 1990. (T. 40-41, 51)

50. On approximately March 7, 1990, Patient H began passing a watery vaginal discharge. On March 8th she informed Respondent about the discharge over the telephone. Respondent stated to her that it was nothing to worry about. On Monday, March 12th, Patient H observed that her stomach was small and that the discharge continued. She went to Respondent's office that morning. Respondent's nurse requested a urine specimen. At that time Patient H noticed a bloody vaginal discharge, which she showed to the nurse. When Respondent arrived to see Patient H, she informed Respondent about the bloody discharge. She also informed him about the previous watery discharge and her stomach getting smaller. Respondent performed a vaginal examination of Patient H and stated to her that her cervix was still closed, that nothing was wrong, and that she had an infection. Respondent did not perform any other tests, such as a check for amniotic fluid. Respondent prescribed flagyl 500 mgs., twice a day. (T. 42-44,

52)

51. Patient H filled the prescription and took one tablet at approximately 12:30 to 1:00 p.m. on March 12th. Approximately two hours later, Patient H began to have lower abdominal pain. At approximately 3:00 p.m. on March 12th, Patient H telephoned Respondent's office and informed his nurse about the pain. The nurse stated that Respondent was out but that she would have him paged. With no word from Respondent, Patient H called his office again at approximately 6:00 p.m. Again the nurse stated that she would page Respondent. At approximately 9:00 p.m., Respondent telephone Patient H. Patient H informed Respondent about the symptoms she was having. Respondent instructed Patient H to drink fluid, wait one half hour, and, if the pain did not go away, to call him back. At approximately 10:30 to 11:00 p.m., Patient H telephoned Respondent and informed him that the pain had not gone away. Respondent advised Patient H to meet him at Brooklyn Hospital. (T. 44-46)

52. Patient H's husband took Patient H to Brooklyn Hospital where she proceeded to the emergency room and then to the 4th floor. At one of Patient H's initial office visits, Respondent had stated that the 4th floor at Brooklyn Hospital is where Patient H should go to find him in an emergency. (T. 47) Patient H. informed nurses and doctors on the 4th floor that Respondent was her physician. Respondent never appeared at the hospital. All efforts to contact him from the hospital by medical personal and subsequently by Patient H herself were unsuccessful. (T. 47-

49)

53. Patient H was evaluated and treated by physicians at Brooklyn Hospital. Those physicians informed her that her membrane had broken and that they would try to prevent her from going into labor. At approximately 11:00 p.m. on March 13th, Patient H delivered a baby. However, the baby did not do well and died at approximately 11:30 a.m. March 14th. (T. 49)

54. After leaving the hospital, Patient H tried on several occasions to contact Respondent, but she was unsuccessful. She visited the office on Church Avenue, but it was closed and the phone was disconnected. Patient H never saw or spoke to Respondent again. (T. 49-50)

55. Patient H's initial complaint of bloody vaginal discharge at the office visit of March 12th indicated premature separation of the placenta, dilatation of the cervix, and commencement of premature labor. The treatment indicated was immediate hospital admission. Respondent failed to do that, or to adequately investigate Patient H's vaginal bleeding, and he inappropriately prescribed flagyl. (T. 110)

CONCLUSIONS

The following conclusions were reached pursuant to the findings of fact herein. All conclusions resulted from a unanimous note of the hearing committee.

REGARDING PATIENT A - FIRST THROUGH FOURTH SPECIFICATIONS

Findings of Fact 9 through 16 herein concern these Specifications as they relate to Patient A. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph A(1)	sustained (Findings of Fact 9-12, 14-15)
paragraph A(2)	sustained (Finding of Fact 9)
paragraph A(3)	sustained (Findings of Fact 9, 11-13, 15-16)
paragraph A(4)	sustained (Finding of Fact 12)

REGARDING PATIENT B - FIRST THROUGH FOURTH SPECIFICATIONS

Findings of Fact 17 through 20 herein concern these Specifications as they relate to Patient B. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph B(1)	sustained (Findings of Fact 17-20)
paragraph B(2)	sustained (Finding of Fact 17)
paragraph B(3)	sustained (Findings of Fact 17-20)

REGARDING PATIENT C - FIRST THROUGH FOURTH SPECIFICATIONS

Findings of Fact 21 through 24 herein concern these Specifications as they relate to Patient C. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph C(1)	sustained (Findings of Fact 21-24)
paragraph C(2)	not sustained (there was no evidence that Respondent was aware of Patient C's history of drug abuse until June 3, 1988. Finding of Fact 23)

REGARDING PATIENT D - FIRST THROUGH FOURTH SPECIFICATIONS

Findings of Fact 25 through 28 herein concern these Specifications as they relate to Patient D. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph D(1)	sustained (Findings of Fact 25-28)
paragraph D(2)	sustained (Findings of Fact 25-28)

