STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Karen Schimke
Executive Deputy Commissioner

June 5, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy Mahar, Esq.
NYS Department of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12237

Dennis J. Bischof, Esq.
Hurwitz & Fine, P.C.
1300 Liberty Building
Buffalo, New York 14202

Frederick Beck, M.D.
922 Twelve Oaks
Carmel, Indiana 46032

RE: In the Matter of Frederick Beck, M.D.

Dear Mr. Mahar, Mr. Bischof and Dr. Beck:

Enclosed please find the Determination and Order (No. 96-141) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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

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

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER

OF

FREDERICK BECK, M.D.

DETERMINATION

AND

ORDER

BPMC-96-141

MR. ANTHONY C. BIONDI, Chairperson, **DONALD F. BRAUTIGAM, M.D.,** and **JAMES O. ROBERSON, M.D.,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(1)(e) and 230(12) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.,** served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **HENRY M. GREENBERG, General Counsel, TIMOTHY J. MAHAR, ESQ.,** Associate Counsel, of Counsel. The Respondent appeared in person and was represented by **HURWITZ & FINE, P.C., SHELDON HURWITZ, ESQ.** and **DENNIS J. BISCHOF, ESQ.,** of Counsel. Evidence was received, witnesses sworn and heard, and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Amended Statement of Charges allege fifteen (15) specifications of professional misconduct, including allegations of gross negligence, gross incompetence, abandonment, negligence on more than one occasion, incompetence on more than one occasion, and failure to maintain records. The charges are more specifically set forth in the Amended Statement of Charges, a copy of which is attached hereto and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	November 2, 1995
Pre-Hearing Conference:	November 16, 1995
Hearing Dates:	November 16, 1995 December 14, 1995 December 15, 1995 February 27, 1996 February 28, 1996 March 12, 1996
Received Petitioner's Proposed Findings of Fact, Conclusions of Law:	April 8, 1996
Received Respondent's Proposed Findings of Fact, Conclusions of Law:	April 8, 1996
Deliberation Date:	April 16, 1996
Place of Hearing:	
November 16, 1995	Buffalo Holiday Inn 620 Delaware Avenue Buffalo, New York 14202
December 14 & 15, 1995	Alliance Building 183 East Main Street Suite 1500 Rochester, New York 1460
February 27 & 28, 1996	Radison Hotel 4243 Genesee Street Buffalo, New York 14225
March 12, 1996	Days Inn 4345 Genesee Street Buffalo, New York

WITNESSES

For the Petitioner:	David Gandell, M.D. John Choate, M.D. Eleanor Wolpert, R.N. Linda Lucernoni, R.N. Patient A Husband of Patient A
For the Respondent:	Ronald Foote, M.D. Donald Schmidt, M.D. Frederick Beck, M.D. Patient D

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

GENERAL FINDINGS

1. Respondent is licensed to practice medicine in the State of New York and is currently registered with the New York State Education Department. (Ex. 2)

PATIENT A

2. Patient A, who saw Respondent for prenatal care between January 29, 1991 through July 31, 1991, was admitted to the Millard Fillmore Suburban Hospital on August 1, 1991 prior to 5:00 a.m. after her membranes had ruptured at home. (Ex. 5, pp. 18, 42; T. 1103)

3. At 5:00 a.m., an external fetal monitor was placed on Patient A. (Ex. 5, p. 42)

4. Following Patient A's admission to the Millard Fillmore Suburban Hospital on August 1, 1991, Dr. Beck first examined her at 7:30 a.m. (Ex. 5, pp. 23, 43)

5. The fetal heart tracing between 4:11 a.m. when the fetal monitor was first applied and 7:30 a.m., when Dr. Beck arrived, shows decreased beat-to-beat variability or short term variability of the fetal heart rate. (Ex. 6, pp. 2-32; T. 146-147)

6. Variable decelerations are evident on the fetal monitoring strip at 4:20 a.m., and a more prolonged deceleration occurred at 5:10 a.m. (Ex. 6, pp. 3, 10; T. 148) There is a second deceleration that goes below 90 beats per minute at approximately 5:10 a.m., which was a moderate to severe deceleration. (T. 149)

7. Pages 11 and 12 of Exhibit 6 of the fetal heart tracing, together show a significant deceleration at approximately 5:20 a.m., starting on the right side of page 11 and continuing on the left side of page 12 that is nearly down to 60 beats per minute. (T. 149)

8. Page 13 of Exhibit 6 illustrates a flat tracing or very little beat-to-beat variability at approximately 5:40 a.m. (T. 150)

9. The fetal heart tracing at 6:10 a.m. (Ex. 6, pp. 18 and 19 together) illustrates a deceleration which lasted 2 1/2 minutes. (T. 151)

10. The nurses had also given Patient A oxygen by mask as early as 6:00 a.m. (T. 152)

11. At 7:10 a.m. the fetal heart rate had increased to 170 beats per minute. (Ex. 6, p. 29; T. 155)

12. According to Dr. Schmidt, the beat to beat variability was minimal to absent at 7:10 a.m. (Ex. 6, p. 29), absent at 7:40 a.m. (Ex. 6, p. 34) and absent at 8:00 a.m. (Ex. 6, p. 36; T. 820)

13. At 7:30 a.m. according to Dr. Beck's note, Patient A's cervix was at 1.5 centimeters dilated, the cervix was 80 percent effaced, and the fetus' head was at -2 station. (Ex. 5, p. 23, 7:30; T. 156)

14. Dr. Beck's note at 7:30 a.m. refers to diminished short term variability, or low beat-to-beat variability, of the fetal heart rate. (Ex. 5, p. 23; T. 159)

15. At 7:30 a.m. Dr. Beck ordered Pitocin for Patient A. (Ex. 5, p. 13; T. 52, 160)

16. The Pitocin was hung and started to run at 8:00 a.m. (T. 52)

17. At 8:10 a.m., there was a significant and prolonged deceleration of the fetus' heart rate as indicated on the fetal heart tracing. (Ex. 6, p. 38; T. 167)

18. During an eight minute period between 8:46 a.m. and 8:52 a.m., the fetus experienced a series of decelerations. (T. 168)

19. Dr. Beck assessed Patient A at 7:30 a.m. and subsequently went to his office. (Ex. 5, p. 23; T. 689, 692-693)

20. Dr. Beck phoned Nurse Linda Lucernoni at 10:40 a.m. (T. 52) At 10:40 a.m., Nurse Lucernoni told Dr. Beck that Patient A's fetus was having consistent variable decelerations. (T. 53)

21. Dr. Beck did not return to the hospital until 12:00 noon as reported in the hospital chart. (Ex. 5, pp. 23, 43 [12:00])

22. Two deep decelerations were evident on the tracings at 9:08 a.m. (Ex. 6, p. 47)

23 A profound deceleration is illustrated on the tracing at 9:20 a.m. (Ex. 6, right side of p. 48, continuing on to p. 49)

