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

Stephen Becker, Physician
568 Church Avenue
Woodmere, N.Y. 11598-2730

June 26, 1991

Re: License No. 169763

Dear Dr. Becker:

Enclosed please find Commissioner's Order No. 11845. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation, surrender, or a actual suspension (suspension which is not wholly stayed) of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. Your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

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

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By: Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR

cc: Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building - Suite 512
14 Harwood Court
Scarsdale, N.Y. 10583

REPORT OF THE
REGENTS REVIEW COMMITTEE

STEPHEN BECKER

CALENDAR NO. 11845

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

STEPHEN BECKER **No. 11845**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

STEPHEN BECKER, 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. A copy of the amended statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

Between March 1, 1990 and October 15, 1990 a hearing was held in seven sessions before a hearing committee of the State Board for Professional Medical Conduct. The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B".

On January 8, 1991, the hearing committee found and concluded that respondent was guilty of the eleventh through sixteenth

specifications and not guilty of the remaining specifications, and recommended that respondent's license to practice in the State of New York be suspended for three years but that such suspension be stayed during that period and that respondent be on probation during that time. The hearing committee further recommended that during that three-year period respondent not engage in private practice but that he may be in "a job" where he has direct supervision; wherever respondent is employed he must advise such institution of the final Order in this matter and that respondent notify the Office of Professional Medical Conduct of all medical institutions where he is employed.

On February 21, 1991, the Commissioner of Health recommended to the Board of Regents that the findings and conclusions of the hearing committee be accepted with the explication in his recommendation, except that the twelfth specification not be sustained and that recommendation of the hearing committee be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On April 3, 1991, respondent appeared before us and was represented by his attorney, Anthony Z. Scher, Esq. Dawn Dwier, Esq. presented oral argument on behalf of the Department of Health.

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

Petitioner's written recommendation as to the measure of

discipline to be imposed, should respondent be found guilty, was "same as the Commissioner of Health."

Respondent's written recommendation was suspension for two years, execution stayed, and probation for two years with a requirement that a practice monitor review respondent's practice at least quarterly and report to the Office of Professional Medical Conduct that respondent is practicing "good and competent medicine."

ISSUES AS TO GUILT

The hearing committee report contains conclusions as to the factual allegations and a general summary as to the specifications as a whole, but does not clearly and separately state respondent's guilt. Although the hearing committee should have fully identified and differentiated the separate acts of professional misconduct committed by respondent and concluded specifically which acts correspond with each definition of professional misconduct it sustained, the report is "minimally adequate" under the circumstances of this matter. See, Shermack v. Board of Regents of the University of the State of New York, 164 A.D.2d 798 (3rd Dept. 1978).

The hearing committee report summary shows that it sustained the twelfth through sixteenth specifications regarding record-keeping and the eleventh specification regarding negligence on more than one occasion. As will be shown, the hearing committee report

does not provide an accurate summary nor fully explain its conclusions as to respondent's professional misconduct.

RECORD-KEEPING

We modify the conclusions of the hearing committee and Commissioner of Health and conclude that respondent has committed unprofessional conduct for his record-keeping violations in the cases of Patients B, D, and E.

The twelfth specification specifically alleges the facts in paragraphs A, A(2) and A(3). However, the hearing committee did not sustain the factual allegations under A(2) and A(3) (see page 11 of its report), allegation A being merely an introductory allegation. The hearing committee, therefore, erred in concluding that respondent was guilty as to conduct he did not commit; so it was not appropriate for the hearing committee to sustain generally all record-keeping specifications without regard to respondent's conduct. We agree with the Commissioner of Health that there is no support for sustaining the twelfth specification.

Similarly, the hearing committee sustained the thirteenth specification relative to Patient B, based on all paragraphs thereof. However, the hearing committee concluded, in part, that respondent did not fail to keep proper records, thereby not supporting guilt under paragraphs B(5)(b) and B(5)(c) (see page 15 of its report).

The hearing committee report and the Commissioner of Health recommendation as to the fourteenth specification do not

demonstrate a basis for sustaining this specification. This record-keeping charge relates to the notes and evaluations of other physicians, and the hearing committee report concludes that respondent did not fail to perform and record the results of a proper evaluation and monitoring (see page 18 of its report). Accordingly, we recommend that respondent be found not guilty of the fourteenth specification.

In our unanimous opinion, respondent is guilty of the thirteenth, fifteenth, and sixteenth specifications to the extent shown in the Health Commissioner's recommendation as to these specifications.

NEGLIGENCE

The hearing committee's summary shows the conclusion to sustain the eleventh specification of negligence on more than one occasion to be a general, unlimited conclusion despite the fact that the hearing committee did not sustain all relevant factual allegations in the numerous paragraphs which formed the basis of that specification. While the hearing committee could properly conclude that respondent was guilty of parts of this specification, it should have so indicated and identified such conclusions and those parts which specifically constituted negligence.

The case of Patient B illustrates that more specificity is needed to aid the Regents Review Committee's understanding of the conclusions reached, especially because of the manner in which the charges were drafted.

Paragraph B(5) is a general allegation of misconduct based specifically on nine subparagraphs. The hearing committee, on the one hand, concluded that paragraph B(5) was "not sustained" even though, on the other hand, the allegations of respondent's negligence were sustained in four of these nine subparagraphs, namely, subparagraphs B(5)(e), B(5)(f), B(5)(g), and B(5)(h). Therefore, we do not accept the hearing committee's anomalous conclusion not to sustain paragraph B(5) because of said conclusions of guilt indicating that respondent did fail to evaluate, monitor, and treat Patient B in the appropriate manner to the extent shown in said subparagraphs. Respondent's negligence further includes and is properly based upon paragraphs B(3), B(4), and B(6). The paragraphs and subparagraphs we sustain are supported, as applicable, by paragraphs B(1) and B(2), which, by themselves, do not constitute separate acts of negligence. Similar problems exist as to the charges involving the other patients.

Accordingly, in our unanimous opinion, as supported by all the allegations sustained by the Commissioner of Health regarding Patient B, respondent is guilty of negligence as to Patient B insofar as alleged in paragraphs B(3), B(4), B(5)(f), B(5)(h), and (B)(6) and, to the extent indicated by the hearing committee, insofar as alleged in Paragraphs B(5)(e) and B(5)(g).

Without explaining and discussing every paragraph and subparagraph in the amended statement of charges, we have proceeded

with this report. We accept the conclusions of the Commissioner of Health that respondent is guilty of the eleventh specification as to Patient B, as aforesaid, and to the extent of subparagraphs A(4)(a), A(4)(c), and C(5)(c), and paragraphs E(2), F(1), F(2), and F(3). Although the Commissioner of Health sustained the eleventh specification as to paragraphs D(3) and E(1), we accept these conclusions insofar as indicated in the hearing committee report. We note that, as applicable, paragraphs A(4)(b), C(1) through C(4), D(1), D(2), and F(4) are supportive paragraphs containing background or other information separate from respondent's conduct which do not constitute, by themselves, separate acts of negligence.

The Commissioner of Health also sustained paragraphs C(6) and E(3) as negligence. These paragraphs were alleged in the amended statement of charges as constituting more than one definition of professional misconduct. The hearing committee report does not specify which definition or definitions were sustained by virtue of the factual allegations it sustained. Paragraph C(6) merely alleges a failure to maintain a record which accurately reflected the care and treatment rendered to Patient C and, in the absence of any indication or clear conclusion of negligence as to paragraph C(6), we conclude that respondent is not guilty of negligence to the extent of paragraph C(6).

Similarly, paragraph E(3) was alleged as constituting fraud

(second specification), negligence (eleventh specification), and record-keeping (sixteenth specification). Paragraph E(3) relates to respondent, after reconsidering his order of nafcillin medication for Patient E, intentionally attempted to discard the sheet of paper on which the order had been written. This conduct constitutes a record-keeping violation, but not negligence. The hearing committee did not sustain this act as fraud and did not specifically state or show any negligence was sustained as to this act. The confusion appears to result from the manner in which the charges are drafted and the manner in which they are addressed in the hearing committee report.