REGARDING PATIENT E - FIRST THROUGH FOURTH SPECIFICATIONS

Finding of Fact 29 through 35 herein concern these Specifications as they relate to Patient E. The hearing Committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph E(1)	sustained (Findings of Fact 29-32, 35)
paragraph E(2)	sustained (Findings of Fact 29, 35)
paragraph E(3)	sustained (Findings of Fact 31-33, 35)
paragraph E(4)	sustained (Findings of Fact 29-32, 34-35)

REGARDING PATIENT F - FIRST THROUGH FOURTH SPECIFICATIONS

Findings of Fact 36 through 41 herein concern these

Specifications as they relate to Patient F. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph F(1)	sustained (Findings of Fact 36-37, 41)
paragraph F(2)	sustained as to June 1, 1988, not sustained as to January 28 or March 10, 1988 (It was not proved that Respondent knew of Patient F's use of methadone until June 1, 1988. Finding of Fact 39)

REGARDING PATIENT G - FIRST THROUGH FOURTH SPECIFICATIONS

Findings of Fact 42 through 48 herein concern these Specifications as they relate to Patient G. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph G(1)	sustained (Findings of Fact 42-43, 45-48)
paragraph G(2)	sustained (Finding of Fact 42)
paragraph G(3)	sustained (Findings of Fact 42-48)

REGARDING PATIENT H - FIRST THROUGH FIFTH SPECIFICATIONS

Findings of Fact 49 through 55 herein concern these Specifications as they relate to Patient H. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph H(1)	sustained (Findings of Fact 49-55)

paragraph H(2)	sustained (Findings of Fact 50-51, 55)
paragraph H(3)	sustained (Findings of Fact 51-52, 54)

CONCLUSIONS REGARDING RESPONDENT'S COMMISSION OF MEDICAL MISCONDUCT

Respondent has been charged with five separate acts of medical misconduct which for purposes of this proceeding are defined as follows:

1. **negligence on more than one occasion (FIRST SPECIFICATION):** Negligence is a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. The phrase "on more than one occasion" refers to separate events of some duration occurring at a particular time and place.

2. **gross negligence (SECOND SPECIFICATION):** Gross negligence is negligent conduct which is egregious or conspicuously bad.

3. **incompetence on more than one occasion (THIRD SPECIFICATION):** Incompetence is conduct which shows a lack of the skill or knowledge necessary to perform a particular act. Again, "on more than one occasion" refers to separate events of some duration occurring at a particular time or place.

4. **gross incompetence (FOURTH SPECIFICATION):** Gross incompetence is conduct which shows an unmitigated lack of the skill or knowledge necessary to perform a particular act.

5. **abandoning or neglecting a patient (FIFTH SPECIFICATION):** This medical misconduct occurs when a physician abandons or

neglects a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care.

DETERMINATION AND ORDER

The hearing committee unanimously determines that Respondent's conduct as described herein in Findings of Fact 9 through 55, in conjunction with the sustaining of all factual allegations charged in the Statement of Charges (except for paragraph C(2) and part of paragraph F(2), constitutes practicing with negligence on more than one occasion, practicing with gross negligence, practicing with incompetence on more than one occasion, and practicing with gross incompetence as charged on pages 6 through 8 of the Statement of Charges.

The hearing committee also unanimously determines that Respondent's conduct as described herein in Findings of Fact 49 through 55, in conjunction with the sustaining of the factual allegations in paragraphs H and H(3) of the Statement of Charges, constitutes abandoning or neglecting a patient as charged on pages8 and 9 of the Statement of Charges.

All five Specifications are sustained.

Respondent has manifested a consistent pattern of inadequate care of patients with a total disregard of medical standards. Additionally, the record shows that he has no sense of responsibility as evidenced by his abandonment of Patient H. Respondent never even attempted to contact this patient at a later

time. It is dangerous for the people of the State of New York for Respondent to be practicing medicine.

IT IS HEREBY ORDERED:

That Respondent's license to practice medicine in the State of New York is revoked.

DATED: New York, New York
October 20, 1992

JANE C. McCONNELL
Chairperson

GEORGE T.C. WAY, M.D.
ARTHUR J. WISE, M.D.

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
CLYDE H. SPRINGER, M.D.	:	CHARGES

----------X

CLYDE H. SPRINGER, M.D., the Respondent, was authorized to practice medicine in New York State on October 24, 1980 by the issuance of license number 144271 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 1991 through December 1992 from 3317 Farragut Road, Apt. A, Brooklyn, New York 11210.

