STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Dennis P. Whalen
Executive Deputy Commissioner

March 19, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael A. Hiser, Esq.
NYS Department of Health
Corning Tower Room 2503
Empire State Plaza
Albany, New York 12237

Anthony Benigno, Esq.
NYS Department of Health
Hedley Park Place
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John H. Fancher, M.D.
Northwest Medical Center
11045 No. 19th Avenue
Phoenix, Arizona

RE: In the Matter of John H. Fancher, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-58) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
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,

Redacted Signature

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

JOHN H. FANCHER, M.D.

DETERMINATION AND ORDER

BPMC-99-58

MARGARET H. McALOON, M.D., Chairperson, **WILLIAM K. MAJOR, Jr., M.D.** and **GEORGE C. SIMMONS, Ed.D.** , duly designated members of the State Board for Professional Medical Conduct, appointed by the 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. **CHRISTINE C. TRASKOS, ESQ.,** served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **HENRY M. GREENBERG,** General Counsel, **MICHAEL A. HISER, ESQ.,** Associate Counsel and **ANTHONY M. BENIGNO, ESQ.,** Assistant Counsel of Counsel. The Respondent appeared by **SCHNEIDER, HARRIS & HARRIS, ROBERT H. HARRIS, ESQ.,** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged twenty-one (21) specifications of professional misconduct, including allegations of fraudulent practice, harassing or abusing a patient, unwarranted treatment, moral unfitness, gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion and inadequate record keeping.

The charges are more specifically set forth in the Statement of Charges dated September 25, 1998, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

WITNESSES

For the Petitioner:	Dr. Zulkharnain
	Beverly Callen, R.N.
	Frank Edwards, M.D.
For the Respondent:	Joan McInerney, M.D.
	Robert Drielinger, M.D.
	William Konczynin, M.D.
	John H. Fancher, M.D.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

1. Respondent, John H. Fancher, was licensed to practice medicine in the State of New York on March 7, 1995, license number 198654 (Petitioner's Exhibit 2, hereinafter Ex. 2).
2. Respondent was served with a Notice of Hearing, Statement of Charges and a Summary of the Department of Health Hearing Rules on October 5, 1998 (Ex. 1a, and Acknowledgment by Respondent's counsel on October 29, 1998 that the Respondent was served with the charges).
3. A hearing was held to adjudicate the charges against Respondent on October 29, 1998, November 20, 1998, December 3, 1998, December 10, 1998 and December 11, 1998.

PATIENT A

4. Patient A, a thirty-eight year old male, presented to the Millard Fillmore Hospital (MFH) Emergency Department on April 20, 1995 with complaints of previous chest pain and burning with urination. He denied chest pain at the time he presented to the Emergency Department and denied shortness of breath with his prior chest pain. He had a history of

asthma, multiple medical admissions for chest pain (but frequently signed out against medical advice), a few minutes of non-radiating chest pain a couple of hours before that was relieved with nitroglycerin, psychiatric history of self mutilation and denied the use of alcohol or tobacco (Ex. 5, p. 4).

5. Dr. Zulkharnain took an adequate history of the patient (T:19-20).

6. After Dr. Zulkharnain presented Patient A to him, Respondent told Dr. Zulkharnain to give the patient one gram of magnesium sulfate, by intramuscular injection (T:22).

7. Dr. Zulkharnain questioned the order given by Respondent. Instead of explaining his rationale to the resident, Respondent simply stated, "You heard me" (T:23). Respondent further stated to Dr. Zulkharnain that its done in New York City, that is, magnesium sulfate was given in these settings in New York to patients that come into the Emergency Room for no medical reason (T:24 & 51). Respondent acknowledged this practice existed in New York City. (T. 831)

8. After Dr. Zulkharnain wrote the order for magnesium sulfate in the patient's chart, registered nurse Beverly Callen saw the order (T:61).

9. As Nurse Callen began to draw the magnesium sulfate into a syringe, she questioned the Respondent as to his reasons for ordering the medication. He told her "because it hurts," "it is to deter him" from coming to the ER for no reason (T:62, 63 and 119). Respondent subsequently discontinued the order.(T. 120) Nurse Callen documented the cancellation by writing in the chart, "Hold per Dr. Fancher. /BC" (Ex. 5, p. 9).

10. Fifteen minutes after the Respondent's initial order he approached Dr. Zulkharnain and told

him to discontinue the magnesium sulfate order. Dr. Zulkharnain then wrote in the chart, "D/C MgSO4" (T:50, Ex. 5, p. 4)

11. During the two and a half-hours at the Emergency Department a history was taken and a physical examination performed. Patient A had an EKG taken and a urine analysis. The patient was discharged with a diagnosis of a urinary tract infection and a prescription for bactrim. (Ex. 5).

12. The very next day, April 21, 1995, Dr. Zulkharnain informed Dr. LaFountain of Millard Fillmore Hospital of Dr. Fancher's order for magnesium sulfate.(T:26).

13. On April 23, 1995 Beverly Callen had a conversation with her nurse manager, Terry Weidman, and she reported this incident along with four other cases in which she felt Dr. Fancher's care was questionable. She documented the incidents in a note which was delivered to Ms. Weidman on the morning of April 24, 1995 (T:64 and 104).

PATIENT B

14. Respondent treated Patient B, a thirty-three year old male, in the Emergency Room of Millard Fillmore Hospital on or about April 22, 1995 for a blow to the head and face from a metal bar. Patient B presented with lacerations his lower lip, right ear and right zygomatic process (Ex. 6, at 2).

