STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

NEW YORK STATE DEPARTMENT OF HEALTH 10

November 7, 1995

RECEIVED
NOV 07 1995
MEDICAL ...

CORRECTED LETTER

Timothy J. Mahar, Esq.
NYS Department of Health
Room 2429 - Corning Tower
Empire State Plaza
Albany, New York 12237

Walter R. Marcus, Esq.
80 John Street - 20th Floor
New York, New York 10038

John A. Rurak, M.D.
Health Center for Women
600 Fitch Street - Suite 206
Elmira, New York 14905-000

EFFECTIVE DATE NOVEMBER 13, 1995

RE: **In the Matter of John A. Rurak, M.D.**

Dear Mr. Mahar, Mr. Marcus and Dr. Rurak:

Due to a wordprocessing error, the cover letter you received regarding the above referenced matter contained an error.

The first sentence of the letter dated November 6, 1995 should have read "Enclosed is the Determination and Order (95-169) of the Professional Medical Conduct Administrative Review Board in the above referenced matter."

The Determination and Order you received is <u>not</u> a corrected copy.

We are sorry for any inconvenience this may have caused you.

Sincerely yours,

Tyrone T. Butler, Director
Bureau of Adjudication

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

November 6, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Dept. of Health
Rm 2429 Corning Tower
Empire State Plaza
Albany, New York 12237

Walter R. Marcus, Esq.
80 John Street - 20th Floor
New York, New York 10038

John A. Rurak, M.D.
Health Center for Women
600 Fitch Street - Suite 206
Elmira, New York 14905-0000

RE: In the Matter of John A. Rurak, M.D.

Dear Mr. Mahar, Mr. Marcus and Dr. Rurak :

Enclosed please find the corrected Determination and Order (No. 95-169) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This corrected copy is being sent to you due to an error in the first document sent to you on September 13, 1995. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

Office of Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

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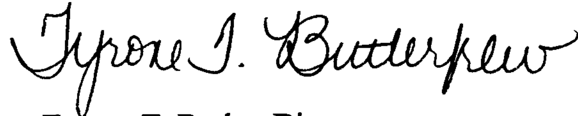
If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

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

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER OF JOHN A. RURAK	**ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER BPMC 95-169**

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on October 13, 1995 to review the Hearing Committee on Professional Medical Conduct (Hearing Committee's) August 7, 1995 Determination finding Dr. John Rurak guilty of professional misconduct. The Respondent requested the review through a Notice which the Board received on August 23, 1995. James F. Horan served as Administrative Officer to the Review Board. Timothy J. Mahar, Esq., filed a brief for the Office of Professional Medical Conduct (Petitioner), which the Review Board received on September 8, 1995, and a reply brief which the Review Board received on September 29, 1995. Walter R. Marcus, Esq. filed a brief for the Respondent, which the Review Board received on September 28, 1995.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and

[1]Sumner Shapiro did not participate in the deliberations in this case.

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- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

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

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

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent, an Obstetrician/Gynecologist, with practicing medicine with gross negligence, gross incompetence, with negligence on more than one (1) occasion, with incompetence on more than one (1) occasion and with failing to maintain adequate records. The charges arose from the Respondent's treatment of eight (8) patients, whom the record refers to as A through H. The charges relating to Patients A through E related to Obstetric care which the Respondent provided to those patients. The charges relating to Patients F and G arose from Gynecological care which the Respondent provided to those patients. The charges relating to Patient H, the Respondent's wife, arose from treatment the Respondent provided to the patient for weight control and leg pain.

The Hearing Committee found that the Respondent was guilty of gross negligence in the treatment of Patients A, B, C, and H, gross incompetence in treatment of Patients A, B, C and H, negligence on more than one (1) occasion in the treatment of Patients A, B, C, D, F and H, incompetence on more than one (1) occasion in the treatment of Patients A, B, C, D F and H, and failing to maintain adequate records for Patient H. The Committee found that the Respondent was not guilty of any misconduct in the cases of Patients E and G.

