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NEW YORK
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HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

131839

January 28, 2013

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Steven Bernhard, D.O.
39-21 Bell Boulevard
Bayside, New York 11361-2060

Jack G. Goldberg, Esq.
& James A. Schiff, Esq.
225 Broadway – Suite 905
New York, New York 10007

Leslie A. Eisenberg, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Steven Bernhard, D.O.

Dear Parties:

Enclosed please find the Determination and Order (No. 13-20) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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.

REDACTED

Sincerely,

REDACTED
James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah
Enclosure

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

COPY

IN THE MATTER

OF

STEVEN BERNHARD, D.O.

DETERMINATION

AND

ORDER

BPMC #13-20

A Notice of Hearing and Statement of Charges were served on STEVEN BERNHARD, D.O., Respondent, on April 3, 2012. Hearings were held pursuant to N.Y. Public Health Law §230 and New York State Admin. Proc. Act §§ 301-307 and 401 on May 30, July 25, August 8, September 27, October 11, and November 14, 2012. All hearings were held at the Offices of the New York State Department of Health, 90 Church Street, New York, New York ("the Petitioner"). **Trevor A. Litchmore, M.D., CHAIR, Thomas T. Lee, M.D., M.B.A. and Thea Graves Pellman,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **David A. Lenihan, Esq.**, Administrative Law Judge, served as the Administrative Officer. The Petitioner appeared by **James E. Dering, Esq.**, General Counsel, by **Leslie A. Eisenberg, Esq.**, Associate Counsel, New York State Department of Health, of Counsel. The Respondent appeared with counsel, **Jack G. Goldberg, Esq.** of the firm of **Goldberg & Schiff** of New York City. Evidence was received, witnesses were sworn or affirmed, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice Of Hearing and Statement of Charges:	April 3, 2012
Answer Filed:	May 4, 2012
Pre-Hearing Conference:	May 4, 2012
Hearing Dates:	May 30, 2012 July 25, 2012 August 8, 2012 September 27, 2012 October 11, 2012 November 14, 2012.
Witnesses for Petitioner:	Herbert Byron Feldman, M.D. Patient A-1 (by Skype[1])
Witnesses for Respondent:	Seena Bernhard. (by Skype)
Deliberations Date:	December 13, 2012

[1] Skype is a software application that allows users to have visual and voice communication by computer. In this case, a personal computer was set up in the hearing room so that the witness could be seen and heard by both sides and vice versa.

STATEMENT OF THE CASE

Petitioner charged Respondent, a licensed physician, with thirty five (35) specifications of professional misconduct. The first through seventh specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion for seven patients, Patients A, E, F, G, H, I and J.

The eighth through fourteenth specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion for seven patients, Patients A, E, F, G, H, I and J.

The fifteenth through twenty-first specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion for seven patients, Patients A, E, F, G, H, I and J.

The twenty-second specification charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence in treating any one of the following seven patients, Patients A, E, F, G, H, I and J.

The twenty-third through twenty-ninth specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient for the same seven patients listed above: Patients A, E, F, G, H, I and J.

The thirtieth through thirty-second specifications charged Respondent with

committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently with regard to patients A-1, A-2 and A-3.

The thirty-third through thirty-fifth specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report or failing to file a report required by law or by the Department of Health or the Education Department with regard to patients A-1, A-2 and A-3.

A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to transcript page numbers or exhibits, denoted by the prefixes "T." or "Ex." These citations refer to 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. All Hearing Committee findings were unanimous. The Hearing Committee did not sustain the charges that pertained to Patients J and F, but did sustain the charges pertaining to all the other patients.

1. Respondent was authorized to practice medicine in New York State on or about August 5, 1977, by the issuance of license number 131839 by the New York State Education Department. (Dept. Ex. 2)

PATIENT A

2. Patient A's initial visit with Respondent took place on April 2, 2001. The documented chief complaint as noted in the record is "refill pain medication for old fractures". However, there is no real clear purpose evident in this record for the visit – other than to get a prescription. (Tr. 29, 32-33; Dept. Ex. 3a and 3b)

3. Respondent failed to take an adequate history on Patient A's initlal visit. Although Respondent noted the patient was there for a refill of pain medication, there is absolutely no information demonstrating that the patient was currently in pain and there is no detail regarding the fractures. There are no details indicating when the fractures occurred or if the fractures noted are the ones causing the patient's present pain. Further, there is absolutely no information regarding prior treatment efforts. There are no details about what medications have been used and whether they have helped the patient. Although there is some social and past medical history listed, there are no details. For instance, Respondent noted "motor vehicle accident" but there are no details about this accident. We do not know when the accident occurred, what was injured, whether the fractures mentioned are from this accident, what the resulting treatments were and where the patient has pain, if, indeed, she has pain. There is also a list of medications which usually means medications the patient is taking but, that is not clear from the medical record. Nor is it clear who prescribed those medications for the patient in the past. (Tr. 29-34, 98-99, 140-141; Dept. Ex. 3a and 3b)

4. Respondent failed to perform a thorough comprehensive physical examination on the initial visit of Patient A. Although some vital signs are noted (height and weight) many are not (pulse, respiration and temperature). There is no note of an examination of the

motor or neurological systems. The only notation is of the heart and lungs. There is no exam of any area of pain. (Tr. 35-36; Dept. Ex. 3a and 3b)

5. Patient A returned to Respondent's office on numerous occasions for the next several years, from 2001 to 2006. (Tr. 36; Dept. Ex. 3a and 3b)

6. Respondent failed to take adequate follow-up histories throughout the period of time that he cared for Patient A. At each of Patient A's subsequent office visits, Respondent never questioned and/or noted whether there was any improvement with the medication that he was administering and prescribing. There are no notations about improvement or changes. There are no notations of continued complaints. There is a complete and absolute absence of any details that would be considered a proper past or present medical history. There is not one adequate follow-up history in the entire medical record. (Tr. 37-42; Dept. Ex. 3a and 3b)

7. One example of an inadequate follow up history is from July 18, 2001. On that day, Respondent noted "acute pain across lumbar spine. Rule out gallbladder pain". Respondent did not ask how long the pain has been present: one hour, one day or, one week. Respondent did not ask what caused the pain since typically gallbladder pain occurs after someone eats fatty foods. There is no questioning and no details about the reported lumbar pain. Although gallbladder pain can radiate, it radiates to the right shoulder blade not the lumbar spine. (Tr. 38-39; Dept. Ex. 3a and 3b)

8. Respondent did not perform appropriate physical examinations of Patient A on her subsequent office visits. Similar to the notation for the first visit, the only notations regarding a physical exam are blood pressure, heart and lungs. (Tr. 41, 43; Dept. Ex. 3a and 3b)

9. Respondent failed to appropriately evaluate Patient A on the occasions where she had a specific complaint. On visits where there are actual complaints noted, such as lumbar pain or sciatica, there are absolutely no notations indicating any exam related to the complaint. For instance, on July 18, 2001, when Patient A complained of acute lumbar pain and Respondent noted " rule out gallbladder pain," he failed to examine the abdomen, where the gallbladder is located and, he failed to examine the back. (Tr. 39-40; Dept. Ex. 3a and 3b)

10. Respondent failed to appropriately evaluate Patient A on the occasions where she had a specific complaint. On each of these visits, Respondent did not take or note an adequate history, he did not perform or note an appropriate physical exam related to the notation of pain and he failed to order any diagnostic tests. On one occasion, October 19, 2005, Respondent noted that the patient fell and hurt her rib cage. He also noted "sent for exrays" (sic) . However, the Respondent noted no details about the fall or reported injury. From this record we don't even know if x-rays were taken. Respondent did not follow-up to ascertain if x-rays were taken and, if so, what they revealed. Respondent did not even examine the patient's ribs to see if they were tender. On another occasion, July 18, 2001, Respondent noted "acute lumbar spine pain, rule out gallbladder pain." Respondent did not take and/or note an adequate history specific to this complaint and, he did not perform and/or note an appropriate exam of the patient. Respondent did not order any diagnostic tests including x-rays, CT or MRI of the spine or a sonogram of the abdomen. Moreover, if the pain persisted, Respondent should have referred the patient to a specialist, which he did not do. (Tr. 128-131; Dept. Ex. 3a and 3b)

11. Respondent failed to properly assess Patient A regarding her complaint of chest pain. On October 26, 2002, Respondent noted "chest pain – lumbar pain + shoulder". Respondent did not take a history related to this complaint and he did not examine the patient at all, including her back and shoulder as it related to this specific complaint. Further, Respondent did not perform a cardiogram to assess the patient's cardiac status – there is no indication of the patient's heart rate or rhythm. There is no notation about this complaint at the next office visit 3 weeks later or, at any subsequent office visit. Respondent utterly failed to assess the patient and to follow-up when she complained of chest pain. (Tr. 43-48: Dept. Ex. 3a and 3b)

12. Respondent treated Patient A inappropriately by treating her without examining her. By failing to examine the patient, Respondent was incapable of determining what care to provide to the patient. Without examining the patient, the physician can only guess. (Tr. 48-49; Dept. Ex. 3a and 3b)

13. Respondent treated Patient A inappropriately by repeatedly prescribing medication for Patient A without adequate medical justification. It is inappropriate to prescribe medication to a patient when the physician does not know what it is given for and whether it is helping the patient. In addition, when a patient clearly has a substance abuse problem – the medical records indicate that Patient A was on heroin and taking street drugs – it is not justifiable to continue to prescribe narcotics to the patient. (Tr. 49-50; Dept. Ex. 3a and 3b)

14. Respondent treated Patient A inappropriately by prescribing Tylenol #4 (Tylenol with Codeine) at an inappropriate rate. First, since there is an inadequate history, it is unclear if the original dose was necessary or appropriate due to the lack of information about her complaints and, whether prior medication had even helped her. Then, as time

went on, there is an absence of information related to progress. Without knowing if the medication helped Patient A, it was inappropriate for Respondent to continue to prescribe it. Second, Respondent prescribed Tylenol #4 for Patient A, prior to the time that a new prescription was warranted. For instance, the prescription written by Respondent on July 18, 2001, was for Tylenol #4 60 milligrams 120. This means that Patient A could take one tablet every four to six hours and the 120 pills should last for one month. However, Respondent provided a subsequent prescription for Patient A for Vicodin (which is essentially the same narcotic because Vicodin is a combination of Tylenol and hydrocodone) on July 24, 2001, only six days later. In another striking example, Respondent provided Patient A with a prescription for Tylenol #4 on March 10, 2004. This time for 90 tablets. However, only 14 days later, he provided an additional prescription to Patient A and then, 14 days later he provided a prescription for 120 tablets of Vicodin – noting at that time, that "the patient is taking street drugs obtained in Brooklyn." (Tr. 50-54, 105-106; Dept. Ex. 3a and 3b)

15. Respondent treated Patient A inappropriately since he failed to offer, order or utilize any non-drug therapy, such as osteopathic manipulation, physical therapy, massage therapy and/or exercise, throughout the time he provided care to Patient A. Instead, he simply provided her with prescriptions for narcotics, at every visit. (Tr. 54-55; Dept. Ex. 3a and 3b)

16. Respondent inappropriately treated Patient A for documented diagnoses without substantiating the diagnoses. For instance, on July 24, 2001, Respondent noted a gallbladder attack but the medical records do not substantiate this diagnosis. Respondent gave Patient A prescriptions for narcotics. However, Respondent did not take a history

particularly as it relates to food (fatty foods can cause pain). Respondent did not examine the abdomen to substantiate tenderness or, to rule in or out, a mass or anything else. Respondent did not order an abdominal sonogram to rule out stones or to evaluate the patient. Respondent did not take or order any blood work to demonstrate liver or gallbladder abnormalities. In another example, on February 20, 2004, Respondent noted chronic neuropathy. Respondent provided Patient A with a prescription for narcotics. However, Respondent's medical record does not include any facts or findings that substantiate the diagnosis of neuropathy. (Tr. 56-67; Dept. Ex. 3a and 3b)

17. Some patients who are abusing drugs or who are addicted to medication may tell the physician things that will get them additional prescriptions. For instance, they may tell the physician that they lost the prescription, that the prescription was destroyed or, that someone took the medication. Such behaviors are referred to as drug-seeking and should be a red flag for the physician that there is a problem. A patient could fill the prescription (obtain the pills) and tell the physician that they lost the prescription. By providing a new prescription, the patient can obtain a second set of pills. Respondent treated Patient A inappropriately by continuing to provide prescriptions for her when she repeatedly claimed that her prescriptions were lost, taken or damaged. (Tr. 57-60, 108-109; Dept. Ex. 3a and 3b)

18. Respondent treated Patient A inappropriately by failing to refer her to a specialist. Respondent should have referred Patient A to a hospital or rehabilitation center when she exhibited signs of substance abuse. In addition, Respondent should have referred Patient A to an orthopedist or neurologist if she indeed complained of back pain and sciatica for as long as he noted, especially since he was not thoroughly and adequately evaluating the

patient for these noted complaints. Respondent failed to refer Patient A to any specialist when the opportunity presented itself. Instead, he simply continued to prescribe narcotics to her. (Tr. 60-61; Dept. Ex. 3a and 3b)

19. Patient A was in dire need of help. She was, according to the Respondent's record, taking street drugs including heroin. She was clearly abusing narcotic medication, obtaining prescriptions from Respondent that included a double dose when Respondent re-wrote prescriptions for her that she claimed were "lost". Respondent should have referred her to a hospital or facility that could manage her appropriately. Respondent should have attempted to enroll her in a drug rehabilitation program or, at least, assisted her in making arrangements to enter such a program, since she clearly could not do so on her own. Respondent should not have continued to prescribe dangerous narcotics for her, especially since he knew she was taking street drugs. However, Respondent should not have cut her off completely without ensuring that she would receive help. (Tr. 60, 110-115, 131-132; Dept. Ex. 3a and 3b)

20. Respondent fabricated medical records for Patient A's family members including her mother, daughter and brother. (Patients A-1, A-2, and A-3) In those medical records, Respondent documented that he issued prescriptions for narcotics on specific dates for Patient A's family members. None of those family members were patients of Respondent. Patient A filled the prescriptions that were written for her family members and she took the pills. (Tr. 373, 375, 382-383, 391; Dept. Ex. 3a, 3b, 4a, 4b, 5a, 5b, 6a, 6b)

21. Patient A died on February 24, 2006. The autopsy report demonstrates that Patient A died of an overdose of narcotics, some of which were prescribed by Respondent. (Tr. 108-114, 143, 372; Dept. Ex. 14)

22. Respondent's medical records for Patient A are completely inadequate. They are illegible and as such are of no use to Respondent or to a subsequently treating physician. It is only possible to understand what is written in the medical record by comparing the original record to the hand-printed version subsequently provided by Respondent. In addition, there is little information in the medical records to make them of any value. Other than some generic comment intended as a chief complaint, a blood pressure and a note indicating a prescription, there is no relevant information documented in the medical record. (Tr. 61-65, 102-105, 144-145; Dept. Ex. 3a and 3b)

23. Although the hand-printed version of the medical record provided by the Respondent's attorney was intended (and expected) to be an exact transcription of the original medical record, there are instances where the two versions are not the same. For instance, the first visit lists medications and a partial past medical history but the transcription version has the heading of "history" written on it. In another more significant example, on March 7, 2002, in pertinent part, Respondent wrote "take it easy for pain medication" in the transcribed version. Yet, in the original record, for that same day, Respondent wrote "little early for pain meds" and "she wants Tylenol #4". (Tr. 61-65, 102-105, 144-145; Dept. Ex. 3a and 3b)

24. Respondent's medical records for Patient A are inadequate. When Respondent provided medication for Patient A, he did not clearly document the medication's name, dosage, purpose and usage. When Respondent re-wrote prescriptions for Patient A, he should have written the prescriptions and dated them with the date of service, not back-dated them to a previous visit. Furthermore, there are notations (on October 3, 2001 and March 10, 2003) in which it is completely unclear if the patient was in the Respondent's

office or simply called on the telephone. A medical record should be clear about the noted interaction with a patient. (Tr. 61-65, 102-105, 144-145; Dept. Ex. 3a and 3b)

PATIENT A-1

25. Patient A-1 is the daughter of Patient A. Patient A-1 is a 45 year-old mother of four who lives in Virginia. As a result, Patient A-1 testified before the hearing committee via Skype. The Respondent's attorney did not object to this manner of testimony and the Department similarly did not object to Skype testimony from the Respondent's sole witness, his mother and office manager, even though it was only from the borough of Queens. (Tr. 366, 370)

26. Patient A-1 has lived in Virginia since 1989. She has never been a patient of Respondent. She never filled any prescription from Respondent and she never took any narcotics prescribed by Respondent. (Tr. 370, 373, 391-394, 413-417)

27. Patient A-1 did see Respondent on one occasion. On that day, she said her mother tricked her. Patient A asked her daughter to drive her to the doctor's office. When they arrived at the location, it was difficult to park so Patient A-1 double parked her automobile. Her mother said to her "you don't understand...today you are the patient". (Tr. 373-374, 387)

28. Patient A-1 walked into the office with her mother. Her mother did all the talking. Respondent did not talk to Patient A-1. Patient A-1 did not talk to Respondent. Respondent did not examine Patient A-1. Within minutes, Respondent handed a prescription to her mother, Patient A, and then they both left. Patient A filled the prescription. Patient A-1

never filled the prescription and she never took the pills. This experience was traumatic for Patient A-1. She was troubled by it and she testified It made her feel like a child. (Tr. 374-375, 412-417, 421, 425)

29. Respondent prepared and submitted to OPMC medical records presumably for Patient A-1, that span the period from May 2002 through September 2005. During that entire time period, Patient A-1 lived in Virginia and had young children. In fact, she had her third child in 2003 and her fourth child in 2006. (Tr. 376-377, 388-389; Dept. Ex. 4a and 4b)

30. Patient A-1 does not have chronic back pain, her birthday is May 25, 1967, and, her blood pressure is normally low. However, the medical record prepared by Respondent for this person and submitted to OPMC indicates chronic back pain for a person with normal blood pressure whose birthday is May 8, 1969. There are numerous dates in the medical record that Patient A-1 can point to in which she was doing something related to her pregnancies. The medical record is erroneous and false. (Tr. 377-379, 397-398; Dept. ex. 4a and 4b)

31. Patient A-1 was never a patient of Respondent. The medical records prepared by Respondent for this person were fabricated. There were no actual office visits on the documented dates – which end prior to the date of Patient A's death. The fabricated records were prepared by Respondent presumably so Patient A could acquire more narcotics. (Tr. 395; Dept. Ex. 4a and 4b)

PATIENT A-2

32. Patient A-2 is the 83 year old mother of Patient A and is the grandmother of Patient A-1. She is not well and was unable to participate in the hearing process. Patient A-1 and Patient A-2 have a good relationship and talk often. They discussed this case. Patient A-1 told the hearing committee that her grandmother said she was never a patient of Respondent's. She never saw Respondent and she did not know his name. (Tr. 381-382)

33. Respondent prepared and submitted to OPMC medical records presumably for Patient A-2, spanning from November 2004 through September 2005. (Dept. Ex. 5a and 5b)

34. Patient A-2 was never a patient of Respondent. The medical records prepared by Respondent for this person were fabricated. There were no actual office visits on the documented dates – which end prior to the date of Patient A's death. The fabricated records were prepared by Respondent presumably so Patient A could acquire more narcotics. (Dept. Ex. 5a and 5b)

PATIENT A-3

35. Patient A-3 is the 54 year old brother of Patient A and the uncle of Patient A-1. Patient A-3 is retarded and functions on a 5 year-old level. He lives with his mother, Patient A-2. Patient A-3 was never a patient of Respondent and he does not suffer from chronic pain. Patient A-1 never discussed this case with Patient A-3 because he would not understand it. Patient A-1 told the hearing committee that she did discuss with Patient A-2 the fact that Patient A-3 was not a patient of Respondent. (Tr. 382-383)

36. Respondent prepared and submitted to OPMC medical records presumably for Patient A-3, spanning from November 2001 through February 2006. (Dept. Ex. 6a and 6b) Patient A-3 was never a patient of Respondent. There were no actual office visits on the documented dates – which end prior to the date of Patient A's death. The medical records prepared by Respondent for this person were fabricated, presumably so Patient A could acquire more narcotics. (Dept. Ex. 6a and 6b)

PATIENT E

37. Patient E, a 52 year old male, saw Respondent initially on January 27, 2004. Respondent failed to take and document an adequate history. There is no clearly documented chief complaint, which needs to be part of a thorough and proper medical history. The medical record does not demonstrate why this patient came to Respondent. The subjective notation, which usually refers to what the patient feels, states "diet, diabetes and neuropathy," which are diagnoses not complaints. Even Respondent's counsel pointed out that no patient would complain and say "I have neuropathy." The medical records do not demonstrate what prior treatments or medications Patient E tried, what medications he was currently taking and/or, what medications Respondent prescribed. (Tr. 158-159, 162-164; Dept. Ex. 7)

38. A reasonably prudent physician, on an initial visit, should initiate a conversation with the patient to help them describe their pain and identify its impact on their life. The physician should ask questions and document answers that relate to the problem or complaint. They should discuss and document factors related to the patient's family history, medical history and history of present illness or problem. Important factors to note

include location and duration of pain, prior treatments and, success or failure with all prior attempted treatments. Respondent failed to do so. (Tr. 16-20,160-163, 262; Dept. Ex. 7)

39. An initial physical examination should be a comprehensive one. The exam should create a base line and should address all systems. The initial comprehensive exam should also include examination of any area that relates to the patient's chief complaint. Respondent's medical record for Patient E demonstrates an absence of a comprehensive initial exam. This medical record includes the patient's weight and blood pressure. There is nothing else legible. There is no respiration, temperature, pulse or heart rate noted in the record. There is no examination of the heart or lungs. Similarly, there is no examination of the legs, abdomen, liver, musculoskeletal system, nervous system, eyes or skin. There is no determination of blood sugar. All of these elements of an examination that are pertinent to diet, diabetes and neuropathy were not performed and documented by Respondent in his initial medical record. (Tr. 165- 171; Dept. Ex. 7)

40. On follow-up visits, Respondent failed to take and note an adequate history. There is absolutely no indication of any progress. There is no indication in this record of ongoing pain or new issues, compliance with treatment or treatment efficacy. (Tr. 261-164, 190-191; Dept. Ex. 7)

41. On follow-up visits, Respondent failed to perform and note any physical examinations. Although there are some vital signs noted, there is a complete absence of physical exams throughout the patient's medical record. (Tr. 191-192; Dept. Ex. 7)

42. Neuropathy is a disturbance of a nerve. The disturbance can be motor or it can be sensory. Neuropathy can be caused by any number of things including a nerve

impingement or metabolic illness, like diabetes and can cause pain but can also cause numbness and tingling. In order to evaluate a person for neuropathy, nerve tests can be done to help distinguish the different types of neuropathy. The etiology of the neuropathy influences the types of treatment. Narcotics are not a standard treatment for neuropathy. (Tr. 178-180, 252-254)

43. Respondent failed to evaluate Patient E for neuropathy. There is no physical exam targeted at any part of the body associated with neuropathy. In fact, the medical record is not clear as to what part of the patient's body is effected and whether there is pain, numbness or tingling. In addition, Respondent did not refer Patient E to a specialist to perform any nerve tests to diagnose neuropathy. As a result, Respondent's medical record does not substantiate the diagnosis of neuropathy. (Tr. 179-180, 187; Dept. Ex. 7)

44. Diabetes is a metabolic disorder that involves a person's ability to metabolize sugar in the body. A person with diabetes needs to maintain a level blood sugar throughout the day, every day. If a person's blood sugar is too high (or too low) they are more likely to develop complications. In order to evaluate a patient who has diabetes, a reasonably prudent physician needs to perform laboratory tests to determine the person's blood sugar. A reasonably prudent physician would also want to know what treatment their patient has been on, whether they have been compliant and, whether it has been successful at maintaining their blood sugar at a normal rate. One way to ascertain this information is to obtain prior medical records for the patient. (Tr. 171-177)

45. Respondent failed to request or obtain prior medical records for Patient E. Patient E arrived at the first visit having mentioned diabetes. Respondent did not perform a blood

sugar level test on that day. Respondent did not note prior medical treatments. Respondent did not document who was treating Patient E prior to that visit. Respondent did not attempt to communicate with another physician seeking medical records regarding Patient E's prior treatment or evaluations. (Tr. 176-177; Dept. Ex. 7)

45. Respondent began treating Patient E for diabetes with medications. However, he did not properly evaluate the patient's blood sugar. There are numerous office visits in which Respondent did not test and document the patient's blood sugar. There are a few laboratory results in the medical record but there are only a few and they are from the later years of treatment (2008-2010). There are no notations in the medical record regarding the patient's blood sugar prior to August 2007 and there is an absence of laboratory results in the medical record prior to July 2008. Patient E's blood sugar varied over time but remained largely out of control for years. During years of treatment, Respondent failed to check the patient's blood sugar and failed to successfully treat his diabetes. (Tr. 172-175, 183-186, 200-201, 223-226; Dept. Ex. 7)