15. Patient B's history states that he was assaulted by a metal cross bar across his face and that he did not lose consciousness. (Ex. 6)

16. The physical examination documented by Respondent was limited to the location of the various injuries. There is no evidence that Respondent performed a neurological examination or an examination of the middle ear. Respondent did not document the length and depth of Patient B's lacerations. (Ex.6)

17. Respondent ordered x-rays of the facial bones and zygomatic arches (Ex. 6, p.2)

18. Respondent wrote that no fracture was found. (Ex. 6, p.2)

19. The laceration of the lip and ear were sutured. (Ex. 6, p.2)

20. A subsequent reading of the x-rays revealed a fracture of the right zygomatic arch with significant buckling and a fracture of the lateral wall of the right maxillary sinus. (Exs. 6, p.8 and 8)

21. Patient B was recalled and seen in the Emergency Room two days later. Examination at that time revealed a rupture of the right eardrum with blood present. (Ex. 6, pp.6-16)

22. The mechanism of injury, a blow to the head with a metal pipe, is medically significant due to concerns of possible head injury, neck injury, fractures, dental injuries and ocular injuries (T:186).

23. A minimally accepted neurologic exam of this patient would consist of a general assessment of the patient's mentation, cranial nerves, and a brief assessment to insure that the nervous system and aspects of the nervous system in the extremities were intact (T:187-188).

24. Respondent failed to perform an adequate neurologic examination of patient B (Ex. 6, at 2) (T:188-9).

25. Respondent failed to diagnose various facial fractures, including a very obvious zygomatic arch fracture (Ex. 6, 2 & 8) (T:192, Dr. McInerney T: 481).

26. Respondent failed to diagnose a ruptured eardrum of the patient's right ear (T:226, 500).

27. Respondent's failure to diagnose and treat the patient's ruptured eardrum subjected the patient to risks of infection, hearing loss and not detecting a possible basal skull fracture (T:222-4).

28. Respondent failed to indicate the extent and location of the wounds (T:228). The medical significance of indicating where the laceration was and its extent is that branches of facial nerves and salivary ducts run under that area, which could have been, damaged (T:228).

29. Respondent failed to adequately document the procedures he used to close the wound(s). Lacerations should be noted by the number of sutures and the type of suture material (Ex. 6, at 2) (McInerney-T:454, 504).

PATIENT C

30. Respondent treated patient C, a fifty-two year old female, in the Emergency Room of Millard Fillmore Hospital on April 23, 1995. The patient presented with a history of severe headache and was unresponsive with left-side weakness and posturing, among other clinical signs. The patient's symptoms were indicative of a cerebral hemorrhage (Ex. 9, 2 & 10).

31. Patient C arrived in the Emergency Room at 5:55 a.m. with a dilated left pupil and was noted to have intermittent movement of the left side. (Ex. 9)

32. Shortly after arrival, Patient C developed severe bradycardia and was given atropine at 6:00 a.m. by the nurse via protocol. (Ex. 9)

33. An NG tube and a Foley catheter were placed. Mannitol was given and a CT scan was ordered. The neurosurgeon was contacted. (Ex. 9)

34. There is no documentation that a physical examination, including a neurological examination, was performed by Respondent. (Ex. 9)

35. The vital signs were stabilized, but Patient C was comatose. The patient was not intubated prior to leaving the Emergency Room. (Ex. 9)

36. Patient C subsequently required intubation while in the Radiology Department. (Ex. 10)

37. Patient C's condition deteriorated from the time she arrived in the Emergency Room until she was transferred to the CAT scan suite. (Ex. 9, 10)

38. Respondent failed to perform an adequate physical examination of the patient (Ex. 9 at 2) (T:238-9, 257-8, 588-9). His physical did not include an examination of the patient's chest, heart or abdomen (T:238-9).

39. Respondent failed to test: for the level of consciousness; the various cranial nerves; facial asymmetry; pupil inequality; motor system in the extremities; and perimeter reflexes (T:248).

40. The patient's deteriorating condition required intubation in the Emergency Department to protect her airway (T:252, 286, Respondent-940). Intubation was also required due to the patient's extremely agitated condition which would have made it impossible to CT scan her without heavy sedation (Respondent-T:940).

41. Respondent agreed that intubation was indicated for Patient C prior to leaving the Emergency Room.

PATIENT D

42. Respondent treated Patient D, a forty-five year old male, on April 18, 1995 in the Emergency Room of Millard Fillmore Hospital. He presented at or about 11:20 P.M. with complaints of a severe headache with nausea and vomiting since mid-afternoon (Ex. 11, at 2).

43. The only history recorded by Respondent for Patient D was that the patient was a 45 year old male with a headache and vomiting once since 3:00 p.m. (Ex. 11)

44. The only physical exam performed or recorded by Respondent was that there was no sinus tenderness and the neuro examination was intact. (Ex. 11)

45. The Respondent diagnosed Patient D with a tension headache and treated him with Toradol and Valium and discharged him home. (Ex. 11)

46. Respondent failed to document in the patient's history the suddenness of the headache's onset (T:315), whether the patient had previously suffered similar headaches (T:315-6),the site of pain of the headache (T:317) and the severity of the headache (T:317).

47. Respondent did not perform and/or record an examination of the patient's head, ears, eyes, nose and throat, Respondent did not ascertain and/or record the suppleness of the patient's

neck, and Respondent did not perform and/or record an adequate neurologic examination of the patient (T:321).

48. There is no documentation in Patient D's record that Respondent adequately evaluated or considered other possible causes of the Patient D's symptoms, i.e., meningitis or subarachnoid hemorrhage. (T. 325-328)

PATIENT E

49. Respondent treated Patient E, a forty-eight year old female, on April 18, 1995 in the Emergency Room at Millard Fillmore Hospital. Patient E presented to the Emergency Department after falling and hitting her head on a door at the chronic care facility where she lived. Over the previous ten days she had suffered multiple falls. The patient had a ventriculo-peritoneal (VP) shunt, which she was worried she may have damaged from her fall (Ex. 12).

