STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 19, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Charles Lynnwood Johnson, M.D.
503 N. Oakland Avenue
Pasadena, CA 91101

Jean Bresler, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: In the Matter of Charles Lynnwood Johnson, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-121) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

CHARLES LYNNWOOD JOHNSON, M.D.

DETERMINATION

AND

ORDER

BPMC - 98 - 121

KENNETH KOWALD (Chair), **JAMES EISENKRAFT, M.D.** and **HILDA RATNER, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE ("**ALJ**"), served as the Administrative Officer.

The Department of Health appeared by **HENRY M. GREENBERG, ESQ.**, General Counsel, by **JEAN BRESLER, ESQ.**, Associate Counsel and **BARRY P. KAUFMAN, ESQ.**, of counsel.

Respondent, **CHARLES LYNNWOOD JOHNSON, M.D.**, appeared by telephone and was not represented by counsel.

A Hearing was held on June 4, 1998. Evidence was received and examined, including a witness who was sworn or affirmed. A Transcript of the proceeding was made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York. (§230 et seq. of the Public Health Law of the State of New York ["**P.H.L.**"])

This case, brought pursuant to P.H.L. §230(10)(p), is also referred to as an "expedited hearing". The scope of an expedited hearing is strictly limited to evidence or sworn testimony relating to the nature and severity of the penalty (if any) to be imposed on the licensee[1] (Respondent).

CHARLES LYNNWOOD JOHNSON, M.D., ("**Respondent**") is charged with professional misconduct within the meaning of § 6530(9)(b) of the Education Law of the State of New York ("**Education Law**"), to wit: "professional misconduct ... by reason of having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state ..." (Department's Exhibit # 1 and § 6530[9][b] of the Education Law).

In order to find that Respondent committed professional misconduct, the Hearing Committee, pursuant to § 6530(9)(b) of the Education Law, must determine: (1) whether Respondent was found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state and (2) whether Respondent's conduct on which the findings were based would, if committed in New York State, constitute professional misconduct under the laws of New York State.

A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

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[1] P.H.L. § 230(10)(p), fifth sentence.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Some evidence presented was rejected as irrelevant. All Findings and Conclusions herein were unanimous. The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was authorized to practice medicine in New York State on July 1, 1983 by the issuance of license number 154576 by the New York State Education Department (Department's Exhibits # 1 & # 2)[2].

2. The State Board For Professional Medical Conduct has obtained personal jurisdiction over Respondent (legal decision made by the Administrative Officer [Respondent was personally served and had no objection to the personal service effected[3]]); (P.H.L. § 230[10][d]); (Department's Exhibit # 1).

3. Respondent is not currently registered with the New York State Education Department to practice medicine in the State of New York (Department's Exhibit # 2) (admitted by Respondent).

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[2] refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit). Dr. Johnson did not submit documentary evidence other than his motion papers which were marked as ALJ Exhibit # 1.

[3] Respondent did object to subject matter jurisdiction. Respondent's objection was overruled by the ALJ prior to the Hearing and again at the Hearing (see ALJ Exhibit # 1 and transcript of the proceedings).

4. The Medical Board of California, Division of Medical Quality through the Department of Consumer Affairs of the State of California ("**California Board**") is a state agency charged with regulating the practice of medicine pursuant to the laws of the State of California (Department's Exhibits # 3, # 4 & #5).

5. On February 22, 1996, the California Board filed an accusation against Respondent charging him with repeated negligent acts, incompetence, gross negligence, and violations of state statutes regulating drugs or controlled substances (Department's Exhibit # 3).

6. On September 6, 1996, the California Board filed a first supplemental accusation against Respondent charging him with additional repeated negligent acts, incompetence, and gross negligence (Department's Exhibit # 3).

7. On April 29, 1997, the ALJ in California issued a proposed decision after 11 days of Hearings in which Respondent appeared and represented himself (Department's Exhibit # 4).

8. On May 29, 1997, the California Board issued a Decision ("**1997 Decision**") which adopted the ALJ's proposed decision of April 29, 1997. The 1997 Decision became effective June 30, 1997 (Department's Exhibit # 5).

