THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

April 12, 1990

Bernard Dolin, Physician
132 South Central Avenue
Elmsford, N.Y. 10523

Re: License No. 078384

Dear Dr. Dolin:

Enclosed please find Commissioner's Order No. 10170. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building - Room 512
Scarsdale, N.Y. 10583

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

BERNARD DOLIN, M.D. **No. 10170**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

BERNARD DOLIN, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced.

Between November 10, 1988 and January 31, 1989 a hearing was held on five different sessions before a hearing committee of the State Board for Professional Medical Conduct.

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "A", which includes a copy of the amended statement of charges. The hearing committee found and concluded that respondent was guilty of the specification charged based upon negligence on more than one occasion to the

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent be censured and reprimanded.

As respondent states in his memorandum, the case of Patient B is "strikingly similar" to the case of Patient A. In both cases, the hearing committee and Commissioner of Health recommend that respondent be found not guilty regarding paragraphs A.1 and B.1. relating to the evaluation of the status of the recipient site before undertaking a split thickness graft and that respondent be found guilty of paragraphs A.2. and B.2. relating to a skin graft. The hearing committee noted, at page 10 of its report, that the parties "agreed" that the issue here was not whether the procedure was done properly, but rather whether it should have been attempted at all.

The hearing committee found that respondent was not guilty of paragraphs A.1. and B.1. because no angiogram or Doppler was necessary to be performed in determining whether or not to attempt a skin graft (findings numbered 5 and 15). Respondent's guilt of paragraphs A.2. and B.2. arose from respondent's assessment to perform a skin graft in the same procedure following debridement (findings numbered 9 and 17). A reasonably prudent physician would not have performed a skin graft in the same procedure immediately following debridement under these patients' circumstances. See transcript pages 113, 115, 125, 156, 163, and 180.

With respect to patient C, the hearing committee found in finding numbered 31, that further monitoring of the electrolytes was indicated. The hearing committee, without elaboration, referred to page 27 of the transcript which shows that further electrolyte determinations should have been but were not performed after November 12, 1985. Accordingly, respondent's negligence as to Patient C was based upon such failure to make an adequate electrolyte determination.

It is our unanimous opinion that with respect to the measure of discipline to be imposed, a one year suspension with execution of the suspension stayed and respondent placed on probation for one year without any monitoring requirement is appropriate under the circumstances, which included negligence committed by respondent against three different patients over the course of a month and a half. We agree with respondent, who informed us that he regularly reads medical literature and takes continuing medical education courses and who is not guilty of incompetence, that monitoring would not be appropriate. We note that the Commissioner of Health did not specify any probation under which respondent could be monitored. See Education Law §6511-a(c).

The recommendation of the Commissioner of Health is unclear, indefinite, and unworkable because the condition under which the suspension may or may not be stayed relates to various times in the future after the penalty becomes effective. Therefore, it is

uncertain whether the suspension is to be stayed immediately, only after he makes arrangements for monitoring, only after such monitoring is approved, only after each quarterly visit is submitted, or after further determinations are made, piecemeal, that the conditions have been fulfilled. Furthermore, there is no mechanism, as there would have been had there been a complete stay and probation imposed, under which to determine a disputed alleged violation of any condition. In our opinion, the formulation of the penalty recommended by the Commissioner of Health would not sufficiently enable the public, the State, and the parties to know, at the time the Order of the Commissioner of Education becomes effective, and at all times during the penalty period, whether respondent may practice medicine and is in compliance with that order. The recommendation of the Commissioner of Health should be modified to assure compliance with Education Law §§6511 and 6511-a.

In our unanimous opinion, giving due consideration to the relative qualifications of the experts produced by the parties herein, the record demonstrates the existence of sufficient support for the findings and conclusions of the hearing committee regarding Patients A, B, and C.

We recommend the following to the Board of Regents:

1. The 43 findings of fact and the conclusions of the hearing committee and the recommendation of the Commissioner of Health as to the findings and conclusions be accepted;
2. Respondent be found guilty, by a preponderance of the evidence, of the specification charged based upon negligence on more than one occasion to the extent of paragraphs A.2., B.2, and C.3., and not guilty of the remaining charges;
3. The recommendation of the hearing committee not be accepted;
4. The recommendation of the Commissioner of Health be modified; and
5. In partial agreement with the recommendation of the Commissioner of Health as to the measure of discipline and in consideration of an appropriate measure of discipline which is in compliance with Education Law §§6511 and 6511-a, respondent's license to practice as a physician in the State of New York be suspended for one year upon the specification of the charges of which we recommend respondent be found guilty and the execution of said suspension be stayed and respondent placed on probation for one year under the terms set forth in the

exhibit annexed hereto, made a part hereof, and marked as Exhibit "C".

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated: 3/3/90

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
BERNARD DOLIN, M.D.	:	COMMITTEE

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TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Kendrick A. Sears, M.D., Chairperson, John A. D'Anna, M.D. and Sister Mary Theresa Murphy, duly designated members of the State Board for Professional Medical Conduct, appointed by t Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to 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 submits this report.

SUMMARY OF CHARGES

Respondent was charged with the following act of professional misconduct as more fully set forth in the Amended Statement of Charges attached hereto:

1. Practicing the profession with negligence and/or incompetence on more than one occasion (FIRST SPECIFICATION)

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	October 11, 1988
Amended Statement of Charges entered in record:	January 18, 1989
Department of Health (Petitioner) appeared by:	Anna D. Colello, Esq. Assistant Counsel
Respondent appeared by:	Wood & Scher, Esqs., By: Anthony Z. Scher, E One Chase Road Scarsdale, New York 1C
Hearing dates:	November 10, 1988 December 15, 1988 December 16, 1988 January 6, 1989 January 31, 1989
Hearing Committee deliberations:	March 2, 1989
Adjournments:	None
Hearing Committee absences:	None
Ruling by Administrative Officer allowing amendment of Statement of Charges over objection of Respondent:	See pages 549-556 of transcript for hearing day of January 31, 1989
Corrections to transcript:	Corrections submitted by Petitioner were uncontes and have been deemed a p of the record.
Witnesses for Petitioner:	Franklin C. Hayford, M.D William B. Clark, M.D. Warren Smith, M.D. Mary F. Healy, R.N.

Witnesses for Respondent:

Bernard Dolin, M.D.
Respondent
Lawrence Panitz, M.D.
Louis DelGuercio, M.D.
Jane Huh, M.D.

FINDINGS OF FACT

The following findings of fact were made after a revi of the entire cord in this matter. Numbers in parentheses ref to transcript pages unless otherwise noted. These citations represent evidence found persuasive by the Hearing Committee whi arriving at a particular finding. Conflicting evidence, if any was considered and rejected in favor of the cited evidence. Al findings were made by unanimous vote.

1. Bernard Dolin, M.D., the Respondent, was authoriz to engage in the practice of medicine in the State of New York September 11, 1956 by the issuance of license number 078364 by t New York State Education Department (uncontested).

2. The Respondent was registered with the State Education Department to practice medicine for the period Januar 1, 1986 through December 31, 1988 from 132 South Central Avenue Elmsford, New York 10523 (uncontested).

FIRST SPECIFICATION

PATIENT A

3. Patient A was an 87 year old female who was admitte to the Phelps Memorial Hospital Center on October 5, 1985, with an ulcer development of her left foot (Exhibit #2A, page 1). Th

admitting physician was Dr. Lawrence Panitz, a board certified family practitioner (Exhibit #2A, pages 2-4).

4. The patient was admitted for a mechanical debridement of the necrotic tissue in the ulcerated area and the possibility of the application of a split thickness skin graft (Exhibit #2A, page 21; 314).

5. No angiogram or Doppler was performed in this case. None was necer- -y, however, as a clinical assessment is utilized in determining whether or not to attempt a skin graft (315-316, 448).

6. On October 11, 1985, under light anesthesia with local supplement, Dr. Dolin excised the remaining necrotic tissue from the ulcerated area (Exhibit #2A, page 7).

7. Dr. Dolin observed a base which he believed was adequate to attempt a split thickness skin graft (262-263). Accordingly, he placed a skin graft on the ulcerated area (Exhibit #2A, page 7).

8. Bleeding at the periphery, or the edges, of the ulcerated area does not indicate that the graft which is placed on the base will take (130).

9. It was not appropriate to perform debridement and a skin graft in the same procedure (161). If the area to be grafted is one which is not richly vascularized, as is the heel, then there must be granulation tissue present. There is little granulation tissue on the surface in a wound which has just been debrided. New capillaries should be allowed to grow which will support a graft. The growing of new capillaries takes several days (180).

Patient B

10. Patient B was admitted by Dr. Dolin to the Phelps Memorial Hospital Center on September 24, 1985 (Exhibit #3A, pag 149).

11. Patient B was an 88 year old female, who was in a contracted position and who would never walk again (404). She developed an ulceration of her left heel while bedridden at a nursing home (Exhibit #3A, page 149).

12. Wet to dry dressing changes at the nursing home failed to stem the necrotic changes (Exhibit #3A, page 149) and the patient was admitted for more definitive treatment (Exhibit #3A, page 149).

13. On October 4, 1985, Dr. Dolin performed a mechanical debridement under general anesthesia (Exhibit #3A, pag 155).

14. After removal of the necrotic tissue, Dr. Dolin applied a split thickness skin graft to the ulcerated area (Exhibit #3A, page 155).

15. No angiogram or Doppler was performed in this case None was necessary, however, as a clinical assessment is utilize in determining whether or not to attempt a skin graft (315-316, 448).

16. The conditions which must be present for a successful skin graft, an adequate vascularized base and the absence of infection, were not present in Patient B on October 4, 1985. There was not an adequate blood supply in the base of the ulcer to support survival of the graft (162, 188). There is not

a lot of soft tissue coverage in the heel so the chance of finding a bed which could support a graft would be almost zero (171, 189). Given the position of this wound and the condition of the pressure sore and necrosis, the conditions necessary for the graft to take would almost certainly not exist (178).

17. It was not appropriate to perform debridement and a skin graft in the same procedure (see Finding of Fact #9 herein).

Patient C

18. Patient C was a 94 year old female who was admitted to the Phelps Memorial Hospital Center from a nursing home for a feeding gastrostomy because her IV's had become infiltrated and could not be restarted (Exhibit #4A, page 1).

19. The patient was non-responsive, vegetative, in an advanced state of senility and she was in a contracted or fetal position (Exhibit #4A, page 2; 196). She was also markedly dehydrated (196).

20. Upon the patient's admission to the hospital, Dr. Dolin ordered a complete blood count, an immediate electrolyte determination and a general profile (Exhibit #4A, page 15; 197).

21. A general profile involves about 15 to 20 blood studies including blood sugar serum glucose and proteins (197).

22. Although no general profile appears as part of Exhibit #4A, the Hearing Committee finds that one was ordered. The term "general profile" appears on the Physician's Order Form at page 15 of Exhibit #4A, and, the number 0003 appears next to "general profile". This signifies that Dr. Dolin's order was placed into the computer system (197-198, 587-588).

23. Dr. Dolin recalled seeing the general profile in this case (198).

24. Although laboratory accession logs (Exhibit #8, A-I) were offered by the Petitioner to prove that the general profile was never done, the Hearing Committee does not find this evidence persuasive. The general profile would have been done o November 9, 1985 because it was ordered after 2:00 PM on Novembe 9, 1985 (589-590).

25. Apparently, on November 10, 1985, there was a mix-up at the laboratory in that the control number for Patient was also assigned to another patient on that day (580-581). Thus on November 10, 1985, the day the general profile would have bee performed, the logs are unreliable.

26. Dr. Dolin's initial order for hydration was 1,000 cc's of 5% glucose in Ringer's Lactate at the rate of 75cc's per hour (Exhibit #4A, page 15; 202).

27. Under the circumstances of this case, Dr. Dolin's initial and subsequent hydration orders were reasonable. In a weak, elderly patient, hydration at too rapid a level could easil result in death (202).

28. Electrolyte determinations are significant as an indication of the acid base balance in the body and the status c the dehydration present (26).

29. To determine the proper fluid management serial electrolytes determinations were required (63).

30. The electrolyte determination made on Patient C's admission was abnormally high suggesting that Patient C was deficient in large amounts of body water (26).

31. Electrolytes were not corrected on November 12 and in fact, they were still severely abnormal. Further monitoring was indicated (27).

32. Dr. Dolin ordered 0.25mg of digoxin intravenously with a repeat or that dose every morning at 8 AM (Exhibit #4A, page 16).

33. This was a reasonable dose (207, 356, 502, 505).

34. There was no clinical evidence that the patient was excessively digitalized. The clinical signs would be arrythmia, slowing of the heart rate and/or vomiting (208). None of these signs were present (208, 40).

Patient D

35. Patient D was a 35 year old female admitted to the Phelps Memorial Hospital Center for a dilation and curettage (D&C) due to menorrhagia (Exhibit #5A, page 5).

36. Although this patient had undergone a prior tubal ligation, it became apparent when Dr. Dolin was performing the D&C that there were products of conception (235-236).

37. The pathology report for this patient indicated "some of the villi show hydropic degeneration and focal trophoblastic proliferation" (Exhibit #5A, page 10).

38. The pathology report contained no recommendation for follow-up (Exhibit #5A, page 10; 237, 538, 542).

39. Dr. Jane Huh, the pathologist, testified that she examined the slides in this case and saw nothing to indicate tha a potential malignancy was involved (538, 542).

40. She further testified that it was customary at Phelps for pathologists to recommend follow-up when they believe that follow-up was necessary (543). She further testified that she believed that Dr. Dolin was aware of this practice (542-543)

41. Dr. Dolin was familiar with the practice and he knew that a similar practice was followed at his other hospitals (237).

42. Dr. Clark did not have the opportunity to review the slides as did Dr. Huh. No pathology was offered contradictin Dr. Huh.

43. Based on her review of the slides, Dr. Huh testified that this was not a possible molar pregnancy with cance possible (539-540). She testified that scalloping of the villi was absent and there was also an absence of cystal formations (539).

CONCLUSIONS

The Hearing Committee's conclusions were made pursuant to the findings of fact herein. All conclusions resulted from a unanimous vote of the Hearing Committee.

Negligence is defined as a failure to exercise the car that would be exercised by a reasonably prudent physician under the circumstances. The Committee concludes as follows regarding the charges of negligence herein:

Patient A

1. The Respondent did not fail to adequately and accurately evaluate the status of the recipient site before undertaking a split thickness graft on Patient A (Finding of Fac # 5).

2. The Respondent improperly performed a skin graft o Patient A's left foot on October 11, 1985 (Findings of Fact # 7, 8 and 9).

The Committee notes that, as agreed to by the parties, the issue here was not whether the procedure was done properly, but rather whether it should have been attempted at all. In concluding that negligence occurred, the Committee does not question the Respondent's ability to perform skin grafts, but it does fault his doing the grafts immediately following debridement

Patient B

3. The Respondent did not fail to adequately and accurately evaluate the status of the recipient site before undertaking a split thickness graft on Patient B (Finding of Fac # 15).

4. The Respondent improperly performed a skin graft o Patient B's heel on October 4, 1985 (Findings of Fact # 14, 16 an 17).

Again, the Committee finds negligence on the Respondent's part for attempting the skin graft under the circumstances, and not for a lack of ability to do the procedure generally.

Patient C

5. The Committee was not convinced by a preponderanc of the evidence that the Respondent failed to obtain and/or evaluate adequate lab tests regarding Patient C (Findings of Fa # 20 through 25).

6. The Respondent did not give inadequate fluid replacement orders (Findings of Fact # 26 and 27).

7. ıe Respondent failed to make an adequate electrolyte determination after November 12, 1985 (Findings of Fact # 28 through 31). The Committee does not believe that the Respondent had clear objectives in mind as to what his goal was in monitoring Patient C.

8. The Respondent did not improperly digitalize Patie C (Findings of Fact # 32 through 34).

Patient D

9. The Respondent did not fail to adequately monitor Patient D for HCG levels (Findings of Fact # 35 through 43).

Incompetence is defined as a lack of expertise or knowledge necessary to practice the profession. The Hearing Committee concludes that the Respondent was not proved to posses a lack of expertise or knowledge, even though some of his acts wer found to be negligent.

RECOMMENDATION

The Hearing Committee, pursuant to its Findings of Fact and Conclusions herein, unanimously recommends the following:

1. Negligence on more than one occasion: The charges of negligence should be sustained regarding paragraphs A.2., B.2. and C.3. in th statement of Charges. Those acts constitute negligence on more than one occasion. No other charges of negligence should be sustained.

2. Incompetence on more than one occasion: No charge of incompetence should be sustained.

3. It is further recommended that the following actio be taken as a result of the Respondent's commission of negligenc on more than one occasion: censure and reprimand. The Hearing Committee does not believe that the Respondent's acts require tha either his license to practice medicine be jeopardized or that formal retraining be imposed.

DATED: April , 1989

Respectfully submitted,

KENDRICK A. SEARS, M.D.
Hearing Committee Chairperson

JOHN A. D'ANNA, M.D.
SISTER MARY THERESA MURPHY

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

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IN THE MATTER : AMENDEI

OF : STATEMEN

BERNARD DOLIN, M.D. : OF CHARC

---X

BERNARD DOLIN, M.D. , the Respondent, was authorized to engage in the practice of medicine in the State of New York c September 11, 1956 by the issuance of License Number 078364 b the State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 132 South Central Avenue, Elmsford, NY 10523.

FACTUAL ALLEGATIONS

A. On or about and between October 6, 1985, and November 18, 1985, Respondent treated Patient A (Patient A ar all other patients are identified in the attached appendix). Patient A was an 87 year old female who was admitted to Phelp Memorial Hospital Center, Tarrytown, New York with an ulcer development of the dorsum of the left foot.

1. Respondent failed to adequately and accurately evaluate the status of the recipient site before undertaking a split thickness graft on Patient A.

2. Respondent improperly performed a skin graft on Patient A's left foot on October 11, 1985.

B. On or about September 25, 1985 through October 14, 198 and again on or about October 18, 1985 through November 19, 1985, Respondent treated Patient B at Phelps Memorial Hospital Center, Tarrytown, New York, for a decubitus ulcer of the left heel.

1. Respondent failed to adequately and accurately evaluate the status of the recipient site before undertaking a split thickness graft on Patient B.

2. Respondent improperly performed a skin graft on Patient B's heel on October 4, 1985.

C. Patient C, a 94 year old female, was admitted under Respondent's care to Phelps Memorial Hospital Center, North Tarrytown, New York on November 9, 1985 because of her inabilit to take adequate liquids. Respondent performed a gastronomy o November 11, 1985.

1. Respondent failed to obtain and/or evaluate adequate lab tests.

2. Respondent gave inadequate fluid replacement orders.

3. Respondent failed to make an adequate electrolyt determination after November 12, 1985.

4. Respondent improperly digitalized the patient using inaccurate and/or excessive doses.

D. Patient D, a 36 year old female, was admitted to Phelp Memorial Hospital Center on September 28, 1986 under the care of Respondent with a complaint of menorrhagia. She had had a

tubal ligation one and a half years earlier and Respondent performed a dilation and curretage on this date.

1. Respondent failed to adequately monitor the patient for HCG levels (human chorionic gonadotropin).

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE AND/OR

INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession of medicine with negligence and/or incompetence on more than o occasion under N.Y. Educ. Law §6509(2) (McKinney 1985) in tha the Petitioner charges that Respondent has committed two or mo of the following:

1. The facts in Paragraphs A and A1, A and A2 B and B1, B and B2, C and C1, C and C2, C and C3, C and C4, and D and D1.

DATED: Albany, New York
January 13, 1989

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Office of Professional Medical Conduct

10170

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

IN THE MATTER :

OF : COMMISSIONER'S

BERNARD DOLIN, M.D. : RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

Hearings in the above-entitled proceeding were held on November 10, 1988, December 15 and 16, 1988, and January 6 and 31, 1989. Respondent Bernard Dolin, M.D., appeared by Wood and Scher, Anthony Z. Scher, Esq., of Counsel. Petitioner appeared by Peter J. Millock, Esq., General Counsel, Anna D. Colello, Esq., of Counsel.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be modified as follows: In lieu of the censure and reprimand recommended by the Committee, Respondent's license should be suspended for one year and such suspension stayed provided that Respondent arrange for his practice to be monitored by a physician approved by the Office of Professional Medical Conduct and that such monitoring physician and the chief of surgery at any hospital in which Respondent performs surger submit quarterly reports attesting that the quality of Respondent's general practice, in the case of the monitoring physician, and surgical practice, in the case of the chiefs of surgery, meets or exceeds applicable standards of practice

While I agree with the Committee that Respondent does not need retraining, I believe monitoring o his practice for one year will better protect hi patients and not unduly inhibit his practice.

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation as modified above.

The entire record of the within proceeding is transmitted with this Recommendation.

Dated: Albany, New York

July 17, 1989

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

EXHIBIT "C"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

BERNARD DOLIN, M.D.

CALENDAR NO. 10170

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall act in all ways in a manner befitting respondent's professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by respondent's profession;

   b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of

Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

BERNARD DOLIN

CALENDAR NO. 10170

The University of the State of New York

IN THE MATTER

OF

BERNARD DOLIN
(Physician)

DUPLICATE
ORIGINAL
VOTE AND ORDER
NO. 10170

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10170, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (March 23, 1990): That, in the matter of BERNARD DOLIN, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The 43 findings of fact and the conclusions of the hearing committee and the recommendation of the Commissioner of Health as to the findings and conclusions be accepted;
2. Respondent is guilty, by a preponderance of the evidence, of the specification charged based upon negligence on more than one occasion to the extent of paragraphs A.2., B.2, and C.3., and not guilty of the remaining charges;
3. The recommendation of the hearing committee not be accepted;
4. The recommendation of the Commissioner of Health be modified; and
5. In partial agreement with the recommendation of the Commissioner of Health as to the measure of discipline and in consideration of an appropriate measure of

discipline which is in compliance with Education Law §§6511 and 6511-a, respondent's license to practice as a physician in the State of New York be suspended for one year upon the specification of the charges of which respondent is guilty and the execution of said suspension be stayed and respondent placed on probation for one year under the terms prescribed by the Regents Review Committee;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and SO ORDERED, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 30th day of March, 1990.

Thomas Sobol

Commissioner of Education