24. There are two severe decelerations evident on the tracing at 9:30 a.m. (Ex. 6, p. 50)

25. The tracing at 10:10 a.m. depicts a prolonged deceleration down to 60 beats per minute on the right side of Exhibit 6, page 56, which never quite recovers to the base line, remains depressed through the next contraction, and only gradually comes up, before the heart rate again decelerates two contractions later. (T. 180-181)

26. The hospital chart indicates that Dr. Beck saw patient A at 12:00 noon. (Ex. 5, p. 43)

27. The fetal tracing between 10:40 and 12:00 (Ex. 6, pp. 61-72) was not reassuring. (T. 184, 693-694)

28. The fetal tracing at 11:15 a.m. illustrates a significant deceleration in which the fetus' heart rate dropped to 60 beats per minute and remained there for a full minute. (Ex. 6, pp. 65-66)

29. The tracings evident at 12:00 noon were considerably worse than those at 8:00 a.m., when Dr. Beck last assessed Patient A. (T. 187)

30. According to Dr. Beck's note at 12:30 p.m., the cervix was 2 to 3 centimeters dilated. (Ex. 5, p. 23)

31. Pitocin was discontinued at 1:00 p.m. (Ex. 5, p. 43)

32. Dr. Beck ordered an amnioinfusion which was initiated at 1:00 p.m. in an apparent effort to address a condition of low amniotic fluid around the fetus. (T. 193)

33. Severe variable decelerations with a late component are evident on pages 74, 75, 76, 78 and 79 (12:13 p.m. - 12:51 p.m.) of the fetal heart tracing. (T. 195-196)

34. An ultrasound performed by Dr. White at Respondent's request indicated decreased amniotic fluid. (Ex. 5, pp. 23, 43)

35. Following his assessment of Patient A at 12:00 noon, Dr. Beck went to his office around 1:55 p.m. (T. 703-707)

36. At 1:20 p.m., twenty minutes after the commencement of the amnioinfusion, the fetus was still experiencing profound decelerations with virtually no beat-to-beat variability. (Ex. 6, pp. 84-85; T. 197)

37. At 2:30 p.m. with the amnioinfusion continuing (Ex. 6, p. 95), Patient A's fetus was again experiencing multiple recurrent decelerations, and the fetal heart rate still fell below 60 beats per minute in some instances. (T. 199)

38. At 2:35 p.m. Nurse Lucernoni called Dr. beck at his office. (T. 56-57) During the 2:35 p.m. phone conversation with Dr. Beck, Nurse Lucernoni reported a probable face presentation of the fetus and the presence of heart rate decelerations, as recorded on the fetal heart tracings. (Ex. 5, p. 45; T. 57) The fetal heart tracings between 1:50 p.m. and 2:40 p.m., illustrate the presence of moderate variable decelerations with minimal variability, according to Nurse Lucernoni. (Ex. 6, pp. 89-96; T. 57-58)

39. Between the 2:35 p.m. phone call to Dr. Beck and 3:10 p.m., a resident, Dr. Theresa Herbert Rush, did an internal examination of Patient A. (T. 59-60)

40. At 3:10 p.m. Dr. Beck was again called by either Nurse Lucernoni or the resident and advised of a face presentation, unknown dilatation and of fetal heart rate decelerations. (Ex. 5, p. 45, 1510; T. 60) Dr. Beck came into the hospital at approximately 3:40 p.m. and remained until the patient delivered. (T. 60-61)

41. The heart rate variability again appeared to be absent at 3:00 p.m., and was totally absent at 3:40 p.m. (Ex. 6, pp. 100, 105; T. 205, 842-843)

42. Dr. Beck's progress note at 3:40 p.m. indicates that Patient A was offered an option of a vaginal delivery versus a cesarean section and wanted to try a vaginal delivery. (Ex. 5, p. 24; T. 206)

43. There is no documentation by Dr. Beck of Patient A's alleged refusal of a cesarean in the progress notes of 12:30 p.m., and 3:40 p.m. (Ex. 5, pp. 23-24), the delivery note of 4:30 p.m. (Ex. 5, p. 24) or in the discharge summary. (Ex. 5, pp. 6-7)

44 At 4:30 p.m. the fetal heart rate variability was totally absent (Ex. 6, p. 105; T. 105) At 3:50 p.m., there are severe decelerations with no variability at 4:00 p.m. (Ex. 6, pp. 106-108; T. 210-211) At 4:30 p.m., the fetal heart rate decelerated to approximately 50 beats per minute (Ex. 6, p. 112) and did not return to the base line. (T. 211) The fetal heart tracing after page 108 of Exhibit 6, 4:00 p.m., has no variability and profound decelerations. (T. 212)

45. The discharge summary indicates that the fetus was delivered stillborn with the umbilical cord wrapped tightly twice around its neck, as well as around its foot and the trunk of its body. (Ex. 5, p. 7; T. 214)

46. The umbilical cord pH of 6.75 was severely below the recognized benchmark for fetal acidosis of 7.2. (Ex. 5, p. 50; T. 216)

PATIENT B

47. Dr. Beck treated patient B for a first pregnancy in 1992. Patient B was then 28 years old, and her due date by ultrasound was August 20, 1992. (Ex. 7, pp. 6-7; T. 305)

48. Patient B went to the Millard Fillmore Suburban Hospital on August 5, 1992 with a possible urinary tract infection and was subsequently admitted to the labor and delivery unit. (T. 306) The hospital record indicates that at 10:15 p.m. Patient B had bloody fluid while in the bathroom, which Dr. Beck later described in the discharge summary as including a moderate amount of blood. (Ex. 8, p. 86; T. 306-307)

49. Dr. Beck's progress note at 10:15 p.m. includes an assessment of a marginal separation, which describes a condition in which the edge of the placenta is separated from the uterus. (Ex. 8, p. 66, T. 310-311)

50. Placenta previa was ruled out by ultrasound. (T. 307-308)

51. Dr. Beck's plan for Patient B, as indicated in his note of 10:15 p.m., was to give Patient B Seconal, which is a barbiturate hypnotic medication. (T. 315)

52. At the time the Seconal was ordered, Patient B was at 36 weeks gestation, approximately 50% effaced, 1.5 centimeters dilated and at -3 station, with contractions as described above, indicative of a early labor for a first pregnancy. (Ex. 8, p. 65)

53. After ordering Seconal for Patient B at 10:15 p.m., Dr. Beck went home and did not return to the hospital until the following morning. (T. 37-38, 1018-1019)

54. According to the entries in the hospital chart, following Dr. Beck's assessment of Patient B at 10:15 p.m. and the assessment of the resident at 11:20 p.m. that the uterus felt firmer than usual, there was no assessment of Patient B by a physician for some eight hours, until Dr. Beck assessed the patient at 7:30 a.m. the following morning. (T. 1027-1029 [Dr. Beck])

55. At 7:30 a.m. on August 6, 1992, Dr. Beck ordered Pitocin for Patient B. (T. 324)

56. The labor note at 11:20 p.m. on the previous evening, August 5, 1992, states that Patient B complained of abdominal pain at the fundus of the uterus and that the uterus felt firmer than usual without contracting. (Ex. 8, p. 86, 2320)

57 Dr. Beck ordered Pitocin for Patient B and then went to his office. (T. 37-38, 1020)

58 The risk of a total abruption of Patient B's placenta did not end until the time of her actual delivery. (T. 328-329, 882)

59 Following delivery, the pathology report for the uterus (Ex. 8, p. 101) indicated an abruption of the placenta, as did the discharge summary. (Ex. 8, p. 40) The discharge summary reported that 30 percent of the placenta had been separated from the uterus. (T. 332)

60 Patient had a CBC on August 5, 1992 at 20:20 hrs with normal results. The following morning the test was repeated with normal results. (Ex. 8, p. 73)

PATIENT C

61 At the time of Dr. Beck's treatment of her on September 22, 1986, Patient C was 16 years old, approximately seven months pregnant, and had received no prenatal care. (Ex. 10, p. 6; T. 91, 351) Patient C was admitted to the Emergency Room of the Kenmore Mercy Hospital at 7:00 p.m. on September 22, 1986 with a history of bleeding and cramping earlier that afternoon. (Ex. 10, p. 6) Patient C had only been referred to Dr. Beck following her admission on September 22, 1986. (Ex. 10, p. 22, 7:30 p.m. note)

62 Eleanor Wolpert was the obstetrical nurse at the Kenmore Mercy Hospital assigned to Patient C on September 22, 1986. (T. 90)

63. At 11:30 p.m. on September 22, 1986, Dr. Beck had already assessed Patient C and had found her to be four centimeters dilated. Patient C had been transferred to the labor wing from the emergency room. Her history included, an approximately eight month pregnancy, bleeding upon admission with meconium stained fluid, no prenatal care, and active labor. (T. 91)

64. Respondent's admission note stated that Patient C was felt to be a possible breech presentation and rule out sepsis. Respondent felt that there was an interuterine fetal demise. (Ex. 10, p. 9)

65. Dr. Beck told Nurse Wolpert that Patient C's fetus was stillborn. (T. 94)

66. There was a notation in the emergency room chart that there were no fetal heart tones heard by Doppler, a device which reflects sound waves off of objects. (T. 354)

67 There were no ultrasound reports contained in the hospital chart nor was there any order for an ultrasound study for Patient C. (T. 357)

68. Laboratory test results reported at the time of Dr. Beck's 11:00 p.m. assessment that Patient C's white blood count was 22,000 which was elevated above the acceptable upper limit of approximately 16,000. (Ex. 10, p. 12; T. 362)

69. The laboratory reports also indicated a fibrinogen of 200 at 10:35 on 9/22/86 and 160 on 9/23/86. (Ex. 10, p. 12)

70 Dr. Beck went home after assessing Patient C at 11:00 p.m. (T. 40-41) Dr. Beck told Dr. Choate that although he made a diagnosis of an abruption and possible D.I.C., Patient C was stable enough for him to leave the hospital. (T. 41) Nurse Wolpert contacted Dr. Beck at his home at 12:55 a.m., September 23, 1986. (T. 97-98)

71 Dr. Beck was not present for the delivery of Patient C. (T. 97) At 2:00 a.m. Nurse Wolpert called Dr. Beck again and advised him of the status of his second patient. (T. 97) Dr. Beck came to the hospital following this conversation. (T. 97) Dr. Beck arrived at the hospital approximately 2:30 a.m. (T. 97-98)

72 The discharge summary refers to the fetus as a fresh stillborn female. (Ex. 10, p. 4)

PATIENT D

73 At the time Dr. Beck treated Patient D in 1992 for her fifth pregnancy, Patient D was 37 years old. Patient D had prenatal visits with Dr. Beck between January 10, 1992 and August 6, 1992. (Ex. 11, p. 54-57; T. 409)

74 Patient D's due date by ultrasound was August 2, 1992. (T. 410)

75 On August 8, 1992, Patient D had a non-stress test performed. (Ex. 11, p. 34; T. 410)

76 Patient D had a fetal heart rate deceleration during her non-stress test, and the fetus was not sufficiently reactive to meet the criteria of a reactive non-stress test. The fetus was then assessed by ultrasound and was found to have normal tone with normal amniotic fluid volume. (Ex. 11, p. 34; T. 412-413)

77 Patient D was admitted to the hospital at 8:00 a.m. the following morning, August 9, 1992. (Ex. 12, p. 37; T. 421) The labor notes indicate that at 8:53 a.m. Patient D's membranes were artificially ruptured and meconium was noted in the amniotic fluid. (Ex. 12, p. 35; T. 421)

78 At 10:15 a.m., Dr. Beck ordered an epidural for Patient D. (T. 424-425)

79 As early at 7:40 a.m. the fetal heart tracing appeared to have gaps and generally appeared to be tracing poorly. (Ex. 12, p. 73; T. 426-428) Further, as early as 8:00 a.m. the fetus appeared to be experiencing some variable decelerations, and at 8:10 a.m. had a severe deceleration that reached as low as 60 beats per minute. (Ex. 12, p. 76; T. 428)

80. The fetal heart tracing continued to remain poor. (Ex. 12, p. 86; T. 430)

81. Soon after she received the epidural at approximately 10:15 a.m., Patient D suffered significant hypotension, with a blood pressure of 80/39, and was placed on oxygen. (Ex. 12, pp. 88-90)

82. The internal scalpel electrode was placed at 10:54 a.m. (Ex. 12, p. 92)

83. Patient D's baby was delivered at 11:25 a.m. (Ex. 12, p. 41)

84 At the time of delivery, meconium was seen by the nurse below the baby's vocal cords, indicating that the baby had aspirated meconium. (T. 435-436)

85 The delivery at 11:25 a.m. by Dr. Beck was accomplished by a means of forceps. (Ex. 12, p. 40)

86 There was no report of a fetal scalp pH in the hospital chart. (T. 439)

PATIENT E

87 Patient E was 26 years old when she was treated by Dr. Beck for her first pregnancy during prenatal visits between July of 1993 through February 1994. (Ex. 13, pp. 12-15) The results of an ultrasound examination performed on September 14, 1993, indicated a due date which was consistent with the date calculated from Patient E's last menstrual period. (T. 363-364)

88 During an office visit on December 20, 1993, Patient E, then 31 weeks by dates, had an elevated blood pressure of 150/84 with a trace of protein in her urine. (Ex. 13, p. 14)

89 Inadequate fetal growth as determined from a measurement of the fundal height was found on the December 20, 1993 office visit. (T. 466)

90 The four week size discrepancy noted between the fundal height and the gestational age on December 20, 1993 was noted by Dr. Beck as the fetus being small for gestational age and a sonogram was ordered, according to his note, to rule out intrauterine growth retardation. (Ex. 13, p. 14)

