STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

August 4, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Barry A. Gold, Esq.
Thuillez, Ford, Gold &
Conolly, Esqs.
90 State Street - Suite 1522
Albany, New York 12207

Gary VanGaasbeek, M.D.
373 Broadway
Kingston, New York 12401

Kevin P. Donovan, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower - Room 2438
Empire State Plaza
Albany, New York 12237-0028

RE: In the Matter of Gary VanGaasbeek, M.D.

Dear Mr. Gold, Dr. VanGaasbeek and Mr. Donovan:

Enclosed please find the Determination and Order (No. BPMC-92-61) of the Hearing Committee in the above referenced matter. This 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
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 than 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), "(t)he 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
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0030

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

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

Very truly yours,

Tyrone T. Butler/nam

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:
Enclosure

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

IN THE MATTER	:	HEARING COMMITTEE'S
OF	:	DETERMINATION AND
GARY VAN GAASBEEK, M.D.	:	ORDER
		ORDER NO. BPMC-92-61

STEPHEN GETTINGER, M.D. (Chair), TERESA S. BRIGGS, M.D. and MICHAEL A. GONZALEZ, R.P.A., duly designated members of the State Board of Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. MAUREEN J.M. ELY, ESQ., served as the Administrative Officer.

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

SUMMARY OF PROCEEDINGS

Date of Service of Notice of Hearing and Statement of Charges: August 14, 1991

Answer to Statement of Charges: None

Pre-Hearing Conference:	November 18, 1991
Hearings Held:	December 10, 1991 December 17, 1991 January 28, 1992 March 5, 1992 April 6, 1992 April 7, 1992 April 21, 1992 April 28, 1992 May 11, 1992 May 26, 1992
Location of Hearings:	Empire State Plaza Albany, New York
Adjournments:	November 22, 1991 (Respondent unable to attend hearing)
Received Petitioner's Proposed Findings of Fact:	June 15, 1992
Received Respondent's Proposed Findings of Fact:	June 15, 1992
Deliberations Held:	June 23, 1992
State Board for Professional Medical Conduct appeared by:	Kevin P. Donovan, Esq. Associate Counsel
Respondent, Gary Van Gaasbeek, M.D., appeared by:	Barry A. Gold, Esq.
Witnesses for State Board for Professional Medical Conduct:	Timothy Vinciguerra Patient D Patient D's Sister
Witnesses for Gary Van Gaasbeek, M.D.	Melody Ann Bruce, M.D. Gary Van Gaasbeck, M.D. Robert Iseman, Esq. Irwin Weiner, M.D. George Verrilli, M.D.
Amendment of Statement of Charges:	November 18, 1991 and April 2, 1992

STATEMENT OF CASE

Gary Van Gaasbeek, M.D. is charged with practicing medicine with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, fraudulently, with moral unfitness, failing to maintain accurate records and willfully making a false report. The basis for these charges are the allegations that Gary Van Gaasbeek, M.D. performed procedures on Patients B through F without an adequate medical indication for doing so, did not obtain a pathological evaluation of fluid aspirated from Patient A's cyst, and falsely answered "no" on his registration application to the question of whether any facility had restricted his privileges. The allegations are set forth with more particularity in the Amended Statement of Charges which is attached hereto as Appendix I.

FINDINGS OF FACT

The following findings of fact were made after a review

of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Gary Van Gaasbeek, M.D., hereinafter referred to as Respondent, was authorized to engage in the practice of medicine in New York State on February 11, 1987 by the issuance of license number 169321 by the New York State Education Department. (T. 6; Ex. 2).

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1991 from 373 Broadway, Kingston, New York. (Exhibit 2).

Patient A

3. Patient A was a 26 year old woman admitted to Kingston Hospital on February 1, 1989 by Respondent for a diagnostic laparoscopy. (Ex. 5).

4. Respondent found a 2 to 3 centimeter cyst on Patient A's right ovary that contained clear fluid. Respondent found no excrescences on the cyst and felt it was a follicular cyst. (T. 685-686).

5. Respondent aspirated fluid from the cyst but did not send the fluid for pathological evaluation. (T. 26-27; Exs. 4 at 8).

6. The reason for sending such fluid for pathological evaluation "is to evaluate for the presence of any malignant cells or the possibility of the cyst being found as being a malignant cyst." (T. 28, Dr. Vinciguerra).

7. A 26 year old woman's possibility of having ovarian cancer or cancer of an ovarian cyst is "at the low end of the spectrum." (T. 35, Dr. Vinciguerra).

Patient B

8. Patient B complained of left lower quadrant pain and dyspareunia on her initial visit to Respondent in August of 1987. (T. 996; Ex. 5 at 1).

9. On October 23, 1987, Patient B called Respondent and complained of breakthrough bleeding. Respondent ordered 2.5 mg of Premarin for five days. (Ex. 5 at 3).

10. Patient B was scheduled for a D & C on October 27, 1987 for therapeutic rather than diagnostic purposes. (T. 1001). Premarin can affect a pathological diagnosis of endometrial tissue. (T. 63, 861, 1001).

11. A prescription of 2.5 mg. of Premarin over a five day period for breakthrough bleeding in accordance with the treatment outlined in Speroff's Clinical Gynecology, Endocrinology and Infertility. (T. 998-999)

12. Patient B was 22 years old at the time of her surgery on October 27, 1987 (Ex. 6 at 2) and was taking birth control pills (Ex. 5 at 1). The risk of post-operative pulmonary embolism from taking Premarin was minimal. (Weiner at T. 862).

13. On October 11, 1988, Respondent ordered 2.5 mg. of Premarin (as a treatment for breakthrough bleeding). Respondent also ordered 50 mg. of Clomid for five days following the end of

Patient B's menstrual cycle. (T. 1002-1003; Ex. 5 at 7).

October 27, 1987 Surgery

14. Patient B was admitted to Kingston Hospital on October 27, 1987 for evaluation under anesthesia, dilatation and curettage, exploratory laparotomy and bilateral ovarian wedge resection. (Ex. 6 at 2). Her pre-operative diagnosis was polycystic ovary syndrome (Ex. 6 at 2).

15. An adequate patient history for a patient complaining of pain includes the nature of the pain, location of the pain, any radiation of the pain, other details regarding the pain, associated symptoms that might localize the pain, and medications taken. (Dr. Vinciguerra, T. 68-69).

16. Patient B's history did not include a menstrual history. (Ex. 6 at 6).

17. An adequate physical examination of a pre-operative patient should include evaluations of the heart, lungs, abdomen, rectum, breasts, and complete pelvic exam including evaluation of everything from the introitus, vagina, cervix, uterus, Fallopian

tubes and adnexa.

18. Respondent's physical examination of Patient B did not include findings from a complete pelvic examination. (Ex. 6 at 7).

19. Respondent ordered a pelvic sonogram on August 24, 1987 and on September 28, 1987 (Ex. 5 at 11, 17). Both sonograms revealed bilateral cystic ovaries with the cysts being no larger than a centimeter in diameter. Respondent also ordered a laboratory profile of Patient B before her surgery on October 27, 1987 (Ex. 6 at 22, 26-33).

20. The cyst on Patient B's left ovary was within normal limits. (Ex. 5 at 11; Dr. Weiner, T. 917).

21. Respondent's reason for not describing the size of the ovaries in his operative report following the October 27, 1987 surgery was that "there (were) two previous sonographic studies that show the precise size of the ovaries, ... less than -- about a month prior to the surgery." (T. 1009).

March 21, 1989 Surgery

22. Patient B's chart contains entries that she saw Drs. Zaccheo, Spellenberger and Amamoo before her surgery in 1989 but there are no entries regarding the results of these consultations. (Ex. 6 at 4, 7).

23. Reasonable standards of medical care require a physician to make entries concerning results of consultations with other physicians (Dr. Vinciguerra, T. 161).

24. Before Patient B's admission to Kingston Hospital on March 21, 1988 for surgery, Respondent ordered pelvic sonograms on December 3, 1987, and March 14, 1988. No cysts were reported being seen on the December 3, 1987 sonogram and a "very small cyst" on the right ovary was seen on the March 14, 1988 sonogram (Ex. 5 at 28, 29). In addition, Respondent ordered a CAT-scan of Patient B's pelvis on March 18, 1988. (Ex. 5 at 30).

25. A lack of gastrointestinal symptoms and use of a pelvic CAT-scan replaced the need for a gastrointestinal work-up or urological evaluation of Patient B prior to surgery. (T. 904,

912, 872).

26. Respondent diagnosed Patient B as having a "polycystic right ovary" on her March 21, 1989 admission. (Ex. 7 at 1, 3, 14).

27. On March 21, 1989, Respondent performed a right oophorectomy and left ovarian cystectomy on Patient B. (Ex. 7 at 14). The tissue removed by Respondent was within normal limits. (Ex. 7 at 16).

28. The "surgery was directed...and had as its goal to relieve pelvic pain. (T. 1005). Patient B continued to experience left lower quadrant pain after her surgical procedures. (T. 924; Ex. 5 at 10).

29. The history for Patient B's March 21, 1989 hospitalization does not provide details of her previous consultations with other physicians or of her previous workup which included the pelvic CAT-scan. (Weiner, T. 875; Ex. 7 at 5).

Patient C

April 5, 1989 Surgery

30. Patient C saw Respondent on March 28, 1989. Her complaints were irregular menses, infertility and right lower quadrant pain. (Ex. 8 at 1).

31. Prior to seeing Respondent, Patient C had seen Dr. Kraft who performed a laparotomy on Patient C on May 10, 1988. (Ex. 17).

32. Patient C told Respondent that Dr. Kraft said she was a "mess inside" and that he came very close to doing a pelvic cleanout. (T. 1055, 1042).

33. Respondent did not include a system overview in his history of Patient C which made Respondent's history of Patient C "poor." (Weiner, T. 934-935).

34. Endocrine tests would not be necessary if a patient was undergoing surgery for relief of pain. (Vinciguerra at 242; Weiner at 936).

35. A sonogram ordered on March 23, 1989, showed a

cystic mass measuring 7.8 cm. (Ex. A).

36. The presence of a multilocular cystic mass confirmed by ultrasound examination was an indication for an ovarian cystectomy. (Vinciguerra, T. 228).

37. In his history of Patient C, Respondent did not mention her complaint of pain or any previous tests performed. The entire history of Patient C's present illness is set forth in a five line paragraph. (Ex. 9 at 12).

38. Respondent did not document the size of the ovarian masses removed from Patient C in his operative reports. (Weiner, T. 941; Ex. 9 at 37-37).

April 21, 1989 Surgery

39. Twelve days after her April 9, 1989 discharge from Kingston Hospital following her April 5 surgery, Patient C was again admitted to Kingston Hospital on April 21, 1989 complaining of acute lower left quadrant pain. (Ex. 10 at 3).

40. Respondent ordered a blood count, urinalyses, sonogram, pelvic examination and flat plate of the abdomen for

Patient C. (Weiner, T. 942; Ex. 8 at 28-38).

41. In testifying about his evaluation of Patient C's pain on April 21, Respondent stated that she had a CAT-scan. (T. 1043). The CAT-scan of Patient C's abdomen was not done until May 2, 1989. (Ex. 8 at 16).

42. Patient C had no fever or elevated white blood count. (Vinciguerra, T. 268).

43. Circumstances that would warrant surgery only 16 days after a prior procedure are a bleeding episode from an abdominal suture released before the blood vessel fully coagulated; a ruptured abscess, an accidental bowel injury, or a foreign body in the patient. (Vinciguerra, T. 268-269). None of these circumstances was present on April 21, 1989. (Vinciguerra, T. 269).

44. Respondent stated that Patient C was "writhing in pain" (T. 1057) but in his physical examination of her, Respondent wrote, "mild tenderness noted in the right lower quadrant there is mild guarding, no rigidity." (Ex. 10 at 7).

45. A diagnosis of post-operative pelvic infection treated with antibiotics was a "reasonable" diagnosis and treatment plan for a patient "two and a half weeks post-operative who has the kind of surgery this patient had who has pain and whose blood count shows a shift to the left." (Weiner, T. 967).

46. Respondent's recorded impression of Patient C following his physical examination was "Pelvic pain, possible bilateral tubovarian abscesses." (Ex. 10 at 7). Abscesses with no evidence of rupture and without fever and without an increase in the white blood count are not a surgical condition. (Vinciguerra, T. 203).

47. Respondent's working diagnosis for Patient C was endometriosis. (T. 1043; Ex. 10 at 1). Later in his testimony, Respondent stated that Patient C had chronic pelvic inflammatory disease (T. 1052) and that the "first choice treatment" for chronic pelvic inflammatory disease is "intravenous antibiotics." (T. 1073).

48. The pathology report from Patient C's first surgery

was signed out on April 7, 1989. (Ex. 9 at 38).

49. Patient C's April 5 surgery was done at Norther Dutchess Hospital, her April 21 surgery was done at Kingston Hospital. (Exs. 9, 10).

Patient D

50. Respondent admitted Patient D to Kingston Hospital on June 6, 1989 for induction of labor. (Ex. 12).

51. The induction was elective. (T. 541).

52. An elective induction in a patient who is past her estimated date of confinement and for whom no risk factors such as tetany, uterine tetany or rupture of the uterus are present, may have been appropriate at an earlier time in obstetrical practice. (Bruce, T. 474-475-528).

53. Elective inductions were considered appropriate prior to 1985. By 1989, elective inductions did not constitute acceptable medical care. In considering whether to do an elective induction, a physician would have to be certain about the mature status of the fetus, and the likelihood of the success of an

elective induction. (Vinciguerra, T. 334-337).

54. Respondent stated that Patient D "expressed extreme anxiety about being delivered by somebody else" and "lived more than an hour away from the hospital." (T. 542).

55. Patient D stated that she did not want to be delivered by the doctor Respondent suggested (T. 1089-1090) and that she only lived ten or fifteen minutes from the hospital. (T. 1087, 1090).

56. When Patient D saw Respondent on June 6, 1989, he told her that she was in labor and should go to the hospital. (T. 1088, 1107).

57. Respondent stated that he discussed the risks of induction with Patient D. (T. 545-546, 572). Patient D did not recall Respondent discussing the possibility of uterine rupture or water intoxication with her prior to her induction and Patient D stated that Respondent did not discuss a failed induction with her. (T. 1092-1097).

58. Patient D's history does not set forth any reasons

for the induction, her physical examination does not include pelvic findings on admission, there is no indication of the condition of the cervix or fetal status prior to induction. (Vinciguerra, T. 303-304; Ex. 12).

59. Respondent ordered 20 units of pitocin in 1,000 cc's of dextrose (Ex. 12 at 30) to start induction of Patient D's labor. (T. 286-287). Respondent's order was for the patient to receive an initial dose of 40 cc's per hour of the oxytocin solution increasing the rate of administration by 10 cc's every 15 minutes up to a maximum of 100 cc's. (Ex. 12 at 30).

60. A concentration of 40 cc's per hour is equivalent to 13.3 milliunits per minutes. (T. 294-295). Acceptable medical standards are that oxytocin be started at no more than 1 to 2 milliunits per minute. Respondent's dose was 6 to 13 times that does. (T. 294-295).

61. Respondent also ordered increases of 10 cc's of the solution every 15 minutes, which at those concentrations is over 3 milliunits per minute. (T. 299). The acceptable rate of increase

at the 15 minutes increments is 1 to 2 milliunits per minute. (T. 300).

62. The protocol for oxytocin administration issued be Northern Dutchess Hospital called for starting concentration of 2 milliunits per minute. (Ex. F).

63. Respondent started Patient D on a concentration of 13.3 milliunits per minute. (Vinciguerra, T. 294-295, 575).

64. Respondent stated that Doctors Verrilli and Temple used oxytocin at Northern Dutchess Hospital "during induction starting at 40 cc's per hour" (13.3 milliunits per minute) and then he copied their use of oxytocin for induction. (t. 576).

65. Dr. Verrilli stated "it was not my routine to initiate induction with two ampules of Pitocin and a thousand cc's a vehicle" (T. 1137), that he "start(s) an induction with one ampule of Pitocin and a thousand cc vehicle at 30 cc's an hour" (T. 1139), that only Dr. Van Gaasbeek starts at the two ampule dose. (T. 1139-1140).

66. A high dose oxytocin protocol used at Albany

Medical Center Hospital was "To induce labor when other methods have been unsuccessful." (Ex. I).

67. Respondent ruptured Patient D's membranes at 1 to 2 cm. dilatation to help accelerate the induction and also to help determine the status of the infant by viewing the fluid to see if there were any meconium which might indicate fetal distress. (T. 557-558).

68. Patient D's cervix was "very unfavorable for induction of labor" and the likelihood of a successful induction resulting from the rupture of the membranes was unlikely. (Vinciguerra, T. 306).

69. Patient D's induction of labor "could have been discontinued if her membranes had not been ruptured." (Bruce, T. 528).

70. The rupture of Patient D's membranes committed Respondent to proceeding with a Caesarean section to deliver the infant and "eliminated the option of discontinuing the induction...and wait[ing] for spontaneous labor." (Vinciguerra,

T. 307, 340).

Patient E

71. Patient E had an estimated date of confinement of April 5, 1989 and a diagonal conjugate of 12.0 cm. "tops." (Ex. 13 at 7). She was five feet tall and her weight ranged from 209 pounds to 227.5 during Respondent's pre-natal care (T. 590; Exhibit 13 at 7).

72. The diagonal conjugate is the clinical measurement of the distance from the apex of the sacral promontory to the lower edge of the pubic ramus. The diagonal conjugate is the measurement of the diagonal distance across the pelvic inlet. (Vinciguerra, T. 355).

73. A diagonal conjugate of 12.0 cm. is "better than average." (Vinciguerra, T. 355). A diagonal conjugate of 11.5 cm. is the cutoff for a borderline pelvis. (Bruce, T. 769, quoting Williams Obstetrics).

74. Respondent stated that a diagonal conjugate of 12.0 cm. "is a borderline measurement" (T. 595) and that a normal

diagonal conjugate is 12.5 cm. (T. 637).

75. It is acceptable to do a Caesarean section without a trial of labor if there is an indication that the fetal weight is above 4500 grams. (Vinciguerra, T. 375).

76. Patient E delivered an 8 lb. 10 oz. (3912 grams) baby. (Ex. 14 at 1).

77. An 8 lb. 10 oz. baby can be delivered vaginally in an adequate pelvis. (Bruce, T. 790).

78. Respondent's first pelvic examination of Patient E revealed convergent pelvic side walls, a narrow pubic arch and a prominent sacrum. (T. 591). Respondent felt that Patient E's baby was "a big enough baby to call it a macrosomia." (T. 628).

Patient F

79. Patient F had an estimated date of confinement of April 12, 1989. (Ex. 15 at 3). The estimated date of confinement was determined from Patient F's last menstrual period. (T. 651).

80. Respondent concluded that Patient F had a large

baby based on abdominal examination and Leopold's maneuvers. (T. 653).

81. Respondent did no fetal testing of Patient F before inducing labor. (Vinciguerra, T. 384; Exs. 15, 16).

82. Respondent ordered induction of labor for Patient F on April 26, 1989 (Ex. 16), two weeks past Patient F's estimated date of confinement. (Finding of Fact 79).

83. The appropriate treatment for a patient past her estimated date of confinement is to start fetal testing to evaluate the status of the baby on a weekly basis. (Vinciguerra, T. 401, 403). The studies are continued "until such time as spontaneous labor occurs or you get a non-reassuring pattern of testing, or the cervix is induceable and you have a good chance for success for a vaginal delivery." (Vinciguerra, T. 403).

84. Patient F's cervix was long and closed at the time of induction. (Ex. 16 at 8). A long closed cervix is not a favorable indication for induction. (Vinceguerra, T. 404-405).

85. Respondent's training "taught [him] at 42 weeks to

take some action to achieve delivery." (T. 654).

86. Respondent ordered 20 units of pitocin in 1,000 cc's of dextrose (Ex. 12 at 30) to start induction of Patient D's labor. (T. 286-287). Respondent's order was for the patient to receive an initial dose of 40 cc's per hour of the oxytocin solution increasing the rate of administrative by 10 cc's every 15 minutes up to a maximum of 100 cc's. (Ex. 12 at 30).

87. A concentration of 40 cc's per hour is equivalent to 13.3 milliunits per minutes. (T. 294-295). Acceptable medical standards are that oxytocin be started at no more than 1 to 2 milliunits per minute. Respondent's dose was 6 to 13 times that dose. (T. 294-295).

88. Respondent also ordered increases of 10 cc's of the solution every 15 minutes, which at those concentrations is over 3 milliunits per minute. (T. 299). The acceptable rate of increase at the 15 minutes increments is 1 to 2 milliunits per minute. (T. 300).

89. Respondent started Patient F on oxytocin at 2:45

p.m. on April 26, 1989 and discontinued the oxytocin at 4:55 p.m. the same day. (Ex. 16 at 57). Respondent's summary states that Patient F was in labor for "6 hours" and that "with the patient receiving good pains for 5 hours, diagnosis of cephalopelvic disproportion was then made and primary Caesarean section was performed." (Ex. 16 at 3). Respondent stated "there is room for doubt" regarding his determination of cephalopelvic disproportion. (T. 675).

90. Patient F's contractions were characterized as "mild" throughout her induction. (Vinciguerra, T. 388; Ex. 16 at 57). "Good pains" are contractions that reach an intrauterine pressure of "20, 25--25, 20, 45 millimeters of water." Mild contractions cannot be characterized as "good pains." (Vinciguerra, T. 388-389).

91. There is no indication for a diagnosis of fetal distress on the fetal monitor strips for Patient F. (Vinciguerra, T. 389; Ex. 16 at 30-50).

92. Respondent made no notation in Patient F's records

of a previous ectopic pregnancy. (T. 659-660, 675; Exs. 15, 16 at 22).

93. Respondent stated that his hospital discharge summary for Patient F was in error regarding the length of time for Patient F's induction. (T. 661-662).

Registration to Practice Medicine

94. By letter dated February 12, 1990, the Chief Executive Officer at Kingston Hospital informed Respondent that the Medical Executive Committee required the following monitoring: chart review; a second opinion prior to any admission; a physician to assist or observe any surgical procedures involving entrance into the peritoneal cavity; ongoing case review in non-surgical admission cases; a second opinion in obstetrical cases involving C-sections with the consultant serving as assistant on the case; a registered nurse to perform pelvic examinations prior to initiation of oxytocin for induction of labor; and all admissions cleared by the supervising physician. (Ex. 19 at 3-5).

95. By letter dated August 7, 1989, Respondent was

notified by the Chief Executive Officer that the Medical Executive Committee's recommendations regarding the supervision of his practice would restrict his privileges if ratified by a decision of the Board of Trustees. (Ex. 19 at 27).

96. The restrictions set forth in the February 12, 1990 letter were substantially the same as those referred to in the August 7, 1989 letter. (T. 712).

The Kingston Hospital By-Laws provide for a right to a hearing regarding an adverse recommendation. If the right to a hearing is waived, the physician is deemed to have accepted the adverse recommendation and the recommendation becomes effective immediately. Respondent withdrew his appeal of the Medical Executive Committee decision on April 26, 1990. (Ex. 19 at 1, 4-5).

97. Respondent sought the advise of his attorney before answering this question on his registration application to practice medicine in New York State for the period from January 1, 1991 through December 1992: "since you last registered, has any

hospital or licensed facility restricted...your professional training, employment or privileges." (T. 723; Ex. 18 at 61).

98. Respondent's attorney advised him that although he was in a monitoring situation, he considered "this to be a gray area" and believed "there is a good faith basis for you to answer this question in the negative." Respondent's attorney further advised him of the "possibility or chance that if you answer this in the negative, someone at a future date is going to say this was not an appropriate answer, and you have to make a judgment based upon the circumstances as they now present themselves to you in your practice as to whether you are comfortable answering this question in the negative in view of the fact that in the future someone may question it." (T. 727).

99. Respondent answered that there were no restrictions on his privileges at any hospital. (Ex. 18 at 61).

CONCLUSIONS

Respondent is charged with professional misconduct

within the meaning of Section 6530(5), (3), (6), (4), (32), (2), (20) and (21) of the Education Law. During the course of its deliberation on these charges, the Hearing Committee consulted a memorandum dated September 19, 1988 prepared by Peter J. Millock, General Counsel for the Department of Health. This document, entitled "Definitions of Professional Medical Conduct under the New York Education Law" set forth suggests definitions for incompetence, gross incompetence, negligence, gross negligence and fraudulent practice. The Administrative Officer amplified the definition of fraudulent practice to conform to case law, in that "a knowing, intentional or deliberate act" is required for fraud pursuant to Section 6509(2) of the Education Law (Brestin v. Commissioner of Education, 116 AD 2nd 359, 359 [3rd Dept. 1986]).

A summary of the definitions used, in pertinent part follows:

> "Gross negligence is...a failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, a disregard of the consequences which may ensue from such failure and an indifference to the rights of others" ...;
>
> "Gross incompetence involves a total and flagrant lack

of necessary knowledge or ability to practice";

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

"Incompetence is a lack of knowledge to practice medicine";

"Fraudulent practice of medicine is an intentional misinterpretation or concealment expressed or inferred from certain acts" and requires scienter which may be inferred."

The Administrative Officer defined the locality rule, a concept arising from medical malpractice law but an issue raised by Respondent, as requiring that a physician conform to "accepted community standards of practice" and "use whatever superior knowledge, skill and intelligence he has" in the treatment of his patients (Toth v. Community Hospital, 22 NY2d 255, 262). The Administrative Officer also cited Rho v. Ambach, 144 AD2d 774 [3rd Dept. 1988] which states that "the 'locality rule' does not insulate from guilt doctors who, like Petitioner, a Board certified forensic pathologist, possess superior knowledge and skills that exceed local standards, and provided the wherewithal [e.g. equipment, personnel, funding] to use these attributes is

available [Riley v. Wieman, 137 AD2d 309, 315]).

Using these definitions as a framework for its deliberations, the Hearing Committee found that by a preponderance of the evidence all of the charges were sustained except the charges of gross negligence, gross incompetence, and moral unfitness. The rationale for these conclusions follows.

Patient A

The Hearing Committee concluded that it was not incompetent or negligent for Respondent to have aspirated fluid from Patient A's cyst and not have sent the fluid for pathological evaluation. The expert witnesses produced by both Petitioner and Respondent felt that the likelihood of finding malignant cells in the fluid was very small. The Hearing Committee concurred and did not sustain the charge.

Patient B

The Hearing Committee agreed with respondent's expert witness, Dr. Weiner who said it was not inappropriate to prescribe 2.5 mg. of Premarin for breakthrough bleeding. Although Dr.

Vinciguerra, Petitioner's expert witness, does not use Premarin in this manner and would not in any case exceed a dose of 1.5 mg., this does not negate the treatment outlined in the widely accepted textbook, Speroff's Clinical Gynecology, Endocrinology and Infertility. Dr. Weiner quoted Speroff which outlined a treatment of 2.5 mg. of Premarin over a five-day period for breakthrough bleeding and the Hearing Committee felt he was accurate. The Hearing Committee felt that any increased risk of thrombophlebitis was minimal since Patient B was a young woman already on birth control pills who was only taking the Premarin for a short course.

The Hearing Committee felt that the lack of a menstrual history for an OB/GYN patient was not a "minor omission" in Patient B's history. Also, there was no notation in Patient B's history regarding the result of her being seen by consultants. The Hearing Committee felt that reports from consultants and Patient B's menstrual history was knowledge that was essential to have in order to treat her.

Respondent did not describe the size of Patient B's ovary in his Operation Report because he had it on sonography and the Hearing Committee felt that this omission for that reason was inexcusable. In addition, the ovary was normal. Respondent stated that he realized Patient B did not have polycystic ovaries when he got the pathology report following her October 27 surgery but he kept treating her for polycystic ovary disease. Dr. Weiner stated that wedge resection was a previously accepted treatment for polycystic ovary disease. The Hearing Committee believed that Respondent performed a wedge resection on Patient B to alleviate her pain despite the fact that the tissue removed at the time of the first laparotomy was normal. The indication for the October 27 surgery was marginal.

The Hearing Committee found that Respondent's diagnostic testing was adequate prior to the March 21, 1989 surgery. Two sonograms had been ordered and a CAT-scan of Patient B's pelvis. A lack of gastrointestinal symptoms and the use of the pelvic CAT-scan replaced the need for a gastrointestinal work-up or

urological evaluation prior to surgery.

The history and physical that was done was inadequate. The Hearing Committee believed that a history becomes very important in treating a patient returning with complaints about pain. The history should have documented the quality of the pain and made references to the locality of the pain. In addition, the history should give a reader a complete picture of what has happened prior to the diagnosis and treatment plan. Respondent's history was very sketchy and only minimally satisfactory. It did not detail the studies done or the treatment tried prior to the surgery.

Respondent diagnosed Patient B as having a "polycystic right ovary" despite the lack of evidence of a large ovarian cyst. The Hearing Committee took note of the fact that the tissue removed from Patient B was within normal limits. The Hearing Committee felt that the goal of the surgery had been the relief of pelvic pain, however, Patient B continued to experience left lower quadrant pain following this surgery.

Patient C

The Hearing Committee concluded that a reasonably prudent physician should have requested the records of Dr. Kraft after Patient C made Respondent aware of his findings. Even Dr. Weiner found Respondent's history of Patient C "poor" and the Hearing Committee felt it was an inadequate history given that there was no system overview. The diagnostic studies done were adequate. Dr. Vinciquerra stated that endocrine tests were not necessary if Patient C was admitted for treatment of pain. Dr. Weiner confirmed this. Since Patient C's adnexal mass and pain were the reasons for her operation, the Hearing Committee concluded that the diagnostic studies done on Patient C were adequate.

The indication for Patient C's laparotomy was based on a mass confirmed by a sonogram. Once Respondent was in the abdomen, it was not inappropriate to remove a corpus luteum cyst.

Patient C's history was inadequate. Respondent did not mention her complaint of pain and the entire course of her illness

is contained in a five-line paragraph. In addition, there is no mention of previous tests done and no findings for her previous laparotomy included. The Hearing Committee felt Patient C's history left much to be desired. Dr. Weiner stated that Respondent's operative report was adequate but could have been better given that Respondent did not include the size of the ovarian cysts in the report. The Hearing Committee agreed with Dr. Weiner.

The Hearing Committee found that the pre-operative evaluation of Patient C before her exploratory laparoscopy on April 21, 1989 was adequate but there was no medical indication for the procedure. Patient C's admission occurred 12 days after her discharge following her April 5 surgery. Patient C had no fever and no elevated white blood count and could have been treated with antibiotics. Although Respondent said that Patient C was "writhing in pain", the Hearing Committee found no documentation on her chart to support that she was experiencing that level of pain. The Hearing Committee found that the

laparoscopy was done without medical indication and that the most reasonable course of treatment, at that time, would have been to treat her with antibiotics.

Respondent's working diagnosis for Patient C was endometriosis. The Hearing Committee did not find it credible that a pathology report signed out on April 7, 1989 was not available to Respondent prior to the April 26 surgery. Respondent should have known Patient C had pelvic inflammatory disease, not endometriosis.

The justification for Patient C's total abdominal hysterectomy was that Patient C and her husband agreed that if she were to be subjected to additional surgery, Respondent should "take everything out." The Hearing Committee felt that the real question was whether the underlying procedure that was done, the exploratory laparoscopy, was necessary and answered that question in the negative. Therefore, the total abdominal hysterectomy was unnecessary at the time it was done but the Hearing Committee felt that Patient C may have ultimately needed the total abdominal

hysterectomy given the clinical findings obtained.

Respondent's expert, Dr. Weiner, "passed on the adequacy of the medical history as being sufficient for an interim history. However, even though only 12 days had intervened between Patient C's discharge and subsequent readmission, she had previously been admitted to Norther Dutchess Hospital, not Kingston Hospital, therefore, this could not be considered an interim history. The Hearing Committee found the history marginal.

Patient D

Respondent and his expert witness, Dr. Bruce, agreed that Patient D's induction was elective. The question presented for the Hearing Committee's determination is whether an elective induction is acceptable practice. The Hearing Committee recognized that elective inductions are discouraged in today's practice for various reasons but that elective inductions are still done. If an elective induction is done, the physician has a responsibility to make sure that the patient has a likelihood of success and that the fetus is mature. Respondent admitted that

the only reason for this induction was that he was going out of town and Patient D did not want the obstetrician he suggested to deliver her. The Hearing Committee found inconsistencies between Respondent's testimony and that of Patient D. Respondent said that he discussed the risks of induction with Patient D but she did not recall him discussing the possibility of uterine rupture or water intoxication and stated Respondent did not discuss a failed induction with her. Respondent said that another reason for Patient D's desire for an elective induction was that she lived more than an hour away from the hospital. The Hearing Committee believed Patient D's testimony that she lived no farther than 15 minutes from the hospital and found that the induction was without medical indication.

Respondent did not adequately document the condition of Patient D or her baby upon admission. Her history contains no reasons for the induction and her physical examination does not include pelvic findings. The Hearing Committee believed Respondent's testimony that he was with Patient D from the time of

admission but did not find credible Respondent's expectation that a nurse would act as his secretary and write down his verbal findings as he made them. Respondent made no notations at all in Patient D's chart, not even in the progress notes. The Hearing Committee concluded that Respondent did not make an adequate statement of the condition of a patient who was going to be induced.

In regard to the oxytocin dose that Respondent used, the Hearing Committee found this was in excess of any published amount and, therefore, an inappropriate dose to use. The important thing about any oxytocin protocol is what dose you start with and Respondent started with a dose that most physicians end with. The Hearing Committee was not persuaded by the evidence introduced regarding the Albany Medical Center High Dose Protocol or the Northern Dutchess Hospital Protocol. The purpose of the Albany Medical Center High Dose Protocol was induction after other methods had been unsuccessful. Respondent testified that he was following the oxytocin dosage used by Doctors Verilli and Temple

at Northern Dutchess Hospital. However, Dr. Verilli testified that he does not use the dose Respondent used for Patient D to start the induction of labor and that only Respondent uses that high a dose of oxytocin to start an induction. All of the experts agreed that the dose used by Respondent was high and not one that they would use.

Respondent testified that he ruptured Patient D's membranes when she was only 1 to 2 cm. dilated to help accelerate the induction and determine the status of the fetus. There was no medical indication for rupture of Patient D's membranes and the rupture was unacceptable unless Respondent was committed to doing a vaginal delivery for which there was a likelihood of success. Even Respondent's expert, Dr. Bruce, testified that the induction could have been discontinued before the membranes were ruptured. After the membranes were ruptured, Respondent was committed to doing the delivery. In this case that meant delivery of Patient D by Caesarean section, an operation that might have been avoided had Patient D's membranes not been ruptured. Patient D

had a 20-hour trial of labor with ruptured membranes and Respondent had no choice but to proceed with the Caesarean section. The Hearing Committee believed that the indication for the Caesarean section was created by Respondent when he ruptured Patient D's membranes.

Patient E

The Hearing Committee found that the definition of transverse diameter has not changed in the past 30 years and accepted the standard testified to by Dr. Vinciguerra and Dr. Bruce quoting Williams: 11.5 cm. or greater is a normal pelvis. Patient E's diagonal conjugate measured 12 cm., a normal pelvis by definition. Respondent testified that he defined a normal diagonal conjugate as 12.5 cm. or greater although he admitted that this was a figure not substantiated by reference to the medical literature. Regarding fetal size, the Hearing Committee accepted 4500 grams as the most widely accepted definition of macrosomia. At birth weight of 8 lbs. 10 oz., Patient E's baby

weighed 3912 grams and could have been delivered vaginally assuming a normal pelvis. If the fetus had weighed 4500 grams or more, an appropriate procedure might have been to have performed a Caesarean section. However, the Hearing Committee felt that since Respondent thought he was dealing with macrosomia and a small pelvis, his decision to proceed with a Caesarean section might have been the most appropriate way for him to proceed. The Hearing Committee also took into account that since Patient E was short and obese a true estimate of fetal weight might have been difficult.

Patient F

Patient F's estimated date of confinement was determined from Patient F's last menstrual period. Although Respondent concluded that Patient F was carrying a large baby, he did no fetal testing prior to her induction. The Hearing Committee concluded that Respondent's automatic induction of Patient F at 42 weeks, without any testing, was inappropriate. The Hearing Committee accepted Dr. Vinciguerra's testimony that testing of

fetal well-being should be done on a weekly basis in a post-date pregnancy. The Hearing Committee also recognized that at one time it was accepted practice by many obstetricians to elect to deliver a patient at 42 weeks without doing fetal testing. The Hearing Committee does not think this represents the best practice of contemporary obstetrics but accepts the Respondent may have been trained in this school of thought. Despite this, the Hearing Committee was disturbed by the fact that the there was no independent confirmation of Patient F's estimated date of confinement by sonogram and believes the estimated date of confinement may have been in error. The Hearing Committee did not believe that the finding of fingertip dilation of the cervix as noted would give Patient F a good chance to succeed with the induction.

The findings and conclusions made for Patient D regarding the dose of oxytocin administered apply to Patient F as well.

The Hearing Committee concluded that two hours is not an

adequate trial of labor prior to performing a Caesarean section and that there was no fetal distress to warrant a Caesarean section. The Hearing Committee did not believe that cephalo-pelvic disproportion was present since Patient F had not progressed far enough in her labor to make that determination and noted that Respondent also believed there was room for doubt regarding this diagnosis. The Hearing Committee considered the testimony of Dr. Bruce and Respondent regarding decelerations of the fetal monitoring strip but found no evidence that this was a consideration for doing the Caesarean section. The only indications listed were the failed induction and cephalopelvic disproportion.

The Respondent's failure to document Patient F's prior ectopic pregnancy made no difference in the management of this patient but the Hearing Committee felt it was a further indication of Respondent's inability to elicit and document a good patient history. Respondent admitted that he made an error in the hospital discharge summary regarding the progress of Patient F's

induction.

Registration to Practice Medicine

The Hearing Committee concluded that Kingston Hospital did place restrictions on Respondent's practice since Respondent was limited in what he could do without the required approval of a supervising physician. The Hearing Committee found that the intent of the question asked on the registration application encompassed this type of restriction and it was quibbling on Respondent's part to state that the word "monitoring" did not mean "restriction." The Hearing Committee found that Mr. Iseman in advising the Respondent that this was a gray area and if he answered the question in the negative that "in the future someone may question it" was prescient.

DETERMINATION

Patient A

A -- not sustained

Patient B

B(1)(a) -- not sustained
B(1)(b) -- not sustained
B(2)(a) -- **sustained as to history and physical**
-- not sustained as to diagnostic studies
B(2)(b) -- not sustained
B(2)(c) -- **sustained**
B(3)(a) -- not sustained
B(3)(b) -- **sustained**
B(3)(c) -- **sustained**

Patient C

C(1)(a) -- **sustained as to history**
-- not sustained as to diagnostic studies
C(1)(b) -- not sustained
C(1)(c) -- **sustained**
C(1)(c)(i) -- **sustained**
C(1)(c)(ii) -- not sustained
C(2)(a) -- not sustained
C(2)(b) -- not sustained
C(2)(c) -- **sustained**
C(2)(d) -- **sustained**

Patient D

D(1) -- **sustained**
D(2) -- **sustained**
D(3) -- **sustained**
D(4) -- **sustained**
D(5) -- not sustained

Patient E

E -- not sustained

Patient F

F(1) -- not sustained
F(2) -- **sustained**
F(3) -- **sustained**
F(4)(a) -- **sustained**
F(4)(b) -- **sustained**

Registration to Practice Medicine

G -- sustained

The Hearing Committee makes the following determination regarding penalty:

1. censure and reprimand for knowingly and falsely answering "no" to the question on the registration to practice medicine as to whether any facility had restricted his privileges;

2. two years of probation;

3. during the period of probation, Gary Van Gaasbeek shall be subject to the following terms:

   a. a supervising physician must be selected at every hospital Respondent practices at. The supervising physician must be the Chief of the OB/GYN Department or someone designated by the Chief. The Chief may designate more than one supervising physician;

   b. a supervising physician will review all charts of hospitalized patients. Prior to hospitalization or admission to ambulatory surgery, Respondent is required to review indications for such admission with the supervising physician or designated substitute;

   c. if surgery is involved, the supervising physician must be present in the operating room as an assistant or observer;

   d. in the case of a non-surgical admission, chart review must be accomplished by the supervising physician and Respondent with discussion of review of patient management and lab data;

   e. Caesarean section indications must be reviewed prior to surgery with the supervising physician, preferably with a pre-operative examination done by the supervising physician with the supervising physician acting as Respondent's assistant at the time of surgery;

f. with the use of oxytocin for either induction or augmentation of labor, the supervising physician is required to perform a pelvic examination before initiation of infusion. A record of the oxytocin administration is required;

g. Respondent is required to average 30 hours of CME a year in obstetrics and gynecology;

h. the supervising physician may recommend specific education programs to be taken by Respondent where levels of practice denote deficiencies;

i. Respondent shall maintain legible medical records which accurately reflect his evaluation and treatment of his patients. In addition to other relevant information, these records shall contain a comprehensive history: physical examination as indicated; patient's chief complaints or present illness; diagnosis and treatment with appropriate data in support thereof; and an accurate record of prescriptions including amount of dosages and duration of treatment; and

j. as long as there is full compliance with every term of probation herein set forth, Respondent may continue to practice his profession in accordance with these terms. However, in the event of non-compliance with, or violation of, any terms of this probation, the Director of the Office of Professional Medical Conduct and/or the State Board for Professional Medical Conduct may initiate a Violation of Probation Proceeding or any other proceeding authorized by the New York Public Health Law.

DATED: **Halesite, New York**

July 24, **1992**

Stephen Gettinger MD

STEPHEN GETTINGER, M.D.
Chairman

TERESA S. BRIGGS, M.D.
MICHAEL A. GONZALEZ, R.P.A.

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

IN THE MATTER	:	AMENDED
OF	:	STATEMENT
GARY VAN GAASBEEK, M.D.	:	OF
	:	CHARGES

----------X

GARY VAN GAASBEEK, M.D., the Respondent, was authorized to practice medicine in New York State on February 11, 1987, by the issuance of license number 169321 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991, through December 31, 1992, from 373 Broadway, Kingston, New York.

FACTUAL ALLEGATIONS

A. The Respondent, on or about February 1, 1989, admitted Patient A (all patient names are listed in Appendix "A") to The Kingston Hospital in Kingston, New York (hereafter the Kingston Hospital). The Respondent, on or about February 1, 1989, did not obtain a pathological evaluation of fluid aspirated from a right ovarian cyst.

B. The Respondent, from on or about August 17, 1987, through at least July 31, 1989, provided medical care to Patient B at his office at 373 Broadway, Kingston, New York (hereafter his office).

1. The Respondent, during the time of his treatment of Patient B, prescribed medication which was inappropriate under the circumstances and/or excessive in dosage.

   a. The Respondent, on or about October 23, 1987, prescribed 2.5 mg Premarin times five days. At the time, Patient B was scheduled to have gynecologic surgery on October 27, 1987.

   b. The Respondent, on or about October 11, 1988, ordered 2.5 mg Premarin for one week after completion of her Triphasil prescription, to be followed with 50 mg Clomid for five days (Clomid 50 mg x 5 days).

2. The Respondent, on or about October 27, 1987, admitted Patient B to The Kingston Hospital for bilateral ovarian wedge resection, possible left oophorectomy and dilatation and curettage.

   a. The Respondent did not obtain an adequate history, perform an adequate physical examination, and/or order adequate diagnostic studies of Patient B before the surgery performed on or about October 27, 1987.

   b. The bilateral ovarian wedge resection was performed on or about October 27, 1987, without adequate medical indication.

   c. The Respondent did not adequately describe the ovaries in his operative report.

3. The Respondent, on or about March 21, 1989, admitted Patient B to The Kingston Hospital.

   a. The Respondent did not perform adequate diagnostic testing prior to performing a right oophorectomy and left ovarian cystectomy on or about March 21, 1989.

   b. The Respondent, on or about March 21, 1989, performed a right oophorectomy and left ovarian cystectomy. The right oophorectomy and/or left ovarian cystectomy were performed without adequate medical indication.

c. The Respondent, on or about March 21, 1989, did not elicit and/or adequately document Patient B's medical history in the hospital record.

C. The Respondent, from on or about March 28, 1989, through at least April 1989, provided medical care to Patient C at his office.

1. The Respondent, on or about April 5, 1989, admitted Patient C to Northern Dutchess Hospital in Rhinebeck, New York.

a. The Respondent did not obtain an adequate history, perform an adequate physical examination, and/or order adequate diagnostic studies of Patient C before the surgery performed on or about April 5, 1989.

b. The Respondent, on or about April 5, 1989, performed a bilateral ovarian cystectomy without adequate medical indication.

c. The Respondent, on or about April 5, 1989, did not accurately record his evaluation and treatment of Patient C in the hospital record, in that:

(i) The Respondent did not adequately document Patient C's medical history in the hospital record.

(ii) The Respondent did not document, in the operative report, an adequate description of the actual pathology, including size, of ovarian masses which he located.

2. The Respondent, on or about April 21, 1989, admitted Patient C to The Kingston Hospital.

a. The Respondent, on or about April 21, 1989, performed exploratory laparoscopy upon Patient C without adequate pre-operative evaluation.

b. The Respondent, on or about April 21, 1989, performed an exploratory laparoscopy upon Patient C without adequate medical indication.

c. The Respondent, on or about April 21, 1989, performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy upon Patient C. The

hysterectomy and/or bilateral salpingo-oophorectomy were performed without adequate medical indication.

d. The Respondent, on or about April 21, 1989, did not adequately document Patient C's medical history in the hospital record.

D. The Respondent, on or about June 6, 1989, admitted Patient D to The Kingston Hospital.

1. The Respondent, on or about June 6, 1989, ordered induction of Patient D's labor without adequate medical indication.

2. The Respondent, on or about June 6, 1989, did not adequately document the condition of Patient D and/or the fetus upon admission.

3. The Respondent, on or about June 6, 1989, ordered an inappropriate dose, rate of administration and/or metho of administration of oxytocin for inducing Patient D's labor.

4. The Respondent intentionally and without adequate medical indication ruptured Patient D's membranes.

5. The Respondent, on or about June 7, 1989, performed a Cesarean section upon Patient D without adequate medica indication.

E. The Respondent, on or about March 25, 1989, admitted Patient E to The Kingston Hospital and performed a Cesarean section without adequate medical indication.

F. The Respondent, on or about April 26, 1989, admitted Patient F to The Kingston Hospital.

1. The Respondent, or or about April 26, 1989, ordered induction of Patient F's labor without adequate medica indication.

2. The Respondent, on or about April 26, 1989, ordered an inappropriate dose, rate of administration and/or metho of administration of oxytocin for inducing Patient F's labor.

The Respondent did not allow an adequate trial of labor prior to performing a Cesarean section.

4. The Respondent maintained records which were inaccurate, in that:

   a. The Respondent, on or about April 26, 1989, did not elicit and/or document in the hospital record, Patient F's history of an ectopic pregnancy.

   b. The Respondent inaccurately documented in the hospital record discharge summary the progress of Patient F's induced labor.

G. The Respondent, on or about October 10, 1990, signed an application for registration to practice medicine in the State of New York, in which he knowingly and falsely answered "no" to a question which asked, in pertinent part, whether any facility had restricted his professional training, employment or privileges since he last registered.

SPECIFICATIONS

FIRST SPECIFICATION

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with incompetence on more than one occasion with the meaning of N.Y. Educ. Law §6530(5) (as added by Ch. 606, Laws of 1991) [formerly N.Y. Educ.Law §6509(2)], in that Petitioner charges two or more of the following:

1. The facts in Paragraphs ~~A~~, B and B.1 and B.1(a), B and B.1 and ~~B.1.(b)~~, B and B.2 and B.2(a), B and B.2 and B.2(b), B and B.2 and B.2(c), B and B.3 and B.3(a), B

and B.3 and B.3(b), B and B.3 and B.3(c), C and C.1 and C.1(a), C and C.1 and C.1(b), C and C.1 and C.1(c)(i), C and C.1 and C.1(c)(ii), C and C.2 and C.2(a), C and C.2 and C.2(b), C and C.2 and C.2(c), C and C.2 and C.2(d), D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, E, F and F.1, F an F.2, F and F.3, F an F.4 and F.4(a), F and F.4 and F.4(b).

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law §6530(3) (as added by Ch. 606, Laws of 1991) [formerly N.Y. Educ. Law §6509(2)], in that Petitioner charges two or more of the following:

2. The facts in Paragraphs A, B and B.1 and B.1(a), B and B.1 and B.1.(b), B and B.2 and B.2(a), B and B.2 and B.2(b), B and B.2 and B.2(c), B and B.3 and B.3(a), B and B.3 and B.3(b), B and B.3 and B.3(c), C and C.1 and C.1(a), C and C.1 and C.1(b), C and C.1 and C.1(c)(i), C and C.1 and C.1(c)(ii), C and C.2 and C.2(a), C and C.2 and C.2(b), C and C.2 and C.2(c), C and C.2 and C.2(d), D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, E, F and F.1, F an F.2, F and F.3, F an F.4 an F.4(a), F and F.4 and F.4(b).

THIRD THROUGH SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence within the meaning of N.Y. Educ. Law §6530(6) (as added by Ch. 606, Laws of 1991) [formerly N.Y. Educ Law §6509(2)], in that Petitioner charges:

3. The facts in Paragraphs B and B.2. and B.2.a, and/or B and B.2 and B.2.b.

4. The facts in Paragraphs B and B.3 and B.3.a, and/or B and B.3 and B.3.b.

5. The facts in Paragraphs C and C.1. and C.1.a, and/or C and C.1 and C.1.b.

6. The facts in Paragraphs C and C.2. and C.2.a. and/or C and C.2 and C.2.b. and/or C and C.2 and C.2.c.

SEVENTH THROUGH TENTH SPECIFICATIONS

GROSS NEGLIGENCE

The Respondent is charged with practicing the profession with gross negligence within the meaning of N.Y. Educ. Law §6530(4) (as added by Ch. 606, Laws of 1991) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges:

7. The facts in Paragraphs B and B.2. and B.2.a, and/or B and B.2 and B.2.b.

8. The facts in Paragraphs B and B.3 and B.3.a, and/or B and B.3 and B.3.b.

9. The facts in Paragraphs C and C.1. and C.1.a, and/or C and C.1 and C.1.b.

10. The facts in Paragraphs C and C.2. and C.2.a. and/or C and C.2 and C.2.b. and/or C and C.2 and C.2.c.

ELEVENTH THROUGH SIXTEENTH SPECIFICATIONS

FAILING TO MAINTAIN ACCURATE RECORDS

The Respondent is charged with failing to maintain a record which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Educ. Law §6530(32) (as added by Ch. 606, Laws of 1991) [formerly N.Y. Educ. Law §6509(9) and 8 NYCRR §29.2(a)(3)(1989)], in that Petitioner charges:

11. The facts in Paragraphs B and B.2 and B.2(c).

12. The facts in Paragraphs B and B.3 and B.3(c).

13. The facts in Paragraphs C and C.1 and C.1(c)(i), and/or C and C.1 and C.1(c)(ii).

14. The facts in Paragraphs C and C.2 and C.2(d).

15. The facts in Paragraphs D and D.2.

16. The facts in Paragraphs F and F.4 and F.4(a) and/or F and F.4 and F.4(b).

SEVENTEENTH SPECIFICATION

FRAUDULENT PRACTICE

The Respondent is charged with practicing the profession fraudulently with the meaning of N.Y. Educ. Law. §6530(2) (as added by Ch. 606, Laws of 1991) [formerly N.Y. Educ. Law §6509(2)], in that the Petitioner charges:

17. The facts in paragraph G.

SIXTEENTH SPECIFICATION

MORAL UNFITNESS

The Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine within the meaning of N. Y. Educ. Law §6530(20) (as added by Ch. 606, Laws of 1991) [formerly Educ. Law §6509(9) and 8 NYCRR §29.1(b)(5)(1987)], in that Petitioner charges:

18. The facts in paragraph G.

NINETEENTH SPECIFICATION

WILLFULLY MAKING OR FILING A FALSE REPORT

The Respondent is charged with willfully making or filing a false report within the meaning of N.Y. Educ. Law §6530(21) [as added by Ch. 606, Laws of 1991; formerly N.Y. Educ. Law §6509(9) and 8 N.Y.C.R.R. §29.1(b)(6)(1987)], in that Petitioner charges:

19. The facts in paragraph G.

DATED: Albany, New York
November 7, 1991

Peter D Van Buren

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