NEW YORK
THE STATE OF LEARNING

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

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

September 20, 1991

John A. Poglinco, Physician
175 Memorial Highway
New Rochelle, New York 10801

Re: License No. 087439

Dear Dr. Poglinco:

Enclosed please find Commissioner's Order No. 12106/10089. This Order goes into effect five (5) days after the date of this letter.

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

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

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By: Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR

cc: Nathan L. Dembin, Esq.
Thurm & Heller
26 Broadway
New York, New York 10004

REPORT OF THE
REGENTS REVIEW COMMITTEE

JOHN A. POGLINCO

CALENDAR NOS. 12106/10089

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

JOHN A. POGLINCO **Nos. 12106/10089**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

JOHN A. POGLINCO, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

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

After a hearing was conducted, the hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B". The hearing committee found and concluded that respondent was guilty of the first specification of the charges based on gross negligence to the extent indicated in its report, the tenth through fourteenth specifications of the charges to the extent indicated in its report, and not guilty of the remaining charges.

JOHN A. POGLINCO (12106/10089)

The hearing committee recommended that respondent's license to practice as a physician in the State of New York be suspended for a period of at least one year and not more than two years. During this period of suspension, the respondent, as a PGY 2, 3, or 4, should successfully complete a residency program which is approved by the American College of Obstetrics and Gynecology, is at least one year in duration, and is in the United States. During this period of suspension, the respondent also should pass a board recertification examination in obstetrics and gynecology. If the respondent meets these two requirements (successful completion of the residency and board recertification) before the end of the two year suspension period, the remainder of that suspension period should be stayed. If the respondent has not met these two requirements (successful completion of the residency and board recertification) at the end of the two year suspension period, his license to practice medicine should be revoked.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted, and that the "imprecise" recommendation of the hearing committee be modified. The Commissioner of Health recommended that respondent's license be suspended to the extent that respondent not be allowed to practice OB/GYN except to allow him to take a certain one year fellowship or residency in OB/GYN, and that upon respondent's successful completion of the fellowship or residency,

respondent's license be suspended for one additional year with such suspension stayed provided respondent complies with the standard terms of probation. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On November 30, 1989, the Regents Review Committee issued its report in this matter, a copy of which, without attachments, is annexed hereto, made a part hereof, and marked as Exhibit "D". The Board of Regents voted on December 15, 1989 to accept the recommendation of the Regents Review Committee, find respondent guilty and not guilty as found and concluded by the hearing committee and Commissioner of Health, and modified the penalty recommendation of the hearing committee and Commissioner of Health. The Board of Regents, in agreement with the Regents Review Committee, suspended respondent's license for one year upon each specification of which respondent was found guilty, said suspensions to run concurrently, and that upon termination of said suspension, respondent thereafter be placed on probation for two years. A copy of the December 15, 1989 vote of the Board of Regents is annexed hereto, made a part hereof, and marked as Exhibit "E".

By its decision, dated February 28, 1991, the Appellate Division, Third Department, modified the prior determination of the Board of Regents by vacating the penalty imposed on respondent and remitted the matter for further proceedings. Poglinco v. Board of

Regents of the University of the State of New York, 566 N.Y.S.2d 733. A copy of the decision of the Appellate Division is annexed hereto, made a part hereof, and marked as Exhibit "F".

The Board of Regents voted on April 26, 1991 to remit this matter to a Regents Review Committee solely with respect to the issue of the penalty to be imposed upon respondent based upon the prior determination of the Board of Regents as to the issue of guilt. A copy of the April 26, 1991 vote of the Board of Regents is annexed hereto, made a part hereof, and marked as Exhibit "G".

On May 29, 1991, respondent appeared before us and was represented by his attorney, Nathan L. Dembin, Esq., who presented oral argument on behalf of respondent. Dawn A. Dweir, Esq., presented oral argument on behalf of the Department of Health.

Both parties were afforded the opportunity to submit additional evidence relating to the issue of the penalty to be imposed on respondent. Respondent submitted a five page letter dated May 15, 1991 along with attachments and submitted an objection, consisting of three pages, to petitioner's exhibits. Petitioner's objections to the receipt of these documents into the record are overruled and these documents are received into the record for the purpose of the above relevant issue.

Petitioner sought to add to the record a cover letter dated May 24, 1991, a series of documents consisting of eight pages starting with a January 29, 1990 letter from St. Agnes Hospital,

a letter dated October 13, 1989, and a packet of materials starting with a list of four enumerated exhibits. Respondent objects to the receipt of the latter packet of materials into the record on various grounds including his claim that they do not relate to the question of respondent's subsequent conduct which formed the basis for the Court's remand of this matter. In light of petitioner seeking to introduce timely further documents into the record after respondent's objection was interposed, we have allowed respondent to also apply his objection to these further proposed documents.

We sustain respondent's objection to the extent that the series of documents, starting with the January 29, 1990 letter from St. Agnes Hospital, insofar as the third, fourth, fifth, and sixth pages thereof and the entire packet of materials starting with a list of four enumerated exhibits will both not be received into the record because, as applicable, they are either not relevant to respondent's subsequent conduct occurring after October 26, 1988, the date the hearing concluded, or are not shown to relate to respondent or a specific time frame. Petitioner's submission of its remaining pages and documents are received into the record and respondent's objection to said remaining pages and documents are overruled on the ground that respondent has not demonstrated a basis for excluding such relevant evidence from the record.

We have considered the record in this matter as transferred by the Commissioner of Health and as added by us. Accordingly,

our independent recommendation is based upon the record as it exists at this time.

Upon remand, petitioner's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was same as Commissioner of Health.

Upon remand, respondent's written recommendation was a six month fellowship training program in gynecology be required and be followed by a year of probation along with respondent's practice being limited to gynecology.

We take a serious view of the professional misconduct committed by respondent. Respondent is guilty of gross negligence, negligence on more than one occasion, incompetence on more than one occasion, unprofessional conduct, and fraud. Respondent was the attending obstetrician for each of the nine patient cases. He committed: 21 incidents of negligence regarding 7 of these patients; 7 incidents of incompetence regarding 3 of these patients, (2 of these 3 patients had both negligence and incompetence committed as to them) 6 incidents of gross negligence regarding 1 of these patients, recordkeeping violations as to all 9 patients, and 3 incidents of fraud and willfully making a false report. Respondent's poor care contributed to one patient's inability to survive. Additionally, a baby's skull fracture was caused by respondent. In some cases, respondent failed to act appropriately and in other cases he performed or provided

unjustified or contraindicated procedures and medications. He failed to appear, examine, diagnose, or deliver or promote delivery of seven patients timely, and inappropriately used forceps on two patients. He also failed to obtain required consultations in two cases. Further, on three applications to two different institutions respondent committed fraud and the willful making of false reports.

We agree with the hearing committee that the "nature and seriousness of the sustained charges reflect the Respondent's lack of knowledge and judgment, and his need for more supervised training" (hearing committee report page 47). We also agree with the hearing committee to the extent that respondent's license as a whole should be suspended immediately. Although the hearing committee recommended a period of suspension of "at least one year and not more than two years", it is our unanimous opinion, that, based on the current record, only one year of suspension should be imposed on respondent. The Commissioner of Health recommended an indefinite suspension to be followed, upon respondent's successful completion of a fellowship or residency, by an additional one year suspension stayed and probation. Furthermore, we partially agree with the Commissioner of Health to the extent that respondent be permitted to commence his retraining during a suspension and, upon respondent's successful completion of the retraining, there be a period of probation. It is our unanimous opinion, based on the

current record, that no further period of a stayed suspension beyond the first year is necessary, and, instead, only an additional period of probation should then be imposed on respondent after a suspension of one year which may be partially stayed as hereinafter recommended.

Respondent has explained his difficulty in finding a residency or fellowship program. Accordingly, the probation we recommend does not limit the retraining program we believe is necessary to a residency or fellowship. Instead, a retraining program, of at least one year in duration and previously approved in writing by the Director of the Office of Professional Medical Conduct, should be sought in order to accommodate practical considerations.

Accordingly, while respondent's conduct warrants a suspension for one year, the penalty we recommend provides for a partial stay of such suspension in order for respondent to pursue retraining. Our recommendation places respondent on probation immediately as well as after the termination of his suspension. This will enable him to both complete his medical ethics course and commence his retraining during the period of suspension and this will protect the public by requiring this retraining to occur sooner and to commence while respondent is suspended. We also have provided a mechanism, within the terms of probation, for respondent to obtain, upon his successful completion of retraining, the sooner termination of the limitation on his practice of

obstetrics/gynecology, which would not be the case had we recommended such retraining only commence after the termination of the suspension.

Respondent's numerous instances of misconduct were committed over a more than four year period between June, 1981, and April, 1986. Three incidents of respondent's fraud and unprofessional conduct occurred in 1986. See thirteenth specification paragraphs 8(A), 8(B), and 8(D). Significantly, in spite of the agreement, entered into on June 28, 1982 between respondent and New Rochelle Hospital, which placed respondent under mandatory supervision for most aspects of his obstetrical care and in spite of the opportunity respondent has had to improve his practice with the assistance and input of other physicians, respondent, after June 28, 1982, failed to obtain required consultations and has continued to render substandard medical care to his patients. In addition, respondent deliberately misrepresented the fact that he was practicing with restricted privileges.

Respondent claims that he has demonstrated, after the misconduct was committed, growth, improvement, and awareness. At oral argument, we inquired as to the reasons why the misconduct occurred through 1986 and how there is assurance that such misconduct will not recur. Respondent's attorney answered that the reasons cannot be explained, but that, whatever caused the misconduct, such reasons do not exist any longer. This answer is not satisfactory and does not assure that the public will be

protected in the future. The record before us does not adequately demonstrate mitigating circumstances based upon respondent's subsequent conduct.

Respondent's subsequent practice at St. Agnes Hospital has been questioned by the Utilization Review Committee. In regard to two separate December, 1989 admissions there, respondent was considered by the Utilization Review Committee to have admitted a patient without indication, not substantiated a condition on admission, and performed gynecology surgery before a urological problem had been completely resolved. The Medical Director and Chairman of the OB/GYN Department at St. Agnes Hospital notified respondent, by letter dated January 29, 1990, that he should obtain written consultations on all surgical procedures.

We agree with petitioner that the following conclusion written by petitioner in 1989 holds true today:

> The evidence has shown that despite any short term improvement Respondent has slipped back into his earlier patterns of poor medical practice. If respondent is to be allowed to practice, strong and decisive measures must be taken to assure that the public is adequately protected.

Regarding the May 15, 1991 submission from respondent's attorney, the attachments to that submission do not show, among the courses respondent has taken, any course in medical ethics. We believe that respondent should be required to take such a course. Moreover, respondent's offer to discontinue obstetrical practice does not change our view. We are not recommending the permanent

prohibition of respondent's practice in such area which may be resumed in the future.

The attachments to the May 15, 1991 submission also include a chart of patients, by number, and admission dates. Such chart contains no further information. The evaluations attached to respondent's submission from physicians who have worked with respondent do not provide any insight into: the reasons why any of the misconduct was committed; whether respondent has been sufficiently remediated since the time of the misconduct; and why respondent has experienced lapses after periods of short term improvement.

We note that we have not recused ourselves, as respondent requested, because we believe that we can render a fair and impartial recommendation. The fact that we are the same Committee which recommended the findings and conclusions in this matter makes us at least as qualified and knowledgeable as any other Regents Review Committee to consider the issue of the appropriate measure of discipline at this time based upon the expanded record we have reviewed.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's recommendation and the Health Commissioner's recommendation as to the measure of discipline be modified as hereafter indicated; and

2. In partial agreement with certain aspects of the recommendations of the hearing committee and Commissioner of Health, and as an appropriate measure of discipline, at this time and under the circumstances herein, respondent's license to practice as a physician in the State of New York be suspended for one year upon each specification of the charges of which respondent was previously found guilty, said suspensions to run concurrently, that execution of said concurrent suspensions be stayed, in part, solely to the extent of permitting respondent to practice only in the retraining program referred to in the terms of probation hereafter imposed on respondent, and respondent be placed immediately on probation for three years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "H".

Respectfully submitted,

ADELAIDE L. SANFORD

SIMON J. LIEBOWITZ

JOHN T. McKENNAN

Chairperson

Dated: June 21, 1991

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

IN THE MATTER OF JOHN A. POGLINCO, M.D.	SECOND AMENDED STATEMENT OF CHARGES

The State Board for Professional Medical Conduct alleges as follows:

1. John A. Poglinco, M.D., hereinafter referred to as the Respondent, was authorized to engage in the practice of medicine in the State of New York on March 22, 1962 by the issuance of license number 087439 by the State Education Department.

