STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

November 26, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Gunezburger, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Amy T. Kulb, Esq.
Jacobson and Goldberg
585 Stewart Avenue
Garden City, NY 11530

George T. Colvin, D.O.
224 N. Wellwood Avenue
Lindenhurst, NY 11757

RE: In the Matter of George T. Colvin, D.O.

Dear Mr. Gunezburger, Ms. Kulb and Dr. Colvin:

Enclosed please find the Determination and Order (No. BPMC-93-195) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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

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

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

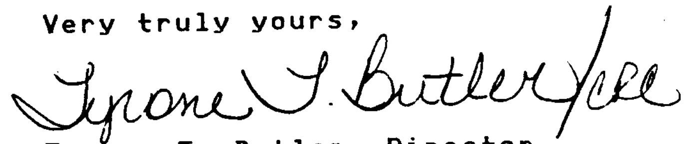
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0030

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

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

Very truly yours,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

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IN THE MATTER	: **HEARING COMMITTEE**
OF	: **DETERMINATION**
GEORGE L. COLVIN, D.O.	: **AND ORDER**

---------------------------------------x NO. BPMC-93-195

MS. CAROLYN C. SNIPE, Chairperson, **SAMUEL MADELL, M.D.**, and **ROBERT J. O'CONNOR, 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 Sections 230(10)(e) and 230(12) of the Public Health Law. **Stephen Bermas, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Recusal of Panel Member:	Jerome Zwanger, M.D., was originally designated as a member of the Hearing Committee. He attended the Sept. 21, 1993 hearing but recused himself on Sept. 23, 1993. (See Appendix A.) Robert J. O'Connor, M.D., was designated as a replacement on the Hearing Committee on Sept. 28, 1993 and attended the hearing on Oct. 7, 1993 and the deliberations on Oct. 26, 1993. (See Appendix B.)

Notice of Hearing dated:	August 19, 1993
Statement of Charges dated:	May 19, 1993
Hearing Dates:	September 21 and October 7, 1993
Deliberation Date:	October 26, 1993
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner Appeared By:	Peter J. Millock, Esq. General Counsel NYS Department of Health BY: Daniel Guenzburger
Respondent Appeared By:	Amy Kulb, Esq.

STATEMENT OF CHARGES

The Statement of Charges have been marked as Petitioner's Exhibit 1 and hereto attached as Appendix C.

CREDIBILITY OF WITNESS

The Panel found Dr. Lewis M. Rothman to be a qualified expert and further found his testimony to be credible.

The Respondent was evasive in responding to questions and changed his answers on several occasions. The Panel did not find him to be a credible witness.

FINDINGS OF FACT

1. George Colvin, D.O., the Respondent, was authorized to practice medicine in New York State on August 22, 1962, by the issuance of license number 88008 by the New York State Education Department. The Respondent is currently registered to practice medicine for the period January 1, 1993 to December 31, 1994 at 224 North Wellwood Avenue, Lindenhurst, New York 11757. (Ex. 1 and 2)

2. The Respondent obtained certification in radiology by the American Osteopathic Board of Radiology in 1965 and obtained certification in nuclear medicine by the American Board of Nuclear Medicine in 1971. He practiced radiology in a variety of institutional settings in New York and New Jersey from 1965 to 1979. In 1977 he commenced the private practice of radiology. The Respondent also conducts a family practice. (T. 103-108, Ex. A)

3. The Respondent evaluated radiographs for Patients A through E between July 12, 1989 and November 10, 1990. The radiographs for Patients A through E were taken and produced in the office of a general practitioner named Dr. Kurk located in Far Rockaway, New York. Since 1977 the Respondent has evaluated 10 to 15 x-rays a week produced in this office. (T. 154,214)

4. During the course of the hearing the Respondent gave conflicting testimony about his role in managing the production of x-rays in Dr. Kurk's office. On the first hearing day, Respondent testified that Dr.Kurk had "an x-ray set up in his office with a technician and equipment", and that Respondent's involvement was limited to reading and reporting on x-rays produced by Dr. Kurk's equipment and employee. (T. 112)

