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

July 23, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ann Hroncich Gayle, Esq.
NYS Dept. of Health
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

Effective Date: 09/21/96

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 Professional Medical Conduct Administrative Review Board in the above referenced matter. The Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Sincerely,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB rlw

Enclosure

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

COPY

IN THE MATTER

OF

MARX JEAN SANTEL, M.D.

ADMINISTRATIVE REVIEW BOARD DETERMINATION AND ORDER NO. 96-49

The Respondent **MARX JEAN SANTEL, M.D**. (Respondent) and the Bureau for Professional Medical Conduct (Petitioner) have both challenged a Hearing Committee on Professional Medical Conduct's (Hearing Committee) Determination, which found the Respondent guilty for professional misconduct, suspended his New York medical license for one year and required a monitor for the Respondent's practice for one additional year. The Administrative Review Board for Professional Medical Conduct (Review Board) sustains the Hearing Committee's Determination finding the Respondent guilty for practicing with gross negligence, negligence on more than one occasion, failing to obtain patient consent and failing to maintain adequate records. Board members **ROBERT M. BRIBER, WINSTON S. PRICE, M.D., SUMNER SHAPIRO, EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** conducted deliberations on May 17, 1996. Dr. Stewart participated in the deliberations by telephone. The Board modifies the Committee's sanction against the Respondent. We sustain the one year suspension, but we vote 5-0 to limit the Respondent's license following the suspension so that the Respondent may practice only in a hospital or clinic licensed pursuant to Public Health Law Article 28. The Board also amends the Committee's Determination to correct two errors in the text. Administrative Law Judge **JAMES F. HORAN** served as the Board's Administrative Officer.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent violated the New York Education Law (McKinney's Supp 1996) by:

- practicing medicine with negligence on more than one occasion, (Educ. Law §6530 (3));
- practicing medicine with gross negligence (Educ. Law §6530 (4));
- practicing medicine with incompetence on more than one occasion (Educ. Law §6530 (5));
- failing to maintain adequate records (Educ. Law §6530 (32)); and
- performing a procedure not duly authorized by the patient (Educ. Law §6530 (26)).

The negligence, incompetence and records charges involved the Respondent's care for eleven patients, on whom the Respondent performed terminations of pregnancy (TOP). The record refers to the patients by the initials A through K, to protect their privacy. The unauthorized procedure charge involved Patients A and K.

Hearing Committee members Robert J. O'Connor, M.D., Chair, Anthony Clemendor, M.D and Olive M. Jacob rendered their Determination on March 13, 1996. Administrative Law Judge Eugene A. Gaer served as the Committee's Administrative Officer. The Committee determined that the Respondent had committed gross negligence in treating Patient A and had failed to obtain Patient A's consent for a procedure. The Committee also determined that the Respondent committed negligence on more than one occasion and failed to maintain adequate records for Patient A through D and F through K. The Committee sustained no charges concerning Patient E's treatment and no charges alleging incompetence on more than one occasion. The Committee also determined that the Respondent had obtained consent for a procedure on Patient H.

The Committee found that the Respondent performed a TOP on Patient A on January 9, 1989. The Committee found that the Respondent had failed to obtain either written or oral consent from Patient A for the procedure. The Committee made the findings on that issue based on testimony by Patient A and they rejected contradictory testimony from the Respondent and his medical secretary Ninon Rodriguez. The Committee concluded that, by performing the unwanted abortion, the Respondent committed gross negligence, in violation of Educ. Law §6530 (4), and that the Respondent performed a procedure without authorization, in violation of Education Law §6530 (26).

The Committee determined that the Respondent had failed to meet the minimum care standard in providing TOP procedures to Patients A through D and F through K. The Committee found that the Respondent failed repeatedly to

- perform adequate physical examinations;
- obtain all necessary tests, and
- perform an evaluation on tissue to determine whether he had removed all products of conception during the procedures.

The Committee concluded that the Respondent's repeated substandard care constituted practicing medicine with negligence on more than one occasion.

The Committee concluded that the Respondent failed to keep adequate medical records for Patients A through D and F through K. The Committee found that the Respondent's records fell below the acceptable standard and failed to contain minimum necessary data. The Committee found that the records lacked patient histories, vital signs and examination notes, and, that notes that did appear lacked sufficient information. The Committee noted that physicians performing similar procedures must note each procedure. Relying on memory could lead to confusion and adverse consequences.

The Committee voted to suspend the Respondent's license for two years. The Committee stayed the second year, on condition that the Respondent undergo monitoring for that year, by a physician whom the Respondent will nominate and whom the Office of Professional Medical Conduct must approve.

REVIEW PROCEDURAL HISTORY

Both parties requested that the Board review the Committee's Determination. The Board received both Review Notices on March 26, 1996. The Review Notices stayed the Committee's penalty automatically, pending the final Determination on the Review [NY Public Health Law §230-c(4)(a)(McKinney Supp. 1996)]. **GEORGE WEINBAUM, ESQ.** submitted a brief for the Respondent, which the Board received on April 25, 1996. **ANN H. GAYLE, ESQ.** submitted a brief for the Petitioner, which the Board received April 26, 1996, and a reply brief which the Board received on May 3, 1996.

ISSUES FOR REVIEW

The Respondent contends that the hearing record fails to support the Respondent's suspension for one year and contends that the Petitioner failed to prove the charges by a preponderance of the evidence The Respondent acknowledges poor record keeping, but contends that no proof demonstrated that he failed to perform proper exams or obtain proper histories. The Respondent contends that the Committee erred in accepting expert testimony by the Petitioner's expert Dr. Rashbaum and by rejecting expert testimony by the Respondent's expert Dr. Berman. The Respondent also contends that the Committee erred in crediting testimony by Patient A and disregarding testimony by the Respondent and his secretary Ms. Rodriguez. The Respondent notes that the only sustained charge alleging gross negligence involved the TOP for Patient A. The Respondent contends that since the record on that charge is unclear, that the Board should not sustain the charge.

The Respondent states that he now works at a hospital and keeps more detailed records. He contends that the one year suspension will result in lost employment and financial hardship for his family The Respondent requests leniency, if the Board feels a sanction is appropriate, and requests that any sanction reflect the charge that the Petitioner proved.

The Petitioner has asked that the Board overturn the Hearing Committee's penalty and revoke the Respondent's license to practice in New York. The Petitioner contends that the Hearing Committee's penalty is mild and that the provision for monitoring is inappropriate, except as a term of probation. The Respondent contends that public protection requires a harsher sanction to prevent additional patient harm.

In the reply brief, Petitioner's counsel contends that the Respondent's assertion, about his current employment and his improved record-keeping, are matters outside the Hearing Record and not properly before the Board.

THE BOARD'S SCOPE OF REVIEW

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

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration. Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

REVIEW BOARD DETERMINATION

A. GUILT FOR MISCONDUCT

The Review Board votes unanimously to sustain the Hearing Committee's Determination finding the Respondent guilty for gross negligence, negligence on more than one occasion, failure to maintain adequate records and failure to obtain Patient A's consent for the TOP. The Committee's Determination is consistent with their findings and conclusions. The record, including testimony from Dr. Rashbaum and Patient A, supports the Committee's findings. The Respondent did not contest the Committee Determination that the Respondent maintained inadequate records.

Patient A's testimony established that the Respondent performed a TOP on Patient A in 1989, without the Patient's written or oral consent. Such conduct constitutes gross negligence and performing professional services without patient authorization. The Committee as the fact finder had the opportunity to assess each witness's credibility and they found Patient A more credible than the Respondent or Ms. Rodriguez.

Dr Rashbaum's testimony established that the Respondent failed repeatedly to perform by medically accepted standards in performing TOP procedures on Patients A through D and F through K. The Committee considered testimony by Dr. Rashbaum and Dr. Berman, and when the testimony conflicted, the Committee found Dr. Rashbaum more credible. At some points, however, the Committee relied on testimony by both experts in determining the proper care standards (Committee Findings of Fact 11, 13, 16, pp. 7 and 8). The Committee acted correctly in finding that the Respondent did not perform a procedure, unless the procedure appeared in the patient's record. If a procedure does not appear in the record, the Committee and the Board can assume that the procedure did not occur. The Respondent's repeated sub-standard care constitutes negligence on more than one occasion.

B. PENALTY

The Review Board votes 5-0 to modify the Hearing Committee's penalty, because we believe that the penalty fails to provide sufficient public protection against the Respondent's carelessness and poor judgment.

The Board votes to suspend the Respondent's license to practice in New York for one year. We disagree with the Respondent's assertion that the Respondent caused no harm. The Respondent subjected Patient A to unwanted surgery and terminated her pregnancy against her wishes. We agree with the Hearing Committee that the Respondent deserves a one year actual suspension for performing an abortion on Patient A without her consent. The Board agrees with the Committee that the Respondent will require supervision following his suspension. We disagree, however, over the time period for which and the extent to which supervision will be necessary. The Board concludes, however, that we can fashion a penalty that will protect the public, without revoking the Respondent's medical license.

The Respondent demonstrated a continuing negligent pattern in treating ten patients over a five year span, 1989-1994. The Respondent repeated the same sub-standard care in all cases by:

- failing to perform adequate examination;
- failing to obtain all necessary laboratory tests; and
- failing to evaluate tissue from a TOP, to confirm that he has terminated the pregnancy and removed all products of conception.

Failing to evaluate the tissue constituted the most serious repeated error. Both the Respondent's expert and the Petitioner's expert agreed that the care standard requires gross tissue evaluation to confirm pregnancy termination (Finding of Fact 16, p. 8). No tissue present could indicate an ectopic pregnancy, which could lead to rupture and maternal death (Tr. p. 33). The Respondent's failure to evaluate the tissue placed each patient at risk. Such carelessness poses a danger to the Respondent's patients.

The Hearing Committee determined that the Respondent's substandard practice did not result from a lack of knowledge. The Board concludes that the Respondent's negligence resulted from carelessness or poor judgment. No retraining course will improve careless practice or poor judgment. The Board finds that we can assure public protection only if we place the Respondent under supervision permanently.

The Board votes 5-0 to limit the Respondent's license to practicing only in a facility licensed under Public Health Law Article 28. Such facilities are subject to state and federal inspection and such facilities will monitor the Respondent's record keeping and his practice. The Board votes 5-0 to limit the Respondent's license further to prohibit him from providing care in any surgical case, unless the Chief of Surgery or the Chief's designee has pre-approved the surgery.

C. CORRECTIONS

The Review Board amends the Committee's Determination to correct the following errors. At page 19, the date in Finding of Fact 74 reads January 19, 1983. We correct that date to read January 19, 1993. At page 29, the first full paragraph concludes by stating Paragraphs B.2, B.2, B.3 are sustained. We correct that to read Paragraphs B.1, B.2, B.3 are sustained.

ORDER

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

1 The Review Board **SUSTAINS** the Hearing Committee's March 13, 1996 Determination finding the Respondent guilty of professional misconduct.

2 The Review Board **AMENDS** the Hearing Committee's Determination on pages 19 and 29, as we note in our Determination.

3 The Review Board **MODIFIES** the Hearing Committee's penalty.

4. The Review Board **SUSPENDS** the Respondent's license to practice medicine in New York for one year.

5 The Review Board **LIMITS** the Respondent's license to practice medicine, as we set out in our Determination.

ROBERT M. BRIBER
SUMNER SHAPIRO
WINSTON S. PRICE, M.D.
EDWARD SINNOTT, M.D.
WILLIAM A. STEWART, M.D.

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

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

DATED: Schenectady, New York

July 18, **1996**

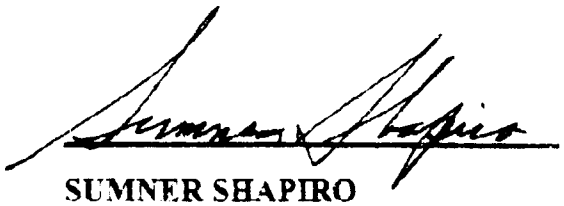
ROBERT M. BRIBER

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

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr Santel

DATED: Delmar, New York

July 17, **1996**



SUMNER SHAPIRO

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

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

DATED: Brooklyn, New York

7/10, **1996**

WINSTON S. PRICE, M.D.

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

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

DATED: Roslyn, New York
July 17, 1996

EDWARD C. SINNOTT, M.D.

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

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

DATED: Syracuse, New York

17 July , **1996**

William A Stewart

WILLIAM A. STEWART, M.D.