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

March 13, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ann Hroncich Gayle, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

George Weinbaum, Esq.
11 Martine Avenue
White Plains, New York 10606

Marx Jean Santel, M.D.
375 Fifth Avenue
4th Floor
New York, New York 10016-3323

RE: In the Matter of Marx Jean Santel, M.D.

Dear Ms. Gayle, Mr. Weinbaum and Dr. Santel:

Enclosed please find the Determination and Order (No. 96-49) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

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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

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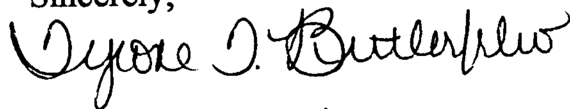
The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist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

COPY

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

IN THE MATTER OF MARX JEAN SANTEL, M.D.	DETERMINATION AND ORDER

BPMC-96-49

The Hearing Committee, composed of **ROBERT J. O'CONNOR, M.D.**, Chairperson, **ANTHONY CLEMENDOR, M.D.**, and **OLIVE M. JACOB** was duly designated and appointed by the Commissioner of Health of the State of New York pursuant to New York Public Health Law §230, subd. 10(e). **EUGENE A. GAER, ESQ.**, Administrative Law Judge, served as Hearing Officer for the Committee.

The Committee, each member of which has considered the entire record in this matter, hereby renders its decision with regard to the charges of professional misconduct filed against Marx Jean Santel, M.D. (the "Respondent"). All findings, conclusions and dispositions herein are unanimous.

STATEMENT OF CHARGES

Respondent has been charged by Petitioner Department of Health (the "Petitioner" or the "Department") with the following five (5) types of professional misconduct, under the definitions contained in New York Education Law §6530:

Practicing the profession with negligence on more than one occasion (§6530, subd. 3) (first specification);

Practicing the profession with gross negligence (§6530, subd. 4) (second, third, fourth, fifth, sixth, seventh, eighth, ninth, tenth, eleventh and twelfth specifications);

Practicing the profession with incompetence on more than one occasion (§6530, subd. 5) (thirteenth specification);

Failing to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient (§6530, subd. 32) (fourteenth, fifteenth, sixteenth, seventeenth, eighteenth, nineteenth, twentieth, twenty-first, twenty-second, twenty-third and twenty-fourth specifications); and

Performing a procedure not duly authorized by the patient (§6530, subd. 26) (twenty-fifth and twenty-sixth specification).

These allegations relate to Respondent's treatment of eleven (11) patients at various times between 1989 and 1994. The charges are more particularly set forth in the Notice of Hearing and Statement of Charges (the "Notice" and "Statement"), a copy of which is attached hereto as Appendix 1.

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	June 1, 1995
Pre-Hearing Conference:	June 20, 1995
Hearing dates:	July 17, 1995 July 24, 1995 September 11, 1995 September 12, 1995 September 28, 1995
Closing briefs submitted on :	October 18, 1995
Deliberation dates:	October 26, 1995 November 8, 1995
Place of Hearing:	New York State Department of Health 5 Penn Plaza New York, New York 10001
Petitioner represented by:	Henry M. Greenberg, General Counsel NYS Department of Health BY: Ann Hroncich Gayle, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York 10001
Respondent represented by:	George Weinbaum, Esq. 11 Martine Avenue White Plains, New York 10606

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WITNESSES

Petitioner called two (2) witnesses:

William K. Rashbaum, M.D.	Expert Witness
Patient A	Fact Witness

Respondent testified in his own behalf and also called two (2) other witnesses:

Joan Berman, M.D.	Expert Witness
Ninon Rodriguez	Fact Witness

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record by the Committee. Citations indicate evidence found persuasive by the Committee in arriving at the finding. "Tr." citations are to the transcript of the hearing. "P.Ex." and "R.Ex." citations are to the exhibits introduced by Petitioner and Respondent. Evidence which conflicted with any finding of the Committee was considered and rejected.

GENERAL FINDINGS

1. Respondent was authorized to practice medicine in the State of New York on August 29, 1972, by the issuance of License No. 113998 by the Department of Education (P.Ex. 2, p. 2) and has remained licensed thereafter. As of the date of the hearings he was current in his registration with the Department of Education for the purpose of practicing medicine in the State. (P.Ex. 2, p. 11)

2. From 1974 to the present Respondent has practiced as an obstetrician and gynecologist. (Tr. 449-450) Approximately 50% of his practice consists of performing the termination of pregnancy ("TOP"). (Tr. 523) During the period 1987-89 Respondent's main office was located at 201 East 30th Street in Manhattan. Thereafter, it was located at 373 and 375 Fifth Avenue in Manhattan. (Tr. 450) At certain times Respondent also maintained an office at 681 Ocean Avenue in Brooklyn. (See P.Ex. 5, p. 1; P.Ex. 10, p. 1; P.Ex. 11, p. 1)

FINDINGS AS TO PROFESSIONAL STANDARDS

3. The term "minimum standard of care" means the standard of care which is generally accepted in the medical community in which the practitioner works with respect to the treatment, procedure and medical specialty under consideration. (See Tr. 191-196; cf. Tr. 168-70, 417-420) As used in these Findings, the term "minimum standard of care" refers to the minimum standard of care in the State of New York during the years 1989-1994 relating to a TOP. Unless otherwise noted, these standards applied uniformly, irrespective of whether the TOP was performed in a hospital, a non-hospital clinic or a physician's private office. (See Tr. 66-69, 191-195)

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4. A first trimester TOP is a termination which takes place through the twelfth week of pregnancy as calculated from the first day of the last menstrual period ("LMP"). A second trimester TOP is a termination which takes place from the twelfth week of pregnancy through the twenty-fourth week as calculated from the first day of the LMP. (Tr. 21)

5. In the first trimester a TOP is performed by dilating the cervix followed by suction and/or sharp curettage. The cervix is gradually dilated with tapered dilators to a degree that it will admit a vacurette of appropriate size which is attached to suction. Suction is applied to the vacurette and the products of conception are removed. The walls of the uterus may be checked with a sharp curette. The products of conception are then examined to ascertain that placental tissue or sac is present; if so, the pregnancy has been terminated. (Tr. 170-171)

6. In the second trimester dilateria are used for dilatation. Dilateria are inserted and then removed the following day, and the procedure is usually done without manual dilatation. Occasionally, manual dilatation is required to augment the dilateria. (Tr. 23-24)

7. The minimum standard of care requires that written consent be obtained from the patient prior to performance of a TOP. (Tr. 189-90, 328; see also Tr. 173-74, 307-08, 323-24)

8. The minimum standard of care requires taking a history, including, as appropriate, a menstrual formula (including age of menarche, frequency and duration of period, LMP), prior obstetrical history (including number of pregnancies, abortions, ectopic pregnancies and caesareans) and a medical and general surgical history. (Tr. 27, 308-309) The importance of taking a history is that it minimizes the risk factors by revealing previous complications or previous surgery; it could thus have a direct impact on the procedure about to be performed. (Tr. 28)

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9. The minimum standard of care requires performing a physical examination, including head and neck, lungs, heart, abdomen, pelvic and rectovaginal examinations. (Tr. 28, 68-70) A physical examination is important because it might reveal problems which could not otherwise be detected, thus enabling the physician to determine whether a TOP could safely be performed in an office setting. (Tr. 70, 221-223)

10. The minimum standard of care requires such laboratory work as urinalysis, hematocrit, hemoglobin, blood type and Rh factor. (Tr. 29)

11. Urinalysis was necessary for these reasons: (a) if there was glucose in the urine and the patient was potentially diabetic, blood sugar would have to be monitored; (b) if there was protein in the urine, the patient might have limited renal function, which would have to be evaluated before surgery; and (c) if there were ketones in the urine, the patient might be acidotic, which also would require evaluation. (Tr. 29-30; cf. Tr. 309-310, 328-330)

12. Determination of hematocrit and hemoglobin are necessary to learn whether the patient is severely anemic, in which case it would be unwise to perform the TOP in a doctor's office or non-hospital clinic. Determination of blood type and Rh factor are necessary because Rh negative patients must be immunized with Rhogam to protect against the possibility of isoimmunization from the pregnancy that is being terminated. (Tr. 29, 183-185, 187-189; see also Tr. 124, 461, 476)

13. The minimum standard of care requires monitoring of vital signs, including blood pressure, pulse and temperature. (Tr. 32, 70-71, 166-168, 253-254, 314; cf. Tr. 468-471, 527-529)

14. Completion by the patient of a history form does not obviate the need for the physician to conduct the physical examination, do the necessary laboratory work, check the vital signs and follow up on any abnormalities indicated by the patient's history. (See Tr. 28-29, 87-88)

15. The minimum standard of care requires an operative note, stating, among other things, what procedures were performed; what sedation and/or anesthesia was used (including the agents, amounts, number of times and method of administration); whether the cervix was dilated and, if dilateria were used, the number and the amount of time they were in place. (Tr. 31-32, 36-37, 92-93, 168-69, 175-77)

16. In both a first and second trimester TOP there must be gross evaluation of the tissue, followed by a microscopic evaluation, to confirm that the pregnancy has been terminated and that all the necessary products of conception have been removed. (See Tr. 196-200, 425-429)

17. To meet the minimum standard of care the patient's history and vital signs, the physical examination, the laboratory tests and the operative note must all be recorded in the patient's chart. (Tr. 37-38)

