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

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

April 23, 1993

Andre Jean Baptiste, Physician
P.O. Box 59
Roosevelt Island Station
New York, New York 10044

Re: License No. 141328

Dear Dr. Baptiste:

Enclosed please find Commissioner's Order No. 12936. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. 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. In the event you are also served with this Order by personal service, the effective date of the Order is the date of personal service.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you may, pursuant to Rule 24.7 (b) of the Rules of the Board of Regents, a copy of which is attached, apply for restoration of your license after one year has elapsed from the effective date of the Order and the penalty; but said application is not granted automatically.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:
Gustave Martine
GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR
cc: Robert S. Asher, Esq.
295 Madison Avenue
New York, N.Y. 10017

REPORT OF THE
REGENTS REVIEW COMMITTEE

ANDRE JEAN BAPTISTE

CALENDAR NO. 12936

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

ANDRE JEAN BAPTISTE **No. 12936**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

Between April 2, 1991 and June 11, 1991 a hearing was held in the instant matter on three sessions before a hearing committee of the State Board for Professional Medical Conduct which subsequently rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "A". The statement of charges, as amended therein, is annexed hereto, made a part hereof, and marked as Exhibit "B". Allegation B(1)(j) was withdrawn from the charges.

The hearing committee concluded unanimously that respondent, Andre Jean Baptiste, was guilty of negligence on more than one occasion (fifteenth specification), incompetence on more than one occasion (sixteenth specification), unprofessional conduct for excessive tests and treatments not warranted by the conditions of the patients (twenty-fourth through thirtieth specifications), and

unprofessional conduct for record-keeping violations (thirty-first through thirty-seventh specifications). The hearing committee concluded, by a majority vote of 2-1, that respondent was guilty of gross negligence (first through seventh specifications) and gross incompetence (eighth through fourteenth specifications). The hearing committee concluded unanimously that respondent was not guilty of practicing fraudulently (seventeenth through twenty-third specifications). The hearing committee recommended that respondent's license to practice medicine be suspended for ten years and stayed upon meeting certain specified terms.

The Commissioner of Health, by designee, recommended to the Board of Regents that the findings and conclusions of the hearing committee be accepted, the recommendation of the hearing committee be rejected, and, in lieu thereof, respondent's license to practice medicine be revoked. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On May 27, 1992, respondent appeared in person and was represented by Robert S. Asher, Esq. Roy Nemerson, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation as to the penalty to be imposed, should respondent be found guilty, was the same as that of the Commissioner of Health that respondent's license be revoked. Respondent's written recommendation as to the penalty to be imposed, should respondent be found guilty, was that respondent's

license be suspended and said suspension be stayed with supervision and continuing medical education.

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

This matter concerns 37 specifications brought against respondent as to 7 different patients. Each specification relates to various paragraphs of separate factual allegations, many of which are repeated in several specifications. Furthermore, these factual allegations relate to the multiple visits each patient had with respondent.

Petitioner's case consisted of its producing respondent's office medical records for each patient and the review and evaluation of these records by petitioner's expert witness. No patient or subsequent treating physician testified at the hearing. Moreover, petitioner did not call any witness to testify who personally observed respondent's care and treatment of these patients or who had obtained knowledge as to such care and treatment separate and apart from respondent's records for these patients. The witness petitioner produced based his evaluation of the cases of Patients A-G and the care and treatment respondent provided such patients on only the information he could discern from their patient records.

The conclusions rendered in a professional discipline proceeding should clearly show the extent of respondent's guilt. However, the hearing committee's report and the designee's

recommendation do not identify which individual or combination of paragraphs were sustained for each definition of professional misconduct. While the penalty recommendation section of the hearing committee report indicates generally, on pages 60-66, the facts which were sustained and, on page 67, the vote as to the groups of specifications, the hearing committee did not separately state the paragraphs of charges which were concluded, in whole or in part, to constitute any particular definition of professional misconduct. Similarly, the designee merely accepted, without further elaboration, the hearing committee's conclusions and referred generally to "such failings" by respondent. The hearing committee and designee should have clearly specified, for each separate definition of professional misconduct sustained, both the particular specifications and paragraphs to which their conclusions relate to the extent of the applicable allegations. Therefore, in order to analyze the issues presented by this matter and to provide a coherent report, we will provide, as appropriate, the necessary elaboration regarding what conclusions we have reached as to respondent's conduct.

I. NEGLIGENCE ON MORE THAN ONE OCCASION

The charges against respondent include allegations, with respect to Patients A-F, that respondent failed to take an adequate medical history, failed to perform an adequate physical examination, and failed to do an appropriate follow-up and evaluation. Among other things, the hearing committee and designee

found that respondent committed these failures of care and treatment. The hearing committee concluded that inadequacies in respondent's practice of medicine as to Patients A-F were demonstrated by his failures to follow-up complaints and to establish a diagnosis.

In our unanimous opinion, respondent is guilty of the fifteenth specification of negligence on more than one occasion, as hereafter specified in our conclusions, for his negligence, in the cases of Patients A through F, with respect to his failures to take an adequate medical history; perform an adequate physical examination; and do an appropriate follow-up and evaluation. Through expert testimony, petitioner has proven, by a preponderance of the evidence, that respondent has committed such negligence on more than one occasion.

Petitioner's expert witness, Dr. Leslie, determined that respondent, in his practice of medicine, deviated from the standard of care accepted in the practice of medicine which a reasonably prudent physician should have followed under the circumstances. Dr. Leslie had a sufficient basis for formulating his opinions. He reviewed respondent's office medical records for each patient and interpreted respondent's records to show that, in the cases of Patients A-F, respondent did not take an adequate history, perform an adequate physical examination, and do an appropriate follow-up and evaluation. Dr. Leslie's opinions thus were not merely grounded on the subjects of the lack of justification in

respondent's records for prescriptions and orders and of other inadequacies in those records.

On the other hand, respondent did not come forward to rebut petitioner's prima facie case of negligence in these areas. Respondent did not claim, testify, or produce proof that there was an adequate history, physical examination, or follow-up in these cases.* Respondent's expert declared that he was not testifying to dispute these allegations. Transcript page 325 (hereafter T. _____). He conceded that he would have obtained "a better history" and conducted "a more thorough examination" than did respondent. Id.

Respondent's hearing position was that he could not "defend the fact that there isn't an adequate history, an adequate reason given in the chart." T. 417. After the hearing committee report had been received by respondent's attorney, said attorney wrote that respondent was "largely in agreement with the Findings and Recommendation of the Hearing Committee". He did not specifically challenge any of the findings regarding respondent's failures as to the medical histories, examinations, and evaluations and follow-up in the cases of Patients A-G. Instead, respondent's attorney said "(w)e are not going in to any of those areas." T. 416. In his

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*Respondent was not required to testify in this matter and no adverse inference has been drawn because he did not testify. Also, the burden of proof remained on petitioner.

proposed findings of fact, no findings of any kind were proposed as to these acts having occurred, adequately or otherwise, or as to respondent conforming to the standard of care in these areas. Moreover, these proposals expressly declare that where respondent has conceded guilt, proposed findings have been eliminated. While respondent raised a defense against allegations that he prescribed medications without medical indication or when contraindicated, respondent has not raised any defense as to the allegations upon which we find him to be guilty of negligence on more than one occasion. Nor has respondent shown that there was any other information which petitioner's expert should have considered before rendering his opinions in this matter.

To the extent referred to above, the hearing committee and designee concluded correctly that negligence on more than one occasion was established as to Patients A through F. However, the remaining charges of negligence as to Patients A-F and the charges of negligence as to Patient G have not been proven.

The hearing committee and designee have not demonstrated negligence by respondent insofar as he is charged with failing to record an adequate history or physical examination. Respondent's negligence is instead predicated on the absence of an adequate history and an adequate physical examination from which a record could have been made. Therefore, respondent did not fail to record a history or physical examination which he took or performed. In our opinion, the charge of negligence as to failing to record

medical histories and physical examinations may not be sustained as such charges alternatively are unproven, contrary to other charges and findings, or duplicative of other charges. We note that respondent is properly held responsible for failing to maintain patient records which accurately reflect the evaluation and treatment he did provide.

Furthermore, negligence has not been established as to the charges involving respondent knowingly prescribing medications or knowingly ordering sonograms without medical indication. With respect to these negligence charges as well as to the separate allegations concerning incompetence and excessive tests and treatments not warranted by the conditions of the patients, the hearing committee and designee did not render findings as to each element of these charges regarding respondent knowingly acting without medical indication. Furthermore, the hearing committee and designee did not conclude that respondent's guilt was based upon such conduct. The different conclusions that "the drugs prescribed were not inappropriate in all cases" and that drugs and sonograms were ordered without a diagnosis being established do not adequately support the determination to sustain these charges that respondent knowingly prescribed medications or knowingly ordered sonograms without medical indication.

Significantly, the record in this matter does not and, in view of petitioner's reliance on only the medical records for each patient, cannot demonstrate that the medications were ordered and

the sonograms were prescribed without medical indication based upon the patient's actual conditions and true needs for tests and treatments. The medical records did not completely reveal these circumstances. Respondent's guilt is premised on his not establishing a diagnosis because he failed to perform an adequate work-up of the patients. Inasmuch as respondent thus did not adequately know the indications for his prescriptions and orders and inasmuch as petitioner has not attempted to adduce proof as to the proper diagnosis in these cases had respondent learned all relevant medical circumstances, respondent is not negligent for knowingly prescribing medications and ordering sonograms without medical indication. The burden of proof was not on respondent to demonstrate the appropriate diagnosis for each patient or the indications for his prescriptions or orders.

II. **RECORD-KEEPING**

A key reason why we do not know whether respondent's prescriptions and orders were medically indicated is the poor quality of respondent's medical records. Respondent's expert witness testified that he would not write records the way respondent did. That expert further testified that he would not accept respondent's medical records as being "complete records" and that he would, "of course" require more information to be recorded. In general, a reader of respondent's medical records would not see much information other than general impressions and could not tell, from those records, respondent's thinking in these patient cases.

T. 321-323. Respondent's expert witness did not dispute "the problems with the records" and he did not approve of the adequacy of the information contained in them. T. 324.

Respondent's memorandum of law to the Health Department "admits" that respondent's medical records are "incomplete" in not showing the medical indication for the medications respondent ordered for Patients A-G. Respondent's memorandum also states, on page 2, that respondent does "not deny that the medical records are incomplete and that most, if not all of the Charges which relate to medical record keeping, have been sustained." The summation by respondent's attorney acknowledges that respondent's medical records are "very poor", "deficient", "incomplete", and "substandard". T. 415, 416, and 418.

The findings of fact recommended by the hearing committee and designee as to the general record-keeping charges are inexplicably limited to the mere words in the Regents' rule (8 N.Y.C.R.R. §29.2(a)(3)) that respondent failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient. Such unspecific, formulaic, and conclusory findings do not reveal: the particular aspect of respondent's evaluation and treatment of the patients which was not accurately recorded; what specific deficiency was found to exist in respondent's medical records; and the substance of the record-keeping conduct upon which respondent was found guilty by the hearing committee and designee. Additionally, the hearing committee's report and the designee's

recommendation do not reveal that the guilt found therein is not repetitive of the different charges relating to respondent's alleged failures to record an adequate medical history and an adequate physical examination. Compare, paragraphs A.3,, A.4, B.3, B.4, C.2, C.3, D.2, D.3, E.3, E.4, F.3, F.4, G.2, and G.3 of the charges with paragraphs A.6, B.7, C.5, D.5, E.7, F.7, and G.5 of the charges.

The Board of Regents can, and here must, render additional findings of fact. Based upon the record and the positions of the parties, we believe it is clear that petitioner has proven, by a preponderance of the evidence, that respondent is guilty of unprofessional conduct for record-keeping deficiencies as charged in the thirty-first through thirty-seventh specifications. See, Schwarz v. Board of Regents of University of New York, 89 A.D.2d 711 (3rd Dept. 1982); and Amarnick v. Sobol, ___ A.D.2d ___, 586 N.Y.S.2d 356 (3rd Dept. 1992).

III. UNACCEPTABLE FINDINGS AND CONCLUSIONS

The findings and conclusions of the hearing committee and designee that respondent is guilty of the charges other than those referred to in Parts I and II herein (negligence and record-keeping) cannot be accepted. This part of our report will show that, with respect to each patient case, their recommendations as to some of the charges cannot withstand scrutiny.

The hearing committee and designee sustained charges in the face of contradictory findings and conclusions. They sustained

paragraph F(1)(a) of the charges involving the prescription of Valium not being medically indicated on June 19, 1988 when they concluded that the prescriptions for Valium were medically indicated. (Compare, hearing committee report pages 57 and 65). Also, they sustained paragraph E(1)(b) of the charges involving the prescriptions of Sinequan being contraindicated on March 29, 1986, April 23, 1986, and May 6, 1986 when they concluded that the use of Sinequan was not contraindicated. (Compare, hearing committee report pages 53 and 64). Further, they sustained paragraph A(1)(e) of the charges involving the prescription of oral Penicillin not being medically indicated on May 1, 1987 when they only concluded that there was no indication for IM Penicillin on that date. (See, hearing committee report page 40 and compare, finding 37 as to March 4, 1987 and May 1, 1987). Additionally, they concluded that Motrin was contraindicated on September 23, 1987 and October 9, 1987, as charged in paragraph D(1)(f), when these prescriptions were only a relative contraindication which, according to the hearing committee, would not result in a conclusion that the drug was contraindicated. See, hearing committee report pages 39, 40, and 49 and finding 59. With respect to the prescription of Motrin on December 3, 1987, the hearing committee and designee did not state whether they found an absolute or a relative contraindication. However, in view of the above and of their basis for finding a contraindication being limited to the gastrointestinal complaint before December 3, 1987, it appears that

this prescription was also considered to be a relative contraindication which would not result in the conclusion that the drug was contraindicated.

The hearing committee and designee sustained charges regarding medications without rendering required findings or conclusions as to those charges. They sustained paragraph G(1)(i) of the charges involving there being no indication for prescribing Keflex when there is no finding that respondent prescribed Keflex for Patient G. Also, they sustained paragraph E(1)(i) of the charges involving the prescribing of Motrin for Patient E on February 20, 1987 when there is no finding that respondent prescribed Motrin for Patient E on February 20, 1987. Further, they sustained paragraph G(1)(b) of the charges involving the prescribing of Periactin on all the visits charged when there is no finding that respondent prescribed Periactin on both September 22, 1986 and the ninth visit, which is the September 22, 1986 visit.

No conclusion was recommended by the hearing committee and designee regarding whether Sinequan was contraindicated on April 14, 1986, as alleged in paragraph E(1)(b) of the charges, Amoxicillin was not indicated on September 9, 1986, as charged in paragraph E(1)(n), and Valium was not indicated on May 13, 1987, as charged in paragraph B(1)(a).

The hearing committee and designee sustained charges, separate from those relating to medications, without rendering required findings or conclusions as to those charges. They sustained

paragraphs A(2) of the charges as to four sonograms and B(2) of the charges as to four other sonograms, each involving respondent's alleged knowingly ordering sonograms without medical indication, when no findings or conclusions were recommended regarding both respondent acting knowingly and the sonograms being without medical indication. Instead, unlike the conclusions rendered as to paragraphs E(2) and F(2) of the charges, the conclusions as to paragraphs A(2) and B(2) of the charges were limited to respondent's records not including support for the sonograms ordered. (Compare, hearing committee report pages 41, 46, 56, and 58). The conclusions as to paragraphs A(2) and B(2) are not adequate to sustain those charges. Additionally, regarding paragraphs A(2), B(2), E(2), and F(2) of the charges, there is no reference by the hearing committee and designee to respondent knowing that the sonograms were without medical indication.

The hearing committee and designee sustained paragraph C(4) of the charges involving respondent's alleged failure to do appropriate follow-up and evaluation of various patient complaints when there is no finding that respondent failed in these regards. (See, findings 52 and 54). Also, they sustained paragraph C(4) of the charges as to the complaint of amenorrhea not being followed-up appropriately, paragraph B(5) of the charges as to the finding regarding SGPT not being followed-up appropriately, paragraph E(5) of the charges as to the failure to notate certain data, and paragraph F(5) of the charges regarding follow-up as to possible

acute arthritis secondary to hyperuricemia when findings to these effects were not recommended. Further, they sustained paragraphs A(4), B(4), and C(3) of the charges involving respondent failing to record an adequate physical examination when there was no finding as to such failure to record and there was a finding that respondent failed to perform an adequate physical examination. In contrast, findings were rendered as to paragraphs D(3), E(4), and F(4) that respondent failed to both perform and record an adequate physical examination.

The hearing committee and designee sustained paragraphs B(1)(a) as to February 27 and paragraph B(1)(g) as to April 14 when these visits were not referred to in the charges. (See, hearing committee report pages 61 and 62). The hearing committee report, on pages 41 and 46, refers to Patient E when the discussion relates to Patients A and B respectively. It refers on page 35 to Patient F when the findings relate to Patient G.

The hearing committee and designee found in finding 71 that respondent failed to adequately evaluate or follow-up on Patient E's complaint of hepatomegaly, as charged in paragraph E(6). In spite of this finding and the unqualified conclusion that there is no evidence of respondent's "efforts to follow-up and evaluate the complaints presented by Patient E", the hearing committee and designee did not sustain paragraph E(6) as to hepatomegaly. (See, hearing committee report pages 56 and 65).

The hearing committee and designee sustained paragraphs G(2)

through G(5) of the charges when there are no conclusions rendered as to those charges. In the case of Patient G, unlike the other patient cases, these is no conclusion that respondent's practice of medicine is inadequate due to his failure to establish a diagnosis and to justify the evaluation and treatment of the patient. Significantly, paragraph G(4) was sustained by the hearing committee and designee involving respondent's diagnosis of "rheumatic arthritis". However, as shown in finding 92, respondent diagnosed "rheumatoid arthritis". Inasmuch as there is no finding or conclusion that respondent made any inappropriate diagnosis for Patient G's arthritis and as the record does not demonstrate that Patient G did not have the condition respondent diagnosed, paragraph G(4) will not be sustained.

IV. GROSS NEGLIGENCE

In our unanimous opinion, respondent's negligent acts have not been proven to rise to the level of gross negligence as charged in the first through seventh specifications. The evidence adduced by petitioner, which was limited to facts determinable from respondent's records, does not show various circumstances and aspects regarding the conditions of Patients A-G or respondent's care and treatment of them. Although respondent's inadequate histories, physical examinations, and follow-ups, have been demonstrated to constitute negligence, as aforesaid, the proof and findings are not sufficient to establish that such conduct also constitutes gross negligence. Petitioner's expert testified

regarding "minimal" standards of medical care (eg., T. 260 and 276) and he did not expressly indicate that he considered respondent's conduct in these cases to be anything other than ordinary negligence.

The hearing committee and designee did not consider or find respondent's negligent conduct to be "egregious". The different standard they employed (see, hearing committee report pages 37-38) is not the standard previously followed by the courts for assessing the issue of gross negligence. Rho v. Ambach, 74 N.Y.2d 318 (1989); and Enu v. Sobol, 171 A.D.2d 302 (3rd Dept. 1991). The record does not contain sufficient evidence for us to assess this issue independently and to find respondent's conduct to meet the correct standard.

Gross negligence as to the separately charged acts of failing to take adequate histories, perform physical examinations, and do follow-up and evaluation is not established by testimony that the quality of the care provided by respondent "was generally suboptimal" or that respondent's records do not indicate a "justification for the use of the medication". T. 149 and 173. The hearing committee and designee, who sustained various individual paragraphs without specifying those found to be the basis for finding gross negligence, have not demonstrated that the negligent conduct we have found reflects gross negligence by respondent. Rather, they concluded that the drugs respondent prescribed, "while not appropriate in all cases", "were ordered

without any attempt to establish a diagnosis". However, this was not charged in any paragraph sustained. Although separate paragraphs of the charges involve allegations that medications were prescribed without medical indication, the hearing committee and designee may not establish gross negligence on the basis of conclusions which were beyond the scope of all the charges.

INCOMPETENCE

In our unanimous opinion, respondent is not guilty of gross incompetence as charged in the eighth through fourteenth specifications or of incompetence on more than one occasion as charged in the sixteenth specification. Petitioner's expert neither testified as to respondent's level of knowledge or ability to practice nor was he in any position to do so. He was asked to testify, on the basis of records which did not reveal much meaningful information, regarding the care a reasonably prudent physician would exercise. Eg., T. 177, 178, 180, 185, and 186. Moreover, although the hearing committee and designee sustained charges regarding respondent knowing that various prescriptions and sonograms were not indicated or warranted, the hearing committee and designee found respondent was incompetent as to these charges. This record is not sufficient to sustain the eighth through fourteenth and sixteenth specifications.

EXCESSIVE TESTS AND TREATMENT

Again, the full extent of the patients' conditions is not shown in the hearing record in this matter. Petitioner has not

proven that, regardless of the adequacy of respondent's work-up of a patient's case, the tests and treatments provided by respondent were "excessive" for the patient's actual condition. We note that respondent has not conceded that the patients did not need the medication respondent prescribed or that they did not have a medical condition upon which respondent prescribed medication. The record, including the findings recommended by the hearing committee and designee, thus, without regard to other charges, does not support the conclusions that respondent committed unprofessional conduct as charged in the twenty-fourth through thirtieth specifications. Accordingly, in the absence of proof that respondent provided excessive tests and treatments not warranted by the conditions of the patients, the twenty-fourth through thirtieth specifications will not be sustained.

We unanimously recommend the following:

1. The findings of fact of the hearing committee and the recommendation of the Health Commissioner's designee as to those findings of fact be accepted, except finding of fact 94 not be accepted, findings of fact 41, 48, 55, 61, 62, 68, 69, 87, 88, 95, and 96 not be accepted to the extent they relate to the failure to record, and finding of fact 71, not be accepted to the extent its relates to hepatomegaly.
2. The following additional findings of fact, referable to Patients A through G be accepted:

98 Respondent's medical records for Patients A-G are incomplete in that they do not show the medical indication for the medications respondent ordered for the patients.

99 Respondent's medical records for Patients A-G do not provide others who read these records meaningful medical information about the care and treatment respondent provided to the patients.

100 A physician reviewing respondent's medical records for Patients A-G would not see much information other than general impressions and could not tell, from these records, what respondent was thinking in these patient cases.

101 Respondent's medical records were not complete records.

102 Respondent's expert witness did not approve of the quality of respondent's medical records. (T. 320-325).

103 Respondent's medical records for the January 6, 1987, May 1, 1987, and May 19, 1987 visits by Patient A refer to "back pain". Respondent did not indicate in this medical record the "localization of the back pain". (T. 25-26).

104 Respondent's medical records for the March 4, 1987 visit by Patient A refer to skin infection. There is no description in those records of where the infection is, how long the patient had that infection, whether there is a discharge coming from the infection, whether it is superficial or whether it is deeper, and whether the patient had any systemic symptoms. A prudent physician should have recorded this information. (T. 29-30).

105 Respondent maintained medically poor records for Patient A. The entries on these records are subjective. Not very much was recorded in these records. (T. 35, 65, 32).

106 Respondent's medical records for the September 8, 1986 and September 24, 1986 visits by Patient B refer to this patient as having "anxiety". Respondent did not elaborate on what he meant by this term. A prudent physician would have elaborated as to what he meant by the term "anxiety". (T. 71-72).

107 Respondent's medical records for Patient B are poor in quality. (T. 94).

108 The quality of the care represented in respondent's medical record for Patient C was

relatively poor. (T. 131-132).

109 Respondent's entry of "anxiety" on Patient E's medical record is unclear because it is not possible to know, from what respondent wrote, what type of anxiety he was referring to for Patient E. The mere reference to anxiety does not enable the reader of Patient E's medical record to know whether Patient E had an anxiety disorder or symptoms of anxiety, both of which would be an indication for prescribing Valium, or whether Patient E only had anxiety associated with the stress of every day life, which is not an indication for prescribing Valium. (T. 377-379).

110 Respondent's medical records for Patient E do not adequately meet the needs of a reasonably prudent physician in providing medical care to Patient E.

111 In respondent's medical record as to the Keflex prescribed Patient F on August 15, 1986 and the erythromycin prescribed Patient F on August 29, 1986, there is no recording to reflect the presence of an infection. (T. 253).

112 Respondent's medical record for Patient F,

taken as a whole, does not meet the minimum standards that would be complied with by a reasonably prudent physician because there is no insightful, cognitive evaluation of the patient. (T. 260).

113 Respondent's medical record for Patient G is unclear as to his giving Patient G penicillin over a ten day period. The record does not show what kind of Penicillin was given Patient G. (T. 283-284 and 407-408).

114 Respondent's medical record for Patient G is unclear as to some of the doses of Penicillin which were given to Patient G. There is no indication in respondent's medical record for Patient G why the doses of Penicillin varied. (T. 287).

115 The medical record maintained by respondent for Patient G did not, as a whole, meet the minimal standards that should be complied with by a reasonably prudent physician under the circumstances. (T. 278).

3. The conclusions of the hearing committee and the recommendation of the Health Commissioner's designee as to those conclusions be modified;

4. Respondent be found guilty, by a preponderance of the

evidence, of the fifteenth specification to the extent indicated in this report based upon paragraphs A(3), A(4), A(5), B(3), B(4), B(5), B(6), C(2), C(3), C(4), D(2), D(3), D(4), E(3), E(4), E(5), E(6), F(3), F(4), F(5), and F(6), involving respondent's failing to take an adequate medical history; failing to perform an adequate physical examination; and failing to do an appropriate follow-up and evaluation of patient complaints; and of the thirty-first through thirty-seventh specifications to the extent indicated in this report based upon paragraphs A(6), B(7), C(5), D(5), E(7), F(7), and G(5), involving respondent failing to maintain medical records which accurately reflect his evaluation and treatment of the patients; and respondent be found not guilty of the remaining specifications and charges;

5. The recommendation of the hearing committee be rejected; and

6. The recommendation of the Health Commissioner's designee as to the recommendation of the hearing committee be accepted, except the portion of the designee's recommendation involving the effect of the hearing committee's recommendation in the future not be accepted; and respondent's license to practice medicine in the State of New York be revoked upon each specification of the charges of which respondent has been found guilty, as aforesaid.

ANDRE JEAN BAPTISTE (12936)

Respectfully submitted,

FLOYD S. LINTON

THEODORE M. BLACK, SR.

NANCY A. RUCKER

Floyd S. Linton
Chairperson

Dated: 3/3/93

The University of the State of New York

IN THE MATTER

OF

ANDRE JEAN BAPTISTE
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 12936

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 12936, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (April 23, 1993): That, in the matter of ANDRE JEAN BAPTISTE, respondent, as a matter of clarification, the discussion regarding gross negligence, on pages 16-18 of the Regents Review Committee report, is accepted based upon the record, as a whole, demonstrating that the conclusions of the hearing committee and Health Commissioner's designee that respondent committed each act of gross negligence are not sufficiently supported, by a preponderance of the evidence; that 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 Health Commissioner's designee as to those findings of fact be accepted, except finding of fact 94 not be accepted, findings of fact 41, 48, 55, 61, 62, 68, 69, 87, 88, 95, and 96 not be accepted to the extent they relate to the failure to record, and finding of fact 71, not be accepted to the extent it relates to hepatomegaly;
2. The additional findings of fact, 98 through 115 set forth at pages 20 through 23 of the Regents Review Committee

report, referable to Patients A through G be accepted;

3. The conclusions of the hearing committee and the recommendation of the Health Commissioner's designee as to those conclusions be modified;

4. Respondent is guilty, by a preponderance of the evidence, of the fifteenth specification to the extent indicated in the report of the Regents Review Committee based upon paragraphs A(3), A(4), A(5), B(3), B(4), B(5), B(6), C(2), C(3), C(4), D(2), D(3), D(4), E(3), E(4), E(5), E(6), F(3), F(4), F(5), and F(6), involving respondent's failing to take an adequate medical history; failing to perform an adequate physical examination; and failing to do an appropriate follow-up and evaluation of patient complaints; and of the thirty-first through thirty-seventh specifications to the extent indicated in the report of the Regents Review Committee based upon paragraphs A(6), B(7), C(5), D(5), E(7), F(7), and G(5), involving respondent failing to maintain medical records which accurately reflect his evaluation and treatment of the patients; and respondent is not guilty of the remaining specifications and charges;

5. The recommendation of the hearing committee be rejected; and

6. The recommendation of the Health Commissioner's designee as to the recommendation of the hearing committee be accepted, except the portion of the designee's recommendation involving the effect of the hearing committee's recommendation in the future not be accepted; and respondent's license to practice medicine in the State of New York be revoked upon each specification of the charges of which respondent has been found guilty, as aforesaid;

and that Deputy Commissioner Henry A. Fernandez be empowered to

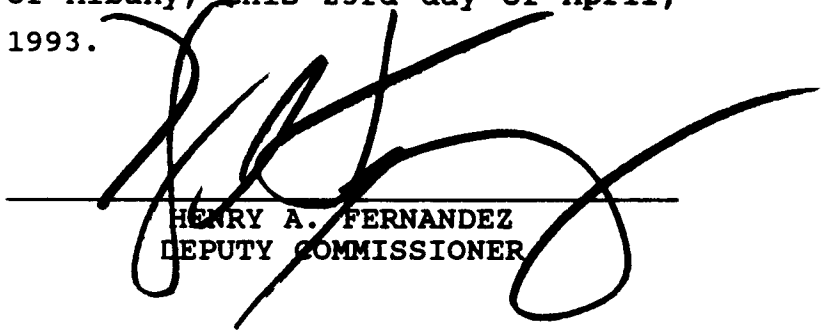
execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

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, Henry A. Fernandez, Deputy Commissioner, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand, at the City of Albany, this 23rd day of April, 1993.



HENRY A. FERNANDEZ
DEPUTY COMMISSIONER