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

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

February 1, 1991

Joseph S. Matala, Physician
99 Rolling Hills Drive
West Seneca, N.Y. 14224

Re: License No. 089376

Dear Dr. Matala:

Enclosed please find Commissioner's Order No. 11346. 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: Joseph V. McCarthy, Esq.
1620 Liberty Bldg.
Buffalo, N.Y. 14202

REPORT OF THE
REGENTS REVIEW COMMITTEE

JOSEPH S. MATALA

CALENDAR NO. 11346

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

JOSEPH S. MATALA **No. 11346**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

JOSEPH S. MATALA, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on February 24, May 4, May 18, and November 10, 1989 hearings were held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of the first specification of the charges based on gross negligence

and gross incompetence to the extent indicated in its report, the second specification of the charges based on gross negligence and gross incompetence, the third specification of the charges based on gross negligence and gross incompetence, the fourth specification of the charges based on gross negligence and gross incompetence, and the fifth specification of the charges based on negligence on more than one occasion and incompetence on more than one occasion to the extent indicated in its report. The charge of incompetence on more than one occasion with respect to patient D was withdrawn. The hearing committee recommended that respondent's license to practice as a physician in the State of New York be revoked.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted, and that the recommendation of the hearing committee be rejected as indicated in his recommendation. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On November 7, 1990 respondent appeared before us in person, and was represented by an attorney, Joseph V. McCarthy, Esq., who appeared before us and presented oral argument on respondent's behalf. Kevin P. Donovan, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation, which is the same as the

Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State of New York be suspended for five years, and such suspension should be stayed provided that respondent's care to all of his obstetrical patients is monitored by a board certified obstetrician approved by the Office of Professional Medical Conduct.

Respondent's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was: "As originally recommended by the State two (2) years suspension, stayed, with monitoring of obstetrical patients".

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's October 24, 1990 letter and petitioner's October 31, 1990 reply thereto.

We agree with the hearing committee's findings and conclusions and find that they are appropriately based on the evidence in the record and that they reflect a proper evaluation of respondent's actions.

With regard to the measure of discipline, we agree with the hearing committee that revocation is appropriate in this case. Respondent's misconduct consists of negligence on more than one occasion, incompetence on more than one occasion, gross negligence, and gross incompetence. Such misconduct cannot be adequately

addressed in this case by the five year conditionally stayed suspension recommended by the Commissioner of Health. In this regard, it is noted that such a conditional stay is not authorized by statute. Furthermore, we do not agree with the Commissioner of Health's rationale that respondent's training and board certification call for a lesser penalty than revocation. Respondent, despite his training and credentials, has committed conspicuously bad conduct that represents a serious departure from minimal standards of medical practice. In our unanimous opinion, revocation is the appropriate penalty under the circumstances of this case.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to those findings of fact and conclusions be accepted;
2. The hearing committee's recommendation as to the measure of discipline be accepted, and the Commissioner of Health's recommendation as to the measure of discipline not be accepted;
3. Respondent be found guilty, by a preponderance of the evidence, of the first specification of the charges based on gross negligence and gross incompetence to the extent

indicated in the hearing committee report, the second specification of the charges based on gross negligence and gross incompetence, the third specification of the charges based on gross negligence and gross incompetence, the fourth specification of the charges based on gross negligence and gross incompetence, and the fifth specification of the charges based on negligence on more than one occasion and incompetence on more than one occasion to the extent indicated in the hearing committee report; and

4. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which we recommend respondent be found guilty.

Respectfully submitted,

GERALD J. LUSTIG, M.D.

MELINDA AIKINS BASS

PATRICK J. PICARIELLO

Chairperson

Dated: January 8, 1991

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
JOSEPH S. MATALA, M.D.	:	CHARGES

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JOSEPH S. MATALA, M.D., the Respondent, was authorized to practice medicine in New York Sate on September 10, 1962 by the issuance of license number 089376 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 99 Rolling Hills Drive, West Seneca, New York 14224.

FACTUAL ALLEGATIONS

A. With respect to Patient A (Patient A and all other patients are identified in Appendix A), treated by the Respondent in the Respondent's office at 531 Center Road, West Seneca, New York, for an intrauterine pregnancy, including both prenatal and post-partum care, from approximately February 24, 1987 to December 8, 1987, the Respondent:

1. Failed to adequately take and/or record Patient A's blood pressure during the prenatal period;
2. Failed to perform a post-partum Pap test as indicated;

3. Failed to adequately investigate Patient A's trichomonas in the post-partum period;

4. Performed a cervical cauterization on or about December 8, 1987 which was unnecessary and improper;

5. Performed the above-mentioned cervical cauterization without obtaining Patient A's informed consent;

6. Failed to adequately document the indications for or performance of the above-mentioned cervical cauterization;

B. With respect to Patient B, admitted to Mercy Hospital, Buffalo, New York on or about June 25, 1985, upon whom the Respondent performed a dilitation and curettage followed by an exploratory laporotomy, the Respondent:

1. Failed to recognize the possibility of an ectopic pregnancy in a timely manner;

2. Failed to appropriately treat complications following dilitation and curettage.

C. With respect to Patient C, admitted to Mercy Hospital on or about May 1 and May 13, 1980, for oxytocin challenge tests, and on May 15, 1980 for delivery of an intrauterine pregnancy, upon whom the Respondent performed an emergency C-section on May 15, the Respondent:

1. Failed to perform the second oxytocin challenge test in a timely manner;

2. Failed to deliver the pregnancy in a timely manner.

D. With respect to Patient D, admitted to Mercy Hospital on or about January 7 and January 16, 1975 for "hyperemesis", and on or about January 21, 1975 for delivery of an intrauterine pregnancy, the Respondent:

1. Failed to investigate possible diabetes during the gestational period;

2. Failed to diagnose diabetes during the gestational period.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGENCE AND/OR

GROSS INCOMPETENCE

The Respondent is charged with professional misconduct by reason of practicing the medical profession with gross negligence and/or gross incompetence within the meaning of N.Y. Education Law §6509(2) (McKinney 1985) in that the Petitioner alleges:

1. The facts contained in Paragraph A.
2. The facts contained in Paragraph B.
3. The facts contained in Paragraph C.
4. The facts contained in Paragraph D.

FIFTH SPECIFICATION

NEGLIGENCE AND/OR INCOMPETENCE

ON MORE THAN ONE OCCASION

The Respondent is charged with professional misconduct by reason of practicing the medical profession with negligence and/or incompetence on more than one occasion within the meaning of N.Y. Education Law §6509(2) (McKinney 1985), in that the Petitioner alleges

5. The facts contained in two or more of Paragraphs A and A(1), A(2), A(3), A(4), A(5), A(6), B and B(1), B(2), C and C(1), C(2), D and D(1) and/or D(2).

WITHDRAW INCOMPETENCE ON MORE THAN ONE OCCASSION WITH REGARD TO (D) PATIENT D

11/10/89

DATED: Albany, New York
January 23, 1989

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical
Conduct

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

IN THE MATTER	:	HEARING
OF	:	COMMITTEE
JOSEPH S. MATALA	:	REPORT

TO: THE HONORABLE DAVID AXELROD, M.D.
Commissioner of Health, State of New York

The undersigned Hearing Committee (the Committee) consisting of Priscilla R. Leslie R.N.P., Chairperson, John P. Frazer, M.D. and Lemuel A. Rogers, M.D. was duly designated and appointed by the State Board for Professional Medical Conduct (the Board). Jonathan M. Brandes, Administrative Law Judge served as Administrative Officer.

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

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

RECORD OF PROCEEDINGS

Statement of Charges dated:	January 23, 1989
Notice of Hearing returnable:	
Place of Hearing:	Buffalo, New York
Respondent served with copy of Notice of Hearing and Charges:	Service Admitted February 24, 1989
The State Board for Professional Medical Conduct appeared by:	Ralph Bavaro, Esq. and Paul R. White, Esq. Associate Counsel Office for Professional Medical Conduct Albany, New York
The Respondent appeared in person and was represented by:	Maloney, Gallup, Roach Brown & McCarthy, P.C. Joseph V. McCarthy, Esq. of Counsel 1620 Liberty Bldg. Buffalo, New York 14202
Respondent's present address:	99 Rolling Hills Drive West Seneca, New York 14202
Hearings held on:	February 24, 1989 May 4, 1989 May 18, 1989 November 10, 1989
Briefs submitted:	January 5, 1990
Deliberations held:	January 11, 1990
Record closed:	January 5, 1990

SUMMARY OF PROCEEDINGS

1. The Statement of Charges alleges that the Respondent has committed acts which evidence gross incompetence, gross

negligence, and negligence and/or incompetence on more than one occasion. The allegations arise from the treatment of some four patients. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

2. The Petitioner called these witnesses:

Fred Storm, M.D.	Medical Director Upper Hudson Planned Parenthood Board certified obstetrician/gynecologist
M.G.	Patient/fact witness

3. Respondent testified on his own behalf and called these witnesses:

William P. Dillon, M.D.	Associate Professor of Obstetrics and Gynecology SUNY Buffalo Board certified maternal/fetal medicine and obstetrician/gynecologist expert witness

LEGAL DISCUSSION BY THE ADMINISTRATIVE OFFICER

Respondent has moved to dismiss this matter citing laches, statute of limitations and/or unreasonable delay. As a first point it must be noted that the Commissioner has prohibited dismissal of charges under 10 NYCRR 51.9 (d)(2). Furthermore under 10 NYCRR 51.11 (d)(10)(i) and (ii), where the time period between the date of the notice of hearing and the date of the first day of hearing is one year or less a claim of unreasonable delay shall be denied. The notice of hearing in this case is dated

January 23, 1989 and the first date of hearing was held on February 24, 1989. Thus Respondent's claim of delay cannot be considered pursuant to 10 NYCRR 51.11.

Nevertheless, a brief discussion of this legal issue follows: The Appellate Courts in this state have consistently rejected appeals, in matters of professional discipline, based solely upon time delay whether argued as laches, statute of limitation or a violation of the State Administrative Procedure Act (SAPA). See, Wolf v. Ambach, 95 AD2d 877 (3rd Dept, 1983); Chaplan v. Ambach, 91 A.D.2d 736 (3rd Dept, 1982); Fishman v. Ambach, 98 AD2d 854 (3rd Dept, 1983); Erdos v. N.Y.S. Department of Education, 105 AD2d 504 (3rd Dept, 1984), lv to appeal den. 64 NY2d 604 (1985); Matter of Axelrod, 103 AD2d 1007 (4th Dept, 1984); Sinha v. Ambach 91 AD2d 703 (3rd Dept, 1982).

It was generally within the province of the presiding officer to grant relief where a party could show significant and definite prejudice in the conduct of litigation arising from the passage of time. In 1985, the Court of Appeals affirmed this concept in Cortlandt Home v. Axelrod (66 NY2D 169). In Cortlandt the court stated: "the passage of time, standing alone, does not, (...) serve as a basis for judicial intervention, with prermptory effect, into the administrative process." (66 NY2d at 177). The court went on to say that if relief is to be granted a party must show any alleged administrative delay has "significantly and irreparably harmed (the party) in mounting a defense." The

context of the Court's remarks make it clear that relief can only be granted where the passage of time has made testimony and/or evidence of a significant nature, unavailable.

In this case, the alleged delay has not resulted in any apparent prejudice to Respondent. The State's case was based almost entirely on medical records. Respondent had ample opportunity to examine the medical records, comment upon, them and cross-examine the Department's medical expert. At no time did Respondent prove, or even allege, that through the passage of time he had lost access to any relevant witness or evidence. Indeed, with regard to review of the records, Respondent and his expert were on at least an equal plane with Petitioner and Petitioner's expert with regard to marshalling and assessing the evidence.

Accordingly, Respondent's motion for relief due to administrative delay is denied.

FINDINGS OF FACT WITH REGARD TO PATIENT A

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. The Hearing Committee unanimously reached each of the following findings of fact unless otherwise noted.

PATIENT A

A1. Patient A, a twenty-four year old female, was treated by Respondent for obstetric and gynecological care between February 1987 and December 1987 (Exhibit 2).

A2. Patient A first came to Respondent's office on February 24, 1987, at which time Patient A was approximately four months pregnant, i.e., her last menstrual period was October 26, 1986 (Exhibit 2, p. 16; Exhibit 3).[1]

A3. During the office visit of February 24, 1987, Respondent performed a Pap test on Patient A (Exhibit 2, p. 16). Patient A had no signs or symptoms of a Trichomonas infection on February 24, 1987 (T. 33; Exhibit 2, p. 16). However, the results of the Pap test, reported on February 26, 1987 revealed a Trichomonas infection (T. 57, 60; Exhibit 3). On March 6, 1987, Respondent prescribed Sultrin vaginal cream for the Trichomonas infection (T. 23; Exhibit 2, p. 16).

A4. Sultrin vaginal cream is not the treatment of first choice for a Trichomonas infection. The optimal treatment is an

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[1] Note that Exhibit 2 and Exhibit 3 are both copies of the Respondent's office record for Patient A. The exhibits are substantially identical. Exhibit 3, however, contains a laboratory report of a February 24, 1987 pap test, whereas Exhibit 2 does not. Also, the prenatal record contained in Exhibit 3 (next to last page) reflects three office visits for Patient A (July 24, July 31, and August 10, 1987), not reflected on Exhibit 2, p. 16.

antibiotic which was not prescribed because of Patient A's pregnancy (74-75, 91).

A5. Patient A had ten prenatal office visits (Exhibit 3). The prenatal record indicates that Patient A's blood pressure was not taken at each visit. The record shows blood pressures taken on February 24, March 24, May 26, June 11, and June 25, 1987 (T. 524; Exhibit 2, p. 16, Exhibit 3). The prenatal record is consistent with Patient A's recollection that her blood pressure was not taken on every office visit (T. 31).

A6. The primary purpose of monitoring a blood pressure prenatally is to provide a baseline in order to be able to detect the development of preeclampsia, a very serious condition in pregnancy. Blood pressure should be monitored at each prenatal visit (T. 66-71, 91, 524).

A7. Patient A delivered her baby without incident on August 20, 1987 (T. 20).

A8. Patient A saw Respondent for her first post-partum office visit on September 22, 1987. During this six-week check-up, Respondent performed an internal examination and prescribed birth control pills for Patient A. Respondent did not perform a Pap test (20-21, 55-56; Exhibit 2, p. 22).

A9. Patient A next made contact with Respondent in early December 1987. Patient A telephoned Respondent's office and complained of irregular vaginal bleeding. An office appointment was made by December 8, 1987 (T. 21-22).

A10. On December 8, 1987, Patient A went to the Respondent's office. Patient A checked-in with Respondent's receptionist and was handed a prescription by the receptionist for Sultrin vaginal cream (T. 22-23; Exhibit 4). Patient A was asked to enter an examining room and prepare for an internal examination. Patient A did so and waited for Respondent to enter (T. 23-24, 57).

A11. Respondent entered the examining room. The following discussion occurred between the Respondent and Patient A in the examination room:

> Respondent asked Patient A some questions about her condition. Patient A was situated on examining table with legs up in stirrups and Respondent placed a metal plate under her buttocks. Patient A noticed a small tool in Respondent's hand. Respondent told Patient A he was about to cauterize her cervix. Patient A sat straight up and asked Respondent why she was being cauterized; Respondent simply told her it was necessary. Patient A asked Respondent on what he based his conclusion; Respondent said he could tell by looking. Respondent did not provide a further explanation or state what he saw; Respondent became agitated and told Patient A that she was questioning his judgment and that if she didn't want the cauterization performed, he would not perform it; Patient A asked for a brief explanation of the procedure; Respondent said many women have cauterization done, that it's done on a regular basis, and that many women who have cauterization never get cervical cancer (T. 24-25, 27-29, 43-51, 57-58, 410).

A12. Respondent was in the examination room with Patient A for a total of approximately 10 minutes at the time he performed the cauterization (T. 29-30, 57-58, 419).

A13. In the examining room immediately following the cauterization, there was discussion about whether Patient A had read the package insert that accompanied her birth control pills. There was further discussion about cigarette smoking and its relation to irregular vaginal bleeding (T. 25-27, 59). Respondent gave Patient A a prescription for Ortho-Novum, which was a different birth control pill than had previously been prescribed. Respondent told Patient A she was due for her next annual Pap test in March 1988, but she should call the "free clinic" because Respondent was no longer accepting Medicaid patients (T. 27; Exhibit 4; Exhibit 2, p. 22).

A14. Respondent's office record for Patient A's December 8, 1987 visit states "Bleeding for three weeks on and off; Cautery." This was written by Respondent's nurse prior to the examination (T. 421, 422, 425). There is no information in Respondent's office record regarding findings from a physical examination. There is no listing of the indications or basis for performing a cauterization. There were no diagnostic tests or studies nor any description of the procedure. The record does not indicate the condition of Patient A after the procedure (T. 83, 90, 409-410; Exhibit 2, p. 22).

A15. Diagnostic tests and studies are indicated before cervical cauterization is performed. This work-up should include performance of a Pap smear. If the Pap smear is anything other than normal (particularly showing cervical dysplasia), performance of a colposcopy and biopsy is indicated. If dysplasia or other abnormality is confirmed by biopsy, cauterization or other treatment may be performed (T. 82, 98, 112-113, 115-116).

CONCLUSIONS WITH REGARD TO PATIENT A

The first allegation herein is that Respondent failed to take and/or record Patient A's blood pressure during her pre-natal visits. There is no dispute that blood pressure should be monitored at each pre-natal visit. Indeed Respondent asserts Patient A's blood pressure was measured at each visit but sometimes he and his staff failed to record same. The Committee finds unanimously that this charge should be sustained on two grounds: First of all, from a purely pedantic view point, a measurement taken but unrecorded constitutes the same violation of acceptable standards of medicine as a measurement not taken at all. The very purpose of taking a blood pressure (and other vital signs) is to give the practitioner a record of values so that a base line can be established. There is no other method to obtain the normal range for a given patient. Absent such baseline information, the practitioner, and his successor where necessary,

cannot adequately protect the obstetrical patient from such life-threatening conditions as pre-eclampsia.

Of equal significance to the Committee in sustaining this charge is the issue of credibility. When any witness testifies there is a non-empirical aspect to their presentation which determines whether or not the trier of fact believes what the witness says. Plausibility, circumstantial evidence and deportment are some of the factors upon which the trier of fact relies to conclude whether a given witness is or is not credible. In this case the Committee decides that it does not find Respondent to be a credible witness. With regard to this specific allegation, Respondent defended by alleging the pressures were measured but simply not recorded. The Committee finds that recording a blood pressure is so fundamental to basic medical care that Respondent's representation is simply not believable. Respondent's assertion defies logic and common sense. Furthermore, where an obstetrical record is missing such fundamental information as pre-natal blood pressures there is significant motivation for a Respondent to conform his testimony to acceptable medical standards rather than reality. The Committee finds that to be the case here.

Factual Allegation A.1 is unanimously sustained.

In allegation A.2 Respondent allegedly "failed to perform a post-partum pap test <u>as indicated</u>" (emphasis supplied). To sustain this charge the state must show Respondent did not

perform a post-partum pap test and that such a test was indicated. The Committee defined the term "indicated" to mean that acceptable standards of medical practice required Respondent to see the test was performed.

The Committee finds unanimously that Respondent did not, in fact, perform a post-partum pap test on this patient. However the Committee also finds that such a test was not indicated. It is the unanimous conclusion of this committee that since this patient had had a pap smear within the previous year with no evidence of abnormal cytology, no further test was required at the time in question. While this patient was found to have trichomonas during her pregnancy, such a condition, contrary to the Department's assertion, is not an indication for a pap smear. Allegation A.2 is sustained in part but will not form the basis for sustaining any specification.

The findings of the Committee with regard to allegation A.3 are similar to those in allegation A.2. The State charges Respondent did not "adequately" investigate this patient's trichomonas condition in the post-partum period. The Committee finds unanimously that Respondent made no investigation of this Patient's trichomonas in the post-partum period. But the Committee further finds that the failure to investigate this condition, after the pregnancy, did not constitute any sort of inadequacy. In this case Respondent had treated the patient for trichomanas prior to delivery. After delivery the patient made

no complaint relating to the condition. While some may argue that post-delivery investigation was warranted, the Committee does not believe the failure to investigate trichomanas, where the patient has no obvious symtoms, approaches the level of medical misconduct. As written, the allegation will be sustained but will not form the basis for sustaining any specification.

Allegation A.3 is sustained.

Allegations A.4, A.5 and A.6 concern the performance of a cervical cauterization on December 8, 1987 which was allegedly

(A.4) unnecessary and improper

(A.5) performed without patient consent

(A.6) performed without adequate documentation of the indications for same.

Allegations A.4 and A.6 are closely related and will be treated together below. Turning to allegation A.5, the question presented is whether, upon the facts in evidence, it can be said patient A gave an informed consent to a cervical cauterization. There is no dispute that Respondent performed the procedure. It is of primary note that patient A appeared at this hearing and testified. The Committee found Patient A entirely credible. She was straightforward in her answers on both direct and cross examination. She spoke with clarity as to what she could and could not recall. She did not reflect any sort of vendetta or other hidden agenda. For these reasons the testimony of Patient A was

entitled to and given significant weight. As stated previously, the Committee did not find Respondent to be a credible witness.

Having so found, the Committee concludes that Respondent did not obtain an informed consent from Patient A prior to performing a cervical cauterization. While the Committee does not believe a written statement from a patient is necessary, the Committee does believe that minimal standards call for a careful explanation of the physician's intentions, the reasons for the procedure, the risks involved, some acknowledgement by the patient that there is an understanding of the physician's presentation and finally, patient assent to the procedure. Upon the facts presented, the Committee finds none of these standards were met. The Committee finds Respondent presented the procedure as a virtual fait accompli in that the patient was already in stirrups, had a metal plate beneath her buttocks and was being approached with an instrument when she raised the question of what was about to happen. The Committee finds that Respondent, not the patient, should have brought up the topic well prior to positioning the patient. The Committee further finds the physical position of Patient A at the time was hardly conducive to a minimal opportunity to weigh the merits of an approaching medical procedure. Moreover, the Committee finds Respondent's reply to the patient's questions were significantly limited and less than adequately informative.

Allegation A.5 is sustained

With regard to the necessity, propriety and documentation of this procedure (allegations A.4 and A.6) the fact is that no one will ever know unequivocally whether this cautery was necessary since Respondent performed no diagnostic studies or tests in this regard proir to the procedure and provided virtually no documentation of any kind. While the patient note in Respondent's record refers to intermittent bleeding for a three weeks duration, this alone is not an adequate basis for cauterization. Indeed, the cauterization destroyed the very tissue which could have given the information necessary upon which to decide if cautery was warranted. Upon review of all the evidence, the Committee concludes that Respondent's statement to investigator Pulera that he routinely cauterizes 90% of his obstetrical patients (see Ex.5) was accurate and not hyperbole as suggested by Respondent. Where one routinely performs cauterization it tends to explain a paucity of documentation.

Having so found, the Committee concludes the cauterization herein was improper on two grounds: First, the patient, as previously stated did not have an opportunity to give informed consent. Second, a cauterization is improper unless it is necessary. Since Respondent made no attempt to ascertain the underlying cause of this patient's bleeding he could not have known if the cautery was necessary. Absent a documented reason for this patient's bleeding which can be appropriately corrected

by cautery, the procedure is unnecessary and is therefore improper.

As previously stated, there is an utter insufficiency of any documentation for this procedure. Neither the reasons for the cauterization nor the outcome of the procedure, including patient condition is reported. There were no tests or other diagnostic procedures recorded. Accordingly the Committee finds Respondent did not adequately document any aspect of this procedure.

Allegation A.4 is sustained.

Allegation A.6 is sustained.

CONCLUSIONS WITH REGARD TO SPECIFICATIONS ONE AND FIVE

Having sustained factual allegations presented by the Petitioner, the Committee now turns its attention to a discussion of what, if any, violations of the Education Law and Regulations were established by these allegations. In its consideration of each of the specifications, the Committee was asked if the acts proven constituted simple negligence and/or incompetence on more than one occasion, and/or gross negligence and/or gross incompetence. In its deliberations, the standards used by the Committee were these: negligence is a deviation from that level of care which would be expected of a prudent physician in New York State; gross negligence is an egregious deviation from that standard characterized by wanton and/or willful behavior "or

multiple acts of negligence that cumulatively amount to egregious conduct..." (Matter of Rho v. Ambach (74 NY2D 318)(1989), at p.322); incompetence is a level of expertise which falls below that to be expected of a physician in New York State; gross incompetence is an egregious deviation from the standard.

The above standards were employed throughout the Committee's deliberations herein. With regard to patient A, as previously stated, the Committee finds no violation of acceptable medical standards with regard to charges A.2 (no post-partum pap test) and A.3 (no post-delivery investigation of trichomonas). With regard to charge A.1(pre-natal blood pressure), the Committee finds Respondent guilty of negligence. Furthermore, as previously explained, the Committee finds Respondent's failure to measure and record this patient's blood pressure to constitute an egregious deviation from standards of prudent care. The Committee did not find this conduct to constitute incompetence.

In reference to charge A.4, the Committee finds Respondent's performance of an unnecessary and improper cauterization constitutes an egregious deviation from both standards of prudence and competence. For the reasons set forth earlier the Committee finds both gross negligence and gross incompetence.

Moving to charge A.5, the Committee finds an egregious deviation from standards of prudence. The failure to obtain an informed consent seriously violates basic standards of acceptable

medical care. The Committee believes Respondent knew he needed this patient's informed consent thus they find no evidence of incompetence.

Finally, the Committee finds Respondent's failure to document the basis for this cauterization and any other facts about the procedure (charge A.6) constitutes a severe deviation from standards of prudence and competence. Exhibit 5 which states Respondent cauterizes 90% of his patients shows both a glaring lack of professional judgement and a failure to meet current standard of knowledge.

Accordingly, Specification One which alleges gross negligence and/or gross imcompetence is sustained. The acts of negligence and incompetence herein shall be combined with the other charges to sustain specification five.

FINDINGS OF FACT WITH REGARD TO PATIENT B

B1. On June 3, 1985, Patient B, a thirty-two year old female, telephoned Respondent's office and complained of irregular periods. An office appointment was made for June 7th (Exhibit 5, p. 29).

B2. On June 5, Patient B again telephoned Respondent's office complaining of substantial pain, discomfort and continued "spotting". Patient B's appointment was changed from June 7 to June 6. Respondent also directed that Patient B undergo an

emergency HCG test (human chorionic gonadotropin) (Exhibit 6, p. 29; Exhibit 6A).

B3. The HCG test reported on June 6, 1985, for a specimen collected on June 5, indicated a HCG quantity of 4,786. An HCG value of from 1,000-10,000 corresponds with the fourth week of gestation in a normal pregnancy (T. 121-122; Exhibit 6, p. 24).

B4. Patient B was seen in Respondent's office on June 6, 1985 for prenatal care. The prenatal record indicates that Patient B's last menstrual period was April 18, 1985. Therefore, by date calculation, Patient B was approximately seven weeks pregnant (Exhibit 7, p. 9).[2]

B5. An ultrasound examination of Patient B performed in Respondent's office on June 6, 1985, revealed no gestational sac. Respondent ordered a repeat ultrasound in two weeks and a repeat HCG test in one week. Patient B was advised to call if her bleeding increased or if she experienced shoulder or lower abdominal pain (Exhibit 6, p. 28).

B6. A second HCG test reported on June 14, 1985, for a specimen collected June 13, revealed an HCG quantity of 14,050 (Exhibit 6, p. 25). This represented an HCG increase much lower than what would be expected in a normal pregnancy. The HCG

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[2] It is noted that the expected HCG value cited above refers to actual weeks of gestation. Dating by last menstrual period is not as accurate (T. 507-508).

quantity should double approximately every two days. Therefore, the HCG level on June 13, eight days after the first HCG test on June 5, would be expected to be approximately 70,000 in a normal pregnancy (T. 123-124, 494-496, 589).[3]

B7. During an office visit of June 20, 1985, when Patient B was nine weeks pregnant by date calculation, a second ultrasound examination was performed on Patient B. The ultrasound revealed an "area within the uterus where gestational sac may be forming <sic> (rind). . . ??? cyst on right side". Respondent ordered a repeat ultrasound in two weeks and a repeat HCG test in one week (Exhibit 6, p. 27)..

B8. On June 24, 1985, Patient B experienced vaginal bleeding and pain. Tylenol with codeine was prescribed for the patient's pain. Respondent's office made arrangements on June 24th to have Patient B admitted to Mercy Hospital for a dilatation and curettage (D & C) the following day (Exhibit 6, p. 7, Exhibit 7, p. 9).

B9. Patient B was admitted to Mercy Hospital at 7:15 a.m. on June 25, 1985. Patient B's admission/pre-operative diagnosis was "incomplete abortion". Respondent, prior to this admission, had ruled out the diagnosis of ectopic pregnancy (T. 502; Exhibit 7, pp. 1, 2, 12).

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[3] Errata notation, p. 123, line 16, should say "inadequate", not "adequate".

B10. Respondent performed no pelvic examination during his prenatal care of Patient B. A pelvic examination would have revealed whether patient B's uterus was enlarged. A pelvic examination can provide additional clinical information as to whether or not a Patient's pregnancy is ectopic (T. 619-620).

B11. At approximately 9:00 a.m. on June 25, Respondent performed a D & C on Patient B. According to the pathology report only a small amount of curettages was submitted for pathologic examination. Furthermore, no products of conception were found by the pathologist. The pathologic examination confirmed the diagnosis of ectopic pregnancy (T. 602, 610; Exhibit 7, p. 16).

B12. The removal of only small amounts of tissue upon curettage was a further indication of an ectopic pregnancy (T. 126-127).

B13. Respondent did not send tissue to the pathologist for frozen section evaluation while Patient B was still in the operating room (T. 137-138, 602-604).

B14. Following the performance of the D & C, Patient B was taken to the recovery room at approximately 9:15 a.m. While in the recovery room, Patient B went into shock. She experienced a sudden onset of abdominal pain, decreased blood pressure, increased pulse and falling hematocrit and hemoglobin (T. 127, 133-134, Exhibit 7, pp. 2, 14).

B15. In the recovery room Patient B underwent an EKG, and was medicated for abdominal pain. Respondent ordered an

emergency sonogram (T. 504), which was performed after filling Patient B's bladder (Exhibit 7, pp. 14, 31). The results of the ultrasound were reported as: "Somewhat limited study due to sub-optimal bladder distention. Mild to moderate amount of fluid in the cul-de-sac. Small right adnexal cyst" (Exhibit 7, p. 31). In addition, Respondent performed a culdocentesis (Exhibit 7, pp. 2, 14).

B16. Patient B was prepared for surgery, discharged from the recovery room at 11:50 a.m., and taken to the operating room for an exploratory laparotomy. The exploratory laparotomy revealed a ruptured ectopic pregnancy (Exhibit 7, p. 20).

CONCLUSIONS WITH REGARD TO PATIENT B

Allegation B.1 charges Respondent failed to recognize the possibility of an ectopic pregnancy in a "timely manner". To sustain the charge the state must show Respondent failed to recognize the possibility of an ectopic pregnancy and that such a diagnosis could have been made upon the facts available earlier than when Respondent made his finding. The State has proven these points by clear and convincing evidence: On June 6, 1985, Patient B by HCG test was approximately four weeks pregnant. Upon ultra-sound examination performed the same day, no gestational sac was seen. These two facts are, in combination, clearly inconsistent with a normal pregnancy and would have immediately alerted a prudent physician to a number of untoward possibilities.

High on the list of considerations would have been an ectopic pregnancy. Thus by June 6, a prudent, competent physician had a basis for a differential diagnosis of ectopic pregnancy. Respondent did not entertain such a diagnosis on June 6 nor did he so find on June 14 when the results of an HCG test were again inconsistent with a normal pregnancy; nor did he so find on June 20 after an abnormal ultra-sound examination. On June 25, Respondent, still failing to recognize an ectopic pregnancy, performed a D & C on Patient B. Little tissue was retrieved and there were no products of conception found. This constitutes further clear evidence of an ectopic pregnancy, yet Respondent still did not perceive same. Finally, on June 25, shortly after the D & C, after Patient B went into shock, and after Respondent performed a sonogram and a culdocentesis, the ectopic nature of the pregnancy was noted by Respondent.

The Committee finds Respondent had ample evidence to find an ectopic pregnancy early on, yet he ignored same. Respondent amplified his ignorance by failing to perform any pelvic examination during his pre-natal care of Patient B. Such an examination, which is fundamental to basic standards of acceptable medical care, in this situation, would have revealed if this patient's uterus was enlarged and/or if the cervix was closed, thereby providing further clinical data upon which to base a diagnosis. Respondent admitted he did not think this was an ectopic pregnancy until the patient was in post-op after the

D & C. Such is not the conclusion of a prudent, competent practitioner, given the information available.

Allegation B.1 is sustained.

In allegation B.2 Respondent is charged with a failure to appropriately treat Patient B's complications after the D & C procedure. Many of the Committee's remarks under B.1 are applicable here in that a prudent, competent, physician would have recognized an ectopic pregnancy prior to the D & C on June 25. Thus the patient would not have gone into shock at all. Nevertheless, given a patient upon whom a D & C is performed, who produces little tissue and then goes into shock, a sonogram and culdocentesis are unnecessary wastes of precious time. Such a patient warrants an immediate return to surgery. Respondent's failure to immediately return this patient to surgery constitutes a failure of appropriate treatment. Parenthetically, the Committee takes note Respondent alleged he could not recall much about this Patient's case. The Committee finds these events to be so extraordinary that Respondent's alleged memory failure is incredible. This adds weight to their earlier conclusions regarding Respondent's veracity.

Allegation B.2 is sustained.

CONCLUSIONS WITH REGARD TO SPECIFICATIONS TWO AND FIVE

As was stated earlier, the Committee finds Respondent entirely mismanaged this case. His failure to recognize the clear

symptoms of an ectopic pregnancy and immediately retur this patient to surgery from post-op shows a severe deviation from expected standards of prudence and expertise. The facts adduced under charges B.1 and B.2 support conclusions of gross negligence and gross incompetence. These conclusions sustain the lesser included offenses of negligence and incompetence which, when combined with the earlier conclusions, sustain negligence and/or incompetence on more than one occasion.

Specification Two is sustained

Specification Five is sustained

FINDINGS OF FACT WITH REGARD TO PATIENT C

C1. Patient C, a thirty-two year old female, was treated by Respondent from October 1979 to May 1980 for prenatal care and delivery of an intrauterine pregnancy (Exhibit 8).

C2. Patient C had two previous pregnancies in which labor had to be induced (T. 644-645; Exhibit 8, p. 1).

C3. Patient C's first prenatal office visit with Respondent was on October 5, 1979. Patient C's last menstrual period was July 12, 1979. Based on this date, Patient C's estimated date of delivery was calculated as April 19, 1980. (T. 176; Exhibit 8, p. 1; Exhibit 9C, p. 4).[4]

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[4] Exhibit 8, p. 1 and Exhibit 9C, p. 4, are both copies of the prenatal record. However, Exhibit 9C, p. 4, in Patient C's

C4. During an office visit of December 19, 1979, a sonogram was performed on Patient C. Respondent's notes read "re-scan one month to measure head" (T. 181-183;[5] Exhibit 8, p.1; Exhibit 9C, p. 4 and Exhibit 8A).

C5. During an office visit of January 10, 1980, Respondent performed an ultrasound examination which revealed Patient C's infant to be in a breech presentation with a 6.3 centimeter biparietal diameter. Respondent noted "26 weeks" (gestational age).[6] (T. 177, 179; Exhibit 8, p. 1, Exhibit 9C, p. 4, Exhibit 8A).

C6. Upon ultrasound examination on February 13, 1980, Respondent noted a gestational age of thirty-one weeks (Exhibit 8A). Both the finding of twenty-six weeks gestational age on January 10, and thirty-one weeks gestational age on February 13, 1980, are consistent with an estimated date of delivery of April 14, 1980 (T. 192-198). Based on these ultrasound examinations,

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hospital chart, only reflects office visits through March 6, 1980. Exhibit 8, p. 1 of the office chart covers the entire prenatal period through May 15, 1980.

5 Errata notation: p. 181, line 25 should refer to Exhibit 8A, not 8C.

6 The determination of biparietal diameter through ultrasound examination enables one to arrive at a gestational age, and therefore, helps to predict estimated date of delivery (T. 187-188). The use of sonographic measurement to arrive at gestational age is more accurate and reliable earlier in pregnancy rather than later (T. 180).

Respondent and/or his office sonographer calculated a "sonar due date" of April 14, 1980 (T. 448-449; Exhibit 8, p. 1; Exhibit 9C, p.4; Exhibit 8A).

C7. Findings from a subsequent ultrasound examination performed on march 6, 1980 confirmed good fetal growth and did not alter the estimated date of delivery of April 14, 1980 (T. 198-200).

C8. On May 1, 1980, at approximately forty-two weeks gestation (T. 209), Patient C was sent to Mercy Hospital in Buffalo for an oxytocin challenge test (OCT) on an outpatient basis.[7] Patient C's history and physical examination noted an estimated date of delivery of April 14, 1980 (Exhibit 9A, p.2). The OCT was negative (Exhibit 9A, p. 5; Exhibit 9C, pp. 48-68), indicating that Patient C's fetus was in good condition. There was no fetal compromise (T. 204-205, 207-208).

C9. The negative OCT of May 1 was sufficient grounds to predict fetal well-being for the next 48 to 72 hours (T. 221-224).

C10. A chart entry for Patient C's office visit of May 9, 1980, some eight days later, states "fetal movement, cardiac activity." No sonography was performed (T. 210-211; Exhibit 8, p. 1).

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[7] An OCT measures the fetus' ability to withstand stress and the ability of the placenta to transmit oxygen to the fetus (T. 222-223).

C11. On May 13, 1980, at approximately forty-four weeks gestation, twelve days after the first OCT test, Patient C was again sent to Mercy Hospital for an OCT test (T. 212; Exhibit 9B). On the history and physical examination, Patient C's due date was noted as April 14, 1980 (Exhibit 8, p. 2).

C12. A progress note on May 13 states "Patient here today for OCT due to post-daturism and breech presentation. Not done". Respondent did not write this note but he did sign it. (T. 212-213, 453-454; Exhibit 9B, p.5).

C13. The nurse's note for May 13 (Exhibit 9B, p. 8) states that an OCT was attempted but that no response was obtained to intravenous oxytocin (T. 213-214). The monitor tracings for the attempted OCT (Exhibit 9C, pp. 69-73), confirm that the OCT was not successful (T. 214). Exhibit 9C, p. 69, states "OCT 5/13/80 did not take."

C14. Following the failed OCT test on May 13, Patient C was discharged home (Exhibit 9B, p. 8).

C15. On May 15, following an office visit with the Respondent, Patient C went to the Mercy Hospital at approximately 6:30 p.m. Patient C arrived in labor. The baby's presentation was still breech, and a primary C-section was carried out. An eight pound, six ounce female infant was delivered at 8:25 p.m. (Exhibit 9C, pp. 1, 2, 6).

C16. The hospital chart for Infant C (Exhibit 10) describes post maturity: "At four hours of age, the patient was

on the respirator, pale and dusky with meconium staining, extremely hypotonic, wasted, post-mature looking" (T. 219-220; Exhibit 9C, p. 2).

CONCLUSIONS WITH REGARD TO PATIENT C

Charge C.1 alleges Respondent failed to perform a second oxytocin challenge test in a timely manner. An oxytocin challenge test (OCT) is utilized where an obstetrical patient fails to deliver near her due date. The purpose of the test is to assure the fetus remains uncompromised. Patient C was due to deliver approximately April 14, 1980. On May 1, Respondent performed an OCT which indicated good fetal well-being. This test was timely and consistent with acceptable standards of medical care. However, an OCT can predict fetal well-being for only 48 to 72 hours. Respondent's expert witness testified that standards of acceptable medical practice in 1980 called for a second OCT no more than seven days from the first. Respondent did not attempt to perform a second OCT until May 13 1980. This test was a failure. Respondent's assessment of fetal movement and cardiac activity on May 9 was no substitute for an OCT by at least May 8 or sooner. The Committee finds that at 42 weeks gestation, Respondent should have seen this patient at least weekly and should have performed an OCT at each visit. The unsuccessful OCT should have been repeated. Respondent's failure to provide timely OCT's violated acceptable standards of medical care.

Allegation C.1 is sustained.

Allegation C.2 states Respondent failed to deliver the pregnancy in a timely manner. The Committee finds Respondent did indeed fail to deliver patient's infant as soon as he should have. The Committee finds that in 1980, prudence and competence would direct a physician to induce labor at 42 weeks given the risks of post-maturity. That this patient had required induction in the past strengthens this conclusion. This patient was allowed to continue past forty-three weeks. The delay, in light of what was known, was a clear violation of acceptable medical standards.

Allegation C.2 is sustained.

CONCUSIONS WITH REGARD TO SPECIFICATIONS THREE AND FIVE

Respondent failed to perform a second OCT and allowed this pregnancy to continue without delivery far beyond the time prudence and competence would dictate. The Committee finds the violations to be serious lapses in fundamental obstetrical practice. They therefore find egregious deviations from standards and conclude Respondent committed both gross negligence and gross incompetence.

Specification Three is sustained.

Specification Five is sustained.

FINDINGS OF FACT WITH REGARD TO PATIENT D

D1. Patient D, an eighteen year old female, was treated by Respondent from June 1974 to January 1975 (Exhibit 11). Respondent was Patient D's primary obstetrician and the attending physician for her hospitalizations of January 7, January 16, and January 21, 1975 (T. 279-282; Exhibit 11; Exhibits 12a-d).

D2. Patient D's initial office visit was on June 25, 1974. Patient D's estimated date of delivery was February 9, 1975 (Exhibit 11, p. 8; Exhibit 12D, p. 5).[8]

D3. Respondent obtained four urine specimens for screening from Patient D during the prenatal period. Respondent obtained no blood specimens during the prenatal period to test for blood sugar (Exhibit 12d, pp. 3, 5).

D4. A blood screen is more accurate than a urine screen in testing for blood sugar (T. 284-286).[9]

D5. During an office visit of January 2, 1975, Patient D's weight was 121 1/2 pounds. During Patient D's previous office visit of December 20, 1974, her weight was 131 pounds (Exhibit 12d, p. 5).

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[8] Exhibit 11, p. 8 and Exhibit 12d, pp. 4, 5, are both copies of Patient D's prenatal record. Henceforth, citation to the prenatal record will be to Exhibit 12d, p. 5, which is the more legible copy.

[9] Note that a test for blood type and RH ordered by Respondent in the prenatal period (see Exhibit 12d, p. 2), was not done. In any event this test would not have yielded a blood sugar value (T. 316).

D6. Respondent later documented (Exhibit 12d, p. 2, Discharge Summary of February 1, 1975) that Patient D "had a normal pregnancy until specifically on January 2, 1975, when she was seen in the office with weight loss, swollen legs, and pain. She was given a Penicillin shot for her cold, Compazine suppositories for her recurrent nausea and vomiting."

D7. On January 7, 1975, at approximately 6:45 p.m., Patient D was admitted to Mercy Hospital with a diagnosis of hyperemesis graviderum. Patient D was suffering from weakness, dizzy spells, edema, nausea, emesis, and abdominal pain (Exhibit 12b, pp. 2, 3, 4).

D8. A urinalysis performed on January 7, 1975 revealed 3+ glucose and moderate ketones (Exhibit 12b, p. 5). A normal glucose is 0. The maximum glucose on a urine screen is 4+ (T. 294).

D9. A urinalysis of 3+ glucose was a significant abnormality which strongly suggested diabetes (T. 294-295, 296-297).

D10. During Patient D's hospitalization from January 7 through January 12, 1975, she was treated symptomatically for her nausea and vomiting and with intravenous fluids. No blood sugar test or other follow-up of the 3+ glucose finding was performed (T. 295; Exhibit 12b).

D11. Although Patient D was suffering from dehydration during her January 7th hospitalization, no lab test for

electrolytes was performed. Such a test would have included a blood sugar test (T. 312-314, 377).

D12. On January 12 Patient D was discharged from the hospital. The cause of her symptomatology was not known (T. 296-297).

D13. On January 16, 1975, Patient D was again admitted to Mercy Hospital with a diagnosis of hyperemesis (Exhibit 12c, p. 2).

D14. A urinalysis on January 16, 1975, again revealed a 3+ glucose with a large amount of ketones (Exhibit 12c, p. 5).

D15. During Patient D's hospitalization from January 16 until January 20, 1975, Patient D was treated with intravenous fluids, anti-nausea agents, and sedation (Exhibit 12c, p. 2). No test for blood sugar or other investigation of the 3+ glucose finding was performed (T. 295-296, 297-298, 303; Exhibit 12c).

D16. Patient D was discharged on January 20th. (T. 296-297).

D17. On January 21, 1975, at approximately 12:30 p.m., Patient D was admitted to Mercy Hospital in labor. At approximately 7:30 p.m. Respondent delivered an 8 pound 10 ounce stillborn, macerated infant (Exhibit 12d, pp. 9, 12).

D18. Subsequent to delivery, Patient D developed chills, cough, and drowsiness. A physician, other than Respondent, then made the diagnosis of diabetes (Exhibit 12d, pp. 2, 3).

CONCLUSIONS WITH REGARD TO PATIENT D

Under allegations D.1 and D.2 Respondent is charged with a failure to investigate (D.1) and diagnose (D.2) diabetes during this patient's gestational period. The Committee finds Respondent did fail to investigate diabetes in this patient who bore clear signs and symptoms of same and that this failure to investigate led to a culpable failure to diagnose diabetes in this patient. A prudent, competent, physician would have taken a blood sugar test upon noting this patient's weight loss on January 2. The 3+ glucose results of January 7 and January 16 also clearly indicated further study to rule out diabetes. Here, as with patient B, Respondent ignored obvious, classic, symptoms of a dangerous condition. The Committee finds it particularly remarkable that Respondent did not perform an electrolyte test on January 7 given the patient's dehydrated state. It is impossible to distinguish, under the facts and circumstances herein, a dividing line between the failure to investigate and the failure to diagnose diabetes in this patient. The symptoms were obvious yet Respondent failed to take action. It follows that he was unable to arrive at a basic and fundamental diagnosis.

Allegations D.1 and D.2 are sustained.

CONCLUSIONS WITH REGARD TO SPECIFICATION FOUR AND FIVE

In this case Respondent had ample evidence of possible diabetes. Had he followed up on the clear warning signs it is

reasonable to conclude he would have drawn the obvious diagnosis. Both his failure to investigate and diagnose Patient D's diabetes constitute extremely serious lapses in medical prudence and competence. The Committee concludes Respondent's acts under charges D.1 and D.2 evidence gross negligence and gross incompetence.

Specification Four is sustained

Specification Five is sustained

RECOMMENDATIONS

Respondent is board certified and recertified in Obstetrics and Gynecology. He obviously knows what to say and write for examiners in order to pass stringent standards. Yet the actions proven here show egregious lapses of fundamental medicine. Furthermore, the lapses are not isolated events but rather characterize three entire episodes of case management. For instance, in patient B, Respondent, despite repeated obvious signs and symptoms did not diagnose an ectopic pregnancy until Patient B went into shock in the recovery room. When Respondent treats patients, his care does not meet minimal standards. For these

reasons the Committee believes that retraining will be of no value here. The license of Respondent to practice medicine should be REVOKED.

DATED:
Syracuse, N.Y.

This 16 Day of July 1990

Respectfully Submitted,

Priscilla R. Leslie, R.N.P.

John P. Frazer M.D.
Lemuel A. Rogers M.D.

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

IN THE MATTER :

OF :

JOSEPH S. MATALA :

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 24, 1989, May 4, 1989, May 18, 1989 and November 10, 1989. Respondent, Joseph S. Matala, appeared by Joseph V. McCarthy, Esq. The evidence in support of the charges against the Respondent was presented by Ralph Bavaro, Esq. and Paul R. White, Esq.

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

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

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Hearing Committee that Respondent's license to practice medicine be revoked should be rejected and, in lieu thereof, Respondent's license should be suspended for five years and such suspension be stayed provided that Respondent's care to all of his obstetrical patients is monitored by a board certified obstetrician approved by the Office of Professional Medical Conduct. In determining

whether Respondent's performance as a physician warrants revocation or stayed suspension of his license, I must weigh several factors including the extent of his deviation from standard practice, his current practice capability, and the possible impact of retraining and monitoring. My essential task is to measure the risk a respondent may pose to future patients against some unspecified, but minimal risk, of imperfection that patients implicitly assume when seeking professional assistance. This does not reduce to some neat formula that poor care a certain number of years ago, gross negligence, or negligence without fraud does or does not warrant license revocation. Each case must be assessed on its own facts.

This case demonstrated repeated instances of poor care by Respondent. His care of Patient B was particularly reprehensible. Nevertheless, Respondent is well-trained and board certified. His performance does not evidence any deviations from standard care which appropriate monitoring by a second obstetrician could not reveal in a timely fashion. Therefore, I recommend that he be allowed to remain in practice with monitoring.

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
September 5, 1990

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

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

JOSEPH S. MATALA

CALENDAR NO. 11346

The University of the State of New York

IN THE MATTER

OF

JOSEPH S. MATALA
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11346

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11346, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (January 23, 1991): That, in the matter of JOSEPH S. MATALA, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to those findings of fact and conclusions be accepted;
2. The hearing committee's recommendation as to the measure of discipline be accepted, and the Commissioner of Health's recommendation as to the measure of discipline not be accepted;
3. Respondent is guilty, by a preponderance of the evidence, of the first specification of the charges based on gross negligence and gross incompetence to the extent indicated in the hearing committee report, the second specification of the charges based on gross negligence and gross incompetence, the third specification of the charges based on gross negligence and gross incompetence, the

fourth specification of the charges based on gross negligence and gross incompetence, and the fifth specification of the charges based on negligence on more than one occasion and incompetence on more than one occasion to the extent indicated in the hearing committee report; and

4. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent was found guilty;

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

and it is

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

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

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 31st day of January, 1991.

Thomas Sobol

Commissioner of Education