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 3, 1991

John Kall, Physician
a/k/a John A. Kalliathparambil
36 Dogwood Lane
Irvington, N.Y. 10533

Re: License No. 142420

Dear Dr. Kall:

Enclosed please find Commissioner's Order No. 11549. 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:
Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er
Enclosures

CERTIFIED MAIL- RRR
cc: Robert Wild, Esq.
Garfunkel, Wild & Travis
175 Great Neck Road
Great Neck, N.Y. 11021

REPORT OF THE
REGENTS REVIEW COMMITTEE

JOHN KALL
a/k/a JOHN A. KALLIATHPARAMBIL

CALENDAR NO. 11549

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

JOHN KALL
a/k/a JOHN A. KALLIATHPARAMBIL

No. 11549

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

REPORT OF THE REGENTS REVIEW COMMITTEE

JOHN KALL a/k/a JOHN A. KALLIATHPARAMBIL, 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.

This disciplinary proceeding was properly commenced and on eight dates from February 27, 1990 to June 26, 1990 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges, with the exception of the appendix, 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, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was not guilty

of the eight specifications and recommended that they be dismissed.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted. However, in lieu of the Committee's recommendation and based on the Committee's own conclusions, the Commissioner further recommended that the first and second specifications of the charges be sustained, that respondent's license be suspended for one year, and that the suspension be stayed provided that respondent enrolls in a remedial course in primary care of at least three months duration acceptable to the Office of Professional Medical Conduct. If respondent fails to complete the approved course, the stay will be removed and the suspension reinstated. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On January 25, 1991 respondent appeared before us in person and was represented by his attorney, Robert Andrew Wild, Esq. who presented oral argument on behalf of respondent. Daniel Guenzburger, Esq. presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was a one year stayed suspension, with the stay conditioned on respondent's completion of a three month remedial course in primary care approved by the Office of Professional Medical Conduct.

Respondent's written recommendation as to the measure of discipline to be imposed was that no penalty is justified by the facts and circumstances of this case.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's January 11, 1991 memorandum.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's findings of fact, as set forth in its report at pages 8 through 14, and the Commissioner of Health's recommendation as to those findings be accepted;
2. The hearing committee's conclusions, as set forth in its report at pages 14 through 18, and the Commissioner of Health's recommendation as to those conclusions be accepted;
3. The hearing committee's vote upon each of the specifications, as set forth in its report at page 19, not be accepted;
4. The Commissioner of Health's recommendation as to guilt be accepted;
5. Respondent be found guilty, by a preponderance of the evidence, of the first and second specifications of the

charges to the extent indicated by the Commissioner of Health and not guilty of the remaining allegations;

6. The recommendation of the hearing committee to dismiss the specifications of the charges not be accepted;

7. The recommendation of the Commissioner of Health as to the measure of discipline be modified; and

8. In partial agreement with the Commissioner of Health, respondent's license to practice as a physician in the State of New York be suspended for one year upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently, and that the execution of said suspensions be stayed at which time respondent be placed on probation for a period of one year under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D", which include courses of training in infectious diseases and recordkeeping.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith

Chairperson

Dated: 2/28/91

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
JOHN KALL, M.D.	:	CHARGES
a/k/a	:	
JOHN A. KALLIATHPARAMBIL, M.D.	:	

----------X

JOHN KALL, M.D. a/k/a JOHN A. KALLIATHPARAMBIL, M.D. the Respondent, was authorized to practice medicine in New York State on June 20, 1980 by the issuance of license number 142420 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991.

FACTUAL ALLEGATIONS

A. On or about and between September 27, 1983 and August 13, 1985, Respondent treated Patient A (the identity of Patient A and the other patients is contained in the Appendix) at his office at 1577A Westchester Avenue, Bronx, New York on fifteen occasions. During his treatment of Patient A, who was 4 years old at the time of the first visit, Respondent:

EXHIBIT "A"

1. Failed to take a complete and adequate past medical history at Patient A's initial visit. On each office visit, Respondent failed to evaluate treatment rendered in prior visits and failed to take an adequate history of Patient A's presenting complaints and related symptoms.

2. Failed to perform complete and adequate physical examinations.

3. Failed to administer indicated immunizations.

4. On or about November 10, 1983, December 4, 1984, January 8, 29, 1985, February 19, 1985, Respondent treated Patient A for asthma but failed to investigate the underlying cause of Patient A's asthma, to explore the possibilities of alternative treatment, and/or to seek consultation with a specialist.

5. On or about November 10,1983, Respondent treated Patient A for asthma with Elixophyllin, 2 tsp. p.o. stat., and IM Epinephrine, 0.1 ml. stat. The dosages of Elixophyllin and Epinephrine administered were too low to be effective.

6. On or about January 10, 1984, April 12, 1984, November 29, 1984, January 8, 29, 1985, February 19, 1985

and August 13, 1985, Respondent ordered throat cultures, but failed to follow-up on the performance and results of the cultures.

7. On or about April 12, 1984 Respondent prescribed Elixir of Terpin Hydrate with Codeine which is contraindicated in children under six years of age unless the child suffers from a complication from coughing such as vomiting, loss of sleep, inability to feed properly.

8. Respondent failed to maintain an adequate record of Patient A's past medical history, presenting complaints and symptoms, immunization history, and the results of physical examinations. In addition, Respondent failed to record laboratory test results and/or file laboratory reports in Patient A's file.

B. On or about and between November 15, 1983 and November 27, 1984 Respondent treated Patient B at his office on four occasions. During his treatment of Patient B, who was 7 months old at the time of the first visit, Respondent:

1. Failed to evaluate the treatment rendered in prior visits and failed to take adequate histories of Patient B's presenting complaints and related symptoms.

2. Failed to perform complete and adequate physical examinations.

3. Failed to maintain an adequate record of the Patient B's past medical history, presenting complaints and symptoms, immunization history, and the results of physical examinations. In addition, Respondent failed to record laboratory test results and/or file laboratory reports in Patient B's file.

4. Failed to administer indicated immunizations.

5. On or about November 15, 1983, January 26, 1984, February 8, 1984, and November 27, 1984, Respondent ordered throat cultures, but failed to follow-up on the performance and results of the cultures.

6. On or about February 8, 1984 and November 27, 1984, when Patient B was respectively ten and nineteen months old, Respondent prescribed two hundred fifty (250) milligrams of Amoxicillin every eight hours for ten days. The prescribed dosages of Amoxicillin were excessive.

C. On or about and between February 7, 1985 and August 9, 1986 Respondent treated Patient C at his office on nine occasions.

During his treatment of Patient C, who was one and one-half years old at the time of the first visit, Respondent:

1. Failed to evaluate treatment rendered in prior visits and failed to take adequate histories related to Patient C's specific complaints and symptoms.

2. Failed to perform adequate physical examinations.

3. Failed to ascertain immunizations needed by the patient.

4. Failed to maintain an adequate record of Patient C's past medical history, presenting complaints and symptoms, immunization history, medications prescribed and the results of physical examinations. In addition, Respondent failed to record laboratory test results and/or file laboratory reports in Patient C's file.

5. Failed to administer indicated immunizations.

6. On or about March 26, 1985 the Respondent prescribed Elixir of Terpin Hydrate with Codeine which is contraindicated in children under six years of age unless the child suffers from complications related to the coughing such as vomiting, loss of sleep, inability to feed properly.

2/28/90 AMENDED DELETE UNDERLINED

7. On or about February 7, 1985, Respondent diagnosed tonsillitis and conjunctivitis without supporting the diagnosis with cultures of the eye and throat.

8. On or about March 15, 1986, the Respondent observed that Patient C suffered from dehydration, but failed to properly rehydrate the patient.

9. On or about January 16, 1986, when Patient C was two years and five months old, the Respondent prescribed Acetyl Salicylic Acid Grain 5 Suppositories No. 12. Patient C had a temperature of 101 degrees Fahrenheit. The prescription of medication containing aspirin to a febrile infant is contraindicated.

10. On or about February 7, 1985, March 26, 1985, September 26, 1985, February 8, 1986, and May 10, 1986, when Patient C was between one year and six months and two years and nine months old, the Respondent prescribed two hundred and fifty (250) milligrams of Amoxicillin every eight hours. On or about January 16,1986 and August 9, 1986, when Patient C was respectively one year and five months and three years old, the Respondent prescribed three hundred and seventy-five milligrams of Amoxicillin every eight hours for ten days. The dosages of Amoxicillin prescribed were excessive.

D. On or about and between November 26, 1983 and September 2, 1986 Respondent treated Patient D at his office on fifteen occasions. During his treatment of Patient D, who was 33 years old at the time of the first visit, Respondent:

1. Failed to take an adequate general history and adequate histories related to Patient D's specific complaints and symptoms.

2. Failed to perform adequate physical examinations.

3. Failed to maintain an adequate record of Patient D's past medical history, presenting complaints and symptoms, medications prescribed and the results of physical examinations. In addition, Respondent failed to record laboratory test results and/or file laboratory reports in Patient D's file.

4. On or about March 27, 1984, Respondent prescribed Fastin without documenting a comprehensive program of weight reduction.

5. On or about March 27, 1984, Respondent prescribed both Fastin and Pseudoephedrine. The combined use of the two medications is inappropriate.

6. On or about April 17, 1984, June 5, 1984, July 26, 1984, November 19, 1985, and June 10, 1986, Patient D presented with complaints of abdominal pain. Respondent failed to diagnose the cause of the pain, and/or seek consultation with a specialist.

7. On or about June 5, 1984 Respondent presented with a chief complaint of pain in the right upper quadrant. Respondent prescribed Compazine, Tagamet, Mylanta, and Bentyl. The treatment of Patient D with all of the above medications was excessive and not indicated.

8. On or about July 26, 1984 Respondent ordered an ultrasound test of the gall bladder and abdomen, but failed to follow-up on the performance and results of the tests.

9. On or about January 3, 1985 Respondent diagnosed the patient as suffering from an upper respiratory infection. Respondent prescribed Septra, Chlortrimeton, Neosynephrin, Elixir of Terpin Hydrate with Codeine, Tagamet, Mylanta, and Motrin. The treatment of Patient D with all of the above medications was excessive and not indicated.

10. On or about November 26, 1983, March 27, 1984, and January 3, 1985 and Ocober 10, 1985 Respondent prescribed Elixer of Terpin Hydrate with Codeine which was contraindicated because Patient D was allergic to the medication.

11. On or about August 21, 1985 Respondent ordered various blood tests but failed to follow-up on the performance and results of the tests.

E. On or about and between November 29, 1983 and August 12, 1986, Respondent treated Patient E at his office on eleven occasions. During his treatment of Patient E, who was 31 years old at the time of the the first visit, Respondent:

1. Failed to take an adequate general history and adequate histories related to Patient E's specific complaints and symptoms.

2. Failed to maintain an adequate record of Patient E's past medical history, presenting complaints and symptoms, and the results of physical examinations. In addition, Respondent failed to record laboratory reports in Patient E's file.

3. On or about December 15, 1984, and January 17, 1985 Respondent administered Intra-Muscular Procaine Penicillin without indication.

4. On or about April 10, 1984, October 18, 1984, December 15, 1984 and August 22, 1985 Respondent ordered throat cultures but failed to follow-up on the performance and results of the cultures.

5. On or about November 21, 1985 Respondent diagnosed a urinary tract infection without supporting the diagnosis with appropriate clinical observations and laboratory tests.

F. On or about and between November 10, 1983 and February 9, 1984 Respondent treated Patient F on four occasions at his office. During his treatment of Patient F, who was 26 years old at the time of the first visit, Respondent:

1. Failed to take an adequate general history and adequate histories related to Patient F's specific complaints and symptoms.

2. Failed to maintain an adequate record of Patient F's past medical history, presenting complaints and symptoms, and the results of physical examinations. In addition,

Respondent failed to record laboratory test results and/or laboratory reports in Patient F's file.

3. On or about November 10, 1983 Respondent prescribed Tranxene without indication.

4. On or about November 10, 1983 and February 9, 1984 Respondent prescribed Fiorinal containing Codeine no.3 without indication.

5. On or about November 10, 1983 Respondent ordered an electrocardiogram and audiogram without indication.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE
ON MORE THAN ONE OCCASION

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

1. The facts in paragraphs A and A1, A2, A3, A4, A5, A6, A7, and/or A8; B and B1, B2, B3, B4, B5, and/or B6; C and C1, C2, C3, C4, C5, C6, C7, C8, C9, and/or C10; D and D1, D2, D3, D4, D5, D6, D7, D8, D9, D10 and/or D11; E and E1, E2, E3, E4 and/or E5; F and F1, F2 , F3, F4, and/or F5.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE
ON MORE THAN ONE OCCASION

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

2. The facts in paragraphs A and A1, A2, A3, A4, A5, A6, A7, and/or A8; B and B1, B2, B3, B4, B5, and/or B6; C and C1, C2, C3, C4, C5, C6, C7, C8, C9, and/or C10; D and D1, D2, D3, D4, D5, D6, D7, D8, D9, D10, and/or D11; E and E1, E2, E3, E4 and/or E5; and/or F and F1, F2 , F3, F4, and/or F5.

THIRD THROUGH EIGHTH SPECIFICATIONS

FAILING TO MAINTAIN
ADEQUATE RECORDS

The Respondent is charged with professional misconduct pursuant to N.Y. Educ. Law Sec. 6509(9) (McKinney 1985) and within the meaning of 8 N.Y.C.R.R. 29.2(a)(3) (1987) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

3. The facts in paragraphs A and A8.
4. The facts in paragraphs B and B3.
5. The facts in paragraphs C and C4.
6. The facts in paragraphs D and D3.
7. The facts in paragraphs E and E2.
8. The facts in paragraphs F and F2.

DATED: New York, New York
February 7, 1990

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct

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

IN THE MATTER	:	REPORT OF THE
OF	:	HEARING
JOHN KALL JOHN KALLIATHPARAMBIL, MD	.	COMMITTEE

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

Jane C. McConnell, Esq., Chairperson, Daniel Sherber, M.D. and Janice Pride-Boone, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Michael P. McDermott, Esq., Administrative Law Judge, served as Administrative Officer for the Hearing Committee at all the hearings except for the hearing held on April 30, 1990 when Tyrone Butler, Esq., served as Administrative Officer.

After consideration of the entire record, the Hearing Committee submits this report.

Notice Of Hearing And
Statement Of Charges: DATED: February 1, 1990

Answer To The Statement
Of Charges: DATED: February 16, 1990

EXHIBIT "B"

Pre Hearing Conferences:	February 27, 1990
	April 3, 1990
Hearing Dates:	February 27, 1990
	March 20, 1990
	April 3, 1990
	April 17, 1990
	May 1, 1990
	May 15, 1990
	June 5, 1990
	June 26, 1990
Place of Hearing:	New York State Dept. of Health
	8 East 40th Street
	New York, NY 10016
Final Deliberations:	August 10, 1990
	September 7, 1990
Petitioner Appeared By:	Peter J. Millock, Esq.
	General Counsel,
	New York State Dept. of Health
	BY: Daniel Guenzberger, Esq.
	Assistant Counsel, of Counsel

Respondent Appeared By: Garfunkel, Wild & Travis PC
175 Great Neck Road
Great Neck, NY 11021
Robert A. Wild, Esq. and
Judy Eisen, Esq., of Counsel

Rulings On Proposed Amendments
To The Statement Of Charges:

February 27, 1990 — 1 Petitioner moved to amend Charge A(5) to read as follows: On or about November 10, 1983, Respondent treated Patient A for asthma with Elixophyllin, 2 tsp. PO Stat. The dosages of Elixophyllin administered were too low to be effective.

MOTION GRANTED

February 27, 1990 — 2. Petitioner moved to amend Charge C(7) to read as follows: On or about February 7, 1985, Respondent diagnosed tonsillitis

without supporting the diagnosis with cultures of the throat.

MOTION GRANTED

April 30, 1990

3. Petitioner moved to amend the statement of charges as follows:

a) Delete from Charge D(1) "an adequate general history and "

b) Delete from Charge D(3) "past medical history"

c) Delete Charge D(8) in its entirety

d) Delete Charge D(10) in its entirety

e) Delete Charge D(11) in its entirety

f) Delete from Charge E(1) "an adequate general history and"

g) Delete "D(8), D(10) and 1)" from Paragraph (1) of the First Specification

h) Delete "D(8), D(10) and D(11)" from Paragraph (2) of the Second Specification.

MOTION GRANTED

June 26, 1990

4) Petitioner moved to:

a) Amend Charge A(4) to have "December 4, 1984" corrected to read "December 4, 1985

b) Withdraw Charge A(7)

c) Withdraw Charge C(6)

d) Amend Charge C(9) to have "containing **aspirin** to a **febrile** infant is **contraindicated**" to read "containing **aspirin** to <u>this</u>

febrile infant is contraindicated"

e) New updated Petitioner's Ex. 2 substituted for Petitioner's Ex. 2 previously admitted in evidence

MOTIONS GRANTED

June 26, 1990

5. The Parties stipulated that with regard to testimony concerning Patient F, the transcript should be corrected to reflect that those references to "February 7, 1984" were intended to be "February 9, 1984"

GRANTED

SUMMARY OF THE PROCEEDINGS

STATEMENT OF CHARGES: Essentially, the "Statement of Charges" charges the Respondent with practicing the profession with negligence on more than one occasion, with practicing the

profession with incompetence on more than one occasion and with professional misconduct by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patients.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

WITNESSES

Witnesses for the Petitioner:

1. Margaret Lyman, M.D.
2. Eric Vanderbush, M.D.

Witnesses for the Respondent:

1. John Anthony Kall, M.D., (The Respondent)
2. Edward Klibanoff, M.D.
3. Henry M. Frey, M.D.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. John Kall a/k/a John A. Kalliathparambil, M.D. the Respondent, was authorized to practice medicine in New York State on June 20, 1980, by the issuance of license No. 142420 by New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991.

2. The Respondent treated patients A-F at 1577-A Westchester Avenue, Bronx, New York. Another physician worked out of the same office as Dr. Kall on different days of the week. (T. 719). Patients A-F were treated by Dr. Kall and the other physician. Pet. Ex. 4,5,6,7,8,9 and 10)

AS TO PATIENT A

3. During the period September 27, 1983 through August 13, 1985, the Respondent treated Patient A on 15 occasions. (Pet. Ex. 4)

4. Patient A was four years old at the time of her first visit to the Respondent's office on September 27, 1983. The Respondent took a past medical history and recorded that Patient A had had meningitis and febrile convulsions when she was 9 months old (Pet. Ex. 4)

5. On September 27, 1983, Patient A presented with a chief complaint of appetite loss. The Respondent did not record any further information relative to this condition. He recorded immunization as an "impression" but did not follow up on this issue on subsequent visits (Pet. Ex. 4).

6. On November 10, 1983, the Respondent diagnosed Patient A's condition as acute asthma and administered Elixophyllin, 2 tsp., P.O. Stat. He referred the patient to a hospital emergency room because of her condition. The Respondent failed to weigh Patient A at the time of this visit and he failed to ascertain and note any further information regarding the hospital referral in the patient's medical record (Pet. Ex. 4).

7. The Respondent also prescribed Exilophyllin for Patient A on 4 subsequent visits on January 8, 1985, January 29, 1985, February 19, 1985 and December 4, 1985. The Respondent did not weigh the patient on any of these visits (Pet. Ex. 4).

8. To determine the appropriate dosage of Elixophyllin it is necessary to weigh the patient (Tr. 31-33).

9. The Respondent failed to ever evaluate Patient A's response to the anti-asthma medications which he had prescribed (Pet. Ex. 4).

10. The Respondent failed to record in Patient A's medical record the duration of her presenting complaints and symptoms for visits of September 27, 1983, January 10, 1984, April 12, 1984, January 8, 1985, February 19, 1985 and August 13, 1985 (Pet. Ex. 4).

11. The Respondent ordered throat cultures on Patient A on January 10, 1984, April 12, 1984, November 29, 1984, January 8, 1985, January 29, 1985, February 19, 1985 and August 13, 1985. Patient A's medical record does not contain any laboratory reports on the throat cultures and the Respondent did not note the results of the throat culture tests (Pet. Ex. 4).

12. The Respondent ordered no laboratory tests for Patient A other than throat cultures (Pet. Ex. 4).

AS TO PATIENT B

13. During the period November 15, 1983 through November 27, 1984, the Respondent treated Patient B on 4 occasions (Pet. Ex. 5).

14. Patient B was 7 months old at the time of her first visit to the Respondent's office on November 15, 1983. The patient presented with a complaint of fever, cold and nose blocked which was of three days duration. Her temperature was 98 degrees. The Respondent did not record any further medical history and failed to weigh the child (Pet. Ex. 5).

15. On February 8, 1984, Patient B, who was then 10 months old, presented with a complaint of fever of two days duration. She had a temperature of 104 degrees. The Respondent did not weigh the patient nor did he record

any further medical history. The Respondent prescribed Utimox (Amoxicillion) 250 mg. every eight hours for 10 days (Pet. Ex. 5).

16. The average weight of a 10 month old female child is 9 kg.(Pet. Ex. 10). The recommended daily dosage of Amoxicillin for a patient weighing 9 kg. with a severe infection is 360 mg.(Tr. 231). The Respondent prescribed a daily dosage of 750 mg. for Patient B on February 8, 1984 (Pet. Ex. 5).

17. On November 27, 1984, Patient B. who was then 19 months old, presented with a complaint of fever and cough. The Respondent did not note the duration of the patient's symptoms in the medical record. He did not weigh the patient nor did he record any further medical history. The respondent prescribed Utimox (Amoxicillin) 250 mg. every eight hours for 10 days (Pet. Ex. 5).

18. The average weight for a 19 month old female child is 11 kg. (Pet. Ex. 10). The recommended daily dosage of Amoxicillin for a patient weighing 11 kg., who presented with Patient B's condition is 330 mg. (Tr. 236). The Respondent prescribed a daily dosage of 750 mg. of Amoxicillin for Patient B on November 27, 1984 (Pet. Ex. 5).

19. The Respondent did not record a weight for Patient B on any of her visits. He did not record any history of immunizations nor any information concerning the patient's growth and development (Pet. Ex. 5).

20. The Respondent ordered throat cultures on Patient B on January 26, 1984, February 8, 1984 and November 27, 1984. Patient B's medical record does not contain any laboratory reports on the throat cultures and the Respondent did not note the results of the throat culture tests (Pet. Ex. 5).

21. The Respondent ordered no laboratory test for Patient B other than throat cultures (Pet. Ex. 5).

AS TO PATIENT C

22. During the period February 7, 1985 through August 9, 1986 the Respondent treated Patient C on 9 occasions. The Respondent did not record a patient weight during the entire course of treatment (Pet. Ex. 6).

23. Patient C was 1 1/2 years old at the time of her first visit to the Respondent's office on February 7, 1985. The patient presented with a complaint of fever, cough and eye discharge. The Respondent did not record the duration of the patient's symptoms. He made a diagnosis of acute tonsillitis without ordering a throat culture, and prescribed Utimox (Amoxicillin) 250 mg. every 8 hours for 10 days (Pet. Ex. 6).

24. On visits on February 7, 1985, March 26, 1985, September 26, 1985, February 8, 1986 and May 10, 1986, when Patient C was between 1 1/2 years and 2 years 11 months old, the Respondent prescribed Utimox (Amoxicillin) 250 mg. every 8 hours for 10 days (Pet. Ex. 6).

25. On visits on January 16, 1986 when Patient C was 2 1/2 years old and August 9, 1986, when Patient C was 3 years old, the Respondent prescribed Utimox (Amoxicillin) 375 mg. every eight hours for 10 days (Pet. Ex. 6).

26. On April 30, 1985, Patient C presented with a complaint of fever, cough and skin rash. The Respondent did not record the duration of the symptoms, the extent of the fever nor what products (medications, soaps, lotions, etc.) which may have been recently applied to the patient's skin. The Respondent did not describe the location or extent of the rash (Pet. Ex. 6).

27. On January 16, 1986, Patient C presented with a complaint of fever, vomiting and an additional complain which is illegible on the chart. She had a fever of 101 degrees. The Respondent prescribed ASA 5 gr. suppositories.

28. On March 15, 1986, Patient C presented with a complaint of diarrhea and vomiting of one day duration. The Respondent made a diagnosis of mild dehydration and prescribed a compound medication of Levsin, Paregoric and Kaopectate, 64 oz. of Pedialyte and Compazine (Pet. Ex. 6)

AS TO PATIENT D

29. During the period November 26, 1983 through September 26, 1986, the Respondent treated Patient D on 15 occasions. Patient D was 33 years old at the time of her first visit to the Respondent's office on November 26, 1983 (Pet. Ex. 7).

30. On March 27, 1984, the Respondent prescribed Fastin for Patient D. He also prescribed Sudafed. No weight, pulse or blood pressure were record. No comprehensive weight reduction program was recorded (Pet. Ex. 7; Tr. 411 - 412).

31. The possible side effects of Sudafed include nervousness and palpitations and are similar to those of Fastin (Tr. 413 - 414).

32. On April 17, 1984, Patient D presented with a chief complaint of abdominal pain. The Respondent did not ascertain if Patient D had a past history of abdominal pain and there is no evidence that the Respondent performed a physical examination (Pet. Ex. 7; Tr. 417). There was no recording of any side effects or reactions to the medications, including Fastin, which were previously prescribed on March 27, 1984, nor was the patient's weight recorded (Pet. Ex. 7; Tr. 1055 - 1056).

33. On May 8, 1984, Patient D presented with a complaint of abdominal pain and fever. The Respondent suspected that the cause of Patient D's abdominal pain was peptic ulcer disease, ("PUD") (Pet. Ex. 7).

34. On June 5, 1984, Patient D presented with a complaint of right upper quadrant pain. The Respondent prescribed Compazine, Tagamet, Mylanta and Bentyl (Pet. Ex. 7).

35. On June 5, 1984, the Respondent also ordered an upper GI series and an oral cholecystogram to confirm his suspicion of peptic ulcer disease and to rule out gall bladder disease (Pet. Ex. 7).

36. On July 26, 1984, the Respondent continued to treat Patient D for abdominal pain. He reported that the upper GI series and the oral cholecystogram which he had ordered on June 5, 1984 were negative (Pet. Ex. 7).

37. On January 3, 1985, the Respondent diagnosed Patient D as suffering from an upper respiratory infection and prescribed Septra, Chlor-Trimeton, Neo-Synephrine, Elixir of Terpin Hydrate with Codeine, Tagamet, Mylanta and Motrin (Dept. Ex. 7).

38. On the occasion of Patient D's visits on November 26, 1983 and January 15, 1985, the Respondent recorded the Patient's complaints, but failed to record the durations of the chief complaint. The Respondent did record a medical history (Pet. Ex. 7; Tr. 408, 435).

39. There is nothing in Patient D's medical record which indicates that the Respondent ever sought consultation with a Gastroenterologist with regard to Patient D's complaints of abdominal pain. However, the record does indicate that the patient was under the care of a Obstetrician-Gynecologist (Pet. Ex. 7).

AS TO PATIENT E

40. During the period November 29, 1983 through August 12, 1986, the Respondent treated Patient E on 11 occasions. Patient E was 31 years old at the time of the first visit to the Respondent's office on July 29, 1983 (Pet. Ex. 8).

41. On April 10, 1984, October 18, 1984, January 17, 1985 and November 21, 1985 the Respondent treated Patient E for upper respiratory infection ("URI"). The Respondent did not take and record Patient E's temperature on these visits (Pet. Ex. 8).

42. On April 10, 1984, October 18, 1984, December 15, 1984 and August 22, 1985, the Respondent ordered throat cultures for Patient E. Patient E's medical record does not contain any laboratory reports on the throat cultures and the Respondent did not note the results of the throat culture tests (Pet. Ex. 8).

43. On December 15, 1984 and January 17, 1985 the Respondent administered intra-muscular Procaine Penicillin and an oral antibiotic to Patient E for the treatment of an upper respiratory infection (Pet. Ex. 8).

44. On November 21, 1985, the Respondent diagnosed Patient E as having a urinary tract infection. He did not order a urinalysis or a urine culture (Pet. Ex. 8; 874).

AS TO PATIENT F

45. During the period November 10, 1983 through February 9, 1984 the Respondent treated Patient F on 4 occasions. Patient F was 26 years old at the time of her first visit to the Respondent's office on November 10, 1983 (Pet. Ex. 9).

46. On November 10, 1983, Patient F presented with a chief complaint of headaches for 2 years. The Respondent recorded an impression of migraine headache. He also recorded an impression of anxiety reaction. He prescribed Fiorinal with Codeine and Tranxene and ordered an electrocardiogram and an audiogram. He prescribed Fiorinal with Codeine again on February 9, 1984 (Pet. Ex. 9).

47. On November 10, 1983, the Respondent did not record the character and location of Patient F's headache, any associated symptoms and any prior history of treatment. He did not record any details of Patient F's history relating to the cause of anxiety (Pet. Ex. 9).

CONCLUSIONS

AS TO PATIENT A

1. On Patient A's initial visit on September 27, 1983, the Respondent failed to take a complete and adequate past medical history of Patient A's chief complaint. He should have determined the duration of the appetite loss, how the appetite loss began, caloric intake and medical history of Patient A's chief complaint. He should have also determined the source of Patient A's previous health care (Pet. Ex. and Tr. 22-27).

2. The physical examination which the Respondent performed on Patient A on September 27, 1983 was adequate under the circumstances.

3. At the time of the initial visit Dr. Kall did not have a previous immunization record for Patient A and did not know what immunizations were indicated. He did note that immunization was a problem "impression" and asked the patient to return in one week. On all subsequent visits the patient presented with acute illnesses when immunizations would have been inappropriate (Pet. Ex. 4 Tr. 276).

4. On the visit of November 10, 1983 the Respondent recorded a family history of asthma and the fact that the patient had a past history of this illness. However, he did not explore the possibilities of alternative treatment or the effectiveness of his past treatment (Pet. Ex. 4 Tr. 54).

5. The Hearing Committee concludes that a consultation with a specialist was not indicated in the Respondent's treatment of Patient A for asthma.

6. The dosage of Elixophyllin administered by the Respondent to Patient A on November 10, 1983 was on the low side but was appropriate under the circumstances since the patient was referred to a hospital emergency room for treatment and follow up (Pet. Ex. 4 Tr. 103, 1183).

7. The Respondent ordered throat cultures on Patient A on seven occasions. The evidence in the record is contradictory, inconclusive and insufficient for the Hearing Committee to determine whether the Respondent failed to follow up on the performance and results of the throat cultures.

AS TO PATIENT B

8. The Hearing Committee concludes that the Respondent performed adequate physical examinations on each of Patient B's four visits considering that he was treating the patient for acute unrelated episodes. However, the patients weight should have been taken to determine the appropriate dosage of medications as well as to determine the overall development and growth of the child.

9. The Respondent took adequate histories of Patient B's presenting complaints and related symptoms on three of the visits, but failed to do so on the visit of February 8, 1984.

10. Patient B's visits were all for acute episodic illnesses when immunizations are generally contraindicated (Tr. 276).

11. The Respondent ordered throat cultures on Patient B on three occasions. The evidence on the record is contradictory, nconclusive and insufficient for the Hearing Committee to determine if the Respondent failed to follow up on the performance and results of the throat cultures.

12. On two occasions, February 8, 1984 and November 27, 1984 the Respondent prescribed dosages of Utimox (Amoxicillin) 250 mg. which were excessive. However, Amoxcillin in the daily dosages prescribed (750 mg.), generally has no deleterious side effects except perhaps for a mild diarrhea.

AS TO PATIENT C

13. The Respondent performed adequate physical examinations on each of Patient C's visits considering that he was treating the patient for acute unrelated episodes.

14. Since these were unrelated episodic visits, it was unnecessary for the Respondent to evaluate treatments rendered in prior visits.

15. The medical histories obtained by the Respondent were adequate except for the duration and severity of the complaints on the visits of February 7, 1985 and April 30, 1985.

16. The Respondent failed to ascertain immunizations needed by the patient, however all of Patient C's visits were for acute episodic illnesses when immunizations are generally contraindicated.

17. It is not routinely necessary to have a throat culture to make a diagnosis of tonsillitis.

18. It is not clear from the testimony of the medical experts whether the practice of avoiding aspirin products in all febrile infants was the standard of care in 1986. Thus, the Hearing Committee cannot conclude that the use of aspirin in the particular clinical setting of January 16, 1986, was in fact contraindicated.

18a. The treatment employed by the Respondent on March 18, 1986 in treating Patient C's mild dehydration was standard and there is no evidence that he failed to hydrate this patient.

AS TO PATIENT D

19. The Hearing Committee concludes that Respondent generally took adequate histories relating to the Patient D's specific complaints and symptoms. However on two occasions, November 26, 1983 and January 15, 1985 the Respondent failed to record the duration of the chief complaint.

20. The Respondent's physical examinations of Patient D were adequate, however no physical examination is reported for the visit of April 17, 1984.

21. The Respondent recorded and/or filed all laboratory reports in Patient D's medical chart.

22. The Respondent prescribed Fastin for Patient D on March 27, 1984. Such prescribing is inappropriate without proper monitoring and a comprehensive program of weight reduction.

23. The Respondent prescribed both Fastin and Pseudoephedrine on March 27, 1984. The combined use of the two medications is inappropriate when used without appropriate monitoring and follow up.

24. The Respondent ordered appropriate studies and treatment for Patient D's complaints of abdominal pain and consultation with a specialist was not indicated.

25. The Respondent's treatment of Patient D on June 5, 1984 for right upper quadrant pain by prescribing Compazine, Tagamet, Mylanta and Bentyl was not unreasonable.

26. The Respondent's treatment of Patient D on January 3, 1985 for an upper respiratory infection by prescribing Septra, Chlor-Trimeton, Neo-Synephrine, Elixir of Terpin Hydrate with Codeine, Tagamet, Mylanta and Motrin was not unreasonable.

AS TO PATIENT E

27. The Respondent took adequate histories relating to Patient E's specific complaints and symptoms.

28. The Respondent maintained adequate records of Patient E's past medical history, presenting complaints and symptoms, and the results of physical examinations. The medical record contains all laboratory reports except for throat culture reports.

29. The Respondent's administration of IM Procaine Penicillin to Patient E on the visits of December 15, 1984 and January 17, 1985 for the treatment of upper respiratory infection was not inappropriate.

30. The Respondent ordered throat cultures on Patient E on four occasions. The evidence in the record is contradictory, inconclusive and insufficient for the Hearing Committee to determine whether the Respondent failed to follow up on the performance and results of the throat cultures.

31. On November 21, 1985, after making appropriate clinical observations, the Respondent diagnosed Patient E's condition as urinary tract infection but he failed to obtain a urinalysis or a urine culture when laboratory services were available.

AS TO PATIENT F

32. The Respondent took an adequate general history and adequate histories relating to Patient F's specific complaints and symptoms on the visits November 10, 1983 and February 9, 1984.

33. The Respondent maintained adequate records of Patient F's past medical history, presenting complaints and symptoms and the results of physical examinations. The Respondent also recorded laboratory results and/or laboratory reports in Patient F's file.

34. On November 10, 1983 the Respondent diagnosed Patient F's condition as anxiety reaction and prescribed Tranxene accordingly.

35. On November 10, 1983 the Respondent also diagnosed Patient F as having migraine headache and prescribed Fiorinal with Codeine No. 3 which was appropriate.

36. The electrocardiogram and audiogram which the Respondent ordered for Patient F on November 10, 1983 were not indicated.

The Hearing Committee Votes as Follows:

FIRST SPECIFICATION	(Practicing with Negligence on More Than One Occasion) NOT SUSTAINED
SECOND SPECIFICATION	(Practicing with Incompetence On More Than One Occasion) NOT SUSTAINED
THIRD through EIGHT SPECIFICATION	(Failing to Maintain Adequate Records NOT SUSTAINED

RECOMMENDATIONS

The Hearing Committee is aware that (a) the use of Amoxicillin dosages in the pediatric patients was excessive; (b) the use of Fastin in Patient D without the use of a comprehensive weight loss program and monitoring was inappropriate; (c) the electrocardiogram and audiogram ordered by the Respondent for Patient F were not indicated and (d) there are shortcomings in the Respondent's records and office procedures.

Nevertheless, the Hearing Committee, upon deliberating on these issues, concludes that these instances do not rise to a level sufficient to sustain charges of negligence, incompetence or failure to maintain adequate records.

The Respondent's medical records were generally illegible, making it difficult to evaluate patient care without the Respondent deciphering his notes. All of the medical experts called by the Petitioner and the Respondent needed assistance in interpreting the medical records. These experts accepted the Respondent's explanations in the majority of such instances, as did the Hearing Committee, because the explanations were reasonable and were not refuted.

The Hearing Committee believes that if the Respondent had maintained legible records there would have been no need for this disciplinary hearing;

Although the Hearing Committee finds that the Charges against the Respondent are NOT SUSTAINED and recommends that the Charges be DISMISSED, the Hearing Committee also recommends that the Respondent be admonished to maintain legible medical records in the future. The Hearing Committee also encourages the Respondent to participate in annual pediatric infectious disease update courses if he intends to continue seeing pediatric patients in the future.

DATED: New York, New York
Oct 1, 1990

Respectfully Submitted

Jane C. McConnell

Jane C. McConnell, Esq. Chairperson

Daniel Sherber, M.D.
Janice Price-Boone, M.D.

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

IN THE MATTER :

OF :

JOHN KALL :

JOHN KALLIATHPARAMBIL, M.D. :

COMMISSIONER'S RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on February 27, 1990, March 20, 1990, April 3, 1990, April 17, 1990, May 1, 1990, May 15, 1990, June 5, 1990 and June 26, 1990. Respondent, John Kall (Kalliathparambil), M.D., appeared by Robert A. Wild, Esq. The evidence in support of the charges against the Respondent was presented by Daniel Guenzberger, 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. However, based on the Committee's own conclusions, the charges against the Respondent of negligence and incompetence on more than one occasion (Specifications First and Second) should be sustained. The Committee concluded that Respondent

- should have determined the duration of Patient A's appetite loss, how the appetite loss began, Patient A's caloric intake, the medical

EXHIBIT "C"

history of Patient A's chief complaint, and the source of Patient A's previous health care (Conclusion 1)

- did not have a previous immunization record for Patient A and did not know what immunizations were indicated (Conclusion 3)
- did not explore the possibilities of alternative treatment for Patient A's asthma or the effectiveness of his past treatment (Conclusion 4)
- should have taken Patient B's weight (Conclusion 8)
- took an inadequate history of Patient B (Conclusion 9)
- on two occasions, prescribed excessive doses of Amoxicillin to Patient B (Conclusion 12)
- on two occasions, obtained inadequate medical histories from Patient C (Conclusion 15)
- did not ascertain immunizations needed by Patient C (Conclusion 16)
- inappropriately prescribed Fastin to Patient D (Conclusion 22)
- inappropriately prescribed both Fastin and Pseudophedrine to Patient D (Conclusion 23)
- failed to obtain a urinalysis or a urine culture from Patient E (Conclusion 31); and
- ordered electrocardiogram and audiogram for Patient F which were not indicated (Conclusion 36).

These conclusions demonstrated repeated instances of inappropriate and inadequate care to pediatric and adult patients. They support both Specifications First and Second as follows:

Paragraphs	A1	(Conclusion 1)
	A4 (in part)	(Conclusion 4)
	B1	(Conclusion 9)
	B2	(Conclusion 8)
	B6	(Conclusion 12)
	C3	(Conclusion 16)
	C4 (in part)	(Conclusion 15)
	D4	(Conclusion 22)
	D5	(Conclusion 23)
	E5 (in part)	(Conclusion 31)
	F5	(Conclusion 36)

Thus, the Committee's Conclusions support, and I so conclude, that Respondent practiced negligently with respect to Patients A through F and incompetently with respect to those patients.

B. In lieu of the Committee's recommendation, I recommend that Respondent's license be suspended for one year and that suspension stayed provided that Respondent enrolls in a remedial course in primary care of at least three months duration acceptable to the Office of Professional Medical Conduct. If the Respondent fails to complete the approved course, the stay will be removed and the suspension reinstated.

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 described above.

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

DATED: Albany, New York

November 21, 1990

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

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

JOHN KALL
a/k/a JOHN A. KALLIATHPARAMBIL

CALENDAR NO. 11549

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 be in compliance with the standards of conduct prescribed by the law governing respondent's profession;

   b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid,

that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. That respondent shall, at respondent's expense, enroll in and diligently pursue a course of training for infectious diseases, said course of training to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, and to be satisfactorily completed during the period of probation, such completion to be verified in writing and said verification to be submitted to the Director of the Office of Professional Medical Conduct;

3. That respondent shall, at respondent's expense, enroll in and diligently pursue a course of training in recordkeeping, said course of training to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, and to be satisfactorily completed during the period of probation, such completion to be verified in writing and said verification to be submitted to the Director of the Office of Professional Medical Conduct;

4. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

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

JOHN KALL
a/k/a JOHN A. KALLIATHPARAMBIL

CALENDAR NO. 11549

The University of the State of New York

IN THE MATTER

OF

JOHN KALL
a/k/a JOHN A. KALLIATHPARAMBIL
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11549

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11549, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (March 22, 1991): That, in the matter of JOHN KALL a/k/a JOHN A. KALLIATHPARAMBIL, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's findings of fact, as set forth in its report at pages 8 through 14, and the Commissioner of Health's recommendation as to those findings be accepted;
2. The hearing committee's conclusions, as set forth in its report at pages 14 through 18, and the Commissioner of Health's recommendation as to those conclusions be accepted;
3. The hearing committee's vote upon each of the specifications, as set forth in its report at page 19, not be accepted;
4. The Commissioner of Health's recommendation as to guilt be accepted;
5. Respondent is guilty, by a preponderance of the evidence, of the first and second specifications of the charges to

the extent indicated by the Commissioner of Health and not guilty of the remaining allegations;

6. The recommendation of the hearing committee to dismiss the specifications of the charges not be accepted;

7. The recommendation of the Commissioner of Health as to the measure of discipline be modified; and

8. In partial agreement with the Commissioner of Health, respondent's license to practice as a physician in the State of New York be suspended for one year upon each specification of the charges of which respondent was found guilty, said suspensions to run concurrently, and that the execution of said suspensions be stayed at which time respondent be placed on probation for a period of one year under the terms prescribed by the Regents Review Committee, which include courses of training in infectious diseases and recordkeeping;

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 28th day of March, 1991.

Thomas Sobol

Commissioner of Education