50. The only history recorded on Patient E by Respondent is that she was a 48 year old female in a chronic care facility who had fallen several times in the last 10 days, since she started smoking again. (Ex. 12, p.2)

51. The history reported by Respondent did not indicate what precipitated the several falls in the previous days (Ex. 12, at 2). There is no indication whether the patient had lost consciousness, was weak or dizzy prior to the several falls (T:345).

52. The only neurological examination performed or recorded was "HEENT = CNS intact" and "Ext/Neuro grossly intact." (Ex. 12, p.2)

53. Patient E, who had a VP shunt and a very unsteady gait did not have an intact neurological examination. (Ex. 12)

54. The nurses noted that her gait was "very unsteady" (Ex. 12), and Respondent stated that "the note should say, grossly intact for her, because her neuro exam is obviously a very abnormal neurological exam and easily would merit 15 pages of writing. Well, two pages." (T. 1052)

55. Respondent ordered a CBC and chemistries on the Patient E , which were for the most part within normal limits. He also ordered a urinalysis, but a specimen was not obtained from the patient. No other diagnostic tests were ordered. (Ex. 12)

PATIENT F

56. Respondent treated Patient F, a twenty-five year old male, on April 18, 1995 in the Emergency Room of Millard Fillmore Hospital. The patient presented to the Emergency Department with back pain after falling down stairs the evening before (Ex. 13, at 2).

57. The only history recorded by Respondent in Patient F's chart was that he was a 25 year old male who slipped on a screwdriver and fell down stairs landing on his back last night. The pain was worse today and he didn't sleep at night. Positive IDDM. (Ex. 13, p.2)

58. Respondent failed to document the number, height and type of steps the patient fell down (T:365-6).

59. Respondent did not document the specific location or character of the back pain. (Ex. 13; T, 365, 368)

60. Respondent's documented physical examination on Patient F simply stated "no spinal process pain- Pain max in [Right] paravertebral muscle." (Ex. 13, p.2)

61. Respondent failed to evaluate the patient for pain, weakness or numbness in the leg or do a straight leg raising test (T:367).

62. Respondent failed to localize the pain the patient was suffering, whether it was high or low in the back (368).

63. Respondent failed to palpate the patient's chest in order to check for possible broken ribs (T:370).

64. Respondent did not document any neurologic examination (Ex. 13, at 2).

65. Other than an urinalysis, Respondent ordered no other diagnostic tests on Patient F. (Ex. 13)

PATIENT G

66. Respondent treated patient G, an eighty-year-old male, with a previous history of seizure disorder, on April 18, 1995 in the Emergency Room at Millard Fillmore Hospital. The patient presented following a ten minute seizure. He arrived via ambulance on oxygen and an IV had been started. The patient was triaged and given a priority one status. He was alert times two and moaning (Ex. 14).

67. Respondent did not obtain or document any history of this patient other than he suffered from seizure disorder and prostate cancer (Ex. 14, at 2). He did not detail any other presenting

symptoms. The nursing assessment sheet offered the only information as to the condition of this patient (Ex. 14, at 3).

68. Respondent did not perform or document any physical examination of this patient (Ex. 14, at 2).

69. Respondent's entire neurologic examination consisted of recording "post-ictal" (Ex. 14, at 2).

70. A proper neurologic examination would have consisted of indicating a level of consciousness and a check for lateralizing neurologic signs (T:402).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained

The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(4)
Paragraph A.1:	(6 - 10)
Paragraph B:	(14)
Paragraph B.1:	(16, 22 -24)
Paragraph B.2:	NOT SUSTAINED
Paragraph B.3:	(16, 21, 26- 7)
Paragraph B.4:	(16, 19, 28, 29)
Paragraph C:	(30)
Paragraph C.1:	(31 - 34, 38)
Paragraph C.2:	(34, 39)
Paragraph C.3:	(30, 35 -37, 40-41)
Paragraph D:	(42)
Paragraph D.1:	(43, 46-48)

Paragraph D.2:	(44, 47)
Paragraph D.3:	(48)
Paragraph E:	(49)
Paragraph E.1:	(50-51)
Paragraph E.2:	(52-54)
Paragraph E.3:	NOT SUSTAINED
Paragraph F:	(56)
Paragraph F.1:	(57-59)
Paragraph F.2:	(60-63)
Paragraph F.3:	(64)
Paragraph F.4:	NOT SUSTAINED
Paragraph G:	(66)
Paragraph G.1:	(67)
Paragraph G.2:	(68)
Paragraph G.3:	(69-70)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise. The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

FRAUDULENT PRACTICE

NOT SUSTAINED

HARASSING OR ABUSING A PATIENT

NOT SUSTAINED

UNWARRANTED TREATMENT

Third Specification: (Paragraphs A and A.1)

MORAL UNFITNESS

Fourth Specification: (Paragraphs A and A.1)

GROSS NEGLIGENCE

NOT SUSTAINED

GROSS INCOMPETENCE

NOT SUSTAINED

NEGLIGENCE ON MORE THAN ONE OCCASION

Nineteenth Specification: (Paragraphs A and A.1, B and B. 1, B.3 and B.4, C and C. 1, C.2 and C.3, D and D.1, D.2 and D.3, E and E.1 and E.2, F and F.1, F.2 and F.3 , G and G. 1, G.2 and G.3)

