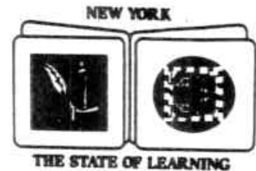

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

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

October 31, 1990

Fred G. Constant, Physician
REDACTED

Re: License No. 123445

Dear Dr. Constant:

Enclosed please find Commissioner's Order No. 11066. This Order and any penalty contained therein 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 or a surrender 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.

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
Enclosures

CERTIFIED MAIL- RRR
cc:

RECEIVED
OCT 31 1990
90805 #10897
Office of Professional Medical Conduct

REPORT OF THE
REGENTS REVIEW COMMITTEE

FRED G. CONSTANT

CALENDAR NO. 11066

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

FRED G. CONSTANT

No. 11066

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

REPORT OF THE REGENTS REVIEW COMMITTEE

FRED G. CONSTANT, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A". Paragraphs D.2. and E.3. were withdrawn by petitioner.

Between July 26, 1989 and October 5, 1989 a hearing was held in four sessions before a hearing committee of the State Board for Professional Medical Conduct. The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B". On April 23, 1990 the hearing committee found and concluded that respondent was guilty of each of the specifications, and

recommended that respondent's license to practice in the State of New York be revoked.

On June 1, 1990 the Commissioner of Health recommended to the Board of Regents that the findings, conclusions, and recommendations of the hearing committee be accepted in full. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On August 10, 1990, respondent appeared before us and was not represented by an attorney. Roy Nemerson, Esq., presented oral argument on behalf of the Department of Health.

We have considered the record in this matter as transferred by the Commissioner of Health.

Petitioner's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that the Commissioner of Health has already indicated petitioner's recommended penalty. At oral argument, respondent told us that he recommends that he should be permitted to practice medicine in the State of New York.

Respondent has practiced since 1985 while his ability to practice was impaired by mental disability. He has committed negligence on more than one occasion and incompetence on more than one occasion with respect to five patients. Also, he committed unprofessional conduct with respect to these same five patients. We agree with the hearing committee that the care rendered by respondent to Patients A through E "was woefully inadequate".

Hearing committee report page 17. Furthermore, respondent's guilt of the first specification is not limited to the time commencing on August 28, 1986 when he treated these five patients.

The hearing committee, on page fifteen line one of its report, refers to paragraph B.2. It is obvious that this reference was meant to be B.3. rather than B.2. Accordingly, we deem that reference to read "B.3."

The first specification appears to refer to eight separate charges under Paragraph A. The first specification is drafted in the same manner as the second and third specifications which refer to separate acts of professional misconduct alleged for each paragraph charged. Neither the hearing committee report nor the Commissioner of Health recommendation attempt to clarify whether the conclusions of guilt as to the first specification relate to eight separate specific acts or to one overall charge.

Respondent may not be, and is not recommended by us to be, guilty of practicing the profession while impaired by mental disability based on the fact that he was a student before he was licensed. See paragraph A.1. Similarly, such guilt cannot properly be based on the facts that respondent was hospitalized at times when he was not practicing the profession. See paragraphs A.3., A.4., A.5., and A.8. Likewise, respondent cannot properly be guilty two times based on his November 1988 behavior and admission. Compare paragraph A.7. and A.8.

In our unanimous opinion, respondent is guilty of the first

specification based on his practicing since 1985 while impaired by mental disability. See hearing committee finding 19, conclusion in full paragraph 2 on page 16, and recommendation in full paragraph 2 on page 19. The eight paragraphs of the first specification of the charges are interpreted by us to mean and are hereby deemed to refer to one overall charge. The various paragraphs charged in the first specification and findings 1 through 19 of the hearing committee report all support and explain respondent's guilt as to this one charge relating to the period "since 1985".

We do not accept the hearing committee's findings of fact 26 and 42 because those findings are beyond the scope of the charges. Also we do not accept the hearing committee's findings of fact 29 and 36 because finding 29 is inadequate to resolve the issues whether patient C, separate from that patient's record, had Ventricular Septal Defect and whether that diagnosis was not medically justified; and finding of fact 36 is inadequate to resolve the issue whether respondent failed to schedule a follow-up visit.

Lastly, the fourth through eighth specifications regarding unprofessional conduct due to record-keeping each relate to respondent's chart for each patient as to complaints, personal, medical and family histories, examinations, diagnoses, interval notes and treatment plans. The hearing committee sustained all the allegations in these paragraphs B.3., C.3., E.4., and F.2., except

for the"deletion" of the words "non-existent" and "interval notes." However, the hearing committee's findings of fact and discussion for each patient do not cover each of the allegations which are sustained. Accordingly, respondent is guilty of the fourth through eighth specifications to the extent found and discussed by the hearing committee.

We unanimously recommend the following to the Board of Regents:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted, except findings of fact 26, 29, 36, and 42 not be accepted;
2. The conclusions of the hearing committee and Commissioner of Health be modified;
3. Respondent is guilty, by a preponderance of the evidence, of the first specification based upon the overall charge as to practicing since 1985, guilty to the extent indicated in the hearing committee's findings and discussion of the fourth through eighth specifications, guilty to the extent indicated in the hearing committee's findings and discussion, except for paragraph D.1. and E.2., of the second and third specifications, and not guilty of the remaining charges and specifications including paragraphs D.1. and E.2.; and
4. The measure of discipline recommended by the hearing

committee and Commissioner of Health be accepted and 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, as aforesaid.

Respectfully submitted,

JORGE L. BATISTA

HERBERT BERNETTE EVANS

GEORGE POSTEL

REDACTED

Chairperson

Dated: 9/17/90

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

IN THE MATTER OF FRED G. CONSTANT, M.D.	: STATEMENT OF CHARGES

FRED G. CONSTANT, M.D., the Respondent, was authorized to practice medicine in New York State on March 26, 1975 by the issuance of license number 123445 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, 1990.

FACTUAL ALLEGATIONS

A. Between on or about 1972 and the present, Respondent has suffered from Schizophrenia or other serious mental illness. The course of this illness has included the following episodes:

EXHIBIT "A"

1. In 1972-1973, Respondent experienced hallucinations while a student at Jefferson Medical College.

2. In 1977, while a resident at Georgetown Veterans Administration Hospital, Respondent suffered psychotic episodes.

3. In December, 1977, Respondent was hospitalized for his mental illness at Howard University Hospital.

4. In April, 1978, Respondent's mental illness caused him to be hospitalized for one month at Prince George County General Hospital. In 1979 he was again hospitalized at Prince George for one month for this condition. His symptoms included hallucinations. He was treated with anti-psychotic medication.

5. On September 17, 1978, Respondent was admitted, on an emergency basis, to Creedmore Psychiatric Center, Queens Village, N.Y. He complained of auditory command hallucinations and persecutory fears. Respondent had stopped taking his prescribed medication. He was found to be a

danger to himself and others. The diagnosis was Paranoid Schizophrenia. Respondent was discharged on September 26, 1978 with a guarded prognosis.

6. Between October 1983 and the present Respondent has been under the care of a private psychiatrist. The psychiatrist diagnosed Respondent's condition as SchizoAffective Schizophrenia. During this period Respondent experienced intermittent hallucinations and other symptoms of schizophrenia.

7. Since 1985, Respondent has worked as a general practitioner at two Medicaid clinics in Brooklyn, New York. In November, 1988, a fellow employee noted a deterioration in Respondent's behavior and notified Respondent's family.

8. On November 19, 1988, Respondent was admitted, on an emergency basis, to Creedmore Psychiatric Center. One month prior, Respondent had stopped taking his psychotropic medications. Over this period Respondent's behavior deteriorated and was characterized by severe

withdrawal, inappropriate laughter, unfounded fear of being poisoned by food, throwing of food and inattention to personal hygiene. During the early days of his hospital stay Respondent refused to take his antipsychotic medications by mouth; as a result, the medication had to be administered intramuscularly. His diagnosis was chronic Schizophrenia, disorganized type. Respondent was discharged on December 14, 1988 with a guarded prognosis.

