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

September 23, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin Roe , Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2438
Albany, New York 12237

John H. Park, M.D.
322 West 57th Street, Apt. 34E
New York, NY 14221

Lisa McDougall, Esq.
Joseph V. Sedita, Esq.
Phillips, Lytle, Hitchcock, Blaine & Huber
3400 Marine Midland Center
Buffalo, New York 14203

RE: In the Matter of John H. Park, M.D.

Dear Mr. Roe, Dr. Park, Ms. McDougall and Mr. Sedita:

Enclosed please find the Determination and Order (No. 94-24R) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Empire State Plaza
Corning Tower, Room 438
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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw

Enclosure

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

COPY

IN THE MATTER

OF

JOHN H. PARK, M.D.

DETERMINATION

FOLLOWING

REMAND

ARB-94-24R

Pursuant to the Order from the Appellate Division for the Third Department, Park v New York State Dept. of Health, __AD 2d__, 635 NYS 2d 353 (Third Dept. 1995), the Administrative Review Board for Professional Medical Conduct (Board) held deliberations on July 19, 1996 and August 23, 1996 to reconsider the penalty which we assessed against the Respondent **JOHN H. PARK, M.D.** (Respondent) for professional misconduct. Board Members **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** took part in the review and reached this Determination. The Board orders the Respondent to undergo retraining under a program recommended by the Physician Prescribed Education Program (PPEP) and we vote to place the Respondent on probation for three years following the retraining.

Administrative Law Judge **JAMES F. HORAN** served as the Board's Administrative Officer and drafted this Determination.

LISA MCDOUGALL, ESQ. and **JOSEPH V. SEDITA, ESQ.** (Philips, Lytle, Hitchcock, Blaine & Huber) represented the Respondent.

KEVIN C. ROE, ESQ., Associate Counsel, represented the New York State Department of Health (Petitioner).

THE CASE TO THIS POINT

In a proceeding pursuant to Pub.H.L. §230(7), the Petitioner filed a Statement of Charges with the State Board for Professional Medical Conduct (BPMC) alleging that the Respondent committed misconduct in violation of New York Education Law (Educ. L.) §6530 (McKinney's Supp. 1996) by:

- practicing medicine with gross negligence (Educ. L. §6530(4));
- practicing medicine with gross incompetence (Educ. L. §6530(6));
- practicing with negligence on more than one occasion (Educ. L. §6530(3));
- practicing medicine with incompetence on more than one occasion (Educ. L. §6530(5)); and
- failing to make available relevant records with respect to an inquiry about his professional conduct (Educ. L. §6530(8)).

The incompetence and negligence charges involved the Respondent's care for five patients, whom the record refers to as Patients A through E, to protect the patient's privacy. The charge that the Respondent failed to make available a medical record related to the record for Patient A.

A three member BPMC Committee, **J. LARUE WILEY, M.D.,** (Chair), **REV. EDWARD J. HAYES** and **ARTHUR H. DUBE, M.D.** conducted a hearing on the Charges, pursuant to Pub.H.L. §230(10)(c), with Administrative Law Judge **LARRY G. STORCH** serving as the Committee's Administrative Officer. The Committee determined that the Respondent had failed to make Patient A's record available with respect to an inquiry about the Respondent's conduct in caring for that patient, in violation of Educ. L. §6530(28). The Committee imposed no penalty for that violation. The Committee also determined that the Respondent had practiced with incompetence on more than one occasion for:

- improperly diagnosing a cataract in Patient B's right eye;
- ordering an ultrasound test for Patient C without medical justification; and
- failing to refer Patient D to a specialist or to obtain a culture and administer antibiotic therapy to treat a possible infection of Patient D's left eye.

The Committee sustained no charges relating to care for Patients A and E and sustained no charges alleging negligence on more than one occasion, gross negligence or gross incompetence.

The Committee voted to suspend the Respondent's medical license, stayed the suspension and placed the Respondent on probation. The probation required that the Respondent undergo an evaluation and retraining under PPEP supervision. The Committee concluded that the Respondent demonstrated deficiencies in his ability to assess properly and to interpret clinical findings, but they noted that they believed the Respondent possessed basic medical skills and was capable of rehabilitation.

Both the Respondent and Petitioner then filed Notices pursuant to Pub.H.L. §230-c(4)(a), requesting that the Board review and overturn portions from the Committee's Determination. Upon reviewing the Determination, the Board sustained the Committee's Determination that the Respondent practiced with incompetence on more than one occasion in treating Patients B, C and D and the Board sustained the Determination that the Respondent failed to make Patient A's record available. The Board overturned the Committee's penalty Determination. The Board found that by failing to impose a penalty for the Respondent's refusal to provide Patient A's records, the Committee excused the violation. The Board imposed a Ten Thousand Dollar ($10,000.00) fine. The Board also limited the Respondent's license to bar him from performing surgery and ordered that the Respondent still undergo a PPEP evaluation to determine whether the Respondent could practice general medicine with retraining. The Board placed the Respondent on probation during the evaluation and any retraining and for three years thereafter.

Upon reviewing the case pursuant to the Respondent's Motion under New York Civil Practice Law and Rules Article 78, the Appellate Division sustained the Board's Determination that the Respondent practiced with incompetence on more than one occasion and failed to make Patient A's record available. The Court also sustained the Ten Thousand Dollar ($10,000.00) fine against the Respondent. The Appellate Division annulled the Board's Determination to bar the Respondent from performing surgery, finding that the BPMC proceedings exonerated the Respondent of all charges relating to recommending, scheduling or performing surgery and that no sustained charges related to

the recommendation of, or performance of surgery. The Court found no basis in the record to support the Board's conclusion that the Respondent incorrect cataract diagnosis for Patient B would have led to unnecessary surgery. The Court then remitted the case to the Board to reconsider an appropriate penalty.

On the same day as the Third Department rendered their decision on the Board's Determination in this case, the Court rendered a decision on an earlier BPMC disciplinary proceeding, which resulted in a Determination by the State Board of Regents, under the former Educ. L. §6510-a(4). In that other decision Park v. Board of Regents, __AD 2d__, 634 NYS 2d 896 (Third Dept. 1995), the Court affirmed the Regent's Determination that the Respondent had practiced with gross negligence and gross incompetence stemming from the Respondent's treatment for five patients. The Court also sustained the Regent's penalty, which suspended the Respondent's license for five years, with four years stayed, on condition that the Respondent obtain retraining in the indications for ophthalmological surgery.

THE PROCEEDINGS AND ISSUES ON REMITTUR

Upon reviewing the Appellate Division's remittur order, the Board advised the parties, through a March 14, 1996 letter from our Administrative Officer, that the parties would have thirty days from receiving that letter to submit briefs to the Board, concerning the appropriate penalty in this case. The Board asked that both parties address the Respondent's current license status in light of the Third Department decision upholding the penalty in Park v. Regents (supra). Our Administrative Officer extended the period for filing briefs by thirty days, at the parties' joint request, because the parties expected to receive the results from the Phase I PPEP Evaluation, which the Respondent had undergone pursuant to the Board's original Determination in this case. The Board then received the Petitioner's brief on May 13, 1996 and the Petitioner's brief on May 15, 1996. On May 8, 1996, the parties' received an extension in time to file reply briefs so they could clarify whether the Respondent had received the final PPEP Evaluation document. The Board received the Respondent's reply on July 5, 1996.

The Respondent's brief proposes that the Board limit the remaining sanction against the Respondent to the Phase I PPEP Evaluation and Phase II Retraining, because the PPEP Evaluation recommended the Respondent for a retraining program involving course work and a fellowship program and because the Respondent is willing and ready to commence the Phase II retraining.

The Petitioner argues that the Board should consider the prior Regents action against the Respondent when considering a penalty in this case, because the prior findings demonstrate that the Respondent's incompetent treatment for Patients B, C and D was comprised in part in a long term and pervasive substandard care pattern. The Petitioner also submitted background documents from the PPEP Evaluation and asked that the Board reject the PPEP Evaluation finding that the Respondent could participate in a retraining program. The Petitioner asks that the Board revoke the Respondent's New York medical license.

In replying to the Petitioner's brief, the Respondent characterizes the Petitioner's request for revocation as irrational. The Respondent contends that the Third Department has already found the Board's limitation on surgery to be severe, at the same time that the third Department sustained the Regent's penalty in the prior case. The Respondent urges that the Board approve the PPEP II Educational Program.

THE BOARD'S REVIEW AUTHORITY

Pub.H.L. §230(10)(i), §230-c(1) and §230-c(4)(b) authorize the Board to review determinations by hearing committees for professional medical conduct and to decide:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Pub.H.L. §230-c(4)(b) permits the Board to remand a case to the Committee for further consideration. Pub.H.L. §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

The Board has the authority to substitute our judgement for that of the Hearing Committee, in deciding upon a penalty Matter of Bogdan 195 AD 2d 86, 606 NYS 2d 381 (Third Dept. 1993), in determining guilt on the charges, Matter of Spartalis 205 AD 2d 940, 613 NYS 2d 759 (Third Dept. 1994), and in deciding credibility issues, Matter of Minielly __AD 2d__, 634 NYS 2d 856, 1995 N.Y. App. Div. LEXIS 12692 (Third Dept. 1995).

THE BOARD'S DETERMINATION

The Board has reviewed the record from this proceeding, the Third Department's decisions in Park v. Department of Health (supra) and Park v. Regents (supra), the parties' briefs and the Respondent's reply brief. As the Third Department has sustained our prior determination on fact issues and on the fine, we limit this review to finding the appropriate penalty to address the substandard care which the Respondent provided to Patients B through D.

The Board votes 5-0 to accept the retraining and probation penalty that the Hearing Committee had originally imposed for the Respondent's incompetent care for Patients B through D, as the appropriate penalty to address that substandard care. The Board finds that this sanction, combined with the fine sustained from our earlier Determination, and with the suspension and remediation which the Respondent has undergone under the Regent's Order will correct the deficiencies in the Respondent's practice and assure protection for the public health.

The Board rejects the Petitioner's request that we revoke the Respondent's license. We agree with the Respondent's contention that, if the Third Department would not sustain a license limitation, the Court will not accept a more severe penalty.

The Board determines that the Respondent shall undergo the Phase II Retraining program which the PPEP Phase I Evaluation has recommended. The Respondent shall be on probation during the Phase II retraining. At such time as the Respondent completes the Phase II Retraining, he shall be on probation for three additional years, under the terms which the Committee imposed in their Determination and which we attach as Appendix I.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER:**

1. The Board **MODIFIES** our prior Determination in this matter (ARB 94-24) as we discuss in this Determination.

ROBERT M. BRIBER

SUMNER SHAPIRO

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF JOHN H. PARK, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Park.

DATED: Schenectady, New York
9/9, **1996**

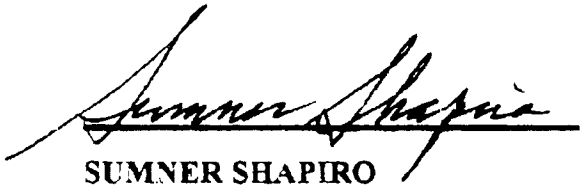
ROBERT M. BRIBER

IN THE MATTER OF JOHN H. PARK, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Park.

DATED: Delmar, New York

Sept. 9, **1996**



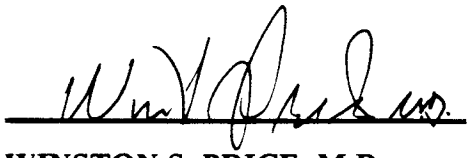
SUMNER SHAPIRO

IN THE MATTER OF JOHN H. PARK, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Park.

DATED: Brooklyn, New York

SEPT 8, **1996**



WINSTON S. PRICE, M.D.

IN THE MATTER OF JOHN H. PARK, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Park.

DATED: Roslyn, New York
Sept 10, 1996

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF JOHN H. PARK, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Park.

DATED: Syracuse, New York
10 Sept. , **1996**

William A Stewart

WILLIAM A. STEWART, M.D.

APPENDIX II

TERMS OF PROBATION

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

3. Dr. Park shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Dr. Park leaves New York to reside or practice outside the State, Dr. Park shall notify the Director of the Office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. Park's probation shall be supervised by the Office of Professional Medical Conduct.

6. Dr. Park shall complete the Phase II Retraining, as recommended by the Physician's Prescribed Educational Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center.

7. The Office of Professional Medical Conduct shall refer Dr. Park to the designated facility for Phase II retraining.

8. Dr. Park shall have quarterly meetings with an employee or designee of the Office of Professional Medical Conduct during the period of probation. During these quarterly meetings Dr. Park's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed.

9. For the first year of probation following retraining, Dr. Park shall have bi-monthly, and for the remaining two years, quarterly meetings with a monitoring physician who shall review his practice. The monitoring physician shall be a board-certified ophthalmologist who has been in practice as such for at least five years, selected by Dr. Park and subject to the approval of the Office of Professional Medical Conduct. This monitoring physician shall review randomly selected medical records and evaluate whether Dr. Park's medical care comports with generally accepted standards of medical practice. Dr. Park shall not practice medicine in New York State until an acceptable monitoring physician is approved by the Office of Professional Medical Conduct.

10. Dr. Park shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the Office of Professional Medical Conduct at the address indicated above.

11. Dr. Park shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If Dr. Park elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

12. If there is full compliance with every term set forth herein, Dr. Park may practice as a physician in New York State in accordance with the terms of probation; provided, however, that upon 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 Dr. Park pursuant to New York Public Health Law Section 230(19) or any other applicable laws.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

July, 28, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

John H. Park, M.D.
635 N. Forest Road
Williamsville, New York 14221

Lisa McDougall, Esq.
Phillips, Lytle, Hitchcock, Blaine & Huber
3400 Marine Midland Center
Buffalo, New York 14203

Kevin C. Roe, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2438
Albany, New York 12237

EFFECTIVE DATE 12/12/94

RE: In the Matter of John H. Park, M.D.

Dear Dr. Park, Ms. McDougall and Mr. Roe:

Enclosed please find the Determination and Order (No. ARB-94-24) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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
Empire State Plaza
Corning Tower, Room 438
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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc

Enclosure

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

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IN THE MATTER	:	ADMINISTRATIVE REVIEW BOARD
OF	:	DETERMINATION AND ORDER
JOHN H. PARK, M.D.	:	NO. ARB-94-24

----------X

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D. and WILLIAM A. STEWART, M.D.[1] held deliberations on May 10, 1994 to review the Professional Medical Conduct Hearing Committee's (Hearing Committee) February 22, 1994 Determination finding Dr. John H. Park guilty of professional misconduct. Both Dr. Park (Respondent) and the Office of Professional Medical Conduct (Petitioner) requested the Review through notices which the Review Board received on February 28, 1994. James F. Horan, Esq. served as Administrative Officer to the Review Board. Kevin C. Roe, Esq., submitted a brief on behalf of the Petitioner on March 30, 1994 and a reply brief on April 11, 1994. Paul V. Sedita, Esq. and Lisa McDougall, Esq., submitted a brief on the Respondent's behalf on March 31, 1994 and a reply brief on April 11, 1994.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1)

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[1]Dr. Stewart participated in the deliberations by telephone.

and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with practicing medicine with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion and failure to produce records. The negligence and incompetence involved the care which the Respondent, an ophthalmologist, provided to five persons, Patients A through E. The record charge relates to records for Patient A.

The Hearing Committee found that the Respondent had been guilty of incompetence on more than one occasion in the care of Patients B, C and D. The Committee did not find incompetence in the care of Patients A or E. The Committee also found that the Respondent had failed to produce records to the Petitioner concerning Patient A. The Committee did not sustain charges that

the Respondent was guilty of gross negligence, gross incompetence or negligence on more than one occasion.

The Committee found that the Respondent was guilty of incompetence for improperly diagnosing a cataract in Patient B's right eye, for ordering an ultrasound test for Patient C without medical justification, and for failing to refer Patient D to a specialist or to obtain a culture and administer appropriate antibiotic therapy to treat a possible infection of Patient D's left eye.

The Committee voted to suspend the Respondent's license to practice medicine, but stayed the suspension and placed the Respondent on probation. The probation terms require that the Respondent undergo an evaluation at the Physician Prescribed Education Program (PPEP) and provides that the Respondent undergo retraining if the PPEP Evaluation determines that the Respondent is a candidate for retraining. The Committee found that the Respondent demonstrated deficiencies in his ability to properly assess and interpret clinical findings, but they noted that they believed that the Respondent possesses reasonable, basic medical skills and is capable of rehabilitation. The Committee ordered that if the Respondent is not a candidate for retraining or is unable to find a suitable retraining program, then the Respondent shall comply with the monitoring and all other terms of the three year probation.

REQUESTS FOR REVIEW

The Petitioner has requested a review of both the Hearing Committee's Determination on the charges and the Committee's penalty.

The Petitioner has asked that the Review Board find the Hearing Committee's Determination, that the Respondent was not guilty of an additional specification of negligence in the care of Patient D, was inconsistent with the Committee's findings on Patient D. The Petitioner contends that the Hearing Committee's findings demonstrate that the Respondent's care of Patient D constituted an additional incidence of incompetence. The Petitioner contends further that the penalty is internally inconsistent because the Committee found that the Respondent demonstrated deficiencies in the basic skill and knowledge, but determined that the Respondent was capable of rehabilitation. The Petitioner also contends that the retraining portion of the penalty is not mandatory because the penalty contains no time frames for completing the PPEP Phase I Evaluation. The Petitioner contends further that the penalty is not mandatory because, if the Evaluation determines that the Respondent is not a candidate for retraining, then the Respondent would be allowed to return to practice, with no retraining.

The Petitioner also contends that it was inappropriate for the Hearing Committee to fail to impose a penalty upon Dr. Park after finding that he refused to make medical records available pursuant to New York Education Law Section 6530(25).

The Respondent has asked that the Board override the

negligence in the treatment of Patients B, C and D.

As to Patients B and C, the Respondent argues that the Respondent's care of these patients was not incompetent and that the specific care involved were not occasions of incompetence. As to Patient D, the Respondent alleges that the Committee's findings are not consistent with a Determination of Incompetence, that the Determination was not supported by the weight of the evidence, that the Respondent was found guilty under facts which were not charged and that the Determination that the care of Patient D was incompetent is an impermissible restraint on physician independence.

REVIEW BOARD DETERMINATION

The Review Board has considered the record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination finding the Respondent guilty of incompetence on more than one occasion in the care which the Respondent provided to Patients B, C and D. The Determination was consistent with the Committee's findings that the Respondent made an improper diagnosis of cataract in Patient B's right eye, that the Respondent ordered and performed an ultrasound test on Patient C without adequate medical justification and that the Respondent had failed to refer Patient D to a specialist, obtain a culture or administer antibiotic therapy when the Patient D's vision deteriorated dramatically while the Respondent was recovering from two invasive procedures.

The Board also sustains the Committee's Determination that the Respondent was guilty of failing to turn over records to the Office of Professional Medical Conduct, in violation of Education Law Section 6530(28). The Review Board overturns the Committee's Determination to impose no penalty on that violation, because the failure to impose some sanction for that violation is inappropriate. A physician is responsible to provide records to the Office of Professional Medical Conduct pursuant to the Office's request. The Hearing Committee noted that the Respondent was not excused from that responsibility because his former counsel had advised him not to turn over the records in a timely manner, but the Hearing Committee concluded that it would not be appropriate to sanction the Respondent for following his lawyer's advise.

The Review Board finds that not applying a sanction for the violation is indeed excusing the violation. The Review Board votes to assess Dr. Park a Ten Thousand ($10,000.00) Dollar fine for the failure to produce records.

As to the Hearing Committee's Determination, to order the Respondent to undergo an evaluation and retraining as the penalty, for acts of incompetence, the Review Board overturns the penalty in part and modifies the penalty in part, because the penalty as written is not appropriate to protect the public or to correct sufficiently the Respondent's acts of incompetence.

The Respondent's practice as an ophthalmologist involves surgery. The findings of incompetence arose from the Respondent's misdiagnosis of Patient B as having a condition, cataract, that requires surgery. The misconduct also involves incompetent care

for Patient D, who was recuperating from two invasive procedures. The Respondent also ordered and performed an unnecessary ultrasound procedure on Patient C. The Committee found that the Respondent demonstrated deficiencies in his ability to properly assess and interpret clinical findings which he observed. The Board notes that the PPEP does not provide retraining in surgery. Further, the Respondent has had years of practice in which he has obviously failed to develop the ability to assess and interpret findings from his observations. If the Respondent has failed to develop those abilities by now, a one year course of retraining is not likely to improve his abilities.

A surgeon who is deficient in assessing and interpreting findings is a danger to the public. The Review Board votes to limit the Respondent's license to prohibit him from practicing surgery, including laser procedures.

The next question is whether the Respondent is capable to practice ophthalmology or general medicine excluding surgery. The Hearing Committee concluded that the Respondent possessed basic medical skills and was capable of rehabilitation and ordered that the Respondent undergo the PPEP Phase I Evaluation. The Review Board modifies the Hearing Committee Determination to refer the Respondent to the PPEP. The Respondent is referred to the PPEP Phase I for an evaluation of his medical skills and a determination whether the Respondent is a candidate for retraining to practice medicine other than surgery. If the Phase I Evaluation determines that the Respondent is a candidate for retraining then the Respondent shall complete Phase II retraining successfully.

The Respondent shall be suspended from the practice of medicine during the evaluation and any retraining, except that the suspension is stayed and the Respondent will be on probation, on condition that within thirty days from the effective date of this Determination the Respondent shall arrange to undergo the PPEP Evaluation. The suspension will be stayed further during any period of retraining, on condition that the Respondent arrange to commence the Phase II retraining within thirty days from receiving the Phase I Evaluation and then that the Respondent successfully complete Phase II retraining. If the Respondent successfully completes Phase II, he shall be on probation for three years under the terms which the Hearing Committee set out in their Determination.

The Review Board overturns the portion of the Hearing Committee's penalty which would allow Dr. Park to complete probation if the PPEP Phase I Evaluation indicates he is not a candidate for retraining or is unsuitable for any available retraining program. That portion of the penalty is totally inappropriate to protect the public and correct the deficiencies in the Respondent's practice.

If the PPEP Phase I Evaluation indicates that the Respondent is not a candidate for retraining to practice medicine, other than surgery, this matter is remanded to the Hearing Committee for further deliberations on an appropriate penalty. Prior to these further deliberations, the Hearing Committee's Administrative Officer should advise the parties as to the date of the deliberations and offer the parties an opportunity to submit additional briefs on the issue of the appropriate penalty in view

of the Phase I Evaluation. Following the deliberation, the Committee should issue a supplemental determination. Either party may request a review of the supplemental determination from the Review Board, by filing a notice with the Board within fourteen days of receiving the supplemental determination. The Respondent shall remain on probation during the remand period and, if there is a request for further review, he shall remain on probation until the Review Board issues a supplemental determination.

The Phase I Evaluation shall be mailed to both parties, to the Hearing Committee and to the Review Board.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board sustains the Hearing Committee on Professional Medical Conduct's February 22, 1994 Determination finding Dr. John H. Park guilty of incompetence on more than one occasion and failure to produce records.

2. The Review Board overrules the Hearing Committee's Penalty in part and modifies the Committee's penalty in part, for the reasons stated in our Determination.

3. The Review Board fines the Respondent Ten Thousand ($10,000.00) Dollars for failure to produce records.

4. The Review Board limits the Respondent's license to prohibit him from practicing surgery, including laser procedures.

5. The Review Board orders that the Respondent undergo an evaluation of his skills to practice medicine, other than

surgery, at the Physicians Prescribed Education Program at Syracuse. If the evaluation determines that the Respondent is a candidate for retraining, the Respondent shall complete Phase II retraining in the PPEP.

6. The Respondent's license to practice medicine, other than surgery, is suspended during the period of evaluation and retraining, but, the suspension is stayed and the Respondent shall be on probation during the period, provided he complies with the conditions which the Board set out in our Determination.

7. If the Respondent completes the evaluation and retraining successfully, the Respondent shall be on probation for an additional three years, under the terms which are set out in the Hearing Committee Determination at Appendix II.

8. If the evaluation determines that the Respondent is not a candidate for retraining, this matter is remanded to the Hearing Committee under the terms set out in this Determination.

ROBERT M. BRIBER

MARYCLAIRE B. SHERWIN

WINSTON S. PRICE, M.D.

EDWARD C. SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF

John H. Park

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of John H. Park, M.D..

DATED: Albany, New York
July 27, 1994

ROBERT M. BRIBER

IN THE MATTER OF

John H. Park, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of John H. Park, M.D.

DATED: Brooklyn, New York

, 1994

WINSTON S. PRICE, M.D.

IN THE MATTER OF

John H. Park, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of John H. Park, M.D.

DATED: Malone, New York
July 9, 1994

Marycliare B. Sherwin

MARYCLAIRE B. SHERWIN

IN THE MATTER OF

John H. Park, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of John H. Park, M.D.

DATED: Brooklyn, New York

July 9, 1994

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF

John H. Park, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of John H. Park, M.D.

DATED: Syracuse, New York

11 July, 1994

William A. Stewart

WILLIAM A. STEWART, M.D.

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

IN THE MATTER	:	**DETERMINATION**
	:	
OF	:	**AND**
	:	
JOHN H. PARK, M.D.	:	**ORDER**

No. BPMC 94-24

A Notice of Hearing and Statement of Charges, both dated October 20, 1992, were served upon the Respondent, John H. Park, M.D. **J. LaRUE WILEY, M.D. (Chair), REV. EDWARD J. HAYES, and ARTHUR H. DUBE, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Kevin C. Roe, Esq., Associate Counsel. The Respondent initially appeared by Offermann, Mahoney, Cassano, Piggott, Greco & Whalen, Francis J. Offermann, Jr., Esq., of Counsel. During the course of proceedings, the Respondent discharged his counsel. Thereafter, the Respondent was represented by Phillips, Lytle, Hitchcock, Blaine & Huber, Joseph V. Sedita., Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	October 23, 1992
Date of Amended Statement of Charges:	March 1, 1993
Date of Second Amended Statement of Charges:	May 20, 1993
Answer to Statement of Charges:	December 3, 1992
Pre-Hearing Conference:	November 16, 1992
Dates of Hearings:	December 3, 1992 January 5, 1993 January 13, 1993 January 14, 1993 January 19, 1993 February 17, 1993 February 18, 1993 February 26, 1993 March 3, 1993 May 21, 1993 May 26, 1993 May 28, 1993 June 2, 1993 June 3, 1993 June 17, 1993 June 18, 1993 June 22, 1993 June 28, 1993
Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendation:	July 19, 1993
Received Respondent's Proposed Findings of Fact and Conclusions of Law:	July 20, 1993
Witnesses for Department	

of Health:	Patient C (Fact) Patient E (Fact) David J. Rodman, M.D. (Fact/Expt) Lewis J. Fein (Fact) Sharon Kuritzky, M.D. (Fact/Expt) George W. Pfohl, M.D. (Fact/Expt) Philip R. Niswander, M.D. (F/E) Mattie Johnson (Fact) Jeffrey K. Harris, M.D. (Expt)
Witnesses for Respondent:	Sylvester Benjamin (Fact) Judith Whitehead (Fact) James V. Aquavella, M.D. (Expt) Henry M. Clayman, M.D. (Expt) Lenora Park (Fact) Sally Schrett (Fact) Lewis J. Fein (Fact) Dorothy Ciccarella (Fact) Corstiaan Brass, M.D. (Expt) John H. Park, M.D. (Fact/Expt)
Deliberations Held:	July 26, 1993 July 27, 1993 August 10, 1993

STATEMENT OF CASE

The Department has charged Respondent, an ophthalmologist, with fifteen specifications of professional misconduct. The charges concern the care and treatment of six patients. During the course of the proceedings, the Department withdrew all allegations concerning one patient (Patient F) and made several modifications to the original charges. The Department has charged Respondent with gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion. In addition, the Department has charged Respondent with the failure to produce the medical records of one patient (Patient A). The

Respondent denied the allegations. A copy of the Second Amended Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. Petitioner's exhibits are identified by numbers, Respondent's exhibits by letters. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered rejected in favor of the cited evidence.

1. John H. Park, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State on December 29, 1971 by the issuance of license number 110946 by the New York State Education Department. At the time of the initial service of charges, Respondent was registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from 170 Maple Road, Buffalo, New York 14221. (Not Contested).

Patient A

2. Respondent treated Patient A, a 79 year old woman, at the Park Eye Center from on or about March 19, 1992 to on or about April 7, 1992. (Ex. 1).

3. A medical record entry dated March 19, 1992 documents visual acuity, without correction, of light perception with projection in both eyes, visual acuity with correction of 20/400 in the right eye and 20/100 in the left eye, and near vision of 20/40- or 400 in the right eye and 20/100 in the left eye. (Ex. 1, p. 4).

4. The March 19, 1992 entry in Patient A's medical record also documents a slit lamp examination finding of combined form of cataract of equal density of both eyes. (1092, 1116; Ex. 1, p. 4).

5. The billing section of Respondent's medical record for Patient A contains a diagnosis of "mature cataract" in the lens of Patient A's left eye, with a corresponding billing code. (Ex. 1, p.12; Ex. 9, p.4).

6. Respondent scheduled Patient A for cataract surgery in her left eye to be performed on April 7, 1992. Ultimately, the surgery was cancelled due to medical complications. (969; Ex. 1, pp. 7, 18).

7. Jeffrey K. Harris, M.D., an ophthalmologist, testified on behalf of the Department. Dr. Harris testified that cataract surgery is indicated in the presence of a cataract causing reduced visual function which interferes with the patient's daily activities, combined with the absence of other pathology which would limit the success of surgery. (1078).

8. On June 20, 1992, Patient A was examined by Dr. Harris at the request of the Department. (1079; Ex. 3).

9. Dr. Harris testified that Patient A had mild nuclear sclerosis of both eyes which was normal for her age. He expressed the opinion that these changes were probably not visually significant. At the same time, Dr. Harris acknowledged that the patient suffered from bad vision. He stated that he suspected that her poor vision was due to optic nerve atrophy rather than cataract. However, he acknowledged that he performed no tests to confirm this suspicion. (1072-1076, 1078,).

10. Dr. Harris testified that, within the practice of ophthalmology, a "mature cataract" is one which involves the entire lens and is completely opaque. He further testified that, since Patient A did not have a cataract of this description, a prudent and competent physician would not diagnose a mature cataract. (1102, 1113, 1386).

11. On April 17, 1992, ten days after last office visit to Respondent, Patient A was seen by David J. Rodman, M.D., an ophthalmologist. (Ex. 2, pp. 1-2).

12. Dr. Rodman testified to the presence of one-plus nuclear sclerosis in the patient's eyes, and that this was consistent with corrected vision as good as 20/20 and as poor as 20/40. (279, 284).

13. Dr. Rodman further testified that the standard threshold for reimbursement of cataract surgery set by the Health Care Finance Agency (hereinafter "HCFA") is visual acuity of 20/4 , corrected. (352-353).

14. Dr. Rodman expressed the opinion that Patient A's poor vision was not the product of an optic nerve problem. He acknowledged that, in the final analysis, he could not account for Patient A's poor vision. (345).

15. When asked for his understanding of the term "mature cataract", Dr. Rodman testified that it is a cataract for which surgery is appropriate. (290).

16. Henry M. Clayman, M.D., an ophthalmologist, testified on behalf of Respondent. Dr. Clayman testified that his preferred definition of "mature cataract" corresponded with that of Dr. Harris. However, he also, testified that it is common for many practitioners to use the phrase "mature cataract" to describe a cataract which they regard as eligible for surgery. (1954-1[illegible].

17. Dr. Clayman testified that he examined copies of slit-lamp photographs of Patient A's cataracts. He expressed the opinion that the cataracts were of sufficient severity to justify an offer of surgery with reasonable expectation that such surgery could significantly improve her vision. (1960-1962, 2061).

18. Dr. Harris testified that standard ophthalmological practice is to operate on the "worse" eye first because, by so doing, one insures that if there is a bad result, the patient will be left with his or her "better" vision. (1472).

19. Dr. Harris further testified that among people in Patient A's age, who couldn't or didn't read, he would have [illegible] operated on the eye with the worse distance vision. (1120-1[illegible].

20. Respondent's medical record for Patient A documents the fact that her corrected near vision was worse in the left eye. This finding was not contradicted. (1446; Ex. 1, p.4).

21. Dr. Clayman testified that, were cataract surgery to be performed, the eye with the worse near vision should be operated on first for patients in this age group. He further testified that he would be concerned with improving the patient's near vision because of her complaint of stumbling, which might have been due to poor near vision. (Ex.1, p. 4; Ex.2, p.1; 1957, 2032).

Patient B

22. Respondent examined Patient B at the Park Eye Center on April 4, 1990. (Ex. 10).

23. Respondent's office medical record for Patient B contains slit lamp examination findings of mild to moderate cataract in the right eye and left eye negative. An impression of moderate cataract in the right eye plus myopia is documented. (Ex. 10, p. 1).

24. Respondent diagnosed cataract in Patient B's right eye. (Stipulation of Parties - 12/4/92; Ex. 10, p. 1; Ex. 13, p. 1; Ex. 13, p.2).

25. Patient B was examined by Sharon Kuritzky, M.D., an ophthalmologist, on August 15, 1990. The patient was seeking a third opinion regarding cataract surgery on the right eye. The patient told Dr. Kuritzky that Respondent had told her she had a

cataract in the right eye which required surgery. (434, 530; Ex. 12, pp. 1, 6).

26. Dr. Kuritzky found both lenses to be normal on slit lamp examination. (436; Ex. 12, pp. 1, 6).

27. Dr. Kuritzky obtained a best corrected vision in the right eye of 20/200 with a high myopic and astigmatic correction. Her diagnostic impression was anisometropia with amblyopia - right eye. Dr. Kuritzky testified that she did not find any medical justification for a diagnosis of cataract in the right eye. (436, 439; Ex. 12, pp. 1, 6).

28. At the request of the Department, Dr. Harris examined Patient B on January 11, 1992. Upon slit lamp examination, Dr. Harris found minimal nuclear sclerosis in both eyes, which was normal given the patient's age (48 years old). (1237-1238; Ex. 13, p. 2).

29. Dr. Harris testified that nuclear sclerosis is not a cataract in the clinical setting, or by clinical practice. Based upon his examination of the patient, Dr. Harris found no medical justification for a diagnosis of cataract in the right eye. (1238-1240, 1242-1243, 1512-1513).

30. Based upon an examination of slit lamp photographs taken by Dr. Harris, Dr. Clayman testified that he found a very minimal cataract in the right eye. He further testified that he found essentially the same degree of opacity in both lenses. However, he admitted that the review of a slit lamp photograph is

less reliable than a complete ophthalmologic examination. (2067, 2070, 2084-2085).

Patient C

31. Respondent examined and treated Patient C at the Park Eye Center on three occasions between January 25, 1990 and February 7, 1990. (Ex. 16A).

32. Respondent diagnosed cataracts in both eyes and made a "tentative" diagnosis of open-angle glaucoma. (Ex. 16A, p.3).

33. Respondent's medical record does not document what he told Patient C about the diagnosis of cataracts or regarding any advice concerning the need for surgery. (Ex. 16A).

34. On March 21, 1990, Patient C began treatment with Philip Niswander, M.D., an ophthalmologist. A history was taken by Dr. Niswander's medical technician, Judith Whitehead. Patient C told Ms. Whitehead that she was not told of any cataracts by Respondent. (1866; Ex. 18, p. 1; Ex. CC).

35. On December 17, 1991, Patient C was seen by Dr. Harris, at the request of the Department. Dr. Harris testified that Patient C told him that Respondent had informed her that he found a cataract in **one** eye, which he said would have to be removed within a year. (1543; Ex. 19, p. 2).

36. On December 3, 1992, Patient C testified that Respondent told her that she had cataracts in **both** eyes that would require surgery in one year. (20-21, 70, 117).

37. Respondent's medical record contains entries dated January 25, 1990 recording findings under slit lamp examination of moderate cataract development in both eyes, 2+ nuclear cataract and 2+ cortical cataract in both eyes. Under "fundus" there is a typewritten notation of "def GLC". Under impression, there are typewritten entries of glaucoma, open angle and senile cataract in both eyes. Under "Impression", there is a handwritten entry of "R/O" or "rule out". Intraocular pressure was recorded as 26 in the right eye and 23 in the left eye. There are handwritten notations that the cup to disk ratio was 0.5 to 0.6 in the right eye and 0.5 in the left eye. (1255-1257; Ex. 16A, p. 3).

38. Patient C testified that Respondent advised her that she had definite glaucoma with severe optic nerve damage. (20, 42-43).

39. Dr. Niswander observed trace nuclear sclerosis in both lenses. During the course of approximately eight office visits occurring between March 21, 1990 and October 12, 1992, Dr. Niswander found borderline intraocular pressures in the right eye, by applanation. At an office visit on February 13, 1992, Dr. Niswander was sufficiently concerned about the possibility of glaucoma to discuss risk factors with Patient C. He also gave her two pamphlets about glaucoma. (747; Ex. 18; Ex. AA; Ex. BB).

40. Dr. Niswander made a diagnosis of ocular hypertension on insurance forms covering services performed on March 21, 1990, April 20, 1990 August 10, 1990 and February 13, 1991. (Ex. J).

41. Dr. Harris examined Patient C on December 17, 1991. Dr. Harris observed mild nuclear sclerosis in both eyes and an inferior cortical opacity in the left eye. (1250-1251; Ex. 19).

42. On December 17, 1991, Patient C's intraocular pressure was 20 in both eyes when tested by applanation. Fundus examination show the optic nerve to be normal in appearance. The cup to disk ratio was 0.5 in the right eye and 0.3 in the left eye. Dr. Harris testified that the difference between the cup to disk ratio from the right to left eye raised a suspicion of glaucoma. He further testified that based upon the borderline intraocular pressures, asymmetry of cup to disk ratio as well as a family history of glaucoma, Patient C was a glaucoma suspect. (1251-1253; Ex. 19).

43. James V. Aquavella, M.D., an ophthalmologist testifying on behalf of Respondent, stated that chronic open angle glaucoma is extremely difficult to diagnose in its' early stages. He felt that the preferred diagnosis in this instance would be either ocular hypertension or glaucoma suspect. (1760, 1777).

44. There was differing testimony concerning the entry "def GLC" contained in Respondent's medical record for Patient C. Dr. Harris interpreted the phrase as meaning "definite glaucoma". Dr. Clayman testified that "definite glaucoma" is not an accepted medical term, nor is there a standardized interpretation of "def GLC". He noted that the phrase "def GLC" was listed under "Findings" rather that "Impression". As a result, he testified that it

be used to indicate a "glaucomatous field defect" or "defect glaucomatous". (1256-1257, 2107-2109, 2128).

45. On February 2, 1990, Respondent ordered and performed an A-scan on Patient C. (Ex. 16A, pp. 4, 7).

46. An A-scan, such as that performed on Patient C, is an ultrasound test to measure the axial length of the eye most commonly used to determine the appropriate intraocular lens for surgery. (646-649, 1266).

47. Dr. Harris testified that he would not perform an A-scan until he was prepared to perform cataract surgery. (1265-1266).

48. Dr. Aquavella testified that an A-scan is a relatively non-invasive test, which is no more invasive than applanation tonometry. Nevertheless, he acknowledged that he would not have ordered an A-scan for Patient C on February 2, 1990. (1780-1781).

49. There was no medical indication for performing an A-scan on Patient C on February 2, 1990. (643-647, 1262-1263, 1776, 1778-1779, 1830-1832, 1834).

Patient D

50. Respondent treated Patient D from on or about [illegible] 3, 1985 to on or about September 25, 1989. Respondent performed cataract surgery on Patient D's left eye on August 27, 1987. performed cataract surgery on Patient D's right eye on November [illegible], 1987. (Ex. 21A).

51. A filtering bleb - a complication of cataract surgery - was first noticed in Patient D's left eye in January 1986. The bleb eventually grew larger and spread onto the cornea. Respondent performed a surgical repair of the filtering bleb on June 6, 1989. (2646-2647; Ex. 21A, p. 12).

52. Slight wound leakage was noted on June 8, 1989. Three additional sutures were inserted, and a bandage lens was applied. (Ex. 21A, p. 13).

53. A medical record entry dated June 13, 1989, indicates that Patient D's visual acuity in the left eye was 20/60. The physical examination was unremarkable. Maxitrol, 4 times a day, was prescribed and Prede Forte was discontinued. Similar findings were recorded on June 23, 1989. (Ex. 21A, pp. 13-14).

54. On August 3, 1989, Patient D complained of a foreign body sensation in the left eye. Respondent examined the patient on August 7, 1989. The eye was tearing and the lids stuck together. Respondent recorded a diagnosis of keratoconjunctivitis of unknown cause. Respondent's plan was to discontinue Maxitrol and Prede Forte, and start Tobradex, four times a day. Apparently, the bandage lens was removed at that time, although it is not noted in the record. The patient was instructed to return in three to four weeks. (2664-2667, Ex. 21A, pp. 14, 15).

55. Dr. Harris testified that he considered the development of keratitis on August 7, 1989 as a more acute problem, insofar as the patient presented a post-operative eye with a

complication. He further testified that there had been a wound leak with an entrance or exit wound into the eye, with corneal involvement. As a result, it was Dr. Harris' opinion that the patient should have been seen sooner than three to four weeks. (1288).

56. Respondent testified that on the same date the left eye had a mucous discharge which was not purulent. There was a slight reaction on the surface of the cornea due to a mechanical irritation. He also testified that the wound site was completely healed. (2658-2659, 2662).

57. Respondent stated that Patient D, who had been his patient for a number of years, knew that he could call Respondent at any time, in the event that he had any questions or changes in his condition. (2678-2679).

58. A medical record entry dated August 21, 1989 documents a telephone call to the patient. The note indicates that Patient D was informed, per Respondent, to use Maxitrol every three hours during the daytime and Prede Forte twice a day. Patient D was also instructed not to put a finger or handkerchief in his eye, but to use Q-tips. The patient was to have an appointment on August [illegible], 1989. (Ex. 21A, p. 16).

59. Patient D was seen by Respondent on August 28, 1989. The patient reported that he had noticed his vision getting blurry a week ago and complained of floaters and something blocking his vision. Respondent recorded vision in the patient's left eye as

20/200, with correction. This represented a deterioration of the patient's vision, which was recorded as 20/70, without correction on August 7, 1989. (Ex. 21A, pp. 15-16).

60. Respondent's record notes that the fundus was difficult to visualize, due to vitritis. There is also a notation that the patient was looking through the side of the implant, rather than the center. No tenderness of the globe on touch was noted, nor conjunctival injection. The wound was intact. Respondent noted a diagnosis of "sterile vitritis". (Ex. 21A, p. 16).

61. Patient D returned to the Park Eye Center later during the day on August 28, 1989, at which time Respondent performed a B-scan (a form of ultra-sound examination). The B-scan showed no sign of retinal detachment. Respondent concluded that the patient had an intraocular lens displacement plus a sterile vitritis of unknown cause. His treatment plan included instructions to discontinue Maxitrol and to continue Tobradex q.i.d. plus Prede Forte b.i.d. The patient was to return in three to four weeks. Respondent planned to re-position the lens if the vitritis cleared. (Ex. 21A, p. 16).

62. Respondent next saw Patient D on September 8, 1989. The medical record documents the fact that Patient D complained of pain and blurry vision, visual acuity in the left eye was light perception with projection, and that hypopian and vitreous webs were found. Respondent recorded a tentative diagnosis of

endophthalmitis and vitritis of unknown cause. Respondent arranged a stat consultation with a retinal specialist. (1286-1287; Ex. 21A, p. 17).

63. Ultimately, Patient D was found to have infectious endophthalmitis and underwent enucleation (surgical removal) of the left eye on October 25, 1989. (1287, 1723-1725; Ex. 21A, p. 18; Ex. VVV; Ex. WWW).

64. Dr. Harris testified that Patient D required more immediate follow-up on August 28, 1989. He noted the severe visual loss in the left eye which occurred within a matter of weeks. Dr. Harris further testified that although the record indicates the presence of a sterile vitritis, it is impossible to make such a determination without obtaining a vitreous culture. (1289-1290).

65. Dr. Harris further testified that the patient demonstrated an overwhelming vitreous reaction, to the point [illegible] the lens implant was physically displaced, causing a rapid loss of vision. He further stated that there was a very aggressive process taking place within Patient D's eye. As a result, he indicated that Respondent should have either obtained a vitreous culture himself and ordered parenteral and intraocular antibiotics or referred the patient to a vitreous/retinal specialist on August 28, 1989. (1289, 1292-1294, 1296-1297).

66. Respondent testified that the patient presented at his office on August 28, 1989 with a substantial reduction in vision and that the vitreous was very hazy. He saw no evidence of [illegible]

leakage, the lids were quiet and the conjunctiva were clear. He saw no evidence of infection. Respondent testified that the lens implant was displaced and that he was very concerned about the process taking place in the patient's eye. (2671-2673).

67. Respondent testified that he considered that the problems might have been caused by mechanical rubbing of the eye, but was not satisfied with this explanation. He asked the patient to return later in the day, at which time he performed a B-scan. The ultrasound scan revealed no sign of retinal detachment. Respondent stated that he looked for possible ciliary body separation or choroidal detachment, but found no evidence of either condition. Respondent stated that based upon these findings, he was very positive that the patient had no evidence of a bacterial, fungal, or viral infectious process. (2672-2673).

68. Respondent testified that Patient D had a history of non-infectious vitreous problems dating back to October, 1[illegible]. He stated that given this history, he felt that the vision loss was due to the displacement of the intraocular lens implant. Consequently, he felt that a conservative treatment approach was warranted. (2675, 2678).

69. Respondent testified that a vitreous tap presented a risk to the patient, and that he had been confident that when the inflammation cleared, the lens displacement could be corrected. (2768-2769).

70. Corstiaan Brass, M.D., an infectious disease specialist, testified on behalf of Respondent. Dr. Brass expressed the opinion that there was no staphylococcal infection present in Patient D's left eye on August 28, 1989. He stated that, had there been such an infection, it's presence would have been very obvious by September 8, 1989. (2484-2485).

71. However, Dr. Brass acknowledged that the presence of vitritis and decreased vision should have raised a suspicion of infection. He stated that the severe consequences of bacterial endophthalmitis require that every effort be made to make a definitive diagnosis and start treatment promptly. Cultures must be obtained whenever a diagnosis of bacterial endophthalmitis is entertained. (2539, 2542).

72. Dr. Brass testified that although it is difficult to be certain of the etiology of a case of endophthalmitis on the basis of clinical findings alone, inflammation associated with pain and/or marked visual loss is more likely due to bacterial infection. (2536).

73. Dr. Brass offered no opinion as to the likelihood of infection based on the patients clinical signs and symptom. (2502).

74. Dr. Brass stated that, based upon a review of the literature, frequent follow-up is required when infectious endophthalmitis is a consideration. The follow-up should occur within twelve to twenty-four hours. (2515-2516).

Patient E

75. Respondent treated Patient E from on or about November 12, 1986, to on or about March 16, 1987. (Ex. 25A).

76. During her care and treatment by Respondent, Patient E was 49 year-old woman. She presented at the Park Eye Center with a history of headaches of unknown cause. She complained of difficulty driving at night due to "halos" around headlights. (Ex. 25A, p. 2).

77. Respondent's medical record for Patient E contains an entry dated November 12, 1986 which documents visual acuity of 20/60 in the right eye and 20/50 in the left eye with correction, 20/40-60 in the right eye and 20/60-70 in the left eye without correction, and near visual acuity of 20/40 in both eyes. (Ex. 25A, p. 2).

78. Respondent's records document the presence of embedded crystalline opacities in both lenses. In an entry dated November 13, 1986, Respondent noted that the pros and cons of cataract surgery were discussed with the patient. The note indicates that Respondent advised Patient E that the cataracts do not seem to be impairing the patient's vision, although the patient complained that her vision was poor. (Ex. 25A, p.3).

79. Patient E testified at the hearing. She stated that Respondent told her that she had an extremely rare condition, that both her lenses were crystallized and would have to be removed.

She further testified that Respondent told her without surgery, her condition would worsen and she would lose her vision. Patient E also stated that Respondent told her that the left eye was worse than the right. Patient E further testified that Respondent told her that the right eye would be done first and the left eye six weeks later. (145-148, 248, 250-251, 256).

80. An entry in the medical record dated December 18, 1986 contains the following statements made by Patient E: "I cannot even enjoy t.v....I cannot live like this...I am not living." (Ex. 25A, p. 3).

81. On January 6, 1987, Respondent performed cataract surgery on Patient E's right eye. (Ex. 25A, pp. 1, 3, 47).

82. Patient E was examined by George W. Pfohl, M.D., an ophthalmologist, on April 26, 1989. The patient had no visual complaints related to her left eye. Visual acuity in the left eye was 20/50-1 without correction, 20/20 with correction, and 20/20 with refraction. Dr. Pfohl did not observe the presence of embedded crystalline opacities in the left lens. (874-876, [illegible]; Ex. 27, p. 1).

83. Dr. Pfohl examined the patient again on June 20, 1990. Visual acuity in the left eye was 20/40-1 without correction and 20/20-3 with correction. (Ex. 27, p. 3).

84. Patient E was examined by Dr. Harris on December 13, 1991, at the request of the Department. (1300; Ex. 35).

85. Dr. Harris obtained visual acuity in the left eye of 20/30 without correction, 20/20 with refraction and J-1 near vision. On slit lamp examination of the left eye, Dr. Harris observed mild nuclear sclerosis and a few anterior whitish opacities. Dr. Harris expressed the opinion that these opacities were not visually significant. (1303; Ex. 35).

86. Dr. Clayman described the opacities observed by Respondent and Dr. Harris as multi-refractile opacities. He expressed the opinion that these opacities could have been responsible for the visual complaints (blurry vision, "halos" around headlights, etc.) reported by Patient E. (2149, 2165).

87. Patient E testified that she told Respondent that her vision was worse in her left eye as compared to the right eye. (146).

88. Patient E has a history of treatment for psychiatric conditions. She has suffered from severe depression since at least 1987. The patient has also complained of lifelong headaches, for which she took approximately 100 Excedrin per week. (211, [illegible]; Ex. 25A, p.2; Ex. 35, p.2).

Failure To Produce Records

89. On or about June 1, 1992, the Office of Professional Medical Conduct of the New York State Department of Health, which had been investigating Respondent's care and treatment of Patient A, made a written request and demand to Respondent that he produce and deliver his complete medical records concerning Patient A, including but not limited to, correspondence, photographs, slides, test results and surgical reports. (552; Ex. 4).

90. Prior to October 20, 1992, the date of the original Statement of Charges in this matter, Respondent did not make any medical records of Patient A available to the Office of Professional Medical Conduct. (558, 562-563, 583; Ex. 5; Ex. 6).

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 parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph B: (22 - 30);

Paragraph B.1: (22 - 30);

Paragraph C: (31 - 49);

Paragraph C.3: (45 - 49);

Paragraph D: (50 - 74);

Paragraph D.4: (50 - 54, 58 - 74);

Paragraph G: (89 - 90).

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

Paragraphs A, A.1, A.2 (2-1 vote) and A.3;

Paragraph B.2;

Paragraphs C.1 and C.2;

Paragraphs D.2 and D.3 (2-1 vote);

Paragraphs E, E.1 and E.2 (2-1 vote).

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

Fourteenth Specification: (B, B.1, C, C.3, D and D.4);

Fifteenth Specification: (G).

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

First Specification;

Second Specification;

Third Specification;

Fourth Specification;

Fifth Specification;

Sixth Specification - Withdrawn by Petitioner;

Seventh Specification;

Eighth Specification;

Ninth Specification;

Tenth Specification (2-1 vote);

Eleventh Specification;

Twelfth Specification - Withdrawn by Petitioner;

Thirteenth Specification.

DISCUSSION

Respondent has been charged with fifteen 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 does 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 Peter J. Millock, Esq., 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 the 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 physician under the circumstances;
>
> **Gross Negligence** is the 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 physician in the practice of medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded (except for the previously-noted 2-1 vote to dismiss Specification Ten--see p. 24 of this Determination and Order), by a preponderance of the evidence, that two specifications (Fourteen and Fifteen) should be sustained, and that the remaining specifications should be dismissed. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

Patient A

The Department raised three factual allegations against Respondent regarding Patient A. The Department alleged that Respondent: diagnosed a mature cataract in the left eye without adequate medical justification; scheduled Patient A for cataract surgery on the left eye without adequate medical justification, and scheduled surgery on the left eye when the right eye was worse, according to his records. The Hearing Committee rejected each of these allegations.

The Department based its allegation regarding the diagnosis of a mature cataract in the left eye on the testimony of Dr.

Harris. Dr. testified that a mature cataract is one which involves the entire lens and is completely opaque. It is incontrovertible that the lens in Patient A's left eye was not completely opaque. Therefore, the Department argues, there was no medical justification for diagnosing a mature cataract.

However, the record clearly established that there are differing usages of the term "mature cataract" within the practice of ophthalmology. Dr. Clayman testified that while he preferred the definition cited by Dr. Harris, it is common for many practitioners to use the phrase to describe a cataract which is eligible for surgery. Indeed, Dr. Rodman, who testified on behalf of the Department, defined "mature cataract", as one for which surgery is appropriate. Therefore, it is obvious that the mere fact that the patient did not have a completely opaque lens in her left eye does not mean that there was inadequate medical justification for diagnosing a mature cataract.

Dr. Harris testified that Patient A had nuclear sclerosis of both eyes which was normal for her age. He expressed the opinion that these changes were probably not visually significant, yet he acknowledged that the patient suffered from bad vision. He suspected that Patient A's poor vision was caused by optic nerve atrophy rather than cataract. However, he performed no tests to confirm this suspicion.

Dr. Rodman also examined Patient A. He testified that the patient's poor vision was <u>not</u> the product of an optic nerve

problem. Dr. Rodman testified that he would not have recommended cataract surgery for Patient A. However, he acknowledged the presence of one-plus nuclear sclerosis in the patient's eyes. He further testified that the nuclear sclerotic cataracts were consistent with corrected vision as good as visual acuity of 20/20 and as poor as 20/40. Ultimately, Dr. Rodman admitted that he could not account for Patient A's poor vision. Moreover, he stated that the threshold for reimbursement of cataract surgery under Medicare is 20/40, corrected.

Both Dr. Harris and Dr. Rodman acknowledged that the patient had vision problems. They both acknowledged that the patient had nuclear sclerotic changes in both eyes. Neither one was able to provide a definitive diagnosis of the cause of the vision problems. They offered differing opinions as to whether or not Patient A's problems were caused by optic nerve atrophy. This divergence of opinion between the two prosecution witnesses demonstrates the subjective, judgmental component in ophthalmic decisions. The Hearing Committee also takes note of Dr. Clayman's testimony that cataracts which might not appear significant to a physician, may nevertheless have a significant impact on the patient's vision. (See, Tr., p. 1974).

Under the totality of the circumstances, it is impossible to conclude that the Department has met its burden of proving by a preponderance of the evidence that Respondent's decision to

schedule Patient A for cataract surgery on the left eye was without medical justification.

The Department further alleged that Respondent scheduled surgery on the left eye when the right eye was worse according to his records. Dr. Harris testified that standard ophthalmologic practice dictates that one operates on the "worse" eye first. In the event that there is a bad result, the patient will be left with his or her "better" vision. He further testified that in his opinion, distance vision is more important for patients in Patient A's age group who couldn't or didn't read. Therefore, he would have operated on the eye with the worst distance vision.

Dr. Clayman presented a different view. He testified that in his opinion, near vision was more important to elderly patients. He noted that it was especially relevant in this case because the medical record documents that the patient had complained of stumbling, which could have been due to poor near vision. Respondent's medical record indicates that the patient's corrected near vision was worse in the left eye. This finding was not contradicted by Dr. Harris.

It should be noted that the Department and Respondent each presented testimony by one of Patient A's children. Patient A's daughter testified on behalf of the Department and her son testified on behalf of Respondent. They presented diametrically opposed versions of the extent of Patient A's reading ability. Given the extreme differences in their testimony, as well as the

absence of any clear motivation for fabrication of testimony on either part, the Hearing Committee decided to discount their testimony.

Under the totality of the circumstances, the Hearing Committee concluded that the Department had failed to prove by a preponderance of the evidence that Respondent scheduled surgery on the left eye when the right eye was worse according to his records. As a result, the Committee did not sustain this factual allegation. Given the fact that the Hearing Committee did not sustain any of the factual allegations regarding Patient A, it therefore follows that the Committee voted not to sustain the First Specification (gross negligence with regard to Patient A), as well as the Seventh Specification (gross incompetence with regard to Patient A).

Patient B

Patient B was examined by Respondent on one occasion, April 4, 1990. At that time, Respondent diagnosed moderate cataract and myopia in the right eye. He then advised the patient of the diagnosis. The patient was subsequently examined by Sharon Kuritzky, M.D. on August 15, 1990. Upon slit lamp examination, Dr. Kuritzky found both lenses to be normal. The patient was also examined by Dr. Harris on January 11, 1992. Upon slit lamp examination, Dr. Harris observed minimal nuclear sclerosis in both eyes, normal for the patient's age.

Dr. Clayman testified regarding his review of copies of slit lamp photographs of Patient B's eyes. He testified that the

found a very minimal cataract in Patient B's right eye. However, when asked whether he observed any difference in the opacity in each lens, he stated that they were pretty much the same. (See, Tr., pp. 2084-2085). Significantly, even Respondent noted that the patient did not have a cataract in the left eye. (See, Ex. 10, p. 1). Dr. Clayman acknowledged that mere review of slit lamp photographs is less reliable than a complete ophthalmologic examination. (See, Tr., p. 2084).

All of the physicians who directly examined Patient B found that she did not have a cataract in her left eye. Dr. Harris and Dr. Kuritzky found no evidence of cataract in the right eye. Dr. Clayman, who only examined photographs found a cataract in the right eye, but also said that both eyes were essentially the same. Under the circumstances, the Hearing Committee concluded that Dr. Clayman's testimony regarding his examination of the slit lamp photographs of Patient B's eyes should not be given credence. As a result, the Hearing Committee concluded that Respondent did diagnose cataract in the right eye without adequate medical justification. Therefore, the Hearing Committee sustained Factual Allegation B.1.

It is uncontested that Respondent advised Patient B that she had a cataract in her right eye. However, if one assumes that Respondent made a good faith diagnosis of cataract, albeit incorrectly, it would not be inappropriate for Respondent to give his diagnosis to the patient. Significantly, the Department did

not charge Respondent with fraud in connection with his diagnosis of cataract in Patient B's right eye. The only information presented by the Department concerning the actions of Respondent with regard to Patient B was his office medical record for the patient. The record (which consisted of only one office visit) contains the results of Respondent's examination, his diagnosis, and a recommendation that the patient return for further follow-up. (See, Ex. 10). There is no evidence that Respondent was acting other than in good faith, based upon his clinical findings.

Under the totality of the circumstances, the Hearing Committee concluded that Factual Allegation B.2 should not be sustained. The Hearing Committee further concluded that Respondent's improper diagnosis of cataract in the right eye demonstrated incompetence, but not gross incompetence, as defined above. The Committee further concluded that Respondent's conduct did not constitute either negligence or gross negligence, as defined above. Consequently, the Hearing Committee did not sustain the Second Specification (gross negligence) and the Third Specification (gross incompetence).

Patient C

The Department alleged that Respondent advised Patient C that she had cataracts in both eyes which would require surgery within one year. (Factual Allegation C.1). The record established at the hearing does not support this contention.

The Department offered into evidence Respondent's medical record for Patient C. The record contains a diagnosis of cataract in both eyes. It is silent as to what Respondent may have advised the patient regarding the diagnosis or the need for surgery within any specific time frame. The Department relied upon the testimony of Patient C to prove the allegation.

Patient C testified at the hearing, nearly three years after the event, that Respondent told her of the cataracts and that she would need surgery within a year. However, this testimony is contradicted by the records and testimony of Dr. Niswander and Dr. Harris. Philip R. Niswander, M.D. examined the patient on March 21, 1990, less than two months after she left the care of Respondent. Patient C told Judith Whitehead, a medical technician working for Dr. Niswander, that Respondent did not tell her she had cataracts. When Patient C was examined by Dr. Harris on December 17, 1991, she told him that Respondent found a cataract in one eye, which would need surgery within a year. Given the discrepancies in the statements made by Patient C, the Hearing Committee determined that she was not a credible witness. As a result, the Committee discounted her testimony and determined that the allegation concerning Respondent's "advice" about cataract surgery should not be sustained.

The Department also alleged that on January 25, 1990, Respondent diagnosed definite glaucoma without adequate medical justification. (Factual Allegation C.2). The Hearing Committee

concluded that this factual allegation was not supported by the record.

The Department presented the testimony of Patient C, who claimed that Respondent told her that she had definite glaucoma with severe optic nerve damage. The Department also placed emphasis on the phrase "def GLC" which was entered under "Fundus Examination" in Respondent's medical record for the patient. In addition, the Department presented the testimony of Drs. Harris and Niswander. Neither physician found evidence of optic nerve damage in the patient. In addition, both physicians testified that a reasonably prudent and competent physician would not diagnose definite glaucoma. However, a careful review of the proof does not support the Department's position.

As was noted previously, the inconsistencies in the statements made by Patient C rendered her testimony not credible. As a result, the Committee discounted her testimony regarding this issue. In addition, Drs. Niswander, Harris, and Aquavella testified that the patient should be considered as suffering from ocular hypertension, or glaucoma suspect. Indeed, Dr. Harris wrote in his report to the Department that the patient presented sufficient findings upon physical examination to consider treatment for glaucoma. (See, Tr., pp. 1589-1590). At one point in his treatment of the patient, Dr. Niswander was sufficiently concerned about the possibility of glaucoma that he discussed risk factors for the disease and gave two pamphlets about glaucoma to Patient C.

It appears, then, that the crux of the Department's case concerning this allegation rests upon the meaning of the phrase "def GLC", which is recorded in the patient's medical record. Dr. Harris interpreted the phrase as meaning "definite glaucoma". However, Dr. Clayman testified that the phrase "definite glaucoma" is not an accepted medical term, nor is there a standardized interpretation for the phrase "def GLC". Given the fact that the entry is placed under the heading "Fundus", rather than "Impression", Dr. Clayman testified that he believed it was meant to signify a finding of "defect glaucomatous" or "glaucomatous field defect". Based upon the totality of the record, the Hearing Committee concluded that the Department had failed to prove this allegation by a preponderance of the evidence.

The Department also alleged that Respondent ordered and performed an A-scan on Patient C without medical justification. It is uncontested that on February 2, 1990, Respondent ordered and performed an A-scan on Patient C. An A-scan is an ultrasound test most commonly used to determine the appropriate intraocular lens implant to use at the time of surgery. Dr. Harris testified that he would not perform an A-scan until he was prepared to perform cataract surgery. Dr. Aquavella testified that an A-scan is a relatively non-invasive test, which is no more invasive than applanation tonometry. Nevertheless, he acknowledged that he would not have ordered an A-scan for Patient C on February 2, 1990.

Based upon the foregoing, the Hearing Committee concluded that Respondent did order and perform an A-scan on Patient C without adequate medical justification. As a result, the Committee sustained factual allegation C.3. The Hearing Committee further concluded that Respondent's conduct in this regard demonstrated incompetence, as defined above. However, the Committee concluded that Respondent's misconduct did not rise to the level of gross incompetence, nor did it demonstrate negligence or gross negligence. Consequently, the Hearing Committee did not sustain the Third and Ninth Specifications.

Patient D

The Department raised three allegations against Respondent concerning his treatment of a postoperative complication in Patient D's left eye. (A fourth allegation was withdrawn by the Department during the hearing.). Factual Allegation D.2 claimed that Respondent failed to schedule for follow-up and/or to examine Patient D in a timely manner after August 7, 1989, and prior to August 28, 1989. For the reasons set forth below, the Hearing Committee did not sustain this allegation.

Respondent performed cataract surgery on Patient D's left eye in August, 1985. The patient developed a filtering bleb in January, 1986. The bleb eventually grew larger and spread onto the cornea. Respondent repaired the bleb on June 6, 1989. Slight wound leakage was noted on June 8, 1989. Respondent inserted three

additional sutures and applied a bandage lens. On June 13, 1989, Respondent recorded visual acuity in the left eye as 20/60.

On August 3, 1989, Patient D complained of a foreign body sensation in the left eye. Respondent examined the patient on August 7, 1989. The patient presented with a discharge from the eye which Respondent described as non-purulent. The eye was tearing and the lids were stuck together. The visual acuity in the left eye was 20/70, without correction. Respondent's diagnosis was keratoconjunctivitis of unknown cause. Respondent changed the patient's medications and removed the bandage lens. The patient was instructed to return in three to four weeks.

Dr. Harris testified that keratitis in a post-operative eye is a complication which required closer follow-up. Respondent stated that the patient exhibited a non-purulent mucous discharge and a slight reaction on the surface of the cornea due to mechanical irritation.

The Department did not quarrel with the changes in medication ordered by Respondent in response to the change in Patient D's condition. It's sole concern here was the alleged delay in scheduling the next follow-up appointment. The Hearing Committee rejected this contention. There was no deterioration in the Patient's vision noted at the time of the August 7, 1989 visit, which might trigger heightened concern. In addition, the patient was informed that he should contact Respondent if there were any changes in his condition. Under the circumstances,

Respondent did not err by failing to examine the patient after August 7, 1989 and prior to August 28, 1989. Consequently, the Committee did not sustain Factual Allegation D.2.

The Department also charged Respondent with failing to schedule for follow-up and/or to examine Patient D in a timely manner after August 28, 1989 and prior to September 6, 1989. (Factual Allegation D.3). The Department also alleged that on or about August 28, 1989, Respondent failed to refer Patient D to a vitreous/retinal specialist or to obtain a vitreous culture and administer appropriate antibiotic therapy. (Factual Allegation D.4).

The record demonstrates that Patient D's condition deteriorated markedly between the August 7 and August 28, 1989 office visits. The patient complained of blurry vision. He also reported lots of floaters, and that something seemed to be blocking his vision. Respondent recorded visual acuity in the left eye as 20/200, with correction. Respondent noted that the fundus was difficult to visualize, due to vitritis, and that the intraocular lens implant was displaced. The medical record for Patient D indicates that there was no tenderness of the globe on touch, no conjunctival injection, and the wound was intact.

Respondent testified that he was very concerned about the patient's condition and asked the patient to return later in the day. At that time, Respondent performed a B-scan, which showed no evidence of retinal detachment. Respondent diagnosed the patient's

condition as intraocular lens implant displacement, and sterile vitritis of unknown cause. He prescribed Tobradex q.i.d. and Prede Forte b.i.d.. The patient was instructed to return in three to four weeks, and Respondent planned to re-position the lens if the vitritis cleared.

Respondent testified that Patient D had a history of non-infectious vitritis in the right eye which cleared with conservative treatment. He felt that the loss of vision in Patient D's left eye was due to the IOL displacement, and not due to infection.

However, Dr. Harris noted that although Respondent diagnosed the vitritis as "sterile", there was no way to know that without obtaining a vitreous culture. Further, it should have been apparent that a very aggressive diseases process was occurring in Patient D's eye. His vision had severely deteriorated, from 20/70, without correction, on August 7, 1989, to 20/200, with correction, on August 28. An overwhelming vitreous reaction, extensive enough to physically displace the intraocular lens implant, was taking place.

It was apparent that Respondent was concerned about the situation, insofar as he brought the patient back to the office to perform a B-scan. However, the patient needed further evaluation on August 28, 1989. According to Dr. Harris, Respondent should have either referred the patient to a vitreous/retinal specialist at that time, or performed a vitreous tap himself. He should have

also started the patient on parenteral and intraocular antibiotics. The medications which Respondent prescribed, Tobradex and Prede Forte, are topical medications, not used to treat vitritis.

Dr. Harris' testimony was corroborated, in part, by Corstiaan Brass, M.D. Dr. Brass is an infectious disease specialist who testified on behalf of by Respondent. Dr. Brass testified that, in his opinion, there was no bacterial infection present in Patient D's eye on August 28, 1989. However, Dr. Brass acknowledged that the presence of vitritis and decreased vision should have raised a suspicion of infection. He stated that the severe consequences of bacterial endophthalmitis require that every effort be made to make a definitive diagnosis and start treatment promptly. Cultures must be obtained whenever a diagnosis of bacterial endophthalmitis is entertained. Dr. Brass also testified that although it is difficult to be certain of the etiology of a case of endophthalmitis on the basis of clinical findings alone, inflammation associated with pain and/or marked visual loss is more likely due to bacterial infection.

The Hearing Committee determined that the testimony of Dr. Harris, as corroborated in part by Dr. Brass, should be given credence. The Committee also took note of the fact that in this case, unlike the other patients at issue, Respondent presented no testimony by an ophthalmologist other than himself. The Hearing Committee concluded that on August 28, 1989, Respondent should have

referred Patient D to a vitreous/retinal specialist or obtained a vitreous culture and administered appropriate antibiotic therapy.

The situation presented on August 28 was urgent. The patient's vision had dramatically deteriorated from the prior visit on August 7, 1989. Respondent found evidence of a vitreous reaction severe enough to cause the displacement of the lens implant. There was no way for Respondent to rule out the presence of an infection without obtaining a vitreous culture. Given the fact that the patient's symptoms had developed following two invasive procedures (repair of a filtering bleb on 6/6/89 and the placement of additional sutures on 6/8/89), it was imperative that Respondent act swiftly to rule out the possibility of a post-operative infection. Instead, Respondent waited until September 6, 1989. The Hearing Committee considered the stat referral of the patient to Dr. Forgash on September 8 and his findings on examination. It was noted that neither Respondent nor the Department called Dr. Forgash to testify as to his findings. The issue here is not whether or not Dr. Forgash was correct in his diagnosis; rather, it is whether or not the condition of the patient on August 28 was of such a critical nature that Respondent should have at that time obtained a vitreous culture and/or referred the patient to a vitreous/retinal specialist. Based upon the foregoing, the Hearing Committee unanimously voted to sustain Factual Allegation D.4.

By a vote of 2 - 1, the Hearing Committee voted not to sustain Factual Allegation D.3. The majority of the Committee believed that the fact that Respondent did not schedule the patient for follow-up prior to September 6, 1989 was essentially irrelevant, given the conclusion that Respondent should have acted more decisively on August 28.

The Hearing Committee further concluded that Respondent's failure to either refer the patient to vitreous/retinal specialist or to obtain the culture and start the patient on appropriate antibiotics demonstrated a lack of the basic skill and knowledge necessary to practice the profession. Consequently, the Committee concluded that Respondent's conduct with regard to Allegation D.4 constituted incompetence. By a vote of 2-1, the Committee determined that Respondent's conduct did not rise to the level of gross incompetence, as defined above.

Respondent was clearly concerned about the change in Patient D's condition. He brought the patient back to the office to perform a B-scan in an attempt to diagnose the situation. He was aware of the problem, but did not have sufficient knowledge to deal with it appropriately. As a result, the Hearing Committee did not believe that Respondent demonstrated an unmitigated lack of skill or knowledge. Consequently, the Committee did not sustain the Tenth Specification. The Hearing Committee further concluded that Respondent's conduct did not constitute either negligence or gross negligence, and did not sustain the Fourth Specification.

Patient E

The Department has alleged that Respondent recommended surgery on Patient E's left eye without adequate medical justification (Factual Allegation E.1), and that he performed cataract surgery on her right eye without medical indication (Factual Allegation E.2). A third Factual Allegation was withdrawn by the Department. For the reasons set forth below, the Hearing Committee voted not to sustain these allegations.

At the outset, it was apparent that the patient presented at the Park Eye Center with substantial visual complaints. She complained of problems because of blurry vision, as well as problems driving at night due to "halos" surrounding the headlights of cars. In addition, she exhibited diminished vision in both eyes (20/60 - right eye, 20/50 - left eye, with correction). The medical record indicates that the patient complained of lifelong headaches requiring 100 Excedrin per week. There is also a note indicating that the patient complained about not being able to enjoy television or living.

Respondent's records document the presence of embedded crystalline opacities in both lenses. When Dr. Harris examined Patient E's right eye, he found mild nuclear sclerosis and noted "anterior whitish opacities". There is an apparent disagreement as to the visual significance of these opacities. Dr. Harris testified that they were not visually significant. Respondent noted that he advised Patient E that the cataracts did not seem to be impairing

the patient's vision. Dr. Clayman testified that the opacities, which he described as "multi-refractile opacities" were consistent with the patient's visual symptoms.

The Department argued that Patient E did not require cataract surgery in either eye. It relied, in part, upon the findings of Dr. Pfohl and Dr. Harris. George W. Pfohl, M.D. examined the patient in April, 1989 and obtained visual acuity in the left eye of 20/20 with correction. Dr. Harris examined the patient in December, 1991 and also obtained a visual acuity of 20/20, with correction. In contrast, Respondent obtained visual acuity in the left eye of 20/50, on multiple occasions.

Dr. Harris acknowledged that when taking a visual acuity, the practitioner is bound by the answers given by the patient. (See, Tr., P. 2560). Therefore, the reliability of the patient's reporting abilities can affect the validity of the acuities obtained. The record established that Patient E has a history of psychiatric treatment for depression, dating back at least to 1987. In addition, she gave a history of lifelong headaches, requiring the use of 100 Excedrin tablets per week. Such a complaint may also be indicative of psychiatric problems. As a result, the Hearing Committee concluded that Patient E was not a reliable reporter. Therefore, the Committee did not place great weight on her testimony, or the discrepancies in visual acuity obtained by the various practitioners.

Patient E presented a very difficult case. She complained of substantial vision problems, even though her visual acuity was not significantly diminished and her cataracts did not appear to be impairing her vision. Even Dr. Harris acknowledged that she was an "unusual" patient and that her case was "very subtle, complicated and with no straightforward areas." (See, Tr., pp. 2591-2592, 2613, 2658). It must be remembered that the Department has the burden of proof in this matter. Under the totality of the circumstances, the Hearing Committee concluded that the Department failed to meet its burden with respect to Patient E. The Hearing Committee voted not to sustain Factual Allegations E.1 (3-0) and E.2 (2-1). As a result, the Hearing Committee did not sustain the Fifth Specification (Gross Negligence) or the Eleventh Specification (Gross Incompetence).

Incompetence On More Than One Occasion

As noted previously, the Hearing Committee concluded that Respondent's conduct demonstrated incompetence with respect to Patients B, C and D. Although the Committee determined that this conduct did not rise to the level of gross incompetence, it is axiomatic that these findings demonstrate incompetence on more than one occasion. As a result, the Hearing Committee voted to sustain the Fourteenth Specification (Incompetence on More Than One Occasion).

Failure To Produce Records

The record clearly established the fact that Respondent failed to provide his records to the Office of Professional Medical Conduct (OPMC) in a timely manner following a written request from the Department. Physicians licensed to practice in New York State have a responsibility to cooperate with OPMC and to provide relevant records when requested. New York Education Law Section 6530(28) defines professional misconduct as "failing to respond within 30 days to a written communication from the department of health and to make available any relevant records with respect to an inquiry or complaint about the licensee's professional misconduct." It is obvious that Respondent failed to comply with the statute. Accordingly, the Hearing Committee voted to sustain the Fifteenth Specification. However, the Hearing Committee also determined that no additional sanction should be imposed upon Respondent due to this violation.

It appears that Respondent's failure to turn over the records in a timely manner was, at least in part, a tactical decision made by his former counsel. This does not excuse Respondent from carrying out his responsibilities under the law. However, the Hearing Committee concluded that it would not be appropriate to sanction Respondent for following the advice of his former counsel, however, inappropriate that advice may be.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be suspended for a period of three years. This suspension shall be stayed, and Respondent placed upon probation, with appropriate re-training, as set forth below. The complete terms of probation are contained in Appendix II, which is attached to this Determination and Order and incorporated herein. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee found that Respondent demonstrated incompetence on more than one occasion, with respect to three of the patients whose care is at issue in this case. Respondent demonstrated deficiencies in his ability to properly assess and interpret the clinical findings which he observed. However, the Committee believes that Respondent possesses reasonable, basic medical skills and is capable of rehabilitation. As a condition of probation, Respondent shall be required to complete the Phase I Evaluation of the Physician's Prescribed Educational Program (PEEP) of the Department of Family Medicine, SUNY Health Science Center. The results of the Phase I evaluation shall be forwarded to the

OPMC. OPMC will then refer Respondent to the designated facility for Phase II retraining, if the results of the Phase I evaluation indicate that Respondent is a candidate for re-education. If as a result of the Phase I evaluation, OPMC determines that Respondent is not a candidate for retraining, or if he is considered a suitable candidate but no satisfactory retraining program is available, as a condition for the stay of suspension Respondent shall comply with the monitoring and all other terms of probation as specified in Sections ONE through TWELVE of Appendix II.

ORDER

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

1. The Fourteenth and Fifteenth Specifications of professional misconduct contained in the Second Amended Statement of Charges, dated May 20, 1993 (Petitioner's Exhibit 41-B) are **SUSTAINED;**

2. The First, Second, Third, Fourth, Fifth, Sixth (withdrawn), Seventh, Eighth, Ninth, Tenth, Eleventh, Twelfth (withdrawn), and Thirteenth Specifications of professional misconduct contained in the Second Amended Statement of Charges are **NOT SUSTAINED;**

3. Respondent's license to practice medicine shall be and is hereby **SUSPENDED** for a period of **THREE (3) YEARS** from the effective date of this Determination and Order. The suspension shall be **STAYED** and Respondent placed on probation for three years.

The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein;

4. Respondent's probation shall be supervised by the Office of Professional Misconduct (OPMC);

5. Respondent shall complete the Phase I evaluation of the Physician's Prescribed Educational Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center;

6. The results of the Phase I evaluation shall be forwarded to the OPMC;

7. The OPMC shall refer Respondent to the designated facility for Phase II retraining, if the results of the Phase I evaluation indicate that Respondent is a candidate for such retraining, and he shall satisfactorily complete same;

8. If, as a result, of the Phase I evaluation, the OPMC determines that Respondent is not a candidate for retraining, or if he is considered a suitable candidate but no satisfactory retraining program is available, as a condition for the stay of suspension Respondent shall comply with the monitoring and all other terms of probation as specified in Sections ONE through TWELVE of Appendix II.

DATED: Albany, New York
18 February, 1994

J. LaRUE WILEY, M.D. (Chair)

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APPENDIX I

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

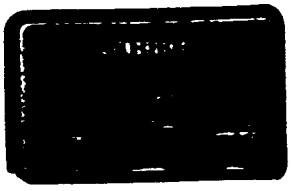
IN THE MATTER OF JOHN H. PARK, M.D.	SECOND AMENDED STATEMENT OF CHARGES

JOHN H. PARK, M.D., the Respondent, was authorized to practice medicine in New York State on December 29, 1971 by the issuance of license number 110946 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, 1991 through December 31, 1992 from 170 Maple Road, Buffalo, New York 14221.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A from on or about March 19, 1992, to on or about April 7, 1992. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent diagnosed a mature cataract in the left eye without adequate medical justification.
2. Respondent scheduled Patient A for cataract surgery on the left eye without adequate medical indication.



3. Respondent scheduled surgery on the left eye when the right eye was worse according to his records.

B. Respondent treated Patient B on or about April 4, 1990. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent diagnosed cataract in the right eye without adequate medical justification.

2. Respondent advised Patient B that she had a cataract in her right eye without adequate medical justification.

C. Respondent treated Patient C from on or about January 25, 1990, to on or about March 19, 1990. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent advised Patient C that she had cataracts in both eyes which would require surgery within one year.

2. On or about January 25, 1990, Respondent diagnosed definite glaucoma without adequate medical justification.

3. Respondent ordered and performed an A scan without adequate medical justification.

D. Respondent treated Patient D from on or about January 3, 1985, to on or about September 25, 1989. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

2. Respondent failed to schedule for follow-up and/or to examine Patient D in a timely manner after August 7, 1989, and prior to August 28, 1989.

3. Respondent failed to schedule for follow-up and/or to examine Patient D in a timely manner after August 28, 1989, and prior to September 6, 1989.

4. On or about August 28, 1989, Respondent failed to refer Patient D to a vitreous/retinal specialist or to obtain a vitreous culture and administer appropriate antibiotic therapy.

E. Respondent treated Patient E from on or about November 12, 1986, to on or about March 16, 1987. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent recommended surgery on the left eye without adequate medical justification.

2. On or about January 6, 1987, Respondent performed cataract surgery on the right eye without adequate medical indication.

withdrawn by Petitioner 6/24/93 - gels

~~3. On or about January 6, 1987, Respondent performed cataract surgery on the right eye without obtaining a second opinion.~~

G. On or about June 1, 1992, the Office of Professional Medical Conduct of the New York State Department of Health which has been investigating Respondent's care and treatment of Patient A, made a written request and demand to Respondent that he produce and deliver his complete medical records, including but not limited to correspondence, photographs, slides, test results and surgical reports, on Patient A. By October 20, 1992, the date of the original Statement of Charges, Respondent had not made any of these records available to the Office of

Professional Medical Conduct of the New York State Department of Health.

SPECIFICATIONS

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Law §6530(4) (McKinney Supp. 1992) in that, Petitioner charges:

1. The facts in paragraphs A and A.1, A.2, and/or A.3.
2. The facts in paragraphs B and B.1, and/or B.2.
3. The facts in paragraphs C and C.1, C.2, and/or C.3.
4. The facts in paragraphs D and D.2, D.3., and/or D.4.
5. The facts in paragraphs E and E.1, E.2., and/or ~~E.3~~.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law §6530(6) (McKinney Supp. 1992) in that, Petitioner charges:

7. The facts in paragraphs A and A.1, A.2, and/or A.3.
8. The facts in paragraphs B and B.1, and/or B.2.
9. The facts in paragraphs C and C.1, C.2, and/or C.3.
10. The facts in paragraphs D and D.2, D.3., and/or D.4.

11. The facts in paragraphs E and E.1, E.2, and/or ~~E.3.~~ withdrawn 6/24/93 gfg

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Education Law Section §6530(3) (McKinney Supp. 1992) in that, Petitioner charges two or more of the following:

13. The facts in paragraphs A and A.1., A.2, A.3; B and B.1, B.2; C and C.1, C.2, C.3; D and D.2, D.3, D.4.; and/or E and E.1, E.2, ~~E.3.~~ - withdrawn 6/24/93 gfg

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5) (McKinney Supp. 1992) in that, Petitioner charges two or more of the following:

14. The facts in paragraphs A and A.1., A.2, A.3; B and B.1, B.2; C and C.1, C.2, C.3; D and D.2, D.3, D.4.; and/or E and E.1, E.2, ~~E.3.~~ withdrawn 6/24/93 gfg

FIFTEENTH SPECIFICATION

FAILURE TO PRODUCE RECORDS

Respondent is charged with failing to make available relevant records with respect to an inquiry or complaint about his professional conduct in violation of New York Education Law §6530(28) (McKinney Supp. 1992) in that, Petitioner charges:

15. The facts in paragraph G.

DATED: Albany, New York
May 20, 1993

Peter D. Van Buren

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

APPENDIX II

APPENDIX II
TERMS OF PROBATION

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

3. Dr. Park shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Dr. Park leaves New York to reside or practice outside the State, Dr. Park shall notify the Director of the Office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. Park's probation shall be supervised by the Office of Professional Medical Conduct.

6. Dr. Park shall complete the Phase I evaluation of the Physician's Prescribed Educational Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center.

7. The results of the Phase I evaluation shall be forwarded to the Office of Professional Medical Conduct.

8.The Office of Professional Medical Conduct shall refer Dr. Park to the designated facility for Phase II retraining, if the results of the Phase I evaluation indicate that Respondent is a candidate for such retraining, and he shall satisfactorily complete same.

9. Dr. Park shall have quarterly meetings with an employee or designee of the Office of Professional Medical Conduct during the period of probation. During these quarterly meetings Dr. Park's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed.

10. For the first year of probation, Dr. Park shall have bi-monthly, and for the remaining two years, quarterly meetings with a monitoring physician who shall review his practice. The monitoring physician shall be a board-certified ophthalmologist who has been in practice as such for at least five years, selected by Dr. Park and subject to the approval of the Office of Professional Medical Conduct. This monitoring physician shall review randomly selected medical records and evaluate whether Dr. Park's medical care comports with generally accepted standards of medical practice. Dr. Park shall not practice medicine in New York State until an acceptable monitoring physician is approved by the Office of Professional Medical Conduct.

11. Dr. Park shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the

Office of Professional Medical Conduct at the address indicated above.

12. Dr. Park shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If Dr. Park elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

13. If there is full compliance with every term set forth herein, Dr. Park may practice as a physician in New York State in accordance with the terms of probation; provided, however, that upon 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 Dr. Park pursuant to New York Public Health Law Section 230(19) or any other applicable laws.

14. If, as a result of the Phase I evaluation by the PPEP, the Office of Professional Medical Conduct determines that Respondent is not a candidate for retraining, or if he is considered a suitable candidate but no satisfactory retraining program is available, as a condition for the stay of suspension Respondent shall comply with the monitoring and all other terms of probation as specified in Sections ONE through TWELVE, as set forth above.