STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

April 25, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Nancy Strohmeyer, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

Anthony Scher, Esq.
Wood & Scher
14 Harwood Court – Suite 512
Scarsdale, New York 10583

Steven Plotnick, M.D.
1097 Old Country Road
Plainview, New York 11803

RE: In the Matter of Steven Plotnick, M.D

Dear Parties:

Enclosed please find the Determination and Order (No. 03-106) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine 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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER

OF

STEVEN PLOTNICK, M.D.
----------X

ORDER #
BPMC 03-106

COPY

DETERMINATION AND ORDER OF THE HEARING COMMITTEE

The undersigned Hearing Committee consisting of **JOHN CHOATE M.D.**, chairperson, **RAFAEL LOPEZ M.D.** and **LOIS JORDAN**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by Steven Plotnick M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

SUMMARY OF PROCEEDINGS

Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Pre-Hearing Conferences:	November 6, 2002

Hearing Dates:		November 13, 2002 December 20, 2002 January 13, 2003 January 21, 2003 January 22, 2003 January 28, 2003
Dates of Deliberation:		February 18, 2003 March 12, 2003
Petitioner appeared by:		NYS Department of Health
	By:	Nancy Strohmeyer, Esq., Assistant Counsel
Respondent appeared:		Wood & Scher 14 Harwood Court - Suite 512 Scarsdale, New York 10583
	By:	Anthony Scher, Esq.

WITNESSES

For the Department:	Patricia Ann Devine, M.D. Patient A Patient B's Daughter Barbara Kohart Kleine
For the Respondent:	Steven Plotnick, M.D. Michael Polcino, M.D. Victor Klein, M.D. Donna Carucci Catherine Neuburger, R.N. Thomas Gallo Steven Palter, M.D.

SIGNIFICANT LEGAL RULINGS

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct. The Administrative Law Judge issued instructions to the Committee when asked regarding the definitions of medical misconduct as alleged in this proceeding.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on or about October 30, 1981, by the issuance of license number 148398 by the New York State Education Department. (Pet. Exh. 2)

PATIENT A

2. Patient A became a patient of the Respondent in December 1997. (Pet. Exh. 3, p. 88; T. 359)

3. Patient A, a thirty-seven year old flight attendant, and her husband had been trying to conceive a baby for approximately three years prior to Patient A becoming the Respondent's patient. (Pet. Exh. 3, p. 91; T. 360)

4. On March 22, 1999, Patient A visited Respondent's Plainview, New York office for an initial prenatal visit. Patient A was then 39 years old and was approximately 10 weeks pregnant after in vitro fertilization. (Pet. Exh. 3, p. 28-29, 33; T. 40-41, 364-66)

5. During the March 22, 1999 visit, Patient A gave a health history, which was recorded on a prenatal flow sheet known as a "Hollister form." Patient A reported her history of infertility, discoid lupus, iron deficiency anemia, and a family history of diabetes. (Pet. Exh. 3, 28-31; T. 365)

6. Respondent performed a physical examination and ordered blood testing during the March 22, 1999 visit. Respondent and Patient A discussed her family history of diabetes and lupus. Because of Patient A's age, she and Respondent also discussed the possibility of performing an amniocentesis. Patient A refused amniocentesis testing. (T. 365-67)

7. On April 2, 1999 Respondent's medical assistant ordered a Glucose Challenge Test (GCT) for Patient A. Patient A was approximately 11 weeks pregnant when she took that test. (Pet. Exh. 3; p. 28, 55; T. 928, 369, 427)

8. Both Department's expert and Respondent agree that a GCT is a screening test to identify patients in need of more extensive testing for gestational diabetes. A GCT should be performed between the 24th and 28th week of gestation. The test requires that the patient drink 50 grams of glucose solution and have blood samples taken one hour later. (T. 49 - 50, 593)

9. A GCT is performed at 24 to 28 weeks of gestation because one of the main causes of insulin resistance in pregnancy is the production of human placental lactogen. By the 24th to 28th week of pregnancy, levels of human placental lactogen are high enough in the mother's bloodstream to reveal hyperglycemia if it exists. (T. 47-48)

10. Due to Patient A's advanced maternal age and her family history of diabetes, Patient A should have had GCT between the 24th and 28th week of her pregnancy. (Pet. Exh 3, p. 31; T. 49-50, 593)

11. Women with gestational diabetes often have no symptoms of the disease and a routine prenatal urine dipstick does not always reveal gestational diabetes. (T. 51-52)

12. Undiagnosed gestational diabetes can impact upon fetal health by increasing the risks for pre-term labor and complications of prematurity, macrosomia or large fetal size, stillbirth or injury to the baby or mother during delivery. Additionally, there is an increased risk of pre-eclampsia or toxemia and pre-term delivery. (T. 53-55)

13. In August 1999, during an office visit, one of Respondent's assistants told Patient A that she was "due" for a GCT. Patient A informed the assistant that a GCT had been performed earlier in her pregnancy. The assistant told Patient A that Respondent would discuss it with her when he came into the examining room. (T. 370-71, 409-10)

14. After Respondent finished his examination of Patient A, he told her that she needed to have a GCT. Patient A told Respondent that she had already had a GCT. Respondent told Patient A that he would "look into it and get back" to her. (T. 371, 410) Patient A had no other conversations with Respondent about a second GCT. (T. 371-72, 411)

15. When Patient A left Respondent's office on August 17, 1999 the laboratory requisition form did not have the glucose challenge test checked off. (Pet. Exh. 3, p. 61)

16. The August 17, 1999 laboratory requisition form does not indicate that Patient A refused to take the GCT. (Administrative Exh. A)

17. Several days later when Patient A was going to the laboratory to have the HIV test performed, she called Respondent's office and informed them that she was returning to the laboratory. Patient A then asked whether she should take another GCT, and if so she asked that a referral for the test be sent via facsimile to the laboratory. (T. 372-73, 408-09)

18. Respondent's office personnel told Patient A that they would speak to the Respondent concerning this test and call her back. About 20 minutes later, someone from Respondent's office called to tell Patient A that she did not need another GCT. (T. 373)

19. The Respondent's office procedure as to laboratory forms is that when the results of the Patient's laboratory tests are received by the Respondent's office the laboratory requisition forms are discarded. (T. 915)

20. Patient A never told any of Respondent's employees that she would not take another GCT because she did not like the taste of the liquid. (T. 374)

21. The testimony of Respondent's nurse, Catherine Neuberger regarding her note dated August 26, 1999 in Patient A's office file indicating that Patient A had refused to repeat a GCT was not credible. (Pet. Exh. 3, p. 56; T. 373-74, 411-12, 959-60)

22. Respondent's testimony regarding a note he wrote on a laboratory result sheet in Patient A's office record stating that he had discussed the April 2, 1999 GCT with Patient A and that he had informed her that the test would have to be repeated was not credible. (Pet. Exh. 3; p. 55; T. 593-94)

23. Respondent's medical assistant, Donna Carucci's, wrote a note dated September 9, 1999 on a laboratory report in Patient A's office chart stating that Patient A refused to have a GCT was not credible. (Pet. Exh. 3, p. 57; T. 411-12, 906-08)

24. The Hollister form does not indicate that Patient A refused to have a GCT. (Pet. Exh. 3)

25. On or about September 9, 1999, Patient A's Hollister form was sent to Winthrop Univerty Hospital (WUH) from Respondent's office. (Pet. Exh. 3, p. 29; Pete Exh. 4, p. 8) There was no information on the laboratory forms regarding a GCT test. (Pet. Exh. 3. p. 7)

26. On October 11, 1999, Patient A had an office visit with Respondent. She was in her 39th week of pregnancy and was extremely uncomfortable. Her pre-pregnancy weight was 145 pounds and in her 39th week of pregnancy she weighed approximately 200 pounds, and she was having difficulty breathing and sleeping. (Pet. Exh. 3, p. 29; T. 376-77, 401-02)

27. Respondent's admitting note dated October 18, 1999, did not indicate that Patient A refused a GCT test. (Pet. Exh. 4)

28. On October 19, 1999 Patient A delivered a stillborn male fetus weighing 11 pounds, 11 ounces and was 23 inches long. (Pet. Exh 4)

29. Patient A subsequently returned to Respondent's office for several visits on October 25, November 18, 23, 1999 and January 5, 2000.

30. At Patient A's postpartum office visits, Respondent did not conduct or order any tests to assess Patient A for gestational diabetes. (Pet. Exh. 3 p. 21, 23, 24)

31. The failure to perform diagnostic testing for gestational diabetes after delivery of this baby failed to meet minimum accepted standards of medical care. (T. 68)

32. In Respondent's discharge summary dated January 29, 2000, there is no information regarding a refusal to take a GCT, however, there is a note regarding Patient A's refusal of an amniocentesis. (Pet. Exh. 3, p. 34-35; Pet. Exh. 4, p. 9-10)

33. On February 8, 2000, nearly three and one half months after Patient A was discharged from WUH, Respondent completed her chart. (T. 1176)

PATIENT B

34. Patient B was a 56 year-old woman when she came to Respondent for gynecological care in January 1993. Patient B was enrolled in the Doppler screening program for ovarian cancer at WUH. As a part of the program she had a yearly sonogram. (T. 437-38, 446, 456, 467-68)

35. Patient B's medical history indicated that her mother and maternal aunt had died of ovarian cancer. In addition, Patient B reported a history of three cesarean sections. (Pet. Exh. 5, p. 6, 21; T. 438)

36. At her initial visit on January 26, 1993, Patient B complained of irregular menses. Respondent performed a pelvic examination and noted that the results were normal. (Pet. Exh. 5, p. 6; T. 237)

37. Patient B was perimenopausal. (T. 290)

38. On February 25, 1993, Patient B had an ultrasound at WUH. The test revealed that there was a cyst on her left ovary and that her right ovary appeared normal. The ultrasound report noted that the left ovarian cyst had grown and that a "small cystic area" was seen "latero-posterior to the endometrium." (Pet. Exh. 5. p. 19).

39. Sometime after the February 25, 1993 ultrasound, Patient B returned to Respondent's office for a consultation. In Patient B's office chart, Respondent wrote "EUA/endometrial biopsy," "video operative laparoscopy, bilateral oophorectomy, frozen section with laser, possible TAH BSO omentectomy" (Pet. Exh. 5, p. 6; T. 238-39)

40. "EUA" refers to an examination under anesthesia. An endometrial biopsy is a procedure in which a surgeon extracts a piece of the endometrium or the lining of the uterine cavity for pathologic diagnosis. (T. 239)

41. A video operative laparoscopy is an operative procedure in which a small incision is made in the abdominal wall through which a laparoscope is inserted to view the abdominal and pelvic contents. Additional instruments are then inserted through the abdominal wall to carry out the surgical procedure. The procedure is viewed by the surgeon on a video screen. (T. 238-39)

42. "TAH BSO" is an abbreviation for a total abdominal hysterectomy and a bilateral salpingo-oophorectomy. An omentectomy is the surgical removal of omentum. (T. 238)

43. On April 20, 1993, Patient B signed a consent form for surgery. The planned surgery included an "exam under anesthesia, endometrial biopsy, video operative laparoscopy, bilateral oophorectomy, frozen section with laser" and "possible TAH/BSO omentectomy." (Pet. Exh. 5, p. 16; T. 252-53)

44. The surgical consent form Patient B signed on April 20, 1993 did not limit her consent and gave Respondent consent to the extended procedures outlined in the form or to different procedures from those outlined in the event that "unforeseen conditions" occurred during the course of the surgery." (Pet. Exh. 5 p. 16; T. 253-54)

45. Patient B's surgery was performed laparoscopically. During the procedure the left ovary was removed completely, but a portion of the right ovary was left behind. (Pet. Exh. 6 p. 25-26)

46. The operative procedure lists "bilateral oophorectomy." (Pet. Exh. 6 p. 17) The narrative of the operative note describes that a portion of the right ovary was left behind but gave no reason for failing to convert the procedure to a laparotomy and removing the remaining tissue. (Pet. Exh. 6 p. 25-6, 30; T. 259-62)

47. The pre-operative anesthesia note states "oophorectomy." (Pet Exh. 6 p. 18)

48. If one ovary is removed and only part of the second ovary, it would be indicated on the operative report as "left oophorectomy and a partial right oophorectomy." (1/28/03 T. 137-8, 143)

49. On May 5th and May 25th, 1993, Patient B went to Respondent's office for a post-operative examination. In Respondent's note of these two visits there is no indication that he informed Patient B that he had failed to obtain all of the right ovary during the surgery or that he discussed the operative report with her. (Pet. Exh. 5 p. 7; T. 264-67)

50. After the surgery, Patient B told her 19 year old daughter that she had both her ovaries removed. (T. 439, 455-56, 458, 479-80)

51. Patient B stopped participating in the WUH Doppler program after her April 1993 surgery. (T. 443)

52. On August 16, 1997, Patient B was admitted to Mercy Medical Center (Mercy) complaining of abdominal pain. (Pet. Exh. 7 p. 25, 27; T. 439-40)

53. Patient B told physicians and nurses at Mercy that both of her ovaries had been removed several years before. (Pet. Exh. 7 p. 27, 29, 32, 44, 45, 67)

54. Radiological studies were performed at Mercy on August 17 and 18, 1997. They revealed a large cystic mass measuring approximately 25 by 15 centimeter located in Patient B's pelvis and extending into her abdomen. Physicians at Mercy suspected an ovarian neoplasm. (Pet. Exh. 7, p. 29, 32)

55. On August 20, 1997, Patient B had an initial consultation with Dr. Richard Barakat at Memorial Sloan Kettering. The Sloan Kettering hospital record indicates that Patient B stated that both of her ovaries removed in 1993 because of her family history of ovarian cancer and that her ovaries had no pathology at the time of surgery. (Pet. Exh. 14 p. 14 p.149; T. 144)

PATIENT C

56. Patient C was a 33 year old woman, pregnant with her second child. Her first child had been delivered via cesarean section due to macrosomia, and she was planning to have a vaginal birth of her second child. (hereinafter "VBAC") (Pet. Exh. 8 p.27)

57. In determining whether a woman is a candidate for a VBAC, a physician must evaluate the type of cesarean section scar the patient had the last time, the indication for the previous cesarean and that there is a vertex presentation of the fetus. This is an ongoing assessment that must be made throughout the pregnancy. (T. 121)

58. During her pregnancy, Patient C was under the care and treatment of the Respondent.

59. On June 24, 1999, in her 40th week of pregnancy, Patient C was admitted to WUH for induction of labor. (Pet. Exh. 9)

60. Shortly after her admission to Labor and Delivery at approximately 12:40 p.m., a resident placed cervidil, a prostaglandin used for ripening the cervix, in Patient C's vagina. A vaginal examination showed that Patient C's cervix was closed, was 80 percent effaced and the vertex of the fetus was at -2 station. (Pet. Exh. 9 p. 48; T. 127-28, 131)

61. By 8:20 p.m., Patient C was in labor and a nurse began to chart her labor progress. (Pet. Exh. 9 p. 21)

62. Labor progress notes are maintained by a nurse and are kept contemporaneous to labor and delivery. These notes exist to document the course of labor and delivery. (T. 134)
There is no other note that records the station. (T. 60)

63. At 8:20 p.m. a resident performed a vaginal examination, the hospital record indicates that Patient C's cervix was dilated to 3 centimeters. An external fetal monitor was applied to record the fetus' heart rate and a contraction monitor known as a "toco" was applied to Patient C's abdomen. (Pet. Exh. 9 p. 50; T. 135-36)

64. The last note on Patient C's chart of a vaginal exam is at 8:40 and it is recorded at minus 2 station. (Exh. 9 p. 50)

65. The heart rate of a healthy fetus during labor has a baseline range between 120 and 160 beats per minute (BPM). The fetal heart rate may decrease within this ideal range during labor due to fetal sleep cycles or maternal medication. Conversely, the fetal heart rate may accelerate due to fetal movement. (T. 141)

66. During maternal contractions the fetal heart rate can change, but it should remain within the baseline range of 120 to 160 BPM. (T. 142)

67. Between 8:27 p.m. and 8;37 p.m. the fetal heart rate ranged from 90 to 180 BPM. During this ten minute period the fetal heart rate dropped to 90 BPM three times, and each decline took place during a contraction. (Pet. Exh. 9, 110; T. 142-44, 147)

68. Between 8:38 and 8:49 p.m., Patient C's baby had a fetal heart rate between 130 and 150 BPM, a normal baseline range for fetal heart rates.

69. At approximately 8:50 p.m. there was a deceleration of the fetal heart rate to 110 BPM during a contraction, an indication of possible fetal distress. Nothing in the labor progress notes indicates that this drop in fetal heart rate was recognized as a concern. (Pet. Exh. 9, 111; p. 21; T. 147)

70. At approximately 9:13 p.m. when Patient C's membranes ruptured, there was a slight depression of the fetal heart rate. Respondent was not present. (Pet. Exh. 9, p. 21, 113; T. 150-51)

71. At 9:16 p.m. Patient C complained of rectal pressure and Respondent was made aware of this via telephone. (Pet. Exh. 9 p. 21)

72. Respondent arrived in the delivery room at 9:25 p.m. and Patient C was positioned for delivery. Between 9:26 and 9:27 p.m., the baseline fetal heart rate declined from 140 BPM to 110 BPM. At 9:30 p.m. the fetal heart rate briefly dropped to 80 BPM. (Pet. Exh. 9 p. 115; T. 152-53)

73. At. 9:45 p.m. the labor progress note reflects that the Respondent was present and the baby's heart rate was 90 BPM. (Pet. Exh 9; T. 159)

74. At 9:51 p.m. the fetal heart rate is 60 BPM and remained at 60 BPM for four to five minutes. (Pet. Exh. 9; T. 161, 163)

75. The earliest clinical sign of a possible uterine rupture in a patient who has had a previous caesarean section is either onset of severe pain or a sudden deceleration of the fetal heart rate. (T. 222)

76. At 9:51 p.m. according to the labor progress note, the Respondent did a vaginal examination and he applied an internal scalp electrode, there is no station recorded. (Pet Exh. 9 p. 50, T. 162-3)

77. When confronted with a fetal bradycardia of this persistence, a reasonably prudent physician would deliver this fetus as expeditiously as possible. (T. 165-66)

78. Respondent transferred Patient C to the operating room at 9:55 p.m. for a trial vacuum delivery. (Pet. Exh. 9 p. 21; T. 166, 174-75)

79. It is contraindicated to proceed with a vacuum delivery when faced with a uterine rupture because of loss of station. (T. 165, 171, 221-4)

80. It is contraindicated to proceed with a vacuum delivery if the station was at minus two or minus three. (T. 171)

81. Respondent failed to write his vacuum attempts or the fetal head station on his delivery note written on the day of delivery. (Pet. Exh. 9 p. 50)

82. At 10:08 p.m. after a failed vacuum extraction, Patient C was transferred to the operating table. (Pet. Exh. 9 p. 21, 45, 119; T. 177-78)

83. Patient C's baby daughter was delivered in an emergency cesarean section at 10:10 p.m. Upon opening the abdomen, the baby was partially in Patient C's abdominal cavity. (Pet. Exh 9, p. 21; T. 178)

84. The baby first blood gas had a ph value of 6.5 indicating that she was severely acidotic. Acidosis occurs when a baby is no longer receiving sufficient oxygen or blood. (T. 192-93)

85. The care rendered to Patient C in the delivery of this baby did not meet minimum standards of medical care. (T. 188)

86. Respondent wrote a delivery note dated June 24, 1999 at 11:55 p.m. Respondent failed to note the delivery attempts by vacuum extraction. (Pet. Exh. 9 p. 50-1)

87. Approximately one month after Patient C's delivery, a neonatalogist, Dr. Davies mentioned to Respondent that he should have described the delivery "more exact" in his delivery note. Respondent then wrote an addendum to his delivery note. (Pet. Exh. 9 p. 51; T. 717-18; 733-34)

88. In his addendum to the delivery note dated July 16, 1999, Respondent notes the vacuum application and states that the fetal head was at a minus 3 station at the time of the application. (Pet. Exh. 9, p. 51)

89. Some time after Respondent wrote his July 16, 1999 addendum, one of the perinatologists at WUH pointed out to Respondent that he had noted in the addendum that the vertex was at minus 3 station prior to the application of the vacuum. (T. 723, 735)

90. In a second addendum dated August 17, 1999, Respondent wrote that at the time of the vacuum extraction attempt, the vertex was at plus 3 station not minus 3 as he had previously noted "in error." (Pet. Exh. 9 p. 52)

91. Delivery notes should be complete and made contemporaneous to the delivery. (T. 202)

92. Respondent's notes concerning the delivery of Patient C's baby do not meet minimum accepted standards of medical care.

DISCUSSION

The Panel was unanimous in its belief that there were issues of negligence and credibility.

In the case of Patient A, the only issue before the Panel was credibility. Both the Respondent and the Department's expert witness agree that a woman with the profile of Patient A should have a Glucose Challenge Test (GCT) at her 24 to 28 weeks of pregnancy. (T. 49-50, 593)

The Respondent contends that he ordered the GCT and Patient A refused to take it because "...she hated the Glu-cola." T. 598 Glue-cola is a liquid the Patient drinks prior to her blood being drawn. (T. 599) As part of Patient A's medical chart kept in the ordinary course of business, a copy of the August 1999 laboratory request form is included. (Pet. Exh. 3, p. 56) On the form is written, " refused GCT"

Patient A testified that she was treated for infertility because she was of advanced age and wanted to become pregnant. (T. 359) Patient A testified that she refused an amniocentesis test because she wanted to have the baby regardless of abnormalities. (T. 375) At eleven weeks of pregnancy, Patient A had a GCT. Patient A testified that on or about August 1999, when she was approximately 26 weeks pregnant, during an office visit, she was asked to take a GCT. She informed the Respondent's assistant that she already had a GCT and the assistant said the Respondent would discuss it with her. The Respondent also told Patient A that she needed to

repeat the GCT. Patient A told the Respondent she had taken a GCT earlier and the Respondent did not understand why she had taken the test early in the pregnancy but he would look into it and get back to her. The Respondent never got back to her. (T. 370 - 1)

The Panel did not find the Respondent to be credible but found the testimony of Patient A credible for the following reasons: the Panel accepted as accurate the form obtained directly from the laboratory which did not contain the phrase "refused GCT"; (Adm. Exh. A); it is improbable that Patient A, who had gone through fertility treatment to conceive and refused amniocentesis testing would refuse to take an important test because of the taste of the liquid; both the laboratory form that the Respondent produced and the form obtained directly from the laboratory did not have the box checked off for the GCT; Respondent's office staff described a "log book" where all requested tests were written, however the Respondent never testified about the log book and was unable to produce it; Respondent's office staff testified that laboratory forms are discarded after the office receives the results of the Patient's laboratory tests and could not explain why Patient A's chart contained the laboratory form. (T. 915). Finally, the Panel found the testimony of the Respondent's two office staff not credible. Ms. Neuburger stated she spoke with Patient A on Friday, August 26, 1999 via telephone. (T. 958) August 26, 1999 is a Thursday, which compounds questions of whether Ms. Neuburger was at the office on that day. Ms. Carruci repeatedly testified to several questions, "I don't know." (T. 918 - 925, 933 - 935) In each one's testimony their memory was selective.

Patient C had a uterine rupture during her labor. Fetal bradycardia, which occurred during Patient C's labor, (T. 162 - 5) is one of the recognized early signs of uterine rupture in VBAC patients, however, the Respondent never considered the possibility of uterine rupture, which would necessitate an immediate caesarean section. Instead, Respondent attempted a

vacuum delivery, which is contraindicated for patients with uterine rupture. When the vacuum delivery failed, he performed a caesarean section. The Panel found the Respondent's failure to consider a uterine rupture in light of a fetal bradycardia on a VBAC patient negligent.

Notwithstanding the uterine rupture, the Respondent agrees that attempting a vacuum delivery when the vertex is at a minus 2 station is contraindicated. (1/21/03 T. 36) The Panel accepts the only recorded indication on the hospital record prior to the vacuum delivery that the vertex was at a minus 2 station.

Patient C's child was born on June 24, 1999. Respondent wrote his first delivery note on June 24, 1999 and did not include any information regarding the vacuum delivery. At the behest of two different physicians at the hospital, Respondent wrote an addendum approximately three weeks after delivery (July 16) stating that at the time of the vacuum attempt, the vertex was at minus 3. On August 17th, one month after the first addendum, Respondent wrote a second addendum stating that at the time of the vacuum attempt the vertex was at plus 3. The only indication of the station of the vertex is in a delivery note written at 8:40, placing the vertex at a minus 2 station. Although the Respondent did a vaginal examination at 9:51, there is no station recorded. (Pet Exh. 9 p. 50, T. 162-3)

The Respondent's failure to include the vacuum attempt in his original delivery note does not meet the minimum standard of care.

The Panel found Patient B's case to be most disturbing.

Patient B was a 56 year old female with a family history of ovarian cancer. She was part of a Doppler study for ovarian cancer at Winthrop University Hospital. (WUH) In January 1993, Patient B went to the Respondent for care (T. 486) because the Doppler study showed a small cyst on her left ovary, which was benign in nature. (T. 490)

The Respondent's testimony regarding what Patient B's requested is confusing. The Respondent testified that Patient B wanted to have only the "cyst removed" from the left ovary. (T. 491, 545) He also testified that Patient B wanted to have the left ovary removed. (T. 524, 529) The Respondent stated that it was his intention prior to surgery to remove the left ovary because of the benign cyst and leave intact the right ovary. (T. 528, 550)

There is no medical justification for the removal of an ovary with a benign cyst. (T. 242 - 3, 251)

The Respondent's testimony that Patient B wanted to have either the cyst removed or the ovary with the cyst removed is not a procedure stated on the consent form she signed. Patient B signed a consent form for a bilateral oophorectomy or more extensive surgery, but not the removal of a cyst or one ovary. (T. 253, 515, 545, 546) Respondent testified that his operative consent forms include more radical procedures if something is discovered at the time of the surgery that is not consistent with the sonogram. (T. 493) But the Respondent never got consent for the procedure he claimed he intended to perform. He testified that he never considered removing both ovaries because it is prohibited by the hospital to remove benign organs. (T. 490, 494, 498, 506, 518, 550, 552, 557, 558, 559)

The Panel did not find the Respondent's testimony credible nor his referral to notes in the chart persuasive. The Panel accepts the Department's position that Patient B wanted and consented to a laporscopic procedure to have both ovaries removed, a bilateral oophorectomy. The Panel came to this conclusion because of the following:

1) Patient B never consented to the removal of a cyst or one ovary

2) Bilateral oophorectomy is listed as the procedure on the patient consent form, post-anesthesia record, nurse's record of operation, in the postop record; (T. 531-32) and operative report;

3) Ms. Kohart Kleine, Vice President of Administration at WUH, testified there was no written policy regarding prophylactic oophorectomy (T. 212);

4) The Respondent claimed that Patient B had endometriosis (T. 495) yet the hospital chart does not indicate endometriosis but rather a hemorrhagic cyst; (T. 516, 553)

5) The Respondent's medical chart in the two post-operative visits failed to document that the Respondent told Patient B that he did not remove both ovaries. (Pet. Exh. 5)

6) The medical chart has no indication that the Respondent had a discussion with Patient B stressing the importance of continuing to follow up the testing on the remaining ovarian tissue. (T. 548)

7) The evidence submitted indicates that approximately four years after the surgery, Patient B informed both Mercy Hospital and Sloan Kettering that she no longer had ovaries.

8) Respondent testified that Patient B "...would be a candidate to have a laparoscopic oophorectomy"(T. 492) and then testified that "We never discussed that [having both ovaries removed]. (T. 494)

9) In light of Patient B's mother and maternal aunt dying from ovarian cancer; (Pet. Exh. 5 p. 21; T. 234) Patient B was part of a Doppler study for ovarian cancer at Winthrop University Hospital; (WUH) and took a proactive approach to her vulnerability to ovarian cancer.

It is clear to the Panel that Patient B had a legitimate concern about her own risk of developing ovarian cancer and that she requested, anticipated, signed consent for, expected and thought that she had a bilateral oophorectomy. Therefore, the procedure the Respondent performed, a partial bilateral oophorectomy, was not medically indicated and totally inappropriate.

The salient point is that Respondent failed to perform a bilateral oophorectomy on Patient B, who had a history of ovarian cancer or inform her that he did not perform a bilateral oophorectomy.

The Respondent placed Patient B in danger of the possibility of developing ovarian cancer, which this Patient attempted to avoid and in fact did occur. **(I'm not sure how many years later)**

In Patients A, B and C, the Panel found a pattern of negligence compounded by the Respondent's fraud and his lack of credibility. The Panel concluded that the fraud committed by the Respondent was so egregious that it possibly led to the deaths of two infants and Patient B. The Respondent continued to deny his negligence at the hearing before this Panel and found the whole situation "repugnant."(T. 521) The Panel's view was unanimous that the Respondent's fraud is unredeemable and leaves no option to practice medicine.

PANEL'S DETERMINATION ON THE CHARGES

NEGLIGENCE ON MORE THAN ONE OCCASION

Paragraphs A1, A5 – SUSTAINED
Paragraphs A2, A3, A4 - NOT SUSTAINED
Paragraphs B2, B3, - SUSTAINED
Paragraphs C1 - C5 - SUSTAINED
Paragraphs D1 - D2 - NOT SUSTAINED

FRAUDULENT PRACTICE

Paragraph A1 - NOT SUSTAINED
Paragraph A6 - SUSTAINED
Paragraph C2 – SUSTAINED

FAILURE TO MAINTAIN RECORDS

Paragraphs A3 - A4 - NOT SUSTAINED
Paragraph A6 - SUSTAINED
Paragraph C1 - 2 - SUSTAINED
Paragraph D1 - 2 - NOT SUSTAINED

MORAL UNFITNESS

Paragraph A6 - SUSTAINED
Paragraph B3 - SUSTAINED
Paragraph B4 - NOT SUSTAINED
Paragraph C2 - SUSTAINED
Paragraph D2 - NOT SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee, unanimously, after giving due consideration to all the penalties available have determined that the Respondent's license to practice medicine in the state of New York should be **REVOKED.**

ORDER

IT IS HEREBY ORDERED:

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

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

DATED: Austerlitz, New York
APRIL 24, **2003**

JOHN CHOATE, M.D.
Chairperson

RAFAEL LOPEZ, M.D.
LOIS JORDAN

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

IN THE MATTER

OF

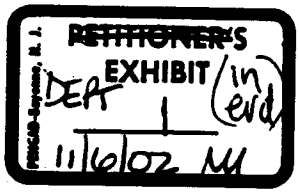
STEVEN PLOTNICK, M.D.

NOTICE

OF

HEARING

TO: Steven Plotnick, M.D.
1097 Old Country Road
Plainview, New York 11803



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on November 13, 2002, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, New York, New York 10001, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for

the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET

OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
November ,2002

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Nancy Strohmeyer
Assistant Counsel
Bureau of Professional Medical Conduct
5 Penn Plaza
New York, New York 10001
(212) 268-6819

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

IN THE MATTER

OF

STEVEN PLOTNICK, M.D.