FINDINGS AS TO PATIENT A

18. Respondent treated Patient A from approximately April 1985 to January 1989. At a visit to his 30th Street office on January 9, 1989 (the "January 1989 visit"), when Patient A was 25 years old, she consulted Respondent in order to confirm her pregnancy and to obtain prenatal

care. (P.Ex. 3, pp. 2, 5-6, 14; Tr. 113-17, 133, 136, 144; see also Tr. 514-517, 551.) Patient A had completed a "New Patient Information Record" (P.Ex. 3, p. 2) on her first visit in 1985, but did not complete such a form at the January 1989 visit[1]. (Tr. 138-139, 516-517; cf. P.Ex. 3, p. 20; Tr. 559)

19. The following facts all relate to the January 1989 visit. At the beginning of the visit Patient A loosened her bra, removed all of her other clothing and put on an examination gown. This was similar to what she had done in the past when Respondent had examined and treated her. (Tr. 118-120, 144)

20. There was initially an internal examination of Patient A and a confirmation that she was approximately seven (7) to eight (8) weeks pregnant. Respondent's medical secretary, Ninon Rodriguez, attempted to have Patient A sign a document without revealing the contents to Patient A, but Respondent informed Rodriguez that Patient A could sign the form after the procedure was performed. The document was a consent for a TOP. (Tr. 115-117, 120-122, 134-135, 137, 145-147; cf. Tr. 459-460, 549-550, 554-556)

21. Respondent discussed with Patient A what she had done during the holidays, but he did not discuss with her the performance of a TOP. Once her sedation took effect, Respondent performed a TOP upon Patient A, who learned after she awakened that she had been subjected to a TOP. (P.Ex. 3, p. 14; Tr. 121-123, 135; cf. Tr. 459-460)

[1]The "New Patient Information Record" was a one-page form in three parts. The first part was a group of boxes asking for miscellaneous information about the patient's address, employer and date of last period. The second asked for the name, address and telephone number of the patient's parent, "If The Patient Is A Minor Or Student". The third part was a "Consent To Abortion" with a blank signature line for the patient. (P.Ex. 3, pp. 2, 20)

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22. Respondent performed the TOP without obtaining the consent of Patient A, who neither signed a consent form nor indicated in any other way that she was consenting to a TOP. (Tr. 121-123, 135, 145-147, 459-461; see also P.Ex. 3, pp. 14, 20)

23. At the January 1989 visit, Respondent tested Patient A's blood type and urinary chorionic gonatropin ("UCG") but did not perform other preoperative laboratory tests upon her, such as hemoglobin, hematocrit and urinalysis. Respondent took and noted Patient A's blood pressure preoperatively, but did not take and note it postoperatively. Respondent did not take or note Patient A's temperature and pulse. (Tr. 166, 168, 175; see also P.Ex. 3, pp. 13-15)

24. At the January 1989 visit, Respondent failed to note on Patient A's chart the identity, amounts, and method of administration of the sedation and/or anesthesia which was used during the TOP. (Tr. 175-177; see P.Ex. 3, p. 14)

FINDINGS AS TO PATIENT B

25. Respondent treated Patient B, who was 25 years old, on February 16 and 23, 1994, at his Fifth Avenue office. A TOP was performed at the February 16th visit. (P.Ex. 4, pp. 1, 4, 7)

26. At Patient B's February 16th visit the only physical examination documented by Respondent was a pelvic examination. The only laboratory tests noted were the UCG and Rh tests. Respondent did not note any of Patient B's vital signs. (P.Ex. 4, p. 7; Tr. 39, 41-42)

27. The only note in Patient B's February 16th chart concerning anesthesia was "VDXyl"[2]. Respondent did not note the method of administration or the amounts. (P.Ex. 4, p. 7; Tr. 40, 59-62)

28. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient B during the February 16th TOP. (Tr. 43, 68; see also P.Ex. 4, p. 7; cf. Tr. 344-346)

29. Respondent did not note on Patient B's chart whether a TOP or any other procedure was performed on her on February 16, 1994. (Tr. 40; see P.Ex. 4, p. 7)

FINDINGS AS TO PATIENT C

30. Respondent treated Patient C, who was 29 years old, on June 5 and 12, 1992, at his Ocean Avenue office. A TOP was performed at the June 5th visit. (P.Ex. 5, pp. 1, 4, 6)

31. At Patient C's June 5th visit the only physical examination documented by Respondent was a pelvic examination. The only laboratory tests noted were the UCG and Rh tests. Respondent did not note any of Patient C's vital signs. (P.Ex. 5, p. 4; Tr. 76-77)

32. With respect to Patient C's June 5th TOP, the only note in the chart concerning anesthesia was "VDXyl". Respondent did not note the method of administration or the amounts. (P.Ex. 5, p. 4; cf. Tr. 78, 81-82)

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[2]Respondent testified that "VDXyl" was his standard abbreviation for "Valium, Demerol, Xylocaine." (Tr. 509, 511-512)

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33. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient C during the June 5th TOP. (See P.Ex. 5, p. 4)

34. Respondent did not note on Patient C's chart whether a TOP or any other procedure was performed on her on June 5, 1992. (Tr. 77-79; cf. P.Ex. 5, pp. 4, 6)

FINDINGS AS TO PATIENT D

35. Respondent treated Patient D from February, 1993 to February, 1994 at his Fifth Avenue office. Patient D was 40 years old at the time of the first visit. (P.Ex. 6, pp. 1, 3-5)

36. Respondent took Patient D's medical history at the visit on February 23, 1993. The only physical examination documented by Respondent was a pelvic examination. The only laboratory tests noted were the UCG and Rh tests. Respondent did not note any of Patient D's vital signs. (P.Ex. 6, p. 8; Tr. 91-92)

37. Respondent performed a TOP on Patient D on February 23, 1993, but Respondent did not note it on Patient D's chart. (Tr. 93; see P.Ex. 6, p. 8)

38. With respect to Patient D's February 23, 1993 TOP, the only note in the chart concerning anesthesia was "VDXyl". Respondent did not note the method of administration or the amounts. (P.Ex. 6, p. 8; Tr. 92-93)

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39. Respondent sent the tissue removed from Patient D during the February 23, 1993, procedure to the MetPath laboratory for evaluation. (P.Ex. 6, pp. 13-14, 16; Tr. 93-94)

40. At the February 22, 1994 visit, Respondent did not take or note Patient D's medical history, even though a year had passed since Patient D's prior TOP. The only physical examination documented by Respondent was a pelvic examination. The only laboratory tests noted were the UCG and Rh tests. Respondent did not note any of Patient D's vital signs. (P.Ex. 6, p. 9; Tr. 94-95)

41. Respondent performed a TOP on Patient D on February 22, 1994, but Respondent did not note it on Patient D's chart. (Tr. 97; see P.Ex. 6, p. 9)

42. With respect to Patient D's February 22, 1994 TOP, the only note in the chart concerning anesthesia was "VDXyl". Respondent did not note the method of administration or the amounts. (P.Ex. 6, p. 9; Tr. 95)

43. Respondent sent the tissue removed from Patient D during the February 22, 1994 procedure to the MetPath laboratory for evaluation. (P.Ex. 6, pp. 11-12, 15; Tr. 96-98)

FINDINGS AS TO PATIENT E

44. Respondent treated Patient E, who was 36 years old, on or about September 26 and 27, 1993, at his Fifth Avenue office. (P.Ex. 7, pp. 1, 3-4, 6-7) Patient E's interval gynecology history stated that she was consulting Respondent because she wanted an abortion. (Id., p. 5) Patient E also signed a consent to abortion. (Id., p. 4)

45. Respondent took an adequate medical history from Patient E. (P.Ex. 7, pp. 5-6; Tr. 369; cf. Tr. 103)

FINDINGS AS TO PATIENT F

46. Respondent treated Patient F, who was 18 years old, on or about December 28 or 29, 1992, and January 7, 1993, at his Fifth Avenue office. A TOP was performed on Patient F during the December visits. (P.Ex. 8, pp. 1, 3-7)

47. During Patient F's December visits the only physical examination documented by Respondent were breast and pelvic examinations. The only laboratory tests noted were a sonogram and the UCG test. Respondent did not note any of Patient F's vital signs. (P.Ex. 8, p. 7; Tr. 210-211, 214-216)

48. During Patient F's December visits Respondent inserted laminaria to begin the process of abortion. (P.Ex. 8, p. 7; Tr. 212-214)

49. Respondent failed to note on Patient F's chart any details concerning administration of anesthesia during the December 29th procedure. (Tr. 216; see also P.Ex. 8, p. 7; cf. Tr. 211)

50. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient F during the December TOP. (Tr. 216-219; see also P.Ex. 8, p. 7)

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51. Respondent did not note on Patient F's chart whether a TOP was performed on her on or about December 28 and 29, 1992. (Tr. 219-221; see also P.Ex. 8, p. 7)

FINDINGS AS TO PATIENT G

52. Respondent treated Patient G, who was 15 years old, on July 8, 1993, at his Fifth Avenue office. A TOP was performed on Patient G during the visit. (P.Ex. 9, pp. 1, 3-4, 7)

53. At Patient G's July 8th visit Respondent took Patient G's medical history. The only physical examination documented by Respondent was a pelvic examination. The only laboratory tests noted were a sonogram and the UCG and Rh tests. Respondent did not note any of Patient G's vital signs. (P.Ex. 9, pp. 5-7; Tr. 231-232)

54. During Patient G's July 8th visit Respondent inserted laminaria to begin the process of abortion. (P.Ex. 9, p. 7; Tr. 233)

55. Respondent noted on Patient G's chart: "2:30 Procedure done under sedation & local." (P.Ex. 9, p. 7)

56. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient G during the July 8th TOP. (See P.Ex. 9. p. 7)

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FINDINGS AS TO PATIENT H

57. Respondent treated Patient H from approximately July 1989 to February 1993 at his Ocean Avenue office[3]. (P.Ex. 10, pp. 1, 6-10)

58. Patient H's medical history was taken at a visit on July 17, 1989. (P.Ex. 10. pp. 6, 9) The first recorded physical examination of Patient H by Respondent is dated August 17, 1989; it was limited to examination of the patient's breast (described only as "normal"), abdomen (described only as "soft") and pelvis. (P.Ex. 10, p. 7; cf. Tr. 240, 243)

59. The only laboratory tests performed at the time of Patient H's August 1989 visit were "BC", Rh and UCG tests[4]. Respondent did not note any of Patient H's vital signs during the visit. (See P.Ex. 10, p. 7; Tr. 240, 392)

60. A TOP was performed on Patient H on August 17, 1989, but Respondent did not record the performance of the procedure in Patient H's chart. The only note in Patient H's chart concerning anesthesia was "VDXyl". Respondent did not note the method of administration or the amounts. (P.Ex. 10, pp. 5, 7; Tr. 240-241)

61. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient H during the August 17, 1989 TOP. (See P.Ex. 10, p. 7; cf. Tr. 393)

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[3]The records of Patient H's age are inconsistent. The year of her birth is given at different points as 1953 (P.Ex. 10, pp. 5-6) and 1956 (Id., pp. 3-4).

[4]If "BC" meant "blood count", no result was recorded for this patient, who reported a history of anemia. (See P.Ex. 10, pp. 6-7; Tr. 240-242, 393, 395-396).

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62. Patient H visited Respondent for a check-up on April 23, 1990, at which time Respondent took and recorded her blood pressure and performed breast and pelvic examinations and a UCG test. (P.Ex. 10, p. 7)

63. Patient H returned to Respondent on May 11, 1990, for a TOP. Respondent performed a pelvic examination and examined her abdomen, but did not perform any other laboratory tests at that time. Respondent did not note any of Patient H's vital signs during this visit. (See P.Ex. 10, pp. 4, 8)

64. Respondent failed to note on Patient H's chart any details concerning the procedure performed, the administration of anesthesia or the tissue removed during the May 11, 1990 procedure. (Tr. 244, 395, 397; see P.Ex. 10, pp. 8, 11)

65. Patient H returned to Respondent on December 10, 1990. Respondent performed a pelvic examination and UCG and Rh tests. No other physical examination or laboratory tests are recorded for that date. Respondent did not note any of Patient H's vital signs during this visit. (See P.Ex. 10, p. 9-10; Tr. 245-246)

66. A TOP was performed on Patient H on December 10, 1990, but Respondent did not record the performance of the procedure in Patient H's chart. The only note in Patient H's chart concerning anesthesia was "VDXyl". Respondent did not note the method of administration or the amounts. (See P.Ex. 10, p. 9-10; Tr. 246-247) Patient H visited Respondent for a follow-up examination later in December 1990. (P.Ex. 10, p. 10)

67. At the December 10, 1990 visit, Patient H did not sign a consent form for a TOP. (See P.Ex. 10, p. 9-10; Tr. 245, 494-496)

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68. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient H during the December 10, 1990 TOP. (See P.Ex. 10, pp. 9-10; cf. Tr. 393)

69. Patient H returned to Respondent for a TOP on February 5, 1993. Respondent performed a pelvic examination and UCG and Rh tests. No other physical examination or laboratory tests are recorded for that date. Respondent did not note any of Patient H's vital signs during this visit. (See P.Ex. 10, pp. 3, 10; Tr. 248)

70. A TOP was performed on Patient H on February 5, 1993, but Respondent did not record the performance of the procedure on Patient H's chart. (See P.Ex. 10, pp. 3, 10; Tr. 249)

71. Respondent noted the administration to Patient H on February 5, 1993, of "VDXyl" as anesthesia, but did not note the method of administration or the amounts. Respondent also noted the administration of ergotrate postoperatively. (P.Ex. 10, p. 10; Tr. 248-249)

72. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient H during the February 5, 1993 TOP. (See P.Ex. 10, p. 10; cf. Tr. 393)

FINDINGS AS TO PATIENT I

73. Respondent treated Patient I, from approximately January 1993 (when Patient I was 34 years old) to May 1994 at his Ocean Avenue office. (P.Ex. 11, pp. 1, 3-5, 8, 12)

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74. Respondent took Patient I's medical history at a visit on January 19, 1983. (P.Ex. 11, p. 5; Tr. 398) Although Patient I stated that she had a history of seizure disorder and anemia, there is no record that Respondent followed up on these problems. The only physical examination documented by Respondent was a pelvic examination. The only laboratory tests noted were the UCG and Rh tests. Respondent did not note any of Patient I's vital signs. (See P.Ex. 11, pp. 5, 8; Tr. 257-258)

75. A TOP was performed on Patient I on January 19, 1993, but Respondent did not record the performance of the procedure on Patient I's chart. (See P.Ex. 11, pp. 4, 8; Tr. 259)

76. Respondent noted the administration to Patient I on January 19, 1993, of "VDXyl", but did not note the method of administration or the amounts. (P.Ex. 11, p. 8; Tr. 258, 399-400)

77. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient I during the January 19, 1993 TOP. (See P.Ex. 11, p. 8; Tr. 259; cf. Tr. 399)

78. Patient I returned to Respondent in January 1994[5]. Respondent performed a pelvic examination and UCG and Rh tests. No other physical examination or laboratory tests are recorded for that date. Respondent did not note any of Patient I's vital signs during this visit. (See P.Ex. 11, p. 12; Tr. 260)

79. A TOP was performed on Patient I on January 6, 1994, but Respondent did not record the performance of the procedure on Patient I's chart. (See P.Ex. 11, pp. 3, 12; Tr. 261)

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[5]Patient I signed a consent to abortion on January 4, 1994, but Respondent's examination and treatment notes are dated January 6, 1994. (P.Ex. 11, pp. 3, 12).

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80. Respondent noted the administration to Patient I on January 6, 1994, of "VDXyl", as anesthesia, but did not note the method of administration or the amounts. (P.Ex. 11, p. 12; Tr. 260-261)

81. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient I during the January 6, 1994 TOP. (See P.Ex. 11, p. 12; Tr. 261; cf. Tr. 399)

FINDINGS AS TO PATIENT J

82. Respondent treated Patient J, from approximately May, 1992 to March, 1994 at his Fifth Avenue office[6]. (P.Ex. 12, pp. 1, 3-5, 8, 8a)

83. Respondent took Patient J's medical history at a visit on May 28, 1992. (P.Ex. 12, pp. 6-7) Although Patient J stated that she had a bleeding problem, Respondent did not follow-up on it. The only physical examination documented by Respondent was a pelvic examination. The only laboratory tests noted were the UCG and Rh tests. Respondent did not note any of Patient J's vital signs. (P.Ex. 12, p. 8; Tr. 262-263; cf. Tr. 406)

84. A TOP was performed on Patient J on May 28, 1992, but Respondent did not record the performance of the procedure on Patient J's chart. (See P.Ex. 12, pp. 5-6, 8; Tr. 264)

[6]The records of Patient J's age are inconsistent. The year of her birth is given at different points as 1964 and 1966. (P.Ex. 12, pp. 4-5, 7).

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85. Respondent noted the administration to Patient J on May 28, 1992, of "VDXyl" as anesthesia, but did not note the method of administration or the amounts. (P.Ex. 12, p. 8; Tr. 264)

86. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient J during the May 28, 1992 TOP. (See P.Ex. 12, p. 8; Tr. 264; cf. Tr. 399)

FINDINGS AS TO PATIENT K

87. Respondent treated Patient K, from approximately May 1993 to June 1994 at his Fifth Avenue office. Patient K was 33 years old at the time of the first visit. (P.Ex. 13, pp. 1, 3-5, 8-9)

88. During Patient K's May 11, 1993 visit the only physical examination documented by Respondent were abdominal and pelvic examinations. The only laboratory tests noted were the UCG and Rh tests[7]. Respondent did not note any of Patient K's vital signs. (P.Ex. 13, p. 9; Tr. 268-269)

89. A TOP was performed on Patient K on May 11, 1993. Respondent did not record the performance of the procedure on Patient K's chart, but did record the insertion of laminaria to begin the process of abortion. (P.Ex. 13, p. 8; Tr. 269-270)

[7]Respondent's office record for Patient K contains an undated medical history, which states that she had diabetes. Nonetheless Respondent never ordered a urinalysis for her. (P.Ex. 13, pp. 7-8; Tr. 268; cf. Tr. 414-415).

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90. Respondent noted the administration to Patient K on May 11, 1993, of "VDXyl" as anesthesia, but did not note the method of administration or the amounts. (P. Ex. 13, p. 8; Tr. 269)

91. Respondent did not perform (or record) an evaluation of tissue in order to determine that all of the necessary products of conception were removed from Patient K during the May 11, 1993, TOP. (See P. Ex. 13, p. 8; Tr. 269)

92. Patient K returned to Respondent on May 14, 1994, suffering from heavy bleeding. (Tr. 497) Respondent's note stated "incomplete abortion/placenta removed from cervix/suction-curettage done with heavy bleeding." (P. Ex. 13, p. 8)

93. Respondent identified the tissue removed from Patient K on May 14, 1994, as placental tissue. (See P.Ex. 13, p. 8; Tr. 412, 497; cf. Tr. 272-273)

94. Respondent did not note any of Patient K's vital signs on May 14, 1994 and did not note whether Rhogam was administered to Patient K on that date.[8] (See P.Ex. 13, p. 8; Tr. 272-274, 410, 415-416; see also Tr. 498-499)

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[8]Respondent's record for Patient K's May 11, 1993, visit notes that she tested Rh negative and that Rhogam was administered on that date. (P.E 13, p. 8)

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CONCLUSIONS AS TO FACTUAL ALLEGATIONS[9]

GENERAL CONCLUSIONS: RECORDKEEPING

It is essential that a physician maintain an accurate record of each patient's history, evaluation and treatment. Besides aiding the treating physician's care of the patient, the maintenance of an accurate record permits a subsequent physician to acquire information necessary for properly treating the patient. (Tr. 36-37; cf. Tr. 249-251, 352-353, 413, 420-422)

Where, as here, a physician performs a large number of relatively similar procedures (see Tr. 467, 522-523), it is important to note the nature and course of each procedure. Reliance on memory about individual patients may be confusing and lead to adverse consequences. (Tr. 37-38)

Respondent's recordkeeping fell far short of the acceptable standard. Whether a matter of the patient's history and vital signs, or of Respondent's physical examination of the patient, his office records frequently fail to contain the minimum necessary data. These shortcomings are set forth with respect to individual patients in the Findings of Fact.

To the extent that Respondent entered any operative notes, they were very deficient. In many cases there was no entry that a TOP was performed. Respondent's position is that by entering "VDXyl" (i.e., Valium, Demerol, Exylocaine), he was recording that a TOP was commenced and, in the absence of any contrary notes, that the procedure was successfully completed and the tissue appropriately evaluated. (Tr. 509-511; see also Tr. 344-346, 350-351)

Respondent's shorthand operative notation cannot be considered adequate. An anesthesia entry should include the dosage and method of administration because the response to a particular drug may vary depending on the patient's individual characteristics.[10] (Tr. 255-256, 353-354, 512-

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[9]Citations to the record in the Findings of Fact are not repeated when they are applicable to corresponding Conclusions.

[10]The Statement phrases the charge that Respondent kept unsatisfactory anesthesia records as "Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient." See, e.g., ¶¶ B.4, C.4, D.5. This charge may fairly be read to

514, 531) "VDXyl" is not even a satisfactory anesthesia entry; it certainly cannot bear the weight of a full operative note. (See Tr. 31-32, 36-37, 92-93, 168-169, 175-177, 255-256)

Also disturbing is Respondent's failure to demonstrate any improvement in recordkeeping. His position in this proceeding has largely been that no charges would have been lodged against him if not for the complaint of Patient A. (See, e.g., Tr. 451-455, 468-472, 574-576, 592-593)

Respondent was aware that he was under investigation since shortly after Patient A was interviewed by the Department in February 1989. (See R.Ex. A; Tr. 451-452, 537-539) Nonetheless, Respondent's records from Patients B, D and I in January and February, 1994 remain as sketchy as those from the visits of Patients A and H in 1989.

This lack of improvement cannot convincingly be excused by the assertion that Respondent may have believed the Department was concerned only with abortion procedures, not recordkeeping. (See Tr. 537-538) As set forth below, many of the Allegations concerning recordkeeping must be sustained.

GENERAL CONCLUSIONS: COUNSELING

For each patient the Statement charges that

> Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed.[11]

Any medical treatment entails some give-and-take between physician and patient during which the patient's needs and options are addressed. A serious procedure such as a TOP necessitates procurement of a signed informed consent from the patient.

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include the failure to identify the amount and method of administration of anesthetic.

[11]The Statement generally, but not always, recites the date when Respondent performed the TOP for which he allegedly failed to provide counseling. See, e.g., ¶¶ B.6, D.7, H.7, I.7; but see ¶¶ E.7, G.7.

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Petitioner has not, however, established the existence of a specific requirement that counseling be provided and noted in the record each time a TOP is performed. The purported counseling requirement was demonstrative neither by statues, regulations of government health agencies nor standards adopted by professional organizations. On this issue the Committee finds the testimony of Respondent's expert witness more convincing than that of Petitioner's. (Compare Tr. 305-308, 32-328, 435-437 with Tr. 30-31, 171-172 See also Tr. 477-482)

Accordingly, **Paragraphs A.5, B.6, C.6, D.7, E.7, F.6, G.7, H.7, I.7, J.7** and **K.6** are **NOT SUSTAINED.**[12]

PATIENT A

On January 9, 1989, Respondent performed a TOP on Patient A, whom he had treated from time to time since April 1985.[13] Patient A never signed a form consenting to a TOP at her January 1989 visit.

The questions is whether the January, 1989 TOP was performed after Patient A gave consent orally, as indicated by Respondent and Rodriguez (Tr. 458-460, 516-517, 552-556), or whether the TOP was performed by mistake during a visit in which Patient A intended only to confirm that she was pregnant and to receive prenatal care, as she herself claims. (Tr. 113-114, 122-123, 133, 136, 144)

[12]Paragraph E.7 is also not sustained because it has not been established that a TOP was performed on Patient E. Paragraph K.6 is also not sustained with respect to the procedure performed on Patient K on May 14, 1994, in view of the emergency situation presented that day. See the Conclusions as to those patients.

[13]As a general statement of the course of Patient A's treatment by Respondent, **Paragraph A** is **SUSTAINED.** Although, as stated in Paragraph A, Patient A was 21 when she saw Respondent in April, 1985 (see P.Ex. 3, pp. 2-4), all the charges relate to her visit on January 9, 1989, when she was 25.

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The Committee found Patient A's testimony to be clear, straightforward and internally consistent. She had been examined by Respondent several times when she was not pregnant, including one (1) visit for removal of an IUD, and did not find the first phases of her January 1989 visit different from prior examinations. (P.Ex. 3, pp. 2-3, 5-6; Tr. 112, 118-120, 126, 136) The other patients in Respondent's waiting room told Patient A that they were there for TOP's, but, having once experienced a TOP, Patient A had no reason to expect she would be subjected to this procedure without her consent.[14] (R.Ex. A, p. 2; Tr. 134-136)

Before Patient A was anesthetized, there was some discussion between Respondent and Rodriguez about the need to have the patient sign a document which the patient had not yet read. (Tr. 121-122, 128, 134-135) It cannot be concluded that Patient A understood this document to be a consent for a TOP. When she first came into the office she had been asked for confirmation of insurance coverage (itself at least as consistent with a patient seeking long term prenatal care as with a TOP). Thus, it was reasonable for Patient A to think that the papers they were discussing might possibly relate to insurance. (See Tr. 142, 147, 552-555)

Patient A conceded that the incident may have resulted from a "lack of communication." (R.Ex. A, p. 2) Yet, she insisted that from the time of making the appointment for the January 1989 visit, she had stated that it was for "prenatal care." As she cogently testified: "You don't use termination of pregnancy and prenatal care in the same sentence." (Tr. 136)

Respondent did not claim that he personally obtained Patient A's consent for the TOP. (See Tr. 458-460, 462-463) When Respondent was certain that a patient desired an abortion (the term Respondent preferred to use in dealing with patients [see Tr. 532-533]), it was his practice to avoid upsetting her by repeatedly mentioning the procedure. (Tr. 462-464)

According to Respondent's testimony, the appointment sheet for January 9, 1989, stated that Patient A had scheduled an abortion. Since Respondent thought he knew why the patient was there, he followed his ordinary practice and did not specifically discuss a TOP with her

[14] A TOP had been performed on Patient A by another physician in 1979 or 1980. (Tr. 127, 137; cf. R.Ex. A, p. 2)

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during the initial pregnancy examination. (Tr. 458-459, 462-463) By the time Rodriguez brought in the unsigned consent form, Respondent had begun anesthetizing Patient A. Respondent believed he should wait until the procedure was over before troubling the patient with paperwork. (Tr. 459-460, 517-518)

Rodriguez testified that Patient A's visit was scheduled by Respondent's other office assistant, who entered it in the appointment book as "AB", i.e., abortion. (Tr. 551-552) On the morning of January 9 Patient A arrived before Rodriguez. However, because Rodriguez was the only office assistant who handled insurance, she discussed the planned abortion with Patient A so that she could call the patient's insurance company to confirm that it covered TOP's. (Tr. 553, 558-559)

Rodriguez expected Patient A to sign the consent form after hearing from the insurer. By the time coverage was confirmed, Respondent was already examining the patient; Rodriguez then went into the examination room to tell him that the consent form had not been signed. According to Rodriguez, Respondent asked Patient A if he could trust her to sign the form after the procedure and the patient said yes. (Tr. 553-555)

Based on all the evidence, including the surrounding circumstances and the witnesses' demeanor and motivation to be truthful, the Committee accepts Patient A's version of the facts and concludes that she did not consent to the TOP performed on January 9, 1989.

Neither Respondent nor Patient A testified to a direct discussion in which the patient requested a TOP. Although Rodriguez claims to have discussed a TOP with Patient A, she was not the office assistant on duty when the patient first presented on the morning of January 9. Her discussion of insurance coverage with Patient A may not have focused as explicitly on an impending TOP as Rodriguez later recalled.

Patient A's behavior immediately after coming out of anesthesia is also probative. Upon learning of the TOP, she began crying, refused to sign any forms or to allow a Rhogam shot and called her husband. (Tr. 122-124, 128, 460-461, 556) This behavior is consistent with being distraught over experiencing an unwanted abortion.

Accordingly, **Paragraph A.1** is **SUSTAINED.**

The other charges also relate to the January 1989 visit. Paragraph A.2 states that Respondent "failed to perform necessary laboratory tests." Respondent typed Patient A's blood and did a UCG test, but there are no hemoglobin, hematocrit and urinalysis records. (See Finding of Fact 23, supra)

Paragraph A.2 is **SUSTAINED.**

Paragraph A.3 states that Respondent "failed to take or note in the chart vital signs of the patient during and subsequent to" the TOP. The record contains no indication that Respondent took or noted Patient A's temperature and pulse. The preoperative blood pressure is recorded, but not the postoperative. Although the patient's distress upon learning of the TOP may partly explain the absence of a record of postoperative vital signs, there is no excuse for not taking and recording vital signs before the procedure. (See Findings of Fact 13, 14 and 17, supra)

Paragraph A.3 is **SUSTAINED.**

Paragraph A.4 also correctly states that "Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to Patient A. (See P.Ex. 3, p. 14)

Paragraph A.4 is **SUSTAINED.**

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PATIENTS B AND C

The charges concerning Patients B and C are similar and may be considered together. Patient B was 25 years old when she underwent a TOP at Respondent's Fifth Avenue office on February 16, 1994. Patient C was 29 years old when she underwent a TOP at Respondent's Ocean Avenue office on June 5, 1992. Each patient had one (1) follow-up visit to Respondent a few days after the TOP, but all the charges relate to the visits when TOP's were performed.

As general statements of the treatments of Patients B and C by Respondent,

Paragraphs B and C are SUSTAINED.

For each patient it is alleged that Respondent failed to perform or note an adequate physical examination (¶¶ B.1 and C.1), to perform necessary laboratory tests (¶¶ B.2 and C.2) and to take or note vital signs before, during and after the TOP (¶¶ B.3 and C.3).

Each of these charges is supported by the record. Respondent documented only the performance of a pelvic examination and noted only UCG and Rh tests with respect to each patient. No hemoglobin or hematocrit test is recorded for either patient, even though Patient C reported a history of anemia. (P.Ex. 5, p. 5) Neither patients' vital signs were noted by Respondent. (See Findings of Fact 26 and 31, supra)

Paragraphs B.2, B.2, B.3, C.1, C.2 and C.3 are SUSTAINED.

It is also alleged that "Respondent failed to note in the chart what, if any, anesthesia and/or drugs were administered" to each patient (¶¶ B.4 and C.4) and whether a TOP or other procedure was performed (¶¶ B.7 and C.7). As each record contains only the unsatisfactory "VDXyl" entry,

Paragraphs B.4, B.7, C.4 and C.7 are SUSTAINED.

A further charge against Respondent is that he did not "evaluate the tissue to determine that all of the necessary products of conception were removed" during the TOP's (¶¶ B.5 and C.5). Such an evaluation is essential. (See Finding of Fact 16, supra) There is no record that it was performed after either of these procedures.

Paragraphs B.5 and C.5 are SUSTAINED.

PATIENT D

Patient D was 40 years old when she underwent a TOP by Respondent at his Fifth Avenue office on February 23, 1993. A year later, on February 22, 1994, Respondent again performed a TOP on this patient. Petitioner's Statement relates to both these procedures. As a general summary of Patient D's treatment,

Paragraph D is **SUSTAINED.**

Paragraph D.1 states:

> On or about February 23, 1993 and February 22, 1994, Respondent failed to obtain an adequate medical history, or note in the chart such history, if any.

This patient's record contains a medical history which was completed on February 23, 1993. (P.Ex. 6, p.7) When she came back a year later no medical history was taken, as it should have been after an interval of that length.

Accordingly, **Paragraph D.1** is **NOT SUSTAINED** insofar as it relates to the 1993 visit and **SUSTAINED** insofar as it relates to the 1994 visit.

It is also correctly alleged that at each visit Respondent failed to perform or note an adequate physical examination (¶ D.2), to perform necessary laboratory tests (¶ D.3) and to take or note vital signs before, during and after each TOP (¶ D.4). The record documents only performance of a pelvic examination and UCG and Rh tests. There is no entry concerning vital signs or any other physical examination. Nor is there a notation of a urinalysis or a hemoglobin or hematocrit test. (See P.Ex. 6, pp. 8-9)

Paragraphs D.2, D.3 and **D.4** are **SUSTAINED.**

For each visit the only anesthesia notation is "VDXyl," with no specification of amounts or method of administration. Accordingly,

Paragraph D.5 is **SUSTAINED.**

Paragraph D.6 states:

> Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about February 22, 1994, or to note in the chart that same was done.

Patient D's record contains a clinical laboratory report from MetPath reporting on the pathology of tissue sent following Patient D's February 22, 1994, procedure. (P.Ex. 6, pp. 11-12, 15) The file also contains a tissue pathology report respecting this patient's 1993 TOP. (P.Ex. 6, pp. 1-14, 16)

Paragraph D.6 is **NOT SUSTAINED.**

The final charge (¶ D.8) respecting this patient is that Respondent did not note on the chart that he performed a TOP at either the 1993 or the 1994 visit. For this patient the record contains the pathology reports in addition to the "VDXyl" entries. However, the record does not contain a notation by Respondent that he performed a TOP. A procedure of that seriousness should be recorded explicitly, not left to inference from other notes.

Paragraph D.8 is **SUSTAINED.**

PATIENT E

Patient E was 36 years old when she visited Respondent in September 1993, seeking an abortion The charges respecting this patient all presuppose that Respondent performed a TOP on her at that time.

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Respondent testified that this did not happen. Although he began the process by inserting laminaria, he did not complete the TOP. He recollected that when Patient E learned that her pregnancy was more advanced than originally thought, she changed her mind and stated that she did not want to go through with the abortion. She then received a refund of the fee for a TOP. (Tr. 488-490)

The office record does not contain anything (not even the "VDXyl" notation) which would refute Respondent's testimony that ultimately no TOP was performed. Petitioner offered no other evidence concerning this patient. Except for the charge concerning Patient E's medical history, which has been found to have been taken adequately (See Finding of Fact 45, supra), all the alleged shortcomings in Respondent's treatment of this patient rest on the assumption that she underwent a TOP. As this has not been proved, the charges cannot survive.

Accordingly, **Paragraphs E.1, E.2, E.3, E.4, E.5, E.6, E.7** and **E.8** are **NOT SUSTAINED.**[15]

PATIENT F

Patient F, was an 18 year old who underwent a TOP on or about December 28 and 29, 1992, at Respondent's Fifth Avenue office; she had one (1) follow-up visit in early January 1993. The charges all relate to the December visits. As a general statement of this patient's visits to Respondent,

Paragraph F is **SUSTAINED.**

[15]Paragraph E is SUSTAINED as a general statement of Patient E's visit to Respondent. Paragraph E.1 is also NOT SUSTAINED because the medical history has been found adequate. Paragraph E.7 is also NOT SUSTAINED because no counseling requirement has been shown to exist.

The Statement alleges that Respondent failed to perform or note an adequate physical examination (¶ F.1), to perform necessary laboratory tests (¶ F.2), to take or note vital signs before, during and after the TOP (¶ F.3) or to note what anesthesia or other drugs were administered (¶ F.4).

The record supports these allegations. Respondent documented only breast and pelvic examinations, a sonogram and the UCG test. No Rh test, much less any other blood work, is noted. No vital signs are noted. There is no anesthesia notation, although there is an entry concerning prescription of postoperative antibiotics. (P.Ex. 8, p. 7; see Tr. 467)

Paragraphs F.1, F.2, F.3 and **F.4** are **SUSTAINED.**

There also is no note that a TOP was performed, as alleged in Paragraph F.7. The notation that Respondent inserted laminaria is not sufficient to constitute an operative note. In addition, as alleged in Paragraph F.5, there is no record of any evaluation of the tissue to determine that the necessary products of conception were removed.

Paragraphs F.5 and **F.7** are **SUSTAINED.**

PATIENT G

Patient G was a 15 year old who underwent a TOP on July 8, 1993, at Respondent's Fifth Avenue office. As a general statement of this patient's treatment by Respondent,

Paragraph G is **SUSTAINED.**

Paragraph G.1 states that "Respondent failed to obtain an adequate medical history, or note in the chart such history, if any." However, this patient's record contains an interval gynecology history and a medical history which were completed on July 8, 1993. (P.Ex. 9, pp. 5-6)

Accordingly, **Paragraph G.1** is **NOT SUSTAINED.**

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The Statement correctly alleges that Respondent failed to perform or note an adequate physical examination (¶ G.2), to perform necessary laboratory tests (¶ G.3), to take or note vital signs before, during and after the TOP (¶ G.4) or to evaluate the tissue to determine that all of the necessary products of conception were removed during the TOP (¶ G.6).

The only physical examination documented by Respondent was a pelvic examination. The only laboratory tests noted were a sonogram and the UCG and Rh tests. Respondent did not note any of Patient G's vital signs and did not note any evaluation of the tissue removed.

Paragraphs G.2, G.3, G.4 and **G.6** are **SUSTAINED.**

Paragraph G.5 alleges that Respondent failed to note the anesthesia administered to Patient G. Although Respondent noted on Patient G's chart the administration of "sedation & local" (and of an antibiotic [P.Ex. 9, p. 7; see Tr. 467]), he did not identify the sedative and local or state the dosages and method of administration.

Paragraph G.5 is **SUSTAINED.**

PATIENT H

Patient H was a woman in her thirties who saw Respondent several times between July 1989 and February 1993, during the course of which she underwent four (4) TOP's. As a general statement of this patient's treatment by Respondent,

Paragraph H is **SUSTAINED.**

Paragraph H.1 alleges that Respondent failed to perform adequate physical examinations at these visits: July or August 17, 1989; May 11, 1990; December 10, 1990; February 5, 1993. The records show that at the August 17, 1989, visit Respondent examined Patient H's pelvis,

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breast and abdomen. At the May 11, 1990, visit Respondent examined only her pelvis and abdomen. (A breast examination had been performed on April 23, 1990.) Respondent performed only pelvic examinations at the December 10, 1990, and February 5, 1993, visits.

Under recognized standards the patient should have received more thorough physical examinations on these occasions. (See Finding of Fact 9, supra)

Paragraph H.1 is **SUSTAINED.**[16]

Paragraph H.2 alleges:

> Respondent failed to obtain adequate consent from this patient for the termination of pregnancy which was performed on or about December 10, 1990.

Patient H's file does not contain a consent form for the December 1990 procedure and Respondent conceded that through an "oversight" none was signed. (Tr. 494-495) Respondent insisted, however, that this patient desired an abortion at that time as evidenced by her returning to Respondent without apparent complaint for follow-up treatment later in the month. (Tr. 496) She also returned for a subsequent TOP in 1993. (P.Ex. 10, pp. 3, 10) While Respondent's position may not be unreasonable, it does not refute the literal accuracy of this charge.

Paragraph H.2 is **SUSTAINED.**

With respect to the date of each TOP, the Statement alleges that Respondent failed to perform necessary laboratory tests (¶ H.3), to take or note vital signs before, during and after the TOP (¶ H.4) or to evaluate the tissue to determine that all of the necessary products of conception were removed during the TOP (¶ H.6).

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[16]Although Patient H completed paperwork at the July 17, 1989, visit to Respondent's office (P.Ex. 10, pp. 5-6), there is no record that Respondent actually examined her that day. Therefore, all subparagraphs sustained under Paragraph H are limited to exclude reference to the July, 1989 visit.

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These charges are all supported in the record. At the August, 1989 visit only blood count, Rh and UCG tests were performed. At the December, 1990 and February, 1993 visits, only Rh and UCG tests were performed. No tests are recorded on the date of the May, 1990 TOP. Respondent did not note any of Patient H's vital signs during any of these visits. Nor is there any record of an evaluation of tissue removed.

Paragraphs H.3, H.4 and **H.6** are **SUSTAINED.**

Paragraph H.5 alleges that Respondent failed to note the identity of anesthesia and other drugs administered during the TOP's. Paragraph H.8 states that Respondent failed to note the performance of the TOP's in the record.

There is no anesthesia record for the May, 1990 procedure. On the other dates the only entry is "VDXyl", except that the February 5, 1993, record also noted the postoperative administration of ergotrate. The record contains no specific entry that a TOP was performed on any of these dates.

For reasons stated above, these entries are not sufficient as either anesthesia or operative notes.

Paragraphs H.5 and **H.8** are **SUSTAINED.**

PATIENTS I AND J

The charges and records concerning Patients I and J are similar and may be considered together. Patient I was 34 years old when she visited Respondent for a TOP on January 19, 1993. In January 1994, she underwent a second TOP by Respondent. The records indicate that she was also examined by Respondent in May, 1994.

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Patient J was about 25 when she visited Respondent for a TOP on May 28, 1992. She visited Respondent at least two (2) more times through March, 1994.[17] As general statements of these patients' treatment by Respondent,

Paragraphs I and **J** are **SUSTAINED.**

Paragraph I.1 states: "On or about January 19, 1993, Respondent failed to obtain an adequate medical history, or note in the chart such history, if any." Paragraph J.1 alleges a similar failure to take Patient J's medical history at her May 28, 1992, visit.

However, both these patients' records contain medical histories bearing the dates alleged in the Statement (January 19, 1993, for Patient I; and May 28, 1992, for Patient J). (P. Ex. 11, p. 5; P.Ex. 12, p.7)

Accordingly, **Paragraphs I.1** and **J.1** are **NOT SUSTAINED.**[18]

It is correctly alleged that, at the time of each TOP under consideration, Respondent failed to perform or note an adequate physical examination (¶¶ I.2 and J.2), to perform necessary laboratory tests (¶¶ I.3 and J.3), to take or note vital signs before, during and after the TOP (¶¶ I.4 and J.4) and to evaluate the tissue to determine that all of the necessary products of conception were removed during the TOP (¶¶ I.6 and J.6).

On the date of each TOP, Respondent documented only the performance of a pelvic examination and noted only UCG and Rh tests. Despite Patient I's history of anemia and Patient

[17]Respondent's notes for Patient J's March 4, 1994, visit contain the "VDXyl" entry (P.Ex. 12, p. 8a), which has otherwise been taken to indicate performance of a TOP. Petitioner has made no allegations concerning that visit.

[18]Finding of Fact 74 noted that Patient I reported a history of seizure disorder and anemia, while Finding of Fact 83 noted that Patient J reported a history of bleeding. Respondent apparently did not consider these problems when he treated the patients. The Statement contains no allegations with respect to this issue.

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J's history of bleeding, no hemoglobin or hematocrit test was recorded for either. (P.Ex. 11, pp. 5, , 12; P.E. 12, pp. 7-8) Respondent also did not note their vital signs or record any evaluation of tissue removed.

Paragraphs I.2, I.3, I.4, I.6, J.2, J.3, J.4 and **J.6** are **SUSTAINED.**

PATIENT K

Patient K was 33 years old when she first visited Respondent at his Ocean Avenue office for a TOP in May, 1993. She was again treated there by Respondent in May and June, 1994 because of heavy bleeding and what Respondent determined to be an "incomplete abortion," i.e., a miscarriage. (P.Ex. 13, p.8; see also Tr. 411-412, 497)

Paragraph K is **SUSTAINED** as a general summary of Patient K's visits to Respondent, subject to understanding the distinction between the reasons for Patient K's 1993 and 1994 visits.

Paragraph K.1 states:

> On or about May 11, 193 and May 14, 1994, Respondent failed to perform an adequate physical examination or note in the chart such examination, if any.

At the time of the 1993 visit, Respondent performed only a pelvic examination; under recognized standards, this was insufficient for an elective TOP. (See Findings of Fact 9 and 14, supra) In contrast, Patient K's May, 1994 visit resulted directly from her heavy bleeding, which required immediate attention. As Respondent properly addressed the patient's major symptom, the physical examination he performed was adequate. (See Tr. 412, 415-416, 497-498)

Paragraph K.2 states that Respondent failed to perform necessary laboratory tests in connection with both the 1993 and 194 visits. As indicated supra (Finding of Fact 88 and

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Footnote 7), this patient required fuller testing at her 1993 visit than the UCG and Rh tests. However, when faced with an emergency situation in May, 1994, Respondent appropriately dispensed with tests.

Paragraph K.4 states that Respondent failed to record the anesthesia administered to the patient on either visit. The May, 1993 record contains the unsatisfactory "VDXyl" entry. There is no anesthesia entry for May, 1994, but it has not been established that any anesthesia was administered during that treatment.[19]

Paragraph K.5 states that Respondent failed to evaluate the tissue to determine that all the necessary products of conception were removed during the May, 1993 and the May, 1994 procedures. There is no such evaluation in the 1993 record. However, the 1994 record may be read as indicating that the tissue was evaluated in the course of completing the described procedure. (See Tr. 272-273, 412, 497; P.Ex. 13, p. 8)

Accordingly, **Paragraphs K.1, K.2, K.4** and **K.5** are **SUSTAINED** insofar as they relate to the May, 1993 treatment and **NOT SUSTAINED** insofar as they relate to the May, 1994 treatment.

Paragraph K.3 states that Respondent failed to note Patient K's vital signs at either the 1993 or 1994 treatment. The failure to note vital signs on both visits cannot be overlooked. This includes the situation presented in 1994, when at least the patient's blood pressure should have been noted. (See Findings of Fact 13 and 94, supra; see also Tr. 416)

Paragraph K.3 is **SUSTAINED.**

---

[19]Respondent's expert witness testified that anesthesia is often not used for the kind of procedure performed on Patient K in May, 1994 (Tr. 416), but Respondent did not testify whether he used any anesthesia at that time.

Paragraph K.7 states that Respondent failed to administer Rhogam to Patient K at her May, 1994 visit or to note that it was administered. Respondent testified that he knew from Patient K's earlier visit that she was Rh negative and required Rhogam and that he has found in his billing records that Patient K paid for a Rhogam shot in May, 1994. (Tr, 498-499) However, that is not noted on the patient's medical record.

Paragraph K.7 is **SUSTAINED** insofar as it states that the chart fails to note the administration of Rhogam in May, 1994.

Paragraph K.8 states that Respondent failed to note the performance of a TOP on May 11, 1993. The record contains entries concerning "VDXyl," insertion of laminaria and administration of Rhogam, but fails to state that there was a TOP. Notation of this procedure should not be relegated to an inference from such entries.

Paragraph K.8 is **SUSTAINED.**

DISPOSITION OF SPECIFICATIONS

The charges against Respondent are grouped into five (5) categories. First is the charge that he committed negligence on more than one occasion. In the context of professional discipline, "negligence" is the "deviation from accepted standards" or "from good and accepted medical practice." Matter of Morfesis v. Sobol, 172 A.D.2d 897, 898, 567 NYS2d 954, 955-956 (3rd Dept.), app. den., 78 NYS2d 856, 574 NYS2d 947 (1991).

Although certain of the Statement's factual allegations have not been proved, the charge of practicing with negligence on more than one occasion has been established. Respondent's failure in examining and treating his patients, as set forth above, evidence many deviations from accepted standards and good medical practice.

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The second group of charges allege that Respondent committed gross negligence in his treatment of each of the patients whose records were presented at the hearing. "Gross negligence" is "a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct." Matter of Rho v. Ambach, 74 NYS2d 318, 322; 546 NYS2d 1005, 1007 (1989).

The Committee has determined that only one (1) of Respondent's actions falls within the definition of gross negligence. That was the performance upon Patient A of an undesired abortion (as alleged in ¶ A.1), which was clearly an error of "egregious proportions." Upon review by the Committee, it is determined that the remainder of Respondent's professional failings introduced at the hearing do not constitute egregious conduct whether looked at in isolation or as a whole.

The third form of misconduct charged against Respondent is practicing with incompetence on more than one occasion. Incompetence is the lack of requisite skill and knowledge on the part of the physician with respect to the practice in which he engages. There is no proof in the record that Respondent lacks the skill or knowledge to practice in his specialty area.

The fourth form of misconduct is the failure to maintain accurate records. Petitioner has amply demonstrated that good recordkeeping is an essential feature of good medical practice. Except for Patient E (where the facts concerning Respondent's treatment have not been established), Respondent's recordkeeping with respect to the patients presented here contain too many gaps to meet acceptable standards.

The final form of misconduct is performance of a procedure not authorized by the patient. This is alleged only with respect to the TOP's performed on Patient A on January 9, 1989, and on Patient H on December 10, 1990. The charge concerning Patient A has been proved.

However, the charge concerning Patient H rests only on the absence from Respondent's files of a consent form signed by that patient on that date. While Petitioner presented no

evidence that Patient H did not desire an abortion on December 10, 1990, Respondent pointed out that this patient returned to him for treatment at least two (2) more times. The Committee cannot conclude that Patient H did not authorize the procedure which was performed on December 10, 1990.

Accordingly, the Committee has entered the following Dispositions of the Specifications of Charges:

FIRST SPECIFICATION (negligence on more than one occasion):

SUSTAINED

SECOND SPECIFICATION (gross negligence with respect to Patient A):

SUSTAINED

THIRD, FOURTH, FIFTH, SIXTH SEVENTH, EIGHTH, NINTH, TENTH, ELEVENTH AND TWELFTH SPECIFICATIONS (gross negligence with respect to Patients B, C, D, E, F, G, H, I, J and K):

NOT SUSTAINED

THIRTEENTH SPECIFICATION (incompetence on more than one occasion):

NOT SUSTAINED

FOURTEENTH, FIFTEENTH, SIXTEENTH AND SEVENTEENTH SPECIFICATIONS (inaccurate recordkeeping with respect to Patients A, B, C and D):

SUSTAINED

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EIGHTEENTH SPECIFICATION (inaccurate recordkeeping with respect to Patient E):

NOT SUSTAINED

NINETEENTH, TWENTIETH, TWENTY-FIRST, TWENTY-SECOND, TWENTY-THIRD AND TWENTY-FOURTH SPECIFICATIONS (inaccurate recordkeeping with respect to Patients F, G, H, I, J and K):

SUSTAINED

TWENTY-FIFTH SPECIFICATION (performing professional services which had not been duly authorized by Patient A):

SUSTAINED

TWENTY-SIXTH SPECIFICATION (performing professional services which had not been duly authorized by Patient H):

NOT SUSTAINED

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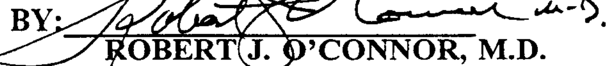
ORDER

The Committee, by unanimous vote, has determined that the following penalty should be, and hereby is,

ORDERED that the license to practice medicine of Respondent **MARX JEAN SANTEL, M.D.** shall be **SUSPENDED** for a period of **TWO (2) YEARS,** but that the **SECOND YEAR** of said suspension shall be **STAYED INDEFINITELY, on the condition** that the practice of Respondent **MARX JEAN SANTEL, M.D.,** shall be **monitored** for a period of **one (1) year** by a physician nominated by Dr. Santel and approved by the Office of Professional Medical Conduct.

DATED: **New York, New York**
March 11 , 1996



BY: **ROBERT J. O'CONNOR, M.D.**

ANTHONY CLEMENDOR, M.D.
OLIVE M. JACOB

NEW YORK STATE DEPARTMENT OF HEALTH

APPENDIX 1

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

IN THE MATTER OF MARX JEAN SANTEL, M.D.	NOTICE OF HEARING

Pet's Ex 1 in Ev. 6/20/95

TO: Marx Jean Santel, M.D.
375 Fifth Avenue
4th Floor
New York, New York

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 26th day of June, 1995, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, 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 attorne for the Department of Health whose name appears below, and at least five days prior to the sc duled hearing date.

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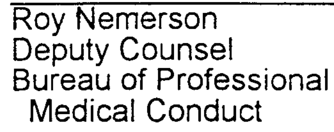
Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995), 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, §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 §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 OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
, 1995



Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Ann Hroncich
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

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

IN THE MATTER OF MARX JEAN SANTEL, M.D.	STATEMENT OF CHARGES

MARX JEAN SANTEL, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 29, 1972, by the issuance of license number 113998 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, age 21, from approximately April 1985 to January 1989, at his office which at the time was located on East 30th Street, New York, New York. (The identities of Patient A and the other patients are disclosed in the attached Appendix.)

1. Respondent failed to inform the patient of the termination of pregnancy which was to be performed on or about January 9, 1989, and he failed to obtain consent from the patient for said termination of pregnancy.
2. On or about January 9, 1989, Respondent failed to perform necessary laboratory tests upon this patient.
3. On or about January 9, 1989, Respondent failed to take or note in the chart vital signs of the patient during and subsequent to the termination of pregnancy.
4. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about January 9,

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1989.

5. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about January 9, 1989.

B. Respondent treated Patient B, age 25, on approximately February 16 and 23, 1994, at his office which is located at 373 Fifth Avenue, New York, New York.

1. Respondent failed to perform an adequate physical examination, or note in the chart such examination, if any.
2. On or about February 16, 1994, Respondent failed to perform necessary laboratory tests upon this patient.
3. On or about February 16, 1994, Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
4. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about February 16, 1994.
5. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about February 16, 1994, or to note in the chart that same was done.
6. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about February 16, 1994.
7. Respondent failed to note in the chart whether a termination of pregnancy or any other procedure was performed upon this patient on or about February 16, 1994.

C. Respondent treated Patient C, age 29, on approximately June 5 and 12, 1992, at his office which is located at 681 Ocean Avenue, Brooklyn, New York.

1. On or about June 5, 1992, Respondent failed to perform an adequate physical examination, or note in the chart such examination, if any.
2. On or about June 5, 1992, Respondent failed to perform necessary laboratory tests upon this patient.
3. On or about June 5, 1992, Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.
4. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about June 5, 1992.
5. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about June 5, 1992, or to note in the chart that same was done.
6. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about June 5, 1992.
7. Respondent failed to note in the chart whether a termination of pregnancy or any other procedure was performed upon this patient on or about June 5, 1992.

D. Respondent treated Patient D, age 40, from approximately February 1993 to February 1994, at his office which is located at 373 Fifth Avenue, New York, New York.

1. On or about February 23, 1993 and February 22, 1994, Respondent failed to obtain an adequate medical history, or note in the chart such history, if any.

2. On or about February 23, 1993 and February 22, 1994, Respondent failed to perform an adequate physical examination, or note in the chart such examination, if any.

3. On or about February 23, 1993 and February 22, 1994, Respondent failed to perform necessary laboratory tests upon this patient.

4. On or about February 23, 1993 and February 22, 1994, Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.

5. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about February 23, 1993 and February 22, 1994.

6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about February 22, 1994, or to note in the chart that same was done.

7. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about February 23, 1993 and February 22, 1994.

8. Respondent failed to note in the chart whether a termination of pregnancy or any other procedure was performed upon this patient on or about February 23, 1993 and February 22, 1994.

E. Respondent treated Patient E, age 36, on approximately September 26 and/or 27,

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1993, at his office which is located at 373 Fifth Avenue, New York, New York.

1. Respondent failed to obtain an adequate medical history, or note in the chart such history, if any.

2. Respondent failed to perform an adequate physical examination or note in the chart such examination, if any.

3. Respondent failed to perform necessary laboratory tests upon this patient.

4. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.

5. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient.

6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy, or to note in the chart that same was done.

7. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed.

8. Respondent failed to note in the chart whether a termination of pregnancy or any other procedure was performed upon this patient.

F. Respondent treated Patient F, age 18, on approximately December 28 and/or 29, 1992, and January 7, 1993 at his office which is located at 373 Fifth Avenue, New York, New York.

1. On or about December 28 or 29, 1992, Respondent failed to perform an adequate physical examination or note in the chart such examination, if any.

2. On or about December 28 or 29, 1992, Respondent failed to perform necessary laboratory tests upon this patient.

3. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy on or about December 28 or 29, 1992.

4. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about December 28 or 29, 1992.

5. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about December 28 or 29, 1992, or to note in the chart that same was done.

6. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about December 28 or 29, 1992.

7. Respondent failed to note in the chart whether a termination of pregnancy or any other procedure was performed upon this patient on or about December 28 or 29, 1992.

G. Respondent treated Patient G, age 15, on or about July 8, 1993, at his office which is located at 373 Fifth Avenue, New York, New York.

1. Respondent failed to obtain an adequate medical history, or note in the chart such history, if any.

2. Respondent failed to perform an adequate physical examination or note in the chart such examination, if any.

3. Respondent failed to perform necessary laboratory tests upon this patient.

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4. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy.

5. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient.

6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy, or to note in the chart that same was done.

7. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed.

H. Respondent treated Patient H, age 35, from approximately July 1989 to February 1993, at his office which is located at 681 Ocean Avenue, Brooklyn, New York.

1. On or about July or August 17, 1989, May 11, 1990, December 10, 1990, and February 5, 1993, Respondent failed to perform an adequate physical examination, or note in the chart such examination, if any.

2. Respondent failed to obtain adequate consent from this patient for the termination of pregnancy which was performed on or about December 10, 1990.

3. Respondent failed to perform necessary laboratory tests upon this patient on or about July or August 17, 1989, May 11, 1990, December 10, 1990, and February 5, 1993.

4. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy on or about July or August 17, 1989, May 11, 1990. December 10,

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1990, and February 5, 1993.

5. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about July or August 17, 1989, May 11, 1990, December 10, 1990, and February 5, 1993.

6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about July or August 17, 1989, May 11, 1990, December 10, 1990, and February 5, 1993, or to note in the chart that same was done.

7. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about July or August 17, 1989, May 11, 1990, December 10, 1990, and February 5, 1993.

8. Respondent failed to note in the chart whether a termination of pregnancy or any other procedure was performed upon this patient on or about July or August 17, 1989, May 11, 1990, December 10, 1990, and February 5, 1993.

I. Respondent treated Patient I, age 34, from approximately January 1993 to May 1994, at his office which is located at 681 Ocean Avenue, Brooklyn, New York.

1. On or about January 19, 1993, Respondent failed to obtain an adequate medical history, or note in the chart such history, if any.

2. On or about January 19, 1993 and January 4 or 6, 1994, Respondent failed to perform an adequate physical examination, or note in the chart such examination, if any.

3. Respondent failed to perform necessary laboratory tests upon this

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patient on or about January 19, 1993 and January 4 or 6, 1994.

4. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy on or about January 19, 1993 and January 4 or 6, 1994.

5. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about January 19, 1993 and January 4 or 6, 1994.

6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about January 19, 1993 and January 4 or 6, 1994, or to note in the chart that same was done.

7. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about January 19, 1993 and January 4 or 6, 1994.

8. Respondent failed to note in the chart whether a termination of pregnancy or any other procedure was performed upon this patient on or about January 19, 1993 and January 4 or 6, 1994.

J. Respondent treated Patient J, age 25, from approximately May 1992 to March 1994, at his office which is located at 373 Fifth Avenue, New York, New York.

1. On or about May 28, 1992, Respondent failed to obtain an adequate medical history, or note in the chart such history, if any.

2. On or about May 28, 1992, Respondent failed to perform an adequate physical examination, or note in the chart such examination, if any.

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3. Respondent failed to perform necessary laboratory tests upon this patient on or about May 28, 1992.

4. Respondent failed to take or note in the chart vital signs of the patient prior, during, and subsequent to the termination of pregnancy on or about May 28, 1992.

5. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about May 28, 1992.

6. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about May 28, 1992, or to note in the chart that same was done.

7. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about May 28, 1992.

8. Respondent failed to note in the chart whether a termination of pregnancy or any other procedure was performed upon this patient on or about May 28, 1992.

K. Respondent treated Patient K, age 33, from approximately May 1993 to June 1994, at his office which is located at 681 Ocean Avenue, Brooklyn, New York.

1. On or about May 11, 1993 and May 14, 1994, Respondent failed to perform an adequate physical examination, or note in the chart such examination, if any.

2. Respondent failed to perform necessary laboratory tests upon this patient on or about May 11, 1993 and May 14, 1994.

3. Respondent failed to take or note in the chart vital signs of the

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patient prior, during, and subsequent to the termination of pregnancy on or about May 11, 1993 and May 14, 1994.

4. Respondent failed to note in the chart what, if any, anesthesia and/or other drugs were administered to this patient on or about May 11, 1993 and May 14, 1994.

5. Respondent failed to evaluate the tissue to determine that all of the necessary products of conception were removed during the termination of pregnancy on or about May 11, 1993 and May 14, 1994, or to note in the chart that same was done.

6. Respondent failed to provide or note in the chart that appropriate counseling was given to the patient with regard to the termination of pregnancy performed on or about May 11, 1993 and May 14, 1994.

7. On or about May 14, 1994, Respondent failed to administer necessary medication (Rhogam) or note in the chart that such medication was given.

8. Respondent failed to note in the chart whether a termination of pregnancy was performed upon this patient on or about May 11, 1993.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1995), in that Petitioner charges Respondent with having committed at least two of the following:

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1. The facts contained in paragraphs A and A1, 2, 3, 4, and/or 5, B and B1, 2, 3, 4, 5, 6, and/or 7, C and C1, 2, 3, 4, 5, 6, and/or 7, D and D1, 2, 3, 4, 5, 6, 7, and/or 8, E and E1, 2, 3, 4, 5, 6, 7, and/or 8, F and F1, 2, 3, 4, 5, 6, and/or 7, G and G.1, 2, 3, 4, 5, 6, and/or 7, H and H1, 2, 3, 4, 5, 6, 7, and/or 8, I and I1, 2, 3, 4, 5, 6, 7, and/or 8, J and J1, 2, 3, 4, 5, 6, 7, and/or 8, K and K1, 2, 3, 4, 5, 6, 7, and/or 8.

SECOND THROUGH TWELFTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1995), in that Petitioner charges Respondent with having committed the following:

2. The facts contained in paragraphs A and A1, 2, 3, 4, and/or 5.
3. The facts contained in paragraphs B and B1, 2, 3, 4, 5, 6, and/or 7.
4. The facts contained in paragraphs C and C1, 2, 3, 4, 5, 6, and/or 7.
5. The facts contained in paragraphs D and D1, 2, 3, 4, 5, 6, 7, and/or 8.
6. The facts contained in paragraphs E and E1, 2, 3, 4, 5, 6, 7, and/or 8.
7. The facts contained in paragraphs F and F1, 2, 3, 4, 5, 6, and/or 7.
8. The facts contained in paragraphs G and G1, 2, 3, 4, 5, 6, and/or 7.
9. The facts contained in paragraphs H and H1, 2, 3, 4, 5, 6, 7, and/or 8.
10. The facts contained in paragraphs I and I1, 2, 3, 4, 5, 6, 7, and/or 8.
11. The facts contained in paragraphs J and J1, 2, 3, 4, 5, 6, 7, and/or 8.
12. The facts contained in paragraphs K and K1, 2, 3, 4, 5, 6, 7, and/or 8.

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THIRTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1995), in that Petitioner charges Respondent with having committed at least two of the following:

13. The facts contained in paragraphs A and A1, 2, 3, 4, and/or 5, B and B1, 2, 3, 4, 5, 6, and/or 7, C and C1, 2, 3, 4, 5, 6, and/or 7, D and D1, 2, 3, 4, 5, 6, 7, and/or 8, E and E1, 2, 3, 4, 5, 6, 7, and/or 8, F and F1, 2, 3, 4, 5, 6, and/or 8, G and G.1, 2, 3, 4, 5, 6, and/or 7, H and H1, 2, 3, 4, 5, 6, 7, and/or 8, I and I1, 2, 3, 4, 5, 6, 7, and/or 8, J and J1, 2, 3, 4, 5, 6, 7, and/or 8, K and K1, 2, 3, 4, 5, 6, 7, and/or 8.

FOURTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1995), in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, in that Petitioner charges:

14. The facts contained in paragraphs A and A3, 4, and/or 5.
15. The facts contained in paragraphs B and B1, 3, 4, 5, 6, and/or 7.
16. The facts contained in paragraphs C and C1, 3, 4, 5, 6, and/or 7.
17. The facts contained in paragraphs D and D1, 2, 4, 5, 6, 7, and/or 8.
18. The facts contained in paragraphs E and E1, 2, 4, 5, 6, 7, and/or 8.
19. The facts contained in paragraphs F and F1, 3, 4, 5, 6, and/or 7.

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20. The facts contained in paragraphs G and G1, 2, 4, 5, 6, and/or 7.

21. The facts contained in paragraphs H and H1, 4, 5, 6, 7, and/or 8.

22. The facts contained in paragraphs I and I1, 2, 4, 5, 6, 7, and/or 8.

23. The facts contained in paragraphs J and J1, 2, 4, 5, 6, 7, and/or 8.

24. The facts contained in paragraphs K and K1, 3, 4, 5, 6, 7, and/or 8.

TWENTY-FIFTH AND TWENTY-SIXTH SPECIFICATIONS

PERFORMING A PROCEDURE NOT DULY AUTHORIZED

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(26) (McKinney Supp. 1995), in that he performed professional services which had not been duly authorized by the patient, in that Petitioner charges:

25. The facts contained in paragraphs A and A1.

26. The facts contained in paragraphs H and H2.

DATED: June 1, 1995
New YorK and New York

ROY NEMERSON
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