INCOMPETENCE ON MORE THAN ONE OCCASION

Twentieth Specification: (Paragraphs D and D.3, E and E.1, G and G.1)

FAILURE TO MAINTAIN RECORDS

Twenty-First Specification: (Paragraphs B and B.1, B.3 and B.4, C and C.1and C.2,D and D.1, D.2 and D.3, E and E.1 and E.2, F and F.2 and F.3, G and G.2 and G.3)

The Hearing Committee further concluded that the following specifications should not be sustained:

First Specification

Second Specification

Fifth through Eighteenth Specifications

DISCUSSION

Respondent is charged with twenty-one (21) specifications alleging professional misconduct within the meaning of Education Law Section 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence

and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Fraud is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that five (5) of the twenty-one (21) specifications of professional misconduct should be sustained. The rationale for the Committee's

conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of the witnesses presented by the parties. The Department's witnesses were Frank Edwards, M.D., Dr. Zulkharnain and Beverly Callen, RN.

Dr. Edwards is a Fellow of the American College of Emergency Physicians. At present, Dr. Edwards is the Medical Director of the Emergency Department, Newark Wayne Hospital, General Medical Director of the Division of Community and Rural Emergency Medicine of the Rochester General hospital/ViaHealth Network, as well as Medical Director, ED of Schuyler Hospital. Dr. Edwards is also a Clinical Assistant Professor of Emergency Medicine, Pediatrics, and Medical Humanities, University of Rochester. (Ex. 4, T. 139-142) The Hearing Committee found Dr. Edwards to be a well-trained and experienced emergency room physician. The Hearing Committee also found him to be unbiased and able to successfully differentiate all issues presented to him. As a result, they gave his testimony great weight.

Dr. Zulkharnain appeared as a fact witness for the Department. On April 20, 1995, he was working as an intern in internal medicine at Millard Fillmore Hospital.(T. 17-18) The Hearing Committee found him to be a credible witness. Dr. Zulkharnain's testimony about Respondent's ordering a shot of magnesium sulfate for Patient A and then discontinuing it, is corroborated by his notations in Patient A's record. (Ex.5, p.4) The Hearing Committee further finds that he has no reason to fabricate his testimony. Therefore, the Hearing Committee gave Dr Zulkharnain's testimony full weight. Beverly Callen, R.N. also testified on factual matters. The Hearing

Committee finds that her notations in the patient's charts were consistent with her testimony. Nurse Callen's testimony corroborates Dr. Zulkharnain's statements with respect to Patient A. Furthermore, the Hearing Committee notes that Nurse Callen timely reported her concerns about Respondent's care to her nurse supervisor. Finally, the Hearing Committee rejects Respondent's position that Nurse Callen reported him after a failed romantic encounter.(T. 797-801, 839) As a result, the Hearing Committee gave Nurse Callen's testimony great weight.

Respondent testified on his own behalf and offered the testimony of three expert witnesses as well as his current employer/partner. Joan McInerney, M.D. is board certified in emergency medicine and internal medicine. She is Chairman of the Department of Emergency Medicine at Nassau County Medical Center.(T. 442-443) The Hearing Committee found Dr. McInerney to be a reasonable and credible witness who was measured in her testimony but evasive about whether Respondent's practices fell below the standard of care. The Hearing Committee, therefore, gave her testimony moderate weight. William Konczynin, M.D., a physician who is board certified in family practice, also testified. Dr. Konczynin is the Director of the Emergency Department at St. Charles Hospital and Rehabilitation Center in Port Jefferson, New York.(T. 667) He is also the Medical Director of Long Island Head Injury Association.(T. 701) The Hearing Committee found Dr. Konczynin to be a well-trained physician. However, at several points in his testimony, they found that he assumed facts not in evidence as the basis for his opinions. The Hearing Committee notes the following examples: With respect to Patient A, that Dr. Zulkharnain and Respondent may have been engaged in a resident/physician academic exercise over the use of magnesium sulfate. (T. 700) With respect to Patient B, Dr. Konczynin made speculative assumptions about Patient B's

fracture and ignored empirical facts because he never reviewed Patient B's actual x-ray. (T. 694) With respect to Patient E, Dr. Konczynin assumed that the ventriculo-peritoneal shunt, had been done years before when there was no information to that effect in the patient's record. As a result, the Hearing Committee gave his testimony limited weight.

Robert Drielinger, M.D., a physician who is board certified in internal medicine, emergency medicine and forensic medicine also testified for Respondent's case. Dr. Drielinger is one of the oral board examiners for the Board of College of Emergency Medicine. He was the director of the Emergency Room at Jackson Heights Hospital in Queens, New York. (T. 562-563) The Hearing Committee finds that Dr. Drielinger also made assumptions not supported by the record throughout his testimony. For example he assumed that Millard Fillmore Hospital was a rural, one doctor hospital (T.590, 599-602, 630-632) Even when Respondent acknowledged a mistake, Dr. Drielinger would not concede the point.(T. 578) Due to his obvious bias and evasiveness, the Hearing Committee gave his testimony little weight.

The Hearing Committee found the testimony of Respondent to be inconsistent. They further found that his attitude was frequently arrogant and cocky. They further note that he was quick to blame everyone else, in particular blaming Millard Fillmore Hospital for failure to provide him with a proper orientation. (T. 797) He also tried to blame his inadequate documentation on the relaxed charting requirements he had acquired while working for the military.(T. 794, 796) The Hearing Committee further finds that Respondent misrepresented about whether he was sued for malpractice. (T. 793, 837, 871-872) As a result, the Hearing Committee found that Respondent was not a credible witness and thus greatly discounted his testimony.

