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OFFICE OF PROFESSIONAL MEDICAL CONDUCT

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

February 16, 1990

James L. Hopkins, Physician
40 North State Street - Apt. 7B
Salt Lake City, Utah 84103

Re: License No. 127538

Dear Dr. Hopkins:

Enclosed please find Commissioner's Order No. 10114. 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: Irwin Birnbaum, Esq.
300 Loew Building
108 West Jefferson Street
Syracuse, N.Y. 13201-1536

REPORT OF THE
REGENTS REVIEW COMMITTEE

JAMES L. HOPKINS

D. 10114

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

JAMES L. HOPKINS **No. 10114**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

JAMES L. HOPKINS, 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 and on September 18, 1987, and January 25, and September 14, 1988, a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

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 concluded that respondent was guilty of paragraphs 4(d)(ii), 4(e)(ii), and 6 of the statement of charges and not guilty of the remaining charges.

The hearing committee recommended that respondent be Censured and Reprimanded and that his practice be limited so that he is not permitted to practice as an emergency room physician unless he goes through an appropriate re-education program such as a residency in that discipline.

On May 25, 1989 the Commissioner of Health, in a revised recommendation, recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted, except as indicated in his revised recommendation, and that the recommendation of the hearing committee be clarified and modified as indicated in his revised recommendation. A copy of the revised recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C". A copy of the original May 18, 1989 recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "D".

On November 2, 1989 respondent appeared before us in person and was represented by his attorney, Irwin Birnbaum, Esq., who presented oral argument on behalf of respondent. Paul R. White,

Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's revised 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 partially suspended to the extent that he not be permitted to practice in an Emergency Room except to permit him to complete a six month supervised training program in emergency medicine approved in advance by the Office of Professional Medical Conduct (OPMC). Upon the successful completion of such program as certified by OPMC, the partial suspension of respondent's license should be continued for two additional years, and such partial suspension stayed, provided respondent's Emergency Room practice is monitored by a physician approved in advance by OPMC. The monitor shall submit quarterly reports to OPMC about the propriety of respondent's Emergency Room practice. Respondent should also be Censured and Reprimanded as recommended by the Committee.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent be credited with the experience which he has had since the commencement of the hearings in satisfaction of all of the penalties recommended by the Commissioner.

We have considered the record as transferred by the

Commissioner of Health in this matter, as well as respondent's October 19, 1989 brief.

With regard to the charges of negligence on more than one occasion, petitioner made the acts of respondent with regard to each single patient into separate specifications. The hearing committee then concluded that respondent was only guilty of paragraphs 4(d)(ii) and 4(e)(ii) of the statement of charges with regard to the issue of negligence. Thus, no specification of which respondent was found guilty contains more than one occasion of negligence. However, we do not find petitioner's artless pleading in the statement of charges to be fatal under the doctrine of Rho v. Ambach, Slip Op. No. 200 (N.Y. Ct. of Appeals, October 19, 1989).

In Matter of Atkinson (Calendar No. 5700) the Board of Regents held that it was permissible to look at the individual paragraphs in the statement of charges that allege negligence and to group them together to find more than one occasion of negligence. Thus, we are not bound by the particular specification headings in reviewing the paragraphs in the statement of charges.

We agree with the hearing committee that respondent should be found guilty, on the issue of negligence on more than one occasion, of paragraphs 4(d)(ii) and 4(e)(ii) of the statement of charges. Since each of these paragraphs involve a different patient, it is our opinion that there is clearly more than one occasion of

negligence and that the Rho doctrine is satisfied in this case. However, we note that we can see no reason why there should ever be a need for more than one specification charging negligence on more than one occasion. Then each occasion of negligence would be charged under the one specification and there would be greater clarity for all concerned. We also agree with the hearing committee that respondent is guilty of the thirteenth specification of the charges and not guilty of the remaining charges. With respect to the specific charge 4(b) we agree with the rationale of the conclusions of the hearing committee set forth at page 9 of the hearing committee report based on fact findings 18 through 32.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 66 findings of fact be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact be accepted;
2. The hearing committee's conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to the hearing committee's conclusions be accepted to the extent hereafter indicated;
3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;

4. Respondent be found guilty, by a preponderance of the evidence, of paragraphs 4(d)(ii) and 4(e)(ii) grouped together as constituting negligence on more than one occasion, and 6 of the statement of charges, and not guilty of the remaining charges;

5. That, based upon respondent's training and work experience subsequent to the incidents in this case, and in consideration of an appropriate measure of discipline under the circumstances, respondent's license to practice as a physician in the State of New York be suspended for one year upon the aforesaid paragraphs constituting negligence on more than one occasion and upon paragraph 6 of which we recommend respondent be found guilty, said suspensions to run concurrently, that execution of said suspensions be stayed, and that, effective upon respondent's return to practice in New York State (written notice of which respondent must provide to the Director of the Office of Professional Medical Conduct within seven days after respondent's return to practice in New York State), respondent be placed on probation for one year under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "E".