FACTUAL ALLEGATIONS

A. Patient A (who is identified with other patients in Appendix A) sought medical care from Respondent at Respondent's office located at 164 Nostrand Avenue, Brooklyn, New York during the period from approximately January 29, 1988 until June 2, 1988. Respondent:

1. Failed to adequately investigate Patient A's medical complaints on January 1, May 5, May 19 and June 2, 1988.

2. Failed to follow-up on abnormal laboratory results on or about January 29, 1988.

3. Inappropriately prescribed Xanex, Sinequan and other drugs on January 29, May 19 and June 2, 1988.

4. Failed to treat open wounds on June 2, 1988.

B. Patient B sought medical care from Respondent at Respondent's office during the period from approximately February 2, 1988 until June 4, 1988. Respondent:

1. Failed to adequately investigate Patient B's medical complaints on February 2, February 24 and May 21, 1988.

2. Failed to follow-up on abnormal laboratory results on or about February 2, 1988.

3. Inappropriately prescribed Valium and other drugs on February 2, February 24 and May 21, 1988.

C. Patient C sought medical care from Respondent at Respondent's office during the period January 26, 1988 until June 3, 1988. Respondent:

1. Failed to adequately investigate Patient C's medical complaints on January 26, May 23, and June 3, 1988.

2. Inappropriately prescribed Valium, on January 26, 1988 despite Patient C's known history of drug abuse.

D. Patient D sought medical care from Respondent at Respondent's office during the period from approximately January 14, until April 1, 1988. Respondent:

1. Failed to adequately investigate Patient D's medical complaints on January 14, January 27, and April 21, 1988.

2. Inappropriately prescribed Valium, Catapres and other drugs on January 14, January 27 and April 21, 1988.

E. Patient E sought medical care from Respondent at Respondent's office during the period from February 5, until March 12, 1988. Respondent:

1. Failed to adequately investigate Patient A's medical complaints on February 5, February 22, March 7 and March 12, 1988.

2. Failed to follow-up on abnormal laboratory results on or about February 5, 1988.

3. Failed to refer Patient E to a pulmonologist despite continued medical complaints of shortness of breath.

4. Inappropriately prescribed Xanax, Theodur and other drugs from February through March 1988.

F. Patient F sought medical care from Respondent at Respondent's office during the period from approximately January 28 until June 1, 1988. Respondent:

1. Failed to adequately investigate Patient F's medical complaints on January 28 and February 24, 1988.

2. Inappropriately prescribed Xanax and Sinequan on January 28, March 10, and June 1, 1988 despite Patient F's use of methadone.

G. Patient G sought medical care from Respondent at Respondent's office during the period from approximately January 28, until May 3, 1988. Respondent:

1. Failed to adequately investigate Patient G's medical complaints on January 28, February 11, March 8, March 30 and May 3, 1988.

2. Failed to follow-up on abnormal laboratory results on or about January 28, 1988.

3. Inappropriately prescribed Valium and other drugs from January through May 1988.

H. In October, 1989 Patient H sought medical/obstetric care from Respondent at Respondent's office located at 2818 Church Avenue, Brooklyn, New York.

1. In an office visit on or about March 12, 1990, Respondent failed to adequately investigate Patient H's vaginal bleeding.

2. On or about March 12, 1990 Respondent inappropriately prescribed Flagyl.

3. On or about March 13, 1990 Patient H complained to Respondent by telephone of experiencing pain after taking the Flagyl. After instructing Patient A to meet him at the Brooklyn Hospital, Brooklyn, New York, Respondent failed to appear or to ever again follow-up on or have any contact with Patient H.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1992) in that Petitioner charges two or more of the following:

1. The facts contained in Paragraphs A and A1-A4, B and B1-B3, C and C1-C2, D and D1-D2, E and E1-E4, F and F1-F2, G and G1-G3, and/or H and H1-H3.

SECOND SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1992), in that Petitioner charges:

2. The facts contained in Paragraphs A and A1-A4, B and B1-B3, C and C1-C2, D and D1-D2, E and E1-E4, F and F1-F2, G and G1-G3, and/or H and H1-H3.

THIRD SPECIFICATION

PRACTICING WITH INCOMPETENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1992), in that Petitioner charges two or more of the following:

3. The facts contained in Paragraphs A and A1-A4, B and B1-B3, C and C1-C2, D and D1-D2, E and E1-E4, F and F1-F2, G and G1-G3, and/or H and H1-H3.

FOURTH SPECIFICATION

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence on more than one occasion under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1992), in that Petitioner charges:

4. The facts contained in Paragraphs A and A1-A4 , B and B1-B3, C and C1-C2, D and D1-D2, E and E1-E4, F and F1-F2, G and G1-G3, and/or H and H1-H3.

FIFTH SPECIFICATION

ABANDONING A PATIENT

Respondent is charged with abandoning or neglecting a patient under and in need of immediate professional care without making reasonable arrangements for the continuation of such care under N.Y. Educ. Law Section 6530(30) (McKinney Supp. 1992), in that Petitioner charges:

5. The facts contained in paragraphs H and H3.

DATED: New York, New York
May 20, 1992

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct