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

August 7, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

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

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

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

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

Enclosed please find the Determination and Order (No. 95-169) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER	DETERMINATION
OF	AND
JOHN A. RURAK, M.D.	ORDER

BPMC-95-169

A Notice of Hearing, dated January 4, 1995, and Statement of Charges, dated January 5, 1995, were served upon the Respondent, John A. Rurak, M.D. **WILLIAM P. DILLON, M.D. (Chair), JOSEPH K. MYERS, M.D., and ANTHONY BIONDI**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Timothy J. Mahar, Esq., Assistant Counsel. The Respondent appeared by Walter R. Marcus, Esq. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	January 9, 1995
Answer to Statement of Charges:	None
Pre-Hearing Conference:	February 22, 1995
Dates of Hearings:	March 3, 1995 March 27, 1995 April 3, 1995 April 24, 1995 May 4, 1995
Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendation:	May 24, 1995
Received Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendation:	May 31, 1995
Witnesses for Department of Health:	Robert C. Tatelbaum, M.D. Patient A's Husband Patient B John W. Choate, M.D.
Witnesses for Respondent:	John A. Rurak, M.D. Patient H Lawrence A. Dolkart, M.D.
Deliberations Held:	June 7, 1995

STATEMENT OF CASE

The Department has charged Respondent with five specifications of professional misconduct. The charges allege that Respondent's medical care and treatment of eight patients demonstrated gross negligence, gross incompetence, negligence and incompetence on more than one occasion, and the failure to maintain accurate medical records.

A copy of the Notice of Hearing and Statement of

Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. 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. Rurak, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State on November 24, 1978 by the issuance of license number 136856 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through December 31, 1996 from The Health Center for Women, Suite 206, 600 Fitch Street, Elmira, New York 14905-0000. (Pet. Ex. #2).

Patient A

2. Patient A was a 28-year old obstetrical patient whose first office visit with Respondent for her pregnancy was on December 6, 1991. Patient A's blood pressure on December 6, 1991 was 122/70 and she exhibited no proteinuria. (Pet. Ex. #4, pp.3 and 4).

3. Patient A had an office visit with Respondent on May 26, 1992, at which time she was approximately 36 weeks pregnant. On that visit, Patient A had a blood pressure of

160/96, a weight gain of 7 1/2 pounds, 3+ to 4+ proteinuria and edema of an unknown amount. Patient A's fundal height on May 26, 1992, was U+6, as it had been since her office visit nearly a month earlier on April 28, 1992. Patient A's symptoms on May 26, 1992, indicated that she was suffering from preeclampsia and perhaps had that condition for weeks or months prior to that date. (27-28, 689, 706; Pet. Ex. #4, p.3).

4. An obstetrician has to consider that a patient with proteinuria has suffered from preeclampsia for some time, as proteinuria normally develops late in the disease process. (437-438).

5. Preeclampsia results 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. (28).

6. The risks and complications of preeclampsia are potentially life-threatening to the mother and the fetus. The vascular spasms can result in the decrease of the blood supply to the mother's vital organs, including her kidneys, liver, heart, brain, lungs, and uterus. Consequently, these organs can be damaged, resulting in convulsions, seizures, cranial hemorrhage and death. Preeclampsia may result in a decrease of the mother's platelets, resulting in the development of small clots in the mother's circulation and compromising the blood supply to the fetus. This may lead to fetal hypoxia (insufficient oxygen), intrauterine growth retardation, brain damage and death (28-29, 713).

7. Once an obstetrician recognizes the condition of preeclampsia, the mother and fetus require further evaluation. The physician should obtain laboratory studies to evaluate the mother's kidneys, liver, and coagulation system, as well as evaluate the viability of the baby. (29-30).

8. The most efficient way to conduct these laboratory studies is in the hospital, which permits the monitoring of both the fetus and the mother, including frequent evaluations by the hospital staff of the mother's blood pressure, pulse, respirations and reflexes, as well as the collection of 24-hour urine specimens for creatinine clearance and total protein study, and the collection of blood for the evaluation of platelets and coagulation function. (30-31).

9. These studies are necessary to assess whether the mother's vital organs have been compromised by the preeclampsia and thus whether the physician will be required to deliver the baby early, as delivery is the main cure for preeclampsia. (31-32, 41-42).

10. In order to determine the degree to which the preeclamptic condition has impaired the blood supply to the placenta, and thus the baby, the baby needs to be monitored. The baby can be assessed by a non-stress test which measures the baby's heart rate when the baby moves. (33).

11. The baby can also be evaluated by a biophysical profile which measures the amniotic fluid volume as well as the baby's activity and breathing, among other things. Although these tests can be performed on an out-patient basis, the tests

can best be conducted and the results obtained more quickly when the mother is admitted to the hospital. (33-34).

12. The blood pressure and proteinuria which an obstetrician measures in his office do not provide the obstetrician with information regarding the condition of the mother's vital organs, which can only be assessed by means of the described laboratory studies. (32-33, 714).

13. Given her blood pressure of 160/96 and proteinuria of 3+ to 4+ on May 26, 1992, Patient A required admission to the hospital for evaluation by the referenced laboratory studies. Further, as she was 36 weeks pregnant at that time, Patient A could have been delivered on May 26, 1992. There would have been no advantage at that point to delaying the delivery (30, 32, 82).

14. Patient A's 7 1/2 pound weight gain between her office visits on May 12, 1992 and May 26, 1992 was probably the result of fluid retention and edema. Preeclampsia can cause an extravasation of fluid from the vascular system into the extravascular space, resulting in the patient retaining fluids instead of excreting them and ultimately resulting in weight gain. Such weight gain would reflect the potential severity of the patient's preeclamptic condition (34-35; Pet. Ex. #4, p. 3).

15. The growth of the fetus can be inferred from the growth of the mother's uterus, which is measured by the fundal height. Patient A showed no growth in the height of the fundus from April 28, 1992 to May 26, 1992. (35-37; Pet. Ex. #4).

16. Where a mother has preeclampsia and the uterus has shown no growth for one month, a reasonably prudent obstetrician

should be concerned that the fetus was suffering intrauterine growth retardation and would monitor the baby by non-stress test and biophysical profile so that any problems could be identified. Such monitoring should be done in the hospital. (36-37).

17. On May 26, 1992 Patient A had 3+ to 4+ proteinuria. Proteinuria is measured by a scale ranging from negative, to trace, to 1+, 2+,3+ and 4+. Proteinuria of 4+ is indicative of severe preeclampsia, suggesting a significant impairment of the mother's kidney function. Under normal circumstances, there is little or no protein present. The amount of protein in the urine is related to the amount of potential damage to the kidney (37-39; Pet. Ex. #4, p.3).

18. Respondent, not having ordered a total protein study or creatinine clearance test, could not have known how severe Patient A's proteinuria was when he sent her home on May 26, 1992. (735).

19. Without reliable information, an obstetrician cannot reasonably exercise his or her clinical judgement. (735).

20. Patient A's 3+ to 4+ proteinuria on May 26, 1992 indicated severe preeclampsia. When severe preeclampsia is present, one must look for other signs of compromise to the patient's condition. For example, a low platelet count may result in bleeding in either the mother or the baby. One of the laboratory tests which is indicated in circumstances of proteinuria is a measurement of the platelet count. (39-40).

21. An obstetrician could not predict on the basis of Patient A's symptoms on May 26, 1992, whether her preeclampsia

might become worse, or if it did worsen, when the further deterioration might occur (710-712).

22. Given Patient A's blood pressure of 160/96, 3+ to 4+ proteinuria and lack of growth of fundal height, on May 26, 1992, accepted standards of medical care required Patient A to be sent directly from Respondent's office to the hospital for admission and observation by the hospital nursing staff of her blood pressure and stability. Further, at the time of her admission on May 26, 1992, orders for a 24-hour urine for creatinine clearance, total protein, liver function study, kidney function study, coagulation study, and platelet count should have been written and the tests performed. Patient A's blood pressure and proteinuria on May 26, 1992 were indicative of severe preeclampsia, and it would not be expected that her condition would improve prior to delivery. (40-41, 81-82, 86).

23. There are no orders in Respondent's records for Patient A's hospitalization on May 26, 1992 or orders for the described laboratory studies on that date. (41).

24. Respondent's failure to hospitalize Patient A on May 26, 1992 and order the described laboratory studies was a gross deviation from accepted standards of medical care. (41-42).

25. According to Respondent, the standard of care followed by the Obstetrical Department of the Arnot Ogden Hospital requires the evaluation of the mother and fetus where the maternal blood pressure is 140/90 and there is trace to 1+ proteinuria. (441).

26. Respondent did not consider ordering liver and kidney function studies for Patient A on May 26, 1992, nor did he consider ordering a non-stress test or biophysical profile for Patient A's baby at that time. (450).

27. Given Patient A's condition as reported on May 26, 1992, Patient A's baby was at risk for intrauterine growth retardation due to lack of proper nutrition, and/or hypoxia. (42).

28. On May 26, 1992 Patient A's baby should have been evaluated by a non-stress test and possibly a biophysical profile. Respondent did not order these evaluations on May 26, 1992. (42-43).

29. Respondent's failure to order a non-stress test and biophysical profile for Patient A's baby was a gross deviation from accepted standards of medical care as Respondent had no means to assess the status of the baby. (43).

30. Dr. Dolkart acknowledged that the vast majority of obstetricians would have evaluated Patient A's fetus on May 26, 1992 to determine fetal viability. (737-738).

31. Respondent's progress note for May 26, 1992 in his office chart provides as follows: "blood pressure increased, protein in urine, 1+ edema, no work, rest on left side, recheck on 5/29, call if headaches, upper epigastric pain occurs". There is no entry in the chart that indicates Respondent thought hospitalization was necessary. (44; Pet. Ex.#4, P.3).

32. It is not appropriate to advise a preeclamptic patient to wait until she suffers a headache before seeking

medical attention, as not all patients who suffer convulsions or cranial hemorrhages complain of headaches. Moreover, in those patients who do complain of a headache prior to a convulsion or cranial hemorrhage, it cannot be predicted how soon after the onset of the headache the cerebral accident will occur and thus whether medical attention can be timely obtained. (46,717).

33. Respondent's instructions to Patient A on May 26, 1992, of no work, rest on left side, and to call if headaches or epigastric pain occur, were not sufficient in view of accepted standards of medical care. (46-47).

34. By instructing the patient to wait until she had headaches or epigastric pain before seeking medical advice, Respondent exposed Patient A to the risk of developing a seizure, resulting in her death and/or her baby's death (47; Pet. Ex. #4, p. 3).

35. Patient A arrived at the Arnot Ogden Hospital Emergency Room on May 27, 1992, at approximately 6:30 p.m. with complaints of epigastric and right upper quadrant pain. On arrival at the emergency room, Patient A's blood pressure was 230/114 and her proteinuria was measured at 4+. These symptoms would indicate that Patient A was severely preeclamptic and that her condition had grown markedly worse. (47-48; Pet. Ex. #5, pp. 12-13).

36. Patient A died on May 29, 1992 of a intracranial hemorrhage suffered on May 27, 1992. (49; Pet. Ex. #5, p.32).

37. An intracranial hemorrhage is a risk of preeclampsia from the perspective that a markedly elevated blood

pressure can cause a rupture of a blood vessel in the brain. (49).

38. Patient A's baby was delivered by Cesarean section on May 27, 1992. The baby was born at 36 weeks gestational age, and weighed 3 lbs. 11 oz. at birth. A birth weight of 3 lbs. 11 oz. for a baby born at 36 weeks gestational age indicates severe growth retardation. (51-52, 82-83; Pet. Ex. #6, p.5).

39. The fact that the baby was discharged from the hospital at approximately two weeks after birth and in reasonably good health does not excuse the failure to evaluate the fetus on May 26, 1992, by non-stress test and biophysical profile, because Respondent had no information as to the baby's status and level of compromise, if any. (52-53).

40. If on May 26, 1992, Respondent advised Patient A to go to the hospital, but she refused, a prudent physician would have documented in the medical record the physician's instruction and the patient's refusal. The refusal would be documented so that others reviewing the record could determine what had been discussed between the patient and physician. (53-54).

41. A reasonably prudent physician would tell a patient in the condition Patient A presented with on May 26, 1992 that her condition might become worse and lead to seizures, and irreversible damage to her kidneys and other organs, which could cause her death. A prudent physician would also tell a patient in such a condition that she was risking the health and life of her baby since there would be no way of monitoring the baby's status from home. (54-55).

42. Respondent's office records do not contain any instruction to Patient A to go to the hospital on May 26, 1992, nor do they indicate that Patient A refused such an instruction, notwithstanding the fact that Respondent testified that he believed that Patient A was acting against medical advice in allegedly refusing an instruction to go to the hospital. (55, 460-461; Pet. Ex. #4, p.3).

43. Respondent testified that Patient A was acting against medical advice in not going to the hospital on May 26, 1992. However, on June 24, 1992 Respondent told a Quality Assurance Committee of the Arnot Ogden Hospital, which was reviewing Respondent's care of Patient A, that Patient A had been a compliant patient. (469).

44. In his testimony in this proceeding, Respondent offered no reason why Patient A did not want to go to the hospital on May 26, 1992, other than that Patient A supposedly did not want to go to the hospital or wanted to try resting at home. (448).

45. The history page of Patient A's hospital chart was dictated by Respondent on May 28, 1992, at which time Respondent knew Patient A's prognosis to be poor and that she was not expected to survive. However, in documenting his instructions of May 26, 1992 to Patient A, Respondent made no reference to the alleged instruction to Patient A to go to the hospital or Patient A's alleged refusal. (462-464; Pet. Ex. #5, p.9).

46. The discharge summary contained in Patient A's

hospital chart was dictated by Respondent after Patient A had died. However, Respondent made no reference in that summary to an instruction to Patient A on May 26, 1992, to go to the hospital or any alleged refusal by Patient A of such an instruction, while the note otherwise repeats in full the instructions contained in Respondent's office note for May 26, 1992. (464-465; Pet. Ex. #5, p.46).

47. A reasonably prudent physician would have documented in the admission note and discharge summary of Patient A's hospital chart any instruction given to Patient A on May 26, 1992 to go to the hospital and/or Patient A's refusal of such an instruction. (56).

48. Respondent did not tell the Quality Assurance Committee that Patient A had refused an instruction to go to the hospital on May 26, 1992. (469-470, 717-722; Pet. Ex. #26).

49. Respondent told the Quality Assurance Committee that he was going to change his practices and would institute a more aggressive in-house (hospital) evaluation of patients in a condition similar to that of Patient A. (470).

50. On June 24, 1992, Dr. Lawrence Dolkart reviewed Respondent's prenatal care of Patient A on behalf of the Arnot Ogden Hospital. At that time, it was his opinion that had Patient A been hospitalized by Respondent on May 26, 1992, the cerebral bleed might have been prevented. (717-722; Pet. Ex. #26).

51. Had Patient A been admitted to the hospital on May 26, 1992, her condition could have been observed at that time and

treated. (64-65).

52. The anti-hypertensive medication Patient A was given on May 27, 1992, could have been given on May 26, 1992 had she been admitted at that time. (65).

53. If an infant suffers intrauterine growth retardation during early gestation, there is a potential for impairment of brain function. (68).

54. A mother's impairment due to preeclampsia often precedes the patient's demonstration of hypertensive changes, and therefore an infant with a birth weight of 3 lbs. 11 oz. may have sustained impairment to its circulation long before the mother actually exhibited hypertension. (68-69).

55. A patient with mild preeclampsia, with blood pressures in the range of 120/80 to 140/90 with no significant proteinuria or edema, can be managed at home with appropriate diagnostic studies ordered and non stress testing conducted in either the office or the hospital. However, only under very select circumstances could a patient be monitored in such a manner from home. (80-81).

Patient B

56. Patient B was a 32-year old obstetrical patient when she first saw Respondent on January 14, 1993. At the time of her first office visit, Patient B's blood pressure was 110/60 and she was approximately 17 weeks pregnant. (91; Pet. Ex. #7, pp. 2-3).

57. Patient B stopped working in late April 1993, because she could not stand on her feet, due to swelling and

associated pain. (347).

58. At the time of her office visit on July 20, 1993, Patient B was approximately 33 weeks pregnant and had a blood pressure of 150/98 and 2+ proteinuria. These findings indicate that Patient B had developed preeclampsia. (91-92, 529, 739; Pet. Ex. #7, p. 3).

59. Given Patient B's condition on July 20, 1993, she should have been admitted to the hospital and laboratory studies should have been ordered to assess her kidney function, liver function, coagulation system. Antepartum testing, such as a non-stress test and biophysical profile, should have been ordered to assess the status of Patient B's fetus. (92-93).

60. Given Patient B's condition on July 20, 1993, she was at risk of sustaining damage to her kidneys, liver, coagulation system, and the progression of her preeclampsia to eclampsia with the attendant risk of seizures. There was a further risk to the baby that the blood circulation to the placenta was decreased, raising the threat of hypoxia. (93).

61. Respondent's records for July 20, 1993 do not contain any orders for the described laboratory studies. (93, 554; Pet. Ex. #7, p.3).

62. Respondent's failure to order the described laboratory studies on July 20, 1993 was not consistent with accepted standards of medical care. (93).

63. Respondent admitted that he did not know why he did not hospitalize Patient B on July 20, 1993. (531-532).

64. According to Respondent's expert, Patient B should

have been reassessed by Respondent later that same day, or the following day. (740).

65. However, Patient B's was not reassessed until two weeks later on August 3, 1993, when she was approximately 35 1/2 weeks pregnant. This was too long an interval between evaluations given her condition on July 20, 1992. At the August 3, 1992 visit, Patient B's blood pressure was 150/110 and she had 3+ protein in her urine. This indicated that her preeclamptic condition had worsened, and that she required hospitalization and possibly delivery. (94, 536-537, 740-742; Pet. Ex. #7, p. 3).

66. The health risks to mother and fetus which existed at the time of the July 20, 1993 visit, were increased at the time of August 3, 1993 visit. (94-95, 743-744).

67. Given Patient B's condition on August 3, 1993, Patient B should have been immediately admitted to the hospital, closely monitored for her blood pressure, had urine and blood studies, and the baby should have been evaluated by non-stress test and biophysical profile. (95, 742-743).

68. Respondent's records do not indicate any order by Respondent for Patient B's admission to the hospital on August 3, 1993 or orders for the described laboratory studies. (96).

69. Respondent's failure to order Patient B's hospitalization on August 3, 1993 and to order the described laboratory studies was a gross deviation from accepted standards of medical care. (96-97).

70. Respondent's instructions to Patient B on August 3, 1993, as reflected in the office note for that date were to

rest, restrict activities and to be rechecked on August 5, 1993. (97; Pet. Ex. #7, p. 3).

71. Given Patient B's condition on August 3, 1993, Respondent's instructions to Patient B were not in accordance with accepted standards of medical care. Patient B had been observed for two weeks after the July 20th visit, and by August 3, 1993 had demonstrated that her condition was not stable. (97-98).

72. Respondent admits that Patient B should have been admitted to the hospital on August 3, 1993, but was not. (532-536).

73. Respondent admits that laboratory studies should have been ordered for Patient B and Patient B's fetus on August 3, 1993, but does not recall why such studies were not done. (539, 541-542).

74. The fact that the patient was hospitalized on August 5, 1993 and the described diagnostic studies were performed at that time, would not change the fact that she required hospitalization and evaluation on August 3, 1993. Patient B's health was placed at serious risk by the failure to hospitalize her earlier than August 5, 1993. (99).

75. Patient B's creatinine clearance on August 6, 1993 was measured at 63, which is significantly decreased, suggesting a considerable degree of impairment to Patient B's kidney function. If kidney function becomes severely compromised, irreparable cell damage could result, and possibly kidney failure. A creatinine clearance level of 63 is a seriously low

level, as a normal value during pregnancy would be between 110 and 140 milliliters per minute. (100; Pet. Ex. #8, p. 49).

76. Given Patient B's condition on August 3, 1993 there was a concern that the baby may not be getting sufficient oxygen or nutrition and could be suffering some form of stress in the uterus. (101-102).

77. Generally accepted standards of medical care required a stress test or biophysical profile of Patient B's fetus on July 20, 1993, or at least by August 3, 1993. There were no orders for a non-stress test or biophysical profile of the baby on either July 20, 1993 or August 3, 1993. (102).

78. Respondent's failure to order a non-stress test or biophysical profile of Patient B's fetus on July 20, 1993 or August 3, 1993 was a gross deviation from generally accepted standards of medical care, due to the fact that Respondent did not have sufficient information concerning the status of the baby and thus exposed the baby to unnecessary risks. (102-103).

79. Patient B's baby was delivered by Cesarean section on August 7, 1993, at 36 week gestation and weighed at birth 3 lbs., 6 oz. The birth weight of 3 lbs., 6 oz. in an infant at that gestational age would indicate severe intrauterine growth retardation. There is a greater incidence of infant mortality in growth retarded infants. (103-104, 553-554, 748-749; Pet. Ex. #8, p. 34).

80. It is probable that Patient B's baby was growth retarded prior to July 20, 1993. (554).

81. Respondent's progress note for August 3, 1993 does

not reflect an intention to hospitalize the patient on that date. Respondent refers to the patient as totally asymptomatic, and apparently used that finding as a basis for recommending rest and restricted activities. (105-106).

82. Respondent had no definite recollection of whether he told Patient B to go to the hospital on either July 20, 1993, or August 3, 1993, or whether she refused to go to the hospital. (549-552).

83. Patient B testified without reservation that she had not been instructed to go to the hospital until August 5, 1993, when she was actually admitted, nor had she ever refused an instruction to be hospitalized. (349-351, 354).

84. If Patient B had refused an instruction on August 3, 1993 to be admitted to the hospital, a reasonably prudent obstetrician would have documented the refusal in a office note. There is no indication in Respondent's office note for Patient B that he instructed her to go to the hospital on August 3 or that Patient B had refused such an instruction. (108-109).

85. There is no reference in the history page of Patient B's hospital chart for August 5, 1993 that an instruction had been given to Patient B on August 3, 1993 to go to the hospital or that such an instruction had been refused. (109; Pet. Ex.#8, p.15).

Patient C

86. Patient C was 18 years old at the time of her first office visit with Respondent on November 12, 1992 for her first pregnancy. (118; Pet. Ex. #10, pp.2-3).

87. At an office visit on January 26, 1993, Patient C had a blood pressure of 160/92 and 2+ proteinuria. Dr. Dolkart testified that this indicated that she had preeclampsia. Respondent, however, did not consider Patient C to have preeclampsia at that time. (507-508, 750-752).

88. Patient C was admitted to the Arnot Ogden Hospital on February 5, 1993 after the hospital staff advised Respondent that Patient C had presented with a blood pressure of 150/100 and 2+ proteinuria during a non-stress test. (118, 505; Pet. Ex. #11, p.10).

89. During that admission, Patient C had certain diagnostic studies performed, including a 24-hour urine for total protein, creatinine clearance, and liver and kidney function studies. Patient C was released from the hospital on February 7, 1993. (119, 478, 506; Pet. Ex. #11, p. 23).

90. Following Patient C's discharge, she continued to present with elevated blood pressures during office visits with Respondent, recorded as high as 160/110 on March 16, and March 23, 1993. Respondent was concerned that Patient C was developing preeclampsia. It was Dr. Dolkart's opinion that Patient C had mild preeclampsia until March 16, 1993 when her office blood pressure elevated to 160/110, indicating a more severe condition. (480, 755-758; Pet. Ex. #10, p. 3).

91. However, Respondent considered the blood pressures recorded at his office to be less valid than blood pressures recorded during Patient C's bi-weekly (and subsequently weekly) non-stress tests which tended to be lower and which were recorded

after the patient had been lying on her left side for at least 30 minutes. (509-510; Pet. Ex. #10, p.3).

92. The fact that a hypertensive obstetrical patient does not exhibit proteinuria does not preclude the existence of preeclampsia. However, there are no recorded tests for proteinuria by Respondent during office visits on March 9 and 23, 1993. Dr. Dolkart acknowledged that these tests should have been performed given the patient's hypertensive condition. (752-753, 761-762, 777).

93. The fact that Patient C's blood pressure was lower during non-stress testing, would indicate that rest was an appropriate treatment for Patient C in terms of management. When the patient was not at rest her blood pressure, as indicated in the office prenatal record, were 160/110. (138-139).

94. A reasonably prudent obstetrician would not discount blood pressures of 160/110 despite the fact that there were fluctuations in the patient's blood pressure. (161).

95. During Patient C's March 16, 1993 office visit, Patient C's blood pressure was 160/110. A blood pressure of 160/110 indicates that Patient C was experiencing vascular spasm, and her that her liver and coagulation system may have been compromised. (119-120; Pet. Ex. #10, p.3).

96. On March 16, 1993, Patient C was at risk of developing a seizure, and her baby's life may have been at risk. Consideration should have been given to delivering the baby on March 16, 1993. (120).

97. Generally accepted standards of medical care

required evaluation of Patient C's renal, kidney and coagulation systems on March 16, 1993. However, there were no orders written by Respondent to conduct any such studies. (120-121).

98. Respondent's failure to order laboratory studies of Patient C on March 16, 1993 was not consistent with accepted standards of medical care, as the patient was exposed to potentially serious damage to her organs, including her kidney and liver. (121).

99. Respondent considered Patient C's elevated blood pressures after April 7, 1993, to be evidence of pregnancy induced hypertension, rather than preeclampsia. However, Respondent also recognized that patients with pregnancy induced hypertension are at risk to suffer cerebrovascular accident and may require evaluation by laboratory studies, including liver and kidney function studies, coagulation studies and platelet counts. (508-509).

100. If Respondent believed that there was a cause other than preeclampsia for the patients hypertension, he should have evaluated the patient to determine what the cause was. (136-137).

101. Respondent's failure to order diagnostic testing of Patient C on March 16, 1993, was a gross deviation from accepted standards of care. (122).

102. The evaluation conducted on Patient C during the hospitalization of February 5, 1993 would not be reliable in assessing her condition on March 16, 1993, as Patient C's condition could have changed in the interim. (122).

103. Patient C underwent a non-stress test on March 29, 1993. The report of that non-stress test documents the administration of Prostin gel, which had been requested by Respondent. The report further notes that the patient was discharged after the administration of the Prostin gel with instructions to return the following day for the induction of labor. (123-124, 484; Pet. Ex.#11, p.84).

104. Prostin gel prepares the cervix for the induction of labor and can induce uterine contractions even after the patient is discharged from the labor room. (123, 514-515, 775).

105. Patient C's blood pressure on office visits on March 16 and March 23, 1993 was 160/110 indicating that the patient had preeclampsia, or at least severe hypertension. Respondent could not have known as of the time of the administration of Prostin gel to Patient C, how the baby would tolerate any form of uterine contraction. The fetus might already have been compromised by the mother's hypertensive condition and might further be stressed by the contractions, which could cause further restriction of the blood circulation to the placenta. (124, 515, 775; Pet. Ex. #10, p.3).

106. It was appropriate to administer Prostin gel to Patient C on March 29, 1993. However, Patient C should have been admitted to the hospital and the baby monitored following the administration of the Prostin gel, to determine the fetus' reaction to any uterine contractions which may have developed following the administration of the gel. (125).

107. The fact that Patient C's baby was having non-

stress tests would not be sufficient to determine whether the baby would be compromised by contractions stimulated by the insertion of Prostin gel. There were no contraction non-stress tests performed on the baby which would apprise the obstetrician of fetal viability during the stress of labor. (149-150).

108. The Prostin gel was actually administered to Patient C by Dr. Surosky. On the same day that the Prostin gel was administered to Patient C, Respondent signed a non-stress report noting that fact and that Patient C had been discharged from the hospital to return the next day for induction of labor. (125-126; Pet. Ex. #11 pp.84-87).

109. Prior to the administration of Prostin gel on March 29, 1993, Dr. Surosky had not treated Patient C since January 28, 1993 and would not have been as familiar as Respondent with the patient's condition. (514).

110. Upon learning that Patient C had been discharged from the hospital following the administration of Prostin gel on March 29, 1993, a reasonably prudent obstetrician would have called Patient C and advised her to go to the hospital for admission. (126-127).

111. There is no order by Respondent to admit Patient C on March 29, 1993. (127).

112. Respondent's failure to order Patient C's admission after the administration of Prostin gel on March 29, 1993, was not consistent with accepted standards of medical care. (127).

113. On March 29, 1993, Respondent was aware that

Prostin gel had been administered to Patient C and that she had been discharged from the hospital. (T.516-517 [Respondent]).

114. The fact that the hospital protocol permitted the discharge of a patient following the administration of Prostin gel, would not preclude a physician from ordering the patient admitted if the physician believed it in the patient's medical interest to do so. (160, 516).

115. On March 30, 1993, the labor record for Patient C's hospital chart notes that as of 12:00 noon the patient was having contractions every 2 to 3 1/2 minutes, indicating a developing labor pattern. Between 12:00 noon and 1:25 p.m., Patient C had recorded blood pressures of 170/100, 160/96 and 150/100. (127-128; Pet. Ex. #11, pp.117-118).

116. Such blood pressures in a preeclamptic patient, should be of concern to an obstetrician as the patient could develop eclampsia seizures during the course of the labor. An obstetrician would not be able to predict at the time these elevated blood pressures were recorded whether the pressures would further elevate or not (128-130, 518, 773-775).

117. As an obstetrician could not know at the onset of labor whether or not the patient's hypertensive disorder would be aggravated, good medical practice dictates that the patient be covered with magnesium sulfate in order to prevent the development of eclampsia. The obstetrician may be over-treating, but it is appropriate to do so in order to prevent seizures. (153-154).

118. If magnesium sulfate is used appropriately, it

presents only minimal risks to the fetus. Moreover, any reaction that the fetus does have to the magnesium sulfate can be reversed with calcium. (154, 784).

119. Respondent should have administered magnesium sulfate to Patient C to prevent the development of seizures. (153, 162).

120. Respondent testified that he did not order magnesium sulfate for Patient C because she did not demonstrate any signs of hyper-reflexivity. (488-490).

121. However, as Respondent acknowledged, the presence of hyper-reflexia is not a prerequisite for the administration of magnesium sulfate to an hypertensive patient. (517).

122. The fact that Patient C's blood pressure moderated subsequently would not have obviated the necessity of administering magnesium sulfate, as Respondent could not know during that time period if the patient's condition was going to improve or further deteriorate. (130-131).

123. Patient C's labor was induced on March 30, 1993, in part because she was hypertensive. (518).

124. Patient C's baby was delivered at approximately 10:40 p.m. on March 30, 1993. (131; Pet. Ex. #11, p.130).

125. Patient C's blood pressures remained elevated to some degree on the first postpartum day, March 31, 1993. (132; Pet. Ex. #11, pp.132-133).

126. Preeclampsia is not a condition that is alleviated immediately following delivery, and a mother is still at risk for developing eclampsia during the first 24 to 48 hours following

birth. Patient C's blood pressures on April 1, 1993, the second day following delivery, were recorded as high as 130/96 and 132/100. According to Respondent, these diastolic pressures were of concern to him. However, Respondent discharged Patient C from the hospital at approximately 12:30 p.m. on April 1, 1993. (132-133, 519, 772; Pet. Ex. #11, pp.136-137).

127. Dr. Dolkart testified that it was appropriate to discharge Patient C from the hospital on April 1, 1993. (767).

Patient D

128. Patient D was a 22-year old obstetrical patient who registered with Respondent for her first pregnancy on January 28, 1991, when she was approximately 10 weeks pregnant. (172; Pet. Ex. #12, pp.2-3).

129. Patient D was 33 1/2 weeks pregnant at the time of her office visit on July 23, 1991 (Ex.12, p.3). On that date, Patient D's blood pressure was 160/90 and she had 2+ proteinuria with edema (172-173; Pet. Ex. #12, p.3).

130. Given Patient D's symptoms of hypertension, proteinuria and edema on July 23, 1991, Respondent should have diagnosed preeclampsia. In addition, the potential risks of compromise to her kidneys, liver, coagulations system, as well as potential risks of compromise to Patient D's fetus should have been recognized and appreciated. (173).

131. Given Patient D's condition on July 23, 1991, she required evaluation of her kidney and liver function and coagulation system. Patient D's baby should have been evaluated by non-stress test and possibly biophysical profile. (173-174).

132. The evaluation of both Patient D's and Patient's baby should have been undertaken on July 23, 1991 following hospitalization. (174).

133. If Respondent did not want to hospitalize the patient on July 23, 1991, then he should have ordered blood drawn for liver and kidney function studies. The patient should also have been instructed to begin a 24-hour urine collection the following day for creatinine clearance and total protein to assess her kidneys. A non-stress test should of been conducted at the hospital on an out-patient basis. (174-175).

134. Respondent did not order the evaluation of either Patient D or Patient D's fetus on July 23, 1991. (175).

135. Respondent's failure to order the evaluation of Patient D or her fetus on July 23, 1991 was not consistent with accepted standards of medical care. (175).

136. It was not Respondent's practice in 1991 to hospitalize patients upon their first presentation with preeclampsia and order diagnostic studies of the mother and fetus. It was Respondent's practice at that time to follow such patients at home to see if they remained stable. (425-426, 434-435).

137. Respondent told Patient D upon discharging her on July 23, 1991 to watch out for signs of worsening preeclampsia; but Respondent admits that the patient would be unable to detect such signs of preeclampsia as elevations in blood pressure. (442).

138. Respondent admits that Patient D's 2+ proteinuria

on July 23, 1991 should have been evaluated by creatinine clearance studies. (442).

139. Respondent testified that after treating Patient D he changed his management of preeclamptic patients and became more aggressive in having such patients evaluated. (435).

140. At the time of Patient D's office visit on July 25, 1991, she was more severely preeclamptic, exhibiting a blood pressure of 160/110 and 4+ proteinuria. (176, 428).

141. Patient D's baby was delivered on July 30, 1991. Patient D's blood pressures on August 1, 1991, were elevated, but lower than the preceding days. (180-181; Pet. Ex. #14, pp.109-110).

142. Given Patient D's condition, generally accepted standards of medical care required further evaluation by the obstetrician relative to Patient D's blood pressure and the necessity of further treatment. (181-182). An obstetrician could not predict whether Patient D's blood pressure would not go higher (197-198). However, Dr. Dolkart testified that it was not necessary to refer the patient to an internist for evaluation of her blood pressure. (181-182, 197-198, 796-798).

Patient E

143. Patient E was an 18-year old obstetrical patient of Respondent, who first registered for her pregnancy on February 23, 1993, at which time she was approximately 21 weeks pregnant (202; Pet. Ex. #15, p.3).

144. Patient E had a first ultrasound performed on March 25, 1993, which reported a fetal age of approximately 20

weeks. (203-204).

145. Patient E had a second ultrasound performed on May 24, 1993 to assess fetal growth. (207, 556).

146. The ultrasound report for the study conducted May 24, 1993 indicated, among other things, that the fetus' abdominal circumference was lagging behind the other anatomical measurements for fetal age, suggesting a possible early intrauterine growth retardation (IUGR). Dr. Tatelbaum testified that follow-up ultrasound studies may be helpful to further evaluate the status of the fetus in such circumstances. (208; Pet. Ex. #15).

147. Dr. Dolkart testified that although it might be helpful to order a follow-up ultrasound, generally accepted standards of practice do not require that one be ordered under the circumstances presented by this case. (810-811).

Patient F

148. Patient F was a 55-year old gynecology patient who first saw Respondent on February 15, 1990 complaining of hot flashes. (222; Pet. Ex. #17 p.1).

149. Hot flashes are a symptom of vascular instability in patients due to a deficiency in their production of estrogen. (222).

150. Hot flashes often make the patient feel very uncomfortable, causing sleeplessness, fatigue and irritability. (222).

151. Respondent's office note of February 15, 1990 indicates that he prescribed Premarin .625 milligrams and Provera

2.5 milligrams to be taken on a daily basis. (233; Pet. Ex. #17, p.1).

152. Premarin is an estrogen tablet used to replace the estrogen that the patient's ovaries no longer satisfactorily produce and to treat and relieve the symptoms of hot flashes. (223).