JAMES L. HOPKINS (10114)

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated: January 11, 1990

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JAMES L. HOPKINS, M.D.	:	CHARGES

----------X

The State Board for Professional Medical Conduct, upon information and belief, charges and alleges as follows:

1. JAMES L. HOPKINS, M.D. hereinafter referred to as the Respondent, was authorized to engage in the practice of medicine in the State of New York on July 1, 1976 by the issuance of License Number 127538 by the State Education Department.

2. 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 7750 South 300 East, Midvale, Utah 84047.

3. The Respondent herein is charged with professional misconduct within the purview of N.Y. Educ. Law §6509 (McKinney 1985 and Supp. 1987) as set forth in the attached Specification.

FIRST THROUGH SIXTH SPECIFICATIONS

4. The Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) in that, among other things and incidents:

(a) The Respondent treated Patient A (Patient A and all other patients referred to herein are identified in Appendix A) in the emergency room of Mercy Hospital, 218 Stone Street, Watertown, New York on January 14, 1985. Patient A was in the emergency room because he had taken an overdose of Navane 10 mg. four hours earlier. The Respondent:

(i) delayed in initiating treatment of this patient with Ipecac; and

(ii) failed to perform an adequate physical examination and order laboratory studies, as documented by the emergency room record.

(b) The Respondent treated Patient B in the emergency room of the hospital on December 26, 1985. Patient B was in the emergency room because of a four to five day history of fever, cough, diarrhea,

headache, nausea and vomiting. The Respondent failed to correctly interpret this patient's chest x-ray study in that he missed a questionable **pneumonia/neoplasm.**

(c) The Respondent treated Patient C in the emergency room of the hospital on September 18, 1985. Patient C was in the emergency room because of an injury to his right hand. The Respondent:

(i) failed to identify that Patient C's injury was to the right fifth metacarpal rather than the right fifth finger;

(ii) failed to correctly interpret Patient C's x-ray study in that an angulated fracture of the distal fifth metacarpal was missed; and

(iii) failed to splint or cast Patient C's fracture.

(d) The Respondent treated Patient D in the emergency room of the hospital on September 16, 1985. Patient D was in the emergency room because she had injured her ankles and fractured the right distal tibia. The Respondent:

(i) failed to order a radiographic examination of the entire right lower leg to exclude the possibility of further injuries to the tibia or fibula; and

(ii) failed to consult with the orthopedic surgeon on call in order to determine whether the fracture should be immediately casted.

(e) The Respondent treated Patient E in the emergency room of the hospital on September 12, 1985. Patient E's blood pressure was extremely elevated as this patient had suddenly discontinued taking his anti-hypertensive medications on September 10, 1985. The Respondent:

(i) inappropriately treated Patient E with intravenous Apresoline and Inderal in light of this patient's recent discontinuance of Wytensin and Tenormin to control his hypertension; and

(ii) failed to perform an adequate physical examination and history, as documented by the emergency room record.

(f) The Respondent treated Patient F in the emergency room of the hospital on October 26, 1985. Patient F was in the emergency room because of a lump in his left eye with redness. The Respondent:

(i) failed to diagnose Patient F's eye injury as a scleral hemorrhage; and

(ii) failed to perform a visual acuity test.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

5. The Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) in that, among other things and incidents:

(a) The State Board for Professional Medical Conduct repeats and realleges the allegations of the First through Sixth Specifications.

THIRTEENTH SPECIFICATION

6. The Respondent is charged with professional misconduct by reason of committing unprofessional conduct within the meaning of N.Y. Educ. Law §6509(9) (McKinney 1985) and N.Y. Admin. Code tit. 8, §29.1(b)(5) (1984) by having engaged in conduct in the practice of medicine which evidences moral unfitness to practice in that, among other things and incidents:

On or about January 23, 1986, the Respondent prepared a false written statement in conjunction with his employment application to the House of the Good Samaritan Hospital in Watertown, New York. The Respondent falsely stated that he resigned from his position at Mercy Hospital because he wanted to devote his full attention to the practice of surgery. In fact, the Respondent was asked to resign from Mercy Hospital or be terminated.

DATED: Albany, New York
August 12, 1987

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Division of Legal Affairs

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

IN THE MATTER OF JAMES L. HOPKINS, M.D.	**REPORT OF** **HEARING** **COMMITTEE**

TO: HONORABLE DAVID AXELROD, M.D.
COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK

The undersigned Hearing Committee (the Committee) consisting of Stanley D. Leslie, M.D., Chairperson, David Lyon, M.D. and Maryclaire Sherwin was duly designated, constituted and appointed by the State Board for Professional Medical Conduct (the Board). Marshall Jay Grauer, Esq. served as the Administrative Law Judge.

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 the Respondent has violated provisions of the 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 a part of the record.

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

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	August 12, 1987
Hearing Dates:	September 18, 1987 January 25, 1988 September 14, 1988
Hearing location:	Airport Inn Syracuse, New York
Date and location of deliberations held by Committee:	December 7, 1988 Airport Inn Syracuse, New York
The State Board for Professional Medical Conduct appeared by:	Paul White, Esq. Empire State Plaza 24th Floor Albany, New York 12237
Respondent appeared by:	Birnbaum & Rojas Irwin Birnbaum, Esq. Of Counsel 108 West Jefferson Street Syracuse, New York 13202
Respondent's Address:	7750 South 300 East Midvale, Utah 84047

WITNESSES

FOR THE DEPARTMENT

GARY TYNDALL, M.D.	Board Certified in Internal Medicine
ANNA SANTORO	Registered Nurse

FOR THE RESPONDENT

MICHAEL JASTERMSKI, M.D.	Board Certified in Internal Medicine and Emergency Medicine
JAMES L. HOPKINS, M.D.	Respondent

SUMMARY OF CHARGES

Respondent, a duly licensed and practicing physician in the State of New York, is charged with professional misconduct by reason of practicing the profession of medicine with negligence and/or incompetence on more than one occasion in his treatment of Patients "A", "B", "C", "D", "E" and "F" in the emergency room at Mercy Hospital in Watertown, New York between September 10, 1985 and January 14, 1986 and is further charged with professional misconduct by reason of committing unprofessional conduct by having prepared a false written statement in conjunction with an employment application on or about January 23, 1986.

PRELIMINARY FINDINGS

1. Respondent was authorized to engage in the practice of medicine in the State of New York on July 1, 1976 by the issuance of license number 127538 and is currently registered to practice for the period of January 1, 1986 through December 31, 1988. (Exh. "G")

FIRST SPECIFICATION

4. The Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) in that, among other things and incidence:

(a) The Respondent treated Patient A in the emergency room of Mercy Hospital, 218 Stone Street, Watertown, New York, on January 14, 1986. Patient A was in the emergency room because he had taken an overdose of Navane 10 mg. four hours earlier. The Respondent:

(i) delayed in initiating treatment of this patient with Ipecac.

FINDINGS

2. Respondent was employed as an emergency room physician at the Mercy Hospital in Watertown, New York from July 1, 1985 through January 17, 1986. (p. 471, 505) (Exh. "G")

3. Patient A, a 27 year old male, came to the Emergency Room at Mercy Hospital at approximately 9:10 a.m. on January 14, 1986 with a history of having taken 12 tablets of Navane 10 mg. at 5:00 a.m. that morning. (p. 34, 35) (Exh. "2")

4. Patient A had obtained the Navane at St. Lawrence Psychiatric Center where he had previously been a patient. (p. 34-35) (Exh. "2")

5. A standard protocol for patients who have taken an overdose of a pharmacological agent is to clear their stomach of any medication that may be present. (p. 37)

6. One method is the use of Ipecac to induce vomiting to clear the stomach. (p. 38)

7. In the case of this patient, who had ingested what appeared to be a non-lethal dose of Navane four hours before presenting at the hospital, an alternative treatment would be not to administer Ipecac at all. (p. 340, 352)

8. The administration of Ipecac by Respondent at 9:47 a.m. was not a deviation from good and accepted standards of medical practice. (p. 337)

9. The poison control center had been telephoned by a

nurse, and shortly thereafter, Respondent personally spoke with poison control in a second telephone call made at approximately 9:35 a.m. (p. 273-276) (Exh. "2")

10. It was not inappropriate for Respondent to telephone the poison control center personally to obtain information and before the administration of Ipecac. (p. 339, 353)

11. The presence or absence of a gag reflex is an important physical finding in a comatose patient. (p. 341)

12. However, Patient A was alert, well-oriented, cooperative and his tongue was midline, indicating there was no oculogyric crisis. Blood pressure and pulse were within normal limits. The testing for gag reflex was not necessary in the management of this case. (p. 341, 348, 350, 351, 357)

CONCLUSIONS

The Hearing Committee, by unanimous vote (3-0), that this charge has not been sustained.

A review of the entire record reveals that the patient had presented himself at 9:10 a.m., over four hours after ingesting what appeared to be a nonlethal dose of Navane. Blood pressure and pulse of the patient were within normal limits. The administration of Ipecac by Respondent was proper but possibly not even necessary at that point in time. There appears to be no deviation from standard practice.

FIRST SPECIFICATION

Paragraph "4(a)(ii)"

The Respondent is further charged with negligence in that he:

> (ii) failed to perform an adequate physical examination and order laboratory studies, as documented by the emergency room record.

FINDINGS

13. Respondent did not perform a comprehensive physical examination on Patient A and appeared to focus primarily on the question of toxicity of the substance Navane. (p. 354)

14. Respondent made an adequate assessment of the central nervous system of the patient. (p. 355)

15. Respondent made an adequate examination prior to medical admission to the hospital. (p. 355)

16. No laboratory studies were indicated prior to the admission of the patient to the hospital. (p. 355, 359)

17. Physical examination documented that no crisis was present with respect to Patient A, and said exam was adequate. (p. 356, 357) (Exh. "2")

CONCLUSIONS

The Hearing Committee concludes by unanimous vote (3-0) that the charge has not been sustained.

Although Respondent admittedly did not perform a comprehensive examination of the patient prior to admitting him to the hospital, the Committee accepts the testimony of

Respondent's expert that in essence the examination was adequate at the time and place and under the circumstances existing.

SECOND SPECIFICATION

Paragraph "4(b)"

Respondent is further charged with negligence in that:

> (b) The Respondent treated Patient B in the emergency room of the hospital on December 26, 1985. Patient B was in the emergency room because of a four to five day history of fever, cough, diarrhea, headache, nausea and vomiting. The Respondent failed to correctly interpret this patient's x-ray study in that he missed a questionable pneumonia/neoplasm.

FINDINGS

18. Patient B, a 39 year old woman, came to the Mercy Hospital emergency room on December 26, 1985 at approximately 9:55 a.m. (Exh. "3")

19. Patient B gave a five day history of fever, vomiting, and headache and a two day history of diarrhea. (p. 633-64) (Exh. "3")

20. The Respondent ordered a chest x-ray, a complete blood count and an SMA and orthostatic blood pressure readings. (p. 64) (Exh. "3")

21. The chest x-ray films showed an abnormality in the lateral aspect of the right upper lobe, which would most likely represent pneumonia, although an alternate diagnosis could be neoplasm. (p. 64-67) (Exh. "3", "9", "10", "14")

22. The abnormality revealed by the patient's chest x-ray

was fairly obvious and could have been seen without difficulty. (p. 67, 70-71, 364, 366)

23. Patient emergency room records do not indicate specifically whether Respondent actually made an interpretation of the x-ray. (p. 78)

24. In Respondent's testimony, he acknowledged that he could have overlooked the problem. (p. 458)

25. The x-rays were evaluated by a radiologist the same day, who concluded, "right upper lobe bronchopneumonia." (Exh. "14")

26. Respondent telephoned Dr. Marilley and described the condition in the x-rays. (p. 451)

27. Based on Respondent's description, Dr. Marilley thought it could be legionella, and Respondent admitted the patient. (p. 452)

28. Dr. Marilley issued orders consisting of a sputum gram stain and culture, two blood cultures taken five minutes apart, and an immunophoresis for legionella. (p. 452) (Exh. "14")

29. Respondent does not recall ever having stated that the patient would be discharged. (p. 452)

30. There are no entries in patient's record indicating that Respondent intended to discharge this patient. (Exh. "3")

31. It is not uncommon to have an emergency room physician overlook a radiographic abnormality. (p. 70-71)

32. An emergency room physician's diagnosis of an x-ray

would be considered tentative pending the determination of a radiologist. (p. 83, 84)

CONCLUSIONS

The Committee concludes by unanimous vote (3-0) that this charge has not been sustained. In reaching this conclusion, the Committee is mindful of the fact that Respondent may not have initially made a correct interpretation of the chest x-rays, although there is no documentation to that effect in the records. It appears that the chest x-rays, both P/A and lateral views, portrayed a fairly obvious abnormality in the patient's lungs. However, the Respondent, as an emergency room physician, is not held up to the same standards of care of a radiologist in interpreting x-rays. The Committee does not believe that Respondent contemplated discharging this patient, as asserted by the Department. The Committee finds that the treatment of Patient B in the emergency room comported with the accepted standards of care.

THIRD SPECIFICATION

Paragraph "4(c)(i)(ii)(iii)"

Respondent is further charged with negligence in that:

> (c) The Respondent treated Patient C in the emergency room of the hospital on September 18, 1985. Patient C was in the emergency room because of an injury to his right hand. The Respondent:
>
> > (i) failed to identify that Patient C's injury was to the right fifth metacarpal rather that the right fifth finger;

(ii) failed to correctly interpret Patient C's x-ray study in that an angulated fracture of the distal fifth metacarpal was missed; and

(iii) failed to splint or cast Patient C's fracture.

FINDINGS

33. Patient C, a 12 year old boy, came to the emergency room at Mercy Hospital on September 18, 1985 at approximately 9:30 p.m. (Exh. "4")

34. Patient C complained of pain in his right fifth finger as a result of striking same on the floor. (p. 100, 101) (Exh. "4")

35. Respondent ordered x-rays of the right fifth finger and subsequently interpreted the x-ray as negative. Respondent believed that "C" suffered a strain to the finger. (p. 101-102, 104)

36. Patient C had, in fact, sustained a fracture of the distal part of the fifth metacarpal. (p. 102-104) (Exh. "12", "D")

37. In his testimony, Respondent admitted missing the fracture and stated that he should have seen it. (p. 428-429)

38. The fracture was a subtle one and not clear. (p. 429)

39. Due to the nature of the fracture, it could easily be missed by a competent emergency room physician. (p. 430)

CONCLUSIONS

It appears that there is no dispute in the record that Patient C did, in fact, have a fracture of the distal fifth metacarpal, as revealed by the x-rays, and Respondent erred when he read said x-rays and formed an incorrect diagnosis. However, the Committee also concludes that the fracture was subtle and not clearly apparent. The Committee does not conclude that this error was below the standards of care and/or was negligence or misconduct, and, therefore, concludes unanimously (3-0) that the charge has not been sustained.

FOURTH SPECIFICATION

Paragraph "4(d)(i)(ii)"

Respondent is further charged with negligence in that:

> (d) The Respondent treated Patient D in the emergency room of the hospital on September 16, 1985. Patient D was in the emergency room because she had injured her ankles and fractured the right distal tibia. The Respondent:
>
> > (i) failed to order a radiographic examination of the entire right lower leg to exclude the possibility of further injuries to the tibia or fibula; and
> >
> > (ii) failed to consult with the orthopedic surgeon on call in order to determine whether the fracture should be immediately casted.

FINDINGS

40. Patient D came to the emergency room at Mercy Hospital on September 16, 1985 at 9:35 p.m. (Exh. "5")

41. "D", a female patient, gave a history that while she

was walking her ankles gave out, and she heard her right ankle snap. (Exh. "5")

42. Respondent examined the patient and found soft tissue swelling, tenderness of both ankles, more severe on the right. (Exh. "5")

43. Respondent ordered x-rays of both ankles. The x-rays revealed a fracture of the right distal tibia. (Exh. "5")

44. Based upon the x-ray report and clinical history, there was no necessity for additional x-rays to be taken of the whole fibula and tibia of this patient. (p. 379)

45. An immediate consultation with an orthopedist to determine the immediate, appropriate care for Patient D was indicated. (p. 118)

46. Respondent did not contact an orthopedist for an immediate consultation to consult on whether immediate casting was necessary or appropriate. (p. 116-119)

47. Respondent sent Patient D home on crutches with instructions not to place her weight on her right leg and to contact her orthopedist within one to two days. (Exh. "5")

48. There was an orthopedist on call the evening of September 16, 1985, and an orthopedic consult was available to the Respondent in connection with the care and treatment of Patient D. (p. 267-268)

CONCLUSIONS

Respondent correctly ordered x-rays of Patient D's ankles and thereafter correctly interpreted same. There is no dispute that, as alleged in paragraph "(d)(i)", Respondent did not order a complete radiographic examination of the entire right lower leg. However, the Committee concludes that it was not necessary under the circumstances, and, therefore, this omission does not constitute negligence. It is the conclusion of the Hearing Committee, however, that with respect to paragraph "(d)(ii)", Respondent's failure to immediately consult with an orthopedic surgeon who was available was negligence by a vote of 2-1, and, therefore, that portion of the charge has been sustained.

FIFTH SPECIFICATION

Paragraph 4(e)(i)(ii)"

Respondent is further charged with negligence in that:

> (e) The Respondent treated Patient E in the emergency room of the hospital on September 12, 1985. Patient E's blood pressure was extremely elevated as this patient had suddenly discontinued taking his anti-hypertensive medications on September 10 ,1985. The Respondent:
>
> > (i) inappropriately treated Patient E with intravenous Apresoline and Inderal in light of this patient's recent discontinuance of Wytensin and Tenormin to control his hypertension; and
> >
> > (ii) failed to perform an adequate physical examination and history, as documented by the emergency room record.

FINDINGS

49. Patient E was a male, 51 years of age, who came to the emergency room of Mercy Hospital on September 12, 1985. (Exh. "6")

50. Patient E gave a history of having been on certain medications and that he had stopped taking them. As a result, he was on a "high" and needed help. (Exh. "6")

51. The medication Patient E had been taking consisted, in part, of Wytensin and Tenormin. "E" was hypertensive, anxious and was talking incessantly. (Exh. "6")

52. Patient E was borderline between uncontrolled hypertension and hypertensive urgency based on a diastolic pressure of 110. (p. 403)

53. Respondent treated Patient E with intravenous Apresoline (2x) intravenous Inderal (1x) and Nitroglycerine paste. (p. 403) (Exh. "6")

54. The administration of the aforesaid medications by the Respondent was appropriate for Patient E's condition. (p. 403)

55. Patient E was subsequently admitted to the hospital and transferred to the intensive care unit. (p. 403-404) (Exh. "6")

56. The documentation of any physical examination of Patient E that may have been made by Respondent was unacceptable and inadequate. (p. 131-132, 422) (Exh. "G")

CONCLUSIONS

With respect to charge "4(e)(i)", the Hearing Committee concludes by a unanimous vote of 3-0 that the charge has not been

sustained. As alleged by the Statement of Charges, Respondent did, in fact, use the medications of Apresoline and Inderal in the treatment of Patient E. However, it is the conclusion of the Committee that the use of those substances was appropriate.

With respect to charge "4(e)(ii)", the Committee concludes by a unanimous vote of 3-0 that this charge has been sustained. The emergency room record portrays little or no physical examination having been performed by Respondent. Respondent's own expert found it unacceptable and inadequate.

SIXTH SPECIFICATION

Paragraph "4(f)(i)(ii)"

Respondent is further charged with negligence in that:

> (f) The Respondent treated Patient F in the emergency room of the hospital on October 26, 1985. Patient F was in the emergency room because of a lump in his left eye with redness. The Respondent:
>
> (i) failed to diagnose Patient F's eye injury as a scleral hemorrhage; and
>
> (ii) failed to perform a visual acuity test.

FINDINGS

57. Patient F was a 43 year old male patient who came to the emergency room of Mercy Hospital on October 26, 1985 at approximately 7:45 p.m. (Exh. "7")

58. Patient F presented with complaints that his left eye had become bloody without any visual disturbances and that a lump had developed in the left corner of the eye. (Exh. "7")

59. Respondent made entries on the chart indicating

localized edema, conjunctivitis and infection, as well as drawing a small diagram of the site of the problem in the eye. (Exh. "7")

60. There is no evidence in the record to base a conclusion that Patient F sustained a scleral hemorrhage in his eye. The Department's expert acknowledged that he was uncertain of this diagnosis but "suspected" a conjunctival or scleral hemorrhage. (p. 144)

61. Respondent did not perform a visual acuity test. (p. 143-146) (Exh. "7")

62. Given the fact that Patient F reported no visual disturbances, a visual acuity test was not mandatory under the circumstances. (p. 440-443)

CONCLUSIONS

The Hearing Committee concludes by unanimous vote of 3-0 that no portion of this charge has been sustained. Although both paragraphs "(i)" and "(ii)" are correct factual statements, i.e., Respondent did not diagnose scleral hemorrhage nor do a visual acuity test, the record does not support any conclusion that a scleral hemorrhage did, in fact, occur or that a visual acuity test was necessary.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

5. The Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) in that, among other things and incidents:

(a) The State Board for Professional Medical Conduct repeats and realleges the allegations of the First through Sixth Specifications.

CONCLUSIONS

The Hearing Committee concludes that none of the allegations under the Seventh through Twelfth Specifications have been sustained.

THIRTEENTH SPECIFICATION

6. The Respondent is charged with professional misconduct by reason of committing unprofessional conduct within the meaning of N.Y. Educ. Law §6509(9) (McKinney 1985) and N.Y. Admin. Code tit. 8, §29.1(b)(5) (1984) by having engaged in conduct in the practice of medicine which evidences moral unfitness to practice in that, among other things and incidents:

> On or about January 23, 1986, the Respondent prepared a false written statement in conjunction with his employment application to the House of the Good Samaritan Hospital in Watertown, New York. The Respondent falsely stated that he resigned from his position at Mercy Hospital because he wanted to devote his full attention to the practice of surgery. In fact, the Respondent was asked to resign from Mercy Hospital or be terminated.

FINDINGS

63. Respondent, a duly licensed and practicing physician, was employed at the emergency room at Mercy Hospital, Watertown, New York, from July 1, 1985 to January 17, 1986. (Exh. "G")

64. On or about September 17, 1986, a hospital representative had a meeting with Respondent during which Respondent was advised that if he did not sign a letter of resignation, he would be terminated. (P. 479-480)

65. Respondent signed a letter of resignation on January 17, 1986. (p. 481) (Exh. "21")

66. On January 23, 1986, in connection with an application for employment at the House of the Good Samaritan Hospital, Respondent signed a written statement prepared by him, which stated in part, "...I resigned from the E.R. at Mercy Hospital because I wanted to devote my full attention to getting into the practice of surgery..."

CONCLUSIONS

The Committee concludes unanimously (3-0) that this charge has been sustained. The record is clear that Respondent's primary reason for resigning was a result of the ultimatum given to him at a meeting with a hospital representative on September 17, 1986. Whether Respondent's statement of January 23, 1986 contained, in part, a true statement, does not alter the fact that it is a misrepresentation. Nor is it relevant that the basis for Mercy Hospital's determination to discharge Respondent may not have been based upon sound reasons or that the reasons had no real connection with Respondent's performance or ability. The fact is, it was clearly a misrepresentation which misled Good Samaritan Hospital and did not reveal to said hospital the true circumstances of Respondent's termination.

RECOMMENDATIONS

As above noted, the Hearing Committee has sustained the charges set forth in:

> Paragraph "4(d)(ii)" - failure to get an orthopedic consultation.
>
> Paragraph "4(e)(ii)" - failure to perform an adequate physical examination and history.
>
> Paragraph "6" - making a false written statement in connection with an employment application.

The Hearing Committee also determined that some of the factual allegations in other charges were true but did not rise to the level of misconduct, i.e. Paragraph "4(b)" - failing to detect abnormality in a chest x-ray and Paragraph "4(c)(ii)"- failing to detect a fracture in an x-ray. After a careful review of its alternatives, the Committee has concluded that the conduct of the Respondent would not support a recommendation of license revocation or suspension.

It is the overall opinion of the Committee that Respondent's performance as an emergency room physician is somewhat sub-par and accordingly recommends that his practice should be limited so that he is not permitted to practice as an emergency room physician unless he goes through an appropriate re-education program such as a residency in that discipline. The precise requirements are left to the discretion of the Commissioner of Health.

With respect to Respondent's false statement in connection

with an employment application, it is recommended that he be censured and reprimanded. The Respondent apparently erroneously believed that having exercised his prerogative by resigning he was at liberty not to reveal the exact circumstances of said resignation in his subsequent employment application.

DATED: ~~February~~ _____, 1989

or March 6, 1989

Respectfully submitted,

Stanley D. Leslie M.D.

STANLEY D. LESLIE, M.D.,
CHAIRPERSON
DAVID LYON, M.D.
MARYCLAIRE SHERWIN

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

IN THE MATTER	:	REVISED
OF	:	COMMISSIONER'S
JAMES L. HOPKINS, M.D.	:	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 September 18, 1987, January 25, September 14, 1988. Respondent James L. Hopkins, M.D., appeared by Birnbaum & Rojas, Irwin Birnbaum, Esq., of Counsel. The evidence in support of the charges against the Respondent was presented by Paul White, 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 and Conclusions of the Committee should be accepted except as follows:

The Committee's Conclusion with respect to the Second Specification (Paragraph 4(b)) should be rejected. The Committee found that the abnormality revealed by Patient B's chest x-ray was "fairly obvious and could have been seen without difficulty" (Finding of Fact #22). The x-ray in question is a simple two view chest x-ray study with a dense infiltrate in the lateral aspect of right upper lobe (Petitioner's Exhibits 9 and 10). It was negligent for Respondent to have missed this abnormality and this Specification should be sustained.

B. The Recommendation of the Committee should be accepted with this clarification and modification. Respondent's license should be partially suspended to the extent that he not be permitted to practice in an ER except to permit him to complete a six month supervised training program in emergency medicine approved in advance by the Office of Professional Medical Conduct (OPMC). Upon the successful completion of such program as certified by OPMC, the partial suspension of Respondent's license should be continued for two additional years, and such partial suspension stayed, provided Respondent's ER practice is monitored by a physician approved in advance by OPMC. The monitor shall submit quarterly reports to OPMC about the propriety of Respondent's ER practice. Respondent should also be censured and reprimanded as recommended by the Committee.

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

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

Dated: Albany, New York
May 25 1989

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

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

IN THE MATTER	:	
OF	:	COMMISSIONER'S
JAMES L. HOPKINS, M.D.	:	RECOMMENDATION

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

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

A. The Findings of Fact and Conclusions of the Committee should be accepted except as follows:

EXHIBIT "D"

The Committee's Conclusion with respect to the Second Specification (Paragraph 4(b)) should be rejected. The Committee found that the abnormality revealed by Patient B's chest x-ray was "fairly obvious and could have been seen without difficulty" (Finding of Fact #22). The x-ray in question is a simple two view chest x-ray study with a dense infiltrate in the lateral aspect of right upper lobe (Petitioner's Exhibits 9 and 10). It was negligent for Respondent to have missed this abnormality and this Specification should be sustained.

B. The Recommendation of the Committee should be accepted with this clarification and modification. Respondent's license should be suspended to the extent that he not be permitted to practice in an ER except to permit him to complete a six month supervised training program in emergency medicine approved in advance by the Office of Professional Medical Conduct (OPMC). Upon the successful completion of such program as certified by OPMC, the suspension of Respondent's license should be suspended for two additional years, and such suspension stayed, provided Respondent's ER practice is monitored by a physician approved in advance by OPMC. The monitor shall submit quarterly reports to OPMC about the propriety of Respondent's ER practice. Respondent should also be censured and reprimanded as recommended by the Committee.

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

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

Dated: Albany, New York
May 18 1989

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

EXHIBIT "E"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

JAMES L. HOPKINS

CALENDAR NO. 10114

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 conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his 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;

   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 respondent during the period of probation, 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; and

b. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient records and hospital charts in regard to respondent's emergency room 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 four months, regarding the above-mentioned monitoring of respondent's emergency room practice to the Director of the Office of Professional Medical Conduct.

3. 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.

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

JAMES L. HOPKINS

CALENDAR NO. 10114

The University of the State of New York

IN THE MATTER

OF

JAMES L. HOPKINS
(Physician)

DUPLICATE ORIGINAL
VOTE AND ORDER
NO. 10114

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10114, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (January 17, 1990): That, in the matter of JAMES L. HOPKINS, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 66 findings of fact be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact be accepted;
2. The hearing committee's conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to the hearing committee's conclusions be accepted to the extent hereafter indicated;
3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;
4. Respondent is guilty, by a preponderance of the evidence, of paragraphs 4(d)(ii) and 4(e)(ii) grouped together as constituting negligence on more than one occasion, and 6 of the statement of charges, and not guilty of the remaining charges;

5. That, based upon respondent's training and work experience subsequent to the incidents in this case, and in consideration of an appropriate measure of discipline under the circumstances, respondent's license to practice as a physician in the State of New York be suspended for one year upon the aforesaid paragraphs constituting negligence on more than one occasion and upon paragraph 6 of which respondent is guilty, said suspensions to run concurrently, that execution of said suspensions be stayed, and that, effective upon respondent's return to practice in New York State (written notice of which respondent must provide to the Director of the Office of Professional Medical Conduct within seven days after respondent's return to practice in New York State), respondent be placed on probation for one year under the terms prescribed by the Regents Review Committee;

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

and it is

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

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

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 31st day of January, 1990.

Thomas Sobol

Commissioner of Education