9. The Hearing Committee accepts the 1997 Decision including the findings of fact and conclusions of law and adopts same as part of its own Findings of Fact (Department's Exhibits # 4 & # 5).

10. Respondent's treatment of Charles P., Tyler H., Charles L., Geraldine L., and Mary G. constituted a departure from the professional medical standard of care required of a physician practicing in similar locality under similar circumstances and constituted negligence in California[4] (Department's Exhibit # 4).

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[4] Violations of California Business and Professions Code §2234(c).

11. Respondent's treatment of Tyler H., Charles L., Geraldine L., Mary G., Francys R., and Michael S. constituted an extreme departure from the professional medical standard of care required of a physician practicing in similar locality under similar circumstances and constituted gross negligence in California[5] (Department's Exhibit # 4).

12. Respondent's treatment of Tyler H. constituted incompetence of the professional knowledge of medical care standards required of a physician practicing in similar locality under similar circumstances[6] (Department's Exhibit # 4).

13. Respondent was also found guilty by the California Board of: (1) repeated acts of clearly excessive prescribing or administering of drugs or treatment; (2) repeated acts of clearly excessive use of diagnostic procedures; and (3) repeated acts of clearly excessive use of diagnostic or treatment facilities[7] (Department's Exhibit # 4).

14. The sanctions imposed by the California Board in its 1997 Decision included the revocation of Respondent's certificate to practice medicine in California. The California Board stayed the revocation and placed Respondent on probation for seven (7) years with numerous terms and conditions (Department's Exhibit # 4).

15. The terms and condition of probation imposed by the California Board include: (1) successfully taking and completing a clinical training program; (2) restriction of Respondent's practice to the clinical training program; (3) after successful completion of said clinical training program, Respondent would be allowed to practice with physician supervision; (4) surveillance of Respondent by the California Board; and (5) payment of $9,725 for reimbursement of the California Board's investigative and prosecution costs (Department's Exhibit # 4).

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[5] Violations of California Business and Professions Code §2234(b).

[6] Violation of California Business and Professions Code §2234(d).

[7] Violation of California Business and Professions Code §725.

16. In addition to the above and as part of the application to the clinical training program, Respondent was required to be evaluated, physically and psychologically (admitted by Respondent).

17. Respondent has not practiced medicine since 1994 (Department's Exhibit # 4); (admitted by Respondent).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that Factual Allegations A and B from the April 7, 1998 Statement of Charges, are SUSTAINED.

The Hearing Committee further concludes, based on the above Factual Conclusion, that the SPECIFICATION OF CHARGES is SUSTAINED.

I **Professional Misconduct under § 6530(9)(b) of the Education Law.**

The California State Board of Medical Examiners is a duly authorized professional disciplinary agency. In 1997, said Medical Board issued a Decision in which Respondent was found guilty of committing gross negligence in the care and treatment of 6 patients; repeated acts of negligence in the care and treatment of 5 patients and incompetence in the care and treatment of 1 patient. In addition Respondent was found guilty of improper professional practice in the excessive use of diagnostic tests and abuse of diagnostic facilities.

Respondent's acts were violations of various sections of California laws which warranted disciplinary action by the California Board. The Hearing Committee finds that Respondent's conduct, as reported in the California ALJ's proposed decision, if committed in New York State, would constitute professional misconduct under, at least, §6530(3)[8], §6530(4)[9] and §6530(35)[10] of the Education Law of the State of New York. Therefore, Respondent has committed professional misconduct pursuant to § 6530(9)(b) of the Education Law.

The Hearing Committee concludes that the Department of Health has shown by a preponderance of the evidence that Respondent was found guilty of improper professional practice by the State of California and his conduct in California would constitute professional misconduct under the laws of New York State. The Department of Health has met its statutory burden of proof.

The Hearing Committee notes that §6530(9)(b) of the Education law does not require a final judicial or quasi-judicial determination as argued by Respondent. Under the first test of the Education Law, the Department of Health is only required to prove that Respondent has been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state. Respondent's claim that the California Board is a quasi-legislative body, even if true, does not rebut the fact that the California Board is a disciplinary agency of the state of California. The Hearing Committee further notes that Respondent has not provided evidence which would indicate that the California Board's 1997

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[8] Each of the following is professional misconduct... [P]racticing the profession with negligence on more than one occasion;

[9] Each of the following is professional misconduct... [P]racticing the profession with gross negligence on a particular occasion;

[10] Each of the following is professional misconduct... [O]rdering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient;

Decision has been stayed in anyway by any California or Federal Courts. The contrary is true in that Respondent has acknowledged that he believes he can practice if he complies with the 1997 Decision. The Hearing Committee also believes that it would be contrary to common sense, the purpose or intent of the law (to protect the public) and the plain language of the law for New York to be prevented from acting on the information presented about Respondent in the 1997 Decision of California Board.

In the event that Respondent is successful in his litigation in California and is able to reverse the California Board's 1997 Decision, Respondent is entitled to request a review of this Determination and Order in New York since it is based on the 1997 California Decision.

DETERMINATION

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service and (10) probation.

The Committee is bound by the documentary evidence presented by the Department. Respondent has failed to provide any meaningful mitigation to the Hearing Committee. Instead Respondent submitted various legal and constitutional arguments about the 1997 California Board Decision and about the illegality of the New York proceedings.

The record clearly establishes that Respondent committed unprofessional conduct in the care and treatment of at least 6 patients as discussed above and in violation of the laws of California.

The Hearing Committee concludes that if this case had been held in New York, on the facts presented, the gross negligence, the negligence, and the excessive tests and treatment, as alleged and found by California, it would have resulted in a finding that Respondent had committed professional misconduct.

The Hearing Committee considers Respondent's misconduct to be very serious. The Hearing Committee finds the testimony submitted by Respondent to be disturbing. Respondent, by his own testimony, indicates to the Hearing Committee that he has no insight that his conduct was not acceptable practice. As the 1997 Decision states:

> "Respondent's failure to appreciate the opinions of others strongly suggests he has not learned the standards of learning, skill, and care, are acquired from a collective body of work of physicians practicing in the entire field of medicine. Respondent seems to be saying -- it is his way or the wrong way. But it is he who for the most was wrong." (Department's Exhibit # 4 at p. 6).
>
> " He made many mistakes in the care and treatment of the many patients involved in this matter, but no evidence showed his mistakes caused any serious injury to them. ... A major concern, however, is Respondent's refusal to acknowledge his mistakes, and his arrogant belief he knows better how to practice medicine than other practitioners. People learn from their mistakes, but Respondent's refusal to acknowledge them makes it difficult for him to learn from them." (Department's Exhibit # 4 at p. 30-31).

Although the 1997 Decision explained, in detail, the events and conduct of Respondent and the factual findings, legal conclusions, and determination as to costs, it was lacking in its explanation as to the reasoning for the lenient sanctions that were imposed. Respondent endangered the life of a number of his patients. It is merely chance or luck that, to date, Respondent's mistakes caused no serious injury.

With regard to the issue of sanctions, it is a generally accepted principal that the State where respondent lived and practiced medicine at the time of the offense has the greatest interest in the issue and the public policy considerations relevant to such disciplinary actions. Thus, greater weight would usually be accorded as to the sanctions issued by the State of California.

However, in this case it appears to the Hearing Committee that the sanctions imposed by California are inadequate and insufficient. Respondent shows no insight, no understanding and refuses to acknowledge his gross errors. In addition, Respondent has not practice medicine since 1994.

The Hearing Committee has insufficient information to believes that Respondent, is capable of providing medically acceptable care and treatment to patients. Given the above, the Hearing Committee does not believe that censure and reprimand is sufficient to address Respondent's failures. Since there was insufficient evidence regarding other areas of Respondent's practice, the Hearing Committee finds that limiting Respondent's practice is not an available penalty. Similarly, the imposition of monetary penalties or public service is not indicated.

The Hearing Committee does not believe that clinical re-training would be sufficient to address Respondent's lack of insight and other deficiencies. The Hearing Committee finds and determines that although probation for 7 years with clinical training and the other terms and conditions imposed by California may be appropriate for California, it is wholly insufficient and inappropriate for New York considering the substantial findings of gross negligence and numerous acts of negligence involved in this matter.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, including the sanction imposed by California, the Hearing Committee determines that revocation is the appropriate sanction under the circumstances. The Hearing Committee unanimously concludes that this sanction strikes the appropriate balance between the need to protect the public, deter future misconduct, punish Respondent, and give deference to our sister state.

With a concern for the health and welfare of patients in New York State, the Hearing Committee determines that revocation of Respondent's license is the appropriate sanction to impose under all of the circumstances presented.

All other issues raised have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The Specification of professional misconduct contained within the Statement of Charges (Department's Exhibit # 1) is **SUSTAINED,** and

2. Respondent's license to practice medicine in the State of New York is hereby **REVOKED.**

DATED: **New York, New York**
June 11, 1998

KENNETH KOWALD (Chair),
JAMES EISENKRAFT, M.D.
HILDA RATNER, M.D.

Charles Lynnwood Johnson, M.D.
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APPENDIX I

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

IN THE MATTER

OF

CHARLES L. JOHNSON, M.D.

STATEMENT

OF

CHARGES

CHARLES L. JOHNSON , M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1, 1983 , by the issuance of license number 154576 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about May 29, 1997, The Division of Medical Quality , Medical Board of California, Department of Consumer Affairs, after a hearing, issued a decision and order which found Respondent guilty of violating Business and Professional Code section 2234(b), Gross Negligence, with regard to his treatment of patient Tyler H.,by reason of findings XIII, and XIV, patient Charles L. by reason of findings XVIII, and XIX, Patient Geraldine L. by reason of findings XX, and XXI, patient Mary G. by reason of findings XXV , patient Frances R. by reason of findings XXX and XXXI, and patient Michael S. by reason of findings XXXII and XXXIII. The California Board found Respondent guilty of violating Business and Professional Code Section 2234(d), incompetence, with regard to patient Tyler H, by reason of findings XIII and XV. The California Board found the Respondent guilty of violating Business and Professions Code §2234 (c), repeated negligence, with regard to his treatment of Patient Charles P. by reason of findings V, VI, Patient Tyler H. by reason of findings XIII, XVI, Patient Charles L. by reason of findings XVIII and Patient Geraldine L. by reason of finding XX, and XXVIII Patient Mary G. by

reason of finding XXIV and XXVI and XXIX. The California Board found the Respondent guilty of violating business and Processions Code §725, repeated acts of clearly excessive prescribing or administering drugs, or treatment, repeated acts of repeated acts of clearly excessive use of diagnostic procedures, and repeated acts of clearly excessive use of diagnostic or treatment facilities by reason of findings XIII, XIV, XVIII, XIX, XXI, XXIV, XXV, XXVI, XXVII, XXVIII, XXX, XXXI, XXXII,and XXXIII.

B. Respondent's Certificate to practice medicine was revoked. The revocation was stayed and the respondent was placed on probation for seven (7) years. The terms of probation included the requirements of periodic interviews, surveillance, training, (respondent's practice limited to the training program), successful completion of training program. At the successful completion of the training program, respondent may practice under the supervision of a monitor. Respondent was required to make payment of $9725.00 for reimbursement of costs to the state of California.

SPECIFICATION OF CHARGES

SPECIFICATION
HAVING BEEN FOUND GUILTY OF
PROFESSIONAL MISCONDUCT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(b)(McKinney Supp. 1998) by having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state (namely N.Y. Educ. Law §§ 6530 (3),

Negligence on more then one occasion, §6530 (4), Gross Negligence, §6530 (5) Incompetence on more then one occasion, and (35), Ordering excessive tests, treatment, or treatment facilities, as alleged in the facts of the following:

1. The facts in Paragraphs A and B.

DATED: April 7, 1998
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct