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

July 6, 1990

John C. Farrell, Physician
242 Main Street
Cornwall-on-Hudson, N.Y. 12518

Re: License No. 087239

Dear Dr. Farrell:

Enclosed please find Commissioner's Order No. 10710. 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 - Suite 512
Scarsdale, N.Y. 10583

REPORT OF THE
REGENTS REVIEW COMMITTEE

JOHN C. FARRELL

CALENDAR NO. 10710

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

JOHN C. FARRELL **No. 10710**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

JOHN C. FARRELL, 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. A copy of the original, first amended, and second amended statement of charges are annexed hereto, made a part hereof, and marked as Exhibit "A".

Between November 9, 1988 and March 1, 1989 a hearing was held on five different sessions before a hearing committee of the State Board for Professional Medical Conduct. The hearing committee report on page two does not show the fifth hearing session of March 1, 1989.

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 "B". The hearing committee report states that the statement of charges is attached thereto. The original hearing committee report transferred to us, however, does not contain this attachment and does not refer to the original statement of charges. Instead, the hearing committee report is based upon the second amended statement of charges.

The hearing committee found and concluded that respondent was guilty of the eleventh through the nineteenth specifications, guilty of the first specification based upon negligence on more than one occasion to the extent indicated on page 28 of its report, and not guilty of the remaining specifications and charges, and recommended that respondent's license to practice as a physician in the State of New York be suspended, said suspension be permanently stayed on specified conditions involving monitoring for two years, and respondent be assessed a civil penalty of $1000. The hearing committee also recommended that if respondent fails to keep records of appropriate quality his license shall be revoked.

The Commissioner of Health recommended to the Board of Regents that the findings and conclusions of the hearing committee be accepted, except for the conclusion with regard to "Allegation J", the 20th specification, be sustained, and the recommendation of the hearing committee be accepted with a clarification involving the

monitoring and a statement that if respondent's records "do not meet accepted standards of completeness and legibility, the stay of supervision of his license may be lifted." A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On April 5, 1990, respondent appeared before us and was represented by his attorney Anthony Z. Scher, Esq., who presented oral argument on behalf of respondent. Daniel J. Persing, Esq., presented oral argument on behalf of the Department of Health.

We have considered the record in this matter as transferred by the Commissioner of Health.

Petitioner's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State of New York be suspended, the suspension be stayed, and respondent be placed on probation with monitoring for two years.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent receive a Censure and Reprimand.

The specifications of the charges brought against respondent do not separately state and number each separate definition of professional misconduct. The first specification concerns negligence "and/or" incompetence on more than one occasion and the second through tenth specifications concern gross negligence

"and/or" gross incompetence. These specifications relate to various groupings of allegations. Within the allegations, respondent is charged with committing one "and/or" another act or failure. Thus, the charges present a myriad of possibilities for determination.

The hearing committee made findings of fact with regard to each of the 9 patients in issue; concluded whether each of the factual allegations were sustained; and concluded whether the specifications charged were sustained. In this manner, the hearing committee sustained introductory factual allegations A, C, D, E, F, G, and I, along with the 14 subparagraphs of A.1., C.1., D.1., D.2., D.3., E.2., E.3., F.1., F.1., F.3., G.1., G.2., G.3., I.2., and I.4. The conclusions of guilty by the hearing committee regarding the first specification relate to the above introductory allegations along with the 9 subparagraphs of D.1., D.3., E.3., F.1., F.3., G.1., G.2., G.3., and I.4. Its conclusions of guilty regarding the eleventh through nineteenth specifications involving record-keeping relate to one specification for each patient but not to specific allegations and subparagraphs. From these charges and the report of the hearing committee, we must ascertain whether respondent is guilty or not guilty of each definition of professional misconduct based on each charged act or failure to act.

The first through nineteenth second amended charges relate to respondent's care and records of 9 patients each over a period of time. In our unanimous opinion, respondent is guilty of unprofessional conduct, under Education Law §6509(9) and 8 N.Y.C.R.R. §29.2(a)(3), for failing to maintain records which accurately reflect the evaluation and treatment of patients as charged in the fifteenth specification (subparagraph E.3.), seventeenth specification (subparagraph G.3.), and nineteenth specification (subparagraph I.4.). These subparagraphs each relate to respondent's failure to provide any documentation in the patient record supporting the use of the drug he prescribed. Respondent is also guilty of such unprofessional conduct under the fourteenth specification (subparagraphs D.1. and D.2.) based upon his failure to record an adequate medical history and to document a comprehensive physical examination initially and throughout the course of treatment.

MEDICAL HISTORIES

Various charges allege respondent's failure to elicit "and/or" record an adequate medical history from a particular patient. The hearing committee report on page 31 summarizes its recommendation by stating that "[w]ith the exception of patient D, only record-keeping was substandard." Aside from patient D, the hearing committee and Commissioner of Health found respondent guilty

regarding the adequacy of the medical history recorded with respect to patients F and G and not guilty regarding the remaining charges as to medical history. Regarding subparagraphs F.1. and G.1., in view of these recommendations that respondent's guilt relates to the recording of the medical histories, we understand the hearing committee and Commissioner of Health as concluding that respondent is not guilty to the extent these subparagraphs relate to the adequacy of the histories elicited by respondent.

We accept the recommendations not to sustain the subparagraphs regarding the adequacy of the medical history recorded except for F.1. and G.1. and we do not accept the recommendations as to F.1. and G.1. For both patients, there were no findings by the hearing committee or Commissioner of Health indicating what history respondent did not, but should have recorded, and what history was elicited but not recorded. Instead, the hearing committee report shows the history which was recorded for patient F (finding 2) and recognizes generally that some history was recorded for patient G (conclusion p.23). The only testimony referred to by the hearing committee as support for its findings in both cases was from respondent. His testimony does not address any failure to record the histories of these patients. In our unanimous opinion, the hearing committee's findings were insufficient to support its conclusions regarding respondent's recording of the medical histories of patients F and G, and a preponderance of the evidence

was not established, in this regard, by the bare conclusion of petitioner's witness that respondent's record of the medical history does not comport with accepted standards of medical care. See T. 271, and 293.

COMPREHENSIVE PHYSICAL EXAMINATIONS

The hearing committee sustained various factual allegations regarding respondent's alleged failure to perform and/or document a comprehensive physical examination for a particular patient. Nevertheless, the hearing committee reasoned that, with respect to subparagraphs A.1., C.1., D.2., E.2., and I.2., the physical examinations were adequate for respondent's purpose of treatment and, therefore, did not constitute a violation of generally accepted medical standards. Hearing committee report p.28. We accept these recommendations.

The hearing committee also concluded that the physical examinations recorded were inadequate for patients G and F. The original subparagraph in this regard concerning patient G was deleted in the amended charges. Amended subparagraph G.2. refers to respondent's prescribing practices without an adequate physical examination. Notwithstanding the hearing committee's conclusion on page 27 of its report that the physical examination recorded was inadequate and notwithstanding subparagraph G.2., respondent cannot be found guilty of record-keeping practices regarding any physical examination of patients G and F. We note subparagraph G.2. was

sustained by the hearing committee and Commissioner of Health even though, contrary to the charge, the hearing committee found (finding 2), that there was no contraindication to the use of these drugs in this patient. With respect to patient F, as previously discussed, the findings and testimony are too conclusory and unclear. Accordingly, we do not accept the recommendations regarding the respondent's documentation of physical examinations as to Patients G and F.

The hearing committee recommended that each specification from the eleventh through the nineteenth be sustained for each patient presented. It did not identify the specific subparagraphs with any particularity. The hearing committee report declared that the specifications require at least one factual allegation to be sustained under each patient before a specification could be sustained. The hearing committee did not sustain any factual allegation for patients B and H. Nevertheless, based on its own scrutiny of each patient record, including patients B and H, the hearing committee found those records to be substandard. In our unanimous opinion, the hearing committee and Commissioner of Health erred, except as indicated above, by finding respondent guilty of each of these 9 specifications.

The hearing committee's duties include making conclusions concerning the charges sustained or dismissed. Public Health Law

§230(10)(g). Having concluded that the alleged failures and acts with respect to patients B and H were not sustained, the hearing committee and Commissioner of Health did not have a basis for finding respondent to have committed the unprofessional conduct charged in the twelfth and nineteenth specifications. As a matter of law, where the factual allegations made in the statement of charges are not sustained, the charges should be dismissed.

In determining the eleventh through nineteenth specifications, we have looked at the transferred record as a whole. The hearing committee may "properly use its expertise to analyze and interpret evidence before it, it could not use such expertise to substitute for evidence." Cohen v. Ambach, 112 A.D.2d 497 (3rd Dept. 1985). The hearing committee has not shown there was any evidence in the record to support the charges regarding patients B and H other than the hearing committee's own analysis of respondent's records. Also, the hearing committee has not rendered findings of fact and conclusions, based on the transferred record as a whole, which are sufficient to reveal how guilt may be found regarding any charges concerning patients A, B, C, and H. Accordingly, we do not accept the recommendation to sustain the eleventh, twelfth, thirteenth, and seventeenth specifications.

NEGLIGENCE IN TREATMENT

The hearing committee recommends that respondent's records be considered substandard and thereby finds guilt with respect to both negligence and unprofessional conduct. While the failure to meet

acceptable record-keeping standards may also constitute negligence, such failure does not, by itself, automatically constitute negligence in all cases.* The definition of negligence utilized by the hearing committee, of the absence of the level of care and diligence expected of a prudent physician, was not satisfied by the hearing committee's mere determination that respondent's documentation was clearly substandard. Similarly, petitioner maintained that respondent would be guilty of negligence if he did not practice in accordance with approved methods and means of treatment. Petitioner's brief, proposed findings, and conclusions p.4. In view of the long-settled rule that unprofessional conduct need not be limited to the treatment of patients, Wernick v. New York State Education Department, 79 A.D.2d 776 (3rd Dept. 1980); Mosner v. Ambach, 66 A.D.2d 912 (3rd Dept. 1978); or to medical practice, Gordon v. Commissioner of Education, 144 A.D.2d 839 (3rd Dept. 1988); Pepe v. Board of Regents, 31 A.D.2d 582 (3rd Dept. 1968), we do not agree with petitioner that the failure to keep accurate records cannot be seen separately from the charges of negligence and that the failure to meet record-keeping standards must result in the charges of negligence being sustained. Id. at p.18. Here, the findings do not establish a relationship between

*Record-keeping failures may constitute negligence, for example, where the hearing record shows that the care which the patient has been provided by respondent or another licensee is affected by respondents record-keeping.

respondent's record-keeping acts and the patient's treatment. Accordingly, the hearing committee has not documented its recommendation that respondent's record-keeping constitutes both negligence and unprofessional conduct.

The hearing committee recommended respondent be found guilty of negligence on more than one occasion, in regard to patient D, of subparagraphs D.1. and D.3. Its report does not clearly show how negligence was established for subparagraph D.1. and does not recommend any negligence be found for subparagraph D.2., even though that factual allegation was sustained.

Subparagraph D.3. concerns respondent's failure to treat patient D's hypertension. Although respondent treated patient D for about five years beginning in April 1980, patient D's hypertension was never brought within normal limits. The hearing committee concluded that respondent's care of this patient's hypertension was woefully and entirely inadequate. It recognized that respondent tried a number of treatment regimens for the hypertension. This treatment, while reasonable initially, T. 255 and 259, did not adequately normalize patient D's blood pressure T.257. In our unanimous opinion, respondent's continuation of an unsuccessful regimen on Patient D for five years when other medications and different dosages were available to control the patient's hypertension constitutes negligence on more than one occasion. T. 259-261 and 245. This regimen was continued by

respondent in spite of it being ineffective. T. 247. Once patient D did not respond to respondent's regimen, a reasonably prudent physician, considering the long term major damage caused by hypertension, T.249, would have changed the treatment plan or referred the patient to another physician for treatment. Respondent did neither and patient D's hypertension was not adequately controlled during these five years T. 262. The changes respondent made in therapy over the course of five years were not significant and respondent's treatment was clearly not effective and appropriate in stabilizing patient D's hypertension. T. 245, 248, and 250.

DATES OF RESPONDENT'S CONDUCT

The charges concerning patients A and F cover a period of twenty or more years back to the 1960's; the charges concerning patients B and C cover a period of more than ten years back to the 1970's. The Administrative Officer properly noted and instructed the hearing committee "that any charges based upon acts which occurred prior to the effective date of the charges must be excluded from their consideration." In accordance with Gould v. Board of Regents, 103 A.D.2d 897 (3rd Dept. 1984), the Administrative Officer dismissed the portion of the charges concerning patients A, B, C, and F in which the acts occurred prior to the dates when the relevant definition of professional misconduct became effective. We accept this legal ruling.

Respondent may not be found guilty of the first specification for conduct occurring before September 1975 and of the eleventh through nineteenth specifications for conduct occurring before October 1, 1977.

The only dates contained in the hearing committee's findings accepted by the Commissioner of Health are the dates when respondent commenced providing medical care to the patient. Those findings did not clearly specify the date or dates when any misconduct was committed by respondent and, therefore, do not clearly show that the findings of misconduct relate solely to the periods after the relevant definition of professional misconduct became effective. We note that the conclusions section of the hearing committee report, except in regard to patient F, does not specify any date when the conduct, on which guilt was found, occurred.

The charge concerning Patient F is in regard to the period May 12, 1966 through at least November 6, 1986. Yet, for this patient, finding 1 is based upon conduct on November 15, 1965 and conclusion F.3. mentions a physical examination in 1961. These 2 dates pre-date and are not within the charges. The conclusions for Patient F state that no physical examination was performed during the relevant statutory period 1971 through 1976. Hearing committee report p. 22. However, this period is completely irrelevant to the guilt recommended as to the sixteenth specification and is mostly

irrelevant to the other guilt recommended as to the first specification. The hearing committee report, in a part subsequent to the findings and conclusions regarding patient F, refers with respect to subparagraph charge F.3., to the different period of 1975 through 1986. Thus, the hearing committee has not precisely particularized the dates when the misconduct found in subparagraph F.1. as well as F.3. occurred.

Finding 2, the only finding made by the hearing committee regarding the history taken for patient F, appears to relate to November 15, 1965. That is the date shown in finding 1 and in Exhibit 8 regarding finding 3, and on transcript p. 530 (hereafter T.___) as cited by the hearing committee. The November 15, 1965 date is not merely background information and is beyond the scope of the charges which originally referred only to March 1986 through at least November 6, 1986 and which were amended to refer to May 12, 1966 through at least November 6, 1986. Subparagraph F.1. is thus not supported by the hearing committee's findings relating to November 15, 1965 or by any of its findings. The Commissioner of Health does not address the manner in which the charges were drafted and the hearing committee report was prepared.

NEW AMENDMENTS

The recommendation of the Commissioner of Health is unclear as to the twenty-first specification. Since both the twentieth and twenty-first specifications are in regard to Allegation J, the

Commissioner of Health does not accept the conclusions of not guilty by the hearing committee as to both specifications. However, he only makes a specific conclusion with regard to the twentieth specification. It appears that the Commissioner of Health meant to sustain that specification but failed to specify his conclusion.

The twentieth and twenty-first specifications were added by the second amended statement of charges dated February 17, 1989. In his letter dated February 22, 1989, respondent's attorney objected to this amendment. At the March 1, 1989 hearing session, the Administrative Officer received the amended statement of charges over respondent's objection. Thus, respondent, at most, was given 12 days notice of this second amendment. This second amendment was received more than 4 months after the original statement of charges, more than 3 months after the hearings began, and 1 month after petitioner called its last witness.

This matter is different from Davidson v. Board of Regents, ___A.D.2d___, 547 N.Y.S.2d 904 (3rd Dept. 1989), where the charges were allowed to be amended during the course of the hearing by the service of late notice. There, respondent did not object to the timeliness of the service of the amended charges and the hearings continued more than 15 days after the amendment. In comparison, respondent's objection to the second amended charges here was considered by the Administrative Officer to be strenuous and by

respondent's attorney to be vigorous. Respondent's attorney contended that this amendment was not sufficient and was not screened before the time of the amendment. Also, here, as opposed to in Davidson, the hearing did not continue 15 days after the amendment was served on respondent. When respondent was served less than 15 days before the last hearing session and the second amendment was accepted into the record on the last hearing date, respondent did not receive the notice required by Education Law §6510(1)(d).

In any event, regardless of the statutory requirements regarding the bringing of charges and of the sufficiency of the content of the twentieth and twenty-first specifications, we would agree with respondent's contention that the new charges added by the second amended statement of charges are improper. See Matter of Emanuel Revici, Cal. No. 8342. This amendment adds a new Allegation J and a new twentieth and twenty-first specifications based thereon. While the focus of the charges prior to the second amendment was on respondent's direct efforts regarding 9 specified patients, the focus of this second amendment is on the different transactions and occurrences related to respondent's employee being permitted to act regarding several unspecified patients. The distinct issue of the employee's administering of injections differs from the transactions and occurrences previously charged.

JOHN C. FARRELL (10710)

Respondent's attorney correctly contends that there is no evidence that the new allegation in the second amended statement of charges was added in compliance with the procedures in Public Health Law §230(10)(a). These procedures require screening before charges are brought. Had these procedural steps occurred, one or both of the twentieth and twenty-first specifications may never have been brought. Respondent was prejudiced by the absence of proven compliance with statutory procedures; the different and unrelated charges added at the end of the hearing (after petitioner had previously amended the charges and presented its witnesses and after respondent produced his witness in response to the existing charges); and the general amended charges which did not specify the injection, date of injection, employee, or patient. See Matter of John H. Park, Cal. No. 8493.

As the Board of Regents said in Park, supra, charges may not be amended without limitation at any time. We note that the second amendment is acknowledged by petitioner to have resulted from the proof educed from a witness called by respondent in regard to the prior charges. Where, as here, the amended charges do not afford respondent with sufficient notice of the charge against him or prejudice or deprive him of a substantial right, the charges may not be amended.

RECOMMENDED PENALTIES

The measure of discipline recommended by the hearing committee and Commissioner of Health include improper recommendations. Their recommendations to suspend respondent's license and to permanently stay the suspension on conditions does not clearly state the length of the suspension and the manner in which there would be further determinations regarding the effectiveness of the conditional stay. If these recommendations mean that respondent's entire license would be suspended either permanently or indefinitely, such recommendations are unauthorized by law. See Education Law §6511. If these recommendations mean that respondent's license would be suspended for a definite period, such recommendations not specifying any definite period are unclear and unworkable.