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 at 150 Lockwood Avenue, New Rochelle, New York 10801.

3. Respondent is charged with professional misconduct within the purview of N.Y. Educ. Law §6509 (McKinney 1985) as set forth in the specifications.

Petitioner's Ex. 22 For Id. 12/[illegible] in evid. 12/[illegible]

EXHIBIT "A"

FIRST THROUGH NINTH SPECIFICATION

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

(A) Patient A (Patients are identified in Appendix A) an 18 year old girl at 20-24 weeks gestation, was admitted to New Rochelle Hospital Medical Center, New Rochelle, New York (hereinafter New Rochelle Hospital) at 8:15 pm on or about November 12, 1985, with abdominal complaints, under the care of Respondent, as attending obstetrician. Respondent's treatment of Patient A failed to meet accepted standards of medical practice in that Respondent failed to diagnose and treat Patient A for abruptio placenta and disseminated intravascular coagulation in a timely manner, specifically:

(i) Respondent failed to properly and timely stimulate labor and promote delivery.

(ii) Respondent failed adequately to monitor Patient A's hematological status in order to ascertain the cause and scope of the bleeding, specifically;

(a) Respondent failed to obtain lab data on clot formation and retraction, including, but not limited to platelet counts, fibrinogen determination, TT, PT, PTT and screening for fibrin slit products, in a timely manner.

(b) Respondent failed to evaluate urinary output.

(c) Respondent failed to monitor pulmonary wedge pressures and central venous pressures.

(d) Respondent failed to consult with a hematologist in a timely manner regarding Patient A's blood loss and amount of blood replacement needed.

(iii) Respondent failed promptly to terminate the pregnancy as soon as the diagnosis of disseminated intravascular coagulation became clear such that Patient A was deprived of her best chance to avoid the complications of complete placental abruption and disseminated intravascular coagulation that ultimately caused her death on December 10, 1985.

(B) Patient B, a 34 year old woman at approximately 20 weeks gestation, was admitted to New Rochelle Hospital on or about December 17, 1983, with ruptured membranes and a temperature of 101, under the care of Respondent, as attending obstetrician. Respondent's treatment of Patient B failed to meet accepted standard of medical practice in that:

(i) Respondent performed an episiotomy which was unjustified given the patients condition, including but not limited to the fact that the episiotomy was performed one hour prior to the delivery of an 11 ounce stillborn.

(ii) Respondent failed to follow up on Patient B's positive VDRL results of December 18, 1983.

(C) Patient C, a 28 year old ~~multiparous~~ Gravida 2 Para 0 AB1 female at thirty weeks gestation, saw Respondent at his office on or about March 24, 1982 at 3:00 p.m. and admitted herself to New Rochelle Hospital at 7:45 p.m. that evening, under the care of Respondent, as attending obstetrician. Respondent's treatment of Patient C failed to meet accepted standard medical practice in that:

amended 10-12-88 dla

(i) Respondent failed to take any steps to diagnose and treat Patient C for premature onset of labor when she presented at his office despite her symptoms, including, but not limited to her complaints of pressure and cramping upon vaginal examination.

(ii) Respondent misdiagnosed the fetal presentation when he noted "vertex at pelvic floor" upon vaginal examination 29 minutes before he performed a vaginal delivery of a double footling breech presentation.

(iii) Respondent used pitocin which was contraindicated by the fact that Patient C was a double footling breech presentation.

(iv) Respondent failed to perform cesarean section in the face of a double footling breech presentation.

(D) Patient D, a 21 year old woman at 38 weeks gestation, was admitted to New Rochelle Hospital at 7:40 am on or about December 12, 1983 with a blood pressure of 148/108, under the care of Respondent, as attending obstetrician. Respondent's treatment of Patient D failed to meet accepted standard of medical practice in that;

(i) Respondent failed to see and examine Patient D until three hours after admission, despite being informed of her hypertensive status.

(ii) Respondent failed to order anti convulsive medication for Patient D until the end of three hours period during which she had continued diastolic blood pressures over 100.

(iii) Respondent used Pitocin in a manner that was contraindicated by Patient D's condition of being fully dilated, having a history of coupling of contractions and a stat x-ray pelvimetry that revealed an average to low normal pelvis.

(iv) Respondent failed to deliver Patient D in a timely fashion despite pre-eclampsia and fetal distress.

(v) Respondent failed appropriately to monitor Patient D by, among other things, being in constant attendance in the face of symptoms of pre-eclampsia, meconium staining, and continued coupling of contractions.

(E) Patient E, a 15 year old girl at 37+ weeks gestation, was admitted to New Rochelle Hospital on or about November 23, 1981 through December 1, 1981, with a diagnosis of labile hypertension after a weight gain of ten pounds in one week and marked edema in the lower extremities, under the care of Respondent, as attending obstetrician. She was readmitted at 40+ weeks gestation in an acutely hypertensive condition on or about December 11, 1981 under the care of Respondent, as attending obstetrician. During this admission she delivered Baby E, who was diagnosed at birth with post maturity syndrome. Respondent's treatment of Patient E failed to meet accepted standards of medical practice in that:

(i) Respondent failed to deliver Patient E during her first admission to New Rochelle Hospital when her blood pressure was under control.

(ii) Respondent failed to remain in sufficient patient contact with Patient E during her labor in the face of her symptoms of pre-eclampsia.

(iii) Respondent failed to arrange for the presence of an anesthesiologist during Patient E's labor in face of acute hypertension and the attendant risks of seizure or need for emergency intubation.

(F) Patient F, a 26 year old primigravida, was admitted to New Rochelle Hospital at 41 weeks gestation on or about March 26, 1982 under the care of Respondent, as attending obstetrician. Respondent's treatment of Patient F failed to meet accepted standard of medical practice in that:

(i) Respondent failed to deliver Patient F in a timely fashion despite her condition, including, but not limited to more than 72 hours of ruptured membranes.

(ii) Respondent used pitocin in a manner which was contraindicated, including but not limited to starting and stopping pitocin administration several times over a 36 hour period, specifically:

March 27 - 9:30 to 10:50 a.m. (4 gtts/min).
10:45 a.m. to 11:48 a.m. (Pitocin off)
11:48 a.m. to 12:40 p.m. (8 gtts/min)
12:40 p.m. to 1:30 p.m. (Pitocin off)
1:30 p.m. to 6:30 p.m. (8-12 gtts/min)
6:30 a.m. to 8:33 a.m. (Pitocin off)
March 28 - 8:33 a.m. to 12:15 p.m. (8-16 gtts/min)
12:15 p.m. to 5:55 p.m.(Pitocin off)
5:55 p.m. to 11:25 p.m. (8-20 gtt/min)

(iii) Respondent failed to perform a vaginal examination on Patient F before initiating pitocin administration.

(iv) Respondent failed to be personally present in a manner consistent with Patient F's condition, including, but not limited to prolonged rupture of membranes, occiput posterior presentation (as revealed by x-ray pelvimetry on March 26) and oxytocin stimulation.

(v) Respondent attempted to deliver Patient F with Kielland forceps despite the fact that this type of forceps was contraindicated by her condition.

(vi) Respondent inappropriately applied forceps with such excessive force as to cause Baby F to sustain a cephalohematoma in the right parieto-occipital area and a depressed skull fracture in the right tempora-occipital area.

(G) Patient G, a 24 year old woman, was admitted to New Rochelle Hospital at 6:50 pm on or about June 4, 1981 at 39 weeks gestation under the care of Respondent, as attending obstetrician. Respondent's treatment of Patient G failed to meet accepted standard of medical practice in that:

(i) Respondent caused oxytocin stimulation to be administered at 2:42 a.m. which was not indicated by the patient's condition, including, but not limited to the fact that Patient G had progressed from six to eight centimeters dilitation between 2:00 and 2:15 a.m.

(ii) Respondent failed to call for the presence of another physician at the delivery of Patient G despite her condition, including, but not limited to, the presence of meconium stained fluid at 2:37 a.m.

(iii) Respondent used Elliot forceps to deliver Patient G which were not indicated by her condition.

(H) Patient H, a 36 year old multiparous female, was admitted to New Rochelle Hospital at 41 weeks gestation at 4:55 am on or about February 13, 1984, under the care of Respondent, as attending obstetrician. Respondent's treatment of Patient H failed to meet accepted standard of medical practice in that:

(i) Respondent failed to appear and examine Patient H until more than 4 hours after she was admitted despite her condition, including but not limited to maternal fever and rupture of membranes, bloody fluid with a distinct odor noted at 7:30 a.m. and continued fetal heart rate decelerations.

(ii) Respondent used oxytocin stimulation during a period of approximatley six hours in a manner which was contraindicated in the face of this patient's condition, including, but not limited to continued fetal heart rate decelerations, coupling of contractions, and chorioamnionitis.

(iii) Respondent used pitocin in a manner which was contraindicated in that he restarted pitocin at 12 gtts/min after the pitocin had been off for 50 minutes.

(iv) Respondent failed to deliver Patient H in a timely manner, until 3:37 p.m., despite her condition including, but not limited to, chorioamnionitis, approximatley 8 hours of continued fetal heart decelerations with slow return to baseline (including a 30 second deceleration to 50 beats per minute at 8:55 a.m.) maternal fever and, coupling of contractions.

(I) Patient I, a ~~27~~ 20 year old woman, was admitted to New Rochelle Hospital on November 5, 1981 at 38+ weeks gestation, under the care of Respondent, as attending obstetrician. Respondent failed to meet accepted standards of medical practice in that:

(i) Respondent failed to appear and examine Patient I during 10 hours and 8 minutes while she was in labor at New Rochelle Hospital including approximately two and a half hours after which Respondent was informed of Patient I's status at 5:22 am, (i.e., 5 centimeters dilation, moulding ++, 0 station, contractions 3-4 minutes x 45 seconds).

(ii) Respondent used trial forceps in Patient I despite her condition, including but not limited to moulding ++++ at 8 centimeters dilation and poor progress in labor.

(iii) Respondent failed to perform a cesarean section in a timely fashion despite Patient I's condition, including but not limited to increased blood pressures, moulding ++++ at 11:15 am and 1:55 pm, and draining of large amounts of meconium.

TENTH SPECIFICATION

5. Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) by practicing the profession with negligence on more than one occasion in that, among other things and instances:

(A) The State Board for Professional Medical Conduct repeats the allegations of the First through Ninth Specifications of this Statement of Charges.

(B) Respondent failed to obtain a consultation from a staff obstetrician as was required under the agreement between Respondent and the medical board of New Rochelle Hospital Medical Center dated June 28, 1982, for nine patients, specifically patients A - I.

ELEVENTH SPECIFICATION

6. Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) by practicing the profession with incompetence on more than one occasion in that, among other things and instances:

The State Board for Professional Medical Conduct repeats the allegations of the First through Tenth Specifications of this Statement of Charges.

TWELFTH SPECIFICATION

7. Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6509(9) (McKinney 1985) by committing unprofessional conduct as defined by the Board of Regents in its rules or by the Commissioner of the Department of Education in regulations approved by the Board of Regents in that, among other things and incidents:

(A) Respondent failed to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient, within the meaning of N.Y. Admin. Code tit. 8, §29.2(a)(3) (1981), specifically;

(i) Patient A

(ii) Patient B

(iii) Patient C

(iv) Patient D

(v) Patient E

(vi) Patient F

(vii) Patient G

(viii) Patient H

(ix) Patient I

THIRTEENTH SPECIFICATION

8. Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law 6509(2) (McKinney 1985) in that he has practiced the profession of medicine fraudulently as follows;

(A) On or about April 1, 1986, Respondent made a written application for re-appointment to the Calvary Hospital Medical Staff on which he falsely answered "no" to the question, "has your request for any specific clinical privileges at another hospital been denied or granted with stated limitations?" while being aware that his clinical privileges at New Rochelle Hospital Medical Center had previously been limited by the following;

1. Except in cases of a bona fide emergency where the delay associated with obtaining a written consultation would increase the risk to patient or fetus, he had to obtain written pre-operative consultation from an appropriate member of the Medical Center Staff on all surgery for which he had privileges.

2. He had to obtain consultation prior to using obstetrical forceps except in instances where the welfare of mother or fetus were clearly in imminent danger.

3. He had to obtain consultation in all cases of high risk pregnancies or prolonged labor including but not limited to cases involving diabetes, hypertension and preeclampsia.

(B) On or about April 1, 1986, Respondent made a written application for re-appointment to the Calvary Hospital Medical Staff on which he falsely answered "no" to the question, "have you been involved in any malpractice actions or have there been any judgments of settlements of any malpractice actions?" while being aware that he had been involved in a number of malpractice actions, some of which had been settled.

(C) On or about November 20, 1985, Respondent submitted a written response to New Rochelle Hospital Medical Center's request for Medical Staff Historical Information in which he represented that there were no pending malpractice actions against him while aware that there were pending malpractice actions against him.

(D) On or about January 2, 1986, Respondent submitted a written response to St. Agnes' Hospital request for information, required by the malpractice legislation passed in June, 1985, in which he represented that there was only one known pending malpractice action against him despite the fact that he knew that there were additional malpractice actions pending against him at the time.

FOURTEENTH SPECIFICATION

9. Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6509(9) (McKinney 1985), by committing unprofessional conduct as defined by the Board of Regents in its rules by the Commissioner of the Department of Education in regulations approved by the Board of Regents, by willfully making false reports within the meaning of N.Y. Admin. code tit. 8 §29.1(b)(6) (1981), specifically:

The State Board for Professional Medical Conduct repeats the allegations of the Thirteenth Specification of this Statement of Charges.

Dated: Albany, New York
Dec 2, 1987

Kathleen M. Tanner
KATHLEEN M. TANNER
Director
Office of Professional
Medical Conduct

(S/S)

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

IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
JOHN A. POGLINCO, M.D.	:	COMMITTEE

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

Stanley D. Leslie, M.D., Chairperson, Ann Shamberger, and Jerome L. Ditkoff, D.O., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Debra L. Smith served as the Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Date of Notice of Hearing and Statement of Charges (Dept. Ex. 1):	May 18, 1987
Amendments to Statement of Charges:	
Department's Amended Statement of Charges (Dept. Exs. 2 and 3) admitted in evidence	July 8, 1987 (T: 6-9)

Department's Second Amended Statement of Charges (Dept. Ex. 22) admitted in evidence	December 2, 1987 (T: 902-903)
Department's motions to amend Second Amended Statement of Charges made and granted	January 20, 1988 (T: 918-920) October 12, 1988 (T: 1936-1938)
Hearing dates:	1987: July 8, August 26, September 9, September 16, October 7, November 4, December 2 1988: January 20, March 9, May 18, June 22, August 24, September 7, October 12, October 26
Deliberations:	December 14 and 21, 1988
Adjournments:	
Respondent's request for adjournment of July 8, 1987 hearing date (additional time to prepare) made and denied	June 16, 1987
Department's request for adjournment of October 28, 1987 hearing date (witness unavailable) made and granted	October 7, 1987 (T: 625)
Adjournment of May 4, 1988 hearing date (Hearing Committee member unavailable)	January 20, 1988 (T: 1002-1004)
Respondent's request for adjournment of April 20, 1988 hearing date (witness unavailable) made and granted	March 9, 1988 (T: 1177)
Place of hearing:	Offices of New York State Department of Health 8 East 40th Street Third Floor New York, New York

Department of Health appeared by:	Dawn A. Dweir, Esq. 8 East 40th Street Third Floor New York, New York 10016
Respondent appeared by:	Kenneth Harfenist, Esq. 55 Old Turnpike Road - Suite 105 Nanuet, New York 10954
Witnesses for Department of Health:	William J. Ledger, M.D. Emil Maffucci, M.D.
Witnesses for Respondent:	Mortimer G. Rosen, M.D. Anthony Loiacono, M.D. John A. Poglinco, M.D. (Respondent)
Hearing Committee absences:	
Ann Shamberger	September 16, 1987
Jerome L. Ditkoff, D.O.	Very brief portions of October 7, 1987, December 2, 1987 and August 24, 1988

Ms. Shamberger and Dr. Ditkoff each hereby affirm tha she or he has read and considered any evidence introduced and t transcript for those portions of the hearing at which she or he was not present.

Stipulation between parties concerning medical malpractice actions:	January 20, 1988 (T: 912-913, 926-928)

SUMMARY OF CHARGES

In the Second Amended Statement of Charges (Dept. Ex. 22 - copy attached), the Respondent, John A. Poglinco, M.D., wa charged with professional misconduct pursuant to Education Law

§6509. The specific charges were: practicing the profession with gross incompetence and/or gross negligence (Education Law §6509(2)) (First through Ninth Specifications); practicing the profession with negligence on more than one occasion (Education Law §6509(2)) (Tenth Specification); practicing the profession with incompetence on more than one occasion (Education Law §6509(2)) (Eleventh Specification); failing to maintain accurate records (Education Law §6509(9), paragraph 29.2(a)(3) of Title 8 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR)) (Twelfth Specification); practicing the profession fraudulently (Education Law §6509(2)) (Thirteenth Specification); and willfully making false reports (Education Law §6509(9), 8 NYCRR 29.1(b)(6)) (Fourteenth Specification).

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. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. John A. Poglinco, M.D., the Respondent, was authorized to practice medicine in the State of New York on March 22, 1962 by the issuance of license number 087439 by the New York State Education Department. (Dept. Ex. 11)

2. The Respondent was registered with the New York State Education Department to practice medicine for the period

January 1, 1986 through December 31, 1988 from 150 Lockwood Avenue, New Rochelle, New York 10801. (Dept. Ex. 11)

Patient A

3. Patient A, an 18 year old girl at 20-24 weeks gestation, was admitted to New Rochelle Hospital Medical Center, New Rochelle, New York (New Rochelle Hospital) on November 12, 1985 at 8:15 p.m. She had abdominal complaints and was under the care of the Respondent, her attending obstetrician. (Dept. Ex. 5)

4. On admission Patient A's pulse was 120. Her respirations were 40. She gave a history of right lower quadrant pain associated with nausea and vomiting. (Dept. Ex. 5)

5. Upon admission, the Respondent examined the patient and ordered a CBC with platelet count. (T: 79, 1410; Dept. Ex. 5)

6. When she was admitted, Patient A showed marked anemia with a hematocrit of 27.6, a hemoglobin of 9.7, and a platelet count of 139,000. (T:31; Dept. Ex. 5, Resp. Ex. A)

7. Vaginal bleeding was first noticed at 10:00 p.m. on November 12, 1985. (Ex. 5, p. 125)

8. These symptoms suggested a diagnosis of early placental separation. (T: 1412, 1424-1431; Dept. Ex. 5)

9. After examining the patient at 10:22 p.m. on November 12, 1985, the Respondent made a diagnosis of probable abruptio placenta. Although the patient's sheet, under the sheet and blanket were saturated with bright red blood, the Respondent only ordered that the patient be observed for further bleeding.

He did nothing to treat the patient's abruption. (T: 47-48; Dept. Ex. 5, pp. 6 and 125)

10. The Respondent did not attempt to rupture Patient A's membranes because the tightly closed cervix prohibited any instrumentation and any attempt to rupture the membranes through this closed cervix would be misguided and likely result in injury to the patient. (T: 1413)

11. Once the diagnosis of placental abruption was made, the most important thing for the health and welfare of the mother was to terminate the pregnancy. (T: 29-31, 38, 962)

12. The difficulty with bleeding due to an abruption is that the bleeding causes coagulation products in the blood to be consumed to the point that products are eliminated and the patient's blood cannot clot at any other sights. (T: 28)

13. Patient A's chances to survive the complications associated with her condition would have been improved in direct relation to the earlier the timing of the emptying of her uterus. (T: 29-31, 965)

14. At 10:15 p.m. on November 12, 1985, the Respondent ordered a CBC, hemoglobin, hematocrit, fibrinogen and two units of blood. These orders were not stat. (T: 56-57, 85, 1410, 1413; Dept. Ex. 5)

15. At that time the Respondent did not order TT, PT, PTT and screening for fibrin slit products and should have. (T: 56-57, 1482; Dept. Ex. 5)

16. At that time the Respondent did not order that Patient A's urine be monitored and should have. (T: 56-57; Dept. Ex. 5)

17. At around midnight the diagnosis of consumption coagulopathy should have been clear to the Respondent. (T: 103, 995, 999; Dept. Ex. 5)

18. At 12:20 a.m. on November 13, 1985 the following laboratory results were reported to the Respondent: hematocrit of 22.1, hemoglobin of 7.8 and platelets of 118,000. (T: 100-101; Dept. Ex. 5)

19. At 1:10 a.m. a fibrinogen of 86 was reported to the Respondent. (T: 103; Dept. Ex. 5, p. 63A)

20. A prudent physician learning of these blood results would have been extremely afraid that the patient had disseminated intravascular coagulation (DIC). (T: 103)

21. The Respondent admitted that as of this time Patient A was a good candidate for DIC. He, however, did nothing other than ordering an infusion of blood at 1:10 a.m. (T: 1482; Dept. Ex. 5)

22. This infusion of blood would have no effect on ending the process of DIC. (T: 103, 998)

23. At 1:10 a.m., when the Respondent obtained the fibrinogen report, at the latest, he should have consulted with a hematologist about Patient A's blood loss, the clotting problems and the amount of blood replacement needed. The Respondent did not consult with a hematologist until shortly before the patient's hysterotomy (Finding of Fact 27). (T: 57; Dept. Ex. 5)

24. At 5:10 a.m. the Respondent ordered repeat hemoglobin, hematocrit and fibrinogen tests. (T: 111; Dept. Ex. 5, p. 128)

25. Throughout this time the Respondent failed to monitor the patient's pulmonary wedge pressures and central ven pressures, and should have. The hospital had the capability f this monitoring. (T: 442-443; Dept. Ex. 5)

26. At 5:30 a.m. on November 13, 1985 the Responden discussed the use of vaginal prostaglandins with Dr. Hoffman, obstetrician, and determined that prostaglandins would be the preferred method of stimulation of labor for this patient. (T: 1415)

27. At 11:30 a.m. on November 13, 1985, 13 1/2 hour after the initial uterine bleeding , the Respondent had Patien taken to the operating room for a hysterotomy. (Dept. Ex. 5)

28. As a result of this delay in performing the hysterotomy, clotting deficiencies took place. As a result an due to bleeding from the incision, Patient A required a second laparotomy, which was performed on November 13, 1985 at 8:45 p. (Dept. Ex. 5)

29. Patient A died on December 10, 1985 as a result complications of the placental abruption and disseminated intravascular coagulation (DIC). (Dept. Ex. 5)

30. The poor care by the Respondent contributed to Patient A's inability to survive the complications associated wi placental abruption. Patient A's death was probably preventabl (T: 61, 982)

Patient B

31. Patient B, a 34 year old woman at 20 weeks gestation, was admitted to New Rochelle Hospital on December 16, 1983 under the care of the Respondent, her attending obstetrician. At that time her temperature was 101.2°. At 11:05 p.m., shortly after the patient's admission to the hospital, the Respondent ruptured her membranes. (Dept. Ex. 6)

32. On December 17, 1983 at 12:50 a.m. the Respondent performed an episiotomy on Patient B. (Dept. Ex. 6, p. 4)

33. At 1:50 a.m., about 4 hours after Patient B's admission to the hospital, the Respondent spontaneously delivered Patient B of an 11 ounce stillborn. (Dept. Ex. 6)

34. The Respondent's performance of an episiotomy one hour before the spontaneous delivery of an 11 ounce stillborn constituted a departure from accepted standards of medical practice. (T: 184-188)

35. Patient B's hospital chart contains a positive serology from a serum specimen taken on December 18, 1983. (Dept. Ex. 6, p. 33-34)

36. The Respondent dictated his discharge summary on March 22, 1984, more than 3 months after Patient B was discharged from the hospital. At least at the time of that dictation, the Respondent was aware of this positive VDRL (Finding of Fact 35). (Dept. Ex. 6, p. 19)

37. There is no documentation in Patient B's hospital record, including the discharge summary, or in the Respondent's office record for Patient B that the Respondent attempted to notify Patient B about this positive VDRL. (T: 1558; Dept. Ex. 6, Resp. Ex. G)

38. Patient B did not have a telephone. Her mother's telephone number was not included in the Respondent's office records for Patient B. (Resp. Ex. G)

39. Knowing this positive VDRL, a physician has the responsibility to follow up by contacting the patient. If such follow up were made, that physician would document that follow up and a plan of action in the patient's medical record, including the discharge summary. (T: 189-190, 1039)

40. Patient B did not have surgery, did not require the use of obstetrical forceps, and did not have a high risk pregnancy or prolonged labor. (T: 1956-1957; Dept. Ex. 6)

Patient C

41. Patient C, a 28 year old Gravida 2 Para 0 who had one previous abortion and who was at 30 weeks gestation, saw the Respondent at his office on March 24, 1982 at 3:00 p.m. Patient C complained of pressure and cramping. The Respondent performed a vaginal examination. (T: 1923; Resp. Ex. C)

42. These complaints of pressure and cramping are symptoms that would cause a prudent physician to consider the possibility of premature labor in a 30 week gestation. Pressure

and cramping may be the only symptoms of premature onset of labor. (T: 719-720)

43. The Respondent admitted that these symptoms were consistent with premature onset of labor. (T: 1931)

44. The Respondent should have obtained a pelvic sonogram and a hematocrit. (T: 756)

45. The Respondent then should have evaluated Patient C for uterine activity for a period of time with the use of a monitor and evaluation of the cervix. (T: 708, 722, 725)

46. The Respondent failed to take appropriate steps to diagnose and treat Patient C's premature onset of labor when she presented at his office on March 24, 1982. The Respondent admitted that he made no effort to monitor Patient C for uterine activity. (T: 710-711, 723, 1933; Resp. Ex. C)

47. Instead the Respondent just sent Patient C home. (T: 1933; Resp. Ex. C)

48. About five hours later, at 7:45 p.m. on March 24, 1982, in active labor, Patient C admitted herself to New Rochelle Hospital. (Resp. Ex. C)

49. At that time Patient C was fully dilated and the presenting part was palpable. (Resp. Ex. C)

50. At that time Patient C's vital signs were stable. (Resp. Ex. C)

51. At 8:00 p.m. the Respondent performed a vaginal examination and noted "vertex at pelvic floor". (Resp. Ex. C)

52. "Vertex at pelvic floor" was an incorrect diagnosis. The correct diagnosis was a double footling breech. (T: 753; Resp. Ex. C)

53. The Respondent did not depart from accepted standards of medical practice by diagnosing the fetal presentation as vertex since it is difficult to ascertain the fetal presentation in a patient who is fully dilated, has a bulging bag of water, and has a three pound baby at 30 weeks gestation. (T: 1345, 1928-1929; Resp. Ex. C)

54. At 8:15 p.m. on March 24, 1982 the Respondent started pitocin. (T: 731-732, 1924; Resp. Ex. C)

55. There was no need for pitocin. Patient C was making good progress. There was no evidence of stress or of a cord prolapse. The use of pitocin was contraindicated, regardless of the presenting part. (T: 741-746, 1350; Resp. Ex. C)

56. At the amniotomy at 8:28 p.m. on March 24, 1982, the Respondent made the diagnosis of a double footling breech. (T: 1930; Resp. Ex. C)

57. At 8:29 p.m. Patient C was delivered vaginally with a double footling breech. (Resp. Ex. C)

58. The Respondent did not depart from accepted standards of medical practice by not performing a cesarean section since there would not have been enough time to perform a cesarean section in the one minute from the time of the amniotomy to the time of delivery. Also it is not always appropriate to deliver a double footling breech presentation by cesarean section. (T: 742, 1347-1348; Resp. Ex. C)

Patient D

59. Patient D, a 21 year old primigravida at 38 weeks gestation, was admitted to New Rochelle Hospital on December 12, 1983 at 8:40 a.m. under the care of the Respondent, her attending obstetrician. At that time she was in early active labor, had a blood pressure of 148/108 and had a trace of albumin in her urine. (T: 244-246, 1731; Dept. Ex. 7A, p. 21)

60. At 8:40 a.m. on December 12, 1983 the Respondent was notified of Patient D's admission to the hospital and of her condition. (Dept. Ex. 7A)

61. At 9:00 a.m. messages were left for the Respondent to call the labor room. Reports about Patient D's condition were given to the Respondent at 9:36 a.m. and 10:45 a.m. (Dept. Ex. 7A, pp. 21-22)

62. At 11:39 a.m. the Respondent saw and examined Patient D. (T: 249, 1732; Dept. Ex. 7A, p. 22)

63. During this period of time, Patient D's blood pressure continued to be elevated. The additional readings were 150/108 at 9:16 a.m., 130/100 at 9:30 a.m., 130/102 at 10:19 a.m., 130/100 at 11:00 a.m. and 140/110 at 11:20 a.m. The lowest diastolic reading, which was 100, was 30 higher than Patient D's prenatal diastolic of 70. (Dept. Ex. 7A, pp. 21-22)

64. The Respondent should have seen and examined Patient D immediately after he was notified of her condition. He needed to observe her in order to make the necessary clinical

bedside decisions about her care without delay. (T: 271-272, 1070, 1089; Dept. Ex. 7A)

65. Patient D had all the earmarks of pregnancy related hypertension or preeclampsia. This was her first baby, she was in early labor showing a significantly elevated blood pressure and she had albumin in her urine. (T: 225, 232, 266, 274; Dept. Ex. 7)

66. Throughout Patient D's medical record, the Respondent made a diagnosis of preeclampsia. (Dept. Ex. 7A)

67. Patient D's hypertension made her a high risk pregnancy. (T: 1085)

68. With Patient D's elevated blood pressure, there was a possibility of her convulsing from the first moment she was in the labor room. (T: 232; Dept. Ex. 7A)

69. When the Respondent saw and examined Patient D at 11:39 a.m., he ordered magnesium sulfate, found the patient's cervix to be six to seven centimeters dilated, and performed an amniotomy noting that the patient had meconium fluid. (T: 249, 1732; Dept. Ex. 7A, p. 22)

70. Thereafter the fetal heart rate was normal with occasional coupling of contractions and Patient D's blood pressure stabilized within normal limits. (Dept. Ex. 7)

71. The Respondent failed to monitor Patient D appropriately by being in constant attendance with her. The Respondent admitted that he was not present at 1:20 p.m. and 1:35 p.m. when coupling of contractions was noted. (T: 239-240, 1752; Dept. Ex. 7)

72. On December 12, 1983 at 6:53 p.m., when the second stage of labor was almost completed, the Respondent started pitocin. The last vaginal exam before this pitocin administration was at 6:30 p.m. and noted full dilatation at +2 station. (Dept. Ex. 7A, p. 24)

73. This use of pitocin was not clearly indicated because Patient D was fully dilated, she was in good active labor on her own, the fetus was in a posterior position, and there was no evidence of fetal distress at that time. (T: 238; Dept. Ex. 7)

74. However, this use of pitocin was not contraindicated. (T: 1048, 1739-1741)

75. At 8:33 p.m. on December 12, 1983, within 12 hours from the admission to the hospital, Patient D's baby was delivered. (Dept. Ex. 7A, pp. 1, 25)

76. The Respondent did not consult with an obstetrician about Patient D. (Dept. Ex. 7)

Patient E

77. Patient E, a 15 year old primigravida at term, was admitted to New Rochelle Hospital on November 23, 1981 under the care of the Respondent, her attending obstetrician. (Dept. Ex. 10A)

78. At the time of this admission, Patient E weighed approximately 250 pounds. She had gained approximately 75 pounds during her pregnancy and had gained 10 pounds in the week before this admission. (T: 631-632, 1849-1850; Dept. Ex. 10A)

79. At the time of this admission, the patient had marked edema in her lower extremities and her blood pressure was 130/80. (T: 1850; Dept. Ex. 10A, pp. 6, 36)

80. On admission the Respondent described Patient E as a "full term with an IUP" and documented his working diagnosis of eclampsia. (Dept. Ex. 10A)

81. On November 26, 1981, after 3 days of bed rest at New Rochelle Hospital, Patient E still had edema in both feet, still had all elevated blood pressures (150/96, 124/100, 140/90, 150/100, 130/96) and had a trace of albumin in 4 out of 5 urine samples tested. Patient E's initial prenatal blood pressure was 120/70. (Dept. Ex. 10A, p. 32; Dept. Ex. 10C, p. 7)

82. On November 27, 1981 at 9:35 a.m. the Respondent examined the patient, found the patient's cervix to be one fingertip dilated, performed an oxytocin challenge test and continued with induction to attempt to ripen the cervix. (T: 643, 1851; Dept. Ex. 10A, p. 18)

83. At 12:55 p.m. the Respondent turned off the pitocin because the patient had no response to the pitocin. (T: 644, 1851-1852; Dept. Ex. 10A, p. 20)

84. On November 28, 1981 at 10:10 a.m. the Respondent examined the patient and restarted pitocin. (T: 646; Dept. Ex. 10A, p. 22)

85. Although the patient had some contractions, there was no change in the patient's cervix. Therefore, at 12:20 p.m. the pitocin was turned off. (T: 648, 1852; Dept. Ex. 10A, p. 23)

86. On December 1, 1981 at 6:30 a.m. the patient's blood pressure was normal, 120/80. (T: 651; Dept. Ex. 10A, p. 40)

87. On December 1, 1981 the Respondent discharged Patient E, undelivered. (Dept. Ex. 10A)

88. A prudent physician would not have discharged this patient undelivered. There is always a concern that whatever control was achieved, which usually is based on just bedrest, could be lost and the patient may return in poorer shape than when she was under control in the hospital. (T: 413; Dept. Ex. 10A)

89. During this first admission the Respondent should have delivered Patient E with a cesarean section. (T: 412, 675-676, 687; Dept. Ex. 10A)

90. The Respondent concluded that there was no urgency to deliver Patient E during this first admission. (T: 1858)

91. Five days later, on December 5, 1981 at 12:10 a.m., Patient E was admitted to New Rochelle Hospital for the second time. (Dept. Ex. 10B)

92. The Respondent failed to come in and see this patient until more than 15 hours later at 3:30 p.m. (Dept. Ex. 10B)

93. During this admission, a non-stress test was performed and the indication for the test was noted to be "post dates". (Dept. Ex. 10B)

94. Not one vaginal exam was noted during this admission. (T: 416; Dept. Ex. 10B)

95. Patient E was discharged on the same day, December 5, 1981, undelivered. (Dept. Ex. 10B)

96. On December 11, 1981 at 5:45 a.m. Patient E was admitted to New Rochelle Hospital for the third time. At that time her blood pressure was 150/100. She was in labor. A dip stick urine indicated albumin urea plus 1. (T: 413-414; Dept. Ex. 10C)

97. The Respondent was informed but did not come in to see Patient E until 5 hours later at 10:45 a.m. (Dept. Ex. 10C)

98. Between Patient E's admission and the Respondent's arrival, Patient E was acutely hypertensive with additional blood pressure readings of 148/88 (7:30 a.m.), 160/100 (8:10 a.m.), 148/110 (9:00 a.m.) and 150/110 (9:45 a.m.). At 7:30 a.m. Patient E's knee jerk reflexes were brisk. (Dept. Ex. 10C)

99. Patient E was a patient who could have had seizures and she was a candidate for a cerebral vascular accident. (T: 701)

100. The Respondent's failure to come in and see Patient E until 5 hours after her admission constituted a departure from accepted standards of medical practice. The Respondent should have come in and seen the patient immediately after he was informed of her vital signs. He then should have treated the patient with magnesium sulfate, especially with the significant elevations in blood pressure from the readings noted in the patient's second admission. (T: 701-702, 1311, 1313; Dept. Exs. 10B and 10C)

101. After seeing Patient E at 10:45 a.m., the Respondent left. He was not with the patient at 11:20 a.m. and 11:59 a.m. and he had to be called by the nurses to come in because Patient E's blood pressure was 180/120. (T: 419-420; Dept. Ex. 10C)

102. At 12:10 p.m. the Respondent examined the patient and at 12:12 p.m. the Respondent ordered magnesium sulfate. (T: 659; Dept. Ex. 10C, p. 33)

103. The Respondent provided an explanation about his contact with Patient E during this period of time. (T: 1860-1861)

104. The Respondent did not arrange for the presence of an anesthesiologist during Patient E's labor although the hospital had 24 hour anesthesia coverage. (T: 441, 601, 1862; Dept. Ex. 10C)

105. Patient E was delivered on December 11, 1981. She was delivered by caesarean section due to her lack of progress and preeclampsia. (Dept. Ex. 10C).

106. Baby E was diagnosed at birth with post maturity syndrome. (Dept. Ex. 10D)

Patient F

107. Patient F, a 26 year old primigravida, was admitted to New Rochelle Hospital at 41 weeks gestation at 1:20 a.m. on March 26, 1982 under the care of the Respondent, her attending obstetrician. At that time Patient F had been leaking fluid for 72 hours. (Dept. Ex. 8)

108. At 2:30 a.m. the Respondent was made aware of the patient's admission to New Rochelle Hospital. (T: 320; Dept. Ex. 8A, p. 23)

109. At 1:00 p.m. the Respondent examined the patient. (T: 325; Dept. Ex. 8A, p. 25)

110. The x-ray pelvimetry of March 26, 1982 showed an occiput posterior presentation. (Dept. Ex. 8)

111. The Respondent took no action to stimulate labor until 9:30 a.m. on March 27, 1982, 32 hours after Patient F's admission. At that time the Respondent started pitocin. pitocin should have been started right away. (Dept. Ex. 8A, pp. 1, 26)

112. Mortimer G. Rosen, M.D., an expert witness on behalf of the Respondent, testified that he did not take issue with this delay. However, in an article he coauthored in 1977, Dr. Rosen wrote that delivery in term pregnancies preferably should be accomplished within 12 hours of the rupture of the membranes. (T: 1126; Dept. Ex. 31)

113. No assessment of the cervix was done before the pitocin was started. The last vaginal examination performed had been 27 hours earlier on March 26, 1982 at 6:00 a.m. At the time of that last vaginal examination, Patient F was 2 centimeters dilated with a long and thick cervix. (T: 1584-1585; Dept. Ex. 8A, pp. 23, 26)

114. The Respondent testified that in his opinion it was important to this patient's well-being that no vaginal examinations be performed. However, the first order in a list of orders bearing his signature was "nurse may examine patient per vagina". (T: 1630; Dept. Ex. 8A)

115. The Respondent should have performed a vaginal examination before starting pitocin. Without performing a vaginal exam there was no way for the Respondent to know if the clinical picture of the cervix had changed and, therefore, whether it would be favorable for induction. The Respondent's failure to perform a vaginal examination before starting the pitocin constituted a

departure from accepted standards of medical practice. (T: 306, 1140, 1142; Dept. Ex. 8)

116. The Respondent administered pitocin as follows:

March 27, 1982 --	9:30 a.m. to 10:50 a.m.	(4 gtts/min)
	10:45 a.m. to 11:48 a.m.	(Pitocin off)
	11:48 a.m. to 12:40 p.m.	(8 gtts/min)
	12:40 p.m. to 1:30 p.m.	(Pitocin off)
	1:30 p.m. to 6:30 p.m.	(8-12 gtts/min)
	6:30 a.m. to 8:33 a.m.	(Pitocin off)
March 28, 1982 --	8:33 a.m. to 12:15 p.m.	(8-16 gtts/min)
	12:15 p.m. to 5:55 p.m.	(Pitocin off)
	5:55 p.m. to 11:25 p.m.	(8-20 gtts/min)

(Dept. Ex. 8)

117. The Respondent used Kielland forceps to try to deliver Patient F. In his discharge summary, the Respondent stated that despite going to full dilatation,

> "[t]he patient could not be delivered as an occiput anterior and it was necessary to turn the vertex manually to occiput transverse. Because of extreme difficulty in achieving adequate anesthesia, a transverse delivery with Kielland forceps was impossible since patient was moving continuously and the 2nd blade of the Kielland could not be applied." (Dept. Ex. 8A, p. 2)

118. Kielland forceps are designed to rotate the head of the fetus and are not designed for delivery. (T: 313)

119. The use of Kielland forceps without adequate anesthesia is very dangerous to the mother and baby. The Respondent's use of Kielland forceps departed from accepted standards of medical practice. (T: 314, 359, 1125, 1146; Dept. Ex. 8)

120. Patient F delivered Baby F on March 28, 1982 at 11:25 p.m., almost three days after her admission to the hospital. The Respondent applied Elliot forceps at delivery. (Dept. Ex. 8)

121. Two days after Baby F was admitted to the nursery, it was noted that the baby boy had a cephalohematoma. The diagnosis of a depressed skull fracture was then made. As a result, Baby F was transferred to Albert Einstein College of Medicine on March 31, 1982. (Dept. Ex. 8)

122. The competent producing cause of these injuries was the Respondent's substandard use of forceps. The Respondent's use of forceps during delivery was the most likely cause of Baby F's injuries. (T: 314, 367, 1132; Dept. Ex. 8)

Patient G

123. Patient G, a 24 year old multiparous woman, was admitted to New Rochelle Hospital on June 4, 1981 at 6:50 p.m. under the care of the Respondent, her attending obstetrician. (Dept. Ex. 9A)

124. On June 5, 1981 at 2:20 a.m. the Respondent saw Patient G. (Dept. Ex. 9A, p. 17)

125. At 2:37 a.m. the Respondent ruptured the patient's membranes and meconium stained fluid was noted. (Dept. Ex. 9A, p. 18)

126. At 2:42 a.m. the Respondent started oxytocin stimulation. (Dept. Ex. 9A, p. 18)

127. The Respondent did not depart from accepted standards of medical practice in this administration of oxytocin. (T: 1328-1329)

128. At 2:53 a.m. the Respondent delivered Patient G. (Dept. Ex. 9A, p. 18)

129. The Respondent did not call for the presence of another physician at the delivery. There was neither the time nor a reason for the Respondent to call for another physician. (T: 1329; Dept. Ex. 9)

130. The Respondent used Elliot forceps to deliver the patient. This use of these forceps was acceptable. (T: 1330, 1340; Dept. Ex. 9A, p. 18)

Patient H

131. Patient H, a 35 year old woman, was admitted to New Rochelle Hospital on February 13, 1984 at 4:55 a.m. under the care of the Respondent, her attending obstetrician. Although Patient H was multiparous, she had had her last baby many years before (in 1967). She had a history of chronic anemia and she was very overweight (260 pounds). (Dept. Ex. 16)

132. At the time of her admission to the hospital, Patient H had a fever and ruptured membranes. At 7:30 a.m. on February 13, 1984 a bloody vaginal fluid with a distinct odor was noted. (Dept. Ex. 16)

133. At 5:00 a.m. and at 8:00 a.m. on February 13, 1984 the Respondent was notified, by telephone, of the patient's condition. (Dept. Ex. 16)

134. The Respondent admitted that a temperature elevation is always of concern to him. (T: 1689)

135. With Patient H's noted foul smelling vaginal fluid, a prudent physician would have speculated, with reasonable probability, that an infection was present and would have ordered a culture. (T: 1190, 1195; Dept. Ex. 16)

136. The Respondent admitted that it would have been appropriate to culture this foul smelling fluid but no cultures were ordered. (T: 1691, Dept. Ex. 16)

137. With the combination of Patient H's odorous vaginal fluid and elevated temperature, a prudent physician would have been concerned about the possibility of chorioamnionitis. Chorioamnionitis refers to inflammation of the membranes around the fetus. From a clinical point of view, it is an infection of the intrauterine cavity in which there is significant colonization of bacteria in the amniotic fluid and inflammation of the membranes secondary to that. (T: 765, 848; Dept. Ex. 16)

138. During the time when the Respondent did not come to the hospital, the nurses, greatly concerned about the patient's need for medical evaluation, asked Dr. Burns, an obstetrician, to review Patient H's graph. At 8:00 a.m. Dr. Burns examined the patient. He then stayed with the patient until the Respondent arrived. (T: 1212, 1674; Dept. Ex. 16)

139. The Respondent came to see the patient on February 13, 1984 at 9:00 a.m., four hours after her admission to the hospital. At that time the Respondent examined Patient H and applied a second spiral electrode. (T: 812-813; Dept. Ex. 16)

140. The Respondent waited too long to see Patient H. Within one hour after he was notified of the condition of this high risk patient, the Respondent should have gone to the hospital to evaluate her fever, obtain a history and conduct a physical examination. (T: 763-764, 1689; Dept. Ex. 16)

141. At 9:52 a.m. on February 13, 1984 the Respondent began the administration of pitocin, stopped it at 1:10 p.m. and restarted it at 2:00 p.m. at 12 gtts./min. At 3:37 p.m. Patient H was delivered. (Dept. Ex. 16)

142. This use of pitocin was appropriate and was not contraindicated. The patient was tolerating labor. With a few exceptions, the fetal heart decelerations returned to normal. There was some coupling of contractions but the coupling was insufficient to be of a permanent nature. Pitocin can be administered to a patient with chorioamnionitis if, as here, the fetal heart rate was acceptable and was being monitored. (T: 1179; Dept. Ex. 16)

143. The Respondent's restarting pitocin at 12 gtts./min. at 2:00 p.m. (Finding of Fact 141) was not contraindicated. When pitocin is off for such a short period of time, it is acceptable medical practice to restart pitocin at the same level as it was stopped. (T: 1180-1181; Dept. Ex. 16)

144. The Respondent did not obtain a consultation in this high risk pregnancy case. The Respondent admitted that he did not ask Dr. Burns or any other physician to see this patient, and that he had no way of knowing that Dr. Burns was in the hospital. (T: 1644, 1696, 1705; Dept. Ex. 16)

Patient I

145. Patient I, a 20 year old primigravida at 38+ weeks gestation, was admitted to New Rochelle Hospital at 4:00 p.m. on November 5, 1981 under the care of the Respondent, her attending obstetrician. (Dept. Ex. 14)

146. She was a high risk patient. (T: 606; Dept. Ex. 14)

147. On November 5, 1981 at 5:25 p.m., the Respondent performed a vaginal examination and noted Patient I to be 4 centimeters dilated at 0 station with good effacement. No examination for fetal presentation was noted. (Dept. Ex. 14, p. 42)

148. At that time the Respondent ruptured Patient I's membranes. (Dept. Ex. 14, p. 42)

149. At 9:37 p.m. the Respondent saw the patient again and performed a second vaginal examination. He found Patient I had progressed to 6 centimeters dilatation. Again there was no notation of fetal presentation. (Dept. Ex. 14, p. 43)

150. Following this examination, the Respondent left the hospital. (Dept. Ex. 14)

151. The Respondent should not have left the hospital after finding this patient to be 6 centimeters dilated at 9:37 p.m. (T: 1239; Dept. Ex. 14)

152. By 11:30 p.m. that night Patient I had made no real progress. The vaginal examination of this patient at 11:30 p.m.

demonstrated an arrest of the active phase cervical dilatation. (T: 860-861, 865, 879, 883-884, 1240; Dept. Ex. 14)

153. At 11:30 p.m. the Respondent was informed of the patient's condition by telephone. At that time he should have come in to evaluate the patient but failed to do so. (T: 860-861, 865, 879, 883-884, 1240; Dept. Ex. 14)

154. A prudent physician, who after evaluation determined that there was not absolute disproportion, would have tried to improve the quality and frequency of Patient I's contractions with IV pitocin and would have monitored the status of the baby very closely. If there had not been a response and significant progress after 2 to 4 hours, a prudent physician would have performed a cesarean section. The Respondent failed to so perform a cesarean section in a timely manner. (T: 884; Dept. Ex. 14)

155. The vaginal examination of Patient I on November 6, 1981 at 5:22 a.m. also demonstrated an arrest of the active phase cervical dilatation which required the Respondent's evaluation. (T: 879, 1240; Dept. Ex. 14)

156. The Respondent was called again on November 6, 1981 at 5:22 a.m. and at 6:48 a.m. The Respondent did not come in to the hospital. He was called again at 7:30 a.m. (Dept. Ex. 14)

157. The Respondent returned to the hospital on November 6, 1981 at 7:45 a.m., more than 10 hours after he had left. (Dept. Ex. 14)

158. At 11:15 a.m. there was ++++ moulding. At 11:40 a.m. Patient I was draining a large amount of meconium. During this hospitalization Patient I had increased blood pressures. (Dept. Ex. 14)

159. At 1:55 p.m. on November 6, 1981 Patient I was 8 centimeters dilated with ++++ moulding. (Dept. Ex. 14)

160. In the opinion of Emil Maffucci, M.D., Director of Obstetrics and Gynecology at New Rochelle Hospital, the baby was too high and too tight for a forceps delivery. He felt a cesarean section was indicated. (T: 437-438, 608; Dept. Ex. 14)

161. Despite Dr. Maffucci's advice, at 2:20 p.m. the Respondent attempted to use trial forceps. (Dept. Ex. 14)

162. There was no chance that Patient I could be delivered under local anesthesia with forceps, with her background of persistent occipital posterior, a lot of moulding, and poor progress in more than 24 hours of labor. (T: 891; Dept. Ex. 14)

163. The use of these trial forceps was contraindicated (T: 867, 888, 1247, 1264, 1268-1269; Dept. Ex. 14)

164. At 2:32 p.m. on November 6, 1981 Patient I was transferred to the operating room. A cesarean section was then performed. (Dept. Ex. 14)

Additional Findings

165. The Respondent and New Rochelle Hospital entered into an agreement dated June 28, 1982. This agreement required the Respondent to obtain a consultation under any of the following circumstances: (1) pre-operatively and in writing for all surgery

(except in a defined emergency situation), (2) before the use of obstetrical forceps (except in a defined imminent danger situation), and (3) in a high risk pregnancy or in a case with prolonged labor (with specified examples). (T: 1952; Dept. Ex. 12A)

166. The medical records maintained by the Respondent for each of these patients, Patients A through I, were not accurate, were not timely and were incomplete. (Dept. Exs. 5, 6, 7, 8, 9, 10, 14, 16; Resp. Exs. C, G)

167. There was no admitting physical examination by the Respondent in Patient D's chart. (T: 1754-1758; Dept. Ex. 7A)

168. The Respondent failed to dictate a discharge summary for Patient E's admission. Mortimer G. Rosen, M.D. testified that the Respondent could have made more notes in Patient E's chart. (T: 416, 1296; Dept. Ex. 10)

169. The Respondent's discharge summary for Patient G did not accurately reflect the care and treatment rendered. It also did not include the reason for his use of forceps. (Dept. Ex. 9A, p. 2)

170. In his discharge summary for Patient H, the Respondent stated that the patient became exhausted and pitocin was stopped. This statement was not accurate as shown by the patient's labor and delivery record. (Dept. Ex. 16)

171. The Respondent admitted that he did not prepare complete medical records. (T: 2014)

172. On April 1, 1986 the Respondent made a written application for reappointment to the medical staff of Calvary

Hospital, Bronx, New York. One of the questions on that application form was the following: "Has your request for any specific clinical privileges at another hospital been denied or granted with stated limitations?" The Respondent answered "No" to that question. (Dept. Ex. 29)

173. At the time that he completed this application for Calvary Hospital, the Respondent knew that his clinical privileges at New Rochelle Hospital Medical Center had been limited in accordance with the agreement between the Respondent and New Rochelle Hospital dated June 28, 1982 (Finding of Fact 165). (Dept. Ex. 12A)

174. Another one of the questions on the Respondent's April 1, 1986 application to the Calvary Hospital medical staff was the following: "Have you been involved in any malpractice actions or have there been any judgments or settlements of any malpractice actions?" The Respondent answered "No" to that question. (Dept. Ex. 29)

175. At the time that he completed this application for Calvary Hospital, the Respondent knew about at least five malpractice actions involving him. For three of these malpractice actions, the Respondent had signed "Consent to Settle" forms, one of which was dated July 1, 1985. (Dept. Exs. 23, 25, 26, 27, 28)

176. On November 20, 1985 the Respondent completed a written Medical Staff Historical Information form for New Rochelle Hospital Medical Center. That form requested information about pending malpractice actions against him. The Respondent's answer

was the following: "never went to court[,] always dropped or settled". (Dept. Ex. 12D)

177. There was no evidence presented that the Respondent knew that there were any malpractice actions pending against him as of November 20, 1985. (Record as whole)

178. On January 2, 1986 the Respondent completed a written form for St. Agnes Hospital, White Plains, New York. This form requested information required by the June 1985 malpractice legislation before a physician's hospital privileges were renewed. That form requested information about pending malpractice actions against him. The Respondent provided information about one case. (Dept. Ex. 30)

179. At the time that he completed this form for St. Agnes Hospital, the Respondent knew that there were additional malpractice actions pending against him. (T: 1987-1989)

CONCLUSIONS

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

I. Practicing with negligence or incompetence, gross or on more than one occasion (First through Eleventh Specifications)

Negligence was defined as a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Gross negligence was defined as negligence with a disregard of the consequences and an indifference to the rights of others. Incompetence was defined as a lack of the skill

or knowledge necessary to practice medicine. Gross incompetence was defined as unmitigated incompetence.

Patient A (First, Tenth and Eleventh Specifications)

Patient A was admitted to New Rochelle Hospital at 8:15 p.m. on November 12, 1985 (Finding of Fact 3). After examining the patient at 10:22 p.m., the Respondent made a proper diagnosis of abruptio placenta (Findings of Fact 3-9). Once that diagnosis was made, the pregnancy should have been terminated (Findings of Fact 11-13). However, the Respondent did not terminate the pregnancy until November 13, 1985 at 11:30 a.m. (Finding of Fact 27). A second laparotomy was then required and Patient A ultimately died (Findings of Fact 28-30). The Respondent, therefore, failed to properly and timely promote delivery by a cesarean section. That failure constitutes negligence. The Respondent properly did not stimulate labor (Finding of Fact 10). The factual allegations set forth in paragraph 4(A)(i) of the Second Amended Statement of Charges (the charges), therefore, should be sustained in part and not sustained in part, as set forth above.

When the Respondent decided not to terminate the pregnancy in the late evening of November 12, 1985, he needed to monitor the patient's hematological status. The Respondent failed to obtain lab data frequently enough and in a timely manner (Findings of Fact 9, 14-15, 24) (paragraph 4(A)(ii)(a) of the charges). The Respondent did not evaluate urinary output (Findings of Fact 9, 16) (paragraph 4(A)(ii)(b) of the charges).

The Respondent did not monitor pulmonary wedge pressures and central venous pressures (Finding of Fact 25) (paragraph 4(A)(ii)(c) of the charges). The Respondent did not consult with a hematologist in a timely manner (Finding of Fact 23) (paragraph 4(A)(ii)(d) of the charges). This failure by the Respondent to adequately monitor Patient A's hematological status constitutes negligence.

With the information, including reported laboratory results, available in the early hours of November 13, 1985, the diagnosis of disseminated intravascular coagulation (DIC) should have been and was clear to the Respondent (Findings of Fact 17-22). However, the Respondent still did not terminate the pregnancy until 11:30 a.m. on that day (Finding of Fact 27). A second laparotomy was then required and Patient A ultimately died (Findings of Fact 28-30). This further failure by the Respondent to promptly terminate the pregnancy as soon as the DIC diagnosis was clear (paragraph 4(A)(iii) of the Charges) constitutes negligence.

The Respondent's failure to exercise proper care in not terminating Patient A's pregnancy in the late evening of November 12, 1985 was compounded by his continued failure to exercise proper care thereafter. The factual allegations which should be sustained as set forth above constitute gross negligence.

The Respondent obtained a consultation in this case from an obstetrician as required by the June 28, 1982 agreement between the Respondent and New Rochelle Hospital (Findings of Fact 26,

165). Therefore, the factual allegation of paragraph 5(B) of the charges as it relates to Patient A should not be sustained.

Patient B (Second, Tenth and Eleventh Specifications)

The Respondent performed an episiotomy on Patient B about three hours after the patient's admission to the hospital and about one hour before spontaneous delivery (Findings of Fact 31-33). This episiotomy was not justified at the time it was performed (Finding of Fact 34). The performance of the episiotomy in and of itself does not constitute negligence. The performance of the episiotomy at the time it was performed (paragraph 4(B)(i) of the charges) constitutes negligence.

At least as of March 22, 1984 the Respondent knew that Patient B's VDRL of December 18, 1983 was positive (Findings of Fact 35-36). The Respondent did not attempt to notify Patient B of those results either in writing or verbally (Findings of Fact 37-39). The Respondent had the responsibility to follow up on these positive VDRL results by attempting to notify Patient B (Finding of Fact 39). The Respondent's failure to meet that responsibility (paragraph 4(B)(ii) of the charges) constitutes negligence.

These actions or inactions of the Respondent which constitute negligence, as set forth above, do not constitute gross negligence, as defined.

No consultation in this case was required by the June 28, 1982 agreement between the Respondent and New Rochelle Hospital (Findings of Fact 40, 165). Therefore, the factual

allegation of paragraph 5(B) of the charges as it relates to Patient B should not be sustained.

Patient C (Third, Tenth and Eleventh Specifications)

When Patient C came to the Respondent's office on March 24, 1982 at 3:00 p.m., she had the symptoms of possible premature onset of labor (Findings of Fact 41-43). The Respondent should have taken action to diagnose and treat Patient C for premature onset of labor (Findings of Fact 44-45). The Respondent failed to take these actions and instead sent the patient home (Findings of Fact 46-47). This failure to take these steps to diagnose and treat Patient C for premature onset of labor (paragraph 4(C)(i) of the charges) constitutes negligence.

The factual allegations of paragraph 4(C)(ii) of the charges should be sustained (Findings of Fact 51-52, 57). However, this misdiagnosis does not constitute negligence or incompetence (Finding of Fact 53).

Patient C was admitted to the hospital at 7:45 p.m. on March 24, 1982 (Finding of Fact 48). With her condition at that time and thereafter, there was no need for pitocin (Findings of Fact 49, 55, 57). The Respondent's use of pitocin was contraindicated (Findings of Fact 54-55). This use (paragraph 4(C) (iii) of the charges) constitutes negligence.

The factual allegations of paragraph 4(C)(iv) of the charges should be sustained (Findings of Fact 57-58). However, there was no reason to perform a cesarean section (Findings of

Fact 48, 50, 56-58). Therefore, this failure to perform a cesarean section does not constitute negligence or incompetence.

These actions or inactions of the Respondent which constitute negligence, as set forth above, do not constitute gross negligence, as defined.

The June 28, 1982 agreement between the Respondent and New Rochelle Hospital was not in effect at the time the Respondent provided this care to Patient C (Findings of Fact 41, 54, 165). Therefore, the factual allegation of paragraph 5(B) of the charges as it relates to Patient C should not be sustained.

Patient D (Fourth, Tenth and Eleventh Specifications)

The factual allegations of paragraph 4(D)(i) of the charges should be sustained (Findings of Fact 59-63). The Respondent should have seen Patient D as soon as possible (Finding of Fact 64). He then could have initiated the treatment which he did finally initiate at 11:39 a.m. (Finding of Fact 69). The Respondent's failure to see and examine Patient D during this three hour period constitutes negligence.

When the Respondent did see Patient D at 11:39 a.m., he ordered magnesium sulfate, an anti-convulsive medication (Finding of Fact 69). The Respondent needed to be with the patient to make this clinical bedside decision (Finding of Fact 64). However, with this patient's seriously elevated blood pressure and the possibility of convulsions, the decision to order this medication needed to be made as soon as possible after the patient's admission to the hospital (Findings of Fact 59-61, 63-64, 68).

The Respondent's failure to order this medication for three hours after the patient's admission to the hospital (paragraph 4(D)(ii) of the charges) constitutes negligence.

The factual allegations of paragraph 4(D)(iii) of the charges should not be sustained (Findings of Fact 72-74).

Although Patient D had meconium fluid and preeclampsia, she became stable and had progress with her labor (Findings of Fact 59, 63, 65-66, 69-70, 73). She had a timely delivery, within twelve hours from her admission to the hospital (Findings of Fact 59, 75). Therefore, the factual allegations of paragraph 4(D)(iv) of the charges should not be sustained.

The Respondent needed to be in constant attendance with Patient D, particularly in light of her preeclampsia (Findings of Fact 59, 63, 65-69, 71). However, the Respondent did not see the patient for three hours after her admission and was not in constant attendance thereafter. This failure by the Respondent appropriately to monitor Patient D (paragraph 4(D)(v) of the charges) constitutes negligence.

These actions or inactions of the Respondent which constitute negligence, as set forth above, do not constitute gross negligence, as defined.

The June 28, 1982 agreement between the Respondent and New Rochelle Hospital required the Respondent to obtain a consultation in this high risk pregnancy with hypertension and preeclampsia (Findings of Fact 59, 63, 65-68, 165). The Respondent failed to obtain this consultation (Finding of Fact 76). This failure by the Respondent to obtain this required

consultation (paragraph 5(B) of the charges as it relates to Patient D) constitutes negligence.

Patient E (Fifth, Tenth and Eleventh Specifications)

Patient E was first admitted to New Rochelle Hospital on November 23, 1981 with elevated blood pressure, with edema and weighing 250 pounds (Findings of Fact 77-81). During this hospitalization Patient E's blood pressure was brought under control (Finding of Fact 86). The Respondent attempted to use pitocin without success (Findings of Fact 82-85). The Respondent should then have delivered Patient E with a cesarean section (Finding of Fact 89). Instead the Respondent discharged the patient, undelivered, despite the potential problems which in fact developed (Findings of Fact 87-88, 96). The Respondent's conclusions about the appropriate treatment for Patient E (Finding of Fact 90) showed his lack of skill and/or knowledge necessary to practice medicine. The Respondent's failure to deliver Patient E during this first admission (paragraph 4(E)(i) of the charges) constitutes incompetence.

Patient E was admitted for a third time to New Rochelle Hospital on December 11, 1981 with a dangerously elevated blood pressure and albumin in her urine (Findings of Fact 96, 98-99). The Respondent should have seen the patient immediately and then ordered magnesium sulfate right away (Finding of Fact 100). Instead he did not come in and see the patient for five hours (Finding of Fact 97). When the Respondent did come in, he did not remain with the patient and thus delayed ordering magnesium

sulfate (Findings of Fact 101-102). By a 2-1 vote, the Hearing Committee concluded that the Respondent's explanation about his contact with Patient E (Finding of Fact 103) showed his lack of skill and/or knowledge necessary to practice medicine. By a 2-1 vote, the Hearing Committee concluded that the Respondent's failure to remain in sufficient patient contact with Patient E during this third admission (paragraph 4(E)(ii) of the charges) constitutes incompetence. The third member of the Hearing Committee concluded that it constitutes negligence.

