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

IN THE MATTER	DETERMINATION
OF	OF THE
JUSTIN CHARLES TERRA, M.D.	HEARING COMMITTEE

A Notice of Hearing and Statement of Charges, both dated October 17, 1991, were served upon the Respondent, Justin Charles Terra, M.D. **STEPHEN A. GETTINGER, M.D. (Chair), STANLEY D. LESLIE, M.D.,** and **JANE C. McCONNELL, ESQ.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ESQ., ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Silvia P. Finkelstein, Esq., Associate Counsel. The Respondent appeared by Iannuzzi & Iannuzzi, John Nicholas Iannuzzi, Esq. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

SUMMARY OF PROCEEDINGS

Date of Service of Notice of Hearing and Statement of Charges against Respondent	October 31, 1991
Answer to Statement of Charges:	None
Pre-Hearing Conference:	November 15, 1991
Dates of Hearing:	November 21, 1991 December 16, 1991 December 23, 1991 January 6, 1992

Department of Health appeared by:	Silvia P. Finkelstein Associate Counsel
Respondent appeared by:	Iannuzzi & Iannuzzi 233 Broadway New York, NY 10007 John Nicholas Iannuzzi, of Counsel
Witnesses for Department of Health:	Lynn Borgatta, M.D.
Witnesses for Respondent:	None
Received Department's Proposed Findings of Fact, Conclusions of Law and Letter Brief:	February 4, 1992
Received Respondent's Memorandum of Law:	February 5, 1992
Received Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendation:	February 12, 1992
Deliberations Held:	February 21, 1992

STATEMENT OF CASE

The Department has charged Respondent with gross negligence, negligence on more than one occasion, incompetence on more than one occasion, fraudulent practice of medicine, ordering treatment or use of treatment facilities not warranted by the condition of the patient and the failure to maintain accurate records. The charges relate to the medical care and treatment of twenty-four patients.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent

evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Respondent was authorized to practice medicine in New York State on November 8, 1965 by the issuance of license number 095765 by the New York State Education Department. (Dept. Ex. Z).

2. Respondent is currently registered with the New York State Education Department to practice medicine for period January 1, 1991 through December 31, 1992 from 1662 Crescent Drive, Thiells, New York 10984. (Dept. Ex. Z).

3. Respondent, an obstetrician/gynecologist, rendered medical care to Patients A through X. (Dept. Ex. A through X).

4. The performance of a first trimester abortion is justified only when a definitive diagnosis of pregnancy is appropriately pursued and established by the physician, assuming the patient wants to have an induced abortion. It is always the physician's responsibility to establish such a diagnosis, through detailed history and appropriate physical examination, laboratory tests, and/or sonography when necessary. (40-44, 67, 550-553, 555-556, 591).

5. An adequate history to support a diagnosis of pregnancy would include, at a minimum, inquiries as to the last menstrual period, past cycles, prior pregnancies, prior abortions, existing medical conditions, allergies, medications taken, and/or systemic illnesses. The age of a suspected pregnancy is generally calculated in weeks from the date of the last menstrual period.,

(40, 44, 49-50, 550-551, 555-556, 601-602).

6. An adequate physical examination to support a diagnosis of pregnancy would include, at a minimum, an abdominal examination and a bimanual pelvic examination looking for enlargement of the uterus, the size of the uterus, the orientation of the uterus, the presence or absence of any other pelvic masses, and/or the patient's vital signs. The size of the uterus is generally measured in weeks and should be related to the age of the pregnancy as measured in weeks since the last menstrual period. (41-42, 45-47, 572).

7. A diagnosis of pregnancy should be confirmed by laboratory tests, including a properly administered, sensitive urine test. A diagnosis of pregnancy can also be confirmed by a blood pregnancy test (Beta HCG Subunit) and /or ultrasound. When clinically necessary, ultrasound will confirm the size and location of the pregnancy. (41, 43-44, 551, 553, 568, 560).

8. When pregnancy is suspected and a patient presents with a positive urine pregnancy test and a normal or minimally enlarged uterus, a diagnosis of pregnancy has not been confirmed. A patient with those symptoms could have an extremely early pregnancy, a pregnancy that is not in the uterus, or a false positive urine pregnancy test. Under those circumstances, the performance of an abortion, without ultrasound confirmation of the size of the pregnancy or clinical confirmation of the growth of the uterus, is not indicated and creates risks for the patient. (42-45, 560-561, 591-593).

9. When clinical findings include a positive urine pregnancy test and a normal or minimally enlarged uterus, it is generally accepted medical practice to wait a week or two and re-examine the patient, or perform an ultrasound examination to determine the location and size of the pregnancy, or to order a quantitative blood pregnancy to determine the level of pregnancy hormone in the patient's blood. (42-44).

10. It is generally accepted medical practice that the size of a patient's uterus should be seven to eight weeks before it is reasonable to perform a first trimester abortion, in the absence of ultrasound confirmation of the size and location of the pregnancy. (46-47, 551, 560).

11. First trimester abortions can be performed under either local or general anesthesia, depending on the available facilities, in accordance with the physician's and patient's choice. (47-48, 571).

12. Prior to the administration of anesthesia, acceptable standards of practice require that the physician obtain a history from the patient including, but not limited to, existing medical conditions that would increase the risks associated with anesthesia, past operations, allergies, medications, systemic illnesses, any heart disease, lung disease, and/or liver disease. In addition, certain laboratory tests would be necessary, including screening for diabetes, and a blood count. (49-50, 555, 597-598).

13. A prudent physician who performs first trimester

abortions keeps accurate medical records reflecting the treatment rendered. The medical record should contain the following: the patient's history, the patient's vital signs, the findings on physical examination, the results of laboratory tests, including the urine or blood pregnancy tests used, consents to the abortion and to the administration of anesthesia, identity of the physician who performed the abortion, the time and date of the procedure, confirmation of size of the pregnancy, the type of anesthetic agents used and the amounts administered, by what means the cervix was dilated, the type of instruments used to remove the pregnancy, the type and amount of tissue removed, and /or the amount of blood estimated to have been lost. (51-56, 568, 572-574).

14. An ectopic pregnancy is any pregnancy outside of the normal intrauterine location. The majority of ectopic pregnancies occur in a fallopian tube. Ectopic pregnancies, if not surgically removed, may continue to grow and may rupture the tissue where they are implanted, possibly resulting in bleeding, shock and death. (56-57).

15. When an ectopic pregnancy is suspected, a reasonable clinician would document that fact in the patient's medical record, and order appropriate follow-up. (584-585).

16. On or about September 25, 1987, Respondent performed a suction curettage under general anesthesia on Patient A. (Dept. Ex. A).

17. On or about August 13, 1987, Respondent performed a curettage under general anesthesia on Patient B. (Dept. Ex. B).

18. On or about September 5, 1987, Respondent performed a suction curettage under general anesthesia on Patient C. (Dept. Ex. C).

19. On or about October 12, 1987, Respondent performed a suction curettage under general anesthesia on Patient D. (Dept. Ex. D).

20. On or about October 18, 1987, Respondent performed a suction curettage under general anesthesia on Patient E. (Dept. Ex. E).

21. On or about September 19, 1987, Respondent performed a curettage under local anesthesia on Patient F. (Dept. Ex. F).

22. On or about September 14, 1987, Respondent claimed to have performed a termination of pregnancy under general anesthesia on Patient G. (Dept. Ex. G).

23. On or about August 14, 1987, Respondent performed a curettage with general anesthesia on Patient H. (Dept. Ex. H).

24. On or about August 25, 1987, Respondent performed a suction curettage under general anesthesia on Patient I. (Dept. Ex. I).

25. On or about September 15, 1987, Respondent performed a suction curettage under general anesthesia on Patient J. (Dept. Ex. J).

26. On or about September 13, 1987, Respondent performed a suction curettage under general anesthesia or T.O.P. on Patient K. Subsequently, on or about September 26, 1987, Respondent performed a suction curettage under general anesthesia on Patient K. (Dept.

Ex. K).

27. On or about October 29, 1987, Respondent performed a suction curettage under general anesthesia on Patient L. (Dept. Ex. L).

28. On or about August 8, 1987, Respondent performed a suction curettage under general anesthesia on Patient M. (Dept. Ex. M).

29. On or about August 19, 1987, Respondent performed a suction curettage under general anesthesia on Patient N. (Dept. Ex. N).

30. On or about August 13, 1987, Respondent performed a curettage under general anesthesia on Patient O. (Dept. Ex. O).

31. On or about September 12, 1987, Respondent performed a curettage under general anesthesia on Patient P. (Dept. Ex. P).

32. On or about November 14, 1987, Respondent performed a T.O.P. under local anesthesia on Patient Q. (Dept. Ex. Q).

33. On or about October 30, 1987, Respondent performed a suction curettage under general anesthesia on Patient R. (Dept. Ex. R).

34. On or about October 16, 1987, Respondent attempted a D & C under general anesthesia on Patient S. On or about October 23, 1987, Respondent attempted another D & C under general anesthesia on Patient S. On or about October 31, 1987, Respondent performed a curettage on Patient S. (Dept. Ex. S).

35. On or about September 19, 1987, Respondent performed a suction curettage under general anesthesia on Patient T. (Dept.

Ex. T).

36. On or about August 27, 1987, Respondent performed a suction curettage under general anesthesia on Patient U. (Dept. Ex. U).

37. On or about August 3, 1987, Respondent claimed to have performed a T.O.P. under general anesthesia on Patient V. (Dept.EX. V).

38. On or about August 15, 1987, Respondent performed a curettage under general anesthesia on Patient W. (Dept. Ex. W).

39. On or about September 29, 1987, Respondent performed a curettage under general anesthesia on Patient X. (Dept. Ex. X).

40. Respondent did not adequately document his evaluation of Patients A through X prior to performing the procedures listed in Paragraphs 16 through 39, inclusive, as listed above. (60-67).

41. With regard to each Patient A through X Respondent failed to document an adequate history. (Patient A: 73-74, 76-77, 78-80; Dept. Ex. A); (Patient B: 90-95; Dept. Ex. B); (Patient C: 97, 100-102; Dept. Ex. C); (Patient D: 102-107; Dept. Ex. D); (Patient E: 107-111; Dept. Ex. E); (Patient F: 111-116; Dept. Ex. F); (Patient G: 116-119; Dept. Ex. G); (Patient H: 119-123; Dept. Ex. H); (Patient I: 124-127; Dept. Ex. I); (Patient J: 127-131; Dept. Ex. J); (Patient K: 131-139; Dept. Ex. K); (Patient L: 139-142; Dept. Ex. L); (Patient M: 142-145; Dept. Ex. M); (Patient N: 145-149; Dept. Ex. N); (Patient O: 149-154; Dept. Ex. O); (Patient P: 154-159; Dept. Ex. P); (Patient Q: 159-162; Dept. Ex. Q); (Patient R: 162-167; Dept. Ex. R); (Patient S: 167-176; Dept. Ex.

S); (Patient T: 176-179; Dept. Ex. T); (Patient U: 179-182; Dept. Ex. U); (Patient V: 182-187; Dept. Ex. V); (Patient W 187-190; Dept. Ex. W); (Patient X: 190-193; Dept. Ex. X).

42. With regard to each Patient A through X Respondent failed to document an adequate physical examination. (Patient A: 73-74, 76-77, 78-80; Dept. Ex. A); (Patient B: 90-95; Dept. Ex. B); (Patient C: 97, 100-102; Dept. Ex. C); (Patient D: 102-107; Dept. Ex. D); (Patient E: 107-111; Dept. Ex. E); (Patient F: 111-116; Dept. Ex. F); (Patient G: 116-119; Dept. Ex. G); (Patient H: 119-123; Dept. Ex. H); (Patient I: 124-127; Dept. Ex. I); (Patient J: 127-131; Dept. Ex. J); (Patient K: 131-139; Dept. Ex. K); (Patient L: 139-142; Dept. Ex. L); (Patient M: 142-145; Dept. Ex. M); (Patient N: 145-149; Dept. Ex. N); (Patient O: 149-154; Dept. Ex. O); (Patient P: 154-159; Dept. Ex. P); (Patient Q: 159-162; Dept. Ex. Q); (Patient R: 162-167; Dept. Ex. R); (Patient S: 167-176; Dept. Ex. S); (Patient T: 176-179; Dept. Ex. T); (Patient U: 179-182; Dept. Ex. U); (Patient V: 182-187; Dept. Ex. V); (Patient W 187-190; Dept. Ex. W); (Patient X: 190-193; Dept. Ex. X).

43. With regard to Patients A, B, C, D, G, H, I, L, M, N, O, P, Q, T, U, V and W, the history and physical examination and testing conducted by Respondent prior to performing the above-listed procedures were not adequate to appropriately diagnose pregnancy and to select patients clinically suitable to undergo abortion. (60-67, 85, 613-614); (Patient A: 73-74, 76-77, 78-80; Dept. Ex. A); (Patient B: 90-95; Dept. Ex. B); (Patient C: 97, 100-102; Dept. Ex. C); (Patient D: 102-107; Dept. Ex. D); (Patient

G: 116-119; Dept. Ex. G); (Patient H: 119-123; Dept. Ex. H); (Patient I: 124-127; Dept. Ex. I); (Patient L: 139-142; Dept. Ex. L); (Patient M: 142-145; Dept. Ex. M); (Patient N: 145-149; Dept. Ex. N); (Patient O: 149-154; Dept. Ex. O); (Patient P: 154-159; Dept. Ex. P); (Patient Q: 159-162; Dept. Ex. Q); (Patient T: 176-179; Dept. Ex. T); (Patient U: 179-182; Dept. Ex. U); (Patient V: 182-187; Dept. Ex. V); (Patient W 187-190; Dept. Ex. W).

44. Respondent did not adequately evaluate and note the medical conditions of Patients A through X subsequent to performing the above-listed procedures and prior to the discharge of the patients. (67, 69); (Patient A: 73-74, 76-77, 78-80; Dept. Ex. A); (Patient B: 90-95; Dept. Ex. B); (Patient C: 97, 100-102; Dept. Ex. C); (Patient D: 102-107; Dept. Ex. D); (Patient E: 107-111; Dept. Ex. E); (Patient F: 111-116; Dept. Ex. F); (Patient G: 116-119; Dept. Ex. G); (Patient H: 119-123; Dept. Ex. H); (Patient I: 124-127; Dept. Ex. I); (Patient J: 127-131; Dept. Ex. J); (Patient K: 131-139; Dept. Ex. K); (Patient L: 139-142; Dept. Ex. L); (Patient M: 142-145; Dept. Ex. M); (Patient N: 145-149; Dept. Ex. N); (Patient O: 149-154; Dept. Ex. O); (Patient P: 154-159; Dept. Ex. P); (Patient Q: 159-162; Dept. Ex. Q); (Patient R: 162-167; Dept. Ex. R); (Patient S: 167-176; Dept. Ex. S); (Patient T: 176-179; Dept. Ex. T); (Patient U: 179-182; Dept. Ex. U); (Patient V: 182-187; Dept. Ex. V); (Patient W 187-190; Dept. Ex. W); (Patient X: 190-193; Dept. Ex. X).

45. With regard to Patients A, B, C, D, E, G, I, L, M, N, O, P, Q, T, U and W, Respondent knew or should have known that his

diagnoses of pregnancy had not been adequately confirmed. Respondent should have informed each of these patients that she may not have been pregnant and may not have needed an abortion. (65-67, 84-85, 195, 577-580, 590-591, 593-594, 613-614); (Patient A: 73-74, 76-77, 78-80; Dept. Ex. A); (Patient B: 90-95; Dept. Ex. B); (Patient C: 97, 100-102; Dept. Ex. C); (Patient D: 102-107; Dept. Ex. D); (Patient E: 107-111; Dept. Ex. E); (Patient G: 116-119; Dept. Ex. G); (Patient I: 124-127; Dept. Ex. I); (Patient L: 139-142; Dept. Ex. L); (Patient M: 142-145; Dept. Ex. M); (Patient N: 145-149; Dept. Ex. N); (Patient O: 149-154; Dept. Ex. O); (Patient P: 154-159; Dept. Ex. P); (Patient Q: 159-162; Dept. Ex. Q); (Patient T: 176-179; Dept. Ex. T); (Patient U: 179-182; Dept. Ex. U); (Patient W 187-190; Dept. Ex. W).

46. Patients A through E, G through O and R through X were subjected to general anesthesia by or under the direction of Respondent. For each of these patients, Respondent did not appropriately record the timing of anesthetic administration. Respondent did not adequately note the patients' vital signs while under anesthesia. (51-53, 67-70, 566, 586-587, 605-608; Dept. Ex. A through E, G through O, and R through X).

47. Patients E, F, J, S, V and X evidenced a risk for ectopic pregnancy. Respondent did not adequately treat and/or follow-up on the potentially life-threatening conditions of these patients. (583-584, 593-594, 598-600); (Patient E: 107-111; Dept. Ex. E); (Patient F: 111-116; Dept. Ex. F); (Patient J: 127-131; Dept. Ex. J); (Patient S: 167-176; Dept. Ex. S); (Patient V: 182-

187; Dept. Ex. V); (Patient X: 190-193; Dept. Ex. X).

48. The pathology reports did not confirm that Patients A, B, C, D, G, H, I, L, M, N, O, P, Q, T, U and W were pregnant at the time that Respondent performed the above-listed surgical procedures. Respondent should have known that the pathology reports indicated that each of these patients had not been pregnant. Respondent should have informed the patients with appropriate follow-up,and should have documented such follow-up in the medical records. (73, 86-89, 94-95, 102, 107, 119, 123-124, 127, 138, 142, 145, 148-149, 154-156, 159, 162, 178-179, 181, 187, 579-580, 588-590, 593-594).

49. Respondent failed to keep medical records which accurately represent the condition of his patients and the care rendered to them. (65-67, 198, 563, 572, 574).

50. Although the patient's wishes regarding the performance of an abortion should be considered by the physician in making a determination of the proper care to be rendered to the patient, a first trimester abortion should not be performed where the physician is unable to adequately diagnose pregnancy, and unable to ascertain the size of the uterus. (194-195, 570, 590).

51. It is not acceptable medical practice for a physician and/or medical practitioner to perform a first trimester abortion on a patient where pregnancy has not been adequately confirmed. (47, 67, 591).

52. Respondent did not note the type and amount of

intravenous fluid administered to each of these patients. (Dept. Ex. A through X).

53. Respondent did not note whether each of Patients A through X received oxygen and ventilation. (Dept. Ex. A through X).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise. Numbers in parentheses refer to the specific Findings of Fact which support each conclusion.

FACTUAL ALLEGATIONS

The Hearing Committee concluded that the following Factual Allegations should be sustained:

(1) Paragraph A, to the extent that the Hearing Committee concluded that Respondent did provide medical care to the listed patients and performed the listed surgical procedures on the following patients: A, B, C, D, E, F, H, I, J, K, L, M, N, O, P, R, S, T, U, W and X. (1-3, 16-39).

Discussion

The Hearing Committee compared examples of Respondent's signature, found in Dept. Ex. Z, with the signatures found in the medical records of Patients A through X. (Dept. Ex. A through X). The Hearing Committee concluded that it was more likely than not that the signatures on the medical records were written by Respondent. Thus, they concluded that Respondent was the treating

physician. The Hearing Committee made no finding as to the location where the medical care and treatment was rendered to the identified patients.

The Hearing Committee further concluded that although Respondent did provide medical care to all of the identified patients, the Factual Allegation was not sustained, in part, with regard to several of the patients, as set forth below:

Patients G, Q and V: A review of the records indicates that these patients were not pregnant. Therefore, Respondent did not perform terminations of pregnancy, as alleged;

Patient P: The medical record indicates that a curettage was performed on Patient P, but does not indicate the type of anesthesia administered. Therefore, the Committee did not sustain the allegation with regard to the use of general anesthesia;

Patient S: The medical record for Patient S does not support a conclusion that the attempted D & C performed on October 23, 1987 was performed under general anesthesia.

(2) Paragraph A1(a): (4,5,13,40,41).

(3) Paragraph A1(b): (4,6,13,40,42).

(4) Paragraph A1(c) is sustained with regard to Patients A, B, C, D, G, H, I, L, M, N, O, P, Q, T, U, V and W: (4,7-9,13,43), and not sustained with regard to the remaining patients (E, F, J, K, R, S and X).

(5) Paragraph A1(d): (13,44).

(6) Paragraph A1(e) is sustained as to the first sentence of the allegation, with regard to Patients A, B, C, D, E, G, I, L,

M, N, O, P, Q, T, U and W. The second sentence of the allegation is not sustained. (45).

Discussion

Paragraphs A1(a) through A1(e) alleged failures in Respondent's evaluations of Patients A through X prior to performing abortions on the patients. In the absence of any affirmative evidence introduced by Respondent, the Hearing Committee concluded that where the records contained inadequate documentation of the necessary information, the inadequacy was due to Respondent's failure to obtain such information or perform the necessary physical examinations. Thus, the Committee sustained Paragraphs A1(a), A1(b) and A1(d).

Paragraph A1(c) alleged that the tests performed by Respondent on Patients A through X were not adequate to appropriately select them as clinically suitable to undergo abortions. The Committee sustained this allegation with regard to all patients except Patients E, F, J, K, R, S and X. The Committee reviewed the records for all of the patients and concluded that the pathology reports submitted for these seven patients were sufficiently equivocal as to give the benefit of the doubt to Respondent.

The Hearing Committee found no evidence in the record which demonstrated that Respondent knowingly and falsely informed Patients A through X that they were pregnant. Therefore, the Committee did not sustain the second sentence of Factual Allegation A1(e). However, the Committee concluded, by a

preponderance of the evidence that Respondent knew or should have known that the pre-procedure diagnoses for all of the patients except Patients F, H, J, K, R, S, V and X had not been adequately confirmed. Again, the records for these eight patients were equivocal; as a result, the Hearing Committee did not sustain the allegation with regard to these patients.

(7) Paragraph A2: This allegation was sustained with regard to Patients A through E, G through O and R through X. (12,13,46,51,52).

(8) Paragraph A2(a): This allegation was sustained with regard to the timing of the anesthetic agent administered to these patients, but not sustained as to the amount of agents administered. (46).

(9) Paragraph A2(b): (46).

(10) Paragraph A2(c): (52).

(11) Paragraph A2(d): (53).

Discussion

Factual Allegations A2(a) through A2(d) concern Respondent's alleged failure to maintain accurate records for the identified patients, each of whom received general anesthesia. The Committee sustained these allegations for all of the identified patients, except Patient P. This patient's medical record (Dept. Ex. P) does not indicate that the patient received general anesthesia. The Hearing Committee found that the amounts of anesthetic agents administered were documented in the medical records. As a result, the Committee did not sustain that portion

of Paragraph A2(a) that alleged a failure to note the amount of anesthetic agent administered.

(12) Paragraph A3 is sustained with regard to Patients E, F, J, S, V and X, and not sustained with regard to Patient R. (14,15,47).

Discussion

The Hearing Committee accepted the testimony of Dr. Borgatta and reviewed the medical records. Based upon the record, the Committee concluded that Patients E, F, J, S, V and X all evidenced a risk for ectopic pregnancy and that the medical records clearly demonstrated a lack of adequate follow-up. Based upon its review of the pathology report for Patient R, which noted the presence of sparse chorionic villi, (Dept. Ex. R), the Committee concluded that Respondent probably achieved the termination of an intra-uterine pregnancy. As a result, the Hearing Committee did not vote to sustain the allegation with regard to Patient R.

(13) Paragraph A4: (45,48).

Discussion

The pathology reports contained in the medical records for Patients A through C, H through I, L through N, P through Q, T through U, and W show no signs of pregnancy in the tissue submitted for analysis by Respondent. Therefore, the Hearing Committee concluded that the pathology reports did not confirm a diagnosis of pregnancy in any of the named patients.

(14) Paragraph A4(a): The Hearing Committee did not.

sustain this Factual Allegation. The Committee concluded, based upon a preponderance of the evidence, that Respondent should have reviewed the pathology reports and should have known that the patients were not pregnant. However, the record contains no proof that Respondent did in fact review the pathology reports. Therefore, the Hearing Committee could not conclude that Respondent knowingly failed to inform each of the patients that they had not been pregnant. As a result, this allegation was not sustained.

SPECIFICATION OF CHARGES

The Hearing Committee reached the following conclusions regarding the Specifications of Charges. The citations in parentheses refer to the Factual Allegations which support each specification:

First Specification (Gross Negligence): Sustained with regard to Patients A, B, C, D, E, F, G, H, I, J, L, M, N, O, P, Q, S, T, U, V, W and X; Not Sustained with regard to Patients K and R. (Paragraphs A, A1, A1(a) through (e), A2, A2(a) through (d), A3, and A4).

Second Specification (Negligence On More Than One Occasion): Sustained with regard to Patients A, B, C, D, E, F, G, H, I, J, L, M, N, O, P, Q, S, T, U, V, W and X; Not Sustained with regard to Patients K and R. (Paragraphs A, A1, A1(a) through (e), A2, A2(a) through (d), A3, and A4).

Third Specification (Incompetence On More Than One Occasion): Sustained with regard to Patients A, C, D, H, I, J, L,

M, P, T, U and V; Not Sustained with regard to Patients B, E, F, G, K, N, O, Q, R, S, W and X. (Paragraphs A, A1, A1(a) through (d), A2, A2(a) through (d), A3, and A4).

Fourth Specification (Fraudulent Practice): Not Sustained.

Fifth Specification (Ordering Treatment Or Use Of Treatment Facilities Not Warranted By The Condition Of The Patient): Sustained. (Paragraphs A and A4).

Sixth Specification (Failure To Maintain Accurate Records): Sustained. (Paragraphs A, A1, A1(a), A1(b), A1(d), A2, A2(a) through (d) and A3).

Discussion

Respondent is charged with six specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct under the New York Education Law" sets forth suggested definitions for gross negligence, negligence on more than one occasion, incompetence on more than one occasion, and fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee as a framework for its deliberations.

(1) Fraudulent practice of medicine is an intentional misrepresentation or concealment expressed or inferred from certain acts.

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

(3) Gross negligence is a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, a disregard of the consequences which may ensue from such failure and an indifference to the rights of others.

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

Gross Negligence

The Hearing Committee carefully evaluated the testimony of Lynn Borgatta, M.D., a board-certified obstetrician/gynecologist, the only expert witness presented at the hearing. The Committee found Dr. Borgatta to be a credible witness. In addition, the Committee reviewed the medical records for Patients A through X. The Committee concluded, by a preponderance of the evidence, that the medical care and treatment rendered by Respondent to Patients A through J, Patients L through Q and Patients S through X clearly demonstrated that Respondent failed to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances. The records established that Respondent performed abortions on twenty-two patients when Respondent was unable to adequately confirm the existence of any pregnancies. In spite of

that failure, Respondent subjected these patients to surgical procedures, thereby placing the patients at risk for possible adverse outcomes. The Hearing Committee unanimously concluded that Respondent's behavior in this regard was egregious, and demonstrated a disregard of the consequences which may have ensued, as well as an indifference to the rights of others.

The medical records for Patient K (Dept. Ex, K) indicated that the patient's uterus was enlarged. The patient underwent an unsuccessful suction curettage on September 3, 1987. The patient was followed by Respondent and another suction curettage was performed on September 26, 1987. The pathology report for the tissue removed at that time indicated the presence of products of conception, indicating that a pregnancy had been successfully terminated. Similarly, the medical records for Patient R (Dept. Ex. R) indicated that Respondent did accomplish the removal of pregnancy tissue. While the Hearing Committee found Respondent's care of Patients K and R to be marginal, at best, it did not rise to the level of gross negligence. Therefore, the Hearing Committee sustained the First Specification with regard to Patients A through J, L through Q and S through X.

Negligence On More Than One Occasion

As was set forth more specifically above, the Hearing Committee concluded that Respondent's conduct constituted gross negligence with regard to twenty-two patients. It is axiomatic, then, that the Hearing Committee concluded that Respondent's conduct also constituted negligence on more than one occasion.

Therefore the Hearing Committee sustained the Second Specification with regard to Patients A through J, L through Q and S through X.

Incompetence On More Than One Occasion

The pathology reports contained in the medical records for Patients A, C, D, H, I, J, L, M, P, T, U and V demonstrated that sufficient amounts of tissue to make a proper analysis had not been obtained by Respondent. The Hearing Committee concluded that failure to obtain adequate amounts of tissue needed for a pathology review demonstrated a lack of the skill or knowledge necessary to practice medicine. Accordingly, the Hearing Committee voted to sustain the Third Specification with regard to these twelve patients.

Fraudulent Practice

The records established that Patients A through C, H through I, L through N, P through Q, T through U, and W were not pregnant at the time Respondent performed the surgical procedures upon each of these patients. The Hearing Committee found that Respondent should have reviewed the pathology reports and therefore, should have known that the patients weren't pregnant. However, the Committee found no evidence that Respondent actually did review the pathology reports or that he intentionally failed to inform the patients of the results. Therefore, the Hearing Committee did not find the intentional concealment necessary to sustain a finding of fraud. As a result,the Hearing Committee did not sustain the Fourth Specification.

Ordering Treatment Not Warranted By The Condition Of The Patient

Respondent performed surgical procedures ("abortions") on Patients A, B, C, H,I ,K ,M, N, P, Q, T, U and W in spite of the fact that Respondent knew the patients probably were not pregnant, based upon the history, physical examination and size of the patients' uterus, as described in their medical records. Nevertheless, Respondent performed surgical procedures, under anesthesia, for these patients. The Hearing Committee concluded, by a preponderance of the evidence, that Respondent's conduct constituted the ordering of treatment not warranted by the condition of the patients. Therefore, the Fifth Specification was sustained.

Failure To Maintain Accurate Records

The record clearly established that Respondent's medical records were woefully inadequate. Respondent failed to adequately document the history and physical examination, failed to note the timing of anesthetic agents administered, failed to note the patients' vital signs during and after the surgical procedures, failed to note the type and amount of intravenous fluid administered, failed to note whether the patients received oxygen and ventilation, and failed to note the medical conditions of Patients A through X subsequent to performing the procedures. Therefore, the Hearing Committee concluded that Respondent failed to maintain accurate records and voted to sustain the Sixth Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to its Findings of Fact

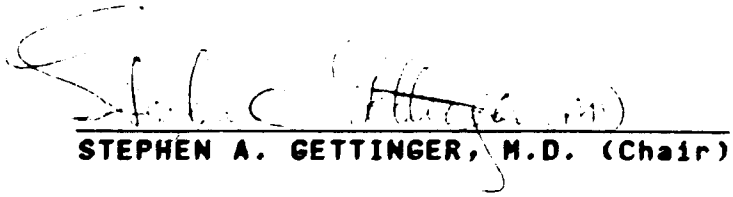
and Conclusions of Law herein, unanimously voted to revoke Respondent's license to practice medicine in the State of New York. This recommendation was reached after due consideration of the full spectrum of available penalties, including suspension, probation, censure and reprimand, or the imposition of monetary penalties.

As noted above, the Hearing Committee concluded that the deficiencies in the medical care rendered by Respondent demonstrated gross negligence, negligence, incompetence and the performance of surgical procedures not warranted by the patients' conditions. Respondent faced these very serious charges, yet chose to present no witnesses to explain or defend his treatment of these patients. The Hearing Committee was especially hindered by the failure of the Respondent to appear and testify.

In the absence of such testimony, the Committee was unable to make any evaluation of Respondent's potential for rehabilitation. Therefore, it would not be appropriate to assess a period of suspension, with appropriate re-training. As a result, the Hearing Committee determined that the appropriate penalty, under all of the circumstances, was revocation.

DATED: New York, New York
March 16, 1992

Respectfully submitted,



STEPHEN A. GETTINGER, M.D. (Chair)

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