91 A sonogram was performed the following day on December 21, 1993. (Ex. 13, p. 33) This second sonogram showed that he fetus was lagging two weeks behind in size when compared to its gestational age. (T. 468)

92. The graphic accompanying the ultrasound report of December 21, 1993 illustrates that the size of Patient E's fetus was two standard deviations below the norm. (Ex. 14, p. 34)

93. On Patient E's next office visit on January 3, 1994, her blood pressure had elevated to 140/100, and measured 140/82 when resting on her left side. (Ex. 13, p. 14)

94. According to Dr. Beck's note of January 3, 1994, Patient E was still working and active, and there are no orders for stopping work or for the reduction of activities. A repeat sonogram for evaluation of possible growth retardation was ordered and performed on January 4, 1994. (Ex. 13, p. 14)

95. The measurement of the fundal height on January 3, 1994, demonstrated a four week discrepancy with the gestational age. (Ex. 13, p. 14)

96. Dr. Beck acknowledged that in general, biophysical profiles are among those tests indicated where intrauterine growth retardation cannot be ruled out. (T. 1072)

97. A third ultrasound was ordered by Respondent and was performed on January 4, 1994. (Ex. 13, p. 31) This third ultrasound showed that the fetus continued to have a two week lag in growth as measured against its gestational age as reported in the first ultrasound. (T. 473-474) The ultrasound reported adequate fetal interval growth. The third ultrasound report also indicates that the fetal body ratios appeared normal. (T. 474)

98 Patient E had symptoms of preeclampsia (toxemia) upon admission to the Millard Fillmore Suburban Hospital on January 15, 1994, including right upper quadrant pain, nausea and vomiting for two days, a blood pressure of 170/100, 1+ proteinuria, and 3+ reflexes. (Ex. 14, p. 7; T. 478) Dr. Beck acknowledged that the patient's condition had on admission deteriorated from the time of her last office visit. (T. 1074-1075)

99 Patient E's blood pressure of 170/100, brisk reflexes and 1+ proteinuria were indicative of severe preeclampsia. (T. 479-481, 934-935) Patient E was also assessed at the time of admission as having a closed, thick cervix and a high fetal vertex, indicating that she was not going to be able to deliver vaginally at that time, but that she would probably require a cesarean section as delivery is the principal cure for preeclampsia (toxemia). (T. 480-481)

100. Dr. Beck gave magnesium sulphate to Patient E upon her admission to prevent seizures. (T. 481, 1077) Seizures are a risk of severe preeclampsia. (T. 481)

101. Dr. Beck also prescribed Labetalol which is a beta blocker to lower Patient E's blood pressure. (T. 483, 935)

102. Patient E had extremely high blood pressures during the night following her admission and required multiple treatments with Labetalol to lower her blood pressure. (T. 483-484)

103. Further, upon her admission, Dr. Beck placed Patient E on bedrest. (Ex. 14, p. 19)

104. As indicated in Patient E's admitting history, she was a high-risk patient. (Ex. 14, p. 27; T. 485-486, 934-935) Dr. Beck's chart entry at 10:30 p.m., the evening of admission, included an impression of pregnancy induced hypertension, and moderate preeclampsia. (Ex. 14, p. 36) He assessed the fetus as small for gestational age with "possible intrauterine growth retardation." (Ex. 14, p. 36)

105. Dr. Beck assessed Patient E at 10:30 p.m. on January 15, 1994 and then went home. (T. 41-42, 1077)

106. Patient E had recorded blood pressures during the period between 10:30 p.m. on January 15, 1994 and 7:00 a.m. on January 16, 1994 including pressures of 196/112 (12:30 a.m.), 170/108 (1:10 a.m.) and 157/103 (4:50 a.m.). (Ex. 14, p. 36-37)

107. The progress note at 4:50 a.m., indicates that Patient E was complaining of headaches with no visual changes. (Ex. 14, p. 37)

108. At 4:50 a.m. on January 16, 1994, Patient E had been on Pitocin for a number of hours, but her pelvis remained closed and the fetus' head was described as ballottable. (T. 492-493)

109. There was minimal beat-to-beat variability to the fetal heart beat with mild variable decelerations and occasional mild late decelerations. (T. 493) Patient E was given oxygen at 6:30 a.m. and placed on her side. (Ex. 14, p. 38; T. 493-494) When Dr. Beck arrived at 7:00 a.m., his assessment was that a cesarean section should be considered "ASAP". (T. 494)

110 David Gandell, M.D testified as an expert witness for the Petitioner. Dr. Gandell is board certified in obstetrics and gynecology. He is presently a clinical associate professor of obstetrics and gynecology at the University of Rochester. (T. 123-124)

111. Donald F. Schmidt, M.D. testified as an expert witness for the Respondent. Dr. Schmidt is board certified in obstetrics and gynecology. He is presently the program director for the SUNY Buffalo obstetrics and gynecology residency program and is on the staff at Children's Hospital and Millard Fillmore Suburban Hospital which are both in Buffalo. (T. 738-740)

112. Ronald J. Foote, M.D. also testified on behalf of the Respondent. Dr. Foote is board certified in obstetrics and gynecology. He was the OB-GYN Clinical Chief at the Millard Fillmore Hospitals from January 1987 to August 1994. At present, Dr. Foote is semi-retired, but he continues as a Clinical Associate Professor of Gynecology/Obstetrics and the Director of the Medical Education Program at the University of Buffalo. (T. 517-519)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(2, 45)
Paragraph A.2:	(35 through 39)
Paragraph A.3:	(40 through 46)
Paragraph B:	(47)
Paragraph C:	(61)

Paragraph D: (73)

Paragraph E: (87)
Paragraph E.4: (98 through 109)

The Hearing Committee further concluded that the following Factual Allegations **should not be sustained:**

Paragraph A.1

Paragraph B.1 (vote 2 to 1), and B.2

Paragraph C.1 through C.4

Paragraph D.1 through D.4

Paragraph E.1 and E.2

The Hearing Committee further concluded that the following Specifications **should be sustained**. The citations in parenthesis refer to the Factual Allegations which support each specification:

NEGLIGENCE ON MORE THAN ONE OCCASION

Eleventh Specification: (Paragraph A and A.2 and A.3)
(Paragraph E and E.4,) (except with respect to evaluate)

The Hearing Committee further concluded that the following Specifications should not be sustained:

First through Third Specifications (Gross Negligence)

Fourth through Sixth Specifications (Gross Incompetence)

Seventh through Tenth Specifications (Abandonment)

Twelfth Specification (Incompetence on More Than One Occasion)

Thirteenth through Fifteenth Specifications (Failure to maintain Records)

DISCUSSION

Respondent is charged with fifteen (15) specifications alleging professional misconduct within the meaning of Education Law Section 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that one (1) of the fifteen (15) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, The Hearing Committee made a determination as to the credibility of the significant witnesses presented by the parties. Significant witnesses for the Petitioner included David Gandell, M.D., Linda Luceroni, RN, Patient A, the husband of Patient A and Eleanor Wolpert, RN.

The Hearing Committee found Dr. Gandell to have the appropriate qualifications for an expert witness, but note that his testimony was based exclusively upon his experience in a large teaching hospital and not the type of community hospital where Respondent worked. They found that Dr. Gandell also based his judgment exclusively upon his own group practice and not upon the experience of a physician in solo practice. The Hearing Committee further notes that Dr. Gandell had the benefit of hindsight in reviewing these five patient's records. The Hearing Committee finally found that Dr. Gandell often overstated the cases before him by trying to make issues significant that were not. The Hearing Committee did not find this to be helpful. As a result, Dr. Gandell's testimony was given minimal weight.

The Hearing Committee also found Nurse Luceroni to be a less credible witness. They believe that her testimony was colored by the tragic loss of Patient A's fetus. The Hearing Committee believes further , that she had some responsibility to manage and oversee Patient A and to consult with a superior to shut off the Pitocin. (T. 799) The Hearing Committee also found that Patient A was likewise emotionally traumatized by her great personal loss. They found Patient A's

husband to be totally incredible particularly regarding his statement that he had a perfect memory. (T 1133) The Hearing Committee found Nurse Wolpert to be a credible, experienced witness. She needed to refer to her notes to testify about this 1986 incident.

With respect to Respondent's case, the Hearing Committee found Respondent to be evasive at times and very cautious in answering the Hearing Committee's questions. The Hearing Committee found however, that Respondent's testimony was overall credible within the bounds in which he provided answers, therefore, his testimony was given moderate weight.

The Hearing Committee found Donald F. Schmidt, M.D. to be well qualified and extremely credible as Respondent's expert witness. His opinions were given in a forthright manner and he did not overstate his case. The Hearing Committee notes that Dr. Schmidt sometimes agreed with aspects of the Petitioner's case. More importantly, the Hearing Committee concurs with Dr. Schmidt that a fetal monitoring strip can be subject to many interpretations and that it is much easier to read retrospectively as Dr. Gandell did, than prospectively as Respondent had to. (T. 747-752, 861) Therefore, the Hearing Committee gave Dr. Schmidt's testimony great weight.

Ronald J. Foote, M.D. also testified for Respondent. The Hearing Committee found that as the OB-GYN Clinical Chief at the Millard Fillmore Hospitals during the time of the incidents in question, Dr. Foote corroborated Respondent's testimony regarding the policies and procedures in place at that time. The Hearing Committee also notes that Dr. Foote never had to discipline Respondent while under his supervision. (T. 525) The Hearing Committee further notes that overall Dr. Foote's testimony was not always relevant to the charges at hand and therefore, his testimony was given moderate weight.

The Hearing Committee also found Patient D to be a credible witness in that she corroborated Respondent's testimony that he makes an attempt to communicate with patients during the course of delivery. The Hearing Committee, however found that she was not qualified to comment upon Respondent's medical judgment with respect to her case.

PATIENT A

Patient A, while under the care of Respondent, delivered a stillborn fetus on August 1, 1991. The Petitioner alleged that Respondent ordered Pitocin which was contraindicated and that Respondent failed to adequately attend and/or evaluate Patient A throughout the course of her labor. Petitioner also alleged that Respondent failed to timely deliver the fetus.

Dr. Schmidt testified that at 7:30 a.m. on August 1, 1991, Respondent assessed Patient A with no risk factors because he assessed that the fetus had satisfactorily responded to scalp stimulation. (T. 789) Therefore, the Hearing Committee finds that Pitocin was indicated to stimulate Patient A's labor at that time, (T. 789-790, 823, 854-855, 860) and that it should have been discontinued at as per the PDR (Ex. 17) "in fetal distress where delivery is not imminent." Therefore, the Hearing Committee concludes that Respondent 's initial ordering of Pitocin was within the appropriate standard of care and charge A.1 is not sustained.

With respect to charge A.2, that Respondent failed to adequately evaluate to Patient A, the Hearing Committee concurs with Dr. Schmidt that the fetal monitoring strips are not only difficult and complicated to read, but there are also many variable factors involved. (T. 746-750, 807) More specifically, Dr, Schmidt stated:

> "The problem is that your are not really looking at the actual direct status of the baby as far as its oxygenation is, what his oxygenation is, what its status is. What you are looking at is the baby's central nervous system effect on the heart rate. There are many variables that are involved in this and you can have strips that look very normal that suddenly they really aren't right and you have other strips that look really terrible but in actuality it may be a very benign thing that is of no consequence to the baby or the mother." (T. 747)

Therefore the part of charge A.2 alleging Respondent's failure to adequately evaluate Patient A is not sustained. The Hearing Committee however, sustains the part of charge A.2 that Respondent failed to adequately attend to Patient A. Respondent ordered an amnioinfusion which was initiated at 1:00 p.m. in an effort to address a condition of low amniotic fluid around the fetus. (T. 193) At 1:20 p.m., shortly after the commencement of the amnioinfusion, the fetus was still experiencing profound decelerations with virtually no beat-to- beat variability. (Ex. 6, pp. 84-85, T. 197) Respondent, however, returned to his office around 1:55 p.m. (T.703-707) The Hearing Committee concurs with Dr. Gandell that it was inappropriate for the attending obstetrician to leave the hospital not knowing whether the amnioinfusion would relieve the fetal distress. (T. 196-197) The Hearing Committee further notes that Respondent did not provide any good reason for not remaining with the patient and failing to return to the hospital until approximately 3: 40 p.m. (T. 60-61) The Hearing Committee concurs with Dr. Schmidt that Respondent has the requisite skills and knowledge to practice obstetrics, (T. 864) but that in this instance, he should have known not to leave Patient A at this significant phase of her delivery.

The Hearing Committee also sustains charge A.3 that Patient A's fetus was not delivered in a timely manner. Dr. Schmidt testified that the delivery was not timely. (T. 857) He stated that he would have recommended that Patient A have a Caesarean section somewhere between 12:30 p.m. and 2:00 p.m. (T. 846). If Patient A had refused to have the C-section, Dr. Schmidt would have told her that "things look very bad and I would be concerned there was no way I could reassure that the baby would be normal and there is a good chance we could lose the baby during labor." (T. 849-850) Dr. Schmidt further added that he would have documented this discussion in the patient's chart. (T. 850)

The Hearing Committee found that the evidence in this instance was insufficient to rise to the level of gross negligence, gross incompetence or abandonment. Therefore, only the Eleventh Specification is sustained with respect to Patient A.

PATIENT B

Respondent is charged with ordering Seconal, a sedative for Patient B which was contraindicated. He is further charged with failing to adequately attend and/or evaluate Patient B during her labor.

Dr. Schmidt testified that Seconal is a relatively mild barbiturate drug prescribed to help a patient sleep. Seconal is frequently given to patients that are pregnant and are in possibly early labor or those who have ruptured membranes and are waiting for labor to start. Dr. Schmidt further stated that he saw nothing in the patient's record to indicate that the Seconal would have caused an adverse outcome or that it would have in any way affected the outcome of Patient B's labor. (T. 871) The Hearing Committee concurs that Respondent's order of Seconal was justified.

Dr. Gandell testified that it is patient abandonment for an obstetrician to leave a patient who has incurred a placental abruption. (T. 319) Dr. Schmidt however, distinguished that the abruption was not total, but partial (only 30 per cent). He explained:

> "A partial abruption is partial separation of the placenta from the uterine wall and the remainder of the placenta supposedly is still intact and functioning. How this relates to the patient has to do with the amount of separation that has occurred, how quickly is it occurring, how well the baby is going to tolerate labor based on the status of the placenta prior to the abruption." (T. 873)

Dr. Schmidt further stated that Respondent adequately monitored and evaluated Patient B. (T. 872, 874) The Hearing Committee notes that Patient B's records indicate that Respondent saw Patient B around 10:15 p.m. on the night of August 5, 1992 and that he consulted with the hospital by telephone at 3:40 a.m. and 6:15 a.m. on the morning of August 6th before assessing her again at 7:30 a.m. (Ex. 8, pp. 86-87) The Hearing Committee further finds that there was insufficient evidence to establish the height of risk of total abruption. Therefore, charges B.1 and B.2 with respect to Patient B are not sustained.

PATIENT C

On September 22, 1986, at approximately 7:00 p.m., Patient C, a 16 year old who had received no prenatal care was admitted to the Emergency Room of Kenmore Mercy Hospital with a history of bleeding and cramping. (Ex. 10, p. 22) Respondent saw Patient C for the first time at 11:30 p.m. Respondent's admission note stated that Patient C was felt to be a possible breech presentation and he ruled out sepsis. He further assessed interuterine fetal demise. (Ex. 10, p.9)

Respondent is charged with failure to order an ultrasound or in the alternative record the results. Dr. Foote testified that an ultrasound was unnecessary because Respondent was able to assess interuterine fetal demise without an ultrasound because no fetal heart was detected and the patient had not felt any fetal movement for a week. (T. 630) Dr. Foote further pointed out that the Clinical Summary states that:

> "GI tract, small bowel shows autolysis, that is dissolution of surface mucosa and the large bowel also shows disruption of the surface mucosa which indicates that the baby was dead for approximately 12 or so hours." (T. 622, Ex. 10, p. 46)

The Hearing Committee concurs with Dr. Foote that ultrasound was not indicated in this instance and charge C.1 is not sustained.

Respondent is charged with failure to adequately attend and/or adequately evaluate Patient C following her admission to the hospital for delivery. Dr. Schmidt testified that Respondent's notes in the patient record clearly indicate his diagnosis of intrauterine fetal demise, that he understands its possible breach presentation, and that he documents his postpartum care. (T. 886) The Hearing Committee further notes that Respondent had ordered a number of lab tests at the time of his initial assessment. (Ex. 10, p.12) They further note that Patient C had no pre-natal care and that Respondent was called into evaluate a patient he had never seen before. (Ex. 10, p. 4, 22, 29) The Hearing Committee concurs with Dr. Schmidt's opinion that Respondent adequately evaluated and attended to Patient C. (T. 886-887) Therefore, charge C.2 is not sustained.

It is further charged that Respondent failed to order antibiotics for Patient C in circumstances in which Respondent had diagnosed possible sepsis. The Hearing Committee notes that the medical record clearly states that Respondent ruled out sepsis in his initial assessment. (Ex. 10, p.9) Dr. Schmidt also testified that the use of antibiotics is not necessarily indicated for a situation like this. (T 888) Therefore, the Hearing Committee does not sustain charge C.3.

It is also alleged that Respondent failed to attend the delivery of Patient C's fetus. Dr. Schmidt testified that in the case of stillborn babies, it is not uncommon for the attending obstetrician not to be present at the delivery. (T. 887) Once an assessment is made, the physician can go home if he or she is comfortable with the coverage provided by the house doctor and the nursing staff. (T. 893) The Hearing Committee finds no deviation from the acceptable standard of medical care with respect to the delivery of Patient C's fetus. Charge C.4 is not sustained.

The Hearing Committee further finds that Respondent adequately documented Patient C's medical record. Therefore, none of the Specifications with respect to Patient C is sustained.

PATIENT D

Respondent treated and attended Patient D for her fifth pregnancy during which she had prenatal visits commencing in January 1992. (Ex. 11, p. 54-57) It is alleged that Respondent deviated from acceptable standards of medical care in several respects.

Respondent is charged with failure to admit Patient D on August 8, 1992 and/or failure to adequately evaluate her fetus and/or record the results. Dr. Schmidt testified that there is no indication in the record that the Patient was in labor on August 8th. (T. 899) On that date, Patient D had a non-stress test performed which was non-reactive . (Ex. 11, p. 34) An ultrasound on that same date indicated that the fetus had an acceptable biophysical profile in that the amniotic fluid volume and fetal tone are normal. (T. 902, Ex. 11, p.33) The Hearing Committee concurs with Dr. Schmidt and finds that there is sufficient evidence in the patient's record to refute charge D.1.

Respondent is also charged with failure to timely place an internal fetal monitor in Patient D following her admission to the hospital on August 9, 1992. Dr. Schmidt discussed the fetal monitoring strips starting at 8:50 a.m., the time of the artificially ruptured membranes. He states that there are no suspicious readings at that time and that it looks fairly good at 9:40 a.m. At 9:50 a.m. there is no deceleration, but the baby begins to move. At 10:00 a.m. the fetal heart rate appears to be normal variability, but a few minutes later there is one variable deceleration. At 10:45 a.m., the external monitor can no longer provide information, but by 10: 54 a.m., the scalp electrode has been applied. (T. 904-905) In Dr. Schmidt's opinion, it was not unreasonable to apply the internal fetal monitor at 10:54 a.m. because that was only minutes after the point when the fetus could no longer be properly assessed by the external fetal strip monitor. (T. 905, 920) The Hearing Committee concurs with Dr. Schmidt's opinion in this instance, thus charge D.2 is not sustained.

Respondent is also charged with failure to adequately evaluate Patient D's fetus, including but not limited to, failure to obtain a timely fetal scalp pH. For reasons stated above, it was found that external monitoring provided adequate information for evaluation until such time that the scalp electrode was placed. Dr. Schmidt further opined that the fetal scalp monitor provided adequate evaluation until the time of delivery approximately one-half hour later. He further added that any additional testing would have been counterproductive and delayed the actual delivery time. (T. 907) With respect to the necessity of the fetal scalp pH, Dr. Schmidt testified that in a hospital like Suburban, where the pHs have to be sent to the lab, it could take up to 45 minutes to get the results and would be contraindicated in this instance where delivery was imminent. (T. 905-907) The Hearing Committee not only agrees with Dr. Schmidt, but notes that the medical record adequately documents Respondent's evaluation of the patient's labor. Therefore, charge D.3 is not sustained.

It is further charged that Respondent's delivery of Patient D's baby was not timely. Dr. Schmidt testified that delivery was very timely. (T. 911) The Hearing Committee again concurs and notes that Respondent intervened to hasten delivery by using forceps. (Ex. 12, p.40) Charge D.4 is not sustained.

For the reasons stated above, none of the Specifications with respect to Patient D is sustained.

PATIENT E

Patient E was treated by Respondent for her first pregnancy during prenatal visits between July of 1993 through February 1994. (Ex. 13, pp.12-15) Respondent is charged with failure to perform and/or record the performance of adequate antenatal testing of Patient E's fetus. Patient E's record indicates that at least 3 sonograms were performed. (Ex. 13, pp. 14,31,33,34) Dr. Schmidt testified that sonograms constitute antenatal testing and that adequate antenatal testing was performed. (T. 924-925) The Hearing Committee concurs with Dr. Schmidt in this instance and therefore Charge E.1 is not sustained.

Respondent is also charged with failure to place Patient E on bedrest in circumstances in which he knew that Patient E's fetus was growth retarded. Dr. Schmidt testified that based upon his review of the ultrasound, it appears that the baby was small for its gestational age as opposed to a growth-retarded baby. (T. 927) Dr. Schmidt further explained that "small for gestational age simply means that the baby is just genetically determined to be a small baby." (T. 926) He distinguished a growth-retarded baby as one that commonly is an asymmetric growth retardation because the baby is getting inadequate amounts of nutrition from the placenta. (T. 927) If the baby is growth retarded, the fetal head usually continues to grow at the proper rate whereas the baby's abdomen and femur grow at a slower rate. (T. 927) Dr. Schmidt concluded that pursuant to the ultrasound, Patient E's baby was symmetric in growth and thus small for gestational age. (T. 927, 933-934, 939-940) In contrast, Dr. Gandell read the ultrasound as indicators of growth retardation. (T. 498-502) The Hearing Committee acknowledges the dispute in the reading of the ultrasound by both medical experts, they, however, find that the evidence is more persuasive in classifying the baby as small for gestational age and thus find insufficient evidence to sustain charge E.2.

Charge E.3 was withdrawn by the Petitioner and thus was not considered by the Hearing Committee.

Finally, Respondent was charged with failure to adequately attend and/or adequately evaluate Patient E during her labor. Dr. Schmidt testified that Respondent's evaluation of Patient E was adequate. The Hearing Committee notes that Respondent clearly evaluated and documented Patient E upon admission for pregnancy induced hypertension and moderate preeclampsia. (Ex. 14, p.36) Respondent prescribed medications and also placed the patient on bedrest. (T. 481, 1077, 483, 935, Ex. 14, p.19) Therefore, the part of charge E.4 with respect to Respondent's failure to adequately evaluate Patient E during her labor is not sustained

However, both Dr. Gandell and Dr. Schmidt agree that Respondent should not have left Patient E at 10:30 p.m. on January 15, 1994, due to her high blood pressure and the risk of eclampsia. (T. 487, 937) The Hearing Committee concurs and finds that Respondent was negligent for leaving a very sick patient and entrusting her welfare to the house officer. Therefore, the part of charge E.4 with respect to Respondent's failure to adequately attend to Patient E during her labor is sustained as part of the Eleventh Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be suspended for two (2) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent shall be placed on probation. The period of suspension and probation shall be tolled until such time as the Director of the Office of Professional Medical Conduct is advised, in writing, that Respondent has commenced a medical practice in New York State. The complete terms of probation are attached to this Determination and Order in Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to stature, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee believes that Respondent needs to know that it is not acceptable medical practice to ignore the needs of Patient A and her distressed fetus or the pre-eclamptic Patient E. While the solo practitioner cannot be with all of his or her patients all of the time, Respondent has an obligation to provide for adequate back-up coverage by another experienced obstetrician to cover situations when significant complications arise during labor.

The Hearing Committee further notes that at present Respondent is not a solo practitioner, but works with the Methodist Medical Group, a subsidiary of Methodist Hospital in Indianapolis, Indiana. The Hearing Committee further believes that Respondent has incurred not only personal stress (T. 643) ,but also significant legal expenses and time away from his employment to defend against the allegations of professional misconduct. Therefore, the Hearing Committee believes that the two year stayed suspension with monitoring of all hospital records will provide adequate protection for future patients in the event Respondent were to return to New York State. Under the totality of the circumstances, the two year stayed suspension with monitoring is the appropriate sanction in this instance.

ORDER

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

1. The Eleventh specification of professional misconduct contained within the Statement of Charges (Pet. Ex. 1) is **SUSTAINED.**

2. The First through Tenth and the Twelfth through Fifteenth Specifications are **NOT SUSTAINED**

3 Respondent's license to practice medicine in New York State is **SUSPENDED** for a period of two (2) years, said suspension to be **STAYED.**

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order.

5. The periods of suspension and probation shall be tolled until such time as the Director of the Office of Professional Medical Conduct is advised, in accordance with the Terms of Probation, of the fact that the Respondent has commenced a medical practice in New York State.

DATED: Albany, New York
June 4 **1996**

MR. ANTHONY C. BIONDI
(Chair)
DONALD F. BRAUTIGAM, M.D.
JAMES O. ROBERSON, M.D.

TO: Timothy Mahar, Esq.
NYS Department of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12237

Dennis J. Bischof, Esq.
Hurwitz & Fine, P.C.
1300 Liberty Building
Buffalo, New York 14202

Frederick Beck, M.D.
922 Twelve Oaks
Carmel, Indiana

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

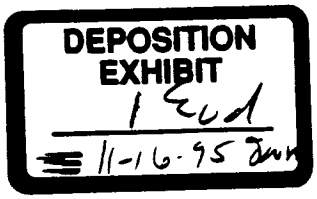
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------x

IN THE MATTER	:	NOTICE
OF	:	OF
FREDERICK BECK, M.D.	:	HEARING

----------x

TO: FREDERICK BECK, M.D.
C/O HURWITZ AND FINE, P.C.
1300 Liberty Building
Buffalo, New York 14202



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct commencing on the 16th day of November, 1995, at 10:00 in the forenoon of that day at the Buffalo Holiday Inn, 620 Delaware Avenue, Buffalo, New York 14202 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and

against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1995), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or

dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
October 20, 1995

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

Timothy J. Mahar
Assistant Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
FREDERICK BECK, M.D.	:	CHARGES

----------X

FREDERICK BECK, M.D., the Respondent, was authorized to practice medicine in New York State on October 29, 1975, by the issuance of license number 125784 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided obstetrical care to Patient A from approximately December 28, 1990 through August 1, 1991 at his office located at 4955 Bailey Avenue, Amherst, New York (office) and at the Millard Fillmore Hospital, 1540 Maple Road, Williamsville, New York ("Millard Fillmore Hospital"). Patient A was admitted to the Millard Fillmore Hospitals's Labor and Delivery Suite at approximately 5:00 a.m. on August 1, 1991, at 38 to 40 weeks gestation, with ruptured membranes and contractions. Patient A spontaneously delivered a stillborn male infant at approximately 4:30 p.m. on August 1, 1991. Respondent's medical care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent ordered Patient A placed on Pitocin on August 1,1991, which was contraindicated.
2. Respondent failed to adequately attend and/or adequately evaluate Patient A throughout the course of her labor.
3. Respondent failed to timely deliver Patient A's fetus.

B. Respondent provided obstetrical care to Patient B from approximately January 24, 1992 through August 9, 1992, at his office and at the Millard Fillmore Hospital. Respondent's medical care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately attend and/or adequately evaluate Patient B during the course of her labor.
2. Respondent ordered the administration of Seconal, a sedative, to Patient B on August 5, 1992, which was contraindicated.

C. Respondent provided obstetrical care to Patient C, following her admission to the Kenmore Mercy Hospital, Kenmore, New York ("Kenmore Mercy Hospital") Emergency Room, from approximately September 22, 1986 through September 23, 1986. Patient C delivered a stillborn female infant on September 23, 1986. Respondent's medical care and treatment of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent failed to order an ultrasound and/or record the results of an ultrasound after Patient C's admission to the hospital for delivery.
2. Respondent failed to adequately attend and/or adequately evaluate Patient C following her admission to the hospital for delivery.
3. Respondent failed to order antibiotics for Patient C in circumstances in which Respondent had diagnosed possible sepsis.
4. Respondent failed to attend the delivery of Patient C's fetus.

D. Respondent provided obstetrical care to Patient D from approximately November 22, 1991 through August 11, 1992 at his office and at the Millard Fillmore Hospital. Respondent's medical care and treatment of Patient D deviated from accepted standards of care in the following respects:

1. Respondent failed to admit Patient D to the hospital on August 8, 1992 and/or failed to adequately evaluate Patient D's fetus and/or failed to record the results of any such evaluation.
2. Respondent failed to timely place an internal fetal monitor in Patient D following her admission to the hospital on August 9, 1992.
3. Respondent failed to adequately evaluate Patient D's fetus on August 9, 1992, including, but not limited to, failing to obtain a timely fetal scalp pH.

4. Respondent failed to timely deliver Patient D's fetus.

E. Respondent provided obstetrical care to Patient E from approximately July 6, 1993 through January 20, 1994 at his office and at the Millard Fillmore Hospital. Respondent's medical care and treatment of Patient E deviated from accepted standards of medical care in the following respects.

1. Respondent failed to perform and/or record the performance of adequate antenatal testing of Patient E's fetus.
2. Respondent failed to place Patient E on bedrest in circumstances in which Respondent knew that Patient E's fetus was growth retarded.
3. Respondent ordered Pitocin for Patient E on June 15, 1994 which was contraindicated.
4. Respondent failed to adequately attend and/or adequately evaluate Patient E during her labor.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ Law §6530(4)(McKinney Supp. 1995) in that Petitioner charges:

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

2. The facts in Paragraphs B and B.1, and/or B and B.2.

3. The facts in Paragraphs C and C.1, C and C.2, C and C.3, and/or C and C.4.

FOURTH THROUGH SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence on a particular occasion under N.Y. Educ. Law §6530(6)(McKinney Supp. 1995) in that Petitioner charges:

4. The facts in Paragraphs A and A.1, A and A.2, and/or A and A.3.

5. The facts in Paragraphs B and B.1, and/or B and B.2.

6. The facts in Paragraphs C and C.1, C and C.2, C and C.3, and/or C and C.4.

SEVENTH THROUGH TENTH SPECIFICATIONS

ABANDONMENT

Respondent is charged with abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, under N.Y. Educ. Law §6530(30) (McKinney Supp 1995), in that Petitioner charges:

7. The facts in Paragraphs A and A.2 and/or A and A.3.
8. The facts in Paragraphs B and B.1.
9. The facts in Paragraphs C and C.2 and/or C and C.4.
10. The facts in Paragraphs E and E.4.

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530(3) (McKinney Supp. 1995), in that Petitioner charges that Respondent committed two or more of the following:

11. The facts in Paragraph A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3 and/or E and E.4.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law §6530(5) (McKinney Supp. 1995), in that Petitioner charges that Respondent committed two or more of the following:

12. The facts in Paragraph A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3 and/or E and E.4.

THIRTEENTH THROUGH FIFTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with failing to maintain records that accurately reflect the evaluation and treatment of his patients, under N.Y. Educ. Law §6530(32) (McKinney Supp. 1995) in that Petitioner charges:

13. The facts in Paragraphs C and C.1.

14. The facts in Paragraphs D and D.1.

15. The facts in Paragraphs E and E.1.

DATED: October 20, 1995
Albany, New York

Peter D. Van Buren

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

APPENDIX II

TERMS AND CONDITIONS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit written notification to the Board, addressed to the Director, Office of Professional Medical Conduct ("OPMC"), Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, address, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. Prior to the commencement of a medical practice in New York State, Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department.

6. Respondent's practice of medicine shall be monitored by a physician monitor, board certified in obstetrics and gynecology, ("practice monitor") approved in advance, in writing, by the Director of the Office of Professional Medical Conduct. Respondent may not practice medicine until an approved practice monitor and monitoring program is in place. Any practice of medicine prior to the submission and approval of the proposed practice monitor will be determined to be a violation of probation.

(a) The practice monitor shall report in writing to the Director of the Office of Professional Medical Conduct or his/her designee, on a schedule to be determined by the office. The practice monitor shall visit Respondent's hospital, medical practice at each and every location, on a random basis and shall examine a random selection of records maintained by Respondent, including patient histories, prescribing information and billing records. Respondent will make available to the monitor any and all hospital records or access to the practice requested by the monitor, including on-site observation. The review will determine whether the Respondent's hospital medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall immediately be reported to the Office of Professional Medical Conduct by the monitor.

(b) Any change in practice monitor must be approved in writing, in advance, by the Office of Professional Medical Conduct.

(c) It is the responsibility of the Respondent to ensure that the reports of the practice monitor are submitted in a timely manner. A failure of the practice monitor to submit required reports on a timely basis will be considered a possible violation of the terms of probation.

7. Respondent will maintain legible and complete hospital medical records which accurately reflect evaluation and treatment of patients. All hospital records will contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record will contain all information required by state rules and regulations regarding controlled substances.

8. All expenses, including but not limited to those of complying with these terms of probation and the Determination and Order, shall be the sole responsibility of the Respondent.

9. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against the Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.