Respondent hospitalized the patient. Similarly, Patient C was not hospitalized or evaluated even after exhibiting dangerously high diastolic blood pressures of 110 on two consecutive office visits on March 16 and 23, 1993.

**Patient A**

The Hearing Committee concluded that Respondent never instructed Patient A to go to the hospital on May 26, 1992. Respondent did not hospitalize her after this visit because it was the first office visit in which she exhibited preeclampsia. Respondent's insistence that he instructed Patient A to go to the hospital is not supported by the record. He did not document his instructions, or the patient's refusal to go to the hospital, in the progress note for the office visit on May 26, 1992. Dr. Tatelbaum testified without contradiction from Dr. Dolkart that a reasonably prudent obstetrician would have documented a refusal of any such instruction. Moreover, common sense indicates that the refusal of such an instruction, in the face of a life-threatening condition, should be documented in some manner.

Respondent also failed to document Patient A's alleged refusal in the admission history and discharge summary in the hospital chart for her admission on May 27, 1992. In addition, Respondent's treatment of Patient A was the subject of review by the Arnot Ogden Hospital's Quality Assurance Committee in June, 1992. Respondent made no mention of any instructions for hospitalization and subsequent refusal by the patient. Indeed, he characterized Patient A as a compliant patient.

Respondent's testimony in this proceeding was the first

time he has ever suggested that Patient A had been instructed to go to the hospital and refused. Based upon the foregoing, the Hearing Committee concluded that the patient never received such an instruction from Respondent on May 26, 1992.

The Hearing Committee found Dr. Dolkart's testimony regarding Respondent's treatment of Patient A to be not credible. Dr. Dolkart testified that it was acceptable to follow the patient from home. He described Patient A as being only mildly preeclamptic when she presented with proteinuria of 3/4+ and blood pressure of 160/96. (*See*, Tr., pp. 690-691, 707-708, 733-736). However, in the hospital's Quality Assurance report on Patient A, Dr. Dolkart criticized Respondent for not hospitalizing the patient on May 26, 1992. These two divergent opinions are not reconcilable. Consequently, the Committee discounted Dr. Dolkart's testimony regarding this patient.

The Hearing Committee unanimously concluded that Respondent's conduct demonstrated an egregious failure to render the medical care that a reasonably prudent physician would have exercised. This conduct warranted a finding of gross negligence with respect to Patient A. Moreover, the Committee concluded that Respondent demonstrated an unmitigated lack of the skill necessary to safely practice the profession. Thus, a finding of gross incompetence was made, as well.

**Patient B**

Respondent's care of Patient B is even more startling than his care of Patient A, although fortunately the outcome was better. Patient B presented at Respondent's office on August 3,

1993 with a blood pressure of 150/110 and 3+ proteinuria. Moreover, this was the second consecutive visit on which the patient had exhibited symptoms of preeclampsia.

Respondent attempted to suggest that he must have recommended hospitalization to Patient B on August 3, 1993, but admitted that he had no clear recollection of doing so. However, Patient B directly testified that she had not been instructed to go to the hospital prior to August 5, 1993, nor had she ever refused an instruction to be admitted. (*See*, Tr., pp. 349-351, 354).

Respondent agreed with Dr. Tatelbaum that Patient B should have been hospitalized, and that she and the fetus should have been evaluated on July 20, 1993. However, he indicated that he could not explain why she was not hospitalized, nor why he waited two weeks to next evaluate the patient on August 3, 1993. Respondent speculated that the delay was possibly due to an error by his staff but offered no proof on this point. (*See*, Tr., pp. 529, 531-535, 549-550).

In addition, Respondent made no attempts to investigate why Patient B had preeclampsia during her third pregnancy, when the disorder is more prevalent in first pregnancies. He failed to elicit any information from the patient that the pregnancy was conceived with a new partner in a second marriage, a potentially important piece of information.

The Hearing Committee unanimously concluded that Respondent's conduct with regard to Patient B constituted both gross negligence and gross incompetence, as defined above.

**Patient C**

When Respondent saw Patient C at her January 26, 1993 office visit, her blood pressure was 160/92 and she had 2+ proteinuria. Respondent's expert acknowledged that the patient had preeclampsia at that time. Contrary to Dr. Dolkart's opinion, Respondent testified that he did not consider the patient to be preeclamptic, yet he ordered her to be re-evaluated in his office two days later. Consistent with his pattern of management of preeclampsia, Respondent stated that he did not consider Patient C to be preeclamptic on January 26, 1993 because this represented her first elevated blood pressure. (*See*, Tr., pp. 507-508).

Patient C was admitted to Arnot-Ogden Hospital on February 5, 1993, after recording a blood pressure of 150/100 and 2+ proteinuria during a non-stress test. Following a series of appropriate diagnostic studies, the patient was discharged on February 7, 1993. Respondent and the experts all agreed that Patient C's blood pressure, as measured in his office following her discharge, was markedly hypertensive. Dr. Dolkart and Dr. Tatelbaum both testified that the patient remained preeclamptic throughout the remainder of the pregnancy. Respondent characterized Patient C's condition after February 7, 1993 as pregnancy induced hypertension ("PIH"). This distinction is without practical significance, as even Respondent acknowledged that severe PIH can result in cerebrovascular accidents, and that evaluation of elevated blood pressures may be warranted.

On March 16, 1993, Patient C presented in Respondent's

office with a blood pressure of 160/110, without evidence of proteinuria. Dr. Tatelbaum testified that the patient should have been hospitalized for further evaluation at that time. According to Dr. Tatelbaum, the fact that the patient did not exhibit proteinuria suggested that her kidneys had not been affected. Nevertheless, evaluation was warranted to assure that her liver, heart and brain were not compromised.

Respondent maintained that hospitalization and evaluation were not required on March 16, 1993 because the patient demonstrated lower blood pressures when resting during non-stress tests. However, there are no documented orders of bed rest for Patient C following her discharge from the hospital on February 7, 1993, and thus no expectation that acceptable blood pressure levels were being maintained by the patient during the day.

All three physicians agreed that the March 29, 1993 administration of Prostin gel to ripen Patient C's cervix could stimulate contractions, aggravating her hypertension. Dr. Tatelbaum testified that in order to prevent compromise to the fetus, Patient C should have been admitted and the fetus monitored following insertion of the gel.

Respondent attempted to place the responsibility for the patient's discharge with Dr. Surosky, who inserted the gel at Respondent's request. However, Dr. Surosky had not seen the patient since January 28, 1993. Respondent was the patient's physician and should have been more familiar with her condition. Dr. Surosky was simply performing a professional curtesy, not

taking over the patient's care. Respondent erred in failing to admit the patient on March 29, following the insertion of Prostin gel.

While in labor on March 30, 1993, Patient C's blood pressures were significantly elevated. During the period from 12:00 noon to 1:25 p.m., pressures of 170/100, 160/96 and 150/100 were recorded. Dr. Tatelbaum testified that Respondent should have administered magnesium sulfate to prevent convulsions. Dr. Dolkart acknowledged that magnesium sulfate was effective in preventing convulsions and presented minimal risks to the mother or fetus when administered appropriately. Respondent further acknowledged that the majority of patients admitted to Arnot Ogden Hospital with PIH received magnesium sulfate during labor. Based on the foregoing, the Hearing Committee unanimously concluded that the failure to administer magnesium sulfate to Patient C was a gross deviation from accepted standards of medical practice.

Patient C delivered on March 30, 1993 and was discharged two days later on April 1, 1993. The last two blood pressures recorded prior to discharge were elevated, at 130/96 and 132/100, respectively. Dr. Tatelbaum testified that this indicated that the patient was unstable and still at risk for a possible seizure. He further testified that the patient should have been kept in the hospital another day to monitor her blood pressure. However, Dr. Dolkart testified that some patients' blood pressures do not return to the normal range for up to six weeks. Under the circumstances, the Hearing Committee concluded

that it was not error for Respondent to discharge the patient on April 1, 1993. As a result, the Hearing Committee did not sustain Factual Allegation C(4).

Based upon the foregoing, the Hearing Committee concluded that Respondent's failure to hospitalize and evaluate Patient C on March 16, 1993, and his failure to administer magnesium sulfate to her during labor demonstrated both gross negligence and gross incompetence. The Committee further concluded that Respondent's failure to admit Patient C following the administration of Prostin gel on March 29, 1993 constituted both negligence and incompetence.

**Patient D**

Patient D, a 22 year-old patient was 33 1/2 weeks pregnant at the time of her office visit on July 23, 1991. Her blood pressure was 160/90 and she had 2+ proteinuria and she had evidence of edema. Given Patient D's symptoms, Respondent should have diagnosed preeclampsia. The patient should have been admitted to the hospital for evaluation, including liver and kidney function studies. In addition, Patient D's fetus should have been evaluated by a non-stress test. In the event that the patient declined hospitalization, these studies could have been performed on an outpatient basis. Respondent, however, took none of these steps. He merely told the patient to watch out for signs of further problems, although he admitted that the patient would be unable to detect such signs of preeclampsia as elevations in blood pressure.

Patient D returned to Respondent's office on July 25,

1991. Her preeclampsia had worsened, with blood pressure of 160/110 and 4+ proteinuria. Ultimately, Patient D's baby was delivered on July 30, 1991.

Respondent conceded that he had not been aggressive enough in his management of Patient D by failing to recommend admission to the hospital for evaluation of herself and the fetus on July 23, 1991. According to Respondent, he became more aggressive in his management of preeclampsia following Patient D's case. However, as noted above, the record does not support this contention.

Patient D's post-partum blood pressures were elevated, but lower than the preceding days. The Hearing Committee concurred with Dr. Dolkart's opinion that a medical consultation regarding the patient's blood pressure was not necessary, and did not sustain Factual Allegation D(3). However, the Committee unanimously concluded that Respondent's failure to appropriately evaluate the patient and fetus on July 23, 1991, demonstrated both negligence and incompetence, as defined above.

**Ultrasound - Patient E**

Patient E was an 18 year-old obstetrical patient, who first registered for her pregnancy on February 23, 1993. She was approximately 21 weeks pregnant at that time. She had an ultrasound performed on March 25, 1993. The ultrasound report indicated a fetal age of approximately twenty weeks.

The patient had a second ultrasound performed on May 23, 1993 to assess fetal growth. The ultrasound report indicated, among other things, that the fetus' abdominal

circumference was lagging behind the other anatomical measurements for fetal age, suggesting possible early intrauterine growth retardation.

Dr. Tatelbaum testified that follow-up ultrasound studies may have been helpful in evaluating the status of the fetus. Dr. Dolkart testified that, although it might be helpful to order a follow-up ultrasound, it was not required in this case. The Hearing Committee found Dr. Dolkart's testimony persuasive on this issue and concluded that the charges regarding Patient E should be dismissed.

**Gynecology Issues - Patient F**

Respondent offered no independent expert testimony to rebut Dr. Tatelbaum's opinion that it was inappropriate to place Patient F on unopposed estrogen therapy from April 16, 1990 through June 19, 1990 and from January 3, 1991 through April 19, 1991, as it posed the risk of the development of hyperplasia and cancer.

Respondent's refutation of Dr. Tatelbaum's opinion that Patient F required diagnostic evaluation of the bleeding she experienced after completing the unopposed estrogen therapy in June, 1990 is contradictory. Respondent testified that after discontinuing the unopposed estrogen therapy in June, 1990, a regimen of estrogen and progesterone was instituted until all hormonal therapy was discontinued in July, 1990. Thereafter, Patient F experienced no bleeding until after she started a regimen of unopposed estrogen (Estraderm patches) in January, 1991. (*See*), Tr., p. 587). Respondent further testified that if

the patient had any episodes of bleeding during the period from July, 1990 to January, 1991 (when she was off the hormones), he would have strongly considered doing a D & C to evaluate her condition. (*See*, Tr., p. 588).

However, as reported by Respondent's admission history for Patient F's April 19, 1991 D & C, the patient had experienced bleeding "on and off for the past nine months". (*See*, Pet. Ex. #18, p. 18). This would include the period from July, 1990 to January, 1991, when the patient was not taking the hormones. Therefore, according to Respondent's own testimony, he should have considered evaluating the patient's bleeding at that time.

With regard to the use of an alternative hormonal replacement regimen, Respondent maintained that the patient, who was never tried on such a regimen, did not desire the withdrawal bleeding which could result from such a protocol. However, there is no documentation of any such discussion with the patient, nor did Respondent present Patient F as a witness at the hearing.

Consequently, the Hearing Committee gave credence to Dr. Tatelbaum's testimony and discounted that of Respondent. The Committee concluded that Respondent's medical care regarding Patient F demonstrated negligence as well as incompetence.

**Prophylactic Antibiotics - Patient G**

Respondent performed a D & C on Patient G, a 40 year-old patient, on May 26, 1992. Although the patient indicated a history of mitral valve prolapse on her patient history form, Respondent did not prescribe prophylactic antibiotics. The Department alleged that this failure to use prophylactic

antibiotics constituted a deviation from accepted standards of practice.

Dr. Tatelbaum testified that one could administer antibiotics prior to the D & C to minimize the risk of bacterial infection of the heart valve. However, he did acknowledge that there is no uniformity of opinion within the profession as to whether or not such prophylactic antibiotics must be administered in all cases where there is a diagnosis of mitral valve prolapse. Accordingly, the Hearing Committee did not sustain the allegation regarding this issue.

Respondent performed a vaginal hysterectomy on Patient G on July 23, 1992. The Department also charged Respondent with improperly ordering prophylactic antibiotics beyond the first 24 hours after surgery. Perioperative antibiotic usage as a prophylactic is generally a short term course, generally not used beyond the first 24 hours after surgery in the absence of evidence of an infection.

Respondent testified that Patient G ran a low-grade fever (up to a high of 100.5°). As a result, Respondent decided to administer antibiotics for an additional 24 hours. The Hearing Committee unanimously concluded that Respondent's conduct in this regard did not constitute professional misconduct. Consequently, the Hearing Committee did not sustain any specifications of professional misconduct with respect to Patient G.

**Patient H**

The charges involving Patient H, who is Respondent's

wife, concern an extended period of time during which Respondent wrote prescriptions for excessive amounts of drugs, including Synthroid and Tylenol with codeine, without valid medical purpose. It is undisputed that Respondent knowingly prescribed excessive amounts of Synthroid for his wife, up to 20 tablets a day over approximately 2½ years. Respondent purportedly prescribed the Synthroid for the purpose of weight control. Synthroid is a thyroid medication given to treat an underactive thyroid gland by promoting normal glandular function. The typical dosage is one tablet (0.2 milligrams) per day. It is not used for the purpose of weight control.

Respondent did not perform any thyroid studies either before or after prescribing the drug. He conducted no physical examinations of his wife and maintained no records of his treatments. His actions placed his wife, who was for all intents and purposes a patient, at extreme risk of serious illness due to the excessive use of Synthroid.

Respondent also prescribed significant quantities of Tylenol with codeine for his wife, purportedly to control chronic pain due to thrombophlebitis of the left leg, as well as bunions. However, there is little objective evidence of such pain, although Respondent alleged that the conditions have persisted since the early 1970s.

Moreover, even assuming that his wife's medical problems were real, Respondent had other options to relieve any pain that she might have experienced. Instead, Respondent merely continued to issue prescriptions for drugs. Eventually, Patient

H required treatment for drug addiction at a rehabilitation facility.

Based on the above, the Hearing Committee concluded that Respondent's conduct with regard to Patient H constituted both gross negligence and gross incompetence. In addition, the failure to maintain adequate records was amply proved by the total absence of any medical records for the patient.

## DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

Respondent has demonstrated a serious lack of the basic skills necessary to practice obstetrics and gynecology, as well as extremely poor judgment. These factors in combination render him unfit to practice medicine.

The Hearing Committee considered the possibility of imposing a period of suspension with retraining, but concluded that Respondent was not an acceptable candidate for retraining. He demonstrated an almost total lack of insight into the problems which brought him before the Hearing Committee. Moreover, Respondent has already demonstrated that he is not capable of

learning from his mistakes. He testified that he became much more aggressive in managing women with preeclampsia following his treatment of Patient D in 1991. However, his treatment of Patients A, B and C amply demonstrated that he made no changes in his practice. This resulted in catastrophic consequences for Patient A. Respondent's treatment of Patient A through D, F and H also demonstrated serious deficiencies in his management of medical and gynecological patients, as well.

The Hearing Committee unanimously determined that Respondent's continued practice of medicine would place the lives of his patients, as well as their unborn children, at grave risk. Consequently, the Committee determined that revocation was the only possible sanction in this case.

**ORDER**

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

1. The First through Fifth Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;

2. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order.

**DATED: Albany, New York**
July 28Th , 1995

William P. Dillon MD

**WILLIAM P. DILLON, M.D. (CHAIR)**

JOSEPH K. MYERS, M.D.
ANTHONY BIONDI

TO: Timothy J. Mahar, Esq.
Assistant Counsel
New York State Department of Health
Corning Tower Building - 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

# APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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| | | |
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| IN THE MATTER | : | NOTICE |
| OF | : | OF |
| JOHN A. RURAK, M.D. | : | HEARING |

----------X

PETITIONER'S EXHIBIT
1 and
2-22-95

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

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1994) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 3rd day of March, 1995, at 9:00 A.M. in the forenoon of that day in the Alliance Building, 183 E.Main Street,Rochester, New York and at such other adjourned dates, times and places as the committee may direct.

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

you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

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

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make

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

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
January 4, 1995

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

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

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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| | | |
|---|---|---|
| IN THE MATTER | : | STATEMENT |
| OF | : | OF |
| JOHN A. RURAK, M.D. | : | CHARGES |

----------X

JOHN A. RURAK, M.D., the 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 November, 1996, from The Health Center For Women, Suite 206, 600 Fitch Street, Elmira, New York 14905-0000.

## FACTUAL ALLEGATIONS

A. Respondent, on or about December 6, 1991, through May 29, 1992, provided obstetrical care to Patient A (Patients are identified in the Appendix A hereto) at Respondent's office at The Health Center for Women, Suite 206, 600 Fitch Street, Elmira, N.Y. (hereinafter office), and at the Arnot Ogden Medical Center, Elmira, New York.

1. Respondent failed to hospitalize Patient A and appropriately evaluate her preeclampsia on May 26, 1992.

2. Respondent failed to appropriately evaluate the condition of Patient A's fetus on May 26, 1992.

B. Respondent, on or about January 14, 1993, through August 11, 1993, provided obstetrical care to Patient B at his office and the Arnot Ogden Medical Center.

1. Respondent failed to appropriately evaluate Patient B's preeclampsia on July 20, 1993.

2. Respondent failed to hospitalize Patient B and appropriately evaluate her preeclampsia on August 3, 1993.

3. Respondent failed to evaluate the condition of Patient B's fetus in a timely manner.

C. Respondent, on or about November 12, 1992, through April 1, 1993, provided obstetrical care to Patient C at his office and the Arnot Ogden Medical Center.

1. Respondent failed to hospitalize Patient C and appropriately evaluate her preeclampsia on March 16, 1993.

Amended by Petitioner 2/22/96 JJS

2. Respondent failed to admit Patient C to a hospital for observation after ~~administering Prostin gel~~ Prostin gel was administered to Patient ~~B~~ C on March 29, 1993.

3. Respondent failed to properly treat Patient C's preeclampsia with magnesium sulfate.

4. Respondent discharged Patient C from the Arnot Ogden Medical Center prior to appropriately evaluating her post-partum elevated blood pressure.

D. Respondent, on or about January 28, 1991, through August 2, 1991, provided obstetrical care to Patient D at Respondent's office and at the Arnot Ogden Medical Center.

1. Respondent failed to appropriately evaluate Patient D's preeclampsia on July 23, 1991.

Amended by Petitioner-stipulation JJS

2. Respondent failed to appropriately evaluate the condition of Patient D's fetus on July 23, 1991.

3. Respondent failed to appropriately treat and/or obtain a medical consultation concerning Patient D's post-partum elevated blood pressure.

E. Respondent, on or about February 23, 1993, through July 27, 1993, provided obstetrical care to Patient E at his office and at Arnot Ogden Medical Center.

Respondent failed to order a repeat ultrasound on Patient E to evaluate fetal growth after an ultrasound on May 24, 1993, suggested the possibility of early interuterine growth retardation.

F. Respondent, in or about February, 1990, through June 19, 1991, provided gynecological care to Patient F for hot flashes, among other conditions, at his office and St. Joseph's Hospital, Elmira, New York.

1. Respondent treated Patient F with estrogen only in a hormonal replacement therapy, rather than estrogen in combination with progesterone, thus exposing Patient F to an increased risk of uterine cancer.

2. Respondent after starting Patient F on hormonal replacement therapy, failed to evaluate Patient F's subsequent uterine bleeding in a timely manner, thus exposing Patient F to an increased risk of undiagnosed uterine cancer.

3. Respondent failed to place Patient F on an appropriate hormonal replacement trial, such as prescribing estrogen for the first 25 days of the month and adding progesterone from the 16th to the 25th day of the month, which may have made the performance of a hysterectomy unnecessary.

G. Respondent, from April 23, 1992, through July 28, 1992, provided gynecological care to Patient G for heavy periods, among other conditions, at his offices and St. Joseph's Hospital.

1. Respondent failed to order prophylactic antibiotics for Patient G prior to performing a dilation and curettage on May 29, 1992, despite Patient G's mitral valve prolapse.

2. Respondent continued to order prophylactic antibiotics after the first 24 hours following Patient G's hysterectomy on July 23, 1992 without any medical indication and/or documenting an indication.

H. Respondent provided medical care to Patient H for weight control and leg pain from approximately May 3, 1990, through January 5, 1993, at Respondent's offices and/or at the patient's home. Respondent prescribed drugs for Patient H as set forth in Appendix B hereto.

Respondent's medical care and maintenance of records of Patient H deviated from accepted standards of care in the following respects:

1. Respondent failed to document the prescriptions for drugs Respondent issued to Patient H as set forth in Appendix B.

2. Respondent failed to obtain and/or record an adequate history and/or supplemental histories of Patient H.

3. Respondent failed to perform and/or record adequate physical examinations of Patient H.

4. Respondent failed to record adequate notes concerning the indications for the drugs he prescribed for Patient H.

5. Respondent prescribed Synthroid to Patient H in excessive quantities and/or over an excessive period of time.

6. Respondent prescribed Tylenol with Codeine to Patient H in excessive quantities and/or over an excessive period of time.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4)(McKinney Supp. 1994; formerly N.Y. Educ. Law §6509[2]) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges the following:

1. The facts in Paragraphs A and A(1), A and A(2), B and B(2), B and B(3), C and C(1), C and C(3), E and E(1), ~~F and E(1), F and F(2), F and F(3)~~, H and H(1), H and H(2), H and H(3), H and H(4), H and H(5), and/or H and H(6).

withdrawn by Petitioner 2/22/95 JJL

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) (McKinney Supp. 1994; formerly N.Y. Educ. Law §6530[2]) by reason of his practicing the profession of medicine with gross incompetence, in that Petitioner charges the following:

2. The facts in Paragraphs A and A(1), A and A(2), B and B(2), B and B(3), C and C(1), C and C(3), E and E(1), ~~F and F(1), F and F(2), F and F(3)~~, H and H(1), H and H(2), H and H(3), H and H(4), H and H(5), and/or H and H(6).

withdrawn by Petitioner 2/22/95 gss

THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ.Law §6530(3) (McKinney Supp. 1994; formerly N.Y. Educ. Law §6509[2]) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

3. The facts in Paragraphs A and A(1), A and A(2), B and B(1), B and B(2), B and B(3), C and C(1), C and C(2), C and C(3), C and C(4), D and D(1), D and D(2), D and D(3), E and E(1), F and F(1), F and F(2), F and F(3), G and G(1), G and G(2), H and H(1), H and H(2), H and H(3), H and H(4), H and H(5), and/or H and H(6).

FOURTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530 (5) (McKinney Supp. 1994; formerly N.Y. Educ. Law §6509[2]) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

4. The facts in Paragraphs:A and A(1), A and A(2), B and B(1), B and B(2), B and B(3), C and C(1), C and C(2), C and C(3), C and C(4), D and D(1), D and D(2), D and D(3), E and E(1), F and F(1), F and F(2), F and F(3), G and G(1), G and G(2), H and H(1), H and H(2), H and H(3), H and H(4), H and H(5), and/or H and H(6).

FIFTH SPECIFICATION

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1994) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

5. The facts in Paragraphs G and G(2), H and H(1), H and H(2), H and H(3), and/or H and H(4).

DATED: January 5, 1995
Albany, New York

Peter D. Van Buren

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