5. Contrary to Respondent's assertion on the first hearing day, Respondent subsequently revealed that he employed the radiologic technician who produced the x-rays for Patients A through E, and that he billed Patients A through E for both the production and the interpretation of the x-rays. (T. 155, 321-322)

6. Respondent testified that he was aware of continuing problems with the x-rays produced in Dr. Kurk's office. He initially testified that between 5 and 7 per cent of the x-rays from Dr. Kurk's office were substandard, but only zero to one-half of one per cent of the x-rays produced in his primary office in Lindenhurst were substandard. (T. 158) He later agreed that a larger number of the films were taken improperly. (T. 352) Respondent testified that some of the problems with the x-rays were the result of faulty equipment. For example, he conceded that the radiographs for Patients A through E indicate that

the 8 by 10 centimeter cassette screen was worn out, but that the Respondent did not change the screen until he was served with the charges in this case. (T. 162, 221) Respondent also acknowledged that some of the problems with the x-rays were the result of poor performance by the technician (T.219), and the lack of proper supervision by Respondent of the technician. (T. 344)

7. The radiologist bears the responsibility for ensuring that the films are of diagnostic quality so that when he renders his opinion, it is as accurate and complete as possible. (T. 19-23, 75) The radiologist has to assume total responsibility for the quality of the images, their appropriateness and their interpretation. (T. 20-26,84) The radiologist must examine the film completely and go beyond the answer to the clinical question. (T. 13-25, 85)

8. The films involved in these charges demonstrate a pattern of neglect with respect to labelling, positioning, processing and exposure techniques. (T. 11-15, 76)

9. When there is a pattern of poor quality films, the radiologist shall either refuse to interpret or fix the problem. (T. 17-19, 93)

10. When a radiologist elects, or feels constrained by the

circumstances, to render a report on a sub-optional film, he should so indicate so that the referring physician will know that the evaluation has been incomplete, and he can request additional film if he feels it is necessary. (T. 1-5, 93)

11. On or about July 12, 1989, the Respondent interpreted two radiographs of Patient A's left scapula that had been taken and produced by Respondent's technician at Dr. Kurk's office. (Ex. 5A and B, T. 23)

12. The radiographs of the left scapula failed to meet medically accepted standards in that the lateral view of the left scapula was so light and underexposed that it failed to reveal any significant detail (T. 26), and the antero-posterior view of the left scapula was underexposed and had extensive processing artifact. (T.27)

13. The radiographs of the left scapula also failed to meet medically accepted standards because they lacked appropriate patient identifying information and the date of the examination. Radiographs should be labelled with a patient name and/or patient identification number and the date of the examination. The purpose of placing patient identifying information on each x-ray is to ensure the radiologist that he is looking at the film of a specific patient. The purpose of dating x-rays is to ensure that the radiologist knows the

proper chronological sequence in which the x-rays were taken. (T. 27-28, Ex. 5A and 5B)

14. If Respondent was absolutely certain that the x-rays of the scapula were of Patient A, Respondent should have had the radiographs appropriately labelled before placing them in storage. (T. 29)

15. Respondent's diagnostic impression was that Patient A's left scapula was in normal limits. The Respondent found no evidence of fracture or dislocation and that the joint space was preserved. (Ex. 6)

16. Since the x-rays of the left scapula were of extremely poor quality and the x-rays were not properly labelled, the Respondent deviated from medically accepted standards by basing his diagnosis on the x-rays. (T. 29)

17. Respondent admitted that the x-rays were of unacceptable quality. He testified that he asked to have the x-rays repeated but that the patient had refused. (T. 116-117)

18. Respondent did not note in his report to the referring physician or in any medical record that he had asked to have the x-rays repeated. In response to questioning by a Hearing Panel member, the Respondent conceded that he should have

noted in his report to the referring physician that the x-rays were substandard and should be repeated. (Ex. 6, T. 175-176). Respondent testified that he was not in the habit of noting such information. (T. 175)

19. In spite of the reservations Respondent had concerning the quality of the x-rays, he stated that he could still make a diagnosis because he was able to see the shoulder joint in the x-rays and because his technician reported that when Patient A had the x-rays taken he was able to remove his shirt and undershirt without assistance, lie on the x-ray table without any trouble, and had no discoloration on his back. (T.117)

20. Respondent testified that he relied on the clinical information reported by the technician in diagnosing that Patient A's scapula was not fractured. Respondent conceded that because of the problems with the radiographs for Patient A, he was not able to determine if there was any underlying pathology in the scapula. (T. 172-174)

21. Respondent should have had the x-rays repeated. Respondent deviated from medically accepted standards in making a diagnosis based on inadequate x-rays (T. 29), and in making a radiological determination based upon clinical information, especially when it was supplied by a non-physician.

22. On or about July 12, 1989 and November 9, 1989, the Respondent performed and evaluated sonograms of the skull. Respondent deviated from accepted medical standards by evaluating Patient A's skull with ultrasound. (T. 32) The ultrasound technique Respondent employed, B mode ultrasonography, is a very indirect way of evaluating whether a patient has an intracranial mass. (T. 31, 181) The test, which had limited diagnostic value in the 60's and early 70's, measures whether there has been a shift of tissue in the skull. However, by 1989, ultrasonography of the skull had been an out-of-date technique for 15 years and had no practical diagnostic value. (T.32)

23. Respondent conceded that he would have ordered an MRI if Patient A had been his patient and that he performed ultrasonography because the primary care physician, Dr. Kurk, requested the test. (T. 185)

24. Respondent's claim that ultrasonography of the skull was an acceptable diagnostic technique in 1989 is not credible. The only medical literature Respondent cited to support the use of ultrasonography for evaluations of a skull is a book he referred to by an author named King published in 1974. (T. 127) Respondent conceded that he knew of no more recent literature. He stated that he performed the ultrasonography because he and Dr. Kurk were old-timers and were used to doing

them. Respondent's justification for that was contradictory and inconsistent with his testimony that he engaged in extensive continuing medical education in order to remain current. (T. 183-5)

PATIENT B

25. On or about March 23, 1990, the Respondent interpreted antero-posterior, lateral neutral, oblique and two lateral flexion projections of the cervical spine. He did not examine a right posterior oblique projection. Respondent concluded that Patient B's spine was normal. (Ex. 8,9A-E)

26. Respondent deviated from medically acceptable standards by basing his diagnosis on cervical spine radiographs of unacceptable quality. The oblique projection had extensive processing artifact in both upper and lower portions of the radiograph. The lateral neutral and lateral flexion projections had artifact in the upper portion of the radiograph. (T. 40)

27. The Respondent deviated from accepted medical standards by not examining both a left and a right oblique projection. the oblique view permits visualization of the neural foramina more clearly than other projections. Since there are neural foramina on both sides of the body, the accepted medical

standard is to evaluate both right and left oblique projections. (T 41-42)

28. Respondent's contention that it is acceptable to only evaluate an oblique projection on the side of the body in which the patient experiences pain is not credible. Although Respondent claimed that his position had support in the medical literature, the information supplied to the Panel by Respondent's attorney referred to the management of an acute cervical spine injury where it is known that it is dangerous to manipulate the neck. Patient B was ambulatory and exhibited no instability of the neck. (T. 165; Appendix D attached hereto)

29. Finally, in response to questioning by a Hearing Panel member, Respondent conceded that he had obtained the wrong single oblique view to evaluate the patient. Since Patient B had pain on the <u>left</u> side, and the Respondent admitted that he examined the <u>right</u> neural foramina, Respondent's practice did not comport with his own theory about examining the neural foramina on the side of the body where the patient experiences pain. (T. 257, 282-283)

30. For the reasons previously set forth in Finding 24, the Respondent deviated from medically accepted standards by

evaluating Patient B's skull by ultrasound on March 28, 1990. (Ex. 11, T. 47-48)

PATIENT D

31. On or about June 26, 1990, the Respondent interpreted an antero-posterior, lateral, and oblique view of the lumbar spine. (Ex. 19A-19C) The Respondent concluded that Patient D's lumbar spine was normal. (Ex. 18)

32. The Respondent deviated from medically accepted standards by failing to accurately note the date of the examination of the lumbar spine in his report and/or failing to correct the date of the examination on the lumbar spine radiographs. The date of the examination on the lumbar spine was June 27, 1990, and the date of the examination on Respondent's report was June 26,1990. The discrepancy between the dates on the x-rays and on the report creates a significant medical and legal concern because of the uncertainty as to whether the report actually refers to the x-rays. (T. 29, 64)

PATIENT E

33. On or about March 30, 1990, the Respondent interpreted antero-posterior, lateral, left posterior oblique and right posterior oblique lumbar spine projections. Respondent diagnosed that

the radiographs of the lumbar spine were negative for fracture and dislocation, that the pedicles, lamina, and transverse process were intact, that spondylitic changes were present and that an IUD was seen in the uterus. (Ex. 22, 23A-C)

34. The Respondent deviated from medically accepted standards by basing his diagnosis on lumbar spine radiographs of unacceptable quality. The antero-posterior view was virtually useless for purposes of radiological evaluation because extensive processing artifact obscured a large portion of the x-ray. (T. 69-72)

35. The Respondent should have repeated the antero-posterior view of the lumbar spine series. (T. 72)

SUPERVISION OF X-RAY PRODUCTION

36. As previously set forth in Findings 3 through 6, on or about and between July 12, 1989 and November 19, 1990, the Respondent interpreted radiographs for Patients A, B, D and E that were taken and developed in Dr. Kurk's office by a radiological technician employed by Respondent. The radiographs for Patients A, B, D and E demonstrate a pattern of substandard practice in which Respondent's radiological technician improperly positioned patients for x-ray examinations, underexposed radiographs, inadequately processed

the x-ray films, and failed to properly identify the radiographs with a patient name, patient identification number, and the date of the examination. (T. 75)

37. A radiologist is responsible for supervising the production of x-rays he evaluates. Such responsibility extends to a situation where a radiologist interprets x-rays produced in another physician's office. The radiologist must ensure that the films are of appropriate diagnostic quality and that the technician takes all of the appropriate views. (T. 75, 85)

38. Respondent deviated from medically accepted standards by inadequately supervising the production of x-rays for Patients A, B, D and E. Since Respondent had evaluated all the x-rays in Dr. Kurk's office since 1977, and since Respondent employed the radiologic technician in the office during the period involving these charges, Respondent was responsible for the substandard quality of x-rays that he evaluated from Dr. Kurk's office. (T. 75-76)

CONCLUSIONS

FIRST: Respondent engaged in professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y.

Education Law Section 6530(3) (McKinney Supp. 1993). Respondent failed to exercise the care that would be exercised by a reasonably prudent licensee, as set forth in Findings of Fact Nos. 6, 8 and 11 through 38.

SECOND: Respondent engaged in professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Education Law Section 6530(5) (McKinney Supp.) Respondent lacked the skill or knowledge necessary to practice the profession of medicine, as set forth in Findings of Fact Nos. 6, 8 and 11 through 38.

THIRD: Respondent engaged in professional misconduct within the meaning of N.Y. Education Law Section 6530(32) by failing to maintain a proper record for Patient A as set forth in Findings of Fact No. 13.

FOURTH: Respondent engaged in professional misconduct within the meaning of N.Y. Education Law Section 6530(32) by failing to maintain a proper record for Patient D as set forth in Findings of Fact No. 32.

DETERMINATION

In the Determination of Penalty, the Panel was faced with the dilemma created by Respondent's simultaneous practice of two distinctly separate medical specialties. All of the charges related to Respondent's practice as a radiologist. His performance as a family practitioner was never under consideration. Nevertheless, since a license to practice medicine permits the practitioner to own and operate x-ray and ultrasonic equipment, the Panel could see no way to restrict the Respondent's ability to practice radiology (a specialty in which he has been found negligent and incompetent) without revoking his license to practice any medicine at all.

Based upon the foregoing, it is the decision of this Panel that Respondent's license be revoked and that a penalty of forty-thousand ($40,000) dollars be imposed upon the Respondent.

Carolyn C. Snipe 11/24/93
Carolyn C. Snipe
Chairperson

Samuel Madell, M.D.
Robert J. O'Connor, M.D.

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

IN THE MATTER OF GEORGE COLVIN, D.O.	STATEMENT OF CHARGES

GEORGE COLVIN, D.O., the Respondent, was authorized to practice medicine in New York State on August 22, 1962 by the issuance of license number 88008 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, 1993 to December 31, 1994 at 224 North Wellwood Avenue, Lindenhurst, New York 11757.

FACTUAL ALLEGATIONS

A. On or about July 12, 1989, the Respondent interpreted two radiographs of Patient A's left scapula at his office at 224 North Wellwood Avenue, Lindenhurst, New York. Patient A was 18 years old at the time of the examination. (The identity of Patient A and the other patients is contained in the Appendix). An unidentified employee of Respondent

took the radiographs for Patient A and the other patients at Respondent's office.

The radiographs of the left scapula were faint due to underexposure of the radiographs. Respondent concluded that the left scapula was within normal limits. In addition, the radiographs did not indicate the date of the examination, the name of the patient, nor the patient's identification number.

On or about July 12, 1989 and November 9, 1989, the Respondent performed and evaluated sonograms of the skull. The photographic stills of the sonograms were blurry and out of focus. In spite of the fact that ultrasonography is ineffective for investigating an adult skull, Respondent concluded on July 12, 1989 that Patient A's skull was normal and on November 9, 1989 he concluded that Patient A had a normal midline echo and a prominent vessel in the left frontal area.

The Respondent's conduct deviated from medically accepted standards, in that:

1. Respondent improperly based his evaluation of the left scapula on radiographs of poor technical quality, and/or failed to note in his report to the referring physician that the poor technical quality of the radiographs precluded an adequate evaluation.

2. Respondent failed to repeat the radiographs of the left scapula.

3. Respondent failed to record the date of the examination, the name of the patient, and a complete patient identification number, on the radiographs of the left scapula.

4. Respondent inappropriately evaluated the skull by ultrasound.

5. The photographic stills Respondent made of the ultrasound examinations were inadequate because of poor technical quality.

B. On or about March 23, 1990, the Respondent interpreted anteroposterior, lateral, lateral flexion, and left posterior oblique cervical spine projections for Patient B. Patient B was 50 years

old at the time of the examination. Respondent did not examine a right posterior oblique cervical spine projection. Extensive processing artifact obscured significant detail on the radiographs of the cervical spine. Respondent concluded that Patient B's cervical spine was normal.

On or about March 23, 1990, the Respondent also examined posteroanterior and lateral projections of Patient B's chest. Because Respondent's radiologic technician improperly positioned the patient for the lateral view of the chest, the projection inadequately depicted the thoracic spine. The Respondent concluded that the projections of the chest failed to disclose evidence of cardiac and pulmonary pathology.

On or about March 28, 1990, Respondent performed and evaluated a sonogram of Patient B's skull. In spite of the fact that ultrasonography is ineffective for investigating an adult skull, Respondent concluded from his ultrasound examination that Patient B's skull was normal.

The Respondent's conduct deviated from medically accepted standards, in that:

1. Respondent improperly based his evaluation of the cervical spine on radiographs of poor technical quality, and/or failed to note in his report to the referring physician that extensive processing artifact on the radiographs precluded an adequate evaluation.

2. Respondent failed to repeat the radiographs of the cervical spine.

3. Respondent failed to examine a right posterior oblique projection of the cervical spine before making a diagnosis.

4. Respondent improperly based his evaluation of the chest on a lateral chest projection that inadequately depicted the thoracic spine, and/or failed to note in his report to the referring physician that the projection inadequately depicted the thoracic spine.

5. Respondent inappropriately evaluated Patient B's skull by ultrasound.

C. On or about July 19, 1989, the Respondent interpreted two radiographs of Patient C's dorsal spine and four radiographs of the cervical spine.

The four radiographs of the cervical spine for Patient C exhibited a variety of photographic blemishes and the x-ray images appeared faint due to underexposure. The Respondent diagnosed spondylotic changes in the cervical spine and a narrowing of the C 4-5 disc space.

All four radiographs of the cervical spine and the two dorsal spine projections lacked the date the radiographs were taken. Further, the lateral dorsal spine projection lacked any information identifying the patient. The only information that identified the patient on the anteroposterior projection of the dorsal spine was an incomplete patient identification number. Although the cervical spine projections had patient identification numbers, the radiographs did not indicate the name of the patient.

The Respondent's conduct deviated from medically accepted standards in that:

1. Respondent improperly based his evaluation of the cervical spine on radiographs of poor technical quality, and/or failed to note in his report to the referring physician that the poor technical quality of the radiographs precluded an adequate evaluation.

2. Respondent failed to repeat the radiographs of the cervical spine.

3. Respondent failed to record the date of the x-ray examination, the name of the patient, and/or the complete patient identification number, on radiographs that lacked such information.

D. On or about and between April 30, 1990 and September 12, 1990, the Respondent interpreted radiographs of Patient D's chest, lumbar spine, thoracic spine, and left knee. The patient identification number on the x-rays of the radiographic examinations did not correspond to the identification number on Respondent's reports of the examinations and the radiographs did not indicate the name of the patient.

On or about April 30, 1990, the Respondent examined a lateral extension, lateral flexion, anteroposterior, and right posterior oblique projections of the cervical spine. He did not examine a left posterior oblique projection. Extensive processing artifact obscured significant detail on the lateral extension and lateral flexion projections. Respondent concluded that Patient D's cervical spine was normal.

On or about April 30, 1990, Respondent also interpreted two projections of Patient D's chest. Because Respondent's radiologic technician improperly positioned the patient for the lateral view of the chest, the projection did not depict the anterior portion of the chest. Respondent concluded that Patient D's chest was normal.

Further, on or about June 26, 1990, the Respondent interpreted three radiographs of Patient D's lumbar spine. The radiographs of the lumbar spine exhibited a variety of photographic blemishes and the x-ray images appeared faint due to underexposure. Respondent concluded that Patient D's lumbar spine was normal. In spite of the fact that Respondent's report is dated June 26, 1990, the date of the radiographic examination indicated on the radiographs is June 27, 1990.

Finally, on or about September 12, 1990, the Respondent interpreted three radiographic projections of the left knee. Extensive processing artifact on the tunnel view projection obscured significant detail. Respondent concluded that Patient D's knee was normal.

The Respondent's conduct deviated from medically accepted standards, in that:

1. Respondent improperly based his evaluation of the chest on a lateral chest projection that inadequately depicted the anterior portion of the chest, and/or failed to note in his report to the referring physician that the projection inadequately depicted the anterior portion of the chest.

2. Respondent failed to repeat the lateral chest projection that he evaluated on April 30, 1990.

3. Respondent failed to examine a left posterior oblique projection before making a diagnosis of the cervical spine.

4. Respondent improperly based his April 30, 1990 evaluation of the cervical spine on radiographs of poor technical quality, and/or failed to note in his report to the referring physician that the poor technical quality of the radiographs precluded an adequate evaluation.

5. Respondent failed to repeat the lateral extension and lateral flexion projections of the cervical spine that he evaluated on April 30, 1990.

6. Respondent improperly based his June 26, 1990 evaluation of the lumbar spine on radiographs of poor technical quality, and/or failed to note in his report to the referring physician that the poor technical quality of the radiographs precluded an adequate evaluation.

7. Respondent failed to repeat radiographs of the lumbar spine that he evaluated on June 26, 1990.

8. Respondent failed to accurately note the date of the examination of the lumbar spine in his report, and/or failed to correct the date of the examination on the lumbar spine radiographs.

9. Respondent improperly based his September 12, 1990 evaluation of the left knee on a tunnel view projection of poor technical quality, and/or failed to note that the poor technical quality of the radiograph precluded an adequate evaluation.

10. Respondent failed to repeat the tunnel view projection of the left knee that he evaluated on September 12, 1990.

E. On or about March 30, 1990, the Respondent interpreted four radiographs of Patient E's lumbar spine. The lumbar spine radiographs exhibited a variety of photographic blemishes. Respondent diagnosed spondylotic changes of the lumbar spine.

Further, on or about November 19, 1990, the Respondent interpreted two chest radiographs. Both projections appeared faint due to underexposure of the radiographs. In addition, because the Respondent's radiologic technician improperly positioned the patient for the lateral view of the chest, the projection did not adequately depict the entire chest. Respondent concluded that Patient E's chest was normal.

The Respondent's conduct deviated from medically accepted standards, in that:

1. Respondent improperly based his March 30, 1990 evaluation of the lumbar spine on radiographs of poor technical quality, and/or failed to note in his report to the referring physician that the poor technical quality of the radiographs precluded an adequate evaluation.

2. Respondent failed to repeat the lumbar spine radiographs.

3. Respondent improperly based his November 19, 1990 evaluation of the chest on radiographs of poor technical quality and on a radiograph that inadequately depicted the chest, and/or he failed to note in his report to the referring physician that the problems with the quality of the radiographs precluded an adequate evaluation.

4. Respondent failed to repeat the chest projections that he evaluated on November 19, 1990.

F. As previously alleged in paragraphs A through E, on or about and between July 12, 1989 and November 19, 1990 the Respondent interpreted radiographs that were taken by a radiologic technician employed by the Respondent. The radiographs for Patients A through E indicate that Respondent's radiologic technician improperly positioned patients for x-ray examinations, underexposed radiographs, inadequately processed the x-ray films, and failed to properly identify the radiographs with a patient name, patient identification number, and the date of the examination.

The Respondent's conduct deviated from medically accepted standards, in that:

1. Respondent inadequately supervised the production of radiographs for Patient's A through E.

SPECIFICATIONS OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993), in that Petitioner charges that Respondent committed two or more of the following:

1. The facts in Paragraphs A and A1, A2, A3, A4, A5; B and B1, B2, B3, B4, B5; C and C1, C2, C3; D and D1, D2, D3, D4, D5, D6, D7, D8, D9, D10; E and E1, E2, E3, E4; and/or F and F1.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1993), in that the Petitioner charges that Respondent committed two or more of the following:

2. The facts in Paragraphs A and A1, A2, A3, A4, A5; B and B1, B2, B3, B4, B5; C and C1, C2, C3; D and D1, D2, D3, D4, D5, D6, D7, D8, D9, D10; E and E1, E2, E3, E4; and/or F and F1.

THIRD THROUGH SIXTH SPECIFICATIONS

FAILING TO MAINTAIN AN ADEQUATE RECORD

Respondent is charged with professional misconduct pursuant to N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1993), by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

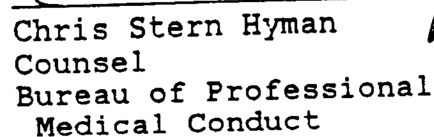
3. The facts in Paragraphs A and A3.

4. The facts in Paragraphs A and A5.

5. The facts in Paragraphs C and C3.

6. The facts in Paragraphs D and D8.

DATED: New York, New York
May 19, 1993



Chris Stern Hyman
Counsel
Bureau of Professional
Medical Conduct

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

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IN THE MATTER	: **AFFIRMATION**
OF	: **OF MEMBER OF THE**
GEORGE L. COLVIN, D.O.	: **HEARING COMMITTEE**

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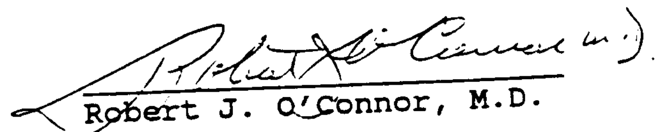
ROBERT J. O'CONNOR, M.D., a duly appointed member of The State Board for Professional Medical Conduct and of the Hearing Committee thereof designed to hear the MATTER OF GEORGE L. COLVIN, D.O., hereby affirms that he was not present at the hearing session conducted on the 21st day of September, 1993 inasmuch as he was not designated as a Hearing Committe member until September 28, 1993. He further affirms that he has read and considered the transcript of proceedings of, and the evidence received at such hearing day prior to deliberations of the Hearing Committee on the 26th day of October, 1993.

DATED: New York, New York
November 5 , 1993



Robert J. O'Connor, M.D.