The University of the State of New York

Education Department

IN THE MATTER

of the

Application of GEORGE A. WOOTAN for restoration of his license to practice medicine in the State of New York

No. 10528

It appearing that the license of GEORGE A. WOOTAN to practice medicine having been revoked by action of the Board of Regents on October 21, 1983, and he having petitioned the Regents for restoration of said license, and the Regents having given consideration to said petition, now pursuant to action taken by the Board of Regents on September 16, 1988, it is hereby

ORDERED that the petition for restoration of license No. 096518, authorizing George A. Wootan to practice medicine in the State of New York is denied, but that the execution of the revocation is stayed and that petitioner is placed on probation for a period of not less than three years under specified terms and conditions.

IN WITNESS WHEREOF, I, THOMAS SOBOL, Commissioner of Education of the State of New York, for and on behalf of the State Education Department, do hereunto set my hand and affix the seal of the State Education Department at the City of Albany, this 4th day of October, 1988.

[redacted]

Commissioner of Education

No. 10528

The license of GEORGE A. WOOTAN, P. O. Box 403, Hurley, NY 12443, to practice medicine in the State of New York, having been revoked by action of the Board of Regents on October 21, 1983 and he having petitioned the Board of Regents for restoration of said license, and the Regents having given consideration to said petition, now, pursuant to action taken by the Board of Regents on September 16, 1988, it was

VOTED that the petition for restoration of license No. 096518, authorizing George A. Wootan to practice medicine in the State of New York, be denied, but that the execution of the order of revocation be stayed and petitioner be placed on probation for a period of not less than three years under specified terms and conditions.

George A. Wootan

TERMS AND CONDITIONS

1. That petitioner, during the period of probation, shall conduct himself in all ways in a manner befitting him professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

2. That petitioner shall submit written notification to the New York State Education Department, addressed to the Executive Director, Office of Professional Discipline, New York State Education Department, 622 Third Avenue, New York, NY 10017, of any employment and practice, of residence and telephone number, of any change in employment, practice, residence, or telephone number within or without the State of New York;

3. That petitioner shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that petitioner has paid all registration fees due and owing to the NYSED and petitioner shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by petitioner to the NYSED addressed to the Executive Director, Office of Professional Discipline, as aforesaid, no later than the first three months of the period of probation;

4. That petitioner shall submit written proof to the NYSED, addressed to the Executive Director, Office of Professional Discipline, as aforesaid, that (1) petitioner is currently registered with the NYSED, unless petitioner submits written proof that petitioner has advised DPLS, NYSED, that petitioner is not engaging in the practice of his profession in the State of New York and does not desire to register, and that (2) petitioner has paid any fines which may have previously been imposed upon petitioner by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

5. That during the period of probation, petitioner must practice under the supervision of a licensed and board-certified physician who shall submit quarterly reports attesting to petitioner's performance and all such practice must take place in a setting approved in advance by the Associate Executive Secretary of the State Board for Medicine.

6. That during the period of probation, petitioner may not engage in providing obstetric services.

7. That prior to engaging in any practice during the period of

Sue Mike,

probation, petitioner must provide evidence, satisfactory to the Associate Executive Secretary of the State Board for Medicine, that petitioner has either successfully completed the Federation of State Medical Boards Special Purpose Examination which is designed to assess current clinical competence for the general undifferentiated practice of medicine of a physician who holds or has held a license, or that petitioner has successfully completed a university-based special program for experienced physicians which program is satisfactory to the Associate Executive Secretary, State Board for Medicine. Tuft

8. That during the first year of supervised practice, petitioner must provide evidence of either 300 hours of continuing education satisfactory to the Associate Executive Secretary, State Board for Medicine, or evidence of recertification in family practice.

9. That upon successful completion of at least three years of supervised practice pursuant to the these terms of probation, petitioner may apply to the Board of Regents for a discharge from probation.

10. That so long as there is full compliance with every term herein set forth, petitioner may continue to practice his aforementioned profession in accordance with the terms of probation and during the aforesaid probationary period; provide, however, that upon receipt of evidence of noncompliance with or any other violation of the aforesaid mentioned terms of probation, the New York State Education Department may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Education Law and the Rules of the Board of Regents as may be appropriate.

REPORT OF THE
REGENTS REVIEW COMMITTEE

GEORGE A. WOOTAN, M.D.

CALENDAR NO. 3056

The University of the State of New York

IN THE MATTER

OF

Proceedings by the State Board for Professional Medical Conduct to determine the action to be taken with respect to the revocation or suspension of the license heretofore granted to

GEORGE A. WOOTAN, M.D. No. 3056

to practice medicine in the State of New York, or such other penalty as is warranted, pursuant to Article 2, Title II-A of the Public Health Law of the State of New York.

Report of the Regents Review Committee

GEORGE A. WOOTAN, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was commenced by service of the notice of hearing and statement of charges upon respondent.

The statement of charges, as amended, charged respondent with practicing the profession with gross negligence on a particular occasion (first specification), with practicing the profession negligently on more than one occasion (second specification), with permitting, aiding and abetting an unlicensed person to perform activities requiring a license

(third specification), with unprofessional conduct (fourth specification), and with practicing the profession with gross incompetence and/or gross negligence (fifth specification). A copy of the charges is annexed hereto, made a part hereof, and marked as exhibit "A".

On twenty-five dates between May 19, 1981 and January 22, 1983, inclusive, a hearing was held before a Hearing Committee of the State Board for Professional Medical Conduct.

Respondent appeared at the hearing and was represented by an attorney.

The Hearing Committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as exhibit "B".

The Hearing Committee found and concluded that respondent was guilty of the first through fourth specifications of the charges, and guilty of the fifth specification of the charges to the extent indicated in its report, and recommended that respondent's license to practice as a physician in the State of New York be revoked.

The Commissioner of Health recommended to the Board of Regents that the findings, conclusions, and recommendation of the Hearing Committee be accepted in full, and that the Board of Regents issue an order adopting and incorporating said findings and conclusions and further adopting as its determination said recommendation. A copy of the

recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as exhibit "C".

On July 13, 1983 respondent appeared before us in person and was represented by his attorney, Richard Greenblatt, Esq. The Department of Health was represented by Marcy E. Feller, Esq. In addition, members of the public were permitted to be present under a variety of restrictions as to recording devices, taking of notes, cameras, and non-interference with the review process.

We have carefully reviewed and considered the entire record, the brief submitted by respondent, the reply submitted by the Department of Health, certain letters received by us subsequent to the meeting and the statements made before us.

We unanimously recommend that the Board of Regents accept the findings, conclusions, and recommendation of the Hearing Committee as well as the recommendation of the Commissioner of Health, and that respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which he was found guilty, as aforesaid.

Respectfully submitted,

MARTIN C. BARELL

LOUIS E. YAVNER

PATRICK J. PICARIELLO

[redacted]

Chairperson

Dated: September 7, 1983

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

IN THE MATTER	:	REPORT OF HEARING OFFICER, FINDINGS OF
OF	:	FACT, CONCLUSIONS OF LAW AND RECOMMENDATION
GEORGE A. WOOTAN, M.D.	:	

TO: The HONORABLE DAVID AXELROD, M.D.
Commissioner of Health of the State of New York

The undersigned, Hearing Committee (the Committee) consisted of Frank E. Iaquinta, M.D., (Chairman), W. Graham Knox, M.D., Fremont C. Peck, M.D., Arthur T. Risbrook, M.D., and Mr. Harold A. Brandt. The Committee was duly designated, constituted and appointed by the State Board of Professional Medical Conduct (the Board). The Administrative Officer was Hyman Roffe, Esq.

The hearing was conducted, pursuant to the provisions of N.Y. Public Health Law § 230, as amended, 1980 and N.Y. State Administrative Procedure Act, Article 3 to receive evidence concerning the charges that the Respondent has violated provisions of N.Y. Education Law § 6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made part of the record.

The Committee has considered the entire record in the above-captioned matter and makes a Report of its Findings of Fact, Conclusions and Recommendations to the New York State Commissioner of Health.

RECORD OF PROCEEDINGS

Statement of Charges dated:	April 23, 1981
Amended:	October 15, 1981
Amended:	January 13, 1982
Amended:	February 9, 1982
Notice of Hearing Returnable:	May 19, 1981
Places of Hearings:	901 North Broadway White Plains, N.Y. 145 Huguenot Street New Rochelle, N.Y. Two World Trade Center New York, N.Y. 10047 8 East 40th Street New York, N.Y. 10016
Answer of Respondent dated:	June 29, 1981
The State Board For Professional Medical Conduct appeared by:	Marcy Feller, Esq. Associate Counsel Office For Professional Medical Conduct
Respondent appeared by:	In person and by Greenblatt, Forrester & Axelrod, Esqs. Richard Greenblatt, Esq. Of Counsel 369 Fullerton Avenue Newburgh, N.Y. 12250
Respondent's present address:	[redacted]
Hearings Held On:	1981 May 19; July 7; Aug. 10; Nov. 10; Dec. 1, 16, 30; 1982 Jan. 5, 19; Feb. 2; Mar. 2, 30; May 5, 13, 27; July 28; Aug. 4; Sept. 8, 22, 28; Nov. 1, 17; Dec. 8, 13; 1983 Jan. 22

SUMMARY OF PROCEEDINGS

On or about April 23, 1981, proceedings were commenced by the New York State Board For Professional Medical Conduct against Respondent pursuant to Public Health Law § 230 by service of a Notice of Hearing and Statement of Charges (78)* charging Respondent with professional misconduct within the meaning of Education Law § 6509 (1980).

The First Specification charges Respondent with gross negligence on a particular occasion within the meaning of Education Law § 6509(2), as amended, in that he failed to administer nitrate silver or some other agent equally effective for preventing purulent conjunctivitis as required by 10 NYCRR 12.2. A second charge under the First Specification was that on or about November 15, 1979, while personally unavailable to his patients, Respondent failed to provide coverage of his home birth practice by a qualified medical doctor and he authorized his answering service to refer his patients requiring home birth assistance to Karen Pardini, a lay person (79, 80).

The Second Specification charges Respondent with practicing the profession negligently on more than one occasion (Education Law § 6509(2) 1980) and repeats allegations set forth in the First Specification (81).

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* REFERS TO PAGE IN TRANSCRIPTS.

The Third Specification charged Respondent with permitting, aiding and abetting an unlicensed person to perform activities requiring a license within the meaning of Education Law § 6509(7), in that on or about November 15, 1979, respondent authorized Karen Pardini, a lay person, to home deliver the baby of his patient, T.B. (81).

The Fourth Specification charged Respondent with unprofessional conduct (81).

On or about October 15, 1981, the Statement of Charges was amended to include additional allegations by adding a Fifth Specification charging Respondent with practicing the profession with "gross incompetence and/or gross negligence" within the meaning of Education Law § 6509(2).

The Fifth Specification is set out verbatim (85-90):

"FIFTH SPECIFICATION

"8. Respondent is further charged with practicing the profession with gross incompetence and/or gross negligence within the meaning of N.Y. Educ. Law §6509(2) (McKinney Supp. 1980), in that:

"a) Between on or about February 17, 1980 and on or about February 22, 1980 in the course of his care and treatment of A.G., Respondent failed to properly diagnose and treat a tracheoesophageal fistula with a blind esophageal pouch.

"b) on or about May 26, 1978 in the course of his care and treatment of M.K., Respondent failed to properly diagnose and treat post-partum hemorrhage secondary to retained secundines.

"c) At a time prior to October 8, 1978 Respondent agreed to perform a home delivery upon his patient J.L., who was of advanced maternal age and whom Respondent knew or should have known was, therefore, a high risk patient for such procedure.

"d) At a time prior to delivery of stillborn baby on October 8, 1978 in the course of his care and treatment of J.L., Respondent failed to properly diagnose and treat prolonged rupture of amniotic membranes.

"e) At a time prior to October 8, 1978 in the course of his care and treatment to J.L., Respondent failed to properly diagnose and treat cephalopelvic disproportion.

"f) On or about October 7, 1978 in the course of his care and treatment of J.L., Respondent failed to properly diagnose and treat prolonged non-productive labor (dystocia).

"g) Respondent's failure to properly diagnose and treat cephalopelvic disproportion in J.L. as alleged, caused fetal distress which contributed to the intrauterine death of the fetus carried by J.L.

"h) On or about October 7, 1978 in the course of his care and treatment of J.L., Respondent administered synthetic oxytocin under circumstances which Respondent knew or should have known were inappropriate.

"i) On or about August 31, 1981 in the course of his care and treatment of L.S., Respondent failed to properly diagnose and treat pre-eclampsia, which resulted in eclampsia.

"j) Respondent's failure to properly diagnose and treat pre-eclampsia and eclampsia in L.S. as alleged, supra, caused perinatal asphyxia and attendant complications in newborn S.S.*

"k) At a time prior to September 23, 1978 Respondent agreed to perform a home delivery upon his patient, R.S., who was of advanced maternal age and whom Respondent knew or should have known was, therefore, a high risk patient for such procedure.

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*As amended (665, 666).

"l) At a time prior to September 28, 1978 in the course of his care and treatment of R.S., Respondent failed to properly diagnose and treat post-maturity.

"m) At a time prior to October 2, 1978 in the course of his care and treatment of R.S., Respondent failed to properly diagnose and treat post-partum hemorrhage.

"n) At a time prior to September 28, 1978 in the course of his care and treatment, and subsequent to his home delivery of, newborn B.S., Respondent failed to properly diagnose and treat perinatal asphyxia.

"o) On or about September 28, 1978 in the course of his care and treatment subsequent to his home delivery of newborn B.S., Respondent failed to properly diagnose and treat meconium aspiration.

"p) Between on or about August 1, 1980 and on or about August 16, 1980 in the course of his care and treatment of B.A.H., Respondent failed to properly diagnose and treat prolonged rupture of amniotic membranes.

"q) On or about August 15, 1980, Respondent instructed his patient, B.A.H. to travel, while in labor, to the home of another woman in labor whom Respondent was then attending.

"r) On or about August 16, 1980 in the course of his care and treatment of B.A.H., Respondent failed to properly diagnose and treat dystocia.

"s) On or about August 16, 1980 in the course of his care and treatment of B.A.H., after approximately 60 hours of non-productive labor Respondent manually pulled the fetus from the patient's uterus.

"t) Respondent's failure to properly diagnose and treat prolonged unproductive labor in B.A.H. as alleged, supra, caused perinatal asphyxia and meconium aspiration in the fetus which contributed to the death of newborn P.H. at 3 days of age."

The charges were amended January 14, 1982 as follows:

"FOURTH SPECIFICATION

"7. Respondent is charged with unprofessional conduct within the meaning of N.Y. Educ. Law, § 6509(9), (McKinney Supp. 1980) and 8 NYCRR 29.1(b)(1) in that:

"d. On or about March 29, 1981, in the course of his care and treatment of C.L. and Newborn L., Respondent abandoned his patient Newborn L. who was in need of immediate professional care, without making reasonable arrangements for the continuation of her care, constituting a violation within the meaning of 8 NYCRR § 29.2(a)(1).

"FIFTH SPECIFICATION

"8. Respondent is further charged with practicing the profession with gross incompetence and/or gross negligence within the meaning of N.Y. Educ. Law § 6509(2) (McKinney Supp. 1980), in that:

"u. On or about March 29, 1981, in the course of his care and treatment of C.L., the Respondent failed to properly manage the premature delivery of said patient's infant, Newborn L.*

"v. On or about March 29, 1981, subsequent to his delivery of Newborn L., Respondent failed to properly treat her respiratory distress.

"w. Between on or about November 1, 1978 and December 7, 1978, in the course of his care and treatment of E.B., Respondent failed to properly diagnose and treat failure to thrive.

"x. Between on or about November 1, 1978 and December 7, 1978, in the course of his care and treatment of E.B., Respondent failed to properly diagnose and manage seizure activity." (91, 92)

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*As amended (1196-1200).

The "dry gas" amendment, dated February 9, 1982, charged:

"FIFTH SPECIFICATION

"8. Respondent is further charged with practicing the profession with gross incompetence and/or gross negligence within the meaning of N.Y. Educ. Law § 6509(2) (McKinney Supp. 1980), in that:

"y. Between on or about February 26, 1979 and on or about February 28, 1979, Respondent failed to properly treat Patient G.W. for the ingestion of a toxic substance, namely dry gas, at Benedictine Hospital, Kingston, New York." (84)

The Respondent interposed an answer dated June 29, 1981 wherein he categorically denied each and every allegation of professional misconduct or other improper conduct and set forth four Affirmative Defenses. The First Affirmative Defense referred to Respondent's failure to instill silver nitrate or equivalent solution in the eyes of newborns and claims such failure resulted from the obstructive interference of the parents which rendered Respondent incapable of strict compliance with 10 NYCRR 12.2. In addition, Respondent contends he properly notified the Department of Health of such obstructive conduct. For the Second, Third and Fourth Affirmative Defenses, Respondent alleges 10 NYCRR 12.2, Education Law § 6509(7), and that 8 NYCRR 29.1(b)(1), 29.1(10), 29.2(1) are unconstitutional in that they are void, for vagueness, are overbroad, under inclusive, and in derogation of Respondent's First and Fifth Amendment rights as protected by the Constitution of the United States.

Counsel for Respondent was further permitted by the hearing officer to amend the answer to categorically deny all charges made by the State Board for Professional Medical Conduct as were amended during the course of these proceedings.

The hearing officer dismisses the First Affirmative Defense (which relates to silver nitrate) on the ground that the question of obstructive interference which rendered Respondent incapable of strict compliance is a question of fact for the Panel.

The hearing officer dismisses the Second, Third and Fourth Affirmative Defenses on the grounds that the sections defining professional misconduct are not unconstitutional and certainly not vague since the language sufficiently apprises the Doctor of the scope of permissible conduct. Furthermore, disciplinary hearings on charges of professional misconduct are not appropriate forums for determining the constitutionality of section 6509 since a disciplinary hearing is administrative in nature and, therefore, totally inappropriate to determine constitutionality of a legislative enactment.

Any challenge to the constitutionality of the regulations must be made to the court. This forum has no jurisdiction or authority to make a determination for the question of unconstitutionality on the ground of vagueness of the regulations.

Davin v. New York State Board of Regents, 1977, 393 NYS2d 832.

Bender v. Board of Regents of University of State of New York, 262 A.D. 627, 30 NYS2d 779.

Irwin v. Board of Regents of the State of New York, 33 A.D. 2d 581, 304 NYS2d 319.

The witnesses who testified on behalf of the Board were:

William O'Neill

Patient B

Etta Koeppen

Bartholomew J. Dutto, M.D.

Albert Louis Bartoletti, M.D.

William Bruce Clark, M.D.

Noel J. M. Carrasco

Witness A.B.

Herman Risemberg, M.D.

Norman N. Burg, M.D.

The witnesses who testified on behalf of the Respondent were:

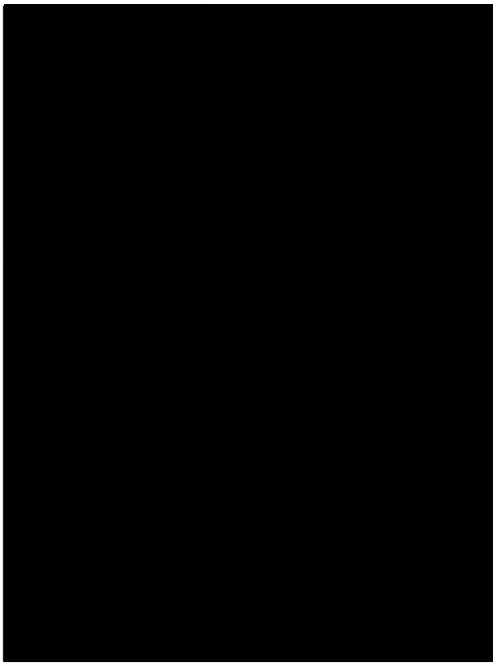
[redacted]

Richard Rothenberg, M.D.

[redacted]

Witnesses who testified on behalf of Respondent (CONT'D)

George A. Wootan, M.D.



Lewis Mehl, M.D., Ph.D.

William Matview, M.D.

NUMBER	DESCRIPTION	FOR ID	IN EV
PETITIONER'S (BOARD'S) EXHIBITS			
1	Notice of hearing and statement of charges		12
2	Hospital records from Benedictine Hospital re Patient B, consisting of 45 pages	60	73
3	Affidavit of Service hereindescribed	61	75
4	General Consent dated July 2, 1979	90	92
5	Three pink sheets of paper marked collectively	188	193
2	Certified copy of Benedictine Hospital record re Patient B		226
6	Photocopy of State Sanitary Code Section 12.2		309
7	Chapter I of the State Sanitary Code, Parts 20.1 through 20.8	344	346
8	Notice to Amend Statement of Charges	347	353
9	Amended Patient Appendix	354	354
10	Certifications of Non-Licensure re Karen Pardini, marked collectively	355	355
11	Sixteen pages comprising letters from Dr. Wootan to Dr. Dutto, marked collectively	359	361
12	Curriculum Vitae re Witness Dr. Bartoletti	416	417
13	Certified hospital record re Patient A.G., aforementioned	417	852
14A	Record from Benedictine Hospital re P.H.	453	453
14B	Hospital record re Patient B.A.H.	453	453

PETITIONER'S (BOARD'S) EXHIBITS (CONT'D)

14C	Hospital record for P.H. from Albany Medical Center	453	453
15A	Benedictine Hospital record re Patient L.S.	517	521
15B	Benedictine Hospital record re Patient S.S.	517	521
15C	Albany Hospital record re Patient L.S.	517	521
15D	Albany Medical Center Hospital record re Patient S.S.	517	523
15E	Discharge summary re Patient S.S.	517	523
15F	Recording of physical parameters observed by Dr. Wootan re Patient L.S. Substituted Exhibit 15F marked in evidence on March 2, 1982	541	
15G	Report re follow-up visit for Patient S.S.	541	544
16A	Albany Medical Center Hospital record re Patient R.S.	553	554
16B	Albany Medical Center Hospital record re Patient B.S.	553	554
16C	Albany Medical Center Hospital record re Patient B.S., herein-described	553	554
	(Note that Exhibit 16C for identification abovementioned was incorporated as part of Exhibit 16B in evidence received at page 554)		
16D	Benedictine Hospital record re Patient B.S.	559	560
16E	Benedictine Hospital record re Patient R.S.	812	845
13	Complete Albany Medical Center record re Patient A.G.		852

PETITIONER'S (BOARD'S) EXHIBITS (CONT'D)

15-E	Substitute copy for Petitioner's Exhibit 15		852
17	Curriculum vitae re Dr. Clark		855
18	Albany Medical Center Hospital records re Patient N.K.		860
19	Photocopy of Dr. Wootan's records re Patient N.K.		861
20	Three-page record from Dr. Wootan re Patient B.A.H.	937	937
21A	Benedictine Hospital record re Patient J.L.	992	993
21B	Albany Medical Center record re Patient J.L.	992	993
21C	Dr. Wootan's record re Patient J.L.	993	993
22	Hereindescribed Notice to Amend Statement of Charges herein		1199
23	Curriculum Vitae of Witness Carrasco		1203
24	Albany Medical Center Hospital record re Female Child L		1204
25	Albany Medical Center Hospital Perinatal Risk Summary		1212
26	Albany Medical Center Hospital Department of Pediatrics/Division of Neonatalogy Discharge Summary		1215
27	Albany Medical Center Hospital record re Patient E.B.		1251
28	Dr. Wootan's record for Eliza Blakely		Marked in evidence on 3/2/82
29	Dr. Wootan's record for Christie Lutz		Marked in evidence on 3/2/82

PETITIONER'S (BOARD'S) EXHIBITS (CONT'D)

30	Curriculum Vitae of Witness Burg	1389	1389
31	One-page document from the University of Oklahoma dated May 4, 1966, hereindescribed	1392	
32	Notice to Amend Statement of Charges		1412
33	Records re Patient G.W. hereindescribed	1412	1426
34	Cover letter from Kingston Hospital dated April 27, 1982 with hereindescribed attachments		1828
8	Aforementioned substituted copy		1829
35	10 pages re Patient T.B.		2932
36	General consent form for Liahona Medical Associates		3596
37	Summary prepared by Donna Sandman re Patient B.A.H.	3626	3816
38	Two-page letter from Dr. Wootan to B.A.H. dated September 2, 1980	3635	3636
39	Copy of portions of EBT of D.L.	3654	Marked in evidence on 12/8/82
40	Aforementioned record re D.B.	3763	
37	Previously marked for identification		3816
41	Three-page letter to Mr. O'Neill from Dr. Wootan, dated April 11, 1979	3855	3860
42	List of phone calls from the Poison Control, Kingston Hospital, dated February 26 and 27 herein described	3898	3899
43	Transcript from the program Nutrition 57 on WHCA, February 27, 1982	3914	3922

44	Transcript of Talk Back, Radio WEOK	3922
45	Transcript of Dialogue 81 on WGY, February 24, 1982	3922

LETTER	DESCRIPTION	FOR ID/IN EV
RESPONDENT'S EXHIBITS		
A	Previously marked for identification only	144
B	Document entitled Silver Nitrate Consent Form	164 165
C	List entitled Supplies Needed for a Home Birth	253 256
D	List of reading material hereindescribed	253
E	Letter from Maxine Odenwald dated September 22, 1981	331
F	Photocopy of Part 12 of Chapter I of the State Sanitary Code	371 (See Exh. 6)
G	Two memoranda from the Office of Health Systems Management	375 (See Exhs. W & X)
H	Document entitled Maternal and Child Health	493 496
I	Document re Obstetrics - Out of Hospital Deliveries	493 496
J	Diagram from Nelson's Textbook of Pediatrics hereindescribed	682 684
K	Records re E.J.B.	1319
L	Copy of Section 12.2 of Chapter I of the State Sanitary Code	2387 2387
M	An outline of the home birth course	2531
N	Requested reading	2531
O	Requested reading	2531
P	A list of high risk factors	2531
Q	A list of vocabulary terms	2531

RESPONDENT'S EXHIBITS (CONT'D)

FINDINGS OF FACT

1. Respondent was authorized to engage in the practice of medicine in the State of New York on June 8, 1966 by issuance of a License No. 096518 by the State Education Department.

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period of January 1, 1980 through December 31, 1982 from R.F.D. Box 1 (Hurley Avenue), Kingston, New York 12401.

3. Respondent is charged with professional misconduct within the meaning of Education Law § 6509, as amended, 1980 as set forth in the Specification attached.

4. First Specification charges Respondent with practicing the profession with gross negligence within the meaning of Education Law § 6509(2), as amended, 1980, in that he failed, immediately on delivery, to drop into the eyes of newborn infants a one percent solution of silver nitrate, or some other agent equally effective for preventing purulent conjunctivitis, as required by 10 NYCRR 12.2.

(a)(b) Respondent was aware of the State Law as corroborated in discussions with Dr. Bartholomew Dutto, Ulster County Health Commissioner (T. 357-413) (Exhs. W and X). The

letters submitted by Respondent to Dr. Dutto in the exhibits above-mentioned are admissions that Respondent failed to comply with the governing regulations. Mr. Puster, husband of a patient, stated the Respondent exerted no influence to try to persuade the patient to permit him to use silver nitrate and the Respondent suggested no other substance (T. 1766-1771). Additionally, Respondent conceded there exists no test which is completely accurate regarding the detection of gonococcus (T. 3874, 3893). Respondent requested his patients to sign a consent form which ostensibly gave them a right to refuse to comply with the health department regulation (Consent Form Exh. B). Respondent failed to administer required medication to a baby born in his office before the child was discharged (T. 1732).

Respondent authorized his answering service to refer his patients requiring home birth assistance to Karen Pardini, a lay person, to whom certificates of non-licensure were received stating that she was not registered, licensed as a registered physician's assistant, registered professional or practical nurse, or registered professional assistant (T. 207). Respondent's answering service owner and operator testified pursuant to Respondent's instructions she was to inform patients for home births that Karen Pardini was covering for him. She also advised that a Dr. Jansen would cover Respondent for hospital deliveries (T. 183-185, 196, 198, 210-211, 2983).

5. Second Specification charges Respondent with practicing the profession negligently on more than one occasion (Education Law § 6509(2) (1980)) and repeated the allegations set out in the First Specification.

6. Third Specification charges Respondent with permitting, aiding and abetting an unlicensed person to perform activities requiring a license within the meaning of Education Law § 6509(7), as amended, 1980 and refers to the same lay person, Karen Pardini, who assisted in a home delivery of the baby of his patient, T.B. The patient and her husband advised the Respondent when he was retained that they wanted only the Respondent to assist in the delivery, and further, that she was never informed that Respondent employed a midwife for home deliveries in his absence (T. 140) (See testimony summarized under First Specification under Paragraph 4(a)(b)).

7. Fourth Specification charges Respondent with unprofessional conduct within the meaning of Education Law § 6509(9), as amended, 1980 and 8 NYCRR 29.1(b)(1) under Paragraph 7 of the Statement of Charges:

(a) The allegations charged in the First Specification, Paragraph 4(a) allege that each listed instance constitutes a violation of 10 NYCRR 12.2.

(b) Respondent knew or should have known that Karen Pardini was not qualified by licensure which constituted a violation within the meaning of 8 NYCRR 29.1(10).

(c) Respondent failed to make reasonable arrangements for continuation of the care of his patient, and further, Respondent knew or should have known patient was approximately 2 to 3 weeks overdue, constituting a violation within the meaning of 8 NYCRR 29.2(1). The recitation of what actually transpired is detailed in the testimony of the answering service operator, Etta Koppen, and Dr. Dutto (T. 105-107, 182-184, 207, 357-413).

(d) The Statement of Charges was amended on January 13, 1982. A (d) was added to paragraph 7 of the Fourth Specification. The charge related to the care and treatment of patient C.L. and newborn L. wherein it was claimed the Respondent abandoned his patient newborn L. who was in need of immediate professional care, without making reasonable arrangements for the continuation of her care.

Patient C.L. was admitted to Albany Medical Center on March 29, 1981 (T. 1203, 1216). Respondent had telephoned concerning a newborn infant who exhibited "cyanosis" and required oxygen (T. 1216). Dr. Noel Carasco, Albany Medical Center Neonatologist, testified he advised Respondent he would accept the infant and would send a transport team (T. 1216). Respondent declined the offer to say the infant and parents were all ready to leave and he would accompany the infant (T. 1217). The infant arrived at Albany Medical Center with his parents who had an oxygen tank obtained from the local Fire

Department (T. 1218). Dr. Carasco testified that Respondent stayed behind for another delivery and kept the oxygen that he had had with him (T. 1219).

The witness said the infant was dusky and cyanotic on arrival and the tank was close to empty at that time. (T. 1210, 1219). The witness further stated the parents were holding the oxygen a little bit too far away which affected the amount of oxygen the baby received (T. 1229-1230).

Respondent stated that one-half hour after the birth of newborn L., he noted her color to be dusky (T. 3718) and he administered oxygen to the infant and that she "pinked up" in color (T. 3719). It appears that on October 6, 1980 C.L. appeared at Respondent's office for her first pre-natal visit of her second pregnancy. Respondent noted that her uterus was enlarged and consistent with twelve to fourteen weeks of pregnancy, indicative of conception in late July or early August, 1980. Upon admission to Albany Medical Center on March 29, 1981, Newborn L. was diagnosed as thirty-five to thirty-six weeks of gestation (T. 1225) (Ex. 24). Despite Respondent's knowledge of the onset, C.L.'s labor in the early hours of March 29, 1981 was premature (T. 3731), Respondent did not advise C.L. to go to a hospital to have her baby. Respondent attended to this delivery at C.L.'s home. It was Respondent's impression that S.L. was suffering from a congenital heart anomaly (T. 3719, 3732, 3751-3752). When questioned about the

type of heart lesion that might have permitted color improvement with oxygen administration, Respondent was unable to articulate even one specific malady (T. 3733). The basis of his opinion was that he heard a murmur (T. 3718).

Fifth Specification

8. On or about October 15, 1981, the Statement of Charges was amended to include additional allegations by adding a Fifth Specification charging Respondent "with practicing the profession with gross incompetence and/or gross negligence" within the meaning of Education Law § 6509(2). The Fifth Specification is recorded and enumerated in Paragraphs 8(a) through (y) of this Amended Statement of Charges.

(a) Testimony of Dr. Bartoletti concerning patient A.G., who had a tracheoesophageal fistula, which was described as "a pouch of the oesophagus, of the swallowing tube" stated that actually what happens is there is a blind ending to the upper part of the oesophagus without any connection between the oesophagus with the stomach (T. 422-423). The patient was very critical upon his arrival at the Albany Medical Center (T. 426). This patient was admitted to the Center five days after his birth (T. 427). The mother testified she reported to the Respondent the child's conditions were mucuosy secretions and coughing (T. 441, 740, 3967-8) (Ex. 13). The Respondent observed this condition on the first three days of life (T. 3161). The witness's opinion was not changed upon cross-examination (T. 679-749).

(b) Patient N.K. was known by Respondent to be a Jehovah's Witness (T. 3193). Her religious beliefs prohibited her from accepting a blood transfusion which increased the risk regarding frequent complication of intra-partum hemorrhage (T. 867). She was admitted to Albany Medical Center three days post partum suffering severe blood loss and anemia (T. 862-3). Respondent visited N.K. on the first day post partum (T. 3205), and though he received frequent reports from N.K. regarding her continued bleeding (T. 881, 893) and performed a blood count on the first day post partum which indicated blood loss from hemorrhage (T. 3210), it was not until patient was in critical state that Respondent referred her to Albany Medical Center (T. 896, 880, 903, 3220-3223). Respondent prescribed Ergotrate (T. 3213) on the second day post partum (T. 3214).

Respondent knew that Albany Medical Center would respect and accommodate N.K.'s religious convictions (T. 3195). Dr. Clark, Petitioner's witness, testified any continued bleeding beyond twenty-four hours post partum should have been evaluated in Hospital and a dilatation and curettage to assure removal of any retained placental tissue which was causing the hemorrhage (T. 870, 905, 933).

(c)(d)(e)(f)(g)(h) Patient J.L. was admitted to Benedictine Hospital at 6:35 A.M. on October 8, 1978. She was thirty years of age. J.L.'s amniotic membranes ruptured more than twenty-four hours earlier, she had been in labor for

forty-eight hours (Ex. 21A) (T.996). Her baby was dead upon admission to Benedictine Hospital (T. 1064) when a Cesarian section was performed subsequent to which she developed multiple abdominal abscess (T. 994).

During the night preceding her admission to the Hospital J.L. was given multiple doses of buccal pitocin by Respondent, an oral form of oxytocin, at her home (Ex. 21C) (T. 1077). At 4:30 A.M. on October 8, when the fetal heartbeat was no longer heard, J.L. was transferred to the Hospital (Ex. 21A, 21C). X-ray pelvimetry after admission revealed a marked narrowing of the pelvic bones, which had caused cephalopelvic disproportion (C.P.D.) (T. 1007). It was obvious the birth canal was too narrow to allow a normal vaginal birth. The autopsy revealed J.L.'s baby died in utero of asphyxia and meconium aspiration. Post-operatively J.L. was hospitalized at Benedictine Hospital and Albany Medical Center until November 12, 1978 for peritonitis (Ex. 21B) (T. 994).

(i)(j)* The patient L.S. at her last visit to Respondent's office exhibited signs of pre-eclampsia, elevated hypertension, edema and proteinuria (T. 1099-1100) (Ex. 15F). Respondent advised increased fluids and salts and informed her to return in three days (T. 793). During the night when her condition deteriorated to eclampsia and was

*Petitioner withdrew the last clause of paragraph 8(j) of the Fifth Specification which reads: "all of which constituted to permanent brain injury in said infant."

manifested by seizures, she was admitted to Benedictine Hospital (Ex. 15A). The infant S.S. was delivered by Cesarian section asphyxiated and cyanotic and had to be resuscitated at birth. After delivery at Benedictine Hospital she was transferred to Albany Medical Center for further care (T. 525) (Ex. 15D). Dr. Bartoletti testified the day before birth L.S. had an elevation of her blood pressure, peripheral swelling and some protein in her urine.

(k)(l)(m)(n)(o) Patient R.S. was thirty-six years old at the time she gave birth to B.S. during her pregnancy. There was a repeated appearance of third trimester bleeding (T. 1128, 1143-1145, 3472), and also bleeding at the onset of labor (T. 3474). A sonogram was performed at Respondent's suggestion (T. 809). The child, B.S. was born heavily meconium-stained (T. 825-830). The umbilical cord remained unclamped and pulsating for about one hour (T. 1129, 3477, 3952). The baby was transported from Benedictine Hospital to Albany Medical Center since the treating doctor at Benedictine Hospital observed no evidence that the meconium aspirated by B.S. from her respiratory and digestive tracts had been suctioned out (T. 837). She remained hospitalized for two and one-half months. Four days post partum R.S. was admitted to Albany Medical Center for hemorrhage (T. 112).

Dr. Bartoletti treated B.S. at Albany Medical Center. He inserted a bigger endotracheal tube and noted, when taken

out, it was occluded but the bottom half of the tube was stained with meconium indicating meconium was below the vocal cords or had been aspirated into the lungs. (Dr. Clark also testified that he considered the patient to be a high risk patient) (T. 1123).

(p)(q)(r)(s)(t) These charges relate to patient B.A.H. as to the newborn baby, P.H. The child was born on August 16, 1980 and the Respondent was the attending physician. The Hospital records indicate that B.A.H. experienced ruptured membranes on July 31, 1980 (T. 455) (Ex. 20). Both events were promptly reported to Respondent (T. 3531, 3537) who advised her to take her temperature frequently (T. 455-456, 3585). B.A.H. visited Respondent's office twice in the first two weeks of August, 1980 and had numerous telephone conversations with him (T. 3536).

Respondent came to B.A.H.'s home to attend delivery at 10:30 P.M. on August 13 (T. 3539), and remained at her home during the night (T. 3541). Respondent left to attend another birth and returned to patient's home at 11:40 P.M., Thursday, August 14, over twenty-four hours since his earlier arrival. He did not examine her and testified that there was no reason to check her at that time (T. 3543). Respondent did not know how often the fetal heart tones which were being mentioned (T. 3588-3590). Her temperature ranged from a low of 97.4 degrees to an elevation of 99.4 degrees (T. 3545) He remained at her

home until August 15 when he left to attend a birth in New Paltz (T. 3551). Respondent spoke to her husband by telephone from the New Paltz home and subsequent to such conversation B.A.H. was transferred to the New Paltz home arriving at 1:50 A.M., Saturday, August 16, 1980 (T. 3553). In the morning of August 16, Respondent noted meconium in B.A.H.'s leaking amniotic fluid (T. 3588). The baby was born in New Paltz at 9:57 P.M. that day.

At birth, the infant was heavily meconium-stained (T. 3622), manifested an Apgar score of two (Ex. 20) and had a heart rate of 80 to 100 beats per minute (T. 3571, 3621). The baby was transported by car to Benedictine Hospital. After admission, the newborn was incubated and resuscitated, given oxygen and medications to correct metabolic acidosis, seizures and asphyxia (T. 462, 468). The baby was then transported to Albany Medical Center, placed in intensive care for three days, until, on August 19, 1980, the baby died (T. 472). The death was diagnosed as asphyxia (T. 473) meconium aspiration, shock, acute renal failure and intracranial hemorrhage (Ex. 14C).

The baby's mother, patient B.A.H., was admitted to the Medical Center on the 20th and discharged on the 24th. Dr. Bartoletti stated that she was admitted because "of infection" (T. 474).*

*Dr. Bartoletti's cross-examination as to patients B.A.H. and P.H. appears at pages 747-776. Dr. William B. Clark also attended the patient B.A.H. and his testimony appears at pages 937-988 of the record. Dr. Clark is board-certified in obstetrics and gynecology (T. 1131).

(u)(v) These charges which pertain to C.L. and Newborn L. should have obviously been recited under paragraph 7(d) of the Fourth Specification and are also included in the Amendment of the Statement of Charges dated January 13, 1982. For such reason, no additional facts are supplied under these sub-sections.

(w)(x) The charges referring to the treatment of Patient E.B. under paragraph 8 in the Fifth Specification were withdrawn by the Petitioner.

(y) The Fifth Specification was amended again on February 9, 1982 to include a charge under paragraph 8(y) which states that on or about February 26, 1979 and on or about February 28, 1979, Respondent failed to properly treat patient G.W. for ingestion of a toxic substance, namely, dry gas, at Benedictine Hospital, in Kingston, New York. The patient G.W. was brought to the emergency room of Benedictine Hospital and said he had drunk twelve ounces of dry gas about five or six hours prior to his arrival. He was sent to the Intensive Care Unit (ICU). The attending physician with regard to this patient was Respondent. The record indicates that Respondent was informed of his admission to the Hospital and placement in the ICU. The record also indicates that Respondent came about one hour after placing the patient in ICU and ordered, among other things, that the patient be transferred to the regular floor and prescribed valium, five milligrams, four times a day (T. 1431). The patient became camatose and later died.

Respondent admits he could not recognize metabolic acidosis when questioned specifically (T. 3791, 3801-3802, 3809).

At the end of the Hearing, permission was granted for the parties to submit written summations. The Board submitted a summation; however, attorney for Respondent submitted two affidavits of doctors licensed in the State of California without any summations.

The Panel's determinations are made pursuant to the Hearing Committee's Findings of Fact, and relate to the Respondent's general performance in the practice of medicine and to his general competence. The conclusions recited hereunder refer to the charges in the Specifications only and indicate the Panel's opinions regarding the Respondent's competence and understanding for the basic tenets of acceptable medical standards.

CONCLUSIONS

The Panel finds by unanimous vote (5-0) as to the First Specification as follows:

Paragraph 4(a)(b) Respondent is guilty with practicing the profession with gross negligence within the meaning of Education Law § 6509(2), as amended, 1980.

The determination is made by virtue of Respondent's admissions, his failure to observe the specific precepts of the law, the documentary proof and the Exhibits, and the predominance of the credible testimony.

In addition, the testimony of Respondent's answering service operator is in complete confirmation of Respondent's contact and performance in referring patients to an unlicensed lay person.

The Panel finds by unanimous vote (5-0) as to the Second Specification as follows:

Paragraph 5 Respondent is guilty with practicing the profession negligently within the meaning of Education Law § 6509(2), as amended, 1980.

The particular Specification repeats each and every allegation charged in the First Specification and the reasons submitted for the determination in the First Specification are repeated with the same effect as if more fully set forth herein.

The Panel finds by unanimous vote (5-0) as to the Third Specification as follows:

Paragraph 6 Respondent is guilty with permitting, aiding and abetting an unlicensed person to perform activities requiring a license within the meaning of Education Law § 6509(7), as amended, 1980.

The Panel's determination is based on Respondent's admissions and the testimony of his witness, a lay person, to home deliver the baby of his patient, T.B.

The Panel finds by unanimous vote (5-0) as to the Fourth Specification as follows:

Paragraph 7(a) Respondent is guilty with unprofessional conduct within the meaning of Education Law § 6509(9), as amended, 1980 and 8 NYCRR 29.1(b)(1).

Respondent is guilty of violating 10 NYCRR 12.2. Respondent's testimony indicates beyond doubt that he was familiar with the section and failed to perform in accordance with the tenet of it; Respondent delegated his professional responsibilities to an unlicensed lay mid-wife simultaneously aiding and abetting Ms. Pardini's illegal practice of activities.

7(b) Respondent is guilty. His patient T.B. was delivered by Ms. Pardini who was not qualified by licensure to perform said procedure, constituting a violation within the meaning of 8 NYCRR 29.1(10).

7(c) Respondent is guilty. The patient T.B. was abandoned by Respondent without his making proper arrangements for her continued care, which act demonstrated Respondent's disregard for the consequences. As a fact, it was necessary for this patient to be taken to the hospital after her delivery.

7(d) Respondent is guilty. Respondent failed to properly diagnose the premature delivery of Newborn L. Respondent's records prove such fact as indicated in Exhibit 29. Respondent's failure to transfer this mother to a hospital immediately upon delivery equipped to cope with L.'s respiratory distress which he should have anticipated constitutes a violation within the meaning of 8 NYCRR 29.2(a)(1); the infant arrived at Albany Medical Center in the company of his parents who had an oxygen tank obtained from a local fire company. Respondent had stayed behind for another delivery. The infant was cyanotic on arrival and the tank was close to empty. The child arrived at the hospital about six hours after Respondent had called the doctor at Albany Medical Center.

The Panel finds by unanimous vote (5-0) as to the Fifth Specification wherein Respondent is charged with practicing the profession with gross incompetence and/or gross negligence within the meaning of Education Law § 6509(2), as amended, 1980 as follows:

Paragraph 8(a) Respondent is guilty. Determination is based on the fact that the child was not hospitalized until the sixth day. Respondent failed to recognize the child's condition as something other than a feeding problem into the fifth day as to his life. The mother's testimony described the condition of her baby who showed symptoms including coughing, not nursing, evidence of milk when he coughed up and a significant loss of weight.

8(b) Respondent is guilty. Respondent failed to refer the mother to the hospital for her delivery and disregarded the mother's hemorrhaging after delivery in the absence of personnel and equipment to cope with such emergency. She was admitted to Albany Medical Center on her third post partum day suffering from blood loss and showing evidence of retained placental tissue. Though N.K. was a Jehovah Witness, Dr. Clark of Albany Medical Center, had no problem in getting the patient to consent to a blood transfusion. Incidentally, examination of Respondent's record disclosed no notations concerning post partum care.

8(c) Respondent is not guilty. There is insufficient proof that the patient was a high risk patient for home delivery.

8(d) Respondent is not guilty. There is insufficient proof that Respondent failed to properly diagnose and treat a prolonged rupture of amniotic membranes. There is a question of doubt as to whether thirty hours can be deemed to be termed a prolonged rupture of amniotic membrane.

8(e)(f)(g)(h) Respondent is guilty. The patient J.L. had prolonged ruptured membranes (more than 24 hours from the time of rupture until delivery) and prolonged labor. Her baby was dead upon admission to Benedictine Hospital where a Cesarian section was performed, subsequent to which she developed an abdominal abscess and multiple abdominal abscesses. During the night preceding her admission to the Hospital, patient was given multiple doses of buccal pitocin by Respondent at her home, a medication inappropriate for home use and the arrested labor occurred because the baby was too large for the pelvis. The patient should have been hospitalized much sooner.

(i) Respondent is guilty. The patient L.S. exhibited marked elevated hypertension, edema, and proteinuria at the last pre-natal visit to Respondent's office. The patient should have been hospitalized for an immediate delivery of the baby. Respondent's cause of treatment was contraindicated and the advice given to the patient to take increased fluids and salts and return for another visit in three days was wholly improper.

(j) Respondent is not guilty. There is no substantial proof that Respondent failed to diagnose eclampsia.

(k) Respondent is not guilty. The isolated finding of advanced maternal age, 36 years, is not sufficient proof of a high risk pregnancy.

(l) Respondent is not guilty. There are too many factors involved and post maturity was not fully established.

(m) Respondent is not guilty. There is no evidence of post partum hemorrhage and inadequate documentation and follow-up of the third trimester bleeding.

(n)(o) Respondent is guilty. Respondent delivered patient B.S. at home. She had been delivered vaginally and covered with meconium. At the time of her arrival at

Benedictine Hospital she was asphyxiated and immediately intubated and transfered to Albany Medical Center. The infant was cyanotic and in critical condition. The infant remained hospitalized for 2-1/2 months in Albany Medical Center.

At birth, the umbilical cord remained unclamped and pulsating for an hour. The treating physician at Benedictine Hospital observed no evidence that the meconium aspirated by B.S. from her respiratory and digestive tracts had been suctioned out. Respondent failed to properly diagnose mother's condition in a timely manner.

(p)(q)(r) Respondent is guilty. Hospital records indicate B.A.H. experienced ruptured membranes on July 31, 1980. Her baby P.H. was born on August 16, 1980. The baby died three days after admission to the Hospital. The mother, B.A.H. was admitted to the Hospital on August 20th and discharged on the 24th, the records indicating she was admitted because of an infection. On August 15, 1980, Respondent instructed the patient to travel while in labor to the home of another woman in labor whom he was then attending. Respondent failed to properly diagnose and treat dystocia and prolonged unproductive labor in B.A.H.

(s) Respondent is not guilty. There is insufficient evidence relating to the charge that Respondent manually pulled the fetus from patient's uterus.

(t) Respondent is guilty. See explanation set forth in (p)(q)(r) hereinabove.

(u)(v) Respondent is not guilty. There is insufficient evidence offered to sustain this charge.

(w)(x) Withdrawn by Petitioner.

(y) Respondent is guilty. Respondent failed to treat the patient G.W. for the ingestion of dry gas at Benedictine Hospital. Patient

was admitted to Benedictine Hospital and transfered to Intensive Care Unit (ICU). Respondent transfered him to the regular floor without documenting the reason for the transfer and without writing up a history and physical. Patient remained unattended by Respondent for several hours when he went into cardiopulmonary arrest or Code Blue. Respondent evidences and further admits a complete lack of or knowledge of a fundamental understanding of the treatment of toxic substance ingestion.

RECOMMENDATION

After consideration of the entire record, which included twenty-five days of hearings in which ten witnesses testified on behalf of the Board and twenty-four witnesses on behalf of the Respondent, an inspection and review of more than fifty documents and Exhibits produced by the Board and approximately twenty-four by the Respondent, the summation submitted by the Board, and the affidavits submitted by Respondent, the Committee assessed Respondent's overall competence and compliance with the basic tenets of acceptable medical standards, and by unanimous vote (5-0) recommends that Respondent's license to practice medicine in the State of New York be revoked.

Dated: New York, New York
March 8, 1983

[redacted]

Frank E. Iaquinta, M.D.
Chairman for the Committee

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

IN THE MATTER	:	COMMISSIONER'S
OF	:	RECOMMENDATION
GEORGE A. WOOTAN, M.D.	:	

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding having been held on May 19; July 7; August 10; November 10; December 1, 16, 30; 1981; January 5, 19, February 2; March 2, 30; May 5, 13, 27; July 28; August 4; September 8, 22, 28; November 1, 17; December 8, 13; 1982 and January 22, 1983, and the Respondent, George A. Wootan, M.D., having appeared personally and represented by Greenblatt, Forester & Axelrod, Esqs., by Richard Greenblatt, Esq., of Counsel, and the evidence in support of the charges against the Respondent having been represented by Peter J. Millock, General Counsel, by Marcy Feller, Esq., of Counsel.

NOW, on reading and filing the transcript of the said hearing, the exhibits and other evidence, and the findings, conclusions and recommendations of the Committee,

I hereby make the following recommendation to the Board of Regents.

A. that the Findings of Fact, Conclusions and Recommendations of the hearing panel be accepted in full; and

B. that the Board of Regents issue an order adopting and incorporating the said Findings of Fact and Conclusions and further adopting as its determination the said Recommendations.

The entire record of the within proceeding is herewith transmitted.

DATED: Albany, New York
April 25, 1983

[redacted]

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

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

IN THE MATTER : NOTICE
OF : OF
GEORGE A. WOOTAN, M.D. : HEARING

TO: GEORGE A. WOOTAN, M.D.
[redacted]

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of Public Health Law, §230, as amended 1980 and State Administrative Procedure Act, Article 3. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Conduct on 19 day of May 1981 at 10:00 in the forenoon of that day at New York State Health Department Office of Professional Medical Conduct, 2 World Trade Center, Room 4919, New York, New York 10047 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be

Pet. Ex 1 I.D.
5/19/81

made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to have subpoenas issued on your behalf to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you.

The hearing will proceed whether or not you appear at the hearing. At the conclusion of the hearing, the committee shall make a determination concerning what action should be taken with respect to your license to practice medicine in the State of New York.

Pursuant to the provisions of Public Health Law, §230, as amended 1980, you may file and answer to the Statement of Charges, including affirmative defenses, if any, not less than ten days prior to the date of the hearing. Such answer shall be forwarded to the Office of Counsel, Professional Medical Conduct, New York State Department of Health, Two World Trade Center, 49th floor, New York, New York 10047.

SINCE THESE PROCEEDINGS MAY RESULT IN A RECOMMENDATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
April 23 1981

[redacted]

THADDEUS J. MURAWSKI, M.D.
Executive Secretary of State Board
for Professional Medical Conduct

Inquiries should be directed to:
Marcy E. Feller, Assistant Counsel

Tel. No. (212) 488-8170

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

X

IN THE MATTER
OF
GEORGE A. WOOTAN, M.D.

: STATEMENT
: OF
: CHARGES

X

The State Board for Professional Medical Conduct, upon information and belief, charges and alleges as follows:

1. GEORGE A. WOOTAN, M.D. Respondent, was authorized to engage in the practice of medicine in the State of New York on June 8, 1966 by the issuance of license number 096518 by the State Education Department.

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period of January 1, 1980 through December 31, 1982 from [redacted]

3. Respondent is charged with professional misconduct within the meaning of Education Law, §6509, amended 1980 as set forth in the Specifications attached.

FIRST SPECIFICATION

4. Respondent is charged with practicing the profession with gross negligence on a particular occasion within the meaning of Education Law, §6509(2), as amended, 1980, in that:

(a) On or about the dates listed below, Respondent failed, immediately on delivery, to drop into the eyes of newborn infants listed below, a one percent solution of nitrate of silver, or some other agent equally effective for preventing purulent conjunctivitis, as required by 10 NYCRR 12.2:

DATE OF DELIVERY	NEWBORN
12/16/78	
1/1/79 or 1/7/79	
1/2/79	
1/8/79	
1/12/79	
1/19/79	
1/20/79	
1/21/79	
1/30/79	
2/3/79	

2/7/79

2/10/79

2/15/79

2/19/79

3/13/79

3/21/79

3/26/79

3/30/79

3/31/79

5/3/79

5/4/79

5/13/79

5/14/79

5/26/79

6/17/79

6/24/79

8/12/79

8/18/79

(b) On or about November 15, 1978 while personally unavailable to his patients, Respondent failed to provide proper coverage of his home birth practice by a qualified medical doctor, in that he authorized his answering service to refer his patients requiring home birth assistance to Karen Pardini, a lay person.

SECOND SPECIFICATION

5. Respondent is further charged with practicing the profession negligently on more than one occasion within the meaning Education Law, §6509(2), as amended, 1980, in that:

The State Board for Professional Medical Conduct repeats each allegation charged in the First Specification with the same effect as if more fully set forth here.

THIRD SPECIFICATION

6. Respondent is further charged with permitting, aiding and abetting an unlicensed person to perform activities requiring a license within the meaning of Education Law, §6509(7), as amended, 1980, in that:

On or about November 15, 1978 Respondent authorized Karen Pardini, a lay person, to home-deliver the baby of his patient, T.B.

FOURTH SPECIFICATION

7. Respondent is charged with unprofessional conduct within the meaning of Education Law, §6509(9), as amended, 1980 and 8 NYCRR 29.1(b)(1) in that:

(a) The State Board for Professional Medical Conduct repeats each allegation charged in the First Specification paragraph 4(a), and further alleges that each listed instance constitutes a violation of 10 NYCRR 12.2.

(b) On or about November 15, 1978, Respondent delegated to Karen Pardini the professional responsibility of delivering, in his absence, the baby born to his patient T.B. when Respondent knew or should have known that Ms. Pardini was not qualified by licensure to perform said procedure, constituting a violation within the meaning of 8 NYCRR 29.1(10).

(c) On or about November 15, 1978, Respondent failed to make reasonable arrangements for the continuation of care of his patient, T.B., who was in need of Respondent's immediate professional care and whose delivery

Respondent knew, or should have known was approximately 2 to 3 weeks overdue, constituting a violation within the meaning of 8 NYCRR 29.2(1).

Dated: Albany, New York
April 23, 1981

[redacted]

THADDEUS J. MURAWSKI, M.D.
Executive Secretary of State Board
for Professional Medical Conduct

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

IN THE MATTER : NOTICE

OF : TO AMEND

GEORGE A. WOOTAN, M.D. : STATEMENT OF

: CHARGES

Pet's Ex 8 ID.
11/10/81
In Ev 11/10/81

TO: GEORGE A. WOOTAN, M.D.
[redacted]

PLEASE TAKE NOTICE that the Statement of Charges in the above Matter is hereby amended, as follows:

FIFTH SPECIFICATION

8. Respondent is further charged with practicing the profession with gross incompetence and/or gross negligence within the meaning of N.Y. Educ. Law §6509(2) (McKinney Supp. 1980), in that:

a) Between on or about February 17, 1980 and on or about February 22, 1980 in the course of his care and treatment of A.G., Respondent failed to properly diagnose and treat a tracheoesophageal fistula with a blind esophageal pouch.

b) Between on or about May 23, 1978 and on or about May 26, 1978 in the course of his care and treatment of N.K., Respondent failed to properly diagnose and treat post-partum hemorrhage secondary to retained secundines.

c) At a time prior to October 8, 1978 Respondent agreed to perform a home delivery upon his patient J.L., who was of advanced maternal age and whom Respondent knew or should have known was, therefore, a high risk patient for such procedure.

d) At a time prior to delivery of stillborn baby on October 8, 1978 in the course of his care and treatment of J.L., Respondent failed to properly diagnose and treat prolonged rupture of amniotic membranes.

e) At a time prior to October 8, 1978 in the course of his care and treatment to J.L., Respondent failed to properly diagnose and treat cephalopelvic disproportion.

f) On or about October 7, 1978 in the course of his care and treatment of J.L., Respondent failed to properly diagnose and treat prolonged non-productive labor (dystocia).

g) Respondent's failure to properly diagnose and treat cephalopelvic disproportion in J.L. as alleged, caused fetal distress which contributed to the intrauterine death of the fetus carried by J.L.

h) On or about October 7, 1978 in the course of his care and treatment of J.L., Respondent administered synthetic oxytocin under circumstances which Respondent knew or should have known were inappropriate.

i) On or about August 31, 1981 in the course of his care and treatment of L.S., Respondent failed to properly diagnose and treat pre-eclampsia, which resulted in eclampsia.

j) Respondent's failure to properly diagnose and treat pre-eclampsia and eclampsia in L.S. as alleged, supra, caused perinatal asphyxia and attendant complications in newborn Stanley Soll, all of which contributed to permanent brain injury in said infant.

k) At a time prior to September 28, 1978 Respondent agreed to perform a home delivery upon his patient, R.S., who was of advanced maternal age and whom Respondent knew or should have known was, therefore, a high risk patient for such procedure.

l) At a time prior to September 28, 1978 in the course of his care and treatment of R.S., Respondent failed to properly diagnose and treat post-maturity.

m) At a time prior to October 2, 1978 in the course of his care and treatment of R.S., Respondent failed to properly diagnose and treat postpartum hemorrhage.

n) At a time prior to September 28, 1978 in the course of his care and treatment, and subsequent to his home delivery of, newborn B.S., Respondent failed to properly diagnose and treat perinatal asphyxia.

o) On or about September 28, 1978 in the course of his care and treatment subsequent to his home delivery of newborn B.S., Respondent failed to properly diagnose and treat meconium aspiration.

p) Between on or about August 1, 1980 and on or about August 16, 1980 in the course of his care and treatment of B.A.H., Respondent failed to properly diagnose and treat prolonged rupture of amniotic membranes.

q) On or about August 15, 1980, Respondent instructed his patient, B.A.H. to travel, while in labor, to the home of another woman in labor whom Respondent was then attending.

r) On or about August 16, 1980 in the course of his care and treatment of B.A.H., Respondent failed to properly diagnose and treat dystocia.

s) On or about August 16, 1980 in the course of his care and treatment of B.A.H., after approximately 60 hours of non-productive labor Respondent manually pulled the fetus from the patient's uterus.

t) Respondent's failure to properly diagnose and treat prolonged unproductive labor in B.A.H. as alleged, supra, caused perinatal asphyxia and meconium aspiration in the fetus which contributed to the death of newborn P.H. at 3 days of age.

Dated: October 15, 1981

[redacted]

THADDEUS J. MURAWSKI, M.D.
Executive Secretary
State Board for Professional
Medical Conduct

Pet's Ex 22
Th-G
1/19/82

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

IN THE MATTER :
OF :
GEORGE A. WOOTAN, M.D. :

NOTICE TO AMEND STATEMENT OF CHARGES

TO: GEORGE A. WOOTAN, M.D.
[redacted]

PLEASE TAKE NOTICE that the Statement of Charges in the above matter is hereby amended, as follows:

FOURTH SPECIFICATION

7. Respondent is charged with unprofessional conduct within the meaning of N.Y. Educ. Law, §6509(9), (McKinney Supp. 1980) and 8 NYCRR 29.1(b)(1) in that:

d) On or about March 29, 1981, in the course of his care and treatment of C.L. and Newborn L., Respondent abandoned his patient Newborn L. who was in need of immediate professional care, without making reasonable arrangements for the continuation of her care, constituting a violation within the meaning of 8 NYCRR §29.2(a)(1).

FIFTH SPECIFICATION

8. Respondent is further charged with practicing the profession with gross incompetence and/or gross negligence within the meaning of N.Y.

Educ. Law §6509(2) (McKinney Supp. 1980),

in that:

u) ~~At a time prior to~~ March 29, 1981, in the course of his care and treatment of C.L., the Respondent failed to properly ~~diagnose and~~ manage the premature delivery of said patient's infant, Newborn L.

v) On or about March 29, 1981, subsequent to his delivery of Newborn L., Respondent failed to properly treat her respiratory distress.

w) Between on or about November 1, 1978 and December 7, 1978, in the course of his care and treatment of E.B., Respondent failed to properly diagnose and treat failure to thrive.

x) Between on or about November 1, 1978 and December 7, 1978, in the course of his care and treatment of E.B., Respondent failed to properly diagnose and manage seizure activity.

Dated: January 13, 1982
Albany, New York

JOHN EADIE
Director
New York State Department of Health
Office of Professional
Medical Conduct

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

IN THE MATTER :

OF :

GEORGE A. WOOTAN, M.D. :

NOTICE TO AMEND STATEMENT OF CHARGES

Let's get 32 Fin: 3/24/82

TO: GEORGE A. WOOTAN, M.D.
[redacted]

PLEASE TAKE NOTICE that the Statement of Charges in the above matter is hereby amended, as follows:

FIFTH SPECIFICATION

8. Respondent is further charged with practicing the profession with gross incompetence and/or gross negligence within the meaning of N.Y. Educ. Law § 6509(2) (McKinney Supp. 1980), in that:

y. Between on or about February 26, 1979 and on or about February 28, 1979, Respondent failed to properly treat Patient G.W. for the ingestion of a toxic substance, namely dry gas, at Benedictine Hospital, Kingston, New York.

DATED: February 9, 1982
Albany, New York

[redacted]

JOHN L. EADIE
Director
Office of Professional Medical Conduct
New York State Department of Health

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

GEORGE A. WOOTAN, M.D.

CALENDAR NO. 3056

The University of the State of New York

IN THE MATTER

OF

GEORGE A. WOOTAN, M.D.

ORIGINAL ORDER
NO. 3056

Upon the report of the Regents Review Committee, under Calendar No. 3056, the record herein and correspondence submitted on behalf of respondent, the prior proceedings had herein pursuant to Article 2, Title II-A of the Public Health Law, the vote of the Board of Regents on October 21, 1983, and in accordance with the provisions of Title VIII of the Education Law, which report and vote are incorporated herein and made a part hereof, it is

ORDERED that, in the matter of GEORGE A. WOOTAN, M.D., respondent, the findings of fact of the Hearing Committee of the State Board for Professional Medical Conduct be accepted; that the conclusions of the Hearing Committee as to the question of guilt of the respondent be accepted; that the recommendation of the Hearing Committee as to the measure of discipline be accepted; that the recommendation of the Commissioner of Health as to the findings of fact of the Hearing Committee be accepted; that the recommendation of the Commissioner of Health as to the conclusions of the Hearing Committee as to the question of guilt of the respondent be accepted; that the recommendation of the Commissioner of Health as to the measure of discipline recommended by the Hearing Committee be accepted; that the recommendation of the Regents Review Committee be accepted; that respondent is guilty of the first through fourth specifications of the charges and guilty of the fifth specification of the charges to the extent indicated in the report of the Hearing Committee; that

GEORGE A. WOOTAN, M.D. (3056)

respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent was found guilty, as aforesaid; and that this determination is not based upon the fact that respondent advocated and practiced home deliveries, but upon the finding that he has been guilty of the specific charges against him, including gross incompetence and gross negligence in his medical practice and that the Board of Regents takes no position on the desirability or undesirability of home deliveries.

IN WITNESS WHEREOF, I, Gordon M. Ambach, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 25th day of October, 1983.

[redacted]

Commissioner of Education

HE UNIVERSITY OF THE STATE OF NEW YORK

In the Matter

of the

Application for the revocation of the authorization and license heretofore granted to George A. Wooton to practice Medicine in the State of New York and for the cancellation of his registration as such and for such other relief as the premises warrant.

STATE OF NEW YORK)
COUNTY OF ~~NEW YORK~~) SS.: Westchester
CITY OF NEW YORK)

Ronald Jacobs, being duly sworn deposes and says:

I am over the age of twenty-one years, and am an Investigator for the State Education Department, 622 Third Avenue, Borough of Manhattan City, County and State of New York.

That on the 27 day of October 1983 at Route 2 County of Ulster City of Hurley, State of New York, I served the Duplic Original Order of the Commissioner of Education, order # 3056 dated the 25 day of Oct 1983, revoking the licer and registration issued to George A Wooton.

That I knew the person so served as aforesaid to be George A Wooton, the person mentioned therein.

[redacted]

Sworn to before me this
31 day of Oct 1983

[redacted]

DOMINICK J. BOLOGNA
Notary Public, State of New York
4763152
Qualified in Rockland County
Commission Expires March 30, 1984