47. Although Respondent's medical records are largely illegible, there appears to be a notation indicating Patient E's anxiety in September of 2008. There is no history to illustrate anxiety. The only apparent note is that the patient is "upset about a house." There is no referral to a psychologist or psychiatrist to adequately evaluate the patient for anxiety. There is inadequate information in the medical record to substantiate a diagnosis of anxiety. However, it appears that Respondent went on to treat Patient E for anxiety with medication. Without a proper assessment for anxiety, it was inappropriate for Respondent to treat Patient E for anxiety. (Tr. 188-190; Dept. Ex. 7)

48. Respondent's medical records for Patient E do not meet minimally accepted standards of care. In fact, the only clear thing about Respondent's medical records is that they are illegible. No practitioner or reviewer could read the medical record and understand the treatment or progress of this patient. The documentation of Respondent's prescribing practice is substandard. There is no clear indication in the medical record as to what medication is being prescribed, for what purpose, in what amount, and the directions associated with the medication. There is no documented information that substantiates any diagnoses or medical justification for repeated prescriptions of controlled substances. (Tr. 211-217, 229-244, 261-264, 269; Dept. Ex. 7)

PATIENT G

49. Didrex is an anorectic[2] agent. It helps reduce appetite. It is a narcotic. The recommended use is as an aid to weight loss, for short term use only. Short term means a few weeks, possibly up to a month. Didrex should not be used if there are contraindications including cardiovascular disease. A person should be thoroughly evaluated and carefully monitored for cardiovascular disease prior to prescribing Didrex. (Tr. 296-300)

50. Patient G, a 5'2" female weighing 128 pounds, presented to Respondent initially on February 19, 1999. Patient G is not considered overweight. The subjective note in Respondent's medical record indicates diet. The history is not clear if she wants a diet or is on a diet and, does not explain why a person of normal weight would seek a diet. The history is inadequate, similar to the other patient case files. Particularly in this case, since

[2] From the Greek, meaning "without appetite."

this patient was seeking a narcotic stimulant, Respondent should have asked about her prior diet efforts, her weight history and whether she has ever tried Didrex before. Moreover, as the treatment ensued, Respondent failed to ask and note anything in the record regarding progress. Other than continuing to prescribe Didrex for years, Respondent did not make one notation about the patient's weight loss efforts. There is no comment about other efforts the patient was making to reduce her weight. And, in fact, the patient was not successful with Respondent's treatment because over the 11 years that he maintained the patient on Didrex, her weight remained the same. (Tr. 293-297; Dept. Ex. 9)

51. Similar to the other patient cases, Respondent did not perform and/or note an appropriate examination of Patient G. Respondent did not document any elements of an examination. Since Respondent prescribed Didrex, Respondent should have examined Patient G for issues related to the warnings associated with Didrex, particularly cardiovascular disease. There Is no exam of the heart and lungs and there is no cardiogram. Respondent failed to perform and note an appropriate physical exam. (Tr. 295-297; Dept. Ex. 9)

52. Respondent inappropriately prescribed Didrex for Patient G. Patlent G was not overweight. Since there is no information about prior weight loss attempts, Respondent should have initially utilized other efforts such as diet, exercise and counseling. There is no medical justification in this case to prescribe the narcotic stimulant Didrex. Respondent didn't take an adequate history and perform an exam; he did not evaluate the patient for any contraindications before prescribing Didrex.

Even if there were an adequate history and physical exam and justification to use Didrex, it should have been used for a few weeks only and as an adjunct to other efforts. It should not have been prescribed as Respondent did, for 11 years, particularly when over the entire period of time that the patient took Didrex, her weight remained the same. (Tr. 295-303, 320-321; Dept. Ex. 9)

53. Respondent treated Patient G inappropriately by continuing to prescribe narcotics for her without addressing behaviors consistent with medication abuse. Respondent should have been alerted to the fact that Patient G, who is not overweight, sought a stimulant for weight loss. The medical record evidences drug seeking behavior. There are numerous notations that the patient "lost" the medication. Respondent used poor judgment in prescribing Didrex for Patient G. (Tr. 297-299; Dept. Ex. 9)

54. There are numerous occasions throughout the medical record indicating Respondent prescribed antibiotics for Patient G. However, in no instance is there a history, physical examination or a documented justification for issuing the prescription. There is insufficient documentation of the prescription: no clear drug name, dosage, purpose and instructions. In addition, the medical record indicates that the patient is allergic to Penicillin. Yet, Respondent prescribed Amoxil, a variant of Penicillin, to Patient G. When a patient indicates an allergy, even if they no longer have the allergy, it is prudent to not prescribe that medication for them. (Tr. 306-310, 316; Dept. Ex. 9)

55. On June 27, 2005, Respondent noted "lump in breast" in the record for Patient G. There is, however, no history or further documentation on this point. It is not clear if he found the lump or if the patient reported finding a lump. There are no details as to where

the lump is, which breast it is in and what, if anything, was done about it. There is no exam of the breast. There is no referral for a mammogram or a specialist. There is absolutely no follow-up. Other than the original notation, the lump in Patient G's breast is not mentioned again. Respondent utterly failed to evaluate the patient and refer her to a specialist when he noted a lump in her breast. (Tr. 305-306; Dept. Ex. 9)

56. Similar to the other patient medical records, the medical records for Patient G do not meet minimally accepted standards of care. The records are illegible. No one can read them and understand the care provided to the patient. There are no histories and physical exams documented. There is insufficient information documented for prescriptions: there is no clear medicine name, dosage, purpose and instructions for use. In fact, for most of the record when Respondent prescribed Didrex to Patient G, he simply drew an arrow from one visit to the next. (Tr. 304-310; Dept. Ex. 9)

PATIENT H

57. Patient H, a 5'4" female weighing 145 pounds, presented to Respondent on July 27, 2001. Respondent's medical record indicates the subjective reason for the visit was diet. Diet is not a chief complaint. There is no indication if the patient wants a diet, is on a diet or has ever attempted to diet. The history is wholly inadequate, similar to the other patient cases. Since this patient seeks a narcotic stimulant, Respondent should have asked about her prior diet efforts, her weight history, her success or failure with Didrex or other weight loss medications. In addition, Respondent should have questioned the patient about her cardiovascular history since he was considering prescribing a medication that is

contraindicated in cases where there is a cardiovascular issue. Respondent did not take and note an adequate history. Moreover, as the treatment progressed, Respondent failed to ask and note anything regarding progress. Other than continuing to prescribe Didrex, Respondent did not make one notation about the patient's weight loss efforts. There is no comment about other efforts the patient is making to reduce her weight. And, in fact, the patient was not successful with Respondent's treatment because over the 9 years that he maintained the patient on Didrex, her weight remained the same. (Tr. 330-335, 339; Dept. Ex. 10)

58. Respondent failed to perform and/or document an appropriate physical examination of Patient H. At the initial visit, there is no comprehensive physical examination noted. There is no examination of her heart and there is no cardiogram. This is critical in a patient for whom medication is being prescribed, especially since the medication carries a warning against use in people with cardiovascular disease. Similar to the other patient cases in this matter, Respondent utterly failed to perform and document appropriate physical examinations of Patient H, on the initial and follow-up visits. (Tr. 335-338; Dept. Ex. 10)

59. Respondent treated Patient H inappropriately by prescribing Didrex for her. Patient H is not obese. Moreover, Respondent did not attempt any other modality with her first. Medication should not be a first line treatment. Respondent did not attempt diet, nutrition counseling, psychiatric counseling and/or, exercise. He simply prescribed Didrex, an anorectic agent. In addition, Respondent maintained Patient H on Didrex for too long a period of time. Didrex is recommended for a few weeks not years. Respondent maintained Patient H on Didrex for 9 years. (Tr. 336-339, 362, 441; Dept. Ex. 10)

60. Respondent did not re-assess Patient H at any time during the 9 years he treated her. There is no evidence in the medical record that Respondent examined or evaluated Patient H for cardiovascular concerns. Although the Respondent documented the patient's weight, there is no consideration of success or failure with this medication. Patient H's weight remained essentially the same over a 9 year period while taking an anorectic agent. The fact that Patient H returned year after year for Didrex suggests that she was addicted to this medication - a fact that Respondent ignored. (Tr. 339-340, 353; Dept. Ex. 10)

61. Like the medical records for the other patients in this case, Respondent's medical record for Patient H does not meet minimally accepted standards of care. The medical record is largely illegible. There is an absence of pertinent information regarding the patient's history. There is no information documented relating to a physical exam other than her weight and blood pressure. When prescribing medication for Patient H, Respondent failed to document the appropriate information. In fact, when continuing to prescribe Didrex, Respondent simply drew an arrow from one visit to the next. (Tr. 333, 339-342; Dept. Ex. 10)