STATEMENT

OF

CHARGES

Steven Plotnick, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 30, 1981, by the issuance of license number 148398 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Patient A, an African-American woman, had a history of miscarriage after a course of in vitro fertilization, as well as discoid lupus, iron deficiency anemia and a family history of diabetes. In early 1999, when she was thirty nine years-old, Patient A became pregnant after in vitro fertilization and sought routine obstetrical care from Respondent at his office at 1097 Old Country Road in Plainview, New York.

1. Respondent failed to perform a glucose challenge test (hereinafter "GCT") at the appropriate time during Patient A's pregnancy.
2. Respondent failed to evaluate Patient A's lupus during her pregnancy.
3. Respondent failed to document, evaluate and treat Patient A's complaints of excessive thirst, urination and edema.
4. Respondent failed to document the use of a vacuum extractor during the delivery.

5. Respondent failed to perform diagnostic testing for gestational diabetes after the delivery of a macrosomic stillborn fetus to Patient A.

6. Respondent knowingly, falsely and with intent to mislead documented that Patient A refused a GCT.

B. On or about January 26, 1993, Patient B had consulted Respondent at his office at 1097 Old Country Road in Plainview, New York, for assessment for a prophylactic bilateral oophorectomy. In this visit with Respondent, Patient B reported that both her mother and a maternal aunt had died of ovarian cancer. In April of 1993, Respondent performed a laproscopic bilateral oophorectomy on Patient B. During the course of the procedure, Respondent removed the left ovary in its entirety, but left behind tissue from the right ovary which adhered to the pelvic wall.

1. Respondent failed to perform or note an appropriate physical examination of Patient B.

2. Respondent failed to convert the laproscopic procedure to an open procedure in order to obtain the remaining ovarian tissue.

3. Respondent knowingly and with intent to mislead failed to inform Patient B that he had not removed all of the ovarian tissue.

4. When confronted by Patient B with his failure to inform her of the ovarian tissue left behind, Respondent falsely and with intent to mislead denied his failure to adequately inform Patient B.

C. Patient C, a thirty three year old woman, came to Respondent for prenatal care during her second pregnancy in late 1998. Patient C's first child had been delivered via cesarean section. On June 24, 1999, in her forty first week of

pregnancy, Patient C was admitted to Winthrop University Hospital for induction of labor. Respondent made two failed attempts at vacuum extraction delivery, Patient C was transferred to an operating table for a cesarean section. When Patient C's abdomen was opened, an infant girl was found outside the uterus in the abdominal cavity. Patient C's uterus had sustained a vertical rupture on its posterior surface.

1. Respondent failed to maintain accurate records of medical treatment rendered to Patient C.
2. Respondent knowingly, falsely and with intent to mislead documented the station of the vertex prior to application of the vacuum extractor.
3. Respondent attempted a vacuum extraction despite the fact that the procedure was contraindicated.
4. Respondent failed to timely diagnose and treat Patient C's uterine rupture.
5. Respondent failed to timely perform a cesarean section on Patient C.

D. Patient D, a twenty nine year-old woman, was seen by Respondent's partner for prenatal care. On August 26, 1992, during her thirty fifth week of pregnancy, Patient D's uterine membranes ruptured prematurely. Patient D was admitted to Winthrop University Hospital on August 28, 1992, and it was noted that the fetus was in a breech position. Patient D eventually progressed into labor and a live infant girl was delivered at approximately on August 30, 1992. Delivery of the baby's head required piper forceps and took approximately three minutes.

1. Upon Patient D's admission, Respondent failed to make or record a plan of care for Patient D's treatment.

2. Respondent knowingly, falsely and with intent to mislead documented that the baby's head was delivered without difficulty.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) 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:

1. Paragraphs A, A1 through A5, B, B1 through B3, C, C1 through C5, and D, D1 through D2.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) 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:

2. Paragraphs A, A1 through A5, B, B, B1 through B3, C, C1 through C5, and D, D1 through D2.

THIRD THROUGH SIXTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A and A6.

4. Paragraphs B, B3 and B4.

5. Paragraphs C and C2.

6. Paragraphs D and D2.

SEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

7. Paragraphs A, A3, A4, A6, B and B1, C, C1 and C2, D, D1 and D2.

EIGHTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of thefollowing:

8. Paragraphs A and A6, B and B3, B4, C and C2, D and D2.

DATED: November , 2002
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct