STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

December 29, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2509
Albany, New York 12237

Willow M. Woodward, M.D.
915 Niagara Street
Niagara Falls, New York 14303

RE: In the Matter of Willow M. Woodward, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-332) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

COPY

DECISION
AND
ORDER
OF THE
HEARING COMMITTEE

IN THE MATTER

OF

WILLOW M. WOODWARD, M.D.

ORDER NO.
BPMC 99-332

The undersigned Hearing Committee consisting of **WALTER M. FARKAS, M.D., Chairperson, DAVID HARRIS, M.D., PETER S. KOENIG,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, ESQ.,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Section 230(10) and 230(12) of the New York State Public Health Law and Sections 301-307 and 401 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **WILLOW M. WOODWARD, M.D.** (hereinafter referred to as "Respondent").

Under Section 230(12) of the Public Health Law, where the Commissioner of Health finds that a physician constitutes an imminent danger to the public and that it would be prejudicial to the interests of the people to delay action until the physician has had an opportunity to be heard, the Commissioner may issue an order suspending the license of the physician. A hearing is then convened and the State has the burden of going forward to show that the physician constitutes an imminent danger to the public. Such an order was issued in this case on August 22, 1997. This proceeding ensued from that order.

COPY Exhibits were received in evidence and made a part of the record. The Committee deliberated on the issue of imminent danger and on the issue of professional misconduct under Section 6530 of the New York Education Law. The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the issue of imminent danger and the charges of medical misconduct.

RECORD OF PROCEEDING

Summary Order Signed / Served	Dated: September 22, 1999	Served: September 27, 1999
Notice of Hearing returnable:	October 1, 1999	
Committee Decision Regarding Imminent Danger Rendered	November 23, 1999	
Location of Hearing:	Hedley Building, Troy, New York	
Respondent's answer dated / served:	N/A	
The State Board for Professional Medical Conduct (hereinafter referred to as "Petitioner" or "The State") appeared by:	**HENRY M. GREENBERG, ESQ.** General Counsel by **TIMOTHY J. MAHAR, ESQ.** Associate Counsel Bureau of Professional Medical Conduct Albany, New York	

Respondent did not appear in person and was not represented by counsel.[1]

---

[1]This matter was originally assigned to Judge Timothy Trost. At that time, Respondent was represented by Carmen Tarantino, Esq. In late September, Judge Jonathan M. Brandes was assigned to the matter. In September 1999, Mr. Tarantino withdrew from the proceeding. On September 28, Respondent personally sent a fax to Counsel for Petitioner. The fax included a request for an adjournment of the October 1 hearing in order to obtain new counsel. With the approval of the hearing committee, the matter was adjourned to November 4, 1999 with certain conditions (these conditions will be discussed at greater length later in this decision). Despite repeated written communications directed to Respondent and despite a telephone conversation between counsel for Petitioner, the Administrative Law Judge and a person who identified herself as a family member with whom Respondent was residing, Respondent has never contacted the undersigned in any way. The fax dated September 28, 1999 is the only communication received from Respondent.

Respondent's present registration address:	915 Niagara Street Niagara Falls, New York 14303.
Respondent's License:	Number: 189067 Registration Date: June 3, 1992
Pre-Hearing Conference Held:	November 9, 1999
Hearings held on:	Default
Conferences held on:	November 9, 1999
Closing briefs received:	November 15, 1999
Record closed:	November 23, 1999
Date of Deliberation:	November 23, 1999

SUMMARY OF PROCEEDINGS

The relevant portion of the Statement of Charges in this proceeding alleges ten grounds of misconduct arising from the care and treatment of six patients and the submission of applications to facilities during July through December 1998:

1. Respondent is charged with medical misconduct by **practicing while impaired** as set forth in N.Y. Education Law Section 6530 (7) (First Specification);

2. Respondent is charged with medical misconduct by **practicing while addicted to or while an habitual user of, substances** as set forth in N.Y. Education Law Section 6530 (8) (Second Specification);

3. Respondent committed medical misconduct by practicing **gross negligence** as set forth in N.Y. Education Law Section 6530 (4) (Third through Sixth Specifications);

4. Respondent committed medical misconduct by practicing **gross incompetence** as set forth in N.Y. Education Law Section 6530 (6) (Seventh through Tenth Specifications);

5. Respondent committed medical misconduct by practicing **negligence on more than one occasion** as set forth in N.Y. Education Law Section 6530 (3) (Eleventh Specification);

6. Respondent has committed medical misconduct by practicing **incompetence on more than one occasion** as set forth in N.Y. Education Law Section 6530 (5) (Twelfth Specification);

7. Respondent committed medical misconduct by practicing **fraud** as set forth in N.Y. Education Law Section 6530 (2) (Thirteenth through Fifteenth Specifications);

8. Respondent committed medical misconduct by exhibiting **conduct which evidences moral unfitness** as set forth in N.Y. Education Law Section 6530 (20) (Sixteenth through Eighteenth Specifications);

9. Respondent committed medical misconduct by **filing a false report** as set forth in N.Y. Education Law Section 6530 (21) (Nineteenth through Twenty First Specifications);

10. Respondent committed misconduct by **failing to maintain appropriate patient records** as set forth in N.Y. Education Law Section 6530 (32) (Twenty-Second through Twenty Fourth Specifications);

The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One.

Petitioner called no witnesses.

Respondent defaulted and called no witnesses.

SIGNIFICANT LEGAL RULINGS:

PART ONE: The State Establishes Jurisdiction over Respondent

Pursuant to Part 230 (10) (d) of the Public Health Law, Petitioner must obtain personal service upon Respondent in order to establish jurisdiction over her. However, jurisdiction can be established where the Notice of Hearing and Statement of Charges is sent to Respondent by registered or certified mail. Service by mail is available where personal service cannot be obtained

after due diligence. The due diligence must be certified under oath. The address to which the documents must be mailed, is the "last known address by the board. (Public Health Law Part 230(10)(d)"

In this case, Petitioner obtained jurisdiction through service by mail (see Exhibit 1 in evidence). Exhibit 1 establishes that Petitioner made a number of efforts to serve Respondent personally and sent the Notice of Hearing and Statement of Charges by mail after the various attempts at personal service were documented under oath (see Exhibits 8 and 9). In addition to mailing the Notice of Hearing and Statement of charges, Petitioner made several additional attempts at personal service and service by mail as other addresses at which Respondent might be found, became known.

On September 28, 1999, Respondent faxed a letter to counsel for Petitioner. In this letter, Respondent referred to the hearing and requested an adjournment. Based upon the contents of the faxed letter, the Administrative Law Judge found that Respondent had actual knowledge of these proceedings.

PART TWO: Respondent Is Found in Default

In a faxed letter dated September 28, 1999, Respondent requested an adjournment. She had disassociated herself from her attorney and was seeking time to obtain new counsel. By letter dated October 1, 1999, the Administrative Law Judge granted the adjournment upon the following conditions:

1. The Order of the Commissioner suspending Dr. Woodward's license to practice medicine shall remain in full force and effect until this matter and any subsequent appeals have been fully exhausted;

2. The time limits listed in Part 230 of the Public Health Law including but not limited to Part 230 (12) shall be deemed fully waived by Respondent;

3. Respondent shall, not later than October 12, 1999, provide the undersigne with an address at which mail will be received by Respondent and telephone number at which Respondent can be reached during norma business hours;

4. This matter shall continue on November 4, 1999 in Cambridge New York a 10 A.M. Respondent shall not be granted an adjournment of this date;

5. Respondent must advise the undersigned of the name and address of new counsel, if any, not later than October 29. Should Respondent fail to obtain counsel or should Respondent desire to proceed without counsel, that information will also be provided not later than October 29;

The letter granting the adjournment was faxed to the fax number on the letter received from Respondent. In addition, a copy of the letter from the Administrative Law Judge was sent to Respondent's last registration address as well as every known address at which there was any likelihood Respondent would receive it. It is to be noted that while the fax number had apparently been disconnected, none of the letters issued by the Administrative Law Judge were returned as undeliverable. It is black letter law that mail which is not returned is deemed received by the addressee.

Subsequent to granting the adjournment, the Administrative Law Judge and Counsel for Petitioner telephoned a number that had been provided by Respondent in the September 28 fax. The person who answered the telephone identified herself[2] as someone who knew Respondent. The person also stated that Respondent sometimes had resided with her in the immediate past. The person who spoke on the phone sounded substantially older than eighteen years of age and was fully conversant in English (the telephone number had a Canadian area code). The Administrative Law Judge urged the person on the telephone to have Respondent call him in order

[2]The name of the person who answered the telephone is known to the Administrative Law Judge and Counsel for Petitioner. As this person is in no way a part of this proceeding, her name is irrelevant and will not be disclosed herein.

that basic communication be established. Several telephone numbers were given to the person on the phone. To date, Respondent has neither telephoned nor communicated in any manner whatsoever, with the Administrative Law Judge. Counsel for Petitioner represents that Respondent has not contacted him either.

The October 1 letter which granted the adjournment for Respondent contained two conditions which set forth a specific time for compliance. The first of the dated requirements, was that Respondent contact the Administrative Law Judge and provide an address to him at which mail would be received by her. This was to have been done not later than October 12. Respondent did not comply with this directive. The second dated condition set forth in the letter granting the adjournment gave Respondent until October 29 to have counsel for Respondent contact the Administrative Law Judge. In the alternative, Respondent was to report to the Administrative Law Judge that she would proceed as her own counsel. Again, Respondent did not comply with this directive.

Having failed to fulfill the conditions upon which the adjournment was granted, Respondent was in default as of October 12, 1999. Nevertheless, In the interest of fundamental fairness, Respondent was given until November 9 to make some effort to be heard. As of the date of this writing, with the exception of the September 28 fax, Respondent has made no effort to participate in this proceeding.

Fundamental due process requires that an accused have notice of a proceeding against him and a reasonable opportunity to be heard. It is the ruling of the Administrative Law Judge that Petitioner did far more than is required by the controlling statutes and due process concepts. While respondents always have a right to answer accusations against them, that right is one which may be waived by a respondent. A waiver can be made by conduct, as where a case is settled.

However, a waiver may also be established by failing to answer the charges. In this case, Respondent has been given every opportunity to answer the charges, but has chosen not to answer the charges. Therefore, on November 9, 1999, the Administrative Law Judge ruled that Respondent was in default.

In addition to ignoring the rulings of the Administrative Law Judge, Respondent has violated basic provisions of Part 230 of the Public Health Law which is the statute which governs this proceeding. Part 230 10(c)(2) provides, in relevant part:

> "... the licensee shall file a written answer to each of the charges and allegations in the statement of charges no later than ten days prior to the hearing,[and] any charge and allegation not so answered shall be deemed admitted....(emphasis supplied).

Furthermore, Part 230 (10)(c)(3) of the Public Health Law provides that "the licensee shall appear personally at the hearing and may be represented by counsel (emphasis supplied)." Respondent has filed no answer and she has not appeared personally in this proceeding.

Respondent has ignored the rulings of the Administrative Law Judge and the statutory provisions of the Public Health Law. Therefore, the Administrative Law Judge ruled that Respondent was in default. Hence, the charges and specifications were admitted by Respondent with the same force and effect as if the charges and specifications had been sustained by the Committee after an evidentiary hearing.

The Administrative Law Judge conferred with the members of the Committee and disclosed the facts stated above to them. The Committee was told that the Administrative Law Judge ruled that upon the failure of Respondent to participate in the proceedings, each of the Specifications in the Notice of Hearing and Statement of Charges (see Exhibit 7) were deemed admitted by Respondent with the same force and effect as if the Committee had made the findings after an evidentiary hearing. Likewise, all statements of fact and the charges themselves, which were

alleged in the Statement of Charges (Exhibit 7), were admitted by Respondent with the same force and effect as if the Committee had made the findings after an evidentiary hearing.

Subsequent to November 9, 1999, Petitioner was given an opportunity to submit Petitioner's investigative file and a written summation to the Committee. Deliberations by conference call were scheduled and held on November 23, 1999. Upon deliberation, the Committee was directed to address themselves solely to penalty based upon the facts and Specifications set forth in the Notice of Hearing and Statement of Charges.

FINDINGS OF FACT

1. Respondent, was authorized to practice medicine in New York State on June 3, 1992, by the issuance of license number 189067 by the New York State Education Department.

2. Respondent is currently registered with the New York State Education Department with a registration address of 915 Niagara Street, Niagara Falls, New York 14303

3. During the period of June and/or July, 1999, Respondent was, at times, impaired for the practice of medicine and practiced medicine while impaired at Mary McClellan Hospital (referred to as McClellan) and associated health care facilities.

4. In July 1999 Respondent provided medical care to Patient A at the Mary McClellan Hospita in Cambridge. Patient A was admitted to McClellan for a urinary tract infection, vomiting, and other conditions.

5. On July 25, 1999, Respondent ordered "Morphine 25 mg IV now, place Narcan at the bedside" for Patient A.

6. The combination of Morphine 25 mg IV and Narcan was inappropriate under the circumstances presented by Patient A.

7. Respondent subsequently changed the order to "Demerol 25 mg IVP now." This prescription was consistent with accepted standards of medical care

8. On July 24 and 25, 1999, Respondent failed to respond appropriately to multiple pages by the nursing staff regarding Patient A's medical status. Respondent did not reply to pages over an approximately five-hour period.

9. Respondent provided medical care to Patient B at McClellan during a July 24, 1999 admission for fever, weakness and jaundice, among other conditions.

10. On July 24, 1999. Respondent failed to perform or document an adequate physical examination of Patient B.

11. On July 25, 1999 Respondent ordered "25 mg Demerol 12 to 24 hours."

12. Respondent changed her orders to: "25 mg Demerol every four hours alternate with morphine every four hours."

13. Respondent subsequently changed the order a second time to Demerol 25 mg IM every four hours as necessary for pain. This order was within accepted medical standards.

14. These pages were from the nursing staff regarding Patient B's medical status.

15. During a July 25, 1999 admission to McClellan, Respondent provided medical care to Patient C. This patient had a history of chronic obstructive pulmonary disease. At the time he was suffering from hypoxia and congestive heart failure, among other conditions.

16. Respondent failed to order an arterial blood gas for Patient C.

17. Accepted standards of medical care required that such a study be ordered for a patient exhibiting the symptoms shown by Patient C.

18. Respondent failed to perform a physical examination of Patient C in a manner consistent with accepted medical standards.

19. Respondent failed to provide documentation consistent with accepted standards of medical care, for any examination which was given.

20. Respondent provided medical care to Patient D at McClellan during a July 25, 199 admission for hypoxia, cellulitis of the legs, and congestive heart failure, among othe conditions. Respondent's medical care of Patient D deviated from accepted standards o medical care in the following respects:

1. Respondent failed to order an arterial blood gas for Patient D.

2. Respondent failed to perform and/or document an adequate physical examination of Patient D.

21. Respondent provided medical care to Patient E on July 7, 1998, at the Olean General Hospital Emergency Room, in Olean, New York for complete heart block and hypotension, among other conditions.

22. Respondent's medical care of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to give appropriate orders regarding the administration of dopamine.

2. Respondent failed to give appropriate orders relating to the use of an external pacemaker.

3. Respondent failed to appropriately manage the resuscitation (cardiac code) of Patient E.

23. Respondent provided medical care to Patient F on July 8, 1998, at the Olean General Hospital Emergency Room, for atrial fibrillation among other conditions.

24. Respondent's medical care of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent ordered and administered Adenocard to Patient F. Adenocard was inappropriate under the circumstances.

2. Respondent failed to initiate timely and appropriate treatments to slow Patient F's heart rate.

25. Respondent provided medical care to Patient G on July 10-11, 1998, at the Olean General Hospital Emergency Room, for cardiac arrest.

26. Respondent's care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1.) Respondent ordered defibrillation of Patient G

2.) The application of defibrillation at the time of the order was contrary to accepted standards of medicine.

27. Respondent provided medical care to Patient H on or about July 11, 1998, at the Olean General Hospital Emergency Room, for periods of apnea. Respondent's care and treatment of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent ordered the administration of Mazicon. Under accepted standards of medicine, this administration was inappropriate.

2. Respondent failed to assess Patient H in a manner consistent with accepted standards of medicine.

28. On July 11, 1998 Respondent provided medical care to Patient I at the Olean General Hospital Emergency Room, for respiratory distress, among other conditions.

29. Respondent's care and treatment of Patient I deviated from accepted standards o medical care in the following respects:

1.) Respondent provided an initial treatment with Proventil and Atrovent. Subsequently Respondent did not treat Patient I in a manner consistent with accepted standards of medicine.

2. Respondent ordered the administration of epinephrine. Under the facts and circumstances at the time, this treatment was inconsistent with accepted standards of medicine.

30. On July 21, 1999, Respondent submitted a medical license registration renewal application to the New York State Education Department. This application for renewal was for the registration period of August 1, 1999 through July 31, 2001. On this application, Respondent made the following representations which Respondent knew or should have known were false:

1.) No hospital had restricted her employment or privileges since her last registration;

2.) Respondent had not voluntarily or involuntarily resigned or withdrawn from an association with a hospital since her last registration to avoid imposition of restrictions or termination of hospital privileges due to professional misconduct, unprofessional conduct, incompetence or negligence.

31. On June 2, 1999 Respondent submitted a pre-employment medical history form to McClellan. In the form, Respondent made the following representations, which Respondent knew or should have known were false:

1.) Respondent was not currently taking any medications.

2.) Respondent was not under treatment for any illness at that time.

32. On March 3, 1999, Respondent submitted an application to Medina Memorial Hospital, Medina, New York, for medical staff and emergency department privileges.

33. Respondent made the following responses and omissions in the application. Respondent knew or should have known these responses and omissions were either false or incomplete:

1.) Respondent had never voluntarily relinquished any medical staff membership, clinical privileges, or affiliation with any healthcare entity while under investigation, threat of investigation, or disciplinary action.

2.) Respondent's medical staff membership, medical staff status, or any other type of affiliation at any healthcare entity had never been suspended, diminished, not renewed, revoked or subjected to probationary condition or had proceedings toward any of those ends instituted or recommend by any official, committee, or governing body of any healthcare entity.

3.) Respondent omitted her affiliation with Olean General Hospital in a response to an application question requesting, among other things, a list of all previous hospital affiliations.

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS

Pursuant to the instructions of the Administrative Law Judge, the Committee finds that the factual allegations are sustained with the same force and effect as if a full evidentiary hearing had been held and the Committee had deliberated after same.

Therefore:

Factual Allegation A IS SUSTAINED;
Factual Allegations B and B (1.) And B (2.) ARE SUSTAINED;
Factual Allegations C and C (1.) Through C (3.) ARE SUSTAINED;
Factual Allegations D and D (1.) And D (2.) ARE SUSTAINED;
Factual Allegations E and E (1.) And E (2.) ARE SUSTAINED;
Factual Allegations F and F (1.) Through F (3.) ARE SUSTAINED;
Factual Allegations G and G (1.) And G (2.) ARE SUSTAINED
Factual Allegations H and H (1.) ARE SUSTAINED;
Factual Allegations I and I (1.) And I (2.) ARE SUSTAINED;
Factual Allegations J and J (1.) And J (2.) ARE SUSTAINED;
Factual Allegations K and K (1.) And K (2.) ARE SUSTAINED;
Factual Allegations L and L (1.) And L (3.) ARE SUSTAINED;
Factual Allegations M and M (1.) Through M (3.) ARE SUSTAINED

CONCLUSIONS WITH REGARD TO SPECIFICATIONS

Respondent has chosen not to defend against the Specifications. This amounts to ar admission of the Specifications with the same force and effect as if a full evidentiary hearing hac been held and the Committee had deliberated after same. Therefore, the Committee sustains each of the specifications.

Therefore:
The First Specification is SUSTAINED;
The Second Specification is SUSTAINED;
The Third through Sixth Specifications are SUSTAINED;
The Seventh through Tenth Specifications are SUSTAINED;
The Eleventh Specification is SUSTAINED;
The Twelfth Specification is SUSTAINED;
The Thirteenth through fifteenth Specifications are SUSTAINED;
The Sixteenth through Eighteenth Specifications are SUSTAINED;
The Nineteenth through Twenty-First Specifications are SUSTAINED;
The Twenty-Second through Twenty-Fourth Specifications are SUSTAINED;

CONCLUSIONS WITH REGARD TO THE SUMMARY ORDER AND FINAL PENALTY

Respondent was given every reasonable opportunity to participate in this proceeding. She has demonstrated that she had actual knowledge of the charges against her. Nevertheless, Respondent has chosen not to participate in the hearing. The very fact that Respondent has made no appearance before this Committee is significant in and of itself. Respondent is charged with practicing medicine while in a state of substance induced impairment. Ignoring a proceeding in which one could lose one's license to practice medicine is behavior not inconsistent with someone who is impaired by substance abuse. Even if Respondent could not afford counsel or is residing too far away to participate in New York, the Committee expects that a physician in possession of all her faculties would have made an effort to contact the various officials associated with this proceeding. Hence, the very fact Respondent has been found in default supports the charges against her.

The Trier of Fact is aware that Respondent has the right to remain silent during a proceeding against her. Therefore, her silence, in and of itself, cannot and does not form the basis for a finding of culpability in this proceeding. Had Respondent made any sort of appearance, she would have been free to remain mute. However, in this case Respondent has not chosen to remain silent, rather, she has chosen to ignore these proceedings. Sitting mute is a right. Failing to answer the charges is also a right. However, a failure to respond to the entire proceeding can, and will have significant consequences.

In addition to finding against Respondent by virtue of her failure to act upon these proceedings, the Trier of Fact finds that each of the incidents alleged by Petitioner are significant and put patients in real danger of serious harm. Hence, any one of the charges would warrant a significant penalty even if each incident stood alone as a single charge. The combination of incidents and the complete absence of any evidence suggesting that rehabilitation is possible, convinces the Trier of Fact that only the most stringent penalty is appropriate in this proceeding.

It is noted that the incidents alleged, though not continuous, occurred between July 1998 and July of 1999. This over approximately a one year time period. The length of time over which the incidents were documented supports a finding that Respondent was not suffering from some momentary lapse caused by over-indulgence or temporary disorder. Rather, the totality of the facts and circumstances over the time period herein, leads the Trier of Fact to find Respondent was, and probably continues to be, seriously impaired. It follows that Respondent should not be allowed to practice medicine.

The Commissioner has found, by virtue of her September 22 Order, that Respondent presents an imminent danger to the people of this state. Given the pattern established by the various incidents admitted by Respondent, the Committee finds the September 22 Order was entirely appropriate. Furthermore, the Committee finds unanimously that the Order should continue in full force and effect and that the license of Respondent to practice medicine in this state should be revoked.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

It is hereby **ORDERED** that:

1. The Factual allegations in the Statement of Charges (attached to this Decision and Order as Appendix One) are **SUSTAINED;**

   Furthermore, it is hereby **ORDERED** that;

2. The Specifications of Misconduct contained within the Statement of Charges (Appendix One) are **SUSTAINED;**

   Furthermore, it is hereby **ORDERED** that;

3. The **SUMMARY ORDER** issued by the Commissioner on September 22, 1999 , (attached to this Decision and Order as Appendix Two) **SHALL BE AFFIRMED WITHOUT MODIFICATION;**

   Furthermore, it is hereby **ORDERED** that;

4. The license of Respondent to practice medicine in the State of New York is **REVOKED;**

   Furthermore, it is hereby **ORDERED** that;

5. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail.

DATED: Rockville Center, New York

December 28, **1999**

Walter M. Farkas, M.D.

WALTER M. FARKAS, M.D.,Chairperson

DAVID HARRIS, M.D.

PETER S. KOENIG

To: **TIMOTHY J. MAHAR, ESQ.**
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2509
Albany, New York 12237

WILLOW M. WOODWARD, M.D.
915 Niagara Street
Niagara Falls, New York 14303

APPENDIX ONE

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
WILLOW WOODWARD, M.D.	:	CHARGES

----------X

WILLOW WOODWARD, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 3, 1992, by the issuance of license number 189067 by the New York State Education Department. Respondent is currently registered with the New York State Education Department with a registration address of 915 Niagara Street, Niagara Falls, New York 14303.

FACTUAL ALLEGATIONS

A. During the period of June and/or July, 1999, Respondent was at times impaired for the practice of medicine and/or practiced medicine while impaired at Mary McClellan Hospital and associated health care facilities.

B. Respondent provided medical care to Patient A at the Mary McClellan Hospital in Cambridge, New York during a July 24, 1999

admission for urinary tract infection and vomiting, among other conditions. Respondent's medical care of Patient A deviated from accepted standards of medical care in the following respects:

1. On July 25, 1999, Respondent ordered "Morphine 25 mg IV now, place Narcan at the bedside" for Patient A, or used words of similar effect, which was excessive and/or inappropriate. Respondent subsequently changed the order to "Demerol 25 mg IVP now", which was acceptable.

2. On July 24-25, 1999, Respondent failed to respond to or timely respond to multiple pages by the nursing staff regarding Patient A's medical status over an approximately five-hour period.

C. Respondent provided medical care to Patient B at Mary McClellan Hospital during a July 24, 1999 admission for fever, weakness and jaundice, among other conditions. Respondent's medical care of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or document an adequate physical examination of Patient B on July 24, 1999.

2. Respondent on July 25, 1999 gave the following two orders, or used words of similar effect, for Patient B each of which was inappropriate:

   "25 mg Demerol 12 to 24 hours." which Respondent changed to

   "25 mg Demerol every four hours alternate with morphine every four hours."

   Respondent subsequently changed the order a second time to Demerol 25 mg IM every four hours as necessary for pain, which was acceptable.

3. On July 24-25, 1999, Respondent failed to respond to or timely respond to multiple pages from the nursing staff regarding Patient B's medical status during an approximately five-hour period.

D. Respondent provided medical care to Patient C, who had a history of chronic obstructive pulmonary disease, at the Mary McClellan Hospital during a July 25, 1999 admission for hypoxia and congestive heart failure, among other conditions. Respondent's medical care of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent failed to order an arterial blood gas for Patient C.

2. Respondent failed to perform and/or document an adequate physical examination of Patient C.

E. Respondent provided medical care to Patient D at the Mary McClellan Hospital during a July 25, 1999 admission for hypoxia, cellulitis of the legs, and congestive heart failure, among other conditions. Respondent's medical care of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to order an arterial blood gas for Patient D.

2. Respondent failed to perform and/or document an adequate physical examination of Patient D.

F. Respondent provided medical care to Patient E on July 7, 1998, at the Olean General Hospital Emergency Room, in Olean, New York for complete heart block and hypotension, among other conditions.

Respondent's medical care of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to give appropriate orders regarding the administration of dopamine.

2. Respondent failed to give appropriate orders relating to the use of an external pacemaker.

3. Respondent failed to appropriately manage the resuscitation (cardiac code) of Patient E.

G. Respondent provided medical care to Patient F on July 8, 1998, at the Olean General Hospital Emergency Room, for atrial fibrillation among other conditions. Respondent's medical care of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent ordered and administered Adenocard to Patient F which was inappropriate.

2. Respondent failed to initiate timely and/or appropriate treatments to slow Patient F's heart rate.

H. Respondent provided medical care to Patient G on July 10-11, 1998, at the Olean General Hospital Emergency Room, for cardiac arrest. Respondent's care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent ordered defibrillation of Patient G at a time when defibrillation was inappropriate and/or contraindicated.

I. Respondent provided medical care to Patient H on or about July 11, 1998, at the Olean General Hospital Emergency Room, for periods of

apnea. Respondent's care and treatment of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent ordered the administration of Mazicon, which was contraindicated.

2. Respondent failed to adequately assess Patient H.

J. Respondent provided medical care to Patient I on or about July 11, 1998, at the Olean General Hospital Emergency Room, for respiratory distress, among other conditions. Respondent's care and treatment of Patient I deviated from accepted standards of medical care in the following respects:

1. Respondent failed to appropriately treat Patient I following an initial treatment with Proventil and Atrovent.

2. Respondent ordered the administration of epinephrine which was inappropriate.

K. On a medical license registration renewal application submitted by Respondent to the New York State Education Department on or about July 21, 1999 for the registration period of August 1, 1999 through July 31, 2001, Respondent made the following representations which Respondent knew or should have known were false:

1. That no hospital had restricted her employment or privileges since her last registration.

2. That she had not voluntarily or involuntarily resigned or withdrawn from an association with a hospital since her last registration to avoid imposition of restrictions or termination of

hospital privileges due to professional misconduct, unprofessional conduct, incompetence or negligence.

L. On a pre-employment medical history form for Mary McClellan Hospital, Respondent made the following representations on or about June 2, 1999, which Respondent knew or should have known were false:

1. That she was not currently taking any medications.

2. That she was not under treatment for any illness at that time.

M. On March 3, 1999, Respondent submitted an application to Medina Memorial Hospital, Medina, New York, for medical staff and emergency department privileges. Respondent made the following responses and omissions to the application, which Respondent knew or should have known were either false or incomplete:

1. That she had never voluntarily relinquished any medical staff membership, clinical privileges, or affiliation with any healthcare entity while under investigation, threat of investigation, or disciplinary action.

2. That her medical staff membership, medical staff status, or any other type of affiliation at any healthcare entity had never been suspended, diminished, not renewed, revoked or subjected to probationary condition or had proceedings toward any of those ends instituted or recommend by any official, committee, or governing body of any healthcare entity.

3. Respondent omitted her affiliation with Olean General Hospital in a response to an application

question requesting, among other things, a list of all previous hospital affiliations.

SPECIFICATIONS

FIRST SPECIFICATION

Practicing While Impaired

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law Sec. 6530(7) by practicing the profession of medicine while impaired by alcohol, drugs, physical disability or a mental disability as alleged in the following factual allegations:

1. The facts set forth in Paragraph A.

SECOND SPECIFICATION

Impairment

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law Sec. 6530(8) in being a habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, or having a psychiatric condition which impairs Respondent's ability to practice medicine as alleged in the following facts:

2. The facts set forth in Paragraph A.

THIRD THROUGH SIXTH SPECIFICATIONS

Gross Negligence

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the following factual allegations:

3. The facts set forth in Paragraphs B and B.1.

4. The facts set forth in Paragraphs F and F.3.

5. The facts set forth in Paragraphs H and H.1.

6. The facts set forth in Paragraphs I and I.1 and/or I and I.2.

SEVENTH THROUGH TENTH SPECIFICATIONS

Gross Incompetence

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the following factual allegations:

7. The facts set forth in Paragraphs B and B.1.

8. The facts set forth in Paragraphs F and F.3.

9. The facts set forth in Paragraphs H and H.1.

10. The facts set forth in Paragraphs I and I.1 and/or I and I.2.

ELEVENTH SPECIFICATION

Negligence on More than One Occasion

Respondent is charged with professional misconduct as defined by Educ. Law §6530(3) by practicing medicine with negligence on more than one occasion as alleged in the following factual allegations:

11. The facts set forth in paragraphs B and B.1, and/or B and B.2, and/or C and C.1, and/or C and C.2, and/or C and C.3, D and D.1, and/or D and D.2, and/or E and E.1, and/or E and E.2, and/or F and F.1, and/or F and F.2, and/or F and F.3, and/or G and G.1, and/or G and G.2, and/or H and H.1, I and I.1 and/or I and I.2, and/or J and J.1, and/or J and J.2.

TWELFTH SPECIFICATION

Incompetence on More Than One Occasion

Respondent is charged with professional misconduct as defined by Educ. Law §6530(5) by practicing medicine with incompetence on more than one occasion as alleged in the following factual allegations.

12. The facts set forth in paragraphs B and B.1, and/or B and B.2, and/or C and C.1, and/or C and C.2, and/or C and C.3, D and D.1, and/or D and D.2, and/or E and E.1, and/or E and E.2, and/or F and F.1, and/or F and F.2, and/or F and F.3, and/or G and G.1, and/or G and G.2, and/or H and H.1, I and I.1 and/or I and I.2, and/or J and J.1, and/or J and J.2.

THIRTEENTH THROUGH FIFTEENTH SPECIFICATIONS

Fraudulent Practice

Respondent is charged with professional misconduct as defined by Educ. Law §6530(2) by reason of her practicing medicine fraudulently, as alleged in the following factual allegations:

13. The facts set forth in Paragraphs K and K.1, and/or K and K.2;

14. The facts set forth in Paragraphs L and L.1, and/or L and L.2;

15. The facts set forth in Paragraphs M and M.1, and/or M and M.2, and/or M and M.3.

SIXTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

Moral Unfitness

Respondent is charged with professional misconduct as defined by Educ. Law §6530(20) by reason of practice conduct which evidences moral unfitness to practice medicine, as alleged in the facts of the following:

16. The facts set forth in Paragraphs K and K.1, and/or K and K.2;

17. The facts set forth in Paragraphs L and L.1, and/or L and L.2;

18. The facts set forth in Paragraphs M and M.1, and/or M and M.2, and/or M and M.3.

NINETEENTH THROUGH TWENTY-FIRST SPECIFICATIONS

Filing A False Report

Respondent is charged with professional misconduct as defined in Educ. Law §6530(21) by reason of having willfully made and filed a false report as alleged in the following factual allegations:

19. The facts set forth in Paragraphs K and K.1, and/or K and K.2;

20. The facts set forth in Paragraphs L and L.1, and/or L and L.2;

21. The facts set forth in Paragraphs M and M.1, and/or M and M.2, and/or M and M.3.

TWENTY-SECOND THROUGH TWENTY-FOURTH SPECIFICATIONS

Record Keeping

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in the following factual allegations.

22. The facts set forth in Paragraphs C and C.1.

23. The facts set forth in Paragraphs D and D.2.

24. The facts set forth in Paragraphs E and E.2.

DATED: September , 1999
Albany, NY

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