PATIENT I

62. Patient I, a 5'11" male weighing 210 pounds, initially saw Respondent on May 20, 2002. Respondent noted the subjective reason for the visit was diet. Again, there is no indication if the patient wants a diet, is on a diet or has ever attempted to diet. The history is wholly inadequate, similar to that seen in the other patient files. Since this patient seeks a narcotic stimulant, Respondent should have asked about his prior diet efforts to manage his weight, his weight history, his success or failure with Didrex or other weight loss

medications. In addition, Respondent should have questioned the patient about his cardiovascular history since he was considering prescribing a medication that is contraindicated in cases where there is a cardiovascular issue. Respondent did not take and note an adequate history. Moreover, as the treatment progressed, Respondent failed to ask and note anything regarding progress. Other than continuing to prescribe Didrex, Respondent did not make one notation about the patient's weight loss efforts. There is no comment about other efforts the patient is making to reduce his weight. And, in fact, the patient was not successful with Respondent's treatment because over the 8 years that he maintained the patient on Didrex, his weight remained the same. (Tr. 426-428, 431-432; Dept. Ex. 11)

63. Respondent failed to perform and document a thorough, appropriate physical examination of Patient I. At the initial visit, there is no comprehensive physical examination. There is no examination of his heart and there is no cardiogram for this patient. This is critical in a patient for whom medication is being prescribed, especially since the medication carries a warning against use in people with cardiovascular disease. In addition, Patient I was overweight so a physical exam for him should have included checking his thyroid, lipid profile and, glucose. Respondent did not do so. Respondent utterly failed to perform and document appropriate physical examinations of Patient I throughout the course of treatment. (Tr. 428-431; Dept. Ex. 11)

64. Respondent inappropriately prescribed Didrex, an anorectic agent, for Patient I, on the first visit, without any evaluation and assessment. Respondent did not attempt any other modality like counseling, nutrition or exercise. Rather, he utilized a prescription drug that carries serious potential side effects. This medication should not be a first line therapy.

As a result, Respondent treated Patient I with weight loss medication without adequately evaluating him. (Tr. 428-433, 441; Dept. Ex. 11)

65. Respondent treated Patient I inappropriately by prescribing Didrex without evaluating this patient for contraindications. Patient I was overweight and should have been evaluated for any number of medical conditions including but not limited to hypothyroidism, metabolic issues or cardiovascular disease. To treat a patient with prescription medications that carry serious side effects, including addictive properties, without proper evaluation falls below the minimal standard of care. (Tr. 429-433; Dept. Ex. 11)

66. Respondent did not re-assess Patient I at any time during the 8 years he treated him. There is no evidence in the medical record that Respondent examined or evaluated Patient I for cardiovascular concerns. Although he documented the patient's weight, there is no consideration of success or failure with the medication. Patient I's weight remained essentially the same over an 8 year period while taking an anorectic agent. The fact that Patient I returned month after month and year after year for Didrex suggests that he was addicted to the medication. This is a fact that Respondent ignored. Respondent completely failed to re-assess his treatment plan for Patient I. (Tr. 431-433; Dept. Ex. 11)

67. Like the medical records for the other patients in this case, Respondent's medical record for Patient I does not meet minimally accepted standards of care. The medical record is largely illegible. There is an absence of pertinent information regarding the patient's history. There is no information documented relating to a physical exam other than his weight and blood pressure. When prescribing medication for Patient I, Respondent

failed to document the appropriate information. In fact, when continuing to prescribe Didrex, Respondent simply drew an arrow from one visit to the next. (Tr. 433; Dept. Ex. 11)

CONCLUSIONS OF LAW

Pursuant to the Findings of Fact as set forth above, the Hearing Committee unanimously concludes that the Factual Allegations and Specifications as set forth in the Statement of Charges, are resolved as follows:

1. The Third, Seventh, Tenth, Fourteenth, Seventeenth, Twenty-first, Thirty-first, Thirty-second, Thirty-fourth, and Thirty-fifth Specifications of professional misconduct, as set forth in the Statement of Charges, are **NOT SUSTAINED;**

2. All the other Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED;**

It is noted that the Hearing Committee did not sustain the charges that pertained to Patients J and F, but did sustain the charges pertaining to the other patients.

These specifications of professional misconduct are listed in New York Education Law §6530. This statute sets forth numerous forms of conduct, which constitute professional misconduct, but does not provide definitions of the various types of misconduct. The definitions utilized herein are set forth in a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," dated January 9, 1996, sets forth suggested definitions for gross negligence, negligence, gross incompetence, and incompetence.

The following definitions were utilized by the Hearing Committee during its deliberations:

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). Gross negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct, Rho v. Ambach, 74 N.Y, 2d 318, 322 (1991). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

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

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

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

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made its conclusions of law pursuant to the factual findings listed above. All of the above conclusions resulted from a unanimous vote of the Hearing Committee.

In arriving at its Conclusions of Law, the Hearing Committee carefully reviewed the Exhibits admitted into evidence, the transcripts of the six (6) hearing days, the

Department's Proposed Findings of Fact, Conclusions of Law, and Sanction as well as the Respondent's Proposed Findings of Fact and Conclusions of Law. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Committee's determination is limited to the Allegations and Charges set forth in the Statement of Charges. (Appendix I)

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a fair preponderance of the evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegations presented are more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim.

3. The specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the charges by a preponderance of the evidence and, as to the veracity of the opposing witnesses; it is for the Hearing Committee to pass on the credibility of the witnesses and to base its inference on what it accepts as the truth.

4. Where a witness' credibility is at issue, the Committee may properly credit one portion of the witness' testimony and, at the same time, reject another. The Hearing Committee understands that, as the trier of fact, they may accept so much of a witness' testimony as is deemed true and disregard what they find and determine to be false. In the

alternative, the Hearing Committee may determine that if the testimony of a witness on a material issue is willfully false and given with an intention to deceive, then the Hearing Committee may disregard all of the witness' testimony.

5. The Hearing Committee followed ordinary English usage and vernacular for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony.

EVALUATION OF TESTIMONY

With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. The Hearing Committee considered whether the testimony presented by each witness was supported or contradicted by other independent objective evidence.

The central witnesses in this case were Doctor Feldman and Patient A's daughter (by Skype) for the Department. Doctor Bernhard did not testify but did present his mother, who is also his office manager, for testimony by Skype

The Respondent chose not to testify. Notwithstanding the failure of the Respondent to testify, the panel carefully reviewed all the testimony and examined all the factual allegations, point by point, in great detail, to determine if they were established by a preponderance of the evidence. From the Respondent's failure to testify, the panel drew a negative inference. The panel noted that the Respondent had personal knowledge of the

facts in this case and did not testify to contradict the proof against him. The Respondent chose not to explain or refute the overwhelming evidence against him.

The panel found the testimony of the Department's main witness, Dr. Feldman, to be credible and persuasive and the panel sustained all of the factual allegations except those pertaining to Patients F and J. For those allegations, the panel found that the Department had not established its case by a preponderance of the evidence, due to the poor quality of the record. It is noted that these patients did not testify and the Department relied on the documentary record alone.

As for the remainder of the allegations, the panel reviewed the entire record and transcript of the hearings and made its determinations on the specific allegations, point by point, for each patient as follows:

For Patient A the panel noted that the record, Exhibits 3 A & B, show that the Respondent documented 52 visits by this patient and that opioids were prescribed on each and every occasion. On March 7, 2002, the record shows that the patient's husband was taking her opioid medication for himself. The Respondent, apparently took no action on this information and only refilled the prescription as he did on every occasion noted. On October 24 , 2003, the record shows that Patient A was on street drugs from Brooklyn and was snorting heroin. Nevertheless, the Respondent, according to his record simply prescribed more Vicodin, an opioid. On March 10, 2003 the record shows that the patient's husband was again taking her medication and the Respondent simply called in another prescription for Loracet, an opioid, for Patient A.

The panel found that the records for Patient A go on to clearly document and establish the Department's case for Gross Negligence. For example, on April 8, 2004, the

record shows that the Respondent advised the patient to "Stay away from Brooklyn drugs" but yet continues to prescribe opioids and makes no referral to drug rehabilitation for this patient. Similarly, on May 14, 2004, the record documents the advice "Don't start street drugs again" yet there is no mention of drug treatment and again a continued prescription for Vicodin. The May 14 record shows a "loss of prescription" but no action taken on this questionable fact from an obvious drug abuser.

The record for Patient A goes on to note that on September 24, 2005, the patient relapsed on street drugs, and yet the Respondent continues to prescribe opioids and makes no referral to drug treatment or rehabilitation. The panel scrutinized this record and found a total of 52 visits with each visit prescribing opioids for a clear and documented drug abuser. In the panel's estimation, this record establishes Negligence on the part of the Respondent on these 52 occasions.

Furthermore, the panel found that on 9 occasions, Gross Negligence was shown by the Respondent. The particular occasions are as follows: March 7, 2002, October 24, 2003, March 10, 2003, February 13, 2004, April 8, 2004, May 14, 2004, November 18, 2004, September 24, 2005 and December 5, 2005. It is noted that an autopsy was performed on this patient on February 25, 2006 by Nassau County Medical Examiner. (Exhibit 14) The Medical Examiner lists the cause of death as acute intoxication by the combined effect of carisoprodol, codeine, meprobamate, and morphine.

The record show that, for years, the Respondent continued to give drugs to an obvious drug abuser. Had the Respondent testified perhaps he could have offered an explanation for his actions. The Respondent chose not to testify and the Hearing

Committee could draw only the negative inference that the Respondent had no explanation for his negligent actions.

The panel found a similarly troubling pattern of negligence in the records for Patient A-3. The record for this patient (Exhibit 6) shows that on November 17, 2001 no prior medical records were reviewed and that the extremities were not examined, and yet opioids were prescribed without any stated cause. The record for December 7, 2001 shows a painfully scant evaluation and the record for January 21, 2002 shows a prescription for Loracet, an opioid, without any examination of the hip, the supposed source of the pain. On April 15, 2002, the record goes on to show that the prescription for Loracet was "lost" and there is no mention of any questioning about drug abuse or any advice given or scrutiny about this "loss."

The panel tabulated the records for patient A-3 and found 59 separate instances of failure to perform an adequate examination or note an adequate record. In these 59 records the panel found 6 instances of clear negligence.

The panel examined the records for patient E (Exhibit 7) and found that the record of the documented 56 visits was, for the most part, illegible. However, the panel was able to ascertain from the record for August 7, 2008 and other days that there were 13 instances of very high glucose, but no examination of the feet or referral to an opthamologist. The panel found this lack of treatment for a clear case of diabetes to be negligent. The record for patient E shows poor management of diabetes and no medications for this condition given.

The panel found the record for Patient F (Exhibit 8) to be largely illegible. From what the panel could ascertain there was a failure to do and record a proper examination or

history for this patient. This inadequate record nevertheless shows a prescription for Vicodin with no clearly evident justification.

The record for Patient H (Exhibit 9) shows over 100 prescriptions for Didrex issued by the Respondent for the period from 1999 to 2010. According to the Department's expert, Dr. Feldman, Didrex is a stimulant for weight loss to be used with careful monitoring for a short period of time: weeks but not months or years. The record shows that the Respondent kept writing this prescription, for this patient, for over a decade. (T. 304) Furthermore, the Respondent prescribed this drug for years for this patient where there was no need for weight loss as she was of normal weight. The record shows that the Respondent saw this patient 140 times over the years and never gave her appropriate monitoring. The panel found that it was negligent for the Respondent to keep prescribing this short term use drug and not refer the patient to a specialist for weight management. The panel noted that this record concludes with the entry for June 15, 2010, well after the investigation began in this case. This final entry states: "Just Diet and Exercise, No more Meds."

The panel counted the prescriptions in the record and found 106 negligent instances of prescriptions for Didrex. It is noted that there were 107 such prescriptions, but the panel gave the Respondent the benefit of the doubt on the first one. However, since each subsequent visit showed no weight loss, the issuance of such a prescription should have ceased after the first visit.

Department's Exhibit 11 shows a similar pattern with negligent prescribing of Didrex for another patient, Patient I. In the case of Patient I there were 63 visits and prescriptions for Didrex issued each time without counseling and monitoring. The panel again found

negligence on 62 of these visits and prescriptions, giving the Respondent the benefit of the doubt on the first visit.

Department's Exhibit 10 shows a similar pattern with negligent prescribing of Didrex for another patient, Patient H. In the case of Patient H there were 56 visits and prescriptions for Didrex issued each time without a physical examination, counseling, referral or monitoring. The panel again found negligence on 55 of these visits and prescriptions, giving the Respondent the benefit of the doubt on the first visit.

Department's Exhibit 12 presents a mostly illegible record. This record is for Patient J. Like the other records in this case, no history is noted and the Department contended that this record shows misconduct because the Respondent prescribed controlled substances without ever knowing what was hurting the patient. On examining this record, the panel noted that the Respondent did refer this patient to a specialist and thus the panel did not find misconduct in the record presented for this patient. The panel concluded that the record for Patient J does not prove negligence or incompetence. However, the panel did note that the record was inadequate due to its illegibility.

Department's Exhibit 8 presents the record for patient F. While the panel agreed that this was an illegible record they could not find the requisite evidence of misconduct to sustain the charges of negligence for this patient.

It is noted that the failure of the Respondent to testify gave rise to an unfavorable inference that there was no adequate justification for the Respondent's actions. The Respondent had the opportunity to explain his conduct and he chose not to do so. The panel was left to draw the conclusion that it did and the bulk of the Department's case was sustained.

VOTE OF THE HEARING COMMITTEE

FIRST, SECOND, FOURTH, FIFTH AND SIXTH SPECIFICATIONS

VOTE: SUSTAINED (3-0)

The first, second, fourth, fifth and sixth specifications in this case charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530 (3) by practicing the profession of medicine with negligence on more than one occasion for each of the named patients.

In its deliberations the panel reviewed the record and testimony as it pertained to these patients and concluded that the Respondent failed to document and perform adequate histories, or examinations, and treatment for the listed patients.

In particular, the panel noted the negligent writing of prescriptions for opioids for many years for an obvious drug abuser. In addition, the Respondent negligently prescribed a diet pill for patients who had no apparent need for such medication. The particular medication in question, Didrex, should have been carefully monitored and given only for a short period of time. There was no monitoring in this case and the drug was given for years to these patients.

THIRD AND SEVENTH SPECIFICAITONS

VOTE: NOT SUSTAINED (3-0)

The panel did not sustain these charges, which pertained to Patients F and J, because the documentary record on which they were based was not persuasive.

EIGHTH, NINTH, ELEVENTH TWELFTH, THIRTEENTH SPECIFICATIONS

VOTE: SUSTAINED (3-0)

These specifications in this case charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530 (5) by practicing the profession of medicine with incompetence on more than one occasion for each of the named patients.

The panel concluded that the Respondent was clearly incompetent in the manner in which he prescribed opioids to obvious drug abusers and continued to provide diet drugs to patients who did not need them. In addition, the panel noted that the Respondent was not competent in the way he handled a patient with diabetes. Again, the panel noted the failure to do necessary examinations or take adequate medical histories.

TENTH AND FOURTEENTH SPECIFICATIONS

VOTE: NOT SUSTAINED (3-0)

The panel did not sustain these charges because the documentary record on which they were based was, for the most part, illegible and therefore not persuasive. It is noted again that these charges relate to Patients F and J.

FIFTEENTH, SIXTEENTH, EIGHTEENTH, NINTEENTH AND TWENTIETH SPECIFICATIONS

VOTE: SUSTAINED (3-0)

These specifications in this case charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530 (4) by practicing the profession of medicine with gross negligence on a particular occasion for each of the named patients.

In its deliberations the panel reviewed the record and testimony as it pertained to each of the named patients and determined, unanimously, that the allegations of gross negligence, with regard to all the patients, except Patients J and F, as set forth in the Statement of Charges, were sustained. As defined above, Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient.

The overwhelming evidence in this case shows that the Respondent, for years, continued to prescribe opioids for his patients without knowing what was wrong with them and without knowing whether these drugs were helping them or just addressing a drug habit. It is clear from the record that several of these patients had drug-seeking behavior and evidence of drug addiction. It is noted that the allegations of gross negligence concerning Patients J and F were not sustained as the documentary record, the only evidence for these patients, was not clear enough to sustain the charges.

SEVENTEENTH AND TWENTY-FIRST SPECIFICATIONS

VOTE: NOT SUSTAINED (3-0)

The panel did not sustain these charges because the documentary record on which they were based was not persuasive. It is noted that these charges relate to Patients F and J.

TWENTY-SECOND SPECIFICATION

VOTE: SUSTAINED (3-0)

This specification in this case charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530 (6) by practicing the profession of medicine with gross incompetence.

The panel found that the Respondent continued to provide opioids to patients who were taking street drugs such as heroin. One of these patients died from drug intoxication, presumably from drugs given her by the Respondent. Similarly, the panel found it grossly incompetent to continue to prescribe diet drugs for patients who did not need them and who were most likely addicted to these drugs.

TWENTY-THIRD THROUGH TWENTY-NINTH SPECIFICATIIONS

VOTE: SUSTAINED (3-0)

These specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain proper records. The records

maintained by Doctor Bernhard are woefully inadequate and, for the most part, completely illegible. The records for the Respondent's patients are devoid of history, diagnosis, treatment plans, and evaluations. They do not reflect what transpired and do not show the treatment rendered his patients.

The panel was unanimous in finding that these record-keeping charges should be sustained.

THIRTIETH SPECIFICATION

VOTE: SUSTAINED (3-0)

This specification charged Respondent with committing professional misconduct as defined in NY Educ Law §6530 (2) by practicing the profession of medicine fraudulently.

VOTE: SUSTAINED (3-0)

It is noted that the charge of practicing the profession fraudulently involves the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine and, made with the intent to deceive. An individual's knowledge that he or she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. Fraud is also a statement or representation with reckless disregard as to the truth of the statement or representation.

The courts have confirmed findings of fraudulent medical practice in several situations. Submitting false bills or claims for services rendered, with knowledge that they were false, supports a charge of fraudulent practice, as does the submission of false and exaggerated medical reports and bills. Holmstrand v. Board of Regents, 71 A.D.2d 725, 419 N.Y.S.2d 223 (3rd Dept. 1979). While "the mere making or filing of a false report, without intent or knowledge of the falsity . . . " (Brestin v. Commissioner of Education, 116

A.D.2d 357, 501 N.Y.S.2d 923 (3rd Dept. 1986) does not constitute fraudulent practice, the hearing committee is free to reject, as not credible, a licensee's mitigating explanations Kenna v. Ambach, 61 A.D.2d 1091, 403 N.Y.S.2d 351 (3rd Dept. 1978). The hearing committee must base its inferences on that which it accepts as the truth. Klein v. Sobol, 167 A.D.2d 625, 562 N.Y.S.2d 856 (3rd Dept. 1990) appeal denied 77 N.Y.2d 809 (1991). In addition, there need not be actual injury caused by the misrepresentation in order for the misrepresentation to constitute fraudulent practice of medicine.

The unambiguous and unrefuted testimony in this case established that the Respondent created medical records for Patient A-1 who was not his patient. Patient A's daughter, Patient A-1 testified that she was never a patient of Respondent and that she did not take, fill and/or use any prescription issued by Respondent. She testified that Patient A's mother and brother were also not patients of Respondent. The panel concluded that the Respondent knew that the records were fabricated. The panel was convinced that the Respondent created these medical records with the intent to deceive. It is clear that the Respondent knew, or should have known, that Patient A-1 was not utilizing the prescriptions issued by him. There is no evidence to the contrary.

Based on the preponderance of the credible evidence, the Hearing Committee concluded that Respondent practiced the profession fraudulently by fabricating medical records for Patients A-1. The Thirtieth Specification was, therefore sustained.

THIRTY-FIRST AND THIRTY SECOND SPECIFICATONS

These specifications charged Respondent with committing professional misconduct as defined in NY Educ Law §6530 (2) by practicing the profession of medicine fraudulently.

VOTE: NOT SUSTAINED (3-0)

These specifications continued the fraud charge established in Specification 30 above and applied it two additional patients, Patients A-2 and A-3. The panel did not sustain

these charges as they were not convinced that the evidence was clear and overwhelming with regard to these two patients, unlike the clear evidence for Patient A-1.

THIRTY-THIRD SPECIFICATION

This specification charged Respondent with committing professional misconduct as defined in NY Educ Law §6530 (21) by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department.

VOTE: SUSTAINED (3-0)

In this charge, Respondent was accused of willfully making or filing a false report by fabricating medical records for Patient A-1, Patient A's daughter. Patient A's daughter testified that she was never a patient of Respondent and that she did not take, fill and/or use any prescription issued by Respondent. She testified that Patient A's mother and brother were also not patients of Respondent. Respondent willfully fabricated these records. Respondent created these medical records with the intent to deceive. He knew, or should have known, that Patient A-1 was not utilizing the prescriptions issued by him. There is no evidence to the contrary.

Based on the preponderance of the credible evidence, the Hearing Committee concludes that Respondent willfully filed or made a false report by fabricating medical records for Patient A-1. The Thirty-third Specification was, therefore, sustained.

THIRTY-FOURTH AND THIRTY-FIFTH SPECIFICATIONS

VOTE: NOT SUSTAINED (3-0)

These specifications continued the False Report charge set forth in the thirty-third specification. While the panel found a false report clearly proved for Patient A-1, it could

not make the same conclusion for Patients A-2 and A-3 and thus concluded, unanimously, that these specifications should not be sustained.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, after due deliberation, unanimously determined that the First, Second, Fourth, Fifth, Sixth, Eighth, Ninth, Eleventh, Twelfth, Thirteenth, Fifteenth, Sixteenth, Eighteenth, Nineteenth, Twentieth, Twenty-second though Twenty-ninth, Thirtieth and Thirty-third Specifications of professional misconduct, as set forth in the Statement of Charges raised against Respondent were sustained.

The Hearing Committee did not rely solely on the testimony of Doctor Feldman in reaching its conclusion that the Respondent's license should be revoked. The panel looked to the entirety of the record, including the testimony of the daughter of Patient A, and the Skype testimony of the Respondent's mother/ office manager.

The Committee has a responsibility to protect the patients of the State. The issue before this Committee is to choose a penalty that offers the best protection to the people of the State. The Committee finds that the Respondent has committed sufficiently egregious misconduct that demands the revocation of his medical license. The Committee concludes that the Respondent' s conduct in this matter has so violated the public trust with regards to his patients that revocation is the only appropriate penalty under the circumstances of this case.

In reaching this conclusion, the Committee considered the full range of penalties available in a case such as this. The Committee concluded that the only way to ensure the safety of the public is to revoke Respondent's medical license. Any other penalty would risk a recurrence of this behavior. The public should not bear that risk.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Third, Seventh, Tenth, Fourteenth, Seventeenth, Twenty-first, Thirty-first, Thirty-second, Thirty-fourth and Thirty-fifth Specifications of professional misconduct, as set forth in the Statement of Charges, are **NOT SUSTAINED;**

2. The First, Second, Fourth, Fifth, Sixth, Eighth, Ninth, Eleventh, Twelfth, Thirteenth, Fifteenth, Sixteenth, Eighteenth, Nineteenth, Twentieth, Twenty-second, Twenty-third through Twenty-ninth, Thirtieth and Thirty-Third Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED;**

3. The Respondent's license to practice medicine is hereby **REVOKED;**

4. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Schenectady, New York

January 24, 2013

REDACTED

Trevor A. Litchmore, M.D.,CHAIR

Thomas T. Lee, M.D., M.B.A.

Thea Graves Pellman,

TO:

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APPENDIX I

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

IN THE MATTER OF STEVEN BERNHARD, D.O.	STATEMENT OF CHARGES

Steven Bernhard, D.O., the Respondent, was authorized to practice medicine in New York State on or about August 5, 1977, by the issuance of license number 131839 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A for compiaints of pain from on or about April 2, 2001, aimost monthly until her death on February 24, 2006. Respondent provided Patient A with prescriptions for controiled substances at most of the 55 visits documented. (Patient names are identified in the appendix.) Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and/or document a thorough history, initially and on repeat visits.

2. Respondent failed to perform and/or document an appropriate physical examination, initially and on repeat visits.

3. Respondent failed to appropriately evaluate Patient A for, and follow-up on, her compiaints of pain.

4. Respondent failed to properly assess Patient A's cardiac status when she complained of chest pain.

5. Respondent inappropriately treated Patient A in that Respondent:

   a. treated Patient A without examining her,

   b. provided Patient A with prescriptions without medical justification,

   c. provided Patient A with prescriptions for Tylenol #4 at an inappropriate dose/rate,

   d. failed to utilize non-drug therapy to treat Patient A's complaints of pain,

   e. treated Patient A for diagnoses without substantiating the diagnoses,

   f. continued to provide prescriptions for Patient A without addressing behaviors consistent with medication abuse, and/or

   g. failed to refer Patient A to specialists including but not limited to a physical therapist, radiologist and/or, neurologist.

6. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to Patient A.

B. Respondent provided the Office of Professional Medical Conduct (OPMC) with a medical record indicating that he saw Patient A-1, Patient A's daughter, a resident of Virginia, from on or about May 13, 2002 through on or about September 26, 2005. Respondent issued prescriptions for controlled substances on most of the purported visits.

1. Respondent knowingly and intentionally created a false record for Patient A-1 by documenting visits that did not occur.

a. Respondent knew the record was false and he intended to mislead with it.

2. Respondent, intending to mislead, wrote each prescription purportedly for Patient A-1 when in fact the prescriptions were for Patient A.

C. Respondent provided OPMC with a medical record indicating that he saw Patient A-2, Patient A's mother, almost monthly from on or about November 23, 2004, through on or about September 26, 2005. Respondent issued prescriptions for controlled substances on most of the purported visits.

1. Respondent knowingly and intentionally created a false record for Patient A-2 by documenting visits that did not occur.

a. Respondent knew the record was false and he intended to mislead with it.

2. Respondent, intending to mislead, wrote each prescription purportedly for Patient A-2 when in fact the prescriptions were for Patient A.

D. Respondent provided OPMC with a medical record indicating that he saw Patient A-3, Patient A's brother, almost monthly from on or about November 17, 2001, through on or about February 6, 2006. Respondent issued prescriptions for controlled substances on most of the purported visits.

1. Respondent knowingly and intentionally created a false record for Patient A-3 by documenting visits that did not occur.

a. Respondent knew the record was false and he intended to mislead with it.

2. Respondent, intending to mislead, wrote each prescription purportedly for Patient A-3 when in fact the prescriptions were for Patient A.

E. Respondent saw Patient E, a 52 year old male with uncontrolled diabetes, almost monthly from on or about January 27, 2004, through on or about October 1, 2010. Respondent provided Patient E with prescriptions for controlled substances at most of the 56 visits documented. Respondent's care and treatment of Patient E deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and/or note an appropriate and thorough history, initially and on repeat visits.

2. Respondent failed to perform and/or note an adequate physical examination, initially and on repeat visits.

3. Respondent failed to adequately evaluate Patient E to substantiate the diagnosis of neuropathy.

4. Respondent failed to request or obtain prior medical records relating to Patient E's diabetes.

5. Respondent inappropriately treated Patient E in that Respondent:

   a. failed to properly evaluate Patient E and/or refer him to a specialist for a definitive diagnosis and/or for treatment,

   b. inadequately treated Patient E for diabetes in that Respondent failed to properly control his blood sugar,

   c. failed to monitor Patient E's diabetes appropriately,

   d. treated Patient E for anxiety without adequate psychological evaluation.

6. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to Patient E.

F. Respondent saw Patient F on or about July 3, 2008, through on or about April 10, 2009. Respondent's care and treatment of Patient F deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and/or note an adequate history.
2. Respondent failed to perform and/or note an appropriate physical exam.
3. Respondent failed to request or obtain prior medical records relating to his reported open heart surgery and kidney cancer.
4. Respondent inappropriately treated Patient F in that Respondent:
   a. treated Patient F without examining him,
   b. provided Patient F with prescriptions without medical justification,
   c. failed to refer Patient F to a physical therapist and/or orthopedist or, for diagnostic testing.
5. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to Patient F.

G. Respondent saw Patient G, a 5'2" female of normal weight (128 pounds), for weight loss, almost monthly from on or about February 19, 1999, through on or about June 15, 2010. Respondent provided Patient G with prescriptions for Didrex (a controlled substance) at most of the 140 visits documented. Respondent's care and treatment of Patient G deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and/or note an appropriate and thorough history, initially and at repeat visits.

2. Respondent failed to perform and/or note an adequate physical examination, initially and at repeat visit.

3. Respondent failed to properly evaluate Patient G and/or refer her to a specialist when she complained of a lump in her breast.

4. Respondent inappropriately treated Patient G in that Respondent:

a. treated Patient G without examining her,

b. prescribed weight-loss medication to Patient G who was not overweight,

c. maintained Patient G on weight-loss medication for an unreasonable period of time,

d. failed to re-assess treatment when weight remained the same over an extended period of time,

e. prescribed antibiotics without medical necessity shown by history, physical examination and diagnosis,

f. continued to provide prescriptions for Patient G without addressing behaviors consistent with medication abuse, and/or,

g. prescribed Amoxil to Patient G who has a known allergy to penicillin.

5. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to Patient G.

H. Respondent saw Patient H, a 5'4" tall female weighing 145 pounds, for weight loss, almost monthly from on or about July 27, 2001, through on or about May 1, 2010. Respondent provided Patient H with prescriptions for Didrex (a controlled

substance) at most of the 56 visits documented. Respondent's care and treatment of Patient H deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and/or note an appropriate and thorough history, initially and at repeat visits.

2. Respondent failed to perform and/or note an adequate physical examination, initially and at repeat visits.

3. Respondent inappropriately treated Patient H in that Respondent:

   a. prescribed weight-loss medication to Patient H,

   b. maintained Patient H on weight-loss medication for an unreasonable period of time, and/or,

   c. failed to re-assess treatment when weight remained the same over an extended period of time.

4. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to Patient H.

I. Respondent saw Patient I, a 5'11" male weighing 210 pounds, for weight loss, almost monthly from on or about May 20, 2002, through on or about May 12, 2010. Respondent provided Patient I with prescriptions for Didrex (a controlled substance) at most of the 62 visits documented. Respondent's care and treatment of Patient deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and/or note an appropriate and thorough history, initially and on repeat visits.

2. Respondent failed to perform and/or note an adequate physical examination, initially and on repeat visits.

3. Respondent failed to adequately evaluate Patient I prior to treating with weight ioss medication.

4. Respondent inappropriately treated Patient I in that Respondent:

a. prescribed Didrex without evaiuating patient for contraindications,

b. failed to recommend restricted diet and exercise program and refer Patient I to a nutritionist, and/or,

c. failed to re-assess treatment when weight remained the same over extended period of time.

5. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to Patient I.

J. Respondent saw Patient J almost monthly from on or about July 9, 2008, through on or about November 9, 2009. Respondent's care and treatment of Patient J deviated from minimaily accepted standards of care in that:

1. Respondent failed to perform and/or document an appropriate and thorough history, initially and on repeat visits.

2. Respondent failed to perform and/or document an adequate physical examination, initially and on repeat visits.

3. Respondent failed to thoroughly evaluate Patient J based on his complaints of pain and/or refer Patient J to a specialist.

4. Respondent inappropriately treated Patient J in that Respondent:

a. treated Patient J without examining him,

b. prescribed medications for Patient J without medical justification, and/or,

c. failed to adequately establish need for trigger point injections.

5. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to Patient J.

SPECIFICATION OF CHARGES

FIRSTH THROUGH SEVENTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. Paragraph A and its subparagraphs.
2. Paragraph E and its subparagraphs.
3. Paragraph F and its subparagraphs.
4. Paragraph G and its subparagraphs.
5. Paragraph H and its subparagraphs.
6. Paragraph I and its subparagraphs.
7. Paragraph J and its subparagraphs.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

8. Paragraph A and its subparagraphs.
9. Paragraph E and its subparagraphs.
10. Paragraph F and its subparagraphs.
11. Paragraph G and its subparagraphs.
12. Paragraph H and its subparagraphs.
13. Paragraph I and its subparagraphs.
14. Paragraph J and its subparagraphs.

FIFTEENTH THROUGH TWENTY-FIRST SPECIFICATIONS

GROSS NEGLIGENCE

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

15. Paragraph A and its subparagraphs.
16. Paragraph E and its subparagraphs.
17. Paragraph F and its subparagraphs.

18. Paragraph G and its subparagraphs.

19. Paragraph H and its subparagraphs.

20. Paragraph I and its subparagraphs.

21. Paragraph J and its subparagraphs.

TWENTYSECOND SPECIFICATION

GROSS INCOMPETENCE

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

22. Paragraph A and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs and/or Paragraph H and its subparagraphs and/or Paragraph I and its subparagraphs and/or Paragraph J and its subparagraphs.

TWENTY-THIRD THROUGH TWENTY-NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

23. Paragraph A and A (6).

24. Paragraph E and E (6).

25. Paragraph F and F (5).

26. Paragraph G and G (5).

27. Paragraph H and H (4).

28. Paragraph I and I (5).

29. Paragraph J and J (5).

THIRTIETH THROUGH THIRTY-SECOND SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

30. Paragraph A-1 and its subparagraphs.

31. Paragraph A-2 and its subparagraphs.

32. Paragraph A-3 and its subparagraphs.

THIRTY-THIRD THROUGH THIRTY-FIFTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by wilifully making or filing a false report, or failing to file a report

required by law or by the department of health or the education department, as alleged in the facts of:

33. Paragraph A-1 and its subparagraphs.

34. Paragraph A-2 and its subparagraphs.

35. Paragraph A-3 and its subparagraphs.

DATE: March 27, 2012
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct