THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

November 15, 1991

Thomas J. Byrne, Physician
REDACTED

Re: License No. 162064

Dear Dr. Byrne:

Enclosed please find the order of the Deputy Commissioner for the Professions No. 12428. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation, surrender, or an actual suspension (suspension which is not wholly stayed) of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. Your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department. In the event you are also served with this Order by personal service, the effective date of the Order is the date of personal service.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you may, pursuant to Rule 24.7 (b) of the Rules of the Board of Regents, a copy of which is attached, apply for restoration of your license after one year has elapsed from the effective date of the Order and the penalty; but said application is not granted automatically.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:
REDACTED

GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR

cc: Thomas G. Smith, Esq.
Harter, Secrest & Emery
700 Midtown Tower
Rochester, New York 14604

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

THOMAS J. BYRNE **No. 12428**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

Respondent was served with the Health Commissioner's summary suspension order and notice of hearing, dated November 14, 1990, together with a statement of charges, a copy of which, with the exception of the appendix of patient names, is annexed hereto, made a part hereof, and marked as Exhibit "A". The Commissioner of Health determined that the continued practice of medicine in the State of New York by respondent constitutes an imminent danger to the health of the people of this State and, pursuant to Public Health Law §230(12), that, effective immediately, respondent shall not practice medicine in the State of New York.

On thirteen sessions, including a pre-hearing conference, from

November 27, 1990 through February 5, 1991 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. On February 5, 1991 having heard both petitioner's and respondent's entire case, the hearing committee recommended that the summary suspension of respondent's license be maintained pending the ultimate resolution of the case by the Board of Regents. The Department of Health issued a conformed statement of charges dated February 11, 1991, a copy of which, with the exception of the appendix of patient names, is annexed hereto, made a part hereof, and marked as Exhibit "B". On February 19, 1991 the Commissioner of Health ordered that the summary order dated November 14, 1990, imposed upon respondent, shall remain in effect. A copy of the February 19, 1991 order is annexed hereto, made a part hereof, and marked as Exhibit "C". On June 24, 1991 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 "D".

The charges upon which the hearing committee determined that respondent was guilty consisted of the sixth specification - gross negligence, involving respondent's failure to personally attend and evaluate a post-operative patient; the eighth through twelfth specifications - gross incompetence, involving patient treatment provided by respondent for pregnancy and delivery; the fifteenth specification - negligence on more than one occasion, involving

patient treatment provided by respondent for pregnancy and delivery; the sixteenth specification - incompetence on more than one occasion, involving patient treatment provided by respondent for pregnancy and delivery; the seventeenth specification - obtaining a license fraudulently, involving respondent falsely representing that he had never been found guilty of professional misconduct, unprofessional conduct or negligence by any other state or country; the eighteenth specification - fraud, involving respondent falsely representing that he had never been found guilty of professional misconduct, unprofessional conduct or negligence by any other state or country; the nineteenth specification -- fraud, involving respondent making false statements in a patient's delivery note. The hearing committee determined that respondent was not guilty of all remaining specifications and charges, with certain specifications having been withdrawn by the Department of Health. The hearing committee recommended that respondent's license be revoked.

The Commissioner of Health recommended that the findings of fact, conclusions and recommendation of the hearing committee be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "E".

On October 16, 1991 respondent appeared before us in person and was represented by his attorney, Thomas G. Smith, Esq., who presented oral argument on behalf of respondent. Kevin C. Roe,

Esq., presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was revocation.

Respondent's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was suspension of respondent's license for one year beginning November 19, 1990. After November 18, 1991, probation for two years conditioned upon respondent's satisfactory completion, within such time, of appropriate remedial instruction, courses or training as the Board of Regents may order.

We have considered the record as transferred by the Commissioner of Health in this matter, respondent's letter to the Regents Review Committee, with exhibits, as well as certain documents submitted by respondent at our hearing.

We unanimously recommend the following:

1. The findings of fact of the hearing committee and the Commissioner of Health's recommendation as to those findings be accepted;
2. The conclusions of the hearing committee as to guilt and the recommendation of the Commissioner of Health as to those conclusions be accepted;
3. Respondent be found guilty, by a preponderance of the

evidence, of the sixth specification - gross negligence, involving respondent's failure to personally attend and evaluate a post-operative patient; the eighth through twelfth specifications - gross incompetence, involving patient treatment provided by respondent for pregnancy and delivery; the fifteenth specification - negligence on more than one occasion, involving patient treatment provided by respondent for pregnancy and delivery; the sixteenth specification - incompetence on more than one occasion, involving patient treatment provided by respondent for pregnancy and delivery; the seventeenth specification - obtaining a license fraudulently, involving respondent falsely representing that he had never been found guilty of professional misconduct, unprofessional conduct or negligence by any other state or country; the eighteenth specification - fraud, involving respondent falsely representing that he had never been found guilty of professional misconduct, unprofessional conduct or negligence by any other state or country; and the nineteenth specification - fraud, involving respondent making false statements in a patient's delivery note and not guilty of the remaining specifications and charges, with certain specifications having been withdrawn by the Department of Health;

4. The recommendation of the hearing committee and the Commissioner of Health as to the measure of discipline be accepted; and

5. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which we recommend respondent be found guilty.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

REDACTED

Chairperson

Dated: 10/31/91

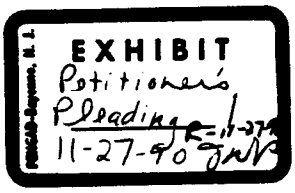
STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

THOMAS J. BYRNE, M.D.

: COMMISSIONER'S
: ORDER AND
: NOTICE OF HEARING



TO: THOMAS J. BYRNE, M.D.
REDACTED

The undersigned, Commissioner of Health of the State of New York, after an investigation and upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, has determined that the continued practice of medicine in the State of New York by THOMAS J. BYRNE, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1990), that effective immediately THOMAS J. BYRNE, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1990).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney Supp. 1990) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1990). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 28th and 29th days of November, 1990 at 10:00 a.m. at 183 East Main Street, Suite 1004, Rochester, New York 14604 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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 made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Moreover, a request for an adjournment in this matter may be regarded as a "delay caused by the physician" within the meaning of N.Y. Pub. Health Law §230(12) (McKinney Supp. 1990) causing the Order of the Commissioner to be continued until the committee makes its recommendation to the Commissioner. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make a determination concerning what action should be taken with respect to Respondent's license to practice medicine in the State of New York.

BECAUSE 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
November 14 1990

REDACTED

DAVID AXELROD, M.D.
Commissioner of Health

Inquiries should be directed to:
KEVIN C. ROE
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
THOMAS J. BYRNE, M.D.	:	CHARGES

----------X

THOMAS J. BYRNE, M.D., the Respondent, was authorized to practice medicine in New York State on May 6, 1985 by the issuance of license number 162064 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991 from Suite 4, 387 East Main Street, Waterloo, New York 13165. Respondent is also registered for the period January 1, 1991 through December 31, 1992 from REDACTED

FACTUAL ALLEGATIONS

A. On or about December 29, 1983, the Board of Medical Examiners of the State of North Carolina found that on or about March 4, 1983 the Respondent intentionally administered Ketamine to a patient in spite of specific instructions not to use this drug in the circumstances in which it was given and that on that

same date, the Respondent deliberately falsified the patient's medical record by omitting to record the prescription and administration of Ketamine. The North Carolina Board concluded that this conduct failed to conform to acceptable and prevailing ethical and professional standards for the practice of medicine in the State of North Carolina. On or about December 29, 1983, Respondent was reprimanded by the North Carolina Board. On or about April 3, 1985, Respondent falsely answered "No" to the question, "Have you ever been found guilty of professional misconduct, unprofessional conduct or negligence in any state or country?" on his Application for License and First Registration to the New York State Education Department.

B. Respondent treated Patient A (all patients are identified in Appendix A) from on or about February 21, 1990 to on or about September 18, 1990 for pregnancy and delivery. On September 17, 1990, Respondent delivered Patient A's baby, Patient B, a male infant with Apgar scores of 1 at 1 minute and 1 at 5 minutes, at the Newark-Wayne Community Hospital, Newark, New York. Respondent's care and treatment of Patients A and B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to admit Patient A to a hospital on September 12, 1990 for observation and evaluation of possible preeclampsia;

2. Respondent failed to make arrangements for a cesarean section of Patient A;

3. Respondent failed to obtain a fetal scalp Ph of Patient B in a timely manner;

4. Respondent failed to assess or arrange for another physician to assess Patient A's condition after 2:00 a.m. on September 17, 1990;

5. Respondent failed to perform a cesarean section on Patient A;

6. Respondent interrupted delivery efforts to obtain a fetal scalp Ph of Patient B without medical indication;

7. Respondent failed to have a pediatrician present at delivery of Patient B;

8. Respondent failed to start chest compressions on Patient B in a timely manner;

9. Respondent failed to insert an umbilical venous line to Patient B in a timely manner;

withdrawn 10/24/90 ~~10. Respondent failed to properly place an ET tube in Patient B;~~

11. Respondent failed to administer an adequate dose of sodium bicarbonate to Patient B;

amended 10/24/90 12. Respondent failed to administer ~~adequate amounts of~~ Epiniphrine to Patient B in a timely manner;

13. Respondent falsely stated in his delivery note that he was not informed of Patient B's fetal heart rate abnormalities until 2:45 a.m. to 2:50 a.m.

C. Respondent treated Patient C from on or about April 12, 1990 to on or about July 31, 1990 for pregnancy and delivery. On July 30, 1990, Respondent delivered Patient C's baby, Patient D, a female infant with Apgar scores at 3 at 1 minute and 5 at 5 minutes, at the Newark-Wayne Community Hospital, Newark, New York. Respondent's care and treatment of Patients C and D failed to meet acceptable standards of medical care, in that:

withdrawn by Pet. 2/7/91 JJS

1. ~~Respondent failed to make contemporaneous progress notes during Patient C's labor;~~

2. Respondent applied a vacuum extractor without medical indication;

3. Respondent used the vacuum extractor for an excessive number of traction pulls;

4. Respondent failed to have a pediatrician present at delivery of Patient D;

withdrawn by Pet. 2/7/91 JJS

5. ~~Respondent failed to order bed rest and close monitoring of Patient C for signs and symptoms of pre-eclampsia in the post-partum period~~.

D. Respondent treated Patient E from on or about October 5, 1989 to on or about May 5, 1990 for pregnancy and delivery. On May 4, 1990, Respondent delivered Patient E's baby, Patient F, a female infant with Apgar scores of 1 at 1 minute and 1 at 5 minutes, at the Newark-Wayne Community Hospital, Newark, New York. Respondent's care and treatment of Patients E and F failed to meet acceptable standards of medical care, in that:

1. On April 30, 1990, Respondent failed to evaluate Patient E with appropriate laboratory studies including but not limited to 24 hour urine for creatinine clearance, platelet count, uric acid, hematocrit, serum BUN, serum creatinine, PT, and/or APTT; failed to order a non stress test; and/or failed to order bed rest;

2. Respondent failed to admit Patient E to a hospital immediately after an office visit on May 3, 1990;

3. Respondent failed to order bed rest for Patient E on admission to the hospital;

4. Respondent failed to order IV fluids for Patient E at admission;

5. Respondent failed to order magnesium sulfate for Patient E;

6. Respondent failed to stabilize Patient E prior to intervention;

7. Respondent inappropriately performed an amniotomy on Patient E with the vertex at the -2 to -3 station exposing the patient to an unnecessary risk of cord prolapse;

8. Respondent discontinued Pitocin on May 4, 1990 at 8:55 a.m. without medical justification;

9. Respondent failed to restart Pitocin in a timely manner;

10. Respondent failed to diagnose Patient E's dysfunctional labor in a timely manner;

11. Respondent inappropriately allowed Patient E to push for over an hour before the cervix reached full dilatation;

withdrawn 11/29/90 JJS ~~12. Respondent failed to order antibiotics for Patient E prior to delivery;~~

withdrawn 11/29/90 JJS ~~13. Respondent failed to make arrangements for a cesarean section of Patient E in a timely manner;~~

14. Respondent failed to have a pediatrician present at delivery of Patient E;

15. Respondent failed to order adequate antibiotics in the post-partum period for Patient E;

16. Respondent failed to establish intravenous access to Patient F in a timely manner;

17. Respondent failed to administer Epiniphrine, sodium bicarbonate, volume expanders and/or Dopamine to Patient F in a timely manner.

E. Respondent treated Patient G from on or about June 16, 1989 to on or about December 23, 1989 for pregnancy and delivery. On December 21, 1989, Respondent delivered Patient G's baby, Patient H, a male infant with Apgar scores of 4 at 1 minute and 6 at 5 minutes, at the Newark-Wayne Community Hospital, Newark, New York. Respondent's care and treatment of

Patients G and H failed to meet acceptable standards of medical care, in that:

withdrawn by Pet. 2/7/91 fgb

1. ~~Respondent failed to order bed rest and close monitoring of Patient G for signs and symptoms of preeclampsia at admission~~;

2. ~~Respondent failed to make contemporaneous progress notes during Patient G's labor~~;

3. ~~Respondent failed to adequately monitor the fetal heart rate during the second stage of labor~~;

4. ~~Respondent failed to make arrangements for a cesarean section of Patient G~~;

5. ~~Respondent failed to obtain a fetal scalp PH of Patient G~~;

6. Respondent applied a vacuum extractor without medical indication;

7. Respondent used the vacuum extractor for an excessive number of traction pulls;

8. Respondent failed to have a pediatrician present at delivery of Patient H.

F. Respondent treated Patient I from on or about June 20, 1988 to on or about February 17, 1989 for pregnancy and delivery. On February 15, 1989, Respondent delivered Patient I's baby, Patient J, a male infant with Apgar scores of 4 at 1 minute and 5 at 5 minutes, at the Geneva General Hospital, Geneva, New York. Respondent's care and treatment of Patients I and J failed to meet acceptable standards of medical care, in that:

withdrawn by Pet. 2/7/91 fgb

1. ~~Respondent failed to make contemporaneous progress notes during Patient I's labor~~;

2. ~~Respondent failed to adequately monitor the fetal heart rate during the second stage of labor~~;

3. Respondent applied a vacuum extractor without medical indication;

4. Respondent used the vacuum extractor for an excessive number of traction pulls;

5. Respondent failed to have a pediatrician present at delivery of Patient J.

G. Respondent treated Patient K from some time prior to March 24, 1988 to March 25, 1988. On March 24, 1988, Patient K was admitted to the Geneva General Hospital, Geneva, New York with complaints of pelvic pain for a diagnostic and therapeutic laparoscopy. Respondent's care and treatment of Patient K failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document a complete medical history;

2. Respondent failed to obtain a pre-operative ultrasound;

3. Respondent inappropriately performed elective surgery without first obtaining necessary information regarding the patient's prior life-threatening post-operative complication;

4. Respondent surgically removed Falope rings without medical indication;

5. Respondent failed to personally attend Patient K and evaluate her condition in the post-operative period.

Withdrawn by Pet. 2/7/91

~~H. Respondent treated Patient L on or about December 2 and 3, 1988. On December 2, 1988, Patient L was admitted to the Geneva General Hospital, Geneva, New York with complaints of pelvic pain for a diagnostic laparoscopy and possible laparotomy. Respondent's care and treatment of Patient L failed to meet acceptable standards of medical care, in that:~~

~~1. Respondent performed a right salpingo oophorectomy without medical justification.~~

SPECIFICATIONS

FIRST THROUGH SEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Education Law §6509(2)(McKinney 1985), in that, Petitioner charges:

1. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, and/or B.13.

2. The facts in Paragraphs C and ~~C.1~~, C.2, C.3, C.4, and/or ~~C.5~~.

3. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12, D.13, D.14, D.15, D.16 and/or D.17.

4. The facts in Paragraphs E and ~~E.1~~, ~~E.2~~, ~~E.3~~, ~~E.4~~, ~~E.5~~, E.6, E.7, and/or E.8.

5. The facts in Paragraphs F and ~~F.1~~, ~~F.2~~, F.3, F.4, and/or F.5.

6. The facts in Paragraphs G and G.1, G.2, G.3, G.4, and/or G.5.

~~7. The facts in Paragraphs H and H.1~~.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence under N.Y. Education Law §6509(2) (McKinney 1985), in that, Petitioner charges:

8. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, and/or B.13.

9. The facts in Paragraphs C and ~~C.1~~, C.2, C.3, C.4, and/or ~~C.5~~.

10. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12, D.13, D.14, D.15, D.16, and/or D.17.

11. The facts in Paragraphs E and ~~E.1~~, ~~E.2~~, ~~E.3~~, ~~E.4~~, ~~E.5~~, E.6, E.7, and/or E.8.

12. The facts in Paragraphs F and ~~F.1~~, ~~F.2~~, F.3, F.4, and/or F.5.

13. The facts in Paragraphs G and G.1, G.2, G.3, G.4, and/or G.5.

14. ~~The facts in Paragraphs H and H.1~~.

FIFTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Education Law §6509(2) (McKinney 1985), in that, Petitioner charges that Respondent committed two or more of the following:

15. The facts in Paragraph B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, and/or B.13; C and ~~C.1~~, C.2, C.3, C.4, and/or ~~C.5~~; D and D.1, D.2,

D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12, D.13, D.14, D.15, D.16, and/or D.17; E and ~~E.1~~, ~~E.2~~, ~~E.3~~, ~~E.4~~, ~~E.5~~, E.6, E.7, and/or E.8; F and ~~F.1~~, ~~F.2~~, F.3, F.4, and/or F.5; G and G.1, G.2, G3, G.4, and/or G.5; and/or ~~H and H.1~~.

SIXTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Education Law §6509(5)(2) (McKinney 1985), in that, Petitioner charges that Respondent committed two or more of the following:

16. The facts in Paragraph B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, and/or B.13; C and ~~C.1~~, C.2, C.3, C.4, and/or ~~C.5~~; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12, D.13, D.14, D.15, D.16, and/or D.17; E and ~~E.1~~, ~~E.2~~, ~~E.3~~, ~~E.4~~, ~~E.5~~, E.6, E.7, and/or E.8; F and ~~F.1~~, ~~F.2~~, F.3, F.4, and/or F.5; G and G.1, G.2, G3, G.4, and/or G.5; and/or ~~H and H.1~~.

SEVENTEENTH SPECIFICATION

OBTAINING THE LICENSE FRAUDULENTLY

Respondent is charged with obtaining a license fraudulently under N.Y. Education Law §6509(1) (McKinney 1985), in that, Petitioner charges:

17. The facts in paragraph A.

EIGHTEENTH THROUGH NINTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE OF MEDICINE

The Respondent is charged with practicing the profession fraudulently under N.Y. Education Law §6509(2) (McKinney 1985), in that, Petitioner charges:

18. The facts in Paragraph A.

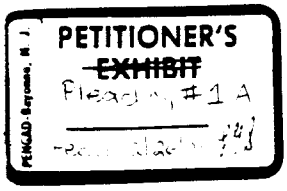
19. The facts in Paragraph B and B.13.

DATED: Albany, New York

REDACTED

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

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



	:	CONFORMED
IN THE MATTER	:	STATEMENT
OF	:	OF
THOMAS J. BYRNE, M.D.	:	CHARGES

THOMAS J. BYRNE, M.D., the Respondent, was authorized to practice medicine in New York State on May 6, 1985 by the issuance of license number 162064 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 198 through December 31, 1991 from Suite 4, 387 East Main Street, Waterloo, New York 13165. Respondent is also registered for the period January 1, 1991 through December 31, 1992 from REDACTED Geneva, New York 14456.

FACTUAL ALLEGATIONS

A. On or about [illegible]ber 29, 1983, the Board of Medical Examiners of the [illegible] North Carolina found that on or about March 4, 1983 the [illegible] intentionally administered Ketamine to a patient in [illegible]ific instructions not to use this drug in the circ[illegible]ich it was given and that on that

same date, the Respondent deliberately falsified the patient's medical record by omitting to record the prescription and administration of Ketamine. The North Carolina Board concluded that this conduct failed to conform to acceptable and prevailing ethical and professional standards for the practice of medicine in the State of North Carolina. On or about December 29, 1983, Respondent was reprimanded by the North Carolina Board. On or about April 3, 1985, Respondent falsely answered "No" to the question, "Have you ever been found guilty of professional misconduct, unprofessional conduct or negligence in any state or country?" on his Application for License and First Registration to the New York State Education Department.

B. Respondent treated Patient A (all patients are identified in Appendix A) from on or about February 21, 1990 to on or about September 18, 1990 for pregnancy and delivery. On September 17, 1990, Respondent delivered Patient A's baby, Patient B, a male infant with Apgar scores of 1 at 1 minute and 1 at 5 minutes, at the Newark-Wayne Community Hospital, Newark, New York. Respondent's care and treatment of Patients A and B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to admit Patient A to a hospital on September 12, 1990 for observation and evaluation of possible preeclampsia;

2. Respondent failed to make arrangements for a cesarean section of Patient A;

3. Respondent failed to obtain a fetal scalp Ph of Patient B in a timely manner;

4. Respondent failed to assess or arrange for another physician to assess Patient A's condition after 2:00 a.m. on September 17, 1990;

5. Respondent failed to perform a cesarean section on Patient A;

6. Respondent interrupted delivery efforts to obtain a fetal scalp Ph of Patient B without medical indication;

7. Respondent failed to have a pediatrician present at delivery of Patient B;

8. Respondent failed to start chest compressions on Patient B in a timely manner;

9. Respondent failed to insert an umbilical venous line to Patient B in a timely manner;

11. Respondent failed to administer an adequate dose of sodium bicarbonate to Patient B;

12. Respondent failed to administer Epiniphrine to Patient B in a timely manner;

13. Respondent falsely stated in his delivery note that he was not informed of Patient B's fetal heart rate abnormalities until 2:45 a.m. to 2:50 a.m.

C. Respondent treated Patient C from on or about April 12, 1990 to on or about July 31, 1990 for pregnancy and delivery. On July 30, 1990, Respondent delivered Patient C's baby, Patient D, a female infant with Apgar scores at 3 at 1 minute and 5 at 5 minutes, at the Newark-Wayne Community Hospital, Newark, New York. Respondent's care and treatment of Patients C and D failed to meet acceptable standards of medical care, in that:

2. Respondent applied a vacuum extractor without medical indication;

3. Respondent used the vacuum extractor for an excessive number of traction pulls;

4. Respondent failed to have a pediatrician present at delivery of Patient D;

D. Respondent treated Patient E from on or about October 5, 1989 to on or about May 5, 1990 for pregnancy and delivery. On May 4, 1990, Respondent delivered Patient E's baby, Patient F, a female infant with Apgar scores of 1 at 1 minute and 1 at 5 minutes, at the Newark-Wayne Community Hospital, Newark, New York. Respondent's care and treatment of Patients E and F failed to meet acceptable standards of medical care, in that:

1. On April 30, 1990, Respondent failed to evaluate Patient E with appropriate laboratory studies including but not limited to 24 hour urine for creatinine clearance, platelet count, uric acid, hematocrit, serum BUN, serum creatinine, PT, and/or APTT; failed to order a non stress test; and/or failed to order bed rest;

2. Respondent failed to admit Patient E to a hospital immediately after an office visit on May 3, 1990;

3. Respondent failed to order bed rest for Patient E on admission to the hospital;

4. Respondent failed to order IV fluids for Patient E at admission;

5. Respondent failed to order magnesium sulfate for Patient E;

6. Respondent failed to stabilize Patient E prior to intervention;

7. Respondent inappropriately performed an amniotomy on Patient [illegible] the vertex at the -2 to -3 station

exposing the patient to an unnecessary risk of cord prolapse;

8. Respondent discontinued Pitocin on May 4, 1990 at 8:55 a.m. without medical justification;

9. Respondent failed to restart Pitocin in a timely manner;

10. Respondent failed to diagnose Patient E's dysfunctional labor in a timely manner;

11. Respondent inappropriately allowed Patient E to push for over an hour before the cervix reached full dilatation;

14. Respondent failed to have a pediatrician present at delivery of Patient E;

15. Respondent failed to order adequate antibiotics in the post-partum period for Patient E;

16. Respondent failed to establish intravenous access to Patient F in a timely manner;

17. Respondent failed to administer Epiniphrine, sodium bicarbonate, volume expanders and/or Dopamine to Patient F in a timely manner.

E. Respondent treated Patient G from on or about June 16, 1989 to on or about December 23, 1989 for pregnancy and delivery. On December 21, 1989, Respondent delivered Patient G's baby, Patient H, a male infant with Apgar scores of 4 at 1 minute and 6 at 5 minutes, at the Newark-Wayne Community Hospital, Newark, New York. Respondent's care and treatment of Patients G and H failed to meet acceptable standards of medical care, in that:

6. Respondent applied a vacuum extractor without medical indication;

7. Respondent used the vacuum extractor for an excessive number of traction pulls;

8. Respondent failed to have a pediatrician present at delivery of Patient H.

F. Respondent treated Patient I from on or about June 20, 1988 to on or about February 17, 1989 for pregnancy and delivery. On February 15, 1989, Respondent delivered Patient I's baby, Patient J, a male infant with Apgar scores of 4 at 1 minute and 5 at 5 minutes, at the Geneva General Hospital, Geneva, New York. Respondent's care and treatment of Patients I and J failed to meet acceptable standards of medical care, in that:

3. Respondent applied a vacuum extractor without medical indication;

4. Respondent used the vacuum extractor for an excessive number of traction pulls;

5. Respondent failed to have a pediatrician present at delivery of Patient J.

G. Respondent treated Patient K from some time prior to March 24, 1988 to March 25, 1988. On March 24, 1988, Patient K was admitted to the Geneva General Hospital, Geneva, New York with complaints of pelvic pain for a diagnostic and therapeutic laparoscopy. Respondent's care and treatment of Patient K failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document a complete medical history;

2. Respondent failed to obtain a pre-operative ultra

3. Respondent inappropriately performed elective surgery without first obtaining necessary information regarding the patient's prior life-threatening post-operative complication;

4. Respondent surgically removed Falope rings without medical indication;

5. Respondent failed to personally attend Patient K and evaluate her condition in the post-operative period.

SPECIFICATIONS

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Education Law §6509(2)(McKinney 1985), in that, Petitioner charges:

1. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.11, B.12, and/or B.13.
2. The facts in Paragraphs C and C.2, C.3, and/or C.4.,
3. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.14, D.15, D.16 and/or D.17.
4. The facts in Paragraphs E and E.5, E.6, E.7, and/or E.8.
5. The facts in Paragraphs F and F.3, F.4, and/or F.5.
6. The facts in Paragraphs G and G.1, G.2, G.3, G.4, and/or G.5.

EIGHTH THROUGH THIRTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence under N.Y. Education Law §6509(2) (McKinney 1985), in that, Petitioner charges:

8. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.11, B.12, and/or B.13.

9. The facts in Paragraphs C and C.2, C.3, and/or C.4.

10. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.14, D.15, D.16, and/or D.17.

11. The facts in Paragraphs E and E.6, E.7, and/or E.8.

12. The facts in Paragraphs F and F.3, F.4, and/or F.5.

13. The facts in Paragraphs G and G.1, G.2, G.3, G.4, and/or G.5.

FIFTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Education Law §6509(2) (McKinney 1985), in that, Petitioner charges that Respondent committed two or more of the following:

15. The facts in Paragraph B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.11, B.12, and/or B.13; C and C.2, C.3, and/or C.4.; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.14, D.15, D.16, and/or D.17; E and E.6, E.7, and/or E.8; F and F.3,

F.4, and/or F.5; and/or G and G.1, G.2, G3, G.4, and/or G.5;

SIXTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Education Law §6509(5)(2) (McKinney 1985), in that, Petitioner charges that Respondent committed two or more of the following:

16. The facts in Paragraph B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.11, B.12, and/or B.13; C and C.2, C.3, and/or C.4.; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.14, D.15, D.16, and/or D.17; E and E.6, E.7, and/or E.8; F and F.3, F.4, and/or F.5; and/or G and G.1, G.2, G3, G.4, and/or G.5;

SEVENTEENTH SPECIFICATION

OBTAINING THE LICENSE FRAUDULENTLY

Respondent is charged with obtaining a license fraudulently under N.Y. Education Law §6509(1) (McKinney 1985), in that, Petitioner charges:

17. The facts in paragraph A.

EIGHTEENTH THROUGH NINTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE OF MEDICINE

The Respondent is charged with practicing the profession fraudulently under N.Y. Education Law §6509(2) (McKinney 1985), in that, Petitioner charges:

18. The facts in Paragraph A.

19. The facts in Paragraph B and B.13.

DATED: Albany, New York

REDACTED

PETER D. [illegible] BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

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

IN THE MATTER :

OF : ORDER

THOMAS J. BYRNE, M.D. :

I have reviewed the transcript pages constituting the Report of the Hearing Committee on the issue of Imminent Danger in this matter, the Committee's finding that Thomas J. Byrne, M.D., Respondent, does present an imminent danger to the health of the people of the State of New York, and the Hearing Committee's recommended action that the Summary Order prohibiting Thomas J. Byrne, M.D., from practicing medicine in the State of New York remain in effect.

Now, upon reading and filing the transcript of the hearing, the exhibits, and other evidence introduced at the hearing, the conclusions and recommendations of the Hearing Committee as set forth in the Report on Imminent Danger, dated February 5, 1991,

EXHIBIT "C"

I HEREBY ORDER THAT:

The Summary Order, dated November 14, 1990, imposed upon Respondent, Thomas J. Byrne, M.D., shall remain in effect.

DATED: Albany, New York
February 19, 1991

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	REPORT OF
OF	THE
THOMAS J. BYRNE, M.D.	HEARING COMMITTEE

TO: Lorna McBarnette, Executive Deputy Commissioner
New York State Department of Health

JAMES F. WRIGHT, M.D. (Chair), PRISCILLA R. LESLIE, and LEMUEL A. ROGERS, JR., M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. LARRY G. STORCH, ESQ., served as the Administrative Officer.

After consideration of the entire record, the Hearing Committee submits this Report.

SUMMARY OF PROCEEDINGS

Date of Service of Commissioner's Order, Notice of Hearing and Statement of Charges: November 19, 1990

Answer to Statement of Charges: November 27, 1990

EXHIBIT "D"

Pre-Hearing Conference:	November 27, 1990
Dates and Places of Hearings:	November 28, 1990 November 29, 1990 December 5, 1990 December 12, 1990 December 13, 1990 December 20, 1990 January 3, 1991 January 8, 1991 January 9, 1991 January 22, 1991 January 31, 1991 February 5, 1991 (All hearings were held at 183 East Main Street Rochester, N.Y. except the hearing held on December 5, 1990. This hearing was held at 42 S. Washington Street, Rochester, N.Y.)
Hearings on Public Access to the Proceedings:	November 28, 1990 (two hearings)
Adjournments:	None
Received Respondent's Memorandum of Law on Issue of Imminent Danger:	February 5, 1991
Hearing Committee's Report on Imminent Danger:	February 5, 1991
Date of Commissioner's Order to continue summary suspension:	February 19, 1991
Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Argument:	March 8, 1991

Received Respondent's Proposed Findings of Fact, Conclusions of Law and Memorandum:	March 11, 1991
Department of Health appeared by:	Kevin C. Roe, Esq. Associate Counsel
Respondent appeared by:	Harter, Secrest & Emery 700 Midtown Tower Rochester, New York 14604-2070 Thomas G. Smith, Esq., of Counsel
Witnesses for Department of Health:	Jonathan M. Davis, M.D. Robert C. Tatelbaum, M.D. Mary Ellen Schlaerth, R.N Leslie Sechrist, R.N. Mary Claeysen, R.N. Michelle Durham, R.N. Patient E
Witnesses for Respondent:	Thomas J. Byrne, M.D. Morris Wortman, M.D. John F. Wood, M.D., D.O. Lester J. Danehy Sandra E. Handwerk
Received Conformed Statement of Charges[1]	February 26, 1991

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[1] Following the issuance of the Hearing Committee's Report on Imminent Danger, the Department withdrew several factual allegations and specifications which had not been the subject of testimony presented to the Hearing Committee relative to the question of imminent danger. The Department subsequently offered into evidence Petitioner's Pleading # 1-A, a Conformed Statement of Charges reflecting these deletions, as well as several amendments to the charges made during the course of the proceedings. Petitioner's Pleading # 1-A was received without objection by Respondent.

STATEMENT OF CASE

By an order dated November 14, 1990, the Commissioner of Health summarily suspended the medical license of the Respondent, Thomas J. Byrne, M.D., on a finding that his continued practice of medicine would constitute an imminent danger to the health of the people of this state. More specifically, the accompanying Statement of Charges alleged nineteen specifications, including allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, obtaining a medical license fraudulently, and the fraudulent practice of medicine. Following the hearings on this matter, which commenced on November 28, 1990 and concluded on February 5, 1991, the Hearing Committee issued its report on imminent danger, on the record. The Hearing Committee recommended that the summary suspension of Respondent's license be maintained pending the ultimate resolution of the case by the Board of Regents. By an Order dated February 19, 1991, the Commissioner ordered that the summary suspension be contained.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in

parentheses refer to transcript page numbers[2] or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

FRAUD

1. On or about December 29, 1983, the Board of Medical Examiners of the State of North Carolina found that on or about March 4, 1983, the Respondent intentionally administered Ketamine to a patient in spite of specific instructions not to use this drug in the circumstances in which it was given and that the Respondent deliberately falsified the patient's medical record by not recording the prescription and administration of Ketamine. The North Carolina Board concluded that Respondent's conduct failed

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[2] Due to a transcription error, the transcripts for both the November 28, 1990 and November 29, 1990 hearing dates begin on page one. To prevent any confusion, all citations to those transcripts will be preceded by the appropriate date. All subsequent transcripts were appropriately paginated, commencing with page 357 in the December 5, 1990 transcript.

"to conform to acceptable and prevailing ethical and professional standards of the practice of medicine in the State of North Carolina." On or about December 29, 1983, Respondent was reprimanded by the North Carolina Board. (Pet. Ex. #1).

2. On or about April 3, 1985, Respondent falsely answered "No" to the question "Have you ever been found guilty of professional misconduct, unprofessional conduct or negligence in any state or country?" on his Application for License and First Registration submitted to the New York State education Education Department (Pet. Ex. #2).

Patients A and B

3. Respondent treated Patient A from on or about February 21, 1990, to on or about September 18, 1990, for pregnancy and delivery. On September 17, 1990, Respondent delivered Patient A's baby, Patient B, a male infant with Apgar scores of 1 at one minute and 1 at five minutes, at the Newark-Wayne Community Hospital, Newark, New York. (Pet. Ex. #3).

4. Respondent saw Patient A on the morning of September 12, 1990, for a prenatal visit. Patient A was a 16 year old, gravida 1, para 0, white female at forty-one

weeks gestation. Her weight was 187 pounds, representing a 42 pound weight gain, and her blood pressure was 104/74. A non-stress test was ordered. (Pet. Ex. #3, p. 14).

5. On September 12, 1990, Patient A was seen at the Newark-Wayne Community Hospital at 10:22 a.m. for a non-stress test. At 10:30 a.m., her blood pressure was 130/90 and on recheck at 10:50, 130/96. Respondent was notified and gave instructions for the patient to go home and take two ounces of castor oil after dinner. (Pet. Ex. #3, p. 38).

6. At 4:00 p.m. on September 16, 1990, Patient A was seen at the Newark-Wayne Community Hospital for monitoring. She was having 1 1/2 to 2 minute contractions, her cervix was 1 to 2 centimeters dilated and 60% effaced, the vertex was at S-3, and her membranes were intact. External monitoring showed a fetal heart rate of between 120-140 with good to average variability. No decelerations were noted. (Pet. Ex. #3, pp. 17-18, 92-108).

7. At approximately 9:00 p.m., the fetal heart rate decreased to 80-90 from 120 for one minute and continued to drop to 60-70 for two minutes. The fetal heart rate slowly recovered to 120-130 by 9:10 p.m.

Respondent was informed and Patient A was admitted to the hospital. (Pet. Ex. #3, pp. 19, 109-110).

8. At approximately 11:30 p.m., Respondent was in attendance and artificial rupture of membranes was performed. The fetal heart rate decelerated to 50-60 for an uncertain period of time because the monitor was not picking up the tracing. By 11:34 p.m., the fetal heart rate had returned to a base line in the 130's. (Pet. Ex. #3, pp. 20, 130-132; 11/29/90, pp. 17-20; 2044).

9. Between 11:30 p.m. on September 16, 1990, and 1:00 a.m. on September 17, 1990, the fetal heart rate monitor showed subtle but persistent late decelerations indicative of fetal distress. (Pet. Ex. #3, pp. 133-144; 11/29/90, pp. 17-20; 2040-2045).

10. At approximately 1:10 a.m., the fetal heart rate decelerated to 70-90 for several minutes. Respondent was notified. (Pet. Ex. # 3, pp. 20, 143-146; 11/29/90; 20-21; 2046).

11. At 1:40 a.m., Respondent attended Patient A and applied a scalp electrode to monitor fetal heart rate. Thereafter, the fetal heart rate showed continued late decelerations. Respondent remained in attendance until

approximately 1:50 to 1:55 a.m. (Pet. Ex. #3, pp. 20, 149-151; 11/29/90, pp. 54-56, 2106).

12. By 1:40 a.m., the fetal heart rate monitor had shown repeated episodes of fetal bradycardia and subtle but persistent late decelerations indicating fetal distress and warranting a fetal scalp pH test and preparation for an cesarean section. (11/29/90, pp. 21-23, 61-62, 84; 2150-2151).

13. Robert C. Tatelbaum, M.D., a board-certified obstetrician - gynecologist, testified that Patient A's condition prior to approximately 1:55 a.m. warranted that she be closely monitored and followed by a physician. Respondent did not attend Patient A from approximately 1:55 a.m. until sometime after 3:00 a.m., nor did he summon another physician to attend her. (Pet. Ex. #3, pp. 20-21, 29; 11/29/90, pp. 30-32, 65; 2150-2151).

14. Between 2:00 a.m. and 2:15 a.m., the fetal heart rate monitor showed significant bradycardia, with decrease of the fetal heart rate to 60 for several minutes and a return to a baseline of 90. At 2:18 a.m., Respondent was notified by the nursing staff concerning the heart rate. He did not attend Patient A, arrange for another physician to attend Patient A, or arrange for a cesarean

section; all of which were warranted. (Pet. Ex. # 3, p. 20-21, 152-153; 11/28/90 pp. 49-53, 11/29/90, pp. 60-62; 377, 470).

15. At 2:30 a.m., Patient A was fully dilated and began pushing. (Pet. Ex. #3, p. 21; 473).

16. At 2:40 a.m., fetal heart rate decelerated to 60 from a baseline of 90 and remained at 60 to 70 for ten minutes. Thereafter, the fetal heart rate remained between 60 to 70 with occasional accelerations to 90 until birth at 3:36 a.m. (Pet. Ex. # 3, pp. 21-22, 29, 157-165; 11/28/90, pp. 140, 157, 159; 11/29/90, pp. 33).

17. Shortly after 2:40 a.m. Nurse Claeyson informed Nurse Schlaerth of the decrease in the fetal heart rate. Nurse Schlaerth informed Respondent who requested that Nurse Schlaerth check the monitor strip. Nurse Schlaerth reviewed Patient A's monitor strip and informed him that the patient's baseline fetal heart rate was 60 with decreased variability. At 2:46 a.m., Nurse Schlaerth returned to Patient A's room, removed the most recent section of the fetal heart rate monitor strip and showed it to Respondent. Respondent instructed Nurse Schlaerth to get the vacuum extractor ready for Patient A. (Pet. Ex.

sixteenth specification - incompetence on more than one occasion, involving patient treatment provided by respondent for pregnancy and delivery; the seventeenth specification - obtaining a license fraudulently, involving respondent falsely representing that he had never been found guilty of professional misconduct, unprofessional conduct or negligence by any other state or country; the eighteenth specification - fraud, involving respondent falsely representing that he had never been found guilty of professional misconduct, unprofessional conduct or negligence by any other state or country; and the nineteenth specification - fraud, involving respondent making false statements in a patient's delivery note and not guilty of the remaining specifications and charges, with certain specifications having been withdrawn by the Department of Health;

4. The recommendation of the hearing committee and the Commissioner of Health as to the measure of discipline be accepted; and

5. 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;

and that the Deputy Commissioner for the Professions be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

THOMAS J. BYRNE (12428)

IN WITNESS WHEREOF, I, Henry A. Fernandez, Deputy Commissioner for the Professions 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, at the City of Albany, this 15th day of NOVEMBER, 1991.

REDACTED

Deputy Commissioner for the Professions

3, pp. 20-21, 29, 153-158; 11/28/90, pp. 54-59, 69-70, 73-74, 78, 97, 99, 120-121, 133-134; 474-476, 2114-2115).

18. At 2:46 a.m., Respondent did not personally attend Patient A, arrange for another physician to attend Patient A, arrange for a cesarean section or arrange for a pediatrician; all of which were warranted by the circumstances, in Dr. Tatelbaum's opinion. (11/28/90. pp. 140, 157-159; 11/29/90, pp. 30-36, 77-78).

19. Shortly after 3:00 a.m. and before 3:10 a.m., Respondent attended Patient A. Respondent did not make arrangements for pediatric attendance at birth or cesarean section at that time. (Pet. Ex. #3, pp. 20-22, 29; 11/28/90 pp. 140, 157-159; 11/29/90 pp. 30-36, 77-78).

20. At 3:10 a.m., a vacuum extractor was applied, used for four traction pulls of one minute each, and discontinued at 3:20 a.m. (Pet. Ex. #3, pp. 22, 26, 29).

21. Between 3:20 a.m. and 3:28 a.m., a fetal scalp Ph was obtained showing a pH level of 6.89, indicating extreme acidosis. While the fetal scalp pH test was being done, Patient A had contractions without the assistance of the vacuum extractor. (Pet. Ex. #3, pp. 22, 29, 85; 11/28/90, p. 100; 475-476).

22. At 3:20 a.m., a fetal scalp pH test was not indicated and interruption of the delivery process was not warranted. (11/29/90, pp. 37-38, 73-74, 84; 2006).

23. At 3:28 a.m., the vacuum extractor was reapplied, used for three traction pulls of one minute each, and discontinued with the birth of Patient B at 3:36 a.m. (Pet. Ex. #3, pp. 22, 26, 29).

24. After the fetal scalp pH of 6.89 was obtained, and prior to delivery, the nurses began to prepare for neonatal resuscitation on their own initiative. Respondent made no request to prepare for resuscitation or for pediatric attendance. (Pet. Ex. #3, pp. 22, 26; 11/28/90, pp. 59-60; 100, 476-477).

25. At birth, Patient B weighed approximately eight pounds. Apgar scores were 1 at one minute, 1 at five minutes and 3 at ten minutes. After birth Patient B was taken to a warmer, dried thoroughly, and oxygen was given via positive pressure ventilation by Respondent. The infant's Heart rate was less than 60, all extremities were limp, color was blue or pale, and spontaneous respirations were absent. At 3:39 a.m., the heart rate was 40 and chest compressions were begun. At 3:40 a.m., the heart rate was 50; chest compressions and positive pressure ventilation

were continued. At 3:41 a.m., Respondent intubated Patient B with a 4.0 endotracheal tube. At 3:42 a.m., 0.1 cc of 4.2% sodium bicarbonate was administered. At 3:44 a.m., 0.4 cc of Epinephrine was given via the endotracheal tube, positive pressure ventilation continued, heart rate was 100, chest compressions were discontinued. At 3:45 a.m., the heart rate was 120. At 3:47 a.m., the heart rate was 150. At 3:50 a.m., the heart rate was 152; positive pressure ventilation was continued. At 3:53 a.m., the heart rate was 150. At 3:55 a.m., the heart rate was 154 and positive pressure ventilation continued. (Pet. Ex. #4, pp. 37-38).

26. At 4:00 a.m., the pediatrician arrived, found the heart rate to be 90, and transferred Patient B to the nursery where chest compressions were restarted, the endotracheal tube was repositioned out of the right main stem bronchus, an umbilical venous line was placed, additional epinephrine and sodium bicarbonate were administered, and the neonatal transfer team from Strong Memorial Hospital was called. (Pet. Ex. #4, pp. 12-14, 31-32).

27. At birth Patient B had no respiratory efforts and the heart rate was less than 60. Chest compressions

should have been initiated within 30 to 60 seconds, but were not begun until 3 minutes of life. (11/28/90, p. 142).

28. Jonathan M. Davis, M.D., a physician who is board-certified in pediatrics and neonatal-perinatal medicine, testified that an umbilical venous line should have been inserted within the first two to four minutes of life, but was not inserted until after the pediatrician arrived and took over care of Patient B. (11/28/90, p. 143).

29. Dr. Davis further testified that Epinephrine should have been administered within the first two to four minutes of life, but was not administered until eight minutes of life (11/28/90, p. 144).

30. The standard and adequate dose for sodium bicarbonate for a neonate in Patient B's condition is 8-12 cc. The 0.1 cc of sodium bicarbonate administered at 3:42 a.m was grossly inadequate. (11/28/90, p. 146-147).

31. Patient B was transferred to the Neonatal Intensive Care Unit of Strong Memorial Hospital at 6:45 a.m. on September 17, 1990 (Pet. Ex. #4, Pet. Ex. #5).

32. Dr. Davis stated that Patient B suffered perinatal asphyxia resulting in hypoxic ischemic encephalopathy and severe brain damage. His neurological prognosis was extremely poor. Dr. Davis further testified that Respondent's deviations from standards of acceptable medical care caused or contributed to this outcome. (11/28/90, pp. 152-153).

33. From approximately 2:15 a.m. until shortly after 3:00 a.m., Respondent attended Patient M in the labor room directly next door to Patient A. Patient M's condition did not require Respondent's presence nor was it medically necessary. (Pet. Ex. #6; 11/28/90, p. 136; 2128).

34. Respondent stated in a handwritten addition to his typewritten delivery note that he was not informed of the 2:00 a.m. to 2:15 a.m. fetal heart rate abnormalities until 2:45 a.m. This statement was false. (Pet. Ex. #3, p. 29; 11/28/90, pp. 49-53; 471).

Patients C and D

35. Respondent treated Patient C from on or about April 12, 1990, until on or about July 31, 1990, for pregnancy and delivery. On July 30, 1990, Respondent

delivered Patient C's baby, Patient D, a female infant with Apgar scores of 3 at one minute and 5 at five minutes, at the Newark-Wayne Community Hospital, Newark, New York. (Pet. Ex. # 6; Pet. Ex. #7).

36. Patient C was admitted to the Newark-Wayne Community Hospital on July 30, 1990, at 5:30 a.m. in spontaneous labor. Patient C was a 23 year old, gravida 1, para 0, white female at 42 weeks gestation. She had labor pains since 11:00 p.m. on the night before admission, with spontaneous rupture of membranes at 4:30 a.m. Vaginal examination revealed the cervix to be 4-5 cm dilated, 80% effaced, with the vertex at -1 station. Contractions were noted to occur every 2 minutes lasting for 40 to 60 seconds. (Pet. Ex. # 6, pp. 34-35).

37. At 7:30 a.m., the cervix was 7-8 cm dilated, 100% effaced, with the vertex at 0 station. The fetal heart rate was continuously monitored by an external monitor and was within normal range with average variability. Respondent was telephoned. (Pet. Ex. 6, pp. 35-36, 94-95).

38. At 8:25 a.m., Respondent performed a vaginal examination and determined that Patient C was fully dilated, 100% effaced with the vertex at 0 station. No

fetal heart rate abnormalities were noted. At 8:35 a.m., Patient C began pushing. At 8:45 a.m., the vertex was noted at 0 station. At 9:30 a.m., the vertex had progressed to +1 to +2 station. A vacuum extractor was applied. (Pet. Ex. #6, pp. 35, 38, 40).

39. At 9:30 a.m., Patient C had been pushing for approximately 55 minutes and the station of the presenting part had progressed. There was no fetal distress or any other maternal or fetal condition which would justify instrument delivery. Dr. Tatelbaum testified that application of the vacuum extractor at that time was inappropriate. (556-559, 563-564, 566-568).

40. Between 9:30 a.m. and 9:52 a.m., the vacuum extractor was used for ten traction pulls lasting approximately one minute each. The vertex was brought down to +3 to +4 station. At 10:13 a.m., the vacuum extractor was reapplied for one additional traction pull and Patient D was delivered over an intact perineum. Shoulder dystocia requiring a "wood screw" maneuver to effect delivery was noted. (Pet. Ex. #6, pp. 38, 41).

41. Dr. Tatelbaum testified that the safe and effective use of the vacuum extractor requires that the number of traction pulls be limited and that its use be

discontinued if delivery is not imminent after five attempts. The number of traction pulls used to deliver Patient D was excessive and inappropriate. (573-576, 604, 619).

42. A pediatrician was not present at delivery and previous preparations for pediatric coverage had not been made. (Pet. Ex. #6).

43. Patient D was a 4448 gm (macrosomic) female with Apgar scores of 3 at one minute, 5 at five minutes and 5 at ten minutes. At birth, heart rate was over 100, spontaneous respirations, muscle tone and reflex were absent. Extremities were blue. In the nursery, Patient D was noted to be limp with no response to pain. Pupils were small and poorly reactive bilaterally. A large cephalhematoma was noted and the right arm was completely limp. Gag reflex was absent. After slight improvement, Patient D was transferred to the Neonatal Intensive Care Unit of Strong Memorial Hospital at 4:30 p.m. with a discharge diagnosis of birth asphyxia secondary to difficult second stage of labor. (Pet. Ex. #7, pp. 12-15).

44. At Strong Memorial Hospital, birth asphyxia was again diagnosed. An electroencephalogram was markedly abnormal, showing a very depressed background and multiple

seizure activity. Patient D suffered a period of apnea, was resuscitated and placed on a ventilator. CT scans showed bilateral hemispheric infarctions and cerebral edema. Patient D suffered extensive brain damage with the cortex completely destroyed and damage to the brain stem as well. On August 11, 1990, a Do Not Resuscitate order was placed and the patient removed from the respirator. On August 13, 1990, she expired. (Pet. Ex. #7; 790-792).

45. Dr. Davis testified that the perinatal asphyxia suffered by Patient D was caused by birth trauma. Respondent's inappropriate and excessive use of the vacuum extractor caused or contributed to the death of Patient D. (792-793 795-796, 801).

Patient E and F

46. Preeclampsia is defined as the development of hypertension with proteinuria, edema, or both, induced by pregnancy after the twentieth week of gestation. Hypertension is defined as a diastolic blood pressure of at least 90 mm Hg or a systolic pressure of at least 140 mm Hg, or a rise in the diastolic pressure of a least 15 mm Hg, or a rise in systolic pressure of 30 mm Hg. Proteinuria is defined as the presence of 300 mg. or more

of protein in a 24-hour urine collection or a protein concentration of 1 g or more per liter in at least two random urine specimens collected six hours or more apart. Chronic Hypertensive Disease is defined as persistent hypertension, of whatever cause, antedating pregnancy or detected before the twentieth week of gestation in the absence of hydatidiform mole or extensive molar change, or hypertension that persists beyond six weeks post-partum. (11/20/90 pp. 39-40, 88; 1915-1920, 1924, 1948-1950, 2015-2017, 2028-2029).

47. Respondent treated Patient E from on or about October 5, 1989, to on or about May 5, 1990, for pregnancy and delivery. On May 4, 1990, Respondent delivered Patient E's baby, Patient F, a female infant with Apgar scores of 1 at one minute and 1 at five minutes, at the Newark-Wayne Community Hospital, Newark, New York. (Pet. Ex. #9).

48. Patient E was a 25 year old, gravida 1, para 0, white female with a last menstrual period of June 13, 1989 and expected date of confinement of March 20, 1990, who was first registered for her pregnancy on October 5, 1989. She occasionally missed periods and was felt to be six to eight weeks pregnant by uterine size

at the time of registration. An ultrasound was obtained on November 6, 1989, and placed the patient at fourteen weeks gestation, giving a due date of May 7, 1990. (Pet. Ex. #9, pp. 11-15).

49. At her first office visit on October 5, 1989, Patient E weighed 202 pounds and had a blood pressure of 114/92. Subsequent blood pressures in the first twenty weeks of pregnancy were 114/72 on October 30, 1989, and 104/70 on November 27, 1989. There was no history of hypertension prior to the pregnancy. Patient E did not meet the diagnostic criteria for chronic hypertension. (Pet. Ex. # 9, pp. 11-15; 2028-2029).

50. Patient E was seen on five additional occasions by Respondent prior to the thirty-sixth week of pregnancy (4/9/90) with blood pressures recorded as follows:

12/18/89: 126/88 recheck: 116/80 (with large cuff)

1/15/90: 108/74

2/19/90: 118/88

3/12/90: 110/82

4/2/90: 114/82 (Pet. Ex. #9, p.14).

51. On April 9, 1990, Patient E was seen by Respondent for a prenatal visit. Blood pressure was 116/92, urine protein was negative and 2+ edema was noted. At a April 23, 1990 office visit, blood pressure was 132/88, proteinuria was 1+ and 3+ edema was noted. (Pet. Ex. #9, p.14)

52. On April 30, 1990, Patient E was seen by Respondent for a prenatal visit with a blood pressure of 124/100, trace proteinuria and 2+ edema. Dr. Tatelbaum testified that appropriate laboratory studies including a CBC and 24 hour protein, bed rest and a non-stress test should have been ordered, but were not. (Pet. Ex. #3, p. 14; (11/29/90, pp. 97-98).

53. On April 30, 1990, Patient E met the diagnostic criteria for preeclampsia. Her condition warranted laboratory studies to evaluate maternal well-being, a non-stress test to evaluate fetal well-being and bed rest. 11/29/90, pp. 96-101).

54. At approximately 11:00 a.m. on May 3, 1990, Patient E was seen by Respondent for a prenatal visit with worsening preeclampsia. Her blood pressure was 144/110 (taken with a large cuff), proteinuria was 3+ and she had 2+ edema. Respondent instructed Patient E to go home, take

samples were taken for laboratory studies. (Pet. Ex. #9, pp. 34, 47, 68, 70).

59. At 8:50 p.m., Patient E's cervix was 1-2 cm dilated, 50% effaced and the station was -3 to -2. Respondent attended and performed an artificial rupture of membranes. Respondent revised his previous orders to 1/2 hour continuous fetal monitoring then 15 minutes every hour with the patient out of bed as desired. (Pet Ex. #9, pp. 38, 40, 47, 97).

60. Dr. Tatelbaum further testified that Patient E should have been stabilized with magnesium sulfate and intravenous fluids prior to induction of labor. The amniotomy with the vertex at -3 to -2 station exposed Patient E to an unnecessary risk of cord prolapse. (11/29/90, pp. 107-109, 142-143).

61. At 9:42 p.m., urinalysis results became available, showing 1+ protein in the urine. (Pet. Ex. #9, p. 70).

62. At 1:45 a.m. on May 4, 1990, Pitocin augmentation of labor was initiated. (Pet. Ex. #9, pp. 41, 47, 98).

63. At 8:00 a.m., Patient E's blood pressure was 154/100, her temperature 100.7, and she was experiencing

castor oil and go to the hospital at 7:00 p.m. if she did not go into labor before then. (Pet. #9, pp. 1 , 40; 927-932).

55. On May 3, 1990, Patient E was severely preeclamptic. Dr. Tatelbaum testified that her condition warranted immediate admission to the hospital for further evaluation and treatment. 11/29/90, pp. 101-103, 125-126, 139-140).

56. Patient E was admitted to the labor area at 8:00 p.m. on May 3, 1990, with a blood pressure of 145/103, 2+ edema, and a temperature of 98.7. At admission, Respondent ordered a Heparin lock, laboratory studies, routine vital signs monitoring, clear liquids, and continuous external fetal monitoring. (Pet. Ex. #9, pp. 34, 40, 97).

57. At admission, and throughout her hospitalization, Patient E was moderately to severely preeclamptic. Dr. Tatelbaum testified that her admission orders should have included magnesium sulfate to prevent convulsions, intravenous fluids and strict bed rest. (11/29/90, pp. 103-105, 125-126, 140).

58. At 8:30 p.m., Patient B's blood pressure was 165/104. Between 8:30 p.m. and 8:53 p.m., blood and urine

contractions every 2 to 4 minutes lasting 40 to 60 seconds. Her cervix was 3-4 cm dilated, 90% effaced and the vertex was at -1 station. (Pet. Ex. #9, p. 49)

64. At 8:55 a.m., contractions were occurring every two to three minutes, lasting 60 seconds. The Pitocin was discontinued. (Pet. Ex. #9, pp. 43, 49, 223-226).

65. At 8:50 a.m., Patient E was twelve hours post amniotomy with five intervening vaginal examinations and an elevated temperature. She remained moderately to severely preeclamptic. The frequency and duration of contractions were adequate and desirable. Pitocin augmentation should not have been discontinued. (Pet. Ex. #9, pp. 48-49; 11/29/90, pp. 110, 144, 160).

66. At 11:30 a.m., laboratory results from 7:32 a.m. showed a white blood cell count of 36, 100. Respondent was aware of the results. At 11:40 a.m., Respondent performed a vaginal examination showing 4 cm cervical dilation, 90% effacement and the vertex at 0 station. The patient's temperature was 100.6. Respondent did not restart the Pitocin. (Pet. Ex. #9, pp. 49, 67; 1978, 1981-1982).

67. At 1:10 p.m., Respondent performed a vaginal examination showing the cervix to be 5 cm dilated. Nursing notations regarding effacement and station are illegible. No progress note was written. (Pet. Ex. #9, pp. 49, 60)

68. At 2:00 p.m., the patient's temperature was 100.1. At 4:00 p.m., her temperature was 99.6. (Pet. Ex. #9, p. 50).

69. At 4:10 p.m., Respondent performed a vaginal examination showing 5-6 cm cervical dilation, 100% effacement and the vertex at -1 to 0 station. Respondent did not restart the Pitocin. (Pet. Ex. #9. p. 50).

70. At 4:10 p.m., Patient E was 19 hours post amniotomy. She remained moderately to severely preeclamptic. Her cervix had dilated only 2 cm in the previous 8 hours. Dr. Tatelbaum testified that a diagnosis of dysfunctional labor should have been made and Pitocin restarted. (11/29/90, pp. 113-116).

71. At 7:15 p.m., a vaginal examination performed by Nurse Durham showed 5-6 cm cervical dilation and the vertex at S-1 station. (Pet. Ex. #9, P. 50).

72. At 8:30 p.m., Respondent performed a vaginal examination which showed 6 cm cervical dilation, 100% effacement, and the vertex at 0 station. Patient E's

temperature was 100.2. Pitocin was restarted. (Pet. Ex. #9, pp. 50, 61).

73. At 9:00 p.m., the patient's temperature was 102.2. Respondent was informed of the temperature and a rising fetal heart rate baseline. At 9:10 p.m., vaginal examination by Respondent showed 7 cm cervical dilation and the vertex at 0 station. Respondent gave permission for Patient E to push and thereafter she pushed with contractions for over one hour prior to full dilation. (Pet. Ex. #9, pp. 46, 51, 54).

74. Dr. Tatelbaum testified that allowing the patient to push prior to full dilation created a risk of injury to the mother's cervix and to the fetus without obstetrical benefit. Patients should not be allowed to push prior to full dilation. (11/29/90, pp. 118-120).

75. Between 9:30 p.m. and 10:00 p.m., the fetal heart rate was tachycardiac ranging between 160 to 180 beats per minute. (Pet. Ex. #9, pp. 51, 327-332).

76. At 10:10 p.m., Patient E's temperature was 104.4. The maternal heart rate was tachycardiac between 110 to 120, and the fetal heart rate was 180-200. Cervical dilation was 9 cm and the station of the vertex was +1. (Pet. Ex. #9, 51, 54).

77. Shortly after the 10:10 p.m. examination, Respondent was informed of the results. He ordered an emergency cesarean section at approximately 10:15 p.m. Respondent did not instruct the nursing staff to call a pediatrician. (Pet. Ex. #9, pp. 46, 54; 697-698, 705, 707).

78. At 10:28 p.m., Respondent applied a vacuum extractor. Traction was applied with seven contractions resulting in delivery of Patient F at 10:40 a.m. (Pet. Ex. #9, p. 46,94).

79. A pediatrician was not in attendance at the birth. (Pet. Ex. #9, p. 94; 698-699).

80. Dr. Tantelbaum testified that the previously described maternal and fetal conditions required arrangements for a pediatrician at delivery. None were made. (11/29/90, p. 121;698-699, 705, 707, 809-810).

81. Patient F's Apgar scores were 1 at one minute, 1 at five minutes and 4 at ten minutes. At birth, the heart rate was less than 60, respiratory efforts were absent, tone was absent, reflex was absent and color was blue or pale. At two minutes of life, the anesthesiologist arrived and shortly thereafter intubated Patient F and administered 2 mg of Epinephrine. Between 10:46 p.m. and

10:50 p.m., a pediatrician arrived and took over the care of Patient F. (Pet. Ex. #11, p. 25, Pet Ex. #9, p. 55).

82. Dr. Davis testified that an umbilical venous line should have been established within 2 to 3 minutes of life and sodium bicarbonate, volume expanders and Dopamine administered shortly thereafter. (815-817).

83. Patient E continued to be preeclamptic following the delivery. Respondent ordered intravenous ampicillin, 1 gram every six hours. Patient E suffered severe septic shock which was not recognized by Respondent. (Pet. Ex #9, pp. 96, 99, 119-124; 11/29/90, pp. 123-126; 931).

84. The antibiotics ordered by Respondent were inadequate in coverage and amount. Greater amounts of Ampicillin, as well as other antibiotics, should have been ordered. (11/29/90, pp. 124-125, 172-173).

85. Patient F was transferred to the Neonatal Intensive Care Unit at Strong Memorial Hospital at 12:51 a.m. on May 5, 1990, with a discharge diagnosis of cardiopulmonary arrest, birth asphyxia and profound sepsis. At Strong Memorial an electroencephalogram showed a flat tracing and ventilatory support was removed. Patient F

expired at 9:50 p.m. at 23 hours of life. (Pet. Ex. #11; Pet. Ex. #12).

86. Dr. Davis testified that Respondent's deviations from the standards of acceptable medical care caused or contributed to the death of Patient F. (11/29/90, pp. 125, 160-162; 817-818).

Patient G and H

87. Respondent treated Patient G from on or about June 16, 1989, to on or about December 23, 1989, for pregnancy and delivery. On December 21, 1989, Respondent delivered Patient G's baby, Patient H, a male infant with Apgar scores of 4 at one minute and 6 at five minutes, at the Newark-Wayne Community Hospital, Newark, New York. (Pet Ex. #13).

88. Patient G was a 28 year old, gravida 1, para 0, white female admitted to the Newark-Wayne Community Hospital on December 21, 1989 at 42 weeks gestation. At admission she weighted 217 pounds, representing a 52 pound weight gain during pregnancy. Her blood pressure was 158/100. Her cervix was 1 cm dilated and 50% effaced. The vertex was at -2 station. (Pet. Ex. #13, pp. 24-26).

89. Patient G was examined by Respondent at 6:00 a.m and found to be 3-4 cm dilated, and 70% effaced, with the vertex at -1 station. Fetal weight was estimated at 8 to 8 1/2 pounds. (Pet. Ex. #13, p. 27).

90. Patient G was fully dilated at 3:45 p.m. and began pushing. The fetal monitor, which had shown no abnormalities, was discontinued at 3:50 p.m. and a cardio-paddle was used to intermittently monitor the fetal heart rate. Between 4:00 p.m. and 4:30 p.m., the nurses noted intermittent "decelerations" of the fetal heart rate between contractions. At 4:15 p.m., a pediatrician was called to stand by for delivery. At 4:30 p.m., the pediatrician was present and Respondent was called. At 4:43 p.m., Respondent arrived. Vaginal examination showed the vertex to be at 0 station. A borderline pelvis with android characteristics was noted. At 4:45 p.m., a vacuum extractor was applied. (Pet. Ex. #13, pp. 31, 39-40).

91. At 4:45 p.m., Patient G had been fully dilated and pushing for only one hour. Dr. Tatelbaum testified that the fetal heart rate irregularities were of unknown significance and further evaluation should have been performed. No maternal or fetal condition existed which would justify a midpelvic instrument delivery.

Application of the vacuum extractor at 4:45 p.m was inappropriate. (Pet. Ex. #13, pp. 31, 35; 412-418, 443-453, 446, 452, 456 - 463

92. Between 4:45 p.m. and 5:34 p.m., the vacuum extractor was used for fifteen traction pulls of approximately one minute each. The vertex moved from O station to approximately +4. At 5:34 p.m., the vacuum extractor was removed. (Pet. Ex. #13, pp. 35-36, 39-40; 423-425, 428-430).

93. Dr. Tatelbaum testified that the safe and effective use of the vacuum extractor requires that the number of traction pulls be limited and that its use be discontinued if delivery is not imminent after five attempts. He further testified that the number of traction pulls used to deliver Patient H was excessive and inappropriate. (432-433, 461).

94. At 5:50 p.m., Patient H, an 8 pound 5 ounce, male infant with Apgar scores of 4 at one minute and 6 at five minutes, was delivered over a midline episiotomy. During delivery a crackling sound was heard as the left shoulder came underneath the symphysis pubis. X-ray examination later confirmed a fractured left clavicle. (Pet. Ex. #13, pp. 38-40; Pet. Ex #14, pp. 10, 18).

95. Prior to application of the vacuum extractor, the pediatrician left the labor area with an instruction to call him when delivery was imminent. The pediatrician was not called prior to delivery and did not arrive until approximately 15 minutes post-partum. (Pet. Ex. #13, pp. 31-32, 3[illegible]; Pet. Ex. #14, p. 14; 713-715, 1657, 1672).

96. At Newark-Wayne Community Hospital, Patient H was noted to have marked molding of the head, a large left cephalhematoma, a fractured left clavicle, metabolic acidosis, abnormal neurological exam and respiratory distress. At 2:15 a.m. on December 22, 1989, Patient H was transferred to the Neonatal Intensive Care Unit at Strong Memorial Hospital. A CT scan performed at Strong Memorial showed massive cerebral edema and subarachnoid and subdural hemorrhages. Patient H developed a very severe seizure disorder and at one year of life was functioning as a one month old. (Pet. Ex. #14; Pet. Ex. #15; 719-720).

97. Dr. Davis testified that Patient H's condition was caused by severe birth trauma and severe perinatal asphyxia. He further testified that inappropriate and excessive use of the vacuum extractor caused or contributed to this outcome. (721).

98. John Wood, M.D. D.O. was called by Respondent to give expert testimony on the use of the vacuum extractor. In the only journal article published by Dr. Wood on the subject, he recommended that the total application time not exceed fifteen minutes. (1234).

Patients I and J

99. Respondent treated Patient I from on or about June 20, 1988, until or about February 17, 1989, for pregnancy and delivery. On February 15, 1989, Respondent delivered Patient I's baby, Patient J, a male infant with Apgar scores of 4 at one minute and 5 at five minutes, at the Geneva General Hospital, Geneva, New York. (Pet. Ex. #16; Pet. Ex. #17)

100. Patient I was a 20 year old, gravida 1, para 0, white female admitted to the Newark-Wayne Hospital on February 15, 1989 at 5:40 a.m. at 41 weeks gestation. Patient I weighed 174 pounds, representing a 60 pound weight gain during pregnancy, and her blood pressure was 122/94. Vaginal examination showed her cervix was 1 cm dilated and the vertex was at 0 station. At 7:30 a.m., meconium stained fluid was noted. At 8:30 a.m., Respondent examined Patient I and found 3 cm cervical dilation, 100%

effacement and the vertex was at -1 station. (Pet. Ex. #16 pp. 5-9, 21-22, 25)

101. At 8:40 p.m. on February 15, 1989, Patient I reached full dilation and was instructed to push with contractions. At 9:03 p.m., she was moved to the delivery room. Contemporaneous nursing notes do not describe the quality of Patient's pushing effort; however, Respondent's dictated delivery note describes them as "very poor." At 9:10 p.m., a vacuum extractor was applied with the vertex at +1 to +2 station. (Pet. Ex. #16, pp. 29-35).

102. At 9:11 p.m., Patient I had been pushing for approximately 31 minutes. Dr. Tatelbaum testified that no maternal or fetal condition existed which would justify instrument delivery. Application of the vacuum extractor at that time was therefore inappropriate. (380-382).

103. Between 9:11 p.m. and 10:03 p.m. the vacuum extractor was used for eighteen traction pulls of approximately one minute each, resulting in the delivery of a 7 pound, 6 ounce, male infant at 10:04 p.m. (Pet. Ex. #16, pp. 31-35; 383).

104. Dr. Tatelbaum testified that the safe and effective use of the vacuum extractor requires that the number of traction pulls be limited and that its use be

discontinued if delivery is not imminent after five attempts. Dr. Tatelbaum expressed the opinion that the number of traction pulls used to deliver Patient J was excessive and inappropriate. (384-385).

105. A pediatrician was not present at the delivery of Patient J and pediatric coverage prior to delivery had not been arranged. (Pet. Ex. #16; Pet. Ex #17).

106. Patient J had Apgar scores of 4 at one minute and 4 at five minutes. After initial resuscitation, an abnormal neurological exam and respiratory distress were noted in the nursery at Newark-Wayne Community Hospital. At 1:50 a.m. on December 22, 1989, Patient J was transferred to the Neonatal Intensive Care Unit at Strong Memorial Hospital, Rochester, New York. (Pet. Ex. #17, pp. 5, 28-33).

107. At Strong Memorial Hospital an electroencephalogram showed a flat line tracing and evidence of brain stem damage. A CT examination showed a skull fracture in the area where the vacuum extractor was applied, massive cerebral edema, subarachnoid hemorrhage and tentorial hemorrhage. Multiple retinal hemorrhages in the area of the macula were noted evidencing birth trauma.

Patient J died shortly before this hearing commenced. (Pet. Ex. #18; 522-524).

108. Dr. Davis expressed the opinion that Patient J's injuries and resultant severe brain damage were the direct result of Respondent's inappropriate and excessive use of the vacuum extractor. (524 -5 25, 547).

Patient K

109. Respondent treated Patient K from March 4, 1988 to May 24, 1990 (Pet. Ex. # 33).

110. Patient K was seen for an initial office visit on March 4, 1988, with complaints of pelvic pain. Past medical history developed by Respondent included a gall stone operation in 1980 and a bilateral tubal ligation by application of falope rings in 1986. No history of surgical complications was developed. Physical examination was noted as showing a flat, soft abdomen, bilateral lower quadrant tenderness, normal size but tender right adnexus and a very tender 5 x 7 cm left adnexus. Respondent's impression was ovarian adhesions and urinary tract infection. His plan was a diagnostic and therapeutic laparoscopy and treatment of the urinary tract infection with ampicillin. (Pet. Ex. #33).

111. At the first office visit Respondent was planning an operative procedure. Dr. Tatelbaum testified that a specific inquiry regarding previous surgical or anesthetic complications should have been made. No such inquiry was made. (632-633, 637-638, 1122).

112. Dr. Tatelbaum further testified that prior to surgery an ultrasound should have been obtained to evaluate the patient's pelvic structures; specifically the 5 x 7 cm left adnexus noted on physical examination. An ultrasound may have provided information necessary to properly plan the nature and extend of the operative procedure. (634-635, 661-662).

113. On March 21, 1988, Patient K was seen at the Geneva General Hospital for preoperative laboratory studies. At that time, Patient K completed and submitted an out patient history checklist which included a history of kidney failure following the 1986 tubal ligation in Augsburg, Germany in 1986. (Pet. Ex. #19, pp. 25-31).

114. On March 24, 1988, Patient K was admitted to the out-patient surgery department at Geneva General Hospital for a diagnostic and therapeutic laparoscopy and possible mini-laparotomy. Blood pressure was 120/70. Respondent's admission history and physical examination

should have included documentation of the 1986 renal shutdown following the tubal ligation. (Pet. Ex. Ex. #19, pp. 7-8; 632).

115. Dr. Tatelbaum testified that prior to undertaking surgery, further information regarding the previous, life-threatening surgical or anesthetic complication should have been obtained. Respondent's discharge summary indicates that Patient K's prior records were requested several weeks prior to surgery, but were unavailable for review. However Respondent's office record for Patient K documents the fact that the records were not requested until March 23, 1988, - one day prior to surgery. (Pet. Ex. #19, p. 4; Pet. Ex. #33; 631-633, 673-674, 1092).

116. At surgery Respondent found no abnormalities. He noted "Both tubes had mild hydrosalpinx. The ovaries appeared to be normal. There was a knuckle of viable fallopian tube clamped with each Falope Ring. There were no abdominal to genital adhesions." Respondent removed both the right and left falope rings and cauterized the adjacent segments of fallopian tubes. (Pet. #19, p. 14; 670).

117. Gross and microscopic examination of surgical specimens by the pathology department failed to

detect hydrosalpinx of the fallopian tubes. (Pet. Ex. # 19, p. 16; 1116).

118. Dr. Tatelbaum testified that surgical removal of the falope rings was not medically justified. falope rings have not been implicated as a cause of pelvic pain. (640-641, 667-669).

119. Patient K was admitted to the outpatient surgery department at 10:50 a.m. Anesthesia started at 11:31 a.m. and surgery began at 11:40 a.m. Surgery was completed at 12:54 p.m. and anesthesia ended at 1:05 p.m. (Pet. Ex. #19, pp. 10, 12, 14).

120. Patient K was received in the recovery room at 1:05 p.m. Her blood pressure was noted at 118/79. Skin was noted to be pale with nail beds cyanotic. At 1:35 p.m., blood pressure was noted to be 80/60. Patient K was placed in the Trendelenburg position. At 1:50 p.m., Respondent was notified by telephone of the patient's condition and drop in blood pressure. Intravenous flow rate was increased and Trendelenburg position maintained. At 2:15 p.m., vital signs returned briefly to preoperative levels. Trendelenburg position was slowly reversed. At 2:35 p.m and 2:40 p.m. blood pressure was noted to be 85/60 and 80/55 respectively. At 2:55, blood pressure was noted

to be 85/55. At 3:00 p.m., Respondent was telephonically notified of the decreased blood pressure and erratic pulse demonstrated by a sinus rhythm rate ranging from 58 to 90 bests per minute. Shortly thereafter, a foley catheter was placed and 150 cc urine obtained. Blood pressure remained decreased and Patient K was again placed in the Trendelenburg position. She was noted to awaken with complains of abdominal pain and nausea but falling back to sleep. Unsuccessful attempts were made to reach the anesthesiologist. The patient's color remained pale. At 3:20 a.m., Respondent was again notified of the low blood pressure and ordered a complete blood count. At 4:20 p.m., Respondent was informed of the laboratory results which showed a 10 point drop in her hematocrit and a 3.3 point drop in her hemoglobin. Patient K remained hypotensive. At 5:30 p.m., Respondent was telephoned and given a status report regarding the patient's vital signs. She remained hypotensive. Respondent instructed the nurses to call him back at 6:30 p.m. At 5:50 p.m., Patient K was complaining of nausea and feeling hot. Her color became very pale. Blood pressure was noted to be 75/40 and the sinus rhythm decreased to 48. Oxygen was applied and the IV flow rate increased. Diaphoresis was noted. Respondent was

telephoned but was unavailable. At 6:10 p.m., Respondent returned the nurses' call and was informed of the patient's vital signs and condition. He ordered Patient K admitted to the intensive care unit for close monitoring. At 6:45 p.m. Patient K was transferred to the intensive care unit. (Pet. Ex. 19, pp. 19-23).

121. On admission to the intensive care unit Patient K's blood pressure was noted to be 114/71 and pulse was 97. Over the next two hours vital signs fluctuated, but were noted to be stable by 9:00 p.m. (Pet. Ex. #19, pp. 40-43).

122. Following surgery, Respondent returned to his office. He next attended Patient K at 9:00 a.m. the following day. (Pet. Ex. #19, pp. 9, 36).

123. Patient K exhibited sustained and significant hypotension in the post-operative period. Her heart rate fluctuated widely. Dr. Tatelbaum testified that the ten point drop in hematocrit and three point drop in hemoglobin indicated a blood loss greater than the 200 cc estimated at surgery. He further testified that Patient K's condition required personal attendance, examination and evaluation by Respondent. (643-646, 654, 687-688, 1101-1102, 1107-1108, 1123).

CONCLUSIONS OF LAW

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

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

(1) Paragraph A (1,2);

(2) Paragraphs B, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.11, B.12, and B.13 (3-34);

(3) Paragraphs C, C.2,C.3 and C.4 (35-45);

(4) Paragraphs D, D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.14, D.15, D.16 and D.17 (46-86);

(5) Paragraphs E, E.6, E7, and E.8 (87-98);

(6) Paragraphs F, F.3, F.4, and F.5 (99-108);

(7) Paragraphs G, G.1, G.2, G.3, G.4 (2-1 vote), and G.5 (109-123).

The Hearing Committee further concluded that the following Factual Allegations should not be sustained:

(1) Paragraph B.1;

(2) Paragraphs B.10, C.1, C.5, D.12, D.13, E.1, E.2, E.3, E.4, E.5, F.1, F.2, H and H.1 (withdrawn by Petitioner).

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each specification:

Sixth Specification: (Paragraphs G and G.5);

Eight Specification: (Paragraphs B, B.2, B.3, B.4, B.5, B.6 and B.7);

Ninth Specification: (Paragraphs C, C.2 and C.3);

Tenth Specification: (Paragraphs D, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10 D.11, D.14, and D.15:

Eleventh Specification: (paragraphs E, E.6 and E.7);

Twelfth Specification: (Paragraphs F, F.3, and F.4);

Fifteenth Specification: (Paragraphs B, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, C, C.2, C.3,

D, D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8 D.9, D.10, D.11, D.14, D.15, E, E.6, E.7, F, F. 3, F.4, G, G.1, G.2, G.3, and G.5);

Sixteenth Specification: (Paragraphs B, B.2, B.3, B.4, B.5, B.6, B.7, B.8 B.9, B.11, B.12, C, C.2, C.3, D, D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.14, D.15, E, E.6, E.7, F, F.3, F.4, G, G.1, G.2, G.3, and G.5);

Seventeenth Specification: (Paragraph A);

Eighteenth Specification: (Paragraph A), and

Nineteenth Specification: (Paragraphs B and B.13).

The Hearing Committee further concluded that the following Specifications should not be sustained:

First Specification;

Second Specification;

Third Specification;

Fourth Specification;

Fifth Specification;

Seventh Specification (Withdrawn by Petitioner);

Thirteenth Specification, and

Fourteenth Specification (Withdrawn by Petitioner).

DISCUSSION

Respondent is charged with professional misconduct within the meaning of Section 6509 of the Education Law. More specifically, Respondent is charged with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, obtaining a medical license fraudulently and practicing the profession fraudulently. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum dated September 19, 1988, prepared by Peter J. Millock, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct under the New York Education Law", sets forth, inter alia, suggested definitions for these violations (The Education Law does not set forth definitions of the various types of professional misconduct).

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

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

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

(3) Gross incompetence is an unmitigated lack of skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

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

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

All conclusions reached by the Hearing Committee were made based upon the preponderance of the evidence presented. The rationale underlying the Committee's conclusions is set forth below.

At the outset, the Hearing Committee made an evaluation of the credibility of the witnesses presented by both parties. It should be noted that, with one exception (Dr. Wortman's testimony regarding Patient K), Respondent presented no independent expert testimony

regarding the care rendered to the patients at issue. In contrast, the Department presented testimony by Robert C. Tatelbaum, M.D. a board-certified obstetrician/gynecologist and an associate professor of clinical obstetrics and gynecology at the University of Rochester Medical Center. In addition, the Department presented Jonathan M. Davis, M.D., who is board-certified in pediatrics and neonatal-perinatal medicine. Dr. Davis is also an assistant professor of pediatrics at the University of Rochester School of Medicine and Dentistry, and the Medical Director of the newborn intensive care unit at Strong Memorial Hospital.

Neither Dr. Tatelbaum nor Dr Davis have any personal stake in the outcome of these proceedings. They both presented testimony which was clear, forthright and candid. In contrast, Respondent's testimony was purely self-serving, and replete with misrepresentations and false statements. As a result, the Hearing Committee gave great weight to the opinions expressed by Drs. Tatelbaum and Davis and gave little credence to Respondent.

Similarly, Respondent essentially presented no testimony on the facts in issue, other than his own. Again, the Committee concluded that his testimony would be

given little credence, because of the numerous inconsistencies between his testimony and the records. The Committee did give credence to the testimony rendered by Mary Ellen Sclaerth, R.N., Leslie Sechrist, R.N., Mary Claeysen, R.N. and Michelle Durham, R.N. regarding the facts and circumstances surrounding the care rendered to Patients A and B.

Patients A and B

Dr. Tatelbaum's testimony was not rebutted by any independent expert witness called by Respondent. Similarly, Dr. Davis' testimony was uncontradicted. The only evidence presented by Respondent was his own testimony. His defense to the charges regarding Patient A and her infant (Patient B) consisted of denials of events recorded in the medical records, invention of events not recorded in the medical records and laying blame on the nursing staff.

Respondent claimed that it would have taken at least one hour to prepare for a cesarean section. Nurse Claeyson, Nurse Schlaerth, Nurse Sechrist, Nurse Durham and Lester J. Danehy, the President of Newark-Wayne Community Hospital, all testified that in their experience the

preparation for the cesarean section would have taken 30 to 45 minutes (61, 110, 132, 480, 1344). The bar graph of unplanned cesarean sections submitted by Respondent (Resp. Ex. I) contains no information regarding emergency or stat cesarean sections. Neither Respondent, nor Mr. Danehy, could testify that any of the depicted procedures were emergencies.

Respondent testified that after the fetal scalp pH was obtained, he instructed the nurses to prepare for a full resuscitation (2067). Nurse Claeyson and Nurse Sclaerth both testified that no such instruction was given and that Nurse Sclaerth began preparations for a resuscitation on her own initiative. (11/28/90, p. 100; 476-477).

Respondent feigned a lack of recollection of being shown the monitor strip at about 2:46 a.m. However, Respondent told the Medical Executive Committee at Newark-Wayne Hospital (MEC) that the monitoring strip was NOT shown to him and that after delivery the strip in question was in one piece (2115-2116). It was only after the testimony of the three nurses involved and the close review of the medical record, that he changed his story.

Nurse Sclaerth described how Respondent looked at the strip and took note of it (11/28/90, pp. 78, 99).

Respondent initially testified that the hospital protocol for pediatric consultation was in effect at the time of Patient A's delivery (2068). He subsequently modified this testimony to a belief or understanding that the protocol was in effect (2070, 2117). However, on September 24, 1990, he told the MEC that he knew the protocol was not in effect at the time of Patient A's delivery (2118, 2135).

Respondent claimed that he believed the nursing staff at the hospital to be well-trained in the interpretation and evaluation of fetal monitoring strips and therefore he relied on them during the care and treatment of Patient A. (2120). He told the MEC that the hospital nurses were not well trained (212). In any event, Respondent was ultimately responsible to his patient.

Prior to the care and treatment of Patient A, Respondent's hospital privileges were restricted to require a consultation in high risk situations such as that presented during Patient's A's labor and delivery. (2136-2138, 2145). Respondent's unwillingness or inability to comply with these restrictions demonstrates that he will

continue to be a danger to his patients if allowed to practice in the future.

The Hearing Committee concluded, by a preponderance of the evidence, that Respondent's conduct with regard to Patient's A and B constituted negligence, but did not rise to the level of gross negligence. Hence the Committee voted not to sustain the First Specification. However, the Committee further concluded that Respondent demonstrated an unmitigated lack of skill or knowledge necessary to manage this labor and delivery rising to the level of gross incompetence. Thus the Committee voted to sustain the Eighth Specification.

Patient's E and F

Again, Respondent offered no independent expert opinion to rebut the testimony of Drs. Tatelbaum and Davis.

In the handwritten admission note, typewritten admission history and physical examination, and discharge summary, Respondent diagnosed Patient E with pregnancy induced hypertension. This rationalization of her gross mismanagement is contradicted by the medical records.

Respondent agreed that his criteria for proteinuria (2+ or 1gm in a 24 hr urine) exceeds the

standard and accepted definition of the American College of Obstetrics and Gynecology (ACOG) and Williams' Obstetrics. Under AC OG standards Patient E exhibited proteinuria. (1915-1916).

The Hearing Committee concluded that there were several key flaws in Respondent's medical management of Patients E and F. Respondent failed to recognize and appropriately treat the patient's developing septic shock. He further failed to take appropriate steps to deliver the child, and failed to call a pediatrician to attend the child. Using the definitions set forth above, the Committee further concluded that Respondent's conduct constituted gross incompetence (Tenth Specification). The Committee again concluded that Respondent was also negligent, but that his negligence did not demonstrate the disregard of the consequences and the indifference to the rights of others, necessary to support a finding of gross negligence. Hence, the Third Specification was not sustained.

Patient K

Morris Wortman, M.D. was called as a witness by Respondent. He agreed with Dr. Tatelbaum that when surgery

is contemplated, patients should be specifically questioned regarding previous complications (1122). Further, he agreed that Patient K's post-operative condition required Respondent's personal attendance, examination and evaluation. (1102, 1107-1108, 1123).

Dr. Wortman's testimony regarding the appropriateness of elective surgery and the removal of the falope rings was based on a strained fact pattern not supported by, and contradicted by, the record. There is no notation of a consultation between Respondent and the anesthesiologist. Dr. Gelband's handwritten pre-anesthesia note makes no mention of any previous complication and classifies Patient K as ASA risk level I. Respondent's operative report did not specify the location of the hydrosalpinx as around the falope rings, nor did his testimony. The absence of a pathology finding of hydrosalpinx contradicts the operative report.

Respondent's testimony regarding Patient K demonstrates beyond doubt the complete absence of credibility to be accorded his statements regarding other patients and issues in this hearing. Respondent testified that he had unsuccessfully sought the patient's prior records several weeks before surgery. This statement is

also contained in the operative report. However, the patient's office record (Pet. Ex. #33) documents that the records were not requested until the day before surgery.

Respondent also testified that the patient's pain resolved following the removal of the falope rings. (1765-1766). The records clearly show, however, that the pain did not disappear, and that Respondent eventually performed a hysterectomy on Patient K. His false statements regarding the instant surgery in the letter to Dr. McCormick (Pet. Ex. # 32) and the records of the later procedure evidence knowledge of his inappropriate surgical conduct, as well as basic dishonesty.

In summary, Respondent took a slip-shod history, rushed the patient to surgery without proper evaluation, subjected her to unnecessary risks for an elective procedure, and then failed to appropriately attend the patient during a post-operative complication. He compounded this mismanagement with abject professional dishonesty in later medical records and his testimony before this Committee.

The Hearing Committee concluded, by a preponderance of the evidence, that Respondent's management of Patient K's medical care warrants a finding of gross

negligence (Sixth Specification). His failure to appropriately attend the patient during the post-operative period demonstrated a complete disregard for the possible consequences and an indifference to the rights of the Patient.

Conversely, in this instance the Committee further concluded that Respondent's conduct demonstrated incompetence, but not the unmitigated lack of skill or knowledge necessary for a finding of gross incompetence. Hence, the Thirteenth Specification was not sustained.

Patients C and D, G and H, I and J

The charges arising out of the medical care rendered to these three sets of patients relate to the use of vacuum extraction in mid-pelvic deliveries.

John Wood, M.D., D.O. was called as a witness by Respondent. Dr. Wood developed the type of soft-cup vacuum extraction device used by Respondent in each of the three deliveries. However, Dr. Wood's testimony was somewhat less than candid and forthcoming. He did not review any of the records regarding the vacuum extractor patients and was unable to express an opinion regarding to the acceptability of their care and treatment. In the only

journal article ever published by Dr. Wood, he recommended that total application time not be allowed to exceed fifteen minutes. In the only study he has ever done, he found an average of three minutes total application time for multiparas and seven minutes for primiparas. Despite his initial claim that the averages were determined based on easy outlet deliveries, he later admitted that the test group included some high station deliveries and majority of midstation deliveries. (1232-1235). Importantly, Dr. Wood testified that elective midpelvic vacuum extractions are inappropriate.

The Hearing Committee gave credence to the testimony presented by Dr. Tatelbaum on behalf of the Department. The Committee concluded that in each of the three deliveries at issue, Respondent inappropriately used the vacuum extractor for mid-pelvic deliveries when not warranted by the circumstances. Further, he used excessive numbers of traction pulls. Respondent's use of the vacuum extractor in these deliveries caused or contributed to the severe injury or deaths of three infants (Patients D, H and J).

The Hearing Committee further concluded that Respondent's conduct in these three instances demonstrated

the unmitigated lack of skill or knowledge necessary to sustain allegations of gross incompetence. (Ninth, Eleventh and Twelfth Specifications). The committee further concluded that Respondent's failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances constituted negligence with regard to each set of patients. However, the Committee did not find the disregard of the consequences and indifference to the rights of others necessary to sustain allegations of gross negligence. Therefore, the Committee voted not to sustain the Second, Fourth and Fifth Specifications.

Negligence on More Than One Occasion; Incompetence on More than One Occasion

As was set forth more specifically above, the Hearing Committee concluded that Respondent's conduct constituted negligence with regard to Patient's A through J, and gross negligence with regard to Patient K. It is axiomatic, then, that the Committee voted to sustain the the Fifteenth Specification (Negligence on More than One Occasion). Similarly, the Committee concluded that Respondent's conduct constituted incompetence, with regard to Patient K, and gross incompetence with regard to

Patient's A- J. Therefore, the Committee also voted to sustain the Sixteenth Specification (Incompetence on More than One Occasion).

FRAUD

Respondent made a false statement to the New York State Education Department with the intent to deceive or mislead them regarding his history of previous disciplinary action in the State of North Carolina. His claim that he believed the New York authorities had knowledge was a fiction. Nowhere in the license application was the Education Department informed of his North Carolina license. Respondent qualified for a New York State license by reason of his certification by the National Board of Medical Examiners and not by reciprocity with the State of North Carolina. Respondent's claim that he did not understand the North Carolina action to be a finding of guilt of professional misconduct, unprofessional conduct or negligence is not credible. The plain language of the North Carolina Order (Pet. Ex. #1) contradicts his assertion.

The Hearing Committee concluded, by a preponderance of the evidence that Respondent obtained his

New York medical license fraudulently (Seventeenth Specification) and that he thereafter practiced the profession fraudulently (Eighteenth Specification). Respondent's false statement in the delivery note for Patient's A and B with regard to the fetal abnormalities also constituted the fraudulent practice of medicine. (Nineteenth Specification).

RECOMMENDATIONS

The Hearing Committee, pursuant to its Findings of Fact and Conclusions of Law herein, unanimously recommends that Respondent's license to practice medicine in the State of New York be revoked. This recommendation was reached after due consideration of the full spectrum of available penalties, including suspension, probation, censure and reprimand, or the imposition of civil penalties of up to $10,000 per violation.

As noted above, the Hearing Committee concluded that the deficiencies in the medical care rendered by Respondent demonstrated gross incompetence, gross negligence, incompetence and negligence. Respondent repeatedly demonstrated an unmitigated lack of the basic knowledge and understanding necessary to practice medicine,

as well as a complete disregard for the well-being of his patients. Respondent is devoid of any semblance of professional integrity and honesty. He has demonstrated over and again his propensity toward dishonesty.

Further, since his residency in North Carolina, he has repeatedly refused to adhere to the guidelines of the profession, and the protocols of the hospitals where he practices. Therefore, the Committee concluded that re-education and rehabilitation would not be appropriate.

Based on the foregoing, the Hearing Committee made the following recommendations:

1. That the Sixth, Eighth through Twelfth, and Fifteenth through Nineteenth Specifications, inclusive, be SUSTAINED;

2. That the First through Fifth, inclusive, Seventh, Thirteenth and Fourteenth Specifications NOT BE SUSTAINED, and

3. That Respondent's license to practice medicine in New York State be REVOKED.

DATED: Watertown, New York
24 JUNE, 1991

Respectfully submitted,

REDACTED

JAMES F. WRIGHT, M.D. (Chair)

Priscilla R. Leslie
Lemuel A. Rogers, Jr., M.D.

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

IN THE MATTER :

OF :

THOMAS J. BYRNE, M.D. :

COMMISSIONER'S

RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on November 28, 1990, November 29, 1990, December 5, 1990, December 12, 1990, December 13, 1990, December 20, 1990, January 3, 1991, January 8, 1991, January 9, 1991, January 22, 1991, January 31, 1991, and February 5, 1991. Respondent, Thomas J. Byrne, M.D., appeared by Thomas G. Smith, Esq. The evidence in support of the charges against the Respondent was presented by Kevin C. Roe, Esq.

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

I hereby make the following recommendation to the Board of Regents. There appears to be no issue regarding the adverse events and neonatal mortality in the cases which brought Dr. Byrne to the attention of the Board for Professional Medical Conduct. There is unanimity that the medical care was below acceptable standards, that the personal responsibility to patients by Dr. Byrne was inadequate to address pressing needs,

and that the reliability of Dr. Byrne's responses to the issues was seriously questioned. The facts were accepted by all including friendly witnesses.

The issue, then, is not whether or not Thomas J. Byrne's actions should be characterized as negligent and/or incompetent, but whether or not his license to practice medicine should be revoked. The alternative is a protracted period of remedial clinical education. Since re-training could not correct failures of professional integrity and honesty, it is my recommendation to accept the conclusion of the Hearing Committee, namely, to revoke the license to practice medicine in the State of New York. Therefore,

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be accepted; and

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
August 29, 1991

REDACTED

ALFRED GELLHORN, M.D.
Director of Medical Affairs
New York State Department of Health

REPORT OF THE
REGENTS REVIEW COMMITTEE

THOMAS J. BYRNE

CALENDAR NO. 12428

ORDER OF THE DEPUTY COMMISSIONER FOR THE PROFESSIONS OF THE STATE OF NEW YORK

THOMAS J. BYRNE

CALENDAR NO. 12428

The University of the State of New York

IN THE MATTER

OF

THOMAS J. BYRNE
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 12428

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 12428, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (November 15, 1991): That, in the matter of THOMAS J. BYRNE, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the Commissioner of Health's recommendation as to those findings be accepted;
2. The conclusions of the hearing committee as to guilt and the recommendation of the Commissioner of Health as to those conclusions be accepted;
3. Respondent is guilty, by a preponderance of the evidence, of the sixth specification - gross negligence, involving respondent's failure to personally attend and evaluate a post-operative patient; the eighth through twelfth specifications - gross incompetence, involving patient treatment provided by respondent for pregnancy and delivery; the fifteenth specification - negligence on more than one occasion, involving patient treatment provided by respondent for pregnancy and delivery; the