B. Between on or about December 12, 1986 and on or about July 1, 1988, Respondent treated Patient A for hypertension at Liberty Medical Group, 787 Liberty Avenue, Brooklyn, New York, 11208 (Liberty).

1. Respondent failed to properly manage Patient A's long-term hypertension. Inappropriate medications were prescribed; medications were not changed when medically indicated; and follow-up visits were not scheduled with sufficient frequency to properly evaluate the effectiveness of prescribed medications.

2. In February, 1987, Patient A had a positive IGM hepatitis antibody test. Respondent failed to note this result; he also failed to take necessary follow-up action, including repeating the test and scheduling follow-up visits.

3. The chart maintained by Respondent for Patient A contains inadequate or non-existent patient complaints, personal, medical and family histories, examinations, diagnoses, interval notes and treatment plans.

C. On or about October 22, 1986, Respondent treated Patient B for chest pain at Liberty Medical Group.

1. Respondent diagnosed angina pectoris in this eleven year old patient without medical justification.

2. Respondent prescribed Nitroglycerine to Patient B which not medically indicated.

3. The chart maintained by Respondent for Patient B contains inadequate or non-existent patient complaints, personal, medical and family

histories, examinations, diagnoses, interval notes and treatment plans.

D. On or about August 28, 1986, Respondent treated Patient C, a six year old, for a bruised left ankle at Liberty Medical Group.

1. Respondent made a diagnosis of Ventricular Septal Defect which was not medically justified.

withdrawn by Petitioner 7/26/89

~~2. Patient C had a microcytic anemia. This condition required a blood smear which Respondent failed to obtain.~~

3. The chart maintained by Respondent for Patient C contains inadequate or non-existent patient complaints, personal, medical and family histories, examinations, diagnoses, interval notes and treatment plans.

E. On or about June 9, 1987, Respondent treated Patient D, a ten year old, for headaches at Liberty.

1. Respondent failed to perform a fundascopic examination.

2. Respondent failed to schedule a follow-up visit in order to monitor the patient's headaches.

Withdrawn by Petitioner 9/13/89

3. ~~The Patient's thyroid function test was abnormal. Respondent failed to note this abnormal result, and failed to order the test repeated.~~

4. The chart maintained by Respondent for Patient D contains inadequate or non-existent patient complaints, personal, medical and family histories, examinations, diagnoses, interval notes and treatment plans.

F. On or about January 20, 1987, Respondent treated Patient E for pelvic pain at Liberty.

1. Respondent notes an ovarian mass in Patient E's medical history. Given the current complaint of pelvic pain, either a pelvic exam should have been performed or the Patient should have

been referred to a gynecologist. Respondent did neither.

2. The chart maintained by Respondent for Patient E contains inadequate or non-existent patient complaints, personal, medical and family histories, examinations, diagnoses, interval notes and treatment plans.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WHILE IMPAIRED

Respondent is charged with practicing the profession while the ability to practice is impaired by mental disability, under N.Y. Educ. Law Section 6509(3)(McKinney 1985), in that Petitioner charges:

1. The facts in paragraphs A and A.1 - A.8.

SECOND SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges Respondent with having committed at least two of the following:

2. The facts in paragraphs B and B.1 - B.3, C and C.1 - C.3, D and D.1 - D.3, E and E.1 - E.4, and F and/or F.1 and F.2.

THIRD SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6509(2)(McKinney 1985) in that Petitioner charges Respondent with having committed at least two of the following:

3. The facts in paragraphs B and B.1 - B.3 C and C.1 - C.3, D and D.1 - D.3, E and E.1 - E.4, and F and/or F.1 and F.2.

FOURTH THROUGH EIGHTH SPECIFICATIONS

COMMITTING UNPROFESSIONAL CONDUCT AS DEFINED BY THE BOARD OF REGENTS

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6509(9)(McKinney 1985), in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient within the meaning of 8 N.Y.C.R.R. 29.2(a)(3)(1981), in that Petitioner charges:

4. The facts in paragraph B.3
5. The facts in paragraph C.3
6. The facts in paragraph D.3
7. The facts in paragraph E.4
8. The facts in paragraph F.2

DATED: New York, New York
May 30, 1989

REDACTED

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct

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

IN THE MATTER OF FRED G. CONSTANT, M.D.	REPORT OF THE HEARING COMMITTEE

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

CHARLOTTE S. BUCHANAN, ESQ., (Chair), PEARL D. FOSTER, M.D., and DONNA B. O'HARE, M.D., duly designated members of the State Board of Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Larry G. Storch, Esq., served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Date of Service of Notice of Hearing and Statement of Charges against Respondent:	June 21, 1989
Answer to Statement of Charges:	None
Pre-hearing Conference:	July 19, 1989

EXHIBIT "B"

Dates and Places of Hearings:	July 26, 1989 8 East 40th Street New York, New York September 13, 1989 1515 Broadway New York, New York October 4, 1989 8 East 40th Street New York, New York October 5, 1989 8 East 40th Street New York, New York
Intra-Hearing Conferences:	None
Adjournments:	None
Received Petitioner's Proposed Findings of Fact and Conclusions of Law:	November 9, 1989
Received Respondent's Closing Argument:	October 26, 1989
Final Deliberations:	November 15, 1989
Department of Health appeared by:	Terrence Sheehan, Esq. Associate Counsel
Respondent appeared by:	Pro Se
Hearing Committee Absences:	None
Witnesses for Department of Health	Elizabeth Muss, M.D. Frederic L. Gannon, M.D.
Witnesses for Respondent:	Peter H. Gruen, M.D. Fred G. Constant, M.D.

STATEMENT OF CASE

The Department has charged Respondent with practicing the profession while his ability to practice was impaired by mental disability. Additionally, Respondent has been charged with practicing with negligence and incompetence on more than one occasion, with regard to the care and treatment of five patients. Respondent has also been charged with the failure to maintain accurate medical records.

Respondent appeared pro se throughout these proceedings. He claimed that he desired legal counsel, but was unable to afford it. Although there is no statutory right to have counsel provided to respondents by the State in disciplinary hearings, the Administrative Officer and counsel for petitioner made extensive efforts to uncover sources of pro bono representation for Respondent. These efforts were, however, unsuccessful. (See, Tr:, pp. 5-8; Pre-Hearing Conference Transcript at pp. 4-8; 16-17).

Pursuant to its authority under Public Health Law Section 230(7), and with the consent of Respondent, the Hearing Committee ordered an independent psychiatric evaluation of

Respondent. This step was taken to address due process concerns regarding Respondent's ability to defend himself in a hearing. The examination was performed by Colter Rule, M.D. His report is incorporated into the record of this hearing as Administrative Law Judge Exhibit #1. Based on Dr. Colter's evaluation, the Hearing Committee concluded that Respondent could be afforded due process through pro se representation.

FINDINGS OF FACT

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

1. Respondent attended Jefferson Medical College during the period 1969-1973. During the period 1972-1973, Respondent experienced hallucinations. (Petitioner's Exhibit #12).

2. During 1977, while a resident at Georgetown University, Respondent suffered psychotic episodes. He was

hospitalized at Howard University Hospital on or about December, 1977. (Petitioner's Exhibit #12).

3. Respondent was subsequently hospitalized for one month for psychiatric treatment at Prince Georges County General Hospital on or about April, 1978, and again in 1979. (Petitioner's Exhibit #12).

4. During the period 1978-1979, Respondent was also treated by a private psychiatrist, who prescribed Haldol, an anti-psychotic medication. (Petitioner's Exhibit #9).

5. On or about September 17, 1978, Respondent was admitted, on an emergency basis, to Creedmoor Psychiatric Center, Queens Village Unit. Respondent had discontinued taking his medication, and was exhibiting bizarre behavior, responding to auditory command hallucinations, and expressing persecutory fears. Respondent was discharged on September 26, 1978, with a diagnosis of schizophrenia-paranoid type. His prognosis was guarded, due to his tendency to stop taking his medication, and a lack of insight regarding his illness. (Petitioner's Exhibit #9).

6. Commencing on or about October 21, 1983, and continuing through the course of this hearing, Respondent was under the care of Peter H. Gruen, M.D. Dr. Gruen is a board

certified psychiatrist, and maintains a private practice in Manhattan. (213-216; Respondent's Exhibit A).

7. Dr. Gruen's working diagnosis for Respondent was a schizo-affective disorder. This was defined as a disorder of mood often characterized by depression, sadness, blueness, lack of drive, or the lack of the capacity to enjoy one's life. (276-285).

8. On repeated occasions, Dr. Constant was diagnosed as a schizophrenic. (163-164; 285-288).

9. Dr. Gruen's treatment of Respondent primarily followed a medical model. He treated Respondent with various medications including Navane and Cogentin. (247; Petitioner's Exhibit #12).

10. Respondent met with Dr. Gruen on a sporadic basis, with as much as a three to four month gap between visits. (249; Petitioner's Exhibit #12).

11. Dr. Gruen testified that Respondent's behavior continued to manifest a persistent attitude of denial toward his illness. (258-260).

12. Respondent continued to experience hallucinations throughout the course of his treatment by Dr. Gruen. (261-262).

13. On or about November 19, 1988, Respondent was admitted, on an emergency basis, to Creedmoor Psychiatric Center.

Approximately 2-4 weeks prior to this admission, Respondent discontinued his psychotropic medication. Respondent's family and co-workers noted a deterioration in his behavior. He became withdrawn, non-communicative, and neglectful of personal hygiene. (307; Petitioner's Exhibit #11).

14. Upon admission, Respondent was catatonic, and experiencing auditory command hallucinations. He refused oral medications and was given Navane by intramuscular injection. (Petitioner's Exhibit #11).

15. Respondent was discharged from Creedmoor Psychiatric Center on December 14, 1988. The discharge summary notes that although Respondent had a superficial understanding of his need for medication, he still denied the need for his hospitalization and the degree of deterioration which he had experienced. Respondent's discharge diagnosis was chronic schizophrenia-catatonic type with acute exacerbation. His prognosis was guarded. (Petitioner's Exhibit #11).

16. Frederic L. Gannon, M.D., a board certified psychiatrist, testified as a expert witness on behalf of Petitioner. (159).

17. In the opinion of Dr. Gannon, Respondent suffers from chronic schizophrenia. This is a psychiatric illness

characterized by a progressive deterioration of the person resulting in problems of thinking, feeling and acting. (164-165).

18. Based upon his review of the records of Respondent's psychiatric hospitalizations and treatment, Dr. Gannor further testified that Respondent's condition was progressively worsening. Respondent's history demonstrated a series of recurring psychotic episodes, commencing in 1972, followed by progressively lower levels of adaptation. (165-167, 276-285).

19. Since 1985, Respondent has been a general medicine practitioner at two clinics -- Liberty Medical Group and Blake Medical Group. Both clinics are located in Brooklyn, New York. (315-316).

20. Elizabeth Muss, M.D., a board certified internist and cardiologist, testified as a expert witness for Petitioner. (25; Petitioner's Exhibit #13).

Patient A

21. Between on or about December 12, 1986 and on or about July 1, 1988, Respondent treated patient A for hypertension at Liberty Medical Group, 787 Liberty Avenue, Brooklyn, New York, 11208. (Petitioner's Exhibit #2).

22. According to the office record of Patient A, on February 9, 1987 a positive IGM Hepatitis anti-body test result was reported. The next visit Patient A had to this clinic was with Respondent on March 18, 1987. On that visit Respondent failed to note that positive result or to take any follow-up action, including repeating the test and scheduling follow-up visits. (33-39; Petitioner's Exhibit #2).

23. The record maintained by Respondent for Patient A was inadequate. With respect to the patient's hypertension, there was no clear picture delineated as to how the patient was faring, whether or not the patient was taking the prescribed medication and what had generally happened in the interval between visits. In addition, there was no explanation contained in the record as to why Sudafed, a drug normally not indicated in patients with a history of hypertension, was prescribed by Respondent. (35-45).

Patient B

24. On or about October 22, 1986, Respondent treated Patient B for chest pain at Liberty Medical Group. (Petitioner's Exhibit #3).

25. On October 22, 1986, Respondent made a diagnosis of "rule out angina pectoris" in this 11-year old patient. The

diagnosis was not substantiated by the patient's office chart. No history of congenital heart disease was mentioned, nor was a cardiogram performed. Respondent prescribed nitroglycerine to this patient although it was not medically indicated. (50-52; Petitioner's Exhibit #3).

26. Respondent diagnosed otitis media, infection of the ear, without first removing wax in the ear to view the eardrum or without taking the patient's temperature. (428-438).

27. The medical record maintained by respondent for Patient B was inadequate in that it contained a diagnosis ("rule out angina pectoris") which was not substantiated, due to a lack of any previous recorded personal medical history, family medical history, or appropriate diagnostic tests. (51-56; Petitioner's Exhibit #3).

Patient C

28. On or about August 28, 1986, Respondent treated Patient C for a bruised left ankle at Liberty Medical Group. (Petitioner's Exhibits #4, 4A).

29. Respondent made a diagnosis of Ventricular Septal Defect (VSD) in Patient C's record. This diagnosis was unsubstantiated. An echo doppler and chest x-ray are necessary

pre-requisites to this diagnosis. Respondent did not order those tests. (58-63).

30. During the hearing, based on Dr. Muss' testimony, Petitioner withdrew the allegation contained in paragraph D.2 of the Statement of Charges. (62).

31. The medical record maintained by Respondent for Patient C, a 6-year old child, did not contain any personal or family medical history, nor did it contain the patient's height, weight or immunization history. (63-65; 378-382).

32. Although the patient's chief complaint was an abrasion on the left ankle, Respondent testified that he did not read or consider a prior podiatric note contained in Patient C's medical record. (415-416).

Patient D

33. On or about June 9, 1987, Respondent treated Patient D for headaches at Liberty Medical Group. (Petitioner's Exhibit #5).

34. Patient D, a 10-year old child, complained of frequent headaches. Respondent made a diagnosis of tension headache. This was inconsistent with the patient's history of

headaches occurring after jumping up and down. (101-102; Petitioner's Exhibit #5).

35. Given the complaint of headaches, a fundascopic examination was indicated in order to rule out brain swelling. Respondent did not perform this examination. (102; Petitioner's Exhibit #5).

36. A follow-up visit should have been ordered for this patient. The record, however, contains no such notation. Although the chart contains a reference to a "note to hospital" there was no indication as to what the note said, why the note was written or what the note concerned. The chart also contained a reference to a "note to teacher." It was also unclear what that note referred to since the medical history and report form contained in the chart was never completed by Respondent and, therefore, it could not have been given to the child's teacher. (111; Petitioner's Exhibit #5).

37. The chart maintained by Respondent for this patient did not contain any past personal medical or family history. (105; Petitioner's Exhibit #5).

38. During the hearing, based on Dr. Muss' testimony, Petitioner withdrew the allegation contained in paragraph E.3 of the Statement of Charges. (104-105).

Patient E

39. On or about January 7, 1987, Respondent treated Patient E for pelvic pain at Liberty Medical Group. The patient also presented complaints of cough productive of green sputum, a stuffy, runny nose, headache, dizziness and nausea. (129; Petitioner's Exhibit #6).

40. Respondent's medical record for Patient E noted that the patient had rheumatic heart disease. This diagnosis or history was unsubstantiated. No heart murmurs were present upon examination. In addition, the chart did not contain any information concerning what medication the patient may have been taking for this condition, nor was there any mention of whether or not the patient was currently symptomatic. (128-129; Petitioner's Exhibit #6).

41. In Respondent's history and diagnosis for this patient he noted the presence of an ovarian mass. Such a finding warranted a gynecological examination. Respondent did not perform such examination nor did he refer the patient to a gynecologist. (131; Petitioner's Exhibit #6).

42. Given the patient complaints indicative of some type of infectious process, it was necessary for Respondent to take this patient's temperature, but he did not do so. (132).

CONCLUSIONS

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 in full:

(1) Paragraph A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, and A.8 (1-15);

(2) Paragraphs B and B.2 (21-23);

(3) Paragraphs C and C.2 (24-27);

(4) Paragraphs D and D.1 (28, 29, 31, 32);

(5) Paragraphs E, E.1 and E.2 (33-37); and

(6) Paragraphs F, and F.1 (39-40).

The Hearing Committee further concludes that the following Factual Allegations should be sustained with the deletion of the words "non-existent", and "interval notes":

Paragraphs B.2, C.3, D.3, E.4, and F.2. (23, 25, 27, 31, 37, 39, 40).

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

(1) Paragraph B.1 (Record as a whole);

(2) Paragraph C.1 (25);

(3) Paragraphs D.2 and E.3 (withdrawn by Petitioner).

The Hearing Committee also concluded that the following Specifications should be sustained:

First Specification: (1-19);

Second Specification: (21-29, 31-37, 39-42);

Third Specification: (21-29, 31-37, 39-42);

Fourth through Eighth Specifications: (23, 25, 27, 31, 36, 37, 40).

DISCUSSION

FIRST SPECIFICATION (Practicing While Impaired)

The record clearly established that Respondent has had a long history of mental illness, dating back to at least 1972-1973. His diagnosis, based on multiple hospitalizations, ~~was~~ is chronic schizophrenia. The Hearing Committee recognized that it is possible for a physician to adequately practice medicine,

despite a diagnosis of mental illness, so long as the individual is receiving appropriate treatment and is complying with such treatment.

However, Respondent's treatment records reflect a series of recurring psychotic breaks requiring hospitalization. These hospitalizations were due, in part, to Respondent's non-compliance with his prescribed medication regime. Further, Dr. Gruen's medical record for Respondent demonstrated an erratic pattern of visits, with up to 3-4 months elapsing between appointments. Finally, Drs. Gruen and Gannon both testified that Respondent continued to maintain a strong denial of his illness and a lack of clinical insight into his condition.

Based upon Respondent's clinical course, the Hearing Committee concluded that Respondent was impaired by his mental illness. In addition, the medical care rendered by Respondent to Patients A through E, as discussed more fully below, was wholly inadequate. The Hearing Committee further concluded that Respondent's inappropriate medical management of these patients was due, in part, to his impairment. Thus, the First Specification should be sustained.

SECOND SPECIFICATION: (Negligence on More than One Occasion):

THIRD SPECIFICATION: (Incompetence on More than One Occasion):

A review of the care rendered to Patient's A through E by Respondent demonstrated that his medical management of these patients was woefully inadequate. In all five cases, Respondent failed to document appropriate personal and family medical histories, or to conduct complete physical examinations, including complete vital signs. He also failed to obtain immunization histories on any of the three pediatric patients presented (Patients B, C and D). There was no correlation between the chief complaints presented by the patients and the examinations performed or diagnoses made by Respondent. He also failed to order the appropriate diagnostic tests necessary to confirm or refute his diagnoses.

Respondent's own testimony demonstrated that his failure to appropriately manage these patients was due to ignorance about basic medicine, and a cavalier attitude toward his practice.

For example, when questioned about the quality of the medical histories taken, Respondent admitted that he was "casual" about going into the family medical histories of his patients. (Tr., p. 346). He further stated that his approach to medicine was as follows: When patients tell him their symptoms, he must treat them unless he can disprove them. (Tr., p. 368). Finally,

when questioned as to why he ignored the podiatry consultation on Patient C (whose chief complaint was an abrasion on the left ankle), Respondent stated that "... I looked at it but I didn't pay any attention to it. Because a podiatrist, I don't know what he knows about medicine, just the feet, so I didn't pay attention to it." (Tr., p. 416).

The Hearing Committee unanimously concluded that Respondent's medical management of patients A through E demonstrated a lack of the basic skill or knowledge necessary to practice medicine, as well as a failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances. Therefore, the Hearing Committee unanimously concluded that the Second and Third Specifications should be sustained.

FOURTH THROUGH EIGHTH SPECIFICATIONS: (Unprofessional Conduct/Medical Records):

As was previously discussed above, Respondent's medical records for Patients A-E lacked any meaningful information about the patients' personal and family medical histories, and physical examination findings, including complete vital signs. In addition, no scheduled follow-up visits were documented for any of the five patients, nor were any specialty referrals noted. The

Hearing Committee unanimously concluded that the Fourth through Eighth Specifications should be sustained, since none of the medical records introduced at the hearing accurately reflected the evaluation and treatment of the identified patients.

RECOMMENDATIONS

The Hearing Committee, pursuant to its Findings of Fact and Conclusions 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 both negligence and incompetence. Further, these deficiencies were due, in part to the impairment caused by Respondent's mental illness. In rejecting the possibility of a suspension, or probation combined with monitoring, it should be noted that Respondent practices in an environment where accountability is at a minimum. He has no hospital privileges and practices as an independent contractor in office space rented from

two clinics. The opportunity for meaningful quality assurance monitoring of Respondent's medical practice is simply not available.

With regard to Respondent's impairment due to mental illness, the Hearing Committee gave credence to the opinions expressed by Dr. Gannon. In particular, Dr. Gannon testified that, given the clinical history of Respondent's schizophrenia, it is apparent that he is on a downward spiral, with little hope for meaningful rehabilitation. This is accentuated by Respondent's persistent and continuing denial regarding the nature of his illness, his history of sporadic visits to his psychiatrist, and his history of non-compliance with his medication regime.

It should be noted that even Respondent's own psychiatrist, Dr. Gruen, described Respondent as struggling to cope in his professional life. (Tr., p. 296). Although Dr. Gruen testified that Respondent was legally competent to handle his own affairs, he was unwilling to express an opinion as to his competence to practice medicine. Given the totality of the circumstances, the Hearing Committee concluded that revocation is the appropriate sanction to be imposed.

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

1. That Specifications One through Eight, as set forth in Department's Exhibit #1, be <u>SUSTAINED</u>; and

2. That Respondent's license to practice medicine in New York State be <u>REVOKED</u>.

DATED: Albany, New York
April 23, 1990

Respectfully submitted,

REDACTED

CHARLOTTE S. BUCHANAN, ESQ. (Chair)

Pearl D. Foster, M.D.
Donna B. O'Hare, M.D.

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

IN THE MATTER OF FRED G. CONSTANT, 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 July 26, 1989, September 13, 1989, October 4, 1989 and October 5, 1989. Respondent, Fred G. Constant, M.D., appeared Pro se. The evidence in support of the charges against the Respondent was presented by Terrence Sheehan, 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:

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
June 1, 1990

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

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

FRED G. CONSTANT

CALENDAR NO. 11066

The University of the State of New York

IN THE MATTER

OF

FRED G. CONSTANT
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11066

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11066, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (October 19, 1990): That, in the matter of FRED G. CONSTANT, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted, except findings of fact 26, 29, 36, and 42 not be accepted;
2. The conclusions of the hearing committee and Commissioner of Health be modified;
3. Respondent is guilty, by a preponderance of the evidence, of the first specification based upon the overall charge as to practicing since 1985, guilty to the extent indicated in the hearing committee's findings and discussion of the fourth through eighth specifications, guilty to the extent indicated in the hearing committee's findings and discussion, except for paragraph D.1. and E.2., of the second and third specifications, and not

guilty of the remaining charges and specifications including paragraphs D.1. and E.2.; and

4. The measure of discipline recommended by the hearing committee and Commissioner of Health be accepted and respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent was found guilty, as aforesaid;

and that the Commissioner of Education 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.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 26th day of October, 1990.

REDACTED

Commissioner of Education