With Patient E's elevated blood pressure readings and weight and with the possibility of a seizure or a cerebral vascular accident, an anesthesiologist needed to be present during Patient E's labor (Findings of Fact 78, 96, 98-99). The Respondent did not arrange for an anesthesiologist to be present (Finding of Fact 104). The Respondent's failure to make these arrangements (paragraph 4(E)(iii) of the charges) constitutes negligence.

These actions or inactions of the Respondent which constitute negligence or incompetence, as set forth above, do not constitute gross negligence or gross incompetence respectively, as defined.

The June 28, 1982 agreement between the Respondent and New Rochelle Hospital was not in effect at the time the Respondent provided this care to Patient E (Findings of Fact 77, 105, 165). Therefore, the factual allegation of paragraph 5(B) of the charges as it relates to Patient E should not be sustained.

Patient F (Sixth, Tenth and Eleventh Specifications)

Although Patient F was admitted to New Rochelle Hospital on March 26, 1982 at 1:20 a.m. with ruptured membranes, the Respondent took no action to stimulate labor until March 27, 1982 at 9:30 a.m. (Findings of Fact 107-108, 111). Pitocin should have been started right away (Findings of Fact 111-112). This failure by the Respondent to initiate delivery of Patient F in a timely fashion (paragraph 4(F)(i) of the charges) constitutes negligence.

The length of time that the Respondent used pitocin was indicated (Findings of Fact 111, 116). Therefore, the factual allegations of paragraph 4(F)(ii) of the charges should not be sustained.

The factual allegations of paragraph 4(F)(iii) of the charges should be sustained (Findings of Fact 111, 113-115). This failure by the Respondent to perform a vaginal examination constitutes negligence.

The Respondent should have come in to see Patient F as soon as possible after he was notified of her admission to the hospital but he failed to do so (Findings of Fact 108-109). The Respondent should have started pitocin right away, as set forth above. Once he started the pitocin, the Respondent then should have stayed with Patient F so that he did not have to start and stop the pitocin as he did (Findings of Fact 107, 110-111, 116). This failure by the Respondent to be personally present (paragraph 4(F)(iv) of the charges) constitutes negligence.

An attempted delivery of Patient F with Kielland forceps, particularly without adequate anesthesia, was

contraindicated (Findings of Fact 117-119). By a 2-1 vote, the Hearing Committee concluded that the Respondent's attempt to deliver Patient F with Kielland forceps (paragraph 4(F)(v) of the charges) constitutes incompetence. The third member of the Hearing Committee concluded that it constitutes negligence.

In addition to his attempted use of Kielland forceps, the Respondent used Elliot forceps at delivery (Findings of Fact 117, 120). As a result of the Respondent' s inappropriate application of forceps, Baby F was injured (Findings of Fact 121-122). This inappropriate application of forceps by the Respondent (paragraph 4(F)(vi) of the charges) constitutes incompetence.

These actions or inactions of the Respondent which constitute negligence or incompetence, as set forth above, do not constitute gross negligence or gross incompetence respectively, as defined.

The June 28, 1982 agreement between the Respondent and New Rochelle Hospital was not in effect or the time the Respondent provided this care to Patient F (Findings of Fact 107, 120, 165). Therefore, the factual allegation of paragraph 5(B) of the charges as it relates to Patient F should not be sustained.

Patient G (Seventh, Tenth and Eleventh Specifications)

The factual allegations of paragraph 4 (G)(i) of the charges should not be sustained (Findings of Fact 123-127).

The factual allegations of paragraph 4(G)(ii) of the charges should be sustained (Findings of Fact 124-125, 128-129).

However, in light of the brief interval between the Respondent's seeing the patient and her delivery, the Respondent's failure to call for the presence of another physician does not constitute negligence or incompetence (Findings of Fact 124, 128-129).

The factual allegations of paragraph 4(G)(iii) of the charges should not be sustained (Finding of Fact 130).

The June 28, 1982 agreement between the Respondent and New Rochelle Hospital was not in effect at the time the Respondent provided this care to Patient G (Findings of Fact 123, 128, 165). Therefore, the factual allegation of paragraph 5(B) of the charges as it relates to Patient G should not be sustained.

Patient H (Eighth, Tenth and Eleventh Specifications)

As set forth in Findings of Fact 131-140, the factual allegations of paragraph 4(H)(i) of the charges, except as to continued fetal heart decelerations, should be sustained. This failure by the Respondent to appear and examine this patient for four hours after her admission to the hospital constitutes negligence.

The factual allegations of paragraph 4(H)(ii) of the charges should not be sustained (Findings of Fact 137, 139, 141-142). The factual allegations of paragraph 4(H)(iii) of the charges should not be sustained (Findings of Fact 141, 143).

Due to the Respondent's delay in coming to the hospital, Patient H's delivery was delayed (Findings of Fact 131-141). On that basis, the factual allegations of paragraph 4(H)(iv) of the charges, except as to continued fetal heart decelerations, should

be sustained. This failure by the Respondent to deliver Patient H in a timely manner constitutes negligence.

The sustained factual allegations of paragraphs 4(H)(i) and (iv) constitute one occasion of negligence. These sustained factual allegations do not constitute gross negligence, as defined.

The June 28, 1982 agreement between the Respondent and New Rochelle Hospital required the Respondent to obtain a consultation in this high risk pregnancy (Findings of Fact 131-132, 140, 165). The Respondent failed to obtain this consultation (Findings of Fact 138, 144). This failure by the Respondent to obtain this required consultation (paragraph 5(B) of the charges as it relates to Patient H) constitutes negligence.

Patient I (Ninth, Tenth and Eleventh Specifications)

The factual allegations of paragraph 4(I)(i) of the charges should be sustained (Findings of Fact 145-153, 155-157). The factual allegations of paragraph 4(I)(ii) of the charges should be sustained (Findings of Fact 152, 155, 159-163). The factual allegations of paragraph 4(I)(iii) of the charges should be sustained (Findings of Fact 148, 152, 154-155, 158-159, 164).

By a 2-1 vote, the Hearing Committee concluded that each of these actions or inactions by the Respondent constitutes incompetence but not gross incompetence, as defined. This conclusion concerning incompetence was based on the fact that after he ruptured Patient I's membranes, the Respondent did not

follow his own reasoning concerning the care of this patient, and on the fact that there was no reason to try to use these forceps. The third member of the Hearing Committee concluded that each of these actions or inactions by the Respondent constitutes negligence and that these three factual allegations constitute gross negligence, as defined.

The June 28, 1982 agreement between the Respondent and New Rochelle Hospital was not in effect at the time the Respondent provided this care to Patient I (Findings of Fact 145, 164-165). Therefore, the factual allegation of paragraph 5(B) of the charges as it relates to Patient I should not be sustained.

Summary

As set forth above, the First Specification (Patient A) as to gross negligence should be sustained to the extent set forth above. As also set forth above, the First Specification as to gross incompetence and the Second through Ninth Specifications (Patients B through I) as to both gross incompetence and gross negligence should not be sustained.

As further set forth above, charges of practicing the profession with negligence should be sustained concerning Patients A, B, C, D, E, F and H. Because the sustained charges constitute practicing the profession with negligence on more than one occasion, the Tenth Specification should be sustained to the extent set forth above.

As also set forth above, charges of practicing the profession with incompetence should be sustained concerning

Patients E, F and I. Because the sustained charges constitute practicing the profession with incompetence on more than one occasion, the Eleventh Specification should be sustained to the extent set forth above.

II. Failing to maintain accurate records (Twelfth Specification)

As set forth in Findings of Fact 166-171, the factual allegations of paragraph 7 of the charges should be sustained. Therefore, the Twelfth Specification should be sustained as to each of the patients.

III. Practicing fraudulently, willfully making false reports (Thirteenth and Fourteenth Specifications)

Practicing the profession fraudulently was defined as the intentional misrepresentation, false representation or concealment of fact. Willfully was defined as knowingly or intentionally.

The factual allegations of paragraph 8(A) of the charges should be sustained (Findings of Fact 165, 172, 173). The meaning of this question on Calvary Hospital's report form was clear from a plain reading of the question. The Respondent's false answer, therefore, was intentionally and knowingly made.

The factual allegations of paragraph 8(B) of the charges should be sustained (Findings of Fact 172, 174, 175). The meaning of this question on Calvary Hospital's report form was clear from a plain reading of the question. Of particular note is the fact that the Respondent had completed a form for one of the

malpractice actions less than one year before the completion of this Calvary Hospital form (Finding of Fact 175). The Respondent's false answer, therefore, was intentionally and knowingly made.

The factual allegations of paragraph 8(C) of the charges should not be sustained (Findings of Fact 176, 177).

The factual allegations of paragraph 8(D) of the charges should be sustained (Findings of Fact 178, 179). Based on a plain reading of St. Agnes Hospital's report form and the Respondent's testimony (Finding of Fact 179), the Respondent's false answer was intentionally and knowingly made.

Based on the sustained factual allegations of paragraph 8(A), (B) and (D) of the charges as set forth above, the Thirteenth and Fourteenth Specifications should be sustained to the extent set forth above.

RECOMMENDATIONS

As set forth above and to the extent set forth above, the Hearing Committee recommends that the following specifications be sustained: First (practicing the profession with gross negligence - Patient A), Tenth (practicing the profession with negligence on more than one occasion - Patients A, B, C, D, E, F, and H), Eleventh (practicing the profession with incompetence on more than one occasion - Patients E, F and I), Twelfth (failing to maintain accurate records), Thirteenth (practicing the profession fraudulently) and Fourteenth (willfully making false reports).

The nature and seriousness of the sustained charges reflect the Respondent's lack of knowledge and judgment, and his need for more supervised training. The Hearing Committee, therefore, unanimously recommends that the following penalty be imposed. The Respondent's license to practice medicine should be suspended for a period of at least one year and not more than two years. During this period of suspension, the Respondent, as a PGY 2, 3 or 4, should successfully complete a residency program which is approved by the American College of Obstetrics and Gynecology, is at least one year in duration, and is in the United States. During this period of suspension, the Respondent also should pass a board recertification examination in obstetrics and gynecology. If the Respondent meets these two requirements (successful completion of the residency and board recertification) before the end of the two year suspension period, the remainder of that suspension period should be stayed. If the Respondent has not met these two requirements (successful completion of the residency and board recertification) at the end of the two year suspension period, his license to practice medicine should be revoked.

DATED: Syracuse, New York
, 1989

Respectfully submitted,

Stanley D. Leslie, M.D.,
Chairperson

Ann Shamberger
Jerome L. Ditkoff, D.O.

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

IN THE MATTER :

OF : COMMISSIONER'S

JOHN A. POGLINCO, M.D. : RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on July 8, August 26, September 9, 16, October 7, November 4, December 2, 1987, January 20, March 9, May 18, June 22, August 24, September 7, October 12 and 26, 1988. Respondent, John A. Poglinco, M.D., appeared by Kenneth Harfenist, Esq. The evidence in support of the charges against the Respondent was presented by Dawn A. Dweir, Esq.

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

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

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

EXHIBIT "C"

B. The Recommendation of the Committee should be modified as follows: The Committee's recommendation is imprecise as to the duration of suspension. Since board certification is not required to practice OB/GYN, the Committee should not have required that Respondent be recertified. Moreover, by postponing a revocation, the Committee allows Respondent to continue to practice now without any retraining. In lieu of the Committee's recommendation, I recommend that Respondent's license be suspended to the extent that he not be allowed to practice OB/GYN except to allow him to take a one year supervised ACOG approved fellowship or residency in OB/GYN approved for the Respondent by the Office of Professional Medical Conduct (OPMC). Upon Respondent's successful completion of the fellowship or residency, as certified by OPMC, the suspension of Respondent's license to practice should be continued for one additional year with such suspension stayed provided Respondent complies with the standard terms of probation.

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation as modified above.

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

Dated: Albany, New York
May 15 1989

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

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

JOHN A. POGLINCO

No. 10089

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

REPORT OF THE REGENTS REVIEW COMMITTEE

JOHN A. POGLINCO, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on July 8, August 26, September 9, September 16, October 7, November 4, and December 2, 1987, and January 20, March 9, May 18, June 22, August 24, September 7, October 12, and October 26, 1988, a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the second amended statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without

EXHIBIT "D"

attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of the first specification of the charges based on gross negligence to the extent indicated in its report, the tenth through fourteenth specifications of the charges to the extent indicated in its report, and not guilty of the remaining charges.

The hearing committee recommended that respondent's license to practice as a physician in the State of New York be suspended for a period of at least one year and not more than two years. During this period of suspension, the respondent, as a PGY 2, 3, or 4, should successfully complete a residency program which is approved by the American College of Obstetrics and Gynecology, is at least one year in duration, and is in the United States. During this period of suspension, the respondent also should pass a board recertification examination in obstetrics and gynecology. If the respondent meets these two requirements (successful completion of the residency and board recertification) before the end of the two year suspension period, the remainder of that suspension period should be stayed. If the respondent has not met these two requirements (successful completion of the residency and board recertification) at the end of the two year suspension period, his license to practice medicine should be revoked.

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

On October 17, 1989 respondent appeared before us in person and was represented by his attorney, Nathan L. Dembin, Esq., who presented oral argument on behalf of respondent. Dawn A. Dweir, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State of New York be suspended to the extent that he not be allowed to practice OB/GYN except to allow him to take a one year supervised ACOG approved fellowship or residency in OB/GYN approved for the respondent by the Office of Professional Medical Conduct (OPMC). Upon respondent's successful completion of the fellowship or residency, as certified by OPMC, the suspension of respondent's license to practice should be continued for one additional year with such suspension stayed provided respondent complies with the standard terms of probation.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent be given continued supervision, probation pending passage of resident qualifying examination, and 100 hours of continuing medical education to be completed in one year.

We have considered the record transferred by the Commissioner of Health in this matter. At the hearing we ruled not to accept any of the submissions offered by petitioner and respondent that were not part of the original record transferred to us by the Commissioner of Health.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 179 findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact and conclusions be accepted;
2. The hearing committee's recommendation and the Commissioner of Health's recommendation as to the measure of discipline be modified as hereafter indicated;
3. Respondent be found guilty, to the extent indicated in the hearing committee's report, by a preponderance of the evidence, of the first specification of the second amended statement of charges based on gross negligence,

as well as the tenth through fourteenth specifications of the second amended statement of charges, and not guilty of the remaining charges; and

4. In partial agreement with certain aspects of the recommendations of the hearing committee and Commissioner of Health, and as an appropriate measure of discipline under the circumstances herein, respondent's license to practice as a physician in the State of New York be suspended for one year upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently, and that upon termination of said suspension respondent thereafter be placed on probation for two years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D".

Respectfully submitted,

ADELAIDE L. SANFORD

SIMON J. LIEBOWITZ

JOHN T. McKENNAN

Adelaide L. Sanford

Chairperson

Dated: November 30, 1989

The University of the State of New York

IN THE MATTER

OF

JOHN A. POGLINCO
(Physician)

DUPLICATE
ORIGINAL
VOTE AND ORDER
NO. 10089

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10089, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (December 15, 1989): That, in the matter of JOHN A. POGLINCO, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 179 findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact and conclusions be accepted;
2. The hearing committee's recommendation and the Commissioner of Health's recommendation as to the measure of discipline be modified as hereafter indicated;
3. Respondent is guilty, to the extent indicated in the hearing committee's report, by a preponderance of the evidence, of the first specification of the second amended statement of charges based on gross negligence, as well as the tenth through fourteenth specifications of the second amended statement of charges, and not guilty of the remaining charges; and

EXHIBIT "E"

4. In partial agreement with certain aspects of the recommendations of the hearing committee and Commissioner of Health, and as an appropriate measure of discipline under the circumstances herein, respondent's license to practice as a physician in the State of New York be suspended for one year upon each specification of the charges of which respondent was found guilty, said suspensions to run concurrently, and that upon termination of said suspension respondent thereafter be placed on probation for two years under the terms prescribed by the Regents Review Committee;

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

and it is

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

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

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 8th day of February, 1990.

Thomas Sobol

Commissioner of Education

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

JOHN A. POGLINCO

CALENDAR NO. 10089

1. That respondent shall make quarterly visits to an employee of and selected by the office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall 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;

   b. That respondent is, at respondent's expense, enrolled in and diligently pursuing a residency program in obstetrics/gynecology, said residency to be at least one year in duration, said residency program to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, and respondent must complete said residency program during the period of probation to the satisfaction of said Director of the Office of Professional Medical Conduct, and that respondent limits his practice of obstetrics/gynecology to said residency program until such completion of said residency program;

   c. That respondent is, at respondent's expense, enrolled in and diligently pursuing a course in medical ethics, said course to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, and respondent must complete said course during the period of probation unless respondent demonstrates to the satisfaction of said Director of the Office of Professional Medical Conduct that respondent cannot comply with said course requirement and said Director of the Office of Professional Medical Conduct excuses respondent from compliance with said course requirement;

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

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

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

2. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding.

Supreme Court—Appellate Division
Third Judicial Department

February 28, 1991

61090

In the Matter of JOHN A. POGLINCO,

Petitioner,

v

BOARD OF REGENTS OF THE UNIVERSITY OF THE STATE OF NEW YORK,

Respondent.

WEISS, J.

Proceeding pursuant to CPLR article 78 (initiated in this court pursuant to Education Law § 6510-a [4]) to review a determination of the Commissioner of Education which suspended petitioner's license to practice medicine in New York for one year.

Petitioner is a board-certified obstetrician and gynecologist. After an extended hearing, a Hearing Panel for the State Board for Professional Medical Conduct (hereinafter Panel) recommended that petitioner be found guilty on charges including gross negligence, negligence on more than one occasion, incompetence on more than one occasion, unprofessional conduct in failing to properly maintain accurate records, fraud and unprofessional conduct relevant to incorrect disclosure in credential and practice history inquiries made by two hospitals. The Panel recommended that petitioner's license be suspended for 1 to 2 years; that petitioner complete a residency program in obstetrics and gynecology; that petitioner pass a board recertification examination in obstetrics and gynecology; and that, upon completion of the residency and the recertification, any remaining suspension be stayed, except that if petitioner should fail to complete the requirements within two years his license should be revoked.

The Commissioner of Health (hereinafter Commissioner) recommended that the finding of guilt be adopted but that a lesser sanction be imposed. The Regents Review Committee (hereinafter Review Committee) adopted the Panel's finding of guilt but proposed a one-year suspension followed by probation for two years, during which petitioner complete a one-year residency program in obstetrics and gynecology and complete a medical ethics course. During probationary retraining, petitioner's practice would be limited to the obstetrics/gynecology residency program. Respondent adopted the findings made by the Panel and the penalty proposed by the Review Committee. This CPLR article 78 proceeding to review the determination ensued.

EXHIBIT "F"

The University of the State of New York

IN THE MATTER

OF

JOHN A. POGLINCO
(Physician)

DUPLICATE
ORIGINAL
VOTE AND ORDER
NO. 10089

In the case of JOHN A. POGLINCO, under Calendar No. 10089, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (April 26, 1991): That, in the case of John A. Poglinco, under Calendar No. 10089, based upon the February 28, 1991 decision of the Supreme Court, Appellate Division, Third Department, in Poglinco v. Board of Regents of the University of the State of New York, 566 N.Y.S.2d 733, this matter be remitted to any Regents Review Committee for further proceedings not inconsistent with the aforesaid Appellate Division decision, said Committee to review the matter solely with respect to the issue of the penalty to be imposed upon respondent based upon the prior determination of the Board of Regents as to the issue of guilt, and to render its recommendation as to the issue of the penalty to the Board of Regents for final determination; and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

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

EXHIBIT "G"

Petitioner initially contends that the Commissioner unjustly refused to accept and review written argument on the merits and both written argument and evidence in mitigation of the penalty.[1] We disagree with this argument. Petitioner had the opportunity at the hearing before the Panel to make any record, to present any argument and to offer any submissions (Public Health Law § 230 [10] [f]); however, there is no provision for posthearing submissions during the Commissioner's review (Public Health Law § 230 [10] [i]).

Petitioner next contends that the refusal of the Review Committee to receive written material was improper. The review procedure does permit input and argument by petitioner, and the letter from the Review Committee giving formal notice of the hearing to be held by it specifically invited his submission of "a brief and/or other papers" (see, Matter of Swartz v New York State Dept. of Educ., 135 AD2d 1002, 1004). However, the Review Committee refused to accept any submissions which were not in the original record and offered no explanation for its departure from its normal procedure. This refusal effectively precluded consideration by respondent of petitioner's subsequent conduct, both good and bad, which has been held to be relevant on the measure of punishment (see, Matter of Davis v Board of Regents of Univ. of State of N.Y., 283 App Div 591, 595). Since the Review Committee's hearing was held on October 17, 1989, a year after the close of the Panel hearing, many subsequent events could well have had a bearing on the sanction. While respondent argues that petitioner was permitted to present oral argument on mitigation to the Review Committee, we find that to be of little moment since there is no indication that such argument was before respondent at the time of its deliberations. Accordingly, the penalty imposed must be vacated and the matter remitted to respondent for further proceedings. We need not reach the merits of petitioner's argument on the excessiveness of the penalty.

Determination modified, without costs, by vacating the penalty imposed; matter remitted to respondent for further proceedings not inconsistent with this court's decision; and, as so modified, confirmed.

MAHONEY, P.J., CASEY, WEISS, MIKOLL and YESAWICH, JR., JJ., concur.

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[1] In his brief, petitioner has not contended that there exists, at any stage, a posthearing right to submit additional evidence on the issue of guilt. Petitioner does not attack the underlying findings of guilt, limiting his brief to penalty issues only.

JOHN A. POGLINCO (10089)

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

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 30th day of April, 1991.

Thomas Sobol

Commissioner of Education

EXHIBIT "H"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

JOHN A. POGLINCO

CALENDAR NOS. 12106/10089

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall 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;

   b. That, during the first year of the period of probation, respondent is, at respondent's expense, enrolled in and diligently pursuing a course in medical ethics, said course to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, and respondent must complete said course during the first year of the period of probation unless respondent demonstrates to the satisfaction of said Director of the Office of Professional Medical Conduct that respondent cannot timely comply with said course requirement and said Director of the Office of Professional Medical Conduct excuses respondent from timely compliance with said course requirement and extends the time for compliance during the period of probation;

   c. That, between the second and fourth months of the first year of the period of probation, respondent is, at respondent's expense, enrolled in and diligently pursuing a retraining program in obstetrics/gynecology, said retraining to be at least one year in duration, said retraining program to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct unless respondent demonstrates to the satisfaction of said Director of the Office of Professional Medical Conduct that respondent

cannot timely comply with said retraining requirement and said Director of the Office of Professional Medical Conduct excuses respondent from timely compliance with said retraining requirement and extends the time for compliance during the period of probation;

d. That, during the first year of probation, respondent shall not practice, offer to practice, or hold himself out to practice as a physician, except insofar as he is permitted to practice in the retraining program, identified in term of probation 1(c), in accordance with the partial stay of the suspension imposed upon respodent;

e. That, subject to the opportunity to obtain an earlier termination of this term of probation as provided in term of probation 1(f), respondent, during the second and third years of the period of probation, shall limit his practice of obstetrics/gynecology to the retraining program identified in term of probation 1(c) herein;

f. That, during the first twenty-five (25) months of the period of probation, respondent must complete said retraining program, identified in term of probation 1(c) herein, to the satisfaction of said Director of the Office of Professional Medical Conduct, and that, upon notification by said Director of the Office of Professional Medical Conduct of the satisfactory completion by respondent of said retraining program, term of probation 1(e) herein shall terminate;

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

h. That, during the second and third years of the period of probation, respondent shall submit

written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234, of any employment and/or practice, and of any change in respondent's employment and/or practice;

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

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

2. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding.

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

JOHN A. POGLINCO

CALENDAR NOS. 12106/10089

The University of the State of New York

IN THE MATTER

OF

JOHN A. POGLINCO
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NOS. 12106/10089

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar Nos. 12106/10089, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED* **(September 13, 1991):** That, in the matter of JOHN A. POGLINCO, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's recommendation and the Health Commissioner's recommendation as to the measure of discipline be modified as hereafter indicated; and
2. In partial agreement with certain aspects of the recommendations of the hearing committee and Commissioner of Health, and as an appropriate measure of discipline, at this time and under the circumstances herein, respondent's license to practice as a physician in the State of New York be suspended for one year upon each specification of the charges of which respondent was previously found guilty, said suspensions to run concurrently, that execution of said concurrent suspensions be stayed, in part, solely to the extent of permitting respondent to practice only in the retraining program referred to in the terms of probation hereafter

*Regent McGivern dissented and Regent Batista abstained.

imposed on respondent, and respondent be placed immediately on probation for three years under the terms set forth in Exhibit H of the report of the Regents Review Committee;

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

and it is

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

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

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 19th day of September, 1991.

Thomas Sobol
Commissioner of Education