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The cases of Patients A through D involve the Respondent's management of those patients for preeclampsia[2]. The Respondent treated Patient D in 1991, Patient A in 1992 and Patients B and C in 1993. The Hearing Committee found that the Respondent's management of the four (4) patients revealed a consistent pattern of delaying hospitalization and diagnostic evaluation of mother and fetus until a condition of preeclampsia was demonstrated over two (2) to three (3) visits. The Committee found that the fallacy of this mode of treatment was that preeclampsia can progress in a matter of hours to a life threatening condition for both mother and fetus. In the case of Patient A, the Respondent saw the Patient on May 26, 1992. The Committee found that there were indications on that day that Patient A was suffering severe preeclampsia. The Committee found that the Respondent should have sent Patient A to the hospital at that time, so the patient and her fetus could be evaluated and so the patient could receive anti-hypertensive medication. The Respondent failed to send the patient to the hospital at that time. Patient A was admitted to the hospital on May 27, 1992 with symptoms indicating severe preeclampsia. The patient suffered an intracranial hemorrhage on that day and died two (2) days later. The Committee also found that the Respondent failed to appropriately evaluate Patients B, C and D for preeclampsia. The Committee found that the Respondent failed to evaluate the fetus in Patient B and D's cases, failed to treat Patient C appropriately for preeclampsia, and failed to treat Patients C and D for elevated blood pressure. The Committee found the Respondent grossly negligent and grossly incompetent in the treatment of Patients A, B and C, and negligent and incompetent in the treatment of Patient D. The Committee noted that the Respondent had testified that after the treatment of Patient D in 1991, he became more aggressive in treating preeclampsia. The Committee, however, found that the Respondent's treatment of Patients A, B and C demonstrated that he had not changed his pattern of practice.

The Committee found the Respondent negligent and incompetent in the treatment of Patient

[2]Preeclampsia occurs during pregnancy when the mother experiences generalized vascular spasms in her small arteries, resulting in elevations in blood pressure and the presence of protein in the patient's urine as a result of kidney involvement (Hearing Committee Finding of Fact 5). Preeclampsia is potentially life threatening to the mother, because the vascular spasms can result in a decrease in blood supply to the mother's vital organs, thereby damaging the organs and resulting in convulsions, seizures, cranial hemorrhage and death. Preeclampsia may also compromise the blood supply to the fetus, leading to fetal hypoxia (insufficient oxygen), intrauterine growth retardation, brain damage, and death (Hearing Committee Finding of Fact 6).

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F. The Committee found that the Respondent placed the patient inappropriately on estrogen therapy for a three (3) month period in 1990. The Committee found that the regimen of estrogen should have been accompanied by progesterone therapy as well. The Committee found that treatment with estrogen alone posed a risk of the development of hyperplasia and cancer. The Committee also found that the Respondent failed to evaluate Patient F in a timely manner for uterine bleeding.

In the treatment of Patient H, the Committee found that the Respondent wrote prescriptions for excessive amounts of drugs including synthroid and Tylenol with codeine, without medical purpose. The Committee found that the Respondent prescribed synthroid, a synthetic thyroid medication, for two and one-half (2 1/2) years for Patient H for weight control The Committee found that synthroid is used to treat an underactive thyroid gland and is not used for the purpose of weight control. The Committee found that when Patient H's thyroid level was tested in 1992, the level was so high it was beyond the ability of the laboratory to measure. The Committee found that the Respondent realized that Patient H was taking excessive amounts of synthroid for inappropriate reasons, yet continued to prescribe the drug to her in excessive amounts. The Committee found the Respondent prescribed significant quantities of Tylenol with codeine to Patient H purportedly for chronic pain, with little objective evidence of such pain. The Committee found that Patient H was eventually treated in a drug rehabilitation facility for addiction in connection with her use of synthroid and Tylenol with codeine. The Committee concluded that the Respondent was guilty of gross negligence, gross incompetence and failure to maintain adequate records for Patient H.

In reaching their conclusions, the Committee found testimony by the Petitioner's expert, Dr. Robert C. Tatelbaum, to be credible. The Committee also found credible testimony by three (3) fact witnesses, Patient B, Patient A's husband and Dr. John Choate. The Committee found the testimony by the Respondent to be clearly biased in his own favor and directly contradicted by the patient records. The Committee noted that the Respondent's expert, Dr. Lawrence Dolkart, worked closely with the Respondent on a frequent basis, and that some of Dr. Dolkart's opinions were contradicted by both Dr. Tatelbaum and by the Respondent.

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The Committee voted to revoke the Respondent's license to practice medicine in New York State. The Committee found that the Respondent demonstrated a serious lack of basic skills necessary to practice Obstetrics and Gynecology, as well as extremely poor judgement. The Committee noted these factors combined to make the Respondent unfit to practice medicine. The Committee noted that the Respondent was not an acceptable candidate for retraining because he demonstrated a total lack of insight into his problems and demonstrated that he was incapable of learning from his mistakes. The Committee noted that although the Respondent claimed to have become more aggressive in managing preeclampsia following his treatment of Patient D in 1991, that his treatment of Patients A, B and C subsequently demonstrated that he had made no changes in his practice. The Committee found that the failure to make changes resulted in catastrophic consequences for Patient A. The Committee noted that the Respondent also demonstrated serious deficiencies in managing medical and gynecological patients as well. The Committee unanimously determined that the Respondent's continued practice of medicine would place the lives of his patients, as well as their unborn children, at great risk.

REQUESTS FOR REVIEW

The Respondent has asked that the Hearing Committee overturn the revocation of the Respondent's license and permit the Respondent to obtain requisite retraining so that he can return to the community to practice Obstetrics and Gynecology safely and with renewed skill and determination. The Respondent notes that he has carefully reviewed and reflected upon the findings and criticisms contained in the Committee's Determination and he accepts and recognizes those criticisms as predominantly valid, although he notes that the Committee judged him too harshly in some aspects. The Respondent argues that he has demonstrated an ability to accept criticism to learn from his mistakes and to modify his practice and procedures accordingly. The Respondent argues that while he has shown that ability to learn from his past mistakes, he recognizes that he does have further to go in that direction and he is not only willing, but desires to improve and hone his skills by entering an intensive retraining program. The Respondent argues that it would be unconscionable to simply

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throw away his many good years of standing in the community as a respected and dedicated physician. The Respondent's brief attaches letters of support from Obstetricians and Gynecologists at the Arnot-Ogden Medical Center in Elmira. The Respondent asks for, at the very least, the opportunity for evaluation by the Syracuse program for a determination as to whether he would be an appropriate candidate for retraining.

The Petitioner asks that the Review Board sustain the Hearing Committee's Determination in all respects. The Petitioner argues that the revocation of the Respondent's license is warranted by the evidence in this case. The Petitioner argues that the Committee's assessment that the Respondent is not a retraining candidate is unassailable, that there has been no showing that there are redeeming qualities to the Respondent's practice and that he has not learned from his mistakes. The Petitioner contends that the Respondent's care of subsequent preeclampsia patients after Patient D was more egregious than the care of Patient D, and that the Respondent's care of Patient B following the death of Patient A was inexcusable. The Petitioner asks that the Review Board not consider testimonials offered by the Respondent's colleagues in the Elmira area because that evidence was not placed before the Hearing Committee.

REVIEW BOARD DETERMINATION

The Review Board considered the record form the hearing below and the briefs from counsel. The Review Board was unable to consider the submissions from the Respondent's colleagues at Arnot-Ogden Medical Center in Elmira, because those documents were not in evidence before the Hearing Committee.

The Review Board votes 4 to 0 to sustain the Hearing Committee's Determination finding the Respondent guilty of gross negligence, gross incompetence, incompetence on more than one (1) occasion, negligence on more than one (1) occasion and failure to maintain adequate records. We find that the Committee's Findings of Fact and Conclusions are consistent with their Determination and that the Determination is supported by the evidence in this case. The Committee's findings demonstrate that the Respondent committed repeated and serious acts of negligence and incompetence

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in his failure to properly evaluate and treat four (4) obstetric patients for preeclampsia. The Findings further demonstrate that the Respondent committed negligence and incompetence in the regimen of hormonal therapy he prescribed for Patient F and in failing to evaluate Patient's F uterine bleeding in a timely manner. The Committee's findings also demonstrate that the Respondent was guilty of gross negligence and gross incompetence in continually prescribing excessive amounts of synthroid and Tylenol with codeine for Patient H.

The Review Board votes 4-0 to sustain the Hearing Committee's Determination revoking the Respondent's license to practice medicine in New York State. The Review Board agrees with the Hearing Committee that the Respondent has demonstrated a serious lack of skills necessary to practice medicine and a serious lack of judgement. The Respondent committed acts of negligence and incompetence in treating obstetric, gynecological and medical patients. The Respondent placed all Patients A through D and their unborn children at risk by failing to appropriately treat those patients for preeclampsia. The Respondent's gross negligence and gross incompetence in treating preeclampsia resulted in the death of Patient A. The Respondent's negligence and incompetence in treating Patient F placed that Patient at an increased risk for cancer. The Respondent's continual and excessive prescribing of drugs for Patient H eventually led to the patient's treatment for drug addiction, arising from her use of synthroid and Tylenol with codeine. The Review Board agrees that the Respondent's continued practice of medicine would place his patients and their unborn children at grave risk.

The Review Board rejects the Respondent's contention that the Respondent is a good candidate for retraining. The Respondent's treatment of Patients A through D demonstrates not only repeated and serious incidents of negligence and incompetence, but also demonstrates that the Respondent is not capable of learning from his mistakes. The Respondent testified at the hearing that he became more aggressive in treating preeclampsia after his treatment of Patient D in 1991. The record demonstrates, however, that after treating Patient D, the Respondent committed even more egregious acts of negligence and incompetence in the treatment of Patients A, B and C. The Respondent should have realized that his pattern of treating preeclampsia posed a risk to his patients, after the results in the treatment in Patient D and after the death of Patient A. The Respondent, however, continued to

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make the same mistakes in the treatment of Patients B and C. There is nothing in the record from this case demonstrating that the Respondent has the ability, insight or motivation to learn from retraining.

The Respondent's misconduct was serious and extensive. We find nothing to demonstrate that the Respondent can correct the deficiencies in practice. The Review Board finds that the revocation of the Respondent's license is the only appropriate penalty in this case.

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ORDER

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

1. The Review Board votes to **SUSTAIN** the Hearing Committee's August 7, 1995 Determination finding Dr. John Rurak guilty of Professional Misconduct.

2. The Review Board **SUSTAINS** the Hearing Committee's Determination revoking the Respondent's license to practice medicine in New York State.

ROBERT M. BRIBER

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

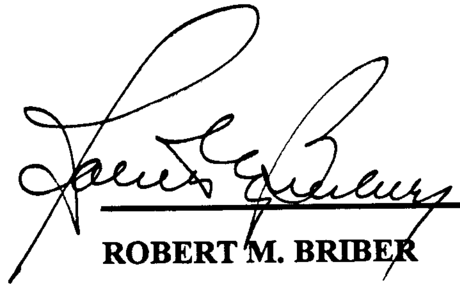
NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF JOHN A. RURAK, M.D.

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

DATED: Albany, New York

10/27, **1995**



ROBERT M. BRIBER

NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF JOHN A. RURAK

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

DATED: Brooklyn, New York
10/25/, **1995**

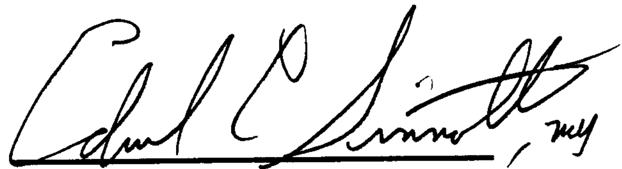
WINSTON S. PRICE, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF JOHN A. RURAK

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

DATED: Roslyn, New York
Oct 27, **1995**



EDWARD C. SINNOTT, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF JOHN A. RURAK

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

DATED: Syracuse, New York
30 Oct. , **1995**

William A Stewart
WILLIAM A. STEWART, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19