Both the eleventh, in part, and the eighteenth specifications are based on the events surrounding Patient F which caused the patient to suffer a cardiac arrest during the administration of chemotherapy, and eventually die. However, these two specifications are drafted differently. Whereas the eighteenth specification regarding improper delegation of professional responsibilities is based on paragraphs F(2), F(3), and F(4), and introductory paragraph F, the eleventh specification is based on paragraphs F(1), F(2), F(3) and/or F(4) and introductory paragraph F. The hearing committee and Commissioner of Health did not sustain the eighteenth specification but sustained the eleventh specification. Respondent claimed that the hearing committee's findings and conclusions were "confusing". Respondent further

claimed that these conclusions are inconsistent. We shall clarify the rationale for evaluating these specifications in a consistent manner.

On September 9, 1989, the date Patient F was scheduled to begin chemotherapy, respondent was the hematology/oncology fellow responsible for mixing the chemotherapy and assuring that it was administered to the Patient. Although respondent had planned for himself to administer, by the push method, chemotherapy agents he mixed, he did not administer the chemotherapy because the Patient had not been premedicated, as respondent wished, in advance by the nursing staff. Then respondent, while on call, absented himself from the hospital to attend a medical seminar about which he had previously informed several people, including the attending physician.

At the first recess of the seminar, respondent called an intern, (PGY 1), told him where the chemotherapy agents were located, and directed the intern to administer them by IV push. Because respondent was outside the hospital and not available by beeper, respondent called the intern again during a break in the seminar and about a half hour after the break. When respondent was advised by the intern that Patient F became anxious while the intern was attempting to administer the cytoxan component, respondent, without evaluating the patient himself or arranging for a more senior physician to evaluate the patient, directed the

intern to administer 1 mg. of Ativan and to then proceed slowly.

Respondent is guilty, in full, of negligence under paragraphs F(1) and F(2) for not discharging his on-call responsibilities when he directed an intern to administer the chemotherapy while respondent was absent and had not arranged for another fellow to do the administration. Respondent is also guilty under paragraph F(3). Under the circumstances demonstrated by the record, a reasonably prudent practitioner absent from the hospital would not have directed the intern alone at either time to proceed with the administration to Patient F.

Based on the above, the hearing committee and Commissioner of Health should have sustained the first sentence of paragraph F(1) instead of concluding that respondent absented himself "after discharging his on-call responsibilities." We do not accept this latter conclusion which is at variance with the remaining conclusions of guilt as to negligence.

EIGHTEENTH SPECIFICATION

With respect to the eighteenth specification, the issue is whether, pursuant to 8 N.Y.C.R.R. §29.1(b)(10), the improper delegation was to a person whom respondent knew or had reason to know was not qualified by training, experience, or licensure to perform the procedure. The hearing committee did not make findings as to this issue because it concluded that the delegation to "another physician" is not the kind of delegation contemplated by the Rule.

There is no basis for concluding that this Rule can never be violated because the delegation was to an intern. The Rule plainly applies, without qualifying or limiting language, to the improper delegation to a "person". The intern is obviously a person within the contemplation of the Rule. Respondent is not immune from guilt if his conduct regarding the intern is found to meet each applicable element of the Rule. There are no findings as to what respondent knew or should have known about the intern or the intern's qualifications to perform this particular procedure.

Respondent claimed that he did not know or ask about the intern's qualifications. The hearing committee did not address what respondent should have known or would have learned had he inquired. Further, the policy of the hospital regarding who may administer this chemotherapy and respondent's awareness of that policy were in dispute. In any event, the eighteenth specification is not based, as was the eleventh specification and the gravamen of the testimony from petitioner's expert, on respondent's absence when the chemotherapy was administered. Paragraph F(1), alleging respondent's absence, is not part of the eighteenth specification. Thus, in view of the different focus of the eleventh and eighteenth specifications and in view of the record, we concur, without accepting the hearing committee's rationale, in the conclusion that respondent is not guilty by a preponderance of evidence as to the eighteenth specification. We note that petitioner does not now

seek a finding of guilty as to this specification.

On the last line of page 29 and on the fourth line of page 30 of the hearing committee report there are references to 8 N.Y.C.R.R. §29.2(9). We assume these to be typographical errors and that reference was intended to 8 N.Y.C.R.R. §§29.2(a)(3) and 29.2(a)(1), respectively; and we deem them to be so corrected.

We recognize that the allegations in paragraphs A and C refer to events occurring before respondent was licensed to practice medicine in the State of New York. Nevertheless, in our unanimous opinion, respondent is accountable for and the public must be protected from misconduct committed when he was authorized to practice. Stern v. Briber, Cal. No. 8 (Sup. Ct., Albany County, August 31, 1989). The administrative officer ruled correctly in denying respondent's motion to dismiss the charges as to Patients A and C or to stay these charges pending respondent's seeking judicial review.

MEASURE OF DISCIPLINE

Respondent was negligent with respect to each of the six patients referred to in the record. In addition to the negligence committed before respondent was licensed to practice medicine in New York, he committed negligence in four of the patient cases after he was licensed. Thus, negligence was committed on various instances over a three-year period between June, 1986 and September, 1989. Respondent is also guilty of unprofessional

conduct for his record-keeping violations regarding four patients.

Respondent does not agree that it is appropriate for him to be under direct supervision during the course of his probation. Instead, respondent seeks review by a monitor of his practice during a two-year probation period. In our unanimous opinion, this would be inadequate and inappropriate.

Petitioner convincingly demonstrated that direct supervision of respondent's practice is essential for a longer period of time. It is our unanimous opinion that respondent's misconduct subsequent to his licensure, standing alone, warrants such direct supervision as well as our recommended measure of discipline.

Respondent's negligence has included his failures to contact a physician and more senior personnel, carry out the instructions of another physician, perform procedures without discussing the matter with a neurologist, and evaluate the patient himself or arrange for a more senior physician to do so. The record reveals other negligence by respondent for his failure to act after being given advice in different cases.

In regard to Patient B alone, after respondent was licensed to practice medicine, respondent was negligent, for example, for failing to monitor the patient's hydration status, writing inadequate admitting orders, issuing an order without testing, and

failing to start an IV. At the same time, respondent's negligence in the cases of Patients D, E, and F have affected the ability of others to review his performance.

The hearing committee and Commissioner of Health believe that respondent "can be guided to becoming a good and able physician in the service of the Community" (hearing committee report page 30). However, the hearing committee and Commissioner of Health did not define the meaning of "private practice"; nor did they explain why respondent should be prohibited from such practice while under direct supervision. Respondent's conclusory assertion before us that he probably will not be able to obtain the required supervision is unconvincing. Together with the Office of Professional Medical Conduct, he must diligently attempt to effectuate such a requirement.

We unanimously recommend the following to the Board of Regents:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted;
2. The conclusions of the hearing committee and Commissioner of Health be modified;
3. Respondent is, by a preponderance of the evidence, guilty

of the eleventh specification of negligence on more than one occasion based on subparagraphs and paragraphs, as applicable, in full under A(4)(a), A(4)(c), B(3), B(4), B(5)(f), B(5)(h), B(6), C(5)(c), E(2), F(1), F(2), and F(3), and also based, in part to the extent indicated by the hearing committee under B(5)(e), B(5)(g), D(3), and E(1), said negligence on more than one occasion is supported, as applicable, by paragraphs B(1), B(2), C(1) through C(4), D(1), D(2), and F(4) and subparagraph A(4)(b); guilty of the thirteenth specification to the extent recommended by the Commissioner of Health; guilty of the fifteenth and sixteenth specifications; and not guilty of the remaining paragraphs and specifications;

4. The measure of discipline recommended by the hearing committee and Commissioner of Health be modified and respondent's license to practice as a physician in the State of New York be suspended for three years upon each specification of the charges of which we recommend respondent be found guilty, as aforesaid, said suspensions to run concurrently, that execution of said concurrent suspensions be stayed, and that respondent be

placed on probation for three years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D", which include provision for the direct supervision of respondent practicing in the setting indicated therein. The above measure of discipline is recommended to be accepted by the Board of Regents within the context that it is warranted whether based upon all of respondent's misconduct or based solely upon respondent's misconduct subsequent to respondent's licensure.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated:

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

IN THE MATTER	:	AMENDED
OF	:	STATEMENT
STEPHEN BECKER, M.D.	:	OF CHARGES

STEPHEN BECKER, M.D., the Respondent, was authorized to practice medicine in New York State on April 3, 1987 by the issuance of license number 169763 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 from 568 Church Avenue, Woodmere, New York.

FACTUAL ALLEGATIONS

A. Patient A, (all patients are identified in the appendix) an 82 year old woman, was admitted to Maimonides Hospital in Brooklyn, New York on June 23, 1986 with a history of dizziness and syncope. Patient A died two days later, during her admission at Maimonides Hospital. Respondent was the PGY-I assigned to Patient A at all times referred to below.

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EXHIBIT "A"

EXHIBIT "A"

1. At or about 9:30 a.m. on June 25, 1986, pursuant to the plan of the attending medical doctor set forth in the hospital chart, Respondent drew arterial blood from Patient A for analysis. Respondent failed to draw a sufficient quantity of blood for analysis.

2. Despite the fact that the chemical laboratory reported "quantity not sufficient for analysis" in connection with the specimen Respondent submitted, Respondent fabricated a result of 75 for the patient's PO2 level in the patient chart.

3. In the same entry Respondent wrote "V/Q scan requested," when in fact, Respondent did not request or perform a ventilation/perfusion scan for Patient A.

4. Respondent failed to evaluate, monitor and treat Patient A's respiratory distress in a timely manner, specifically;

   a) Despite the fact that no analysis was performed at or about 9:30 am because Respondent failed to draw a sufficient amount of blood for analysis, Respondent

at or about 4:05 pm on July 9, 1987 upon the advice of his private medical doctor for treatment of clinical dehydration. Patient B expired during the first night of his admission. Respondent was the PGY II assigned to Patient B during all times referred to below.

1. At or about 4:00 p.m. on July 9, 1987, Patient B's private medical doctor alerted Respondent of Patient B's admission to the hospital. She instructed Respondent to start an IV for Patient B as soon as he arrived on the floor.

2. Approximately 1 hour later Patient B's private medical doctor contacted Respondent to confirm Patient B's arrival to the floor. At that time she repeated her instructions that an IV be started immediately.

3. Respondent failed to carry out the instructions of Patient B's private medical doctor concerning the starting of the IV.

waited approximately eight hours before submitting another specimen of arterial blood for analysis.

b) Blood gas analysis performed at 5:55 p.m. and confirmed 15 minutes later included values generally not considered to be compatible with life, specifically;

	pH	pC02	p02	HC03	02Sat
Normal Values	7.34-7.45	35-45 MM HG	90-100 MM HG	20-24 MMOL/L	95-98%
Time Received					
5:55	7.32	39	19*	20	23
6:10	7.30	43	21*	21	29

c) Despite the highly abnormal results of these blood gas analyses Respondent failed to take appropriate measures to treat Patient A's condition, nor did he contact his more senior personnel for assistance.

B. Patient B a 75 year old male with end stage renal disease was admitted to Bayley Seton Hospital in Staten Island, New York

4. Respondent failed to start the IV after being advised on several occasions by the staff nurse that no IV had yet been started. An IV was not started until at or about midnight at which time a PGY III summoned by the nurse on duty came and started the IV.

5. Respondent failed to attend to Patient B in a manner commensurate with his medical condition, specifically:

a) Respondent failed to see Patient B until more than 4 hours after his admission.

b) Respondent failed to perform and record a proper evaluation of the patient such that he failed to recognize the gravity of the patient's condition.

c) Respondent failed to write admitting orders until at or about 11:30 p.m.

d) Respondent's admitting orders for Patient B for IV fluids, 5% dextrose, 1/3 normal saline in a 1000 cc

bag to run at 50 cc/hour were inadequate for purposes of treating Patient B's dehydration.

e) Respondent failed to start Patient B's IV treatment. Respondent insisted that the intern should start the IV even though the intern was unavailable.

f) Respondent failed to monitor and record the patient's hydration status adequately.

g) Respondent's admitting orders for vital signs to be checked once each shift were inadequate in view of the abnormal blood pressure readings recorded in the patient's chart.

h) Respondent issued an order to continue Patient B on digoxin without testing the digoxin level in his blood.

i) Respondent failed to evaluate Patient B properly in connection with the blood pressure readings recorded after his admitting orders were issued.

6. Respondent failed to maintain a record which accurately reflected the care and treatment rendered to Patient B.

C. Patient C a 90 year old woman, was admitted to Maimonides Medical Center on December 26, 1986 after falling in her bathroom and being unable to eat due to severe back pain and tenderness. At or about 2:00 P.M. on December 28, 1986 Patient C exhibited symptoms of dypsnea. Patient C's respiratory condition continued to deteriorate until her death at 1:30 A.M. the next morning. Respondent was the resident assigned to Patient C at all times referred to below.

1. An arterial blood gas analysis reported at or about 6:41 P.M. on December 28, 1986 revealed the following levels;

	PH	PCO2	PO2	HC03	SAT
NORMAL LEVELS	7.34-7.45	35-45 MM HG	90-100 MM HG	20-24 MMOL/L	95-98 %

7.35	17*	55*	9 L	85%

2. Despite these abnormal results Respondent failed to repeat arterial blood gas analysis until 8:14 p.m. at which point the following results were obtained,

PH	PC02	P02	HC03	SAT
7.26	14*	89	6	94

3. Respondent failed to repeat the arterial blood gas analysis until 10:34 P.M. at which time the following results were obtained;

PH	PC02	P02	HC03	SAT
7.08	17*	89	5	91

4. Subsequent arterial blood gas analyses were reported as follows:

	PH	PC02	P02	HC03	SAT
10:57	7.06	26	95	7	92
11:52	7.24	11	100	5	95
12:34	7.66	18	62*	20	95

12:43	7.13	29	26*	9	30
12:51	7.23	54	33*	22	52
12:58	7.03	39	26*	10	25

5. Despite Patient C's precarious and deteriorating condition from at or about 6:00 p.m. until her death Respondent failed to evaluate, monitor and treat her in an appropriate manner, specifically:

a) Respondent failed to perform and record the results of a proper evaluation and monitoring of Patient C's condition including more frequent blood gases, examination of her lungs, chest X-ray, electrocardiogram, blood chemistries, blood counts and blood enzymes.

b) Respondent failed to institute timely and appropriate treatment for Patient C.

c) Respondent failed to contact the patient's attending physician during approximately the 7 1/2 hours of respiratory distress preceding her death.

d) Respondent failed to contact the Medical Intensive Care Unit for evaluation for admission to that unit.

6. Respondent failed to maintain a record which accurately reflected the care and treatment rendered to Patient C.

D. Patient D, a 47 year-old man, was admitted to Bayley Seton Hospital through its emergency room on the night September 16, 1987 after presenting with complaints of sudden onset of fronto-parietal headache associated with neck stiffness. Respondent was the PGY II in internal medicine assigned to Patient D at all times referred to below.

1. The next afternoon, on September 17, 1987, a neurological consultation was performed at the request of the attending physician. The neurologist who examined Patient D recommended a CT scan with contrast and a lumbar puncture be performed during the afternoon or night of September 17.

2. After the CT scan was performed, at or about 9 p.m., Respondent was informed by the PGY I that Respondent was responsible to perform the lumbar puncture that night as per the neurologist's recommendation.

3. Despite the fact that Respondent's order for nafcillin had already been picked up and transcribed by a staff nurse Respondent removed the page with his nafcillin order from the patient's chart and attempted to discard it in the waste paper basket.

F. Patient F, a 67 year old woman, with non Hogkins lymphoma was admitted to Methodist Hospital in Brooklyn, New York between August 24, 1989 and her death on September 9, 1989. Patient F expired after sustaining a cardiopulmonary arrest during the administration of chemotherapy. Respondent was the hematology/oncology fellow responsible for the preparation and administration of chemotherapeutic agents on September 9, 1989.

1. On September 9, 1989, at a time when he was on duty, Respondent absented himself from Methodist Hospital without discharging his on-call responsibilities. Respondent failed to administer chemotherapy as ordered for Patient F and failed to arrange for another fellow to do so.

3. Respondent decided that the lumbar puncture should wait until the next morning without discussing the matter with the neurologist, or any physician. He did not record any examination of the patient or reason for his decision.

E. Patient E, a 47 year old man, was admitted to Bayley Seton Hospital on or about July 13, 1987 at 6:41 p.m. for bilateral cellulitis of the lower extremities. Respondent was the PGY II in internal medicine assigned to Patient E.

1. Respondent ordered nafcillin, a penicillin derivative, for Patient E despite the fact that Patient E's hospital chart included several references to Patient E's allergy to penicillin.

2. After the nurse on duty picked up and transcribed Respondent's orders, she contacted Respondent to alert him that he had ordered nafcillin IV for a patient allergic to penicillin. Respondent's response, in words or substance was, "how allergic is he to penicillin, are you sure he is dangerously allergic to penicillin."

2. At or about 11 a.m. on September 9, 1989 Respondent telephoned the PGY-1 on call for Patient F and improperly directed him to inject Patient F with chemotherapeutic agents.

3. In a subsequent telephone conversation Respondent was informed that Patient F became agitated during an attempt by the PGY-1 to administer the chemotherapy. Without evaluating the patient himself or arranging for a more senior physician to evaluate the patient Respondent directed the PGY-1 to administer 1 mg Ativan IVPB and then proceed with the infusion.

4. After the Ativan was administered, the PGY-1 continued to infuse the chemotherapeutic agents as per Respondent's direction. During this infusion the patient sustained a cardiopulmonary arrest. Resuscitative efforts were unsuccessful.

SPECIFICATION OF CHARGES

FIRST THROUGH SECOND SPECIFICATIONS

Fraudulent Practice

Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985) in that petitioner charges:

1. The facts in Paragraphs A and A(2), and/or A(3).
2. The facts in Paragraphs E and E(1) and E(3).

THIRD THROUGH FOURTH SPECIFICATIONS

Moral Unfitness to Practice Medicine

Respondent is charged with committing unprofessional conduct within the meaning of NY Educ. Law Section 6509(9)(McKinney 1985), in that his conduct in the practice of medicine evidences moral unfitness to practice medicine within the meaning of 8 N.Y.C.R.R.29.1(b)(5)(1987), Petitioner charges:

3. The facts in paragraphs A and A(2), and/or A(3).
4. The facts in paragraphs E and E(1) and E(3).

FIFTH THROUGH TENTH SPECIFICATIONS

Gross Negligence

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985) by practicing the profession with gross negligence, in that, Petitioner charges:

5. The facts in paragraphs A and A(1), A(2), A(3), A(4), A(4)(a), A(4)(b), and A(4)(c).

6. The facts in paragraphs B and B(1),B(2), B(3), B(4), B(5), B(5)(a), B(5)(b), B(5)(c), B(5)(d), B(5)(e), B(5)(f), B(5)(g), B(5)(h), B(5)(i), and B(6).

7. The facts in paragraphs C and C(1), C(2), C(3) C(4), C(5), C(5)(a), C(5)(b), C(5)(c), C(5)(d), and C(6).

8. The facts in paragraphs D and D(1), D(2), and D(3).

9. The facts in paragraphs E and E(1), E(2) and E (3).

10. The facts in paragraphs F and F(1), F(2), F(3) and F(4).

ELEVENTH SPECIFICATION

Practicing with Negligence on More than One Occasion

Respondent is charged with practicing medicine with negligence on more than one occasion, within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985) in that, petitioner charges Respondent committed 2 or more of the following:

11. The facts in paragraphs A and A(1), A(2), A(3), A(4), A(4)(a), A(4)(b) and/or A(4)(c); B and B(1), B(2), B(3), B(4), B(5), B(5)(a), B(5)(b), B(5)(c),. B(5)(d), B(5)(e), B(5)(f), B(5)(g), B(5)(h), B(5)(i) and/or B(6); C and C(1), C(2), C(3), C(4), C(5), C(5)(a), C(5)(b), C(5) (c), C(5)(d) and/or C(6); D and D(1), D(2) and/or D(3); E and E(1), E(2) and/or E(3), and/or F and F(1), F(2), F(3) and/or F(4).

TWELFTH THROUGH SIXTEENTH SPECIFICATIONS

Poor Records

Respondent is charged with committing unprofessional conduct within the the meaning of N.Y. Educ. Law Section 6509(9)(McKinney 1985) as defined by the Board of Regents in its

rules or by the Commissioner of the Department of Education in regulations approved by the Board of Regents in that Respondent committed unprofessional conduct within the meaning of 8 NYCRR 29.2(a)(3)(1987) in that Respondent failed to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient, specifically Petitioner charges:

12. The facts in paragraphs A and A(2), and A(3).
13. The facts in paragraphs B and B(5)(b), B(5)(c), B(5)(f), and B(6).
14. The facts in paragraphs C and C(5)(a), and C(6).
15. The facts in paragraphs D and D(3).
16. The facts in paragraphs E and E(3).

SEVENTEENTH SPECIFICATION

Patient Abandonment

Respondent is charged with committing unprofessional conduct within the meaning of N.Y. Educ. Law Section 6509(9)(McKinney 1985), in that he abandoned a patient in need of immediate professional care without making reasonable arrangements for the continuation of such care within the meaning of 8 NYCRR 29.2(a)(1) (1987).

17. The facts in paragraphs F and F(1).

EIGHTEENTH SPECIFICATION

Improper Delegation of
Professional Responsibilities

Respondent is charged with committing unprofessional conduct within the meaning of N.Y. Educ. Law Section 6509(9)(McKinney 1985), in that he delegated professional responsibilities to a person when he knew or had reason to know that such person was not qualified by training or experience to perform them within the meaning of 8 NYCRR 29.1(b)(10)(1987).

18. The facts in paragraphs F and F(2), F(3) and F(4).

DATED: New York, New York
3/23/90

/CSH/ by PH

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
OF	:	HEARING
STEPHEN BECKER, M.D.	:	COMMITTEE

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

The undersigned, Hearing Committee (the Committee) consisted of Stanley E. Gitlow, M.D., (Chairman), Leo Fishel, Jr., M.D., Denise Bolan, R.P.A.C. The Committee was duly designated, constituted and appointed by the State Board for Professional Medical Conduct (the Board). The Administrative Officer was Harry Shechtman, A.L.J.

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

The Committee has considered the entire record herein and makes this Report of its Findings of Fact, Conclusions and Recommendations to the New York State Commissioner of Health.

EXHIBIT "A" EXHIBIT "B"

SUMMARY OF PROCEEDINGS

Statement of Charges dated:	January 31, 1990
Notice of Hearing and Statement of Charges served upon Respondent:	February 5, 1990
Notice of Hearing Returnable:	March 1, 1990
Place of Hearing:	8 East 40th Street New York, New York
Answer:	None filed
Amended Statement of Charges filed:	April 16, 1990
Bureau of Professional Medical Conduct appeared by:	Dawn Dwier, Esq. Associate Counsel
Respondent appeared by:	Wood & Scher, Esq. by Anthony Z. Scher, Esq. of Counsel
Pre-Hearing Conference held on:	March 1, 1990
Hearings Held on:	March 1, 1990 April 9, 1990 April 16, 1990 April 7, 1990 July 16, 1990 September 17, 1990 October 15, 1990
Proposed Findings of Fact by Petitioner filed:	November 19, 1990
Proposed Findings of Fact by Respondent filed:	November 19, 1990
Record closed on:	October 15, 1990
Deliberations held on:	November 28, 1990

WITNESSES ON BEHALF OF PETITIONER

Susan Deborah Grossman, M.D.;	attending physician at Bayley Seton Hospital, and coordinators of its residency program
June Katherine Murphy, R.N.;	employed by Bayley Seton Hospital as a specialist in telemetry.
Julia Currar, R.N.;	also known as Bortle; employed by Bayley Seton Hospital as a specialist in telemetry.
Michael Phillips, M.D.;	Associate Director of Department of Medicine at St. Vincent's Hospital.
Dennis P. Conklin, M.D.;	Director of Clinical Pathology at Maimonides Hospital.
David Grob, M.D.;	Director of Internal Medicine at Maimonides Hospital.
Adolfo M. Elizalde, M.D.;	Chief, Hematology and Oncology Division at Methodist Hospital.
Susan Mahony, R.N.;	employed by Bailey Seton Hospital.
Marjorie Starkman, M.D.;	Expert testimony internal medicine.

WITNESSES ON BEHALF OF RESPONDENT

Stephen Becker, M.D.;	Respondent.
Alan Wolkerver, M.D.;	a resident at Maimonides togehter with the Respondent.
John P. Joannow, M.D.;	a Board Certified Internist trained at Lenox Hill Hospital.

ACTIONS BY THE HEARING COMMITTEE

All Findings of Fact, Conclusions and Recommendations were arrived at by unanimous votes of the Committee.

STATEMENT OF THE CASE

The Respondent is charged with eighteen specifications based upon his treatment of six patients, A through F.

In the first and second specifications the Respondent is charged with fraudulent practices based on his treatment of patients A and E (§6509(2) Education Law.

In the third and fourth specifications the Respondent is charged with moral unfitness to practice medicine based on his treatment of patients A and E (§6509(9) Education Law, and 8 NYCRR 29.1(b)(5).

In the fifth through tenth specification the Respondent is charged with Gross Negligence based upon his treatment of patients A through F ((§6509(2), Education Law).

In the eleventh specification the Respondent is charged with practicing with negligence on more than one occasion based upon his treatment of patients A through F (§6509(2) Education Law).

In the twelfth through sixteenth specifications the Respondent is charged with maintaining poor records based on his

treatment of patients A through E (§6509(9) Education Law, and 8 NYCRR 29.2(a)(3).

In the seventeenth specification the Respondent is charged with Patient abandonment based upon his treatment of patient F (§6509(9) Education Law, and 8 NYCRR 29.2(a)(1).

In the eighteenth specification the Respondent is charged with Improper Delegation of Professional Responsibilities based upon his treatment of patient F (§6509(9) Education Law and 8 NYCRR 29.1(b)(10).

The precise acts and omissions of the Respondents are set out at length in the Amended Statement of Charges which should be referred to.

FINDINGS OF FACT GENERALLY

STEPHEN BECKER, M.D., the Respondent, was authorized to practice medicine in New York State on April 3, 1987 by the issuance of license number 169763 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 from 568 Church Avenue, Woodmere, New York.

PATIENT A

FINDINGS OF FACT

1. Patient A was a patient at Maimonides Hospital in Brooklyn, New York who was admitted on June 3, 1986. (Ex. No. 3, at p. 3)

2. Patient A presented with sudden dizziness on June 2, 1986. She denied palpitations, chest pain or loss of consciousness. (Ex. No. 3, at p. 4)

3. When Patient A was in the Emergency Room, an arterial blood gas analysis was performed indicating a pH of 7.48, PCO2 of 27, PO2 of 77, HCO3 of 20 and oxygen saturation level of 95%. (Ex. No. 3 at pp. 6, 9; Ex. No. 16)

4. On June 25, 1986, Patient A's private physician indicated a plan for Patient A which included the analysis of arterial blood gases, a ventilation/perfusion scan if the PO2 decreased and oxygen as necessary. (Ex. No 3, p. 10)

5. On June 25, 1986, Dr. Becker was an unlicensed PGY-1 at Maimonides Hospital, having been licensed on April 3, 1987, (Ex. No. 2; T867). He was assigned, inter alia, to Patient A. (T867)

6. At or about 9:30 A.M. on June 25, 1986, Dr. Becker drew arterial blood from Patient A for the purpose of analysis. (T873-877)

7. Dr. Becker took the arterial blood sample to the laboratory. While there, Dr. Becker observed the technician place a portion of the blood he drew from Patient A into the machine used to analyze arterial blood (T876-879). In this case, the machine was either an ABL I or ABL II. (T350-351)

8. Shortly thereafter, Dr. Becker observed the "nixie tubes" begin to flash with the pH, PO2 and PCO2 parameters. (T877-879)

9. The tubes stopped flashing and Dr. Becker observed that the PO2 value was 75 (T855). He also observed the pH and PCO2 values but could not recall them in his testimony. He did recall, however, that these values did not seem quite normal. (T886)

10. Dr. Becker did not wait in the laboratory to receive the actual printout from the ABL machine. (T879-880)

11. Later in the day on June 25, 1986, Dr. Becker entered an addendum to his earlier note on Patient A. This addendum set forth the PO2 value of 75 that Dr. Becker had observed earlier in the laboratory. Dr. Becker also noted that he had requested a V/Q scan. (Ex. No. 3, at p. 11)

12. Dr. Becker requested the V/Q scan by filling out the appropriate form and dropping it off in the Department of Nuclear Medicine. (T885, 887, 947)

13. Later in the day on June 25, 1986 shortly after the finish of his shift, Dr. Becker went back to Patient A and saw that the V/Q scan had not yet been performed. Accordingly, he drew additional arterial blood for analysis. (T888)

14. The results of this arterial blood gas analysis were logged into the hospital computer at about 5:55 p.m. and the results were abnormal. (Ex. No. 3, at p. 17)

15. Dr. Becker undertook to repeat the test and drew another arterial blood sample for analysis. (T971) Again the results were abnormal. (Ex. No. 3, at p. 17)

16. Despite the abnormal results, Patient A was seen by Dr. Becker to be alert, oriented and comfortable. (T887, 949, 972)

17. Prior to Dr. Becker's observation at about 6:00 p.m., Patient A was seen by the nursing staff at 12:00 p.m., 12:30 p.m. and 3:00 p.m. (Ex. No. 3, at p. 35)

18. According to the nursing notes, at 12:00 p.m., Patient A received nasal oxygen and the chart indicates that she was having no trouble breathing and that she was not in respiratory distress. (Ex. No. 3, at p. 35)

19. At 12:30 p.m., the nursing note indicates that Patient A "feels better". (Ex. No. 3, at p. 35)

20. The note at 3:00 P.M. is silent as to Patient A's condition. The patient's blood pressure was taken and was normal. (Ex. No. 3, at p. 35)

21. Since Dr. Becker observed Patient A to be in no apparent distress, he discounted the results of the arterial blood gas analysis. (T950)

22. He explained the situation to Dr. Brody, the physician whose shift followed his own. (T984, 997) Dr. Becker did not report the situation to his PGY II, because he was not in the hospital. (T997)

24. Respondent's entry which followed that of the attending physician included the following:

> "Repeat ABG, IF A-A gradient will obtain V/Q scan and hypoxic. Start on mimi-hep". (Ex. 3 at p. 11)

25. In order to calculate the A-A gradient a PO2 and PCO2 value are necessary. (T. 918)

26. Respondent relied on the digital read out despite his own assessment that two of the three values that lit up;

"didn't seem all that quite right" (T. 886, 888 and 955). "were somewhat inconsistent". (T. 923) "were somewhat off. (T. 924). "somewhat not right". (T. 924).

27. Respondent did not stick around at the lab for the remaining time, amounting to less than 90 seconds, in order to see the results which would have printed out. T902, T334, 335, 349)

28. Respondent's witness, Dr. Alan Wolkower confirmed that the results of an arterial blood gas could be obtained on a printout 90 seconds after it was entered in the machine. (T. 1139)

29. Respondent went back to Patient A's room after leaving the chemical lab at around 10:00 a.m., and made no note about her condition or the values that he had seen in the chemical lab. (Ex. 3, and T881, 882 and 884)

30. Respondent did not enter the arterial blood gas results for many hours after he saw the results in the lab. (T931)

31. Patient A's chart contains no V/Q scan order. (T. 630)

32. Respondent performed a repeat arterial blood gas eight hours after the 10:00 a.m. test because two of the values that he had observed on the digital read out at 10:00 a.m. did not seem quite right. (T. 888)

33. Respondent did not make any attempt to call Dr. Charnoff the patient's attending physician, nor did he call a senior or chief resident nor a pulmonary consult after the repeat blood gases in the late afternoon. (T. 642, 679, 985)

CONCLUSIONS AS TO THE FACTUAL ALLEGATIONS

SET FORTH IN THE AMENDED CHARGES

1. Respondent did not fail to draw a sufficient quantity of blood for analyses. Allegation is NOT SUSTAINED.

2. Respondent did not fabricate a result of 75 for the Patient's PO2 level in the patient's chart. Allegation is NOT SUSTAINED.

3. There was insufficient proof that the Respondent did not request or perform a ventilation/perfusion scan. Allegation is NOT SUSTAINED.

4. Respondent failed to evaluate, monitor and treat Patient A's respiratory distress in a timely manner, in that

a) he waited approximately eight hours before submitting another specimen of arterial blood for analysis.

b) Blood gas analysis performed at 5:55 p.m. and confirmed 15 minutes later included values generally not considered to be compatible with life, and

c) Despite the highly abnormal results of these blood gas analyses Respondent failed to take appropriate measures to treat Patient A's condition, nor did he contact his more senior personnel for assistance. This allegation is SUSTAINED.

Once Respondent got a reliable arterial blood gas which showed severe respiratory distress Patient A should have been put on at least 40% oxygen. A prudent physician would also have examined patient to see whether she was in fact breathing rapidly, whether her heart rate was higher and would have gotten a portable chest X-ray to see whether anything changed. Expert opinion by Dr. Starkman. (T. 678)

PATIENT B

FINDINGS OF FACT

1. Patient B was a 75 year old male with end stage renal disease. He was admitted to Bayley Seton Hospital in Staten Island, New York at about 4:00 p.m. on July 9, 1987 for treatment of dehydration. (Ex. No. 5 at p. 2)

2. Dr. Becker was the PGY II assigned to Patient B's care. (T. 1023)

3. Dr. Susan Grossman, Patient B's private physician, telephoned Dr. Becker at about 4:00 p.m. on July 9, 1987 to alert him to Patient B's admission to the hospital. She asked Dr. Becker to have an I.V. started for Patient B to provide him with fluids for his dehydration. She briefly discussed Patient B's situation with Dr. Becker and advised him that the patient's blood pressure was low. (in the 70's) (T38-39)

4. Dr. Becker examined Patient B at about 5:00 to 6:00 p.m. (Ex. No. 5 at pp. 6-7, 16)

5. Dr. Becker spoke to Dr. Shah, the intern (PGY I) assigned to him on this shift, and instructed him to start an I.V. for Patient B. (T1158-1159)

6. Shortly after 7:00 p.m., Dr. Becker was notified by the nursing staff that no I.V. had yet been started for Patient B. Dr. Becker paged Dr. Shah and reminded him to start the I.V. (T1166)

7. At about 11:30 p.m., Dr. Becker was in the area of the nursing station on Patient B's floor. Nurse June Murphy advised him that Patient B was deteriorating and that there was still no I.V. started. Dr. Becker ordered the patient put in the Trendelenberg position; he directed Nurse Murphy to ready an I.V. for normal saline and he paged Dr. Shah. (T1168)

8. Dr. Shah did not respond to the page and Dr. Becker went up the stairs to the next floor to find him and have him start the I.V. (T1178-1169)

9. Dr. Kurtzer started the I.V. Shortly thereafter, Dr. Shah arrived and stated that Dr. Becker had sent him. (177)

10. The nurse could not do anything for the patient until admitting orders were written. (T. 76, 171)

11. At or about 5:00 Dr. Grossman called Respondent again to make sure that the patient arrived and that the IV had been started. Respondent informed Dr. Grossman that the patient had just arrived on the floor and he would go and make sure the patient had an IV. (T. 39, 40)

12. As of 9:15 p.m. Respondent had not yet written orders for patient B. (T554, 555)

13. At no time during nurse Mahoney's shift were there orders for Patient B. (T547)

14. Patient B was pronounced dead at 3:56 on July 10, 1989. (Ex. 5) at p. 2)

CONCLUSIONS AS TO FACTUAL ALLEGATIONS

1. and 2. are both SUSTAINED. There was no dispute as to these.

3. Respondent did not carry out the instructions of Patient B's private doctor concerning the starting of the IV. The allegation is SUSTAINED.

4. An IV was not started until at at about midnight by P6Y III who had been called by a nurse on duty. This is SUSTAINED.

5. The Respondent did not fail to attend Patient B in a manner commensurate with his medical condition. This charge is not SUSTAINED.

a) Respondent did not fail to see Patient B, until more than 4 hours after his admissions;

b) did not fail to perform and record a proper evaluation of the patient:

c) did not fail to write admitting orders until at about 11:30 p.m.

d) Respondent's admitting orders were not adequate for the purpose of Treating Patient B's dehydration. a, b, c and d are NOT SUSTAINED.

e) Respondent failed to start Patient B's IV and insisted that the intern should start it. This charge is SUSTAINED to that extent.

f) Respondent failed to monitor and record the patient's hydration status adequately. This charge is SUSTAINED.

g) Respondent's admitting order for vital signs to be checked once each shift were inadequate. This charge is SUSTAINED to that extent.

h) Respondent issued an order to continue Patient B on digoxin without testing the digoxin level in his blood. This charge is SUSTAINED.

i) Respondent did not fail to evaluate Patient B properly in connection with the blood pressure readings recorded after his admitting orders were issued. This charge is not SUSTAINED.

6. Respondent failed to maintain a record which accurately reflected the care and treatment recorded to Patient B. This charge is SUSTAINED.

PATIENT C

FINDINGS OF FACT

1. Patient C was a 90 year old female who was admitted to Maimonidies Hospital on December 26, 1986 after falling in her bathroom and being unable to eat due to back pain and tenderness. (Ex. No. 6, at pp. 6-7)

2. On December 28, 1986, a Sunday, Dr. Becker was the resident assigned to Patient C. (T1011)

3. Dr. Becker was somewhat concerned about the patient and went to the Cardiac Care Unit (CCU) on the first floor to discuss the case with Dr. Chapnick, the PGY II in charge of the CCU, because he believed that Patient C was a potential candidate for the CCU. (T1025-1026)

4. Dr. Chapnick advised Dr. Becker that there was only one bed available in the CCU. Although Dr. Becker opined that Patient C.K. was in greater need of the CCU's facilities, he asked Dr. Chapnick to see both patients since the ultimate responsibility was Dr. Chapnick's. (1028)

5. While Dr. Becker was on the first floor, he went to the Medical Intensive Care Unit (MICU) which was across the hall from the CCU and spoke to Dr. Brad Herman the PGY III in charge of the MICU. (1028 - 1029)

6. Dr. Herman declined to accept Patient C in the MICU. (1029)

7. Dr. Becker next received information about Patient C at shortly after 8:00 p.m. His intern, Dr. Sanni, telephoned him to advise him about the patient's status. Dr. Sanni told Dr. Becker that Dr. Chapnick had just examined the patient and reviewed the electrocardiogram. Dr. Chapnick's note

states that Patient C was comfortable and had no chest pains or shortness of breath. His note further indicates that Patient C was not a candidate for the CCU. (T 1030; Ex. 6 at p. 16)

8. Respondent did not write a note in the patient's chart regarding this physical examination and plan. (Ex. 6)

9. Despite Patient C's emergent and deteriorating condition her private medical doctor was not notified of her condition until after her demise at 1:30 a.m. (T. 1115)

CONCLUSIONS AS TO THE FACTUAL ALLEGATIONS

The Committee is of the opinion that Factual Allegations 1 through 4 do not raise any issues.

5. a) Respondent did not fail to perform and record the results of a proper evaluation and monitoring and

b) Did not fail to institute timely and appropriate treatment. These two allegations are NOT SUSTAINED.

c) Respondent failed to contact the patient's attending physician during the approximately 7 1/2 hours of respiratory distress preceding her death. This allegation is SUSTAINED.

d) Respondent did not fail to contact the Medical Intensive Care Unit for evaluation for admission to that unit. This allegation is not SUSTAINED

6. Respondent failed to maintain a record which accurately reflected the care and treatment recorded to Patient C. This allegation is SUSTAINED.

PATIENT D

FINDINGS of FACT

1. Patient D was a 47 year old male who was admitted to Bayley Seton Hospital on Setpember 16, 1987 presenting with complaints of sudden onset of fronto-parietal headache and neck stiffness. (Ex. No. 7, at p. 1-3)

2. In the afternoon of September 17, 1987, a neurological consultation was performed. The neurologist recommended that a lumbar puncture be performed and that a CT Scan with contrast be performed. (Ex. No. 7, at p. 25)

3. The lumbar puncture was performed the following morning and the results were benign. (T1221)

4. At approximately 3:45 p.m., the following afternoon a neurological consultation by Dr. Jutkowitz was performed at the request of the attending physician. (Ex. 7, at p. 25, 18)

5. Upon examination Dr. Jutkowitz thought that the patient might have a subarachnoid hemorrhage and recommended that a spinal tap should be done as soon as the CT scan was

performed and did not show any mass effect. (T. 137, Ex. 7 at p. 25, (T. 799, 800)

6. As of 4:30 p.m. Respondent was the PGY II whose responsibilities included Patient D. (T. 1210, 1217)

7. The CT Scan with contrast was done at 6:00 p.m. which did not show any mass effect. (Ex. 7 at p. 35)

8. Throughout the night of September 17, 1987 the PGY I called Respondent many times to have him come and assist her in doing the lumber puncture. (T. 138)

9. As a general policy at Bayley Seton Hospital, interns do not do spinal taps alone. (T. 139)

10. Despite the neurologist's recommendation that a lumbar puncture be performed, the PGY I's repeated request's for Respondent assistance in performing the lumbar puncture and the PGY III's directive during midnight rounds that Respondent "go do it" Respondent did not perform the lumber puncture. (T. 138, 1219, Ex. 7, p. 18, 25)

11. Respondent made no attempt to reach Dr. Jutkowitz to discuss any concerns he might have had about the lumbar puncture. (T. 1221, 1226)

12. Respondent wrote no note regarding his decision not to perform the lumbar puncture. (Ex. 7)

3. Although Dr. Becker saw references to a penicillin allergy in the chart, these references did not specify the nature of the allergy. Dr. Becker was unimpressed with the patient's history of a penicillin allergy. (T1248-1249)

4. Dr. Becker's plan for the patient included nafcillin (a penicillin derivative) and Dr. Becker wrote orders for nafcillin to be administered. (Ex. No. 8)

5. Nurse Bortle picked up Dr. Becker's order for nafcillin and called him to alert him to the penicillin allergy notations in the chart. (T1249-1250)

6. Dr. Becker reconsidered his decision to order nafcillin and asked Nurse Bortle to change the nafcillin order. She refused to accept a verbal order and Dr. Becker said he would come to the floor shortly thereafter to change the order in writing. (T1250-1251)

7. When Dr. Becker returned to the floor he discarded the sheet of paper which had his order for nafcillin and wrote an order for Ancef. Since Patient E had already been shampooed, Dr. Becker deleted the "isolation" requirement of his previous order. At that time, there were no orders from other physicians on that page in the chart. (Ex. No. 8; Ex. No. 9 at p. 28)

CONCLUSIONS AS TO THE FACTUAL ALLEGATIONS

1. A neurologist who examined the patient recommended a CT scan with contact and a lumbar puncture to be performed during the afternoon or night of Sept. 17. This allegation is SUSTAINED.

2. After the CT scan was performed at about 9:00 p.m. Respondent was informed by the PGY I that Respondent was responsible to perform the lumbar puncture that night. This allegation is SUSTAINED.

3. Respondent decided that the lumbar puncture should wait until the next morning without discussing the matter with the neurologist and did not record any examination of the patient or reason for his decision. The allegation is SUSTAINED to the extent herein set forth.

PATIENT E

FINDINGS OF FACT

1. Patient E was a 47 year old male admitted to Bayley Seton Hospital on July 13, 1987 for bilateral cellulitis of the lower extremities. (Ex. No. 9, p. (T1248)

2. Dr. Becker reviewed Patient E's chart, took a medical history and performed a physical examination. (Ex. No. 9, pp. 8-9; T1247-1248)

8. Nurse Bortle, upon learning that Dr. Becker had discarded the page in the chart which contained the nafcillin order retrieved that sheet of paper from the waste paper basket. (Ex. No. 8)

9. Respondent admitted that he saw references to Patient E's allergy to penicillin in the emergency room record and nursing record. (T. 1248) Respondent also admitted Patient E informed him that he was allergic to penicillin. (T. 1248)

10. Respondent had not included Patient E's allergy to penicillin in the orders. (T. 225, Ex. 8)

11. Respondent did not include Patient E's allergy in his admitting note nor in his admitting orders. (T97)

CONCLUSIONS AS TO FACTUAL ALLEGATIONS

1. Respondent ordered nafcillin, a penicillin derivative, for Patient E despite the fact that Patient E's hospital chart included several references to Patient E's allergy to penicillin. This allegation is SUSTAINED, the word "several" is eliminated from the conclusion.

2. After the nurse on duty picked up and transcribed Respondent's orders, she contacted Respondent to alert him that he had ordered nafcillin IV for a patient allergic to penicillin. Respondent's response, in words or substance was, "how allergic is he to penicillin, are you sure he is

dangerously allergic to penicillin." This allegation is SUSTAINED.

3. Despite the fact that Respondent's order for nafcillin had already been picked up and transcribed by a staff nurse, Respondent removed the page with his nafcillin order from the patient's chart and attempted to discard it in the waste paper basket. This allegation is SUSTAINED.

PATIENT F

FINDINGS OF FACT

1. Patient F was admitted to Methodist Hospital in Brooklyn, New York on or about August 24, 1989 with non Hogkins lymphoma. (Ex. No. 13, at pp. 8-9)

2. At this time, Dr. Becker was a fellow in hematology/oncology at Methodist Hospital. (T461)

3. Patient F was the private patient of Dr. Adolfo Elizalde, the director of hematology/oncology at Methodist Hospital. (T458)

4. On September 9, 1989, a Saturday, Dr. Becker was the fellow on call in hematology/oncology. (T461)

5. Dr. Becker had previously spoken to Dr. Elizalde about Patient F and Dr. Becker had intended to administer chemotherapy to Patient F in the morning of September 9, 1989. (T461, 1279)

6. Prior to this date, Dr. Becker had made plans to attend a medical seminar in Manhattan. His attendance thereat had been known to several people at Methodist Hospital including Dr. Elizalde. (T1282-1283)

7. In order to be able to administer the chemotherapy and attend the seminar, Dr. Becker wrote orders for the 11 p.m. - 7 a.m. nursing shift to premedicate Patient F so that he could administer the chemotherapy early in the morning on September 9, 1987. (T1279)

8. When Dr. Becker arrived at the hospital early in the morning of September 9, however, he discovered that his order that Patient F be premedicated had not been carried out. (T1281-1282)

9. Dr. Becker left the hospital to attend the seminar with the intent of delegating the administration of the chemotherapy to Dr. Licata, the intern (PGY I) rotating through the hematology/oncology department. (T1284-1285)

10. In a subsequent telephone conversation with Dr. Licata, Dr. Becker learned that when Dr. Licata was attempting to administer the Cytoxan component of the chemotherapy, Patient F became anxious. (T1289-1290)

11. Patient F was known by Dr. Becker to be a moderately anxious patient. (T1290)

patient himself or arranging for a more senior physician to evaluate the patient Respondent directed the PGY-1 to administer 1 mg. Ativan IVPB and then proceed with the infusion."

This allegation is SUSTAINED.

4. The language of the charge is:

"After the Ativan was administered, the PGY-1 continued to infuse the chemotherapeutic agents as per Respondent's direction. During this infusion the patient sustained a cardiopulmonary arrest. Resuscitative efforts were unsuccessful."

This allegation IS SUSTAINED.

THE SPECIFICIATIONS

The First and Second, cover patients A and E. The acts of the Respondent do not in the opinion of the committee constitute fraudulent practice within the purview of Sec. 6509(2).

The Third and Fourth Specifications also cover patient A and E. The acts of the Respondent do not in the opinion of the Committee constitute moral unfitness to practice medicine within the purview of 8 NYCRR 29.1(b)(5).

The Fifth through Tenth Specifications cover all the patients. The acts and omissions of the Respondent in the

12. Dr. Becker advised Dr. Licata to administer 1 mg. of Ativan IVPB to calm Patient F's anxiety and to then proceed with the infusion. (T1290-1291)

13. While Dr. Licata was continuing his attempts to administer the Cytoxan, Patient F went into cardiac arrest and eventually died. (Ex. No. 13, at p. 28)

CONCLUSIONS AS TO THE FACTUAL ALLEGATIONS

1. On September 9, 1989 Respondent absented himself from Methodist Hospital after discharging his on-call responsibilities. The first sentence in the allegation is NOT SUSTAINED.

The Respondent failed to administer chemotherapy as ordered for the patient and failed to arrange for another fellow to do so. This allegation IS SUSTAINED.

2. The language of the charge is:

"At or about 11 a.m. on September 9, 1989 Respondent telephoned the PGY-1 on call for Patient F and improperly directed him to inject Patient F with chemotherapeutic agents." This allegation is SUSTAINED.

3. The language of the charge is:

"In a subsequent telephone conversation Respondent was informed that Patient F became agitated during an attempt by the PGY-1 to administer the chemotherapy. Without evaluating the

opinion of the Committee do not constitute Gross Negligence within the purview of 6509(2).

The Committee applied the definition of gross negligence as set forth in a memorandum by Peter J. Millock, Esq. General Counsel on September 19, 1988 which reads as follows:

"5. GROSS NEGLIGENCE

Negligence is the failure to exercise ordinary care. Gross negligence is the failure to exercise even slight care. "In other words, the act or omission must be of an aggravated character as distinguished from the failure to exercise ordinary care." Weld v. Postal Telegraph Cable Co., 210 N.Y. 59, 72, 103 N.E. 957 (1913). No New York cases specifically apply the meaning of "gross negligence" to a medical context. The Court of Appeals addressed the willfulness of the act or omission in the case of Matter of Jenson v. Fletcher, 277 App. Div. 455, 101 N.Y.S. 2nd (4th Dep't 1950), aff'd, 303 N.Y. 639, 101 N.E. 2nd 759 (1951). The Court stated that:

> It is recognized in this state that "gross negligence" is something more than "ordinary negligence"... Such negligence is defined as "disregard of the consequences which may ensue from the act, and indifference to the rights

of others"... In order to find a "reckless disregard for life or property of others", there must, of necessity, be evidence of a consciousness on the part of the (licensee) of impending dangerous consequences if he persists in his conduct and his failure to desist from such conduct regardless of the consequences. "Recklessness" is defined as "(t)he state of mind accompanying an act, which either pays no regard to its probably or possibly injurious consequences, or which, though foreseeing such consequences, persists in spite of such knowledge."

Matter of Jensen v. Fletcher, 277 App. 454, 101 N.Y.S. 2d 75 (4th Dep't 1950), aff'd 303 N.Y. 639, 101 N.E. 2nd 759 (1951)."

Eleventh Specification covers all of the patients. The committee is of the opinion that the Respondent was negligent on more than one occasions within the purview of Section 6509(2). This specification is SUSTAINED.

The Twelfth through Sixteenth Specification covers patient A through E. The committee is of the opinion that the record keeping by the Respondent was poor within the purview of 8 NYCRR 29.2(9)(3). These specifications are SUSTAINED.

The Seventeenth Specifications charges Patient Abandonment with regard to Patient F. The Committee does not believe that the acts therein alleged constitute abondonment within the purview of 8 N.Y.C.R. 29.2(9)(1). This specification is not SUSTAINED.

The Eighteenth Specification charges the Improper Delegation of Professional Responsibilites, with regard to Patient F. There is grave doubt in the minds of the Committee members that the delegation in this instance is the kind of delegation that is contemplated in Sec. 6509(9). The delegation was made to another physician. The specification is not SUSTAINED.

RECOMMENDATION

The Committee took into consideration the age of the Respondent and the fact that the charges herein took place in a period beginning before his licensure in April 1987 and ending in September of 1989. The Committee feels that the Respondent can be guided to becoming a good and able physican in the service of the Community for many years. The Committee therefore recommends the following:

That the Respondent be suspended from practice for three years but that such suspension be stayed during that

period and that he be on probation during that time; that during such period he shall not engage in private practice but that he may be in a job wherein he has direct supervision; that wherever he is employed he must advise such institution of the content of the Order to be entered herein, and he shall notify the office of Professional Medical Conduct of all medical institutions where he is employed.

DATED: New York, N.Y.
January 8, 1991

Respectfully submitted

Stanley E. Gitlow, M.D.
Chairman
Leo Fishel, M.D.
Denise Bolan, C.R.P.A.

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

IN THE MATTER :

OF : COMMISSIONER'S

STEPHEN BECKER, M.D. : RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on March 1, 1990, April 7, 1990, April 9, 1990, April 16, 1990, July 16, 1990, September 17, 1990 and October 15, 1990. Respondent, Stephen Becker, M.D., appeared by Anthony Z. Scher, Esq. The evidence in support of the charges against the Respondent was presented by Dawn Dweir, 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 with one exception and the following explication: The Committee sustained the Eleventh Specification (negligence on more than one occasion). From its report, the Committee based this conclusion on the following Factual Allegations in the Amended Statement of Charges: A, A(4)(a), A(4)(b), A(4)(c), B, B(1), B(2), B(3), B(4), B(5)(e), B(5)(f), B(5)(g), B(5)(h), B(6), C, C(5)(c), C(6), D, D(1), D(2), D(3), E, E(1), E(2), E(3), F, F(1) (Partially), F(2), F(3) and F(4). The Committee also sustained Specifications Twelfth through Sixteenth. I find

no support in the record to sustain the Twelfth Specification. The remaining specifications were supported by the Committee's findings regarding the following Factual Allegations in the Amended Statement of Charges:

13th Specification:	Paragraphs B and B(5)(f) and B(6)
14th Specification:	Paragraphs C and C(6)
15th Specification:	Paragraphs D and D(3)
16th Specification:	Paragraphs E and E(3)

B. The Recommendation of the Committee should be accepted; and

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
February 27, 1991

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

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

STEPHEN BECKER

CALENDAR NO. 11845

The University of the State of New York

IN THE MATTER

OF

STEPHEN BECKER
(Physician)

DUPLICATE ORIGINAL
VOTE AND ORDER
NO. 11845

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11845, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (June 21, 1991): That, in the matter of STEPHEN BECKER, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted;
2. The conclusions of the hearing committee and Commissioner of Health be modified;
3. Respondent is, by a preponderance of the evidence, guilty of the eleventh specification of negligence on more than one occasion based on subparagraphs and paragraphs, as applicable, in full under A(4)(a), A(4)(c), B(3), B(4), B(5)(f), B(5)(h), B(6), C(5)(c), E(2), F(1), F(2), and F(3), and also based, in part to the extent indicated by the hearing committee under B(5)(e), B(5)(g), D(3), and E(1), said negligence on more than one occasion is supported, as applicable, by paragraphs B(1), B(2), C(1) through C(4), D(1), D(2), and F(4) and subparagraph

A(4)(b); guilty of the thirteenth specification to the extent recommended by the Commissioner of Health; guilty of the fifteenth and sixteenth specifications; and not guilty of the remaining paragraphs and specifications;

4. The measure of discipline recommended by the hearing committee and Commissioner of Health be modified and respondent's license to practice as a physician in the State of New York be suspended for three years upon each specification of the charges of which respondent was found guilty, as aforesaid, said suspensions to run concurrently, that execution of said concurrent suspensions be stayed, and that respondent be placed on probation for three years under the terms prescribed by the Regents Review Committee, which include provision for the direct supervision of respondent practicing in the setting indicated therein; that the above measure of discipline is accepted by the Board of Regents within the context that it is warranted whether based upon all of respondent's misconduct or based solely upon respondent's misconduct subsequent to respondent's licensure;

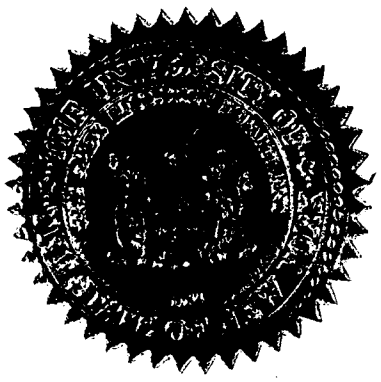
and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

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.

STEPHEN BECKER (11845)



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 25th day of June, 1991.

Thomas Sobol

Commissioner of Education