Herbert Goodman, M.D. also testified by telephone on behalf of Respondent. Dr. Goodman is the Medical Director at the Northwest Medical Center in Tucson, Arizona where Respondent has been employed for the past 2 years. (T. 803-805) Dr. Goodman testified that Respondent sees a high volume of patients, which includes Dr. Goodman's mother. Dr. Goodman stated that Respondent is well liked by his patients and staff and that his charting abilities are excellent. (T. 807-808) The Hearing Committee found Dr. Goodman to be a credible witness, but his testimony had little relevance to the time frame of the charges at hand.

PATIENT A

Patient A was a thirty-eight year old male, who presented to the Emergency Room (ER) at Millard Fillmore Hospital with complaints of previous chest pain and burning with urination. His history included asthma, chest pain and psychiatric problems. Respondent ordered one gram of magnesium sulfate to be administered intramuscularly. It is alleged that this was done intentionally to cause Patient A pain and to deter him form using the ER. It is also alleged that this order was not medically justified. Respondent acknowledged that shots of magnesium sulfate and B12 are frequently given in New York City to satisfy a patient to give him the impression that you are doing everything that needs to be done for him.(T. 831) He also acknowledged giving these shots in the past. (T. 819-821)

For reasons previously discussed regarding credibility, the Hearing Committee found the testimony of Dr. Zulkharnain and Nurse Callen to be credible. The Hearing Committee concludes

that Respondent gave the shot because it would hurt the patient and deter his frequent visits to the ER. The Hearing Committee rejects Respondent's explanation that the drug was given as a placebo, because Patient A's record indicates that he had already been evaluated and given medication.(T. 819) The Hearing Committee further rejects Respondent's explanation that it might have done Patient A some good due to his hypertension, asthma, psychiatric problems and dilation of the coronary arteries.(T. 814-815) The Hearing Committee concurs with Dr. Edwards that there were no medical indications for administering magnesium sulfate for Patient A. (T. 144, 147) They further note that Respondent's expert, Dr. Konczynin would not have ordered the shot for Patient A. (T.699)

Therefore, the Hearing Committee sustains the Third Specification as unwarranted treatment. The Hearing Committee further sustains the Fourth Specification as an act constituting moral unfitness because Respondent knowingly prescribed the magnesium sulfate shot because "it hurts" and would deter the patient from returning to the ER . They also find that ordering the shot without medical justification constitutes negligence. The Hearing Committee, however, finds that because external factors forced Respondent to rescind his order so that the shot was never administered to Patient A, there is insufficient evidence to sustain the specifications of fraudulent practice or of physical abuse or intimidation of Patient A. Therefore , the Hearing Committee does not sustain the First or Second Specifications.

PATIENT B

Patient B was a 33-year old male who was admitted to the ER after incurring a blow to the head and face from a metal bar. It is alleged that Respondent failed to perform and/or document an adequate neurologic examination. The Hearing Committee concurs with Dr. Edwards that a minimally accepted neurologic exam of Patient B would consist of a general assessment of the patient's mentation, cranial nerves and a brief assessment to insure that the nervous system and aspects of the nervous system in the extremities were intact.(T. 187-188) The Hearing Committee also agrees with Dr. Edwards that Respondent failed to perform an adequate neurological examination of Patient B.(T. 188-189) The Hearing Committee concurs with Dr. Edwards that the zygomatic arch fracture should not have been missed by Respondent. (T. 192) Respondent and Dr. McInerney even concede that the x-ray was misread. (T. 190, 481) The Hearing Committee however finds that since Respondent failed to correctly diagnose the fracture, he cannot be faulted for failure to refer Patient B to a specialist for evaluation and treatment of the fracture. Therefore, Charge B.2 is not sustained.

It is further alleged that Respondent failed to perform and/or document an adequate examination of Patient B's right middle ear despite indications of dried blood in the right middle ear. The Hearing Committee finds that because of the type of blow incurred and the blood found in the inner aspect of the ear, Respondent should have examined the ear and diagnosed the ruptured right eardrum. (T. 221-222, 226) It is also alleged that Respondent failed to document the extent and location of the lacerations and adequately document the procedures he used to close the wounds. The Hearing Committee concurs with Dr. Edwards that Respondent failed to document the location of

the sutures and the length and depth of the wounds. The medical significance of indicating where the laceration was and its extent is that branches of facial nerves and salivary ducts run under the area which could have been damaged. (T. 228) The Hearing Committee further finds that Respondent failed to adequately document the procedures he used to close the wounds. Even Dr. McInerney stated that lacerations should be noted by the number of sutures and the type of suture material. (T. 454)

The Hearing Committee concludes that Respondent was negligent in not performing an adequate neurologic as well as a right middle ear exam and failed to adequately document Patient B's record. This charge therefore sustains the Nineteenth and Twenty-First Specifications.

PATIENT C

Respondent treated Patient C, a 52-year-old female in the ER for symptoms that were indicative of a cerebral hemorrhage. It is alleged that Respondent failed to perform and/or document an adequate physical and neurological examination of the patient. Dr. Edwards stated that it would have been appropriate to exam this critically ill patient with a focus on the neurological system and a brief review of vital signs. (T. 238-239, 242) The neurological exam should have focused on Patient C's level of consciousness, ability to move her extremities, her basic reflexes and whether she was flaccid or spastic. (T.238) Listening to the chest would determine if there had been any vomiting and aspiration of gastric contents into the lungs.(T. 243) Dr. Edwards further stated that a brief general exam is appropriate, even in a critical setting because "there are things that will fool you." (T. 258) Dr. Edward's concluded that Respondent's care of Patient C and the documentation

of her medical record failed to meet the minimally accepted standards of practice. (T. 244-250) The Hearing Committee concurs with Dr. Edwards and finds that Respondent failed to provide adequate care to Patient C and also kept inadequate records.