Furthermore, the hearing committee's recommendation to revoke respondent's license if respondent fails to keep records of appropriate quality and the Health Commissioner's recommendation to lift the stay of "supervision" of respondent's license if respondent's records do not meet accepted standards of completeness and legibility are each improper. First, a revocation may not be imposed automatically on the basis of conduct which has not yet occurred whenever, at any time, petitioner believes that any of respondent's records are not appropriate. Second, a revocation may not be imposed unless the Board of Regents, in its discretion, finds the facts then in existence warrant that measure of discipline over any other possible disposition. Third, both the

state and respondent are entitled to a workable and authorized measure of discipline which clearly provides, at all times during the specified period when it is in effect, notice of the particular suspension period and of the times when the stay is in effect, and due process for determining future allegations and the penalty, if any, to be based thereon. Fourth, a conditional stayed suspension does not permit an automatic permanent or indefinite suspension of an entire license in the event the conditions for obtaining the stay are not fully met.

Petitioner's written recommendation as to the measure of discipline also did not specify the period of the suspension sought. However, petitioner did not recommend a permanent stay and did add the recommendation that respondent be placed on probation for two years. In response to our question, petitioner acknowledges that the recommendation of the Commissioner of Health was not clear. Petitioner made the express assumption that the Commissioner of Health, by his recommendation, meant that respondent's license be suspended for two years, said suspension be stayed, and respondent placed on probation for two years. Such recommendation would not include the conditional stay accepted by the Commissioner of Health.

We unanimously recommend the following to the Board of Regents:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those

findings of fact be accepted, except to the extent that those findings of fact support finding respondent guilty of any applicable definition of professional misconduct on the basis of conduct committed by respondent before that definition became effective;

2. The conclusions of the hearing committee and Commissioner of Health as to the first through the nineteenth specifications be modified;

3. The conclusions of the hearing committee and Commissioner of Health as to the twentieth and twenty-first specifications not be accepted and the twentieth and twenty-first specifications be dismissed without prejudice;

4. Respondent be found, by a preponderance of the evidence, guilty of the first specification based upon negligence on more than one occasion to the extent of subparaph D, D.3., fourteenth specification based upon respondent's failure to document a comprehensive physical examination initially and throughout the course of treatment to the extent of charges D, D.1. and D, D.2.), fifteenth, seventeenth, and nineteenth specifications based upon respondent's failure to provide any documentation in the patient record supporting the use of the drug he prescribed to the extent of subparagraphs E, E.3. and G, G.3. and I, I.4., and respondent be found not guilty of the remaining specifications and charges in the first through nineteenth specifications; and

5. The measure of discipline recommended by the hearing committee and Commissioner of Health be rejected and respondent's license to practice as a physician in the State of New York be suspended for one year and respondent be required to perform one hundred hours of public service upon each specification of the charges of which we recommend respondent be found guilty, said suspensions and public service to run concurrently, and the execution of said suspensions 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 "D", said terms of probation to include monitoring of respondent's office record-keeping practices.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith
Chairperson

Dated: 5/30/91

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JOHN C. FARRELL, M.D.	:	CHARGES

----------X

JOHN C. FARRELL, M.D., the Respondent, was authorized to practice medicine in New York State on February 19, 1962 by the issuance of License Number 087239 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 242 Main Street, Cornwall-on-Hudson, New York 12518.

FACTUAL ALLEGATIONS

A. From on or about February 1964 through at least April 1985, Respondent provided medical care to Patient A (all patient names are listed in Appendix) at his office at 242 Main Street, Cornwall, New York (hereinafter "his office").

1. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient A.

2. Respondent failed to elicit and/or record an adequate medical history from Patient A.

EXHIBIT "A"

3. Respondent failed to adequately document therapy of Patient A's several conditions including hypertension and back pain.

4. Respondent failed to perform and/or document adequate periodic testing despite Patient A's known diabetic condition.

B. From on or about August 1973 through at least July 1986, Respondent provided medical care to Patient B at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient B.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient B.

C. From on or about March 1980 through at least April 1986, Respondent provided medical care to Patient C at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient C.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient C.

D. From on or about April 1980 through at least November 1986, Respondent provided medical care to Patient D at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient D.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient D.

3. Respondent failed to adequately treat Patient D's hypertension.

E. From on or about December 17, 1985, through at least November 25, 1986, Respondent provided medical care to Patient E at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient E.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient E.

3. Respondent prescribed Dyazide to Patient E without documenting its medical indication.

F. From on or about March 1986 through at least November 6, 1986, Respondent provided medical care to Patient F at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient F.

2. Respondent failed to perform and/or document adequate periodic testing despite Patient F's known diabetic condition.

3. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient F.

4. Respondent administered or caused to be administered several Vitamin B-12 injections to Patient F, without documentation of their medical indication.

G. From on or about March 20, 1986 through at least December 4, 1986, Respondent provided medical care to Patient G at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient G.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient G.

H. From on or about May 27, 1986, through at least July 22, 1986, Respondent provided medical care to Patient H at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient H, despite his knowledge of Patient H's diagnosed Hodgkins disease.

2. Respondent failed to document a comprehensive physical examination in his records for Patient H.

I. From on or about July 22, 1986 through at least December 4, 1986, Respondent provided medical care to Patient I at his office.

1. Respondent failed to elicit and/or record an adequate history from Patient I.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient I.

FIRST SPECIFICATION

PRACTICING WITH

NEGLIGENCE AND/OR INCOMPETENCE

ON MORE THAN ONE OCCASION

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

1. The facts in Paragraphs A and A.1, A and A.2., A and A.3., and A and A.4., B and B.1., B and B.2., C and C.1., C and C.2., D and D.1., and D and D.2., D and D.3., E and E.1., E and E.2., E and E.3, F and F.1., F and F.2., F and F.3, F and F.4, G and G.1., G and G.2., H and H.1., H and H.2, I and I.1, and/or I and I.2.

SECOND THROUGH TENTH SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

AND/OR GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross negligence and/or gross incompetence under N.Y. Educ. Law §6509(2) (McKinney 1985), in that Petitioner charges:

2. The facts in Paragraphs A and A.1., A and A.2., and A and A.3.

3. The facts in Paragraphs B and B.1., and B and B.2.

4. The facts in Paragraphs C and C.1., and C and C.2.

5. The facts in Paragraphs D and D.1., D and D.2., and D and D.3.

6. The facts in Paragraphs E and E.1., E and E.2., and E and E.3.

7. The facts in Paragraphs F and F.1., F and F.2., F and F.3. and F and F.4.

8. The facts in Paragraphs G and G.1., and G and G.2.

9. The facts in Paragraphs H and H.1., and H and H.2.

10. The facts in Paragraphs I and I.1., and I and I.2.

ELEVENTH THROUGH NINETEENTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS ACCURATELY REFLECTING THE EVALUATION AND TREATMENT OF PATIENTS

Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law §6509(9) (McKinney 1985) and 8 NYCRR §29.2(a)(3) (1987) by failing to maintain records which accurately reflect the evaluation and treatment of Patients, in that Petitioner charges:

11. The facts in Paragraphs A and A.1., and A and A.2.

12. The facts in Paragraphs B and B.1., and B and B.2.

13. The facts in Paragraphs C and C.1., and C and C.2.

14. The facts in Paragraphs D and D.1., and D and D.2.

15. The facts in Paragraphs E and E.1. E and E.2., and E and E.3.

16. The facts in Paragraphs F and F.1., F and F.2., and F and F.3.

17. The facts in Paragraphs G and G.1., and G and G.2.

18. The facts in Paragraphs H and H.1. and H and H.2.

19. The facts in Paragraphs I and I.1., and I and I.2.

DATED: Albany, New York
October 4, 1988

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

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

FIRST
AMENDED
STATEMENT
OF
CHARGES

IN THE MATTER

OF

JOHN C. FARRELL, M.D.

DEC 28 1988
Dept Ex. 13 Id ✓ Ev ✓
ROBERT W. HICKS

JOHN C. FARRELL, M.D., the Respondent, was authorized to practice medicine in New York State on February 19, 1962 by the issuance of License Number 087239 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 242 Main Street, Cornwall-on-Hudson, New York 12518.

FACTUAL ALLEGATIONS

A. From on or about February 1964 through at least April 1985, Respondent provided medical care to Patient A (all patient names are listed in Appendix) at his office at 242 Main Street, Cornwall, New York (hereinafter "his office").

1. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient A.

2. Respondent failed to elicit and/or record an adequate medical history from Patient A.

EXHIBIT (A)

3. Respondent failed to adequately document reasons for Patient A's therapy, including but not limited to B12 injections and diathermy, for Patient A's several diagnosed conditions.

4. Respondent failed to adequately document and/or provide adequate treatment of Patient A's diagnosed hypertension.

5. Respondent failed to perform and/or document adequate periodic testing despite Patient A's known diabetic condition.

6. Respondent prescribed anorectics for Patient A on several occasions during the entire course of treatment, including but not limited to Phentermine and Phendimetrazine to Patient A from at least November 1, 1979 through November 26, 1985, without an adequate physical examination and despite warnings and contraindications of the drugs.

B. From in or about August 1973 through at least July 1986, Respondent provided medical care to Patient B at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient B.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient B.

3. Respondent failed to perform and/or document adequate periodic testing from June 28, 1983, through at least July 24, 1986, despite Patient B's known diabetic condition.

4. Respondent failed to elicit and/or record an adequate history of Patient B's diagnosed multiple sclerosis.

5. Respondent prescribed anorectics for Patient B on several occasions during the course of treatment, including but not

limited to Phentermine and Phendimetrazine from in or about November 1979 through at least May 1980, without an adequate physical examination and despite warnings and contraindications of the drugs.