153. Provera is a synthetic progesterone tablet. Progesterone is a hormone produced in the ovaries during ovulation. It balances the effects of estrogen by protecting the lining of the uterus from over-stimulation. (223-224).

154. If estrogen is used alone, and not in combination with progesterone, the estrogen may over-stimulate the lining of the uterus, making the lining thicker and more glandular. This predisposes the patient to atypical cell formation in the lining, including cancer. (224).

155. The progesterone counteracts the estrogen and decreases or eliminates the likelihood of over-stimulation of the uterine lining by the estrogen. (224).

156. After starting a hormonal replacement therapy of daily estrogen and progesterone, Patient F complained of vaginal bleeding on March 1, March 8, and March 16, 1990. (224).

157. From March 19,1990 until June 19, 1990, the patient was prescribed Premarin, without any order for Provera or any other progesterone. On June 19, 1990, Patient F was again prescribed estrogen in combination with progesterone. However, during the period from June 25, 1990 through April 19, 1991, Patient F experienced periodic bleeding. She underwent a D & C

(dilation and curettage) on April 19, 1991. (226-227, 230-231; Pet. Ex. #18, p.102).

158. The use of unopposed estrogen for the three month period from March to June, 1990, posed the risk of a build-up of tissue and the development of hyperplasia in the uterine lining. (227).

159. On January 3, 1991, the patient again complained of severe hot flashes and Respondent prescribed Estraderm patches, .05 milligram. (228; Pet. Ex. #17, p.2).

160. The Estraderm Patch is placed on the patient's skin and estrogen is released from the patch and absorbed through the skin to provide estrogen replacement. An Estraderm Patch does not have a progesterone component. The Estraderm Patch was reordered by Respondent for Patient F on February 4, 1991, March 18, 1991, and March 25, 1991 Respondent did not order progesterone for Patient F during period from January 3, 1991 through March 25, 1991. (228-229; Pet. Ex. #17, pp. 2-3).

161. During the period from January 3, 1991 through March 25, 1991, during which the patient was using unopposed estrogen, there existed a risk of over-stimulation of the uterine lining and the development of hyperplasia, atypical changes of hyperplasia or cancer formation. (227, 229).

162. Respondent's treatment of Patient F with unopposed estrogen during the periods, March 19, 1990 through June 19, 1990, and from January 3, 1991 through March 25, 1991, was not consistent with generally accepted standards of medical care as it exposed Patient F to an unnecessary risk of developing an

abnormality of the uterus. (229).

163. Respondent maintained that on March 19, 1990 and on January 3, 1990, he intentionally placed Patient F on unopposed estrogen for a three month period after which he intended to withdraw her on progesterone. While Respondent did give Patient F progesterone in June, 1990, he testified that he forgot to give her progesterone after three months of treatment on the Estraderm Patch from January to March, 1991. (583-584, 590-591).

164. Patient F had periodic bleeding from June, 1990 to January, 1991, after being treated with unopposed estrogen from March 19, 1990 to June 19, 1990. (230-231; Pet. Ex. #18, p.102).

165. The bleeding following the use of unopposed estrogen required evaluation by uterine sampling, which should of been performed sometime during the period from July to September of 1990. (231).

166. There are no orders for a uterine sampling procedure during that time period. Respondent's failure to evaluate Patient F's uterine bleeding by such a sampling procedure or other means was not consistent with accepted standards of medical care. (232).

167. The D & C which Patient F underwent on April 19,1991, was not timely as an evaluation of the periodic bleeding which Patient F had after June, 1990. (232).

168. A reasonably prudent gynecologist would have evaluated Patient F's unexplained bleeding prior to April 19, 1991, to ensure that the patient was not developing an

abnormality of the uterus. (232).

169. The indication for the D & C procedure performed on April 19, 1991, as set forth in the history Respondent wrote prior to the procedure, was to rule out an adenocarcinoma of the endometrium as a consequence of the patient's continued bleeding on hormone replacement therapy. (Pet. Ex. #18).

170. Respondent was concerned that Patient F was developing hyperplasia in April, 1991, after having been on unopposed estrogen for three months and having experienced some bleeding, and therefore, performed a diagnostic D & C. However, Respondent states he did not consider such an evaluation necessary in 1990, even after Patient F experienced bleeding following a three month course of unopposed estrogen from April to June, 1990. (591-592, 602-603).

171. Respondent maintains that he did not evaluate Patient F's uterus in July or August of 1990, in part, because an ultrasound performed in August of 1990 did not reveal hyperplasia. However, Respondent admitted that the ultrasound report did not refer to the endometrium. (588, 607).

172. Moreover, Respondent testified that if Patient F had "any episode of bleeding" after he discontinued all hormone therapy from July, 1990 to January, 1991, he would have certainly considered a D & C to evaluate the uterus at that time. He maintained that Patient F had no bleeding during this period. However, this is contradicted by the history Respondent wrote for Patient F's D & C in April of 1991, where Respondent reported "[Patient F] has been bleeding on and off for the past nine

months". This would include the period from July 1990, to January, 1991 [588; Pet. Ex. #18, p.102].

173. The fact that the D & C did not reveal any hyperplasia did not obviate the need for an evaluation of the endometrium during the period from July through September of 1990, as a gynecologist would not know until the sampling procedure was done whether a hyperplasia existed. (232-233).

174. Patient F underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy on June 13 1991. (233; Pet. Ex. #18 p.4).

175. Patient F was still having bleeding at the time of the hysterectomy. This may have been a consequence of the use of unopposed estrogen or the presence of a fibroid. (233-234).

176. An alternative to the hysterectomy would have to been to attempt a different regimen of hormone replacement. (234).

177. The patient had not done well on the daily combination of estrogen and progesterone, nor did she do well on the estrogen therapy alone. An alternative form of hormonal replacement therapy would have been to give Patient F estrogen for the first 25 days of every month and progesterone from the 16th to the 25th day of every month. One could then evaluate the patient to see if that produced normal withdrawal bleeding. (234-235, 249).

178. There were no instructions by Respondent to Patient F to use estrogen for the first 25 days for each month and for the use of progesterone from the 16th to the 25th day.

(236).

179. The failure to attempt Patient F on a hormonal replacement therapy providing for the use of estrogen for the first 25 days of the month and progesterone from the 16th to the 25th day was not consistent with accepted standards of medical care. (236).

180. In the summer of 1990, it was uncertain as to whether the patient's bleeding was caused by the fibroid, or the unopposed estrogen therapy Patient F was receiving. (243-244).

181. As the cause of the bleeding was unknown, a uterine sampling should have been taken in during July or August of 1990 to evaluate the cause of the bleeding. The D & C which Patient F underwent in October 1989 was unrelated to the estrogen replacement therapy Respondent prescribed. (243-244.

182. Given that Patient F had unexplained bleeding in the summer of 1990, it cannot be presumed that she had a normal uterine lining, despite the fact she had a negative D & C in October of 1989, as in the interim she was taking unopposed estrogen. (247-248).

Patient G

183. Patient G was a 40-year old gynecology patient of Respondent who was seen on April 23, 1992 with complaints of heavy menstrual periods over the preceding 6 to 8 months. Respondent diagnosed menorrhagia, which is heavy bleeding at the time of the patient's period. Respondent performed a D & C on May 29, 1992 to evaluate this condition (258-259, 608; Pet. Ex. #19, p.1; Pet. Ex. #20, p.2).

184. Respondent's office notes include a history completed and dated by the patient on May 26, 1992, three days prior to the D & C. (259; Pet. Ex. #19).

185. The May 26, 1992 history form indicates in paragraphs II and X that the patient has mitral valve prolapse. (259; Pet. Ex. #19).

186. The mitral valve is a heart valve. Mitral valve prolapse describes an anatomical change in the mitral valve anatomy, resulting in a deviation in the location of the valve from normal valve placement. (259).

187. A history of mitral valve prolapse could be of concern to a gynecologist who has scheduled a patient for a D & C as bacteria present during the D & C procedure could, during the course of the procedure, enter the blood circulation. The bacteria would be carried to the mitral valve where, due to the defect, an inflammation or infection could develop. (259-260).

188. To reduce the potential likelihood of bacteria entering the blood stream, a patient with a history of mitral valve prolapse could be treated with a prophylactic antibiotic. The antibiotic would be administered an hour before performing the procedure, so that the presence of any bacteria due to the manipulation of the system during surgery would be killed by the antibiotic. (260-261).

189. Dr. Tatelbaum acknowledged that there is no uniformity of opinion as to whether or not prophylactic antibiotics must be given when there is a diagnosis of mitral valve prolapse. (281-282).

190. Respondent performed a vaginal hysterectomy on Patient G on July 23, 1992. Respondent appropriately ordered a prophylactic antibiotic for Patient G to be given one hour prior to the hysterectomy. (263; Pet. Ex. #20, p. 4).

191. Perioperative antibiotic usage as a prophylactic is a short term course, generally not to be used beyond the first 24 hours post surgery in the absence of evidence of an infection. The use of antibiotics beyond the first 24 hours after surgery for a patient not exhibiting symptoms of infection could pose the risk of the patient developing antibiotic resistance to the particular drug or the development of a drug reaction. (264-265, 615-616).

Patient H

192. Respondent was married to Patient H on June 15, 1968. (367).

193. Patient H was initially seen by Dr. Daniel Fisher in November of 1981, with complaints of weight gain, sciatica, thrombophlebitis, foot bunions and ulcers. (287).

194. Patient H saw Dr. Fisher in June of 1984 complaining of her weight, and again in February of 1985 for a cold. (287-288).

195. Patient H saw Dr. Fisher again in April 6, 1990 complaining of stress in her life. (288).

196. Patient H saw Dr. Fisher on April 11, 1990 and at that time it was recorded in Dr. Fisher's medical record that the patient was overdosing on Synthroid, taking as many as 20 per day. (288-289).

197. Synthroid is a thyroid medication given for an underactive thyroid condition. Synthroid promotes normal cell function in the body. An acceptable dosage of Synthroid would be one tablet of 0.2 milligrams per day to achieve normal thyroid function. A history of Patient H taking up to 20 Synthroid tablets a day would indicate that the patient was significantly overdosing on the thyroid medication. (289-290).

198. In Dr. Fisher's note of April 11, 1990 there are instructions to Patient H to stop the use of Synthroid. Dr. Fisher's note of May 1, 1990 indicates that the patient had been off Synthroid for two weeks. (290).

199. Respondent began prescribing Synthroid to Patient H in 1988 and 1989, for weight control. No other physician had ever prescribed Synthroid for Patient H, and Respondent had not performed any thyroid studies either before prescribing the drug or while prescribing it. He presumed Patient H had a normal functioning thyroid when he began to prescribe the drug. (388-389, 409-410).

200. Appendix B of Exhibit 1 is a listing of the prescriptions which Dr. Rurak wrote for Patient H between May 3, 1990 and January 5, 1993. Respondent prescribed Synthroid for Patient H between August 9, 1990 and December 29, 1992. During that 872 day period, Respondent wrote 107 prescriptions for a total of 10,857 Synthroid tablets, or approximately 12.45 Synthroid tablets a day for Patient H. The prescriptions written by Respondent for Patient H for 0.2 milligrams of Synthroid, included instructions to take one tablet every day. (290-291;

Pet. Ex. #1, Appendix B).

201. Respondent's prescriptions of Synthroid for Patient H during the period from August 9, 1990 and December 29, 1992 were a gross deviation from accepted standards of medical care, as a patient taking such a quantity of the medication would in fact be overdosing on the drug. Respondent believed Patient H to have taken all the Synthroid prescribed for her. (291, 419).

202. Respondent was aware that Patient H was taking Synthroid for weight control and further realized that it was not appropriate to prescribe Synthroid for weight control. A person may attempt to inappropriately use Synthroid for weight control because the drug would increase the metabolic rate and cause the individual to burn up calories by having his or her cells overworked. The person's metabolism could be disrupted, resulting in illness. (292, 388-389, 410).

203. Respondent realized that Patient H was taking excessive amounts of Synthroid for an inappropriate reason yet continued to prescribe the drug to her in excessive amounts. (410,417-419).

204. In November of 1992 Patient H had a thyroid study which indicated that her thyroid level was so high that it was beyond the ability of the laboratory to measure. (293).

205. The result of the thyroid study indicates that Patient H was overdosing on Synthroid. Patients using Synthroid at the levels at which Respondent prescribed the drug for Patient H risk potentially fatal cardiac abnormalities. (293-294).

206. Respondent prescribed Tylenol with codeine No. 3

to Patient H during the period from May 3, 1990 to December 30, 1992. During that 972 day period, Respondent wrote 60 prescriptions for a total of 6,000 tablets of Tylenol with codeine No. 3. (294; Pet. Ex. #1, Appendix B).

207. The prescriptions Respondent wrote for Patient H for Tylenol with codeine No. 3 included the instructions that the Patient was to take one to two tablets every four hours as necessary (P.R.N.). (294-295; Pet. Ex. #1, Appendix B).

208. Respondent's prescribing of Tylenol with codeine No. 3 to Patient H during the period from May 3, 1990 to December 30, 1992 represented a deviation from generally accepted standards of medical care, as a patient who takes codeine over a long period of time could develop a dependence on the drug. (295-296).

209. A patient who is taking Tylenol with codeine No. 3 over an extended length of time, such as in the case of Patient H, requires continuing follow-up for assessment of the patient's condition. (295).

210. Respondent's contention that Patient H suffered from chronic pain due to thrombophlebitis, bunions and dental problems, which existed from the early 1970's, is not supported by the record. Between 1975 and 1979, when Respondent was practicing in West Virginia, Patient H did not see any physicians for her alleged chronic pain. In the ten years Patient H saw Dr. Daniel Fisher prior to 1990, thrombophlebitis is referred to only once, as part of a past medical history recorded on her initial visit, and there is no record of Dr. Fisher ever prescribing any

analgesic for Patient H. Respondent maintained that surgery was recommended for Patient H's bunions in the early 1980's; however, surgery to relieve the pain was not performed until 1990. Patient H stated that her busy schedule did not permit her to have the surgery before then. Patient H had no hospitalizations from 1980 to 1990, nor did she have any extended absences from work due to illness during that same time period. Patient H was involved in many social activities, at the same time she was working full time and raising her family. (371, 378, 380-381, 383, 401-403, 405-406, 624-625, 634-636, 651-652; Pet. Ex. #23, p.4).

211. Respondent did not consider Patient H's use of 6 to 8 Tylenol with codeine No.3 tablets a day, every day for 5 to 6 years, to be excessive. (415-416.

212. Patient H testified that the Tylenol with codeine possibly gave her "a high". (653).

213. Respondent did not refer Patient H to any pain clinics for control of her pain, even though he was aware of such clinics in Rochester. (416).

214. Patient H was treated for a three week period in Conifer Park in January, 1993, for drug rehabilitation in connection with her use of Synthroid and Tylenol with codeine. Patient H testified that she has not used Tylenol with codeine since her discharge from that program. (398-401, 649-650).

215. Respondent did not maintain any medical records regarding any prescription he wrote for Patient H because he did not consider her a patient, despite his prescribing of drugs for

her use. (387-388).

216. Generally accepted standards of medical care require that patients receiving drugs such as Synthroid and Tylenol with codeine No. 3 be evaluated by physical examination, which should be repeated during the course of treatment. (296-297).

217. A physical examination was indicated for the use of Synthroid to determine that there were no side effects due to the medication. (296).

218. A physical examination should be performed on a patient receiving Tylenol with Codeine No.3 in order to determine the underlying cause of pain and to provide treatment, with the ultimate goal of discontinuing the use of Tylenol with codeine. (296-297).

219. Respondent did not perform any physical examinations on Patient H at the time he wrote any of the prescriptions. (652-653).

220. Generally accepted standards of medical care require that a physician following a patient's treatment with Synthroid and Tylenol with codeine document in a medical record the patient's medical history, the physical examination, the laboratory parameters, and the medical indications for prescribing the drugs. The purpose of documenting these aspects of a patient's care is to provide the physician with a record from one visit to the next from which the physician could determine the progress of the patient, and what treatments had been attempted in the past. A medical record is also beneficial

to a subsequent treating physician. (297-298).

221. The standard of care requires the documentation of a medical history of the patient so as to create a record from which the progress of the patient could be evaluated. The history is also essential to making a diagnosis, as it is important in identifying the patient's medical problem. (298-299).

222. Respondent's failure to take or document a medical history, make a physical examination or record the medical indications for the prescriptions he wrote for Patient H, was a gross deviation from accepted standards of medical care. (299-300).

CONCLUSIONS OF LAW

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

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

Paragraph A: (2-55);

Paragraph A.1: (3-9, 12-14, 17-26, 31-34, 40-48);

Paragraph A.2: (7, 10-11, 15-16, 26-30);

Paragraph B: (56-85);

Paragraph B.1: (56-65, 82-83);

Paragraph B.2: (65, 67-75, 81-85);

Paragraph B.3: (65-69, 73, 76-79);

Paragraph C: (86-127);

Paragraph C.1: (86-92, 95-98, 101);

Paragraph C.2: (103-114);

Paragraph C.3: (115-122);

Paragraph D: (128-142);

Paragraph D.1: (128-138);

Paragraph D.2: (131-135);

Paragraph F: (148-182);

Paragraph F.1: (148-163);

Paragraph F.2: (164-173, 180-182);

Paragraph F.3: (177-179);

Paragraph H: (192-222);

Paragraph H.1: (200, 215);

Paragraph H.2: (215, 220-222);

Paragraph H.3: (215-220, 222);

Paragraph H.4: (215, 220, 222);

Paragraph H.5: (196-205);

Paragraph H.6: (193-195, 206-214).

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

Paragraph C.4: (125-127);

Paragraph D.3: (141-142);

Paragraph E: (143-147);

Paragraph G: (183-191);

Paragraph G.1: (183-189);

Paragraph G.2: (190-191).

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

First Specification: (Paragraphs A, A.1, A.2, B, B.2, B.3, C, C.1, C.3, H, H.1, H.2, H.3, H.4, H.5);

Second Specification: (Paragraphs A, A.1, A.2, B, B.2, B.3, C, C.1, C.3, H, H.1, H.2, H.3, H.4, H.5);

Third Specification: (Paragraphs A, A.1, A.2, B, B.1, B.2, B.3, C, C.1, C.2, C.3, D, D.1, D.2, D.3, F, F.1, F.2, F.3, H, H.1, H.2, H.3, H.4, H.5, H.6);

Fourth Specification: (Paragraphs A, A.1, A.2, B, B.1, B.2, B.3, C, C.1, C.2, C.3, D, D.1, D.2, D.3, F, F.1, F.2, F.3, H, H.1, H.2, H.3, H.4, H.5, H.6);

Fifth Specification: (Paragraphs H, H.1, H.2, H.3, H.4).

DISCUSSION

Respondent is charged with five specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock,

Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

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

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

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

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

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

The five specifications of misconduct alleged by the Department concerned Respondent's medical care and treatment of eight patients - five obstetrical patients, two gynecology patients, and Respondent's wife. Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that all five specifications of professional misconduct had been sustained, although the allegations regarding Patients E

and G were dismissed.

At the outset, the Hearing Committee assessed the credibility of the witnesses presented by both sides. Respondent testified on his own behalf, and also presented expert testimony by Lawrence A. Dolkart, M.D. Dr. Dolkart is board-certified in obstetrics and gynecology (OB/GYN), as well as board-certified in maternal fetal medicine. (*See*, Tr., pp. 683-684). However, the Committee took notice of the fact that Dr. Dolkart works closely with Respondent on a frequent basis. Some of the opinions offered by Dr. Dolkart were contradicted by the Department's expert, as well as by Respondent.

Respondent also testified on his own behalf. However, his testimony was clearly biased in his own favor, and directly contradicted by the patient records. Consequently, the Hearing Committee did not give his testimony much credence.

In contrast, the Department presented testimony by Robert C. Tatelbaum, M.D. Dr. Tatelbaum is board-certified in obstetrics and gynecology and has maintained a private practice in OB/GYN since 1971. (*See*, Tr., pp. 22-23). Dr. Tatelbaum testified in a direct and forthright manner. He has no demonstrated stake in the outcome of these proceedings, and no personal bias against Respondent was either alleged or proved.

Based on the foregoing, the Hearing Committee concluded that, with some exceptions, Dr. Tatelbaum was the most credible expert presented by the parties. Consequently, his testimony was given the greatest weight.

The Department also presented three fact witnesses -

John W. Choate, M.D., Patient B, and Patient A's husband. The Hearing Committee found all three to be credible witnesses, although their testimony was not crucial to the Committee's analysis of the evidence. The rationale for the Committee's conclusions regarding each patient is set forth below.

Preeclampsia

Respondent's management of the four cases of preeclampsia - Patient D in 1991, Patient A in 1992, and Patients B and C in 1993 - reveal a consistent pattern of delaying hospitalization and diagnostic evaluation of mother and fetus until a condition of preeclampsia is demonstrated over two or three office visits. The fallacy of this mode of treatment, as seen in the case of Patient A, is that preeclampsia can progress in a matter of hours to a life-threatening condition for both mother and fetus.

Respondent testified that after he failed to hospitalize and evaluate Patient D on July 20, 1991, when she presented with a blood pressure of 160/90 and 2+ proteinuria, he became more aggressive in his management of patients with preeclampsia. However, Respondent's care of Patients A, B and C demonstrates that he did not change his pattern of practice. Respondent did not hospitalize or evaluate Patient B or her fetus when she first exhibited preeclampsia on July 20, 1993, nor did he hospitalize her after her next visit, on August 3, 1993. At that time, the patient presented with a blood pressure of 150/110 and 3+ proteinuria. It was not until her third consecutive office visit with dangerously high proteinuria (3/4+), that