It is further alleged that Respondent failed to intubate Patient C in a timely manner despite indications. Dr. Edwards stated that the patient's record indicates that she was deteriorating and that she would be quickly leaving the ER to get a CT scan. The accepted standard of practice is to get the patient intubated before leaving the ER for a CT scan. Dr. Edwards further stated that it is the emergency physician's responsibility to intubate, even after the neurosurgical fellow came into the ER. (T. 252) Even Respondent stated that he thought he had intubated Patient C and that he couldn't conceive of letting her go to CT without one. (T. 941, 946,948) The Hearing Committee finds that Patient C was not intubated in a timely manner. As a result, these charges sustain the Nineteenth and Twenty-First Specifications.

PATIENT D

Respondent treated Patient D, a 45-year-old male for complaints of severe headache with nausea and vomiting since mid-afternoon. It is alleged that Respondent failed to obtain and/or document an adequate history for Patient D. Dr. Edwards stated that the medical record falls below the minimal standards of practice, because it fails to delineate some very important theoretical factors, especially with regard to the abruptness of onset, and the past history of headaches. (T. 320) It is further alleged that Respondent failed to perform and/or document an adequate physical examination of the patient. Dr. Edwards stated that the physical examination performed by

Respondent failed to address important examination factors such a level of consciousness, examining the head, ears, eyes, nose and throat, suppleness of the neck and a neurological exam. (T. 321-325) It is further alleged that Respondent failed to adequately evaluate and/or document the possible causes of the Patient D's symptoms including, but not limited to, meningitis or subarachnoid hemorrhage. Dr. Edwards stated that factors to be considered for meningitis include, presence of fever, stiffness of the neck, mental status changes, nausea, vomiting, respiratory symptoms and a sore throat. (T. 326) He further stated that for a subarachnoid hemorrhage, a thorough history as to the suddenness and severity of the headache was needed and a possible CT scan. (T. 327) Dr. Edwards concluded that in each instance, the minimum standards were not met for history, physical, evaluation of possible causes and record documentation. (T.319-320, 325, 327-328)

Respondent testified that he did not have an independent recollection of Patient D and that his memory is "primarily stimulated by looking at the chart."(T. 998-999) Respondent stated that he gleaned information about his examination and evaluation by reading "between the lines of my notes." (T. 1031) The Hearing Committee concurs with Dr. Edwards's expert opinion. They find Respondent's explanation that he was able to recall all aspects of his evaluation based on his scanty notes as incredible. (T. 1031-1037) The Hearing Committee does not believe that a thorough examination or evaluation was ever performed upon Patient D. They find that this is another example of the pattern of cursory care that Respondent provided to the patients that are the subject of these charges. The Hearing Committee finds that Respondent was not only careless in his care and recordkeeping for Patient D, but that he was incompetent in his failure to properly evaluate

Patient D's headache. As a result, the Nineteenth, Twentieth and Twenty-First Specifications are sustained.

PATIENT E

Respondent treated Patient E, a 48 year-old female in the ER after falling and hitting her head on a door at her chronic care facility. Patient E suffered multiple falls in the past 10 days and she was worried that she may have damaged her ventriculo-peritoneal(VP) shunt. It is alleged that Respondent failed to obtain and/or document an adequate history as well as an adequate neurological examination. Dr. Edwards stated that the history is inadequate because there is no indication if Patient E fell due to weakness, stumbling or loss of consciousness. Also Respondent fails to note the contusion on the right hairline and any evaluation of a possible head injury. (T. 344-345) Dr. Edwards stated that because Patient E had a VP shunt and had recent problems with balance and ambulation, Respondent should have focused on the neurological exam. This would include a quick assessment of the cranial nerves, peripheral strength, deep tendon reflexes and special focus on cerebellum coordination reflexes.(T. 348) The Hearing Committee finds once again that Respondent's recollection of the history and examination of Patient E strains credulity. (T. 1068-1073) They further reject his explanation that Patient E's falls may have resulted from dizziness after she resumed smoking.(T. 1059-1060) Thus, the Hearing Committee concurs with Dr. Edwards that the history, examination and record documentation for Patient E do not meet minimum standards of medical practice. (T. 346-347,349) They further find that Respondent's consideration of smoking as a potential cause for dizziness to constitute incompetence.

It is further alleged that Respondent failed to order adequate diagnostic tests, including but not limited to an electrocardiogram, despite indications. The Hearing Committee does not find sufficient evidence in the medical records to ascertain whether further tests were indicated.

Therefore, this charge sustains the Nineteenth, Twentieth and Twenty-First Specifications.

PATIENT F

Respondent treated Patient F, a 25 year-old male in the ER for back pain after falling down stairs the evening before. It is alleged that Respondent failed to obtain and/or document an adequate history as well as perform and/or document adequate physical and neurological exams.

Dr. Edwards stated that the history lacked information on the height from which Patient F fell and the surface on which he landed. Respondent failed to note whether there was pain, weakness and numbness in the leg in connection with a possible ruptured disc.(T. 366-367) The physical examination was inadequate because Respondent failed to identify if the pain was in the lumbar or thoracic region and to palpate the chest to check for broken ribs. (T. 367-368, 370) Dr. Edwards notes that there is no documentation that a neurological exam was performed. He stated that minimum standards of care require a brief neurological exam of the motor function of the legs and sensation in the reflexes. (T. 370) Dr. Edwards concluded that the history and the examinations did not meet the minimum standards of medical care. (T. 366, 371) The Hearing Committee concurs with Dr. Edwards for the above charges. They again find Respondent providing substandard care to Patient F as well as poor record keeping. However, because of inadequate information in the chart, the Hearing Committee could not decide if the patient's injuries were severe enough to warrant

further testing. Thus, charge F.4 is not sustained.

As a result, the Nineteenth and Twenty-First Specifications are sustained.

PATIENT G

Respondent treated Patient G, an 80-year-old male, with a previous history of seizure disorder in the ER. Patient G arrived via ambulance after suffering a ten minute seizure. It is alleged that Respondent failed to obtain and/or document an adequate history of the patient. It is further alleged that Respondent failed to perform and/or document adequate physical and neurological exams for the patient. Dr. Edwards testified that there is really no history recorded for Patient G of why he came to the ER other than past history of positive for seizures and prostate cancer. (T. 397) Dr. Edwards stated that history needs to be recorded so that another practitioner can understand the clinical reasoning of the initial physician.(T. 398) Dr. Edwards also stated that there is no documentation of a physical exam. (T. 399) A routine physical exam for this patient would include checking the head, eyes, ears, nose, throat, chest and a brief cardiovascular examination all of which could be done in less than 5 minutes. (T. 400-401) Dr. Edwards found no documentation that Respondent performed a neurological examination. (T. 401-402) A minimally acceptable neurological evaluation includes checking the level of consciousness, determining if one side is weaker than the other and evaluating the possibility of a stroke. (T. 402) Dr. Edwards added that "the emergency physician needs to have an approach to patients that is thorough enough within the constraints of time to pick up things that can be hiding there in the bushes, kind of to bite you." (T. 403) Dr. Edwards concluded that Respondent's care of Patient G and the documentation of

the patient's records fell below acceptable standards of practice. (T. 398, 401,403-404)

The Hearing Committee notes that Respondent made no attempt to evaluate why Patient G's Dilantin levels were low, he just assumed the patient was not taking it. Respondent also gave no other thoughts to other conditions, like malabsorption of Dilantin, that may have contributed to the low level of the drug. (T. 1114-1119) The Hearing Committee concurs with Dr. Edwards expert opinion. They find not only lack of care and poor record keeping, but also incompetence for Respondent's lack of knowledge about the malabsorption of Dilantin.

Therefore, these charges sustain the Nineteenth, Twentieth and Twenty-First Specifications.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee believes that the cases presented before them reveals a disturbing pattern of shoddy patient care by Respondent. Respondent has demonstrated a lack of commitment to thoroughness in the history, evaluation and treatment of patients. His documentation of medical records is chronically bad. The short time span of the cases presented at hearing is further indication of Respondent's entrenched cursory approach to patient care and the inherent danger it creates to

patients.

Respondent's demeanor before the Hearing Committee was unrepentant and at times dishonest. Respondent did not truly accept responsibility for his actions except for the missed x-ray for Patient B. Respondent tried to blame everyone for his situation and painted himself as a victim of the actions of the staff and management of Millard Fillmore Hospital. The Hearing Committee believes that Respondent lied when he claimed to recall aspects of his examination of patients by reading between the lines of his scanty documentation. They also find that he lied about his malpractice lawsuits. The Hearing Committee further finds no evidence of remorse by Respondent, and note that he often exhibited an air of justification for his actions. As a result, they find that Respondent's poor attitude does not make him a good candidate for retraining. Under the totality of the circumstances, revocation of Respondent's license is the only appropriate sanction in this instance.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The Third, Fourth, Nineteenth, Twentieth and Twenty-First Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The First, Second, Fifth through Eleventh, and Twelfth through Eighteenth Specifications are **NOT SUSTAINED**; and

3. Respondent's license to practice medicine in New York State be and hereby is **REVOKED.**

DATED: Albany, New York
March 17 **1999**

Redacted Signature

MARGARET H. McALOON, M.D.
(Chairperson)

WILLIAM K. MAJOR, Jr., M.D.
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STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER : STATEMENT

OF : OF

JOHN H. FANCHER, M.D. : CHARGES

----------X

JOHN H. FANCHER, M.D., the Respondent, was authorized to practice medicine in New York State on March 7, 1995 by the issuance of license number 198654 by the New York State Education Department. The Respondent is currently not registered with the New York State Education Department to practice medicine.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, (a list of patients' names is included as appendix A) a thirty-eight year old male, on or about April 20, 1995 in the Emergency Room of Millard Fillmore Hospital, 3 Gates Circle, Buffalo, New York (hereinafter MFH). Patient A presented with chest pain and complaints of burning during urination. Respondent's medical care of Patient A failed to meet accepted standards of medical care in the following respects:

1. Respondent ordered one gram of magnesium sulfate to be administered intramuscularly to intentionally cause the patient pain and deter him from using the Emergency Room services. The patient's presenting symptoms did not medically justify the administration of magnesium sulfate.

B. Respondent treated Patient B, a thirty-three year old male, who received from a blow to the head and face from a metal bar, in the Emergency Room of MFH on or about April 22, 1995. Patient B presented with lacerations to his lower lip, right ear and right zygomatic process. Respondent's medical care of Patient B failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or document an adequate neurologic examination of Patient B.

2. Respondent failed to refer Patient B to an appropriate specialist for evaluation and treatment of maxillofacial injuries including, but not limited to, buckling along the posterior aspect of the zygomatic arch, a comminution of the right zygomatic arch and a fracture of the lateral wall of the right maxillary sinus.

3. Respondent failed to perform and/or document an adequate examination of the patient's right middle ear despite indications of dried blood in the right middle ear.

4. Respondent failed to document the extent and location of the lacerations and adequately document the procedures he used to close the wound(s).

C. Respondent treated Patient C, a fifty-two year old female, in the Emergency Room of MFH on or about April 23, 1995. Patient C had a history of severe headache and was unresponsive with left-side weakness and posturing, among other clinical signs. Respondent's medical care of Patient C failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or document an adequate physical examination of the patient.

2. Respondent failed to perform and/or document an adequate neurologic examination of the patient.

3. Respondent failed to intubate the patient in a timely manner despite indications.

D. Respondent treated Patient D, a forty-five year old male, on or about April 18, 1995 in the Emergency Room of MFH. Patient D presented at or about 11:20 P.M. with complaint of a severe headache with nausea and vomiting since mid-afternoon. Respondent's medical care of Patient D failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of the patient.
2. Respondent failed to perform and/or document an adequate physical examination of the patient.
3. Respondent failed to adequately evaluate and/or document the possible causes of the patient's symptoms including, but not limited to, meningitis or subarachnoid hemorrhage.

E. Respondent treated Patient E, a forty-eight year old female, on or about April 18, 1995 in the Emergency Room of MFH. Patient E presented to the Emergency Department after falling and hitting her head on a door at the chronic care facility where she lived. Over the previous ten days she had suffered multiple falls. Respondent's medical care of Patient E failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of the patient.
2. Respondent failed to perform and/or document an adequate neurologic examination.
3. Respondent failed to order adequate diagnostic tests, including, but not limited to an electrocardiogram, despite indications.

F. Respondent treated Patient F, a twenty-five year old male, on or about April 18, 1995 in the Emergency Room of MFH. Patient F presented to the Emergency Department with back pain after falling down a flight of stairs the evening before. Respondent's medical care of Patient F failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination, including, but not limited to identifying the level of maximal vertebral pain, the presence of pain with spinal range of motion, the presence of chest or abdominal tenderness and whether the neurologic status of the legs was normal.

3. Respondent failed to perform and/or document an adequate neurologic examination.

4. Respondent failed to order appropriate x-rays, including, but not limited to the thoracic and/or lumbar vertebrae, which were indicated given the mechanism of injury.

G. Respondent treated Patient G, an eighty year old male with a previous history of seizure disorder, on or about April 18, 1995 in the Emergency Room of MFH. He presented following a 10 minute seizure. Respondent's medical care of Patient G failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of the patient.

2. Respondent failed to perform and/or document an adequate physical examination of the patient.

3. Respondent failed to perform and/or document an adequate neurologic examination of the patient.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION
FRAUDULENT PRACTICE

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

1. The facts in Paragraphs A and A1.

SECOND SPECIFICATION
HARASSING OR ABUSING A PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(31) by willfully harassing, abusing or intimidating a patient either physically or verbally as alleged in the following facts:

2. The facts in Paragraphs A and A1.

THIRD SPECIFICATION
UNWARRANTED TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(35) by ordering excessive test, treatment or use of treatment facilities not warranted by the condition of the patient as alleged in the

following facts:

3. The facts in Paragraphs A and A1.

FOURTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Education 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 the following:

4. The facts in Paragraphs A and A1.

FIFTH THROUGH ELEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with professional misconduct as defined in N.Y. Education Law §6530(4) by reason of his practicing the profession of medicine with gross negligence, in that Petitioner charges that Respondent committed one of the following:

5. The facts in paragraphs A and A1.

6. The facts in paragraphs B and B1, B and B2 and/or B and B3.

7. The facts in paragraphs C and C1, C and C2 and/or C and C3.

8. The facts in paragraphs D and D1, D and D2 and/or D and D3.

9. The facts in paragraphs E and E1, E and E2 and/or E and E3.

10. The facts in paragraphs F and F1, F and F2, F and F3, and/or F and F4.

11. The facts in paragraphs G and G1, G and G2 and/or G and G3.

TWELFTH THROUGH EIGHTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with professional misconduct as defined in N.Y. Education Law §6530(6) by reason of his practicing the profession of medicine with gross incompetence, in that Petitioner charges that Respondent committed one of the following:

12. The facts in paragraphs A and A1.

13. The facts in paragraphs B and B1, B and B2 and/or B and B3.

14. The facts in paragraphs C and C1, C and C2 and/or C and C3.

15. The facts in paragraphs D and D1, D and D2 and/or D and D3.

16. The facts in paragraphs E and E1, E and E2 and/or E and E3.

17. The facts in paragraphs F and F1, F and F2, F and F3 and/or F and F4.

18. The facts in paragraphs G and G1, G and G2 and/or G and G3.

NINETEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct as defined in N.Y. Education Law §6530(3) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

19. The facts in paragraphs A and A1, B and B1, B and B2, B and B3, B and B4, C and C1, C and C2, C and C3, D and D1, D and D2, D and D3, E and E1, E and E2, E and E3, F and F1, F and F2, F and F3, F and F4, G and G1, G and G2 and/or G and G3.

TWENTIETH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct as defined in N.Y. Education Law §6530(3) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

20. The facts in paragraphs A and A1, B and B1, B and B2, B and B3, B and B4, C and C1, C and C2, C and C3, D and D1, D and D2, D and D3, E and E1, E and E2, E and E3, F and F1, F and F2, F and F3, F and F4, G and G1, G and G2 and/or G and G3.

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TWENTY-FIRST SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct under N.Y. Education Law § 6530(32) by reason that the Respondent failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that Petitioner charges:

21. The facts in paragraphs B and B1, B and B3, B and B4, C and C1, C and C2, D and D1, D and D2, D and D3, E and E1, E and E2, F and F1, F and F2, F and F3, G and G1, G and G2 and/or G and G3.

Dated: September 25 1998
Albany, New York

Redacted Signature

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