C. From on or about April 27, 1970 through at least April 1986, Respondent provided medical care to Patient C at his office.

1. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient C.

2. Respondent prescribed anorectics to Patient C on several occasions during the entire course of treatment, including but not limited to Phentermine and Phendimetrazine, without an adequate periodic physical examination and despite warnings and contraindications of the drugs.

D. From on or about April 1980 through at least November 1986, Respondent provided medical care to Patient D at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient D.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient D.

3. Respondent failed to adequately treat Patient D's hypertension.

E. From on or about December 17, 1985, through at least November 25, 1986, Respondent provided medical care to Patient E at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient E.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient E.

3. Respondent prescribed Dyazide to Patient E without medical indication for its use or documentation thereof.

F. From on or about May 12, 1966 through at least November 6, 1986, Respondent provided medical care to Patient F at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient F.

2. Respondent failed to perform and/or document adequate testing despite Patient F's known diabetic condition.

3. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient F.

4. Respondent administered or caused to be administered several Vitamin B-12 injections to Patient F, without medical indication for its use or documentation thereof.

5. Respondent prescribed anorectics to Patient F on several occasions during the entire course of treatment, including but not limited to Phentermine and/or Phendimetrazine from on or about October 10, 1978 through June 21, 1983, without an adequate periodic physical examination and despite warnings and contraindications of the drugs.

G. From on or about March 20, 1986 through at least December 4, 1986, Respondent provided medical care to Patient G at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient G.

2. Respondent prescribed Phentermine and/or Phendimetrazine to Patient G from at least February 14, 1985 through at least December 4, 1986, without an adequate physical examination and despite warnings and contraindications of the drugs.

3. Respondent prescribed Lasix to Patient G from on or about April 24, 1986, through at least December 4, 1986, without medical indication for its use or documentation thereof.

H. From on or about May 27, 1986, through at least July 22, 1986, Respondent provided medical care to Patient H at his office.

1. Respondent failed to elicit and/or record an adequate medical history from Patient H, despite his knowledge of Patient H's diagnosed Hodgkins disease.

2. Respondent failed to document a comprehensive physical examination in his records for Patient H.

I. From on or about July 22, 1986 through at least December 4, 1986, Respondent provided medical care to Patient I at his office.

1. Respondent failed to elicit and/or record an adequate history from Patient I.

2. Respondent failed to perform and/or document a comprehensive physical examination initially and throughout the course of treatment of Patient I.

3. Respondent prescribed Phentermine and/or Phendimetrazine to Patient I from on or about July 22, 1986 through at least December 4, 1986, without an adequate periodic examination and despite warnings and contraindications of the drugs.

4. Respondent prescribed Lasix to Patient I from on or about August 21, 1986, through at least December 4, 1986, without medical indication for its use or documentation thereof.

FIRST SPECIFICATION

PRACTICING WITH

NEGLIGENCE AND/OR INCOMPETENCE

ON MORE THAN ONE OCCASION

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

1. The facts in Paragraphs A and A.1, A and A.2., A and A.3., and A and A.4., A and A.5., A and A.6., B and B.1., B and B.2., B and B.3., B and B.4., B and B.5. C and C.1., C and C.2., D and D.1., and D and D.2., D and D.3., E and E.1., E and E.2., E and E.3., F and F.1., F and F.2., F and F.3., F and F.4, F and F.5., G and G.1., G and G.2., G and G.3., H and H.1., H and H.2., I and I.1., I and I.2., I and I.3., and/or I and I.4.

SECOND THROUGH TENTH SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

AND/OR GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross negligence and/or gross incompetence under N.Y. Educ. Law §6509(2) (McKinney 1985), in that Petitioner charges:

2. The facts in Paragraphs A and A.1., A and A.2., A and A.3., A and A.4., A and A.5., and A and A.6.

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7. The facts in Paragraphs F and F.1., F and F.2., F and F.3. F and F.4., and F and F.5.

8. The facts in Paragraphs G and G.1., G and G.2., and G and G.3.

9. The facts in Paragraphs H and H.1., and H and H.2.

10. The facts in Paragraphs I and I.1., I and I.2., I and I.3., and I and I.4.

ELEVENTH THROUGH NINETEENTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS ACCURATELY REFLECTING THE EVALUATION AND TREATMENT OF PATIENTS

Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law §6509(9) (McKinney 1985) and 8 NYCRR §29.2(a)(3) (1987) by failing to maintain records which accurately reflect the evaluation and treatment of Patients, in that Petitioner charges:

11. The facts in Paragraphs A and A.1., A and A.2., A and A.3., A and A.4., and A and A.5.

12. The facts in Paragraphs B and B.1., B and B.2., B and B.3., and B and B.4.

13. The facts in Paragraphs C and C.1.

14. The facts in Paragraphs D and D.1., and D and D.2.

15. The facts in Paragraphs E and E.1. E and E.2., and E and E.3.

16. The facts in Paragraphs F and F.1., F and F.2., F and F.3., and F and F.4.

17. The facts in Paragraphs G and G.1., and G and G.3.

18. The facts in Paragraphs H and H.1. and H and H.2.

19. The facts in Paragraphs I and I.1., I and I.2., and I and I.4.

DATED: Albany, New York
December 22, 1988

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

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

IN THE MATTER	:	SECOND AMENDED
OF	:	STATEMENT
JOHN C. FARRELL, M.D.	:	OF CHARGES

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Petitioner's EX 1A
DATE 3-1-89 ID. ✓
DATE 3-1-89 EV. ✓
MARY LOMONOCO
SHORTHAND REPORTER

EXHIBIT "A"

3. Respondent failed to adequately document reasons for Patient A's therapy, including but not limited to B12 injections and diathermy, for Patient A's several diagnosed conditions.

4. Respondent failed to adequately document and/or provide adequate treatment of Patient A's diagnosed hypertension.

5. Respondent failed to perform and/or document adequate periodic testing despite Patient A's known diabetic condition.

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4. Respondent prescribed Lasix to Patient I from on or about August 21, 1986, through at least December 4, 1986, without medical indication for its use or documentation thereof.

J. During the course of treatment of several patients, Respondent permitted an employee to administer injections to patients. The employee was not licensed to perform such an activity when the injections were administered.

FIRST SPECIFICATION

PRACTICING WITH

NEGLIGENCE AND/OR INCOMPETENCE

ON MORE THAN ONE OCCASION

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H and H.2., I and I.1., I and I.2., I and I.3., and/or I and I.4.

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2. The facts in Paragraphs A and A.1., A and A.2., A and A.3., A and A.4., A and A.5., and A and A.6.

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Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law §6509(9) (McKinney 1985) and 8 NYCRR §29.2(a)(3) (1987) by failing to maintain records which accurately reflect the evaluation and treatment of Patients, in that Petitioner charges:

11. The facts in Paragraphs A and A.1., A and A.2., A and A.3., A and A.4., and A and A.5.

12. The facts in Paragraphs B and B.1., B and B.2., B and B.3., and B and B.4.

13. The facts in Paragraphs C and C.1.

14. The facts in Paragraphs D and D.1., and D and D.2.

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16. The facts in Paragraphs F and F.1., F and F.2., F and F.3., and F and F.4.

17. The facts in Paragraphs G and G.1., and G and G.3.

18. The facts in Paragraphs H and H.1. and H and H.2.

19. The facts in Paragraphs I and I.1., I and I.2., and I and I.4.

TWENTIETH SPECIFICATION

PERMITTING AN UNLICENSED PERSON TO

PERFORM ACTIVITIES REQUIRING A LICENSE

Respondent is charged under N.Y. Educ. Law §6509(7) (McKinney 1985) with permitting an unlicensed person to perform activities requiring a license, in that Petitioner charges:

20. The facts in Paragraph J.

TWENTY-FIRST SPECIFICATION

DELEGATING PROFESSIONAL RESPONSIBILITIES

TO AN UNQUALIFIED PERSON

Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law §6509(9) (McKinney 1985) and 8 NYCRR §29.1(b)(10) by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience or by licensure, to perform them, in that Petitioner charges:

21. The facts in Paragraph J.

DATED: Albany, New York
February 17, 1987

PETER D. VAN BUREN
Deputy Counsel

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

IN THE MATTER	:	REPORT OF THE
OF	:	HEARING
JOHN C. FARRELL, M.D.	:	COMMITTEE

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

The undersigned Hearing Committee (the Committee) consisting of Sister Mary Theresa Murphy, Chairperson, Joseph T. Doyle, M.D. and Thomas W. Smith, M.D. was duly designated and appointed by the State Board for Professional Medical Conduct (the Board). Jonathan M. Brandes, Administrative Law Judge served as Administrative Officer.

The hearing was conducted pursuant to the provisions of New York Public Health Law Section 230 and New York State Administrative Procedure Act Sections 301-307 to receive evidence concerning the charges that Respondent has violated provisions of New York Education Law Section 6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made part of the record.

The Committee has considered the entire record in the above-captioned matter and makes this Report of its Findings, Conclusions and Recommendations to the New York State Commissioner of Health.

EXHIBIT "B"

I. RECORD OF PROCEEDINGS

Original Notice of Hearing dated:	October 4, 1988
Second Amended Statement of Charges dated:	February 17, 1989
Notice of Hearing returnable:	November 9, 1988
Place of Hearing:	Albany, New York
Respondent served with copy of Notice of Hearing and Charges:	Service Admitted November 9, 1988
The State Board for Professional Medical Conduct appeared by:	Daniel J. Persing, Esq. NYS Department of Health Office for Professional Medical Conduct Corning Tower Building Empire State Plaza Albany, New York 12237
The Respondent appeared in person and was represented by:	Anthony Z. Scher, Esq. Wood & Scher One Chase Road Scarsdale, New York 10583
Respondent's present address:	242 Main Street Cornwall on Hudson, New York 12518
Hearings held on:	November 9, 1988 December 28, 1988 January 18, 1989 February 1, 1989
Record closed:	March 24, 1989
Deliberations held:	March 29, 1989
Record Reopened:	May 9, 1989
Further Briefs Received:	May 26, 30, 31 and June 9, 1989
Decision on Motion by Administrative Law Judge:	August 22, 1989

Further Deliberations Held: September 15, 1989

II. SUMMARY OF PROCEEDINGS

1. The Statement of Charges alleges that Respondent has committed gross negligence and/or gross incompetence, negligence and/or incompetence on more than one occasion and has failed to maintain adequate records, permitted an unlicensed person to perform activities requiring a license and delegated professional responsibilities to an unqualified person. The allegations arise from the treatment of some nine patients.

The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

2. The Petitioner called these witnesses:

Theodore Zeltner, M.D.	Board Certified Internist; expert witness
Stanley Glick, M.D.	Professor and Chairman, Department of Pharmacology a Toxicology, Albany Medical College; Expert Witness

3. The Respondent testified in his own behalf and called these witnesses to testify.

C[redacted] L[redacted]	[redacted]; Character, Fact Witness
David Mendelson, M.D.	Board Certified Internist an Oncologist; Expert witness

III. SIGNIFICANT LEGAL RULINGS BY THE ADMINISTRATIVE LAW JUDGE

Upon final review of the Committee Report herein, it was noted by the Administrative Law Judge that certain of the allegations herein took place prior to the enactment of the controlling statute and regulation. The Appellate Division, Third Department, has held where acts occur prior to the effective date of a statute or regulation the acts cannot be sustained as professional misconduct inasmuch as the acts did not constitute a violation at the time they were performed (see Gould v. Board of Regents, 103 A.D. 2nd 897 (App. Div., Third Dept., 1984). In the instant case, Specification One relies upon a part of Section 6509(2) of the Education Law which was enacted in 1975 (see L. 1975, C. 109 §30 Eff. September 1, 1975). Thus any act charged under specification one which occurred prior to September 1, 1975 cannot be sustained. In like fashion, specifications two through ten rely upon a part of Section 6509(2) which was enacted in 1971 (see L. 1971, C. 994 §36, Eff. Sept. 1, 1971) therefore any act charged in specifications two through ten which occurred prior to September 1, 1971 cannot be sustained. Finally, specification eleven through nineteen relies upon Section 6509(9) of the Education Law but more particularly upon 8 NYCRR (Education) §29.2(a)(3). This regulation became effective October 1, 1977. Consequently, any acts prior to that date cannot be sustained.

By letter of May 9, 1989, the Administrative Law Judge asked the parties to brief this matter. Writings were received through June 9, 1989. By letter of August 22, 1989, the

Administrative Law Judge informed the parties that Respondent's motion to dismiss charges A, B, C and F was granted in Part.[1] More specifically, the Administrative Law Judge instructed the panel that any charges based upon acts which occurred prior to the effective date of the charges must be excluded from their consideration. Contrary to Respondent's motion, the Committee was not instructed to dismiss any charges in toto. This is because each of the factual presentations in issue alleged both acts occurring prior to enactment as well as acts which took place after the date of statutory or regulatory enactment. Any charges herein which were sustained, as well as the penalty, refer only to acts occurring after 1971, 1975 or 1977 as warranted. Any acts by Respondent occurring prior to the date of enactment were ignored by the Committee as if they had not happened.

As will be seen, this ruling ultimately affected only charges A.1, C.1, F.1 and F.3. All of the other charges which were based at least in part upon acts prior to statutory or regulatory enactment were not sustained and, therefore, moot as to this consideration. This entire matter was fully explained to the panel at their second deliberation September 15, 1989. The report which follows reflects the final rulings of the Administrative Law Judge and the revised instructions given to the panel.

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[1] Regrettably the words "in part" were inadvertently omitted from the August 22nd letter. Clarification was made to the parties by telephone.

IV. GENERAL FINDINGS OF FACT

1. Respondent, John C. Farrell, M.D., was authorized to practice medicine in New York State on February 19, 1962, by the issuance of license number 087239 (Exhibit 1A).

2. Dr. Farrell was registered to practice medicine for the period January 1, 1986 through December 31, 1988 from 242 Main Street, Cornwall-on-Hudson, New York (Exhibit 1A).

FINDINGS OF FACT WITH REGARD TO PATIENT A

1. Respondent commenced treatment of Patient A on or about February 6, 1964 (T. 390; Exhibit §3, p. 25).[2]

2. Initially, he took a brief history and performed a limited physical examination (T. 390, 406).

3. The history consisted of: the patient's diabetic condition, the taking of oral medication, the frequency of the medication, the existence of a swollen thyroid, a contusion of the left chest sustained from a recent fall, the existence of a weight problem, the names of the patient and her husband, the patients' occupation and the existence of a cough coupled with urinary stress incontinence (Exhibit 3, pp. 25, 31; 390-391, 400-401).

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[2] T. refers to transcript page.
Exhibit p. refers to a page in an exhibit.

4. The physical examination consisted of at least the following: examination of the cardiovascular and respiratory systems, weighing of the patient, blood pressure, pulse, urine testing, fasting blood sugars, electrocardiograms, chest x-ray, thyroid scan, a GI series and observation of the patient (Exhibit 3, pp. 1-3, 7-8, 15, 22, 25 and 49-51).

5. Part of the treatment rendered by Respondent for Patient A consisted of diathermy (Exhibit 3, p. 25-back).

6. Patient A had a back problem which is indicated in the chart (Exhibit 3, p. 28). There is an x-ray report in the chart. The date of the x-ray report is immediately prior to the institution of diathermy (Exhibit 3, pg. 28).

7. Patient A was not hypertensive. She was treated by Respondent with a diet, a diuretic and potassium which was adequate under the circumstances (T. 42, 407, 603).

8. Patient A had mild, stable diabetes which was well controlled and which was probably related to her obesity (T. 604). She was monitored by frequent checks of her urine and by periodic fasting blood sugars. Respondent did not perform renal function studies and ophthalmological studies because under all the facts and circumstances he deemed them unnecessary (T. 432-435).

9. Patient A's primary reason for coming to Respondent was to lose weight. He prescribed a program of weight loss consisting of a diet and the use of anorectic drugs (396-399). The patient's occasional higher than normal blood pressure readings did not constitute a contraindication to the use of

anorectics (137-138). Moreover, the length of time that the anorectics were dispensed, on a continuous basis, was reasonable under the circumstances (Exhibit B; 139-143).

CONCLUSIONS WITH REGARD TO PATIENT A AND CHARGES A(1) THROUGH A(6)

The State alleges that Respondent failed to perform a "comprehensive" physical examination of this patient. The Committee finds unanimously that indeed Respondent never performed what could be called a "comprehensive" physical examination of this or any of the other patients cited in the charges. Instead, Respondent performed an examination which was appropriate to the complaint and treatment of the patient and which was therefore adequate. The Committee disagrees with the assertion made by the State that every patient who comes to a practitioner such as Respondent warrants a complete and total physical examination.

In so finding, the Committee concludes that a general practitioner (such as Respondent was at the time in question) may limit his inquiry to the areas of the patient's complaint and those reasonably associated with that complaint. The Committee finds unanimously that Respondent met this standard. Furthermore, the Committee accepts Respondent's testimony as credible that it was his routine to perform examinations of the cardiovascular and respiratory systems and that he did so in this case and the others presented. The Committee acknowledges that there are no specific results noted in Respondent's records. However, the committee

accepts Respondent's testimony that it was his habit to record only positive findings in such examinations. Additionally, the Committee accepts that this was the common practice among general practitioners such as Respondent at the time and does not fall outside of generally acceptable medical standards for that period. Based upon the wording of the factual allegations, the Committee finds it must sustain factual allegation A(1) because Respondent did indeed fail to perform a "comprehensive" examination. However, as will be discussed later, the Committee finds that the factual allegation sustained does not constitute medical misconduct.

CHARGE A(1) is unanimously SUSTAINED.

In Charge A(2) Respondent is charged with failure to elicit and/or record an adequate medical history from this patient. The Committee finds unanimously that the history obtained by Respondent was adequate for the type of treatment he was engaged in. By so finding, the Committee recognizes that Respondent's history was indeed limited but under all the facts and circumstances, including the historical time period in question, and the nature of Respondent'spractice, the history was accepted as a basis for Respondent's treatment and therefore did not fall outside generally acceptable standards of medicine. As a further basis for its findings the Committee notes that the extent of recordkeeping throughout the profession changed

significantly over the twenty years (1964-1985) entailed in this charge.

Charge A(2) is unanimously NOT SUSTAINED.

In Charge A(3) it is alleged Respondent failed to adequately document his reasons for giving Patient A vitamin B12 shots and diathermy treatments. The Committee acknowledges that Respondent gave Patient A vitamin B12 shots from time to time for their placebo effect. In fact, Respondent admitted this. Again, considering all the facts and circumstances, particularly Respondent's general practice and the time period of the treatment, the Committee cannot find any violation of acceptable standards of medical care in either the judicious use of vitamin B12 as a placebo or the failure to specifically document that a placebo was being rendered. As for the diathermy, the Committee finds ample evidence that Respondent provided this care for the patient's back problems and that this was sufficiently documented in the patient record.

The Committee concludes unanimously that Charge A(3) is NOT SUSTAINED.

With regard to Charge A(4), Respondent is alleged to have failed to properly document the patient's hypertension and treat same. The State's own expert was of the opinion that this patient was not hypertensive (T. 42). Therefore, this charge cannot be sustained.

Charge A(4) is unanimously NOT SUSTAINED.

Charge A(5) concerns Respondent's alleged failure to perform and/or adequately document periodic diagnostic tests to follow-up on this patient's known diabetes. The Committee finds unanimously that Respondent followed this patient within acceptable standards of medicine. The Committee finds that the periodic urine and fasting blood sugar tests ordered by Respondent were sufficient, given the nature of Respondent's practice and, most important, the lack of symptomatology exhibited by this patient. The Committee concludes that the patient's diabetes was mild and well controlled. The Committee further concludes the diagnostic tests suggested by the State's expert were beyond the sophistication to be expected of this general practitioner and, absent signs or symptoms of problems, were, under all the facts and circumstances, unnecessary.

Charge A(5) is unanimously NOT SUSTAINED.

In Charge A(6) Respondent is charged with administering anorectic agents to a patient without an adequate physical examination and despite warnings making such drugs contraindicated. Respondent admits giving this patient anorectics over various periods throughout the twenty and more years in question. The thrust of the State's case is that this patient's alleged hypertension and diabetes should have led Respondent to avoid these drugs given their known side effects. The Committee

finds unanimously this patient was not hypertensive but even so, hypertension and diabetes to not entirely rule out the use of anorectic drugs. Rather, it is a matter which falls within the medical judgment of the practitioner. Where, as here, the conditions were well controlled and probably related to obesity in the first place, the advantages of giving anorectics may well out-weigh the possible disadvantages. The key element is the careful monitoring of the patient to see that none of the potential side effects of the drugs occur. The Committee finds Respondent did this. Furthermore, it is the conclusion of the Committee that the Physician's Desk Reference (PDR), which contained many of the warnings alluded to by the State, is not an absolute authority. The monographs contained in the PDR are highly conservative and the individual medical judgment of the practitioner must ultimately guide prescribing practices. Finally, the entire issue of anorectics is still under professional debate, however, the Committee notes that their use was much more widely accepted in the 1960's when the events in issue took place.

Charge A(6) is unanimously NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT B

1. Respondent commenced treatment of Patient B on or about August 20, 1973 (Exhibit 4, p. 1).

2. Prior to the patient's first visit, Respondent received a comprehensive medical history from Patient B's employer

which had recently been elicited (Exhibit 4, pp. 67-75). Respondent reviewed this history with Patient B and also obtained additional information (447-448).

3. Respondent performed a basic physical examination of Patient B. He already had the benefit of a health screening performed by the patient's employer. This included a normal chest x-ray, a normal EKG, no glucosuria and a fasting blood sugar of 123 (Exhibit 4, pp. 67-75). In addition, Respondent performed a general examination of patient B which would include the cardiovascular and respiratory systems. Moreover, the patient's weight and blood pressure were routinely checked. (T. 448-454).

4. Patient B was self monitored for his diabetes (200-204). The chart contains hundreds of urine tests for sugar performed by the patient and numerous fasting blood sugars ordered by the Respondent (Exhibit 4, pp. 36-44, 54-56, 63, 200-204).

5. Respondent diagnosed Patient B as possibly having multiple sclerosis (Exhibit 3, p. 1). A basic history was obtained and the patient was referred to experts for his condition (Exhibit 4, pp. 34, 35, 57-61).

6. Respondent dispensed anorectic drugs to Patient B as an adjunct to a program of weight reduction which included a diet (Exhibit 2, Exhibit A; T. 454-455, 499). There was no evidence of any negative side effects. The drugs prescribed were of value in assisting Patient B in reducing his weight. (Exhibit 4).

CONCLUSIONS WITH REGARD TO PATIENT B
AND CHARGES B(1) THROUGH B(5)

In Charges B(1) and B(2), Respondent is alleged to have failed to elicit and/or record an adequate medical history or comprehensive physical examination. As the record clearly indicates, Respondent had the benefit of an extensive history and examination from the patient's employer. This obviated the necessity of any extensive work-up by Respondent. Nevertheless, Respondent did perform a basic physical and did do a basic history which was entirely adequate for the treatment he was providing.

Charges B(1) and B(2) are unanimously NOT SUSTAINED.

Charge B(3) alleges that Respondent failed to perform and/or document periodic diagnostic tests relating to this patient's known diabetes condition. The record clearly shows, however, this patient carefully monitored himself and showed the data to Respondent. The patient's chart contains hundreds of self conducted urine tests as well as blood-sugar tests ordered by Respondent on a regular basis. This regimen of self testing and periodic blood tests falls well within acceptable standards of medical care.

Charge B(3) is unanimously NOT SUSTAINED.

The allegation in Charge B(4) is that Respondent did not elicit an adequate history of this patient's multiple sclerosis. The record shows, however, that Respondent did obtain a basic

history and referred the patient to the appropriate experts for treatment. Nothing more could have been expected of Respondent under the circumstances.

Charge B(4) is unanimously NOT SUSTAINED.

Charge B(5) is, in most respects, identical to charge A(6) in that Respondent prescribed anorectics to a person for whom such drugs were allegedly contraindicated and without an adequate physical examination. For fundamentally the same reasons as those cited earlier under Charge A(6), the Committee does not sustain this charge. The record herein discloses that this patient's condition did not absolutely rule out the use of appetite suppressants. In this case as in the other, the patient benefited by losing weight without any signs or symptoms of side effects. Here again, the key was the judicious use of individual medical judgment and adequate monitoring. For these reasons and those stated earlier the Committee finds the activities of Respondent in this instance were not inconsistant with acceptable standards of medical care.

Charge B(5) is unanimously NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT C

1. Patient C became Respondent's patient in April 1970 (Exhibit §5 supplement, p. 1). The patient came to Respondent to lose weight (T. 487).

2. A basic physical examination was performed by Respondent. This consisted of observation (the patient was nervous and had swelling of the ankles); she was 5'7 3/4" tall and weighed 243 pounds (T. 487-488); she had no gastrointestinal symptoms; the cardiovascular and respiratory systems were examined (T. 489-490); the abdomen was examined (T. 490). Nothing abnormal was found so Respondent made no notations (T. 490-491).

3. Respondent dispensed anorectic drugs to Patient C to assist in weight loss (T. 493). The patient had been unable to lose weight by other methods (T. 491).

4. No significant contraindications to the use of the anorectics were present and no side effects were noted in the chart (493-494). Although the patient had a slightly elevated blood pressure, the weight loss helped reduce it and no elevation of blood pressure appears to have been sustained due to the anorectics (Ex. 5).

CONCLUSIONS WITH REGARD TO PATIENT C
AND CHARGES C(1) and C(2)

In Charges C(1) and C(2) Respondent is again alleged to have failed to perform a comprehensive physical examination and given anorectic drugs to a patient for whom they were contraindicated. The Committee finds, based upon its earlier reasoning that the physical examinations conducted by Respondent were adequate but certainly not comprehensive. Thus, Charge C(1) must be sustained on what amounts to a technicality. As for Charge

C(2) the Committee again cites its earlier reasoning in finding Respondent's prescriptions fell within the appropriate exercise of reasonable medical judgment and his monitoring was adequate for the care he was providing.

Charge C(1) is unanimously SUSTAINED.

Charge C(2) is unanimously NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT D

1. Patient D first visited Respondent in April 1980 when she was 61 years of age (T. 507).

2. A basic history was taken by Respondent which consisted of at least the following: patient complaint of nervousness, an enlarged thyroid which had previously been evaluated at the medical center at IBM, no complaint of shortness of breath, no peripheral edema (Exhibit 6, p. 1).

3. Respondent also performed and documented a physical examination referring in his notes to the heart sounds, the lungs and the abdomen as well as the enlarged thyroid (Exhibit 6, p. 1; T. 506-509). A weight was recorded, as was a blood pressure (T. 507).

4. Patient D had severe hypertension which was never brought within normal limits. Various medications were prescribed in varying doses. These included Aldomet, Inderal, Lasix, Corgard, Minipres, Valium, Combipres and K-Lyte (Exhibit 6).

CONCLUSIONS WITH REGARD TO PATIENT D AND CHARGES D(1) (2) AND (3)

In Charge D(1) and D(2) the State alleges Respondent failed to elicit and/or record an adequate medical history and physical examination. In Charge D(3), Respondent allegedly failed to properly treat this patient's hypertension. As has been stated earlier, the Committee found Respondent took patient histories and physical examinations limited to the extent of the treatment he was providing. In the cases prior to this, Respondent treated for obesity and/or related diabetes and/or mild hypertension. The histories and physicals which he recorded were thus judged merely adequate by the Committee based upon the routine and relatively limited care rendered. In Patient D, however, the Committee finds a patient with severe hypertension and a limited history and physical examination even by Respondent's standards of care. The Committee finds this unacceptable because more difficult and complex cases warrant greater depth of study than those with simple conditions which are easily and well controlled. Patients A, B and C presented no serious challenge and Respondent's limited depth of study was thus appropriate. In Patient D, however, the condition was dramatic and the level of study shallow at best. This correlates to woefully inadequate care. More specifically, Respondent's patient history was insufficient. The physical examination was not comprehensive for a patient who warranted a detailed and extensive work-up and Respondent's overall care of the patient's hypertension was entirely inadequate. While the

Committee acknowledges Respondent tried a number of regimens for the hypertension, the fact is Patient D was severely hypertensive and made no progress. A prudent physician would have referred this patient to an appropriate specialist.

Charges D(1), D(2) and D(3) are unanimously SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT E

1. Patient E first visited Respondent's office on December 17, 1985 (Exhibit 7, p. 13). He was 59 years old and complained of a back problem. He indicated that his right leg sometimes gave way causing pain (Exhibit 7, p. 13). At a subsequent visit he complained of constipation (Exhibit 7, p. 13). This information does not constitute a comprehensive medical history.

2. Respondent performed and documented an adequate examination of Patient E. An x-ray was ordered; a cardiovascular and respiratory examination was conducted; the abdomen was palpated; a rectal examination was performed. (Exhibit 7, p. 13; T. 518-521). A chest x-ray, cardiogram, blood work-up and blood sugar were advised and noted in the chart, but same were refused by the patient (Exhibit 7, p. 13: T. 518-521).

3. Respondent prescribed Dyazide for Patient E's elevated blood pressure (Exhibit 7, p. 1).

CONCLUSIONS WITH REGARD TO PATIENT E AND CHARGES E(1), E(2) AND E(3)

Charges E(1) and E(2) take issue with the adequacy of Respondent's patient history and physical examination. For the reasons set forth previously, the Committee accepts Respondent's history for this patient as merely adequate. Likewise, the physical examination of this patient was adequate but not comprehensive. As for Charge E(3), Respondent is alleged to have prescribed Dyazide, a hypertensive medication without medical indication or documentation. While the Committee notes Respondent recorded an elevated blood pressure for this patient there is no actual documentation supporting the use of the drug. There was never an actual diagnosis of hypertension nor any other clear support for the use of this drug in the record.

Charge E(1) is unanimously NOT SUSTAINED.

Charges E(2) and E(3) are unanimously SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT F

1. Patient F was first seen by Respondent on November 15, 1965 for weight reduction (T. 529).

2. A history was taken which included the patient's employment; the patient's previous history of surgery for systicmastitis; a regular pulse, lack of complaints about bowel functions, normal menstruation, a previous GI series which revealed a hiatal hernia and a diet relating to the hiatal hernia (Exhibit 8 first supplement, p. 1; T. 529-530).

3. Respondent examined Patient F which included height, weight, blood pressure, pulse, bust size, waist size, hip size, arm size, thigh size, cardiovascular and respiratory systems, hemoglobin, urine testing and thyroid testing (Exhibit 8 first supplement, p.1; T. 530).

4. Patient F was determined to be mildly diabetic and was referred to an area specialist (T. 531). In addition, Respondent prescribed Orinase and performed a glucose tolerance test (T. 531). The patient's urine was tested several times and at least 13 fasting blood sugars are noted in the chart (Exhibit 8).

5. Respondent gave an occasional vitamin B-12 injection to Patient F as a placebo (T. 532).

6. Respondent dispensed anorectic drugs to Patient F to assist in weight loss. This was as an adjunct to the diet Patient F was placed on (Exhibit F, T. 533). Although the anorectics were dispensed over more than five years, there were no continuous periods of use which lasted more than several weeks (Exhibit F, T. 534).

7. No side effects to the anorectics were exhibited by Patient F.

8. Patient F's blood pressure was within normal limits and no contraindications to the use of the drugs were present (T. 535).

CONCLUSIONS WITH REGARD TO PATIENT F AND CHARGES F(1) THROUGH F(5)

With regard to this patient, Respondent is charged with a failure to elicit and/or record an adequate patient history (Charge F(1)) and a failure to perform and/or document a comprehensive physical examination (Charge F(3)). Unlike several of the other cases, Respondent's history for this patient did not even rise to the level of mere adequacy. There is simply an utter paucity of information. As for the physical examination, there was none performed during the relevant statutory period (1971 through 1976). There was one somewhat complete physical examination for this patient (dated 1961) who was seen by Respondent from 1966 through 1986. The Committee finds this inadequate for the level of care given.

Charge F(2) takes issue with Respondent's diagnostic testing of this known diabetic. The Committee finds a sufficient number of urine and fasting blood sugar analyses during the statutory period to satisfy acceptable standards of medical care.

Charge F(4) brings up the issue of administering vitamin B-12 periodically as a placebo. As stated previously, the Committee can find no significant fault in this practice under all the facts and circumstances.

Finally, in Charge F(5) the State again cites Respondent for prescribing anorectics without a sufficient physical examination and despite contraindications and warnings. Utilizing the same reasoning previously stated, the Committee finds

Respondent's prescriptions not outside the realm of acceptable standards of medical treatment.

Charge F(1) is unanimously SUSTAINED.

Charge F(2) is unanimously NOT SUSTAINED.

Charge F(3) is unanimously SUSTAINED.

Charges F(4) and F(5) are unanimously NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT G

1. Patient G became Respondent's patient on March 20, 1986 (T.546; (Exhibit 9 supplement, p.1; T. 545).

2. Respondent dispensed anorectics to Patient G to assist in weight loss (Exhibit 9, pp. 1-2; T. 545-547). The patient's blood pressure was normal and she exhibited no side effects to the drugs. There were no contraindications to the use of anorectics in this patient (T. 554, 557).

3. Respondent also prescribed Lasix for Patient G to assist in weight loss (T. 560-562). The Lasix is noted in the chart along with the other diet medications (Exhibit 9, p. 1).

CONCLUSIONS WITH REGARD TO PATIENT G AND CHARGES G(1) THROUGH G(3)

In this Charge, Respondent is cited for a failure to obtain an adequate history (Charge G(1)) and prescribing anorectics for a patient without an adequate physical examination and despite warnings and contraindications (G(2)). While the Committee recognizes some history and physical examination was

done, no relationship between the work-up and the prescriptions can be established due to the utter paucity of information provided by Respondent. The Committee finds that the history and physical examination recorded were inadequate for the treatment rendered.

Charge G(3) alleges Respondent prescribed Lasix, a diuretic, without medical indication or documentation. While the Committee accepts Respondent's explanation that the drug was prescribed for weight loss, they can find no documentation of any reason whatsoever in Respondent's records.

Charges G(1) through G(3) are unanimously SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT H

1. Patient H was brought to Respondent by his mother who indicated that her son had Hodgkins disease (656). Respondent referred them to a specialist (Exhibit 10, p. 18).

CONCLUSIONS WITH REGARD TO PATIENT H AND CHARGES H(1) AND H(2)

This patient who had Hodgkins Disease was seen briefly by Respondent and referred immediately to an appropriate specialist. Neither a detailed history (Charge H(1)) nor a comprehensive physical (Charge H(2)) was warranted since Respondent was not a treating physician. The Committee does not take issue with Respondent's care herein.

Charges H(1) and H(2) are unanimously NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT I

1. Patient I came to Respondent on July 22, 1986, to lose weight (Exhibit 11, p. 1; T. 574).

2. He took a history which indicated the patient's prior history at weight control; a prior surgery (partial hysterectomy); the patient's general health as being good; an allergy to aspirin; and swelling of the ankles (Exhibit 11, p. 1).

3. Respondent's physical examination of Patient I included auscultation of the precordial fields; auscultation of the lungs; a check for edema (T. 575). No abnormalities were found. Laboratory testing was also done.

4. Respondent dispensed anorectics to Patient I to assist in weight loss as an adjunct to a diet prescribed by him (T. 575-576).

5. The patient's blood pressure was normal and there were no contraindications to the use of anorectics (T. 576). In addition, no side effects were exhibited by the patient (T. 577).

6. Lasix was also dispensed by Respondent to assist Patient I's weight loss (T. 577). The Lasix was charted along with the other diet medications (Exhibit 11, p. 1).

CONCLUSIONS WITH REGARD TO PATIENT I AND CHARGES I(1) THROUGH I(4)

Patient I presents a pattern of charges similar to those seen previously in that Respondent is alleged to have failed to perform and/or document a "comprehensive" physical examination (Charge I(2)) prescribed anorectics despite warnings and contraindications (Charge I(3)) and prescribed Lasix a diuretic without apparent medical indication or documentation (Charge I(4)). Consistent with their earlier findings, the Committee finds Respondent's history and physical to be adequate but certainly not comprehensive. Under all the facts and circumstances, they find no significant fault with the use of anorectics in this case. Finally, while they believe Respondent's testimony that Lasix was prescribed as an adjunct to the weight loss program, they can find absolutely no documentation to support its use in the patient record.

Charge I(1) is unanimously NOT SUSTAINED.

Charge I(2) is unanimously SUSTAINED.

Charge I(3) is unanimously NOT SUSTAINED.

Charge I(4) is unanimously SUSTAINED.

FINDINGS OF FACT AND CONCLUSIONS WITH REGARD TO ALLEGATION J

[redacted] testified she occasionally administered hypodermic injections upon patients as directed by Respondent. [redacted] also testified she is not a licensed professional but was trained

by Respondent's former medical assistant. She also testified she has some knowledge of the potential risks in administering hypodermic injections. The Committee can find no fault in these facts. There is simply no requirement as alluded to by the State that one be licensed to administer a hypodermic syringe. Since the licensure issue is at the heart of this allegation, the Committee does not sustain Charge J.

Charge J is unanimously NOT SUSTAINED.

SPECIFICATIONS ONE THROUGH TEN

Specification one alleges negligence and/or incompetence on more than one occasion. Specification two through ten alleges nine counts of gross negligence and/or gross incompetence. The Committee was instructed that for the purposes of this proceeding negligence was a failure to demonstrate that level of care and diligence expected of a prudent physician in this State. Incompetence was a failure to demonstrate that level of skill and expertise expected of a physician practicing in this State. The Committee was further instructed that gross negligence or gross incompetence represented a severe deviation from standards often characterized in the case of gross negligence as wantonness or a disregard for the consequences.

Utilizing these definitions, the Committee found no acts of incompetence, gross negligence or gross incompetence. They believed, based upon the entire record herein that Respondent possessed and demonstrated the requisite skill and expertise of a

physician in general practice in this State and they found no act sufficient to rise to the level of gross negligence.

While the Committee did sustain fourteen factual allegations, only some of these rise to the level of negligence. Those in which negligence was found are charges:

D, D(1) and D(3)
E and E(3)
F, F(1) and F(3)
G, G(1), G(2) and G(3)
I and I(4)

Many of the factual allegations (A(1), C(1), D(2), E(2) and I(2)) were sustained simply because Respondent's physical examinations were not "comprehensive." In each of the instances sustained, the Committed concluded that the physical examinations, though not comprehensive, were adequate for Respondent's purpose of treatment and, therefore, did not constitute a violation of generally accepted medical standards.

The exception to this was Charge F(3) wherein it was found Respondent documented no adequate physical examination from prior to 1975 through 1986. Respondent's care of this patient was reviewed from 1975 through 1986. During that time, there was no comprehensive physical examination of the patient. This is a violation of minimally acceptable medical standards. In the other charges sustained [D(1), D(3), E(3), F(1), F(3), G(1), G(2), G(3) and I(4)], the Committee did find significant lapses in medical standards.

The basis for the finding of negligence in these charges is essentially the same as the basis for sustaining them as

factual allegations. As set forth previously, Respondent's documentation of symptoms and care, which was at best marginal, in these cases was clearly substandard. His negligent treatment of Patient D's hypertension was previously discussed.

Specification one is unanimously SUSTAINED.

Specifications two through ten are unanimously NOT SUSTAINED.

SPECIFICATIONS ELEVEN THROUGH NINETEEN

While the Committee could not, in most instances, find negligence in the histories, physicals and general records kept by Respondent, this was based substantially on his credible testimony. Specifications eleven through nineteen, however, raise standards which cannot be met through after-the-fact explanations. In these specifications, Respondent is charged with a failure to maintain records which accurately reflect the evaluation and treatment of patients. The Committee was instructed that the regulation in issue (8 NYCRR §29.2(a)(3)) required that a physician's records allow a subsequent treating practitioner to know the patient's basic medical course including history, diagnoses and treatment. The Committee noted this regulation was filed in 1977. They were, therefore, limited to Respondents post 1977 records. Based solely upon the relevant evidence, the Committee finds Respondent's records were deplorable and, therefore, outside acceptable standards of medical care. The records were inadequate in quantity of information and quality of

detail. They were illegible and contained unique abbreviations known only to Respondent. Indeed, Respondent stated "I shudder the thought I should be judged by these notes... they are all jumbled... in no date order and largely indecipherable." To assist himself and his attorney, he prepared a type-written reconstruction of them. That such a reconstruction was necessary shows the essential inadequacy of the records.

The way that these specifications were drafted would require the Committee to sustain at least one factual allegation under each patient to sustain a specification. The Committee did not sustain factual allegations for Patients B and H but, nevertheless, found the records significantly substandard. It is the opinion of this Committee that each patient record before it was subject to its scrutiny and Respondent had clear notice of same. Therefore, the Committee sustains one specification of substandard recordkeeping under Section 6509 of the Education Law and 8 NYCRR 29.2(a)(3) for each patient presented (A through I) for a total of nine specifications.

Specifications eleven through nineteen are unanimously SUSTAINED.

SPECIFICATIONS TWENTY AND TWENTY-ONE

These specifications refer to the fact that [redacted], [redacted], who is not a licensed professional, administered hypodermic injections under Respondent's directions. Respondent stands accused of permitting an unlicensed person to

perform an activity requiring a license (twentieth specification) and delegating professional responsibilities to an unqualified person (twenty-first specification). As previously stated, there is simply no licensure requirement for administration of a hypodermic injection. Furthermore, [redacted] appeared well qualified by training and experience to perform the cited function.

Specification twenty and twenty-one are unanimously NOT SUSTAINED.

RECOMMENDATIONS

Respondent is found guilty of negligence on more than one occasion and maintaining extremely inadequate records. With the exception of Patient D, only recordkeeping was substandard. The following penalty is, therefore, proposed:

> Respondent's license to practice medicine in this State should be suspended.
>
> Said suspension should be permanently stayed on the following conditions:
>
> > For a period of two years, Respondent, at his own expense, shall obtain a physician monitor, acceptable to the Commissioner, whose duty it shall be to review, at the monitor's discretion, sufficient samples of Respondent's office and hospital records to ensure Respondent is meeting all relevant State standards including, but not limited to, legibility. If Respondent fails to keep records of appropriate quality, his license shall be revoked.

In addition, Respondent should be assessed a civil penalty of One Thousand Dollars ($1,000).

DATED: Albany, New York
November 29, 1989

Respectfully submitted,

Sister Mary Theresa Murphy

SISTER MARY THERESA MURPHY (Chairperson)

Joseph T. Doyle, M.D.
Thomas W. Smith, M.D.

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

IN THE MATTER :

OF :

JOHN C. FARRELL, M.D. :

COMMISSIONER'S RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on November 9, 1988, December 28, 1988, January 18, 1989 and February 1, 1989. Respondent, John C. Farrell, M.D., appeared by Anthony Z. Scher, Esq. The evidence in support of the charges against the Respondent was presented by Daniel J. Persing, Esq.

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 of the Committee should be accepted in full;

B. The Conclusions of the Committee should be accepted except with regard to Allegation J. The Petitioner alleged and the Committee found that [redacted] administered hypodermic injections to patients. The act of administering a hypodermic injection is medical treatment. The practice of medicine includes medical treatment. [redacted] is not licensed to practice medicine or to perform medical services. The twentieth specification should be sustained.

EXHIBIT "C"

C. The Recommendation of the Committee should be accepted with the following clarification;

The monitoring physician shall be approved in advance by the Office of Professional Medical Conduct (OPMC). The monitoring physician shall report quarterly to OPMC on the quality of Respondent's records. If Respondent's records do not meet accepted standards of completeness and legibility, the stay of supervision of his license may be lifted.

D. 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 described above.

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

DATED: Albany, New York
January 26, 1990

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

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

JOHN C. FARRELL

CALENDAR NO. 10710

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. That, during the period of probation, respondent shall have respondent's practice monitored, at respondent's expense, as follows:

   a. That said monitoring shall be by a physician selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   b. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient records, office records, and hospital charts in regard to respondent's practice, and respondent shall also be required to make such records available to said monitor at any time requested by said monitor; and

   c. That said monitor shall submit a report, once every three months, regarding the above-mentioned monitoring of respondent's practice to the Director of the Office of Professional Medical Conduct;

3. That respondent, during the period of probation has successfully performed 100 hours of public service to be selected by respondent and previously approved, in writing, by said employee;

4. 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

JOHN C. FARRELL

CALENDAR NO. 10710

The University of the State of New York

IN THE MATTER

OF

JOHN C. FARRELL
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 10710

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10710, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (June 22, 1990): That, in the matter of JOHN C. FARRELL, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted, except to the extent that those findings of fact support finding respondent guilty of any applicable definition of professional misconduct on the basis of conduct committed by respondent before that definition became effective;
2. The conclusions of the hearing committee and Commissioner of Health as to the first through the nineteenth specifications be modified;
3. The conclusions of the hearing committee and Commissioner of Health as to the twentieth and twenty-first specifications not be accepted and the twentieth and twenty-first specifications be dismissed without prejudice;

4. Respondent is, by a preponderance of the evidence, guilty of the first specification based upon negligence on more than one occasion to the extent of subparagraphs D, D.3., fourteenth specification based upon respondent's failure to document a comprehensive physical examination initially and throughout the course of treatment to the extent of charges D, D.1. and D, D.2., fifteenth, seventeenth, and nineteenth specifications based upon respondent's failure to provide any documentation in the patient record supporting the use of the drug he prescribed to the extent of subparagraphs E, E.3. and G, G.3. and I, I.4., and respondent be found not guilty of the remaining specifications and charges in the first through nineteenth specifications; and

5. The measure of discipline recommended by the hearing committee and Commissioner of Health be rejected and respondent's license to practice as a physician in the State of New York be suspended for one year and respondent be required to perform one hundred hours of public service upon each specification of the charges of which respondent was found guilty, said suspensions and public service to run concurrently; that the execution of said suspensions be stayed and respondent placed on probation for one year under the terms prescribed by the Regents Review Committee, which terms of probation include monitoring of respondent's office record-keeping practices;

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 24th day of [illegible], 1990.

Thomas Sobol

Commissioner of Education