STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 11, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jay Stanley Saunders, M.D.
341 Route 306
Monsey, New York 10952

William L. Wood, Esq.
Wood and Scher
The Harwood Building
Scarsdale, New York 10583

David W. Smith, Esq.
Steven J. Masef, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: In the Matter of Jay Stanley Saunders, M.D.

Dear Dr. Saunders, Mr. Wood and Mr. Smith:

Enclosed please find the Determination and Order (No. BPMC-98-107) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

REDACTED
Tyrone T. Butler, Director
Bureau of Adjudication

TTB: crc

Enclosure

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

COPY

IN THE MATTER

OF

JAY STANLEY SAUNDERS, M.D.

DETERMINATION

AND

ORDER

BPMC-98-107

MICHAEL R. GOLDING, M.D., Chairman, HRUSIKESH PARIDA, M.D. and **MS. OLIVE JACOB,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **MICHAEL P. McDERMOTT, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee, on all hearing dates except for the hearing held on February 24, 1998 at which Marc P. Zylberberg, Esq., served as the Administrative Officer.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	November 5, 1997
Statement of Charges dated:	November 12, 1997
Pre-Hearing Conference:	December 30, 1997

Hearing Dates:	January 8, 1998 February 4, 1998 February 11, 1998 February 24, 1998 February 25, 1998 (No Testimony) March 17, 1998 March 31, 1998 April 15, 1998
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Dates of Deliberations:	May 5, 1998 May 26, 1998
Petitioner appeared by:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health BY: David W. Smith, Esq. and Steven J. Masef, Esq., of Counsel
Respondent appeared by:	Wood & Scher The Harwood Building Scarsdale, New York 10583 BY: William L. Wood, Esq.

WITNESSES

For the Petitioner:	1) Aaron G. Meislin, M.D. 2) Hedi Louise Leistner, M.D. 3) Nancy Sculerati, M.D.
For the Respondent:	1) Jay Stanley Saunders, M.D., the Respondent 2) Neil Calman, M.D.

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with Negligence on More than One Occasion; Incompetence on More than One Occasion; Fraudulent Practice; Unnecessary Tests and/or Treatment; Failing to Maintain Records; False, Fraudulent or Deceptive Advertising; and Moral Unfitness.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Jay Stanley Saunders, M.D., the Respondent, was authorized to practice medicine in New York State on April 7, 1986 by the issuance of license number 165803 by the New York State Education Department.

FINDINGS AS TO PATIENT A

2. During the period April, 1993 to September, 1993, the Respondent treated Patient A, a 14 year old female, for a facial rash and other medical conditions (Pet's. Ex. 3; Tr. 21-41).

3. The Respondent diagnosed Patient A with contact dermatitis and inappropriately recorded Mycolog in the patient's chart. However, it appears that Respondent intended the term "Mycolog" to mean something other than "Mycolog", thereby making his patient note inaccurate (Pet's. Ex. 3, p. 2; Tr. 41, 357, 387-389).

4. On April 16, 1993 and again on September 29, 1993, the Respondent performed Tympanography, Acoustic Reflex, Audiometry and Peak Flow Rate Tests on Patient A (Pet's. Ex. 3, p. 3; Tr. 33, 36-37, 989, 1042-1044).

5. The Respondent billed Medicaid for each of these tests (Pet's. Ex. 3, pp. 8-13).

6. Patient A's medical record indicates that the tests performed on April 16, 1993 were medically indicated based on the recorded history and physical findings and also because it was Patient A's initial visit (Pet's. Ex. 3, pp. 2-3; Tr. 24, 44).

7. The tests performed on September 29, 1993 were medically indicated based on the recorded patient history and physical findings (Pet's. Ex. 3, p. 3; Tr. 662-663).

8. By September 29, 1993, Patient A had gained 53 pounds. The Respondent failed to note the obesity and failed to follow-up, evaluate or treat said condition (Pet's. Ex. 3, p. 3; Tr. 31-32, 659-660).

9. The Respondent's medical history for Patient A was incomplete in that it omitted reference to Patient A's significant weight gain and menstrual history (Pet's. Ex. 3).

10. Patient A complained of Eczema. The Respondent treated this condition but failed to note any follow-up (Pet's. Ex. 3, pp. 2-3).

CONCLUSIONS AS TO PATIENT A

The Hearing Committee concludes as follows:

a) The tests performed by the Respondent on April 16, 1993 and September 29, 1993 were medically indicated.

b) Patient A's significant weight gain and menstrual history should have been recorded in the patient's record.

c) The Respondent should have recorded his follow-up treatment of Patient A's Eczema.

d) The Respondent's inappropriate recording of "Mycolog", when in fact he meant something else, was insignificant and not a problem.

FINDINGS AS TO PATIENT B

11. During the period March, 1991 to October, 1993, the Respondent treated Patient B for a rash and other medical conditions (Pet's. Ex. 4; Tr. 81-126).

12. The Respondent performed Tympanography, Acoustic Reflex, Audiometry and Peak Flow Rate tests on March 17, 1991, June 26, 1991, October 2, 1991, November 13, 1991, June 26, 1992, July 1, 1992, October 4, 1992, July 2, 1993 and October 15, 1993 (Pet's. Ex. 4, pp. 2-4; Tr. 84-85, 88, 93, 95-104, 107-108, 112-115, 989, 1042-1044).

13. The Respondent billed Medicaid for each of these tests (Pet's. Ex. 4, pp. 18-25).

14. Patient B's medical record indicates that the tests performed on March 17, 1991, June 26, 1991, November 31, 1991, June 26, 1992, October 2, 1991, October 4, 192, July 2, 1993 and October 15, 1993 were medically indicated based on the recorded physical findings (Pet's. Ex. 4, pp. 2-4; Tr. 709-720).

15. The tests performed on July 1, 1992 were not supported by Patient B's medical record and were inappropriate (Pet's. Ex. 4, p. 3; Tr. 103).

16. On March 17, 1991, the Respondent diagnosed Patient B with enuresis but failed to properly follow up, evaluate or treat said condition (Pet's. Ex. 4, p. 2; Tr. 84, 94, 703-704).

17. On March 17, 1991, the Respondent diagnosed Patient B with "Tinea Pedis". He prescribed Tinactin for the Tinea Pedis but the patient was not compliant. The Tinea Pedis condition was a chronic problem for Patient B because of frequent visits to the Mikva for religious ritual baths (Pet's. Ex. 4; Tr. 104, 510-511, 705).

18. On March 17, 1991, the Respondent noted Patient B's obesity. He continued to record the patient's weight on subsequent visits, but failed to document his evaluation and treatment plan (Pet's. Ex. 4, pp. 2, 3, 4; Tr. 512-518, 758-759).

CONCLUSIONS AS TO PATIENT B

The Hearing Committee concludes as follows:

a) The tests performed by the Respondent were medically indicated except for those tests performed on July 1, 1992.

b) Patient B's enuresis and weight problems were noted, but there is no documented evaluation, management and follow-up in the record.

FINDINGS AS TO PATIENT C

19. During the period December, 1989 to August, 1993, the Respondent treated Patient C for a sore throat and other medical conditions (Pet's. Ex. 5; Tr. 173-206).

20. The Respondent performed Tympanography, Audiometry and Pulmonary Function tests on December 20, 1989, April 8, 1990, October 14, 1990, February 23, 1992, February 7, 1993, July 5, 1993, July 18, 1993 and August 8, 1993 (Pet's. Ex. 5, pp. 2-4, 7-14).

21. The Respondent billed Medicaid for each of these tests (Pet's. Ex. 5, pp. 19-20).

22. Patient C's medical record indicates that all of the tests, with the exception of the Tympanography and Audiometry tests performed on October 14, 1990, were medically indicated based on the recorded history and physical findings (Pet's. Ex. 5; Tr. 761-772).

23. The record fails to document the reasons for the Tympanography and Audiometry tests performed on July 18, 1993. However, an abnormal finding was made indicating the appropriateness of the tests (Tr. 768-770).

24. The Pulmonary Function Test performed on February 23, 1992 was not supported by Patient C's medical record and was inappropriate. In addition, in a patient with a diagnosis of exercise induced asthma, some of the Pulmonary Function tests should be done pre and post exercise. In this case, no post exercise testing was done (Pet's. Ex. 5).

CONCLUSIONS AS TO PATIENT C

The Hearing Committee concludes as follows:

a) The tests performed by the Respondent were medically indicated except for the Tympanography and Audiometry tests performed on October 14, 1990.

b) Since Patient C was diagnosed with exercise induced asthma, some of the Pulmonary Function Tests should have been done post exercise.

FINDINGS AS TO PATIENT D

25. During the period December, 1990 to November, 1993, the Respondent treated Patient D for nasal congestion and other medical conditions (Pet's. Ex. 6; Tr. 272-283).

26. The Respondent performed Tympanography and Pulmonary Function Tests on December 11, 1990, April 21, 1991, April 26, 1991, August 4, 1991, August 25, 1991, October 2, 1991, November 3, 1991, November 24, 1991, May 10, 1992, July 1, 1992, February 2, 1993, February 16, 1993, April 2, 1993 and June 1, 1993 (Pet's. Ex. 6).

27. The Respondent billed Medicaid for each of these tests (Pet's. Ex. 6, pp. 31-36).

28. Patient D's medical record indicates that all of the tests, with the exceptions of the Tympanography performed on February 16, 1993 and June 1, 1993 and the Pulmonary Function Test performed on April 26, 1991, were medically indicated based on the recorded physical findings (Pet's. Ex. 6; Tr. 282-283, 831-848).

29. The Tympanography performed on February 16, 1993 and June 1, 1993 and the Pulmonary Function Test performed on April 26, 1991 were not supported by Patient D's medical record and were inappropriate (Pet's. Ex. 6; Tr. 282-283, 831-848).

30. On April 2, 1993, the Respondent referred Patient D to a gynecologist for a PAP test and for a breast and internal examination (Pet's. Ex. 6, p. 6).

31. Patient D was being treated for depression by a psychiatrist (Pet's. Ex. 6, p. 5).

32. The Respondent performed an extensive work-up for Patient D's arthritis and his drug treatment for this condition was adequate (Pet's. Ex. 6, pp. 9-16; Tr. 821-824).

CONCLUSIONS AS TO PATIENT D

The Hearing Committee concludes as follows:

a) The Tympanography and Pulmonary Function Tests performed by the Respondent were medically indicated, except for the Tympanography performed on February 16, 1993 and June 1, 1993 and the Pulmonary Function Test performed on April 26, 1991.

b) Patient D's arthritis and depression were adequately addressed by the Respondent.

c) While there are minor deficiencies with respect to Patient D's medical record regarding history and physical, they do not reach the level of negligence or incompetence.

FINDINGS AS TO PATIENT E

33. On October 14, 1993, the Respondent treated Patient E for intermittent abdominal pain and other medical conditions (Pet's. Ex. 7; Tr. 305-331).

34. On October 14, 1993, the Respondent performed Tympanography, Acoustic Reflex, Audiometry, and Spirometry (Pet's. Ex. 7; Tr. 309-311).

35. The Respondent billed Medicaid for each of these tests (Pet's. Ex. 7, pp. 7-8).

36. The testing performed by the Respondent on October 14, 1993 was appropriate because the Orange County Department of Social Services had requested a complete evaluation of Patient E.

CONCLUSIONS AS TO PATIENT E

The Hearing Committee concludes as follows:

The testing performed by the Respondent on October 14, 1993 was done pursuant to a request by the Orange County Department of Social Services for a complete evaluation of Patient E and was appropriate.

FINDINGS AS TO CHARGE F

The Respondent advertised in a local newspaper as follows: "Subspecially trained in Allergy, Immunology and rheumatology - Children and Adults". In fact, the Respondent only completed about one-third of a two year fellowship in Allergy, Immunology and Rheumatology. Moreover he does not have privileges at any hospital for Allergy, Immunology and Rheumatology (Pet's. Ex. 8; Tr. 333, 337, 419, 421).

CONCLUSIONS AS TO CHARGE F

The Hearing Committee concludes that the Respondent knowingly intended to mislead by false representations in the advertisement.

VOTE OF THE HEARING COMMITTEE

(All Votes Were Unanimous Unless Otherwise Specified)

FIRST SPECIFICATION: NEGLIGENCE ON MORE THAN ONE OCCASION)

A(1) **SUSTAINED**

A(2) **NOT SUSTAINED**

A(3) **NOT SUSTAINED**

A(4) **NOT SUSTAINED**

A(5) **SUSTAINED**

B(1) **SUSTAINED** only as to the tests performed on July 1, 1992

NOT SUSTAINED as to the tests performed on other dates

B(2) **SUSTAINED**

B(3) **SUSTAINED**

C(1) **SUSTAINED** as to the tests performed on October 14, 1990

NOT SUSTAINED as to the tests performed on other dates

C(2) **SUSTAINED** as to the tests performed on October 14, 1990

NOT SUSTAINED as to the tests performed on other dates

D(1) **NOT SUSTAINED**

D(2) **NOT SUSTAINED**

D(3) **NOT SUSTAINED**

D(4) **SUSTAINED** as to the Tympanography tests performed on February 16, 1993 and June 1, 1993 and as to the Pulmonary Function test performed on April 26, 1991

NOT SUSTAINED as to the tests performed on other dates

E(1) **NOT SUSTAINED**

SECOND SPECIFICATION: (INCOMPETENCE ON MORE THAN ONE OCCASION)

A(1) **NOT SUSTAINED**

A(2) **NOT SUSTAINED**

A(3) **NOT SUSTAINED**

A(4) **NOT SUSTAINED**

A(5) **NOT SUSTAINED**

B(1) **NOT SUSTAINED**

B(2) **NOT SUSTAINED**

B(3) **NOT SUSTAINED**

C(1) **NOT SUSTAINED**

D(1) **NOT SUSTAINED**

D(2) **NOT SUSTAINED**

D(3) **NOT SUSTAINED**

D(4) **NOT SUSTAINED**

E(1) **NOT SUSTAINED**

THIRD THROUGH EIGHTH SPECIFICATIONS; (FRAUDULENT PRACTICE)

A(3) **NOT SUSTAINED**

A(4) **NOT SUSTAINED**

A(6) **NOT SUSTAINED**

B(1) **NOT SUSTAINED**

B(4) **NOT SUSTAINED**

C(1) **NOT SUSTAINED**

C(2) **NOT SUSTAINED**

D(4) **NOT SUSTAINED**

D(5) **NOT SUSTAINED**

E(1) **NOT SUSTAINED**

E(2) **NOT SUSTAINED**

F **SUSTAINED**

NINTH THROUGH THIRTEENTH SPECIFICATIONS:

(UNNECESSARY TESTS AND/OR TREATMENT)

A(2) **NOT SUSTAINED**

A(3) **NOT SUSTAINED**

A(4) **NOT SUSTAINED**

B(1) **SUSTAINED** as to the tests performed on July 1, 1992

NOT SUSTAINED as to the tests performed on other dates

C(1) **SUSTAINED** as to the tests performed on October 14, 1990

NOT SUSTAINED as to the tests performed on other dates

D(4) **SUSTAINED** as to the Tympanography tests performed on February 16, 1991 and June 1, 1993 and as to the Pulmonary Function Test performed on April 26, 1991

NOT SUSTAINED as to the tests performed on other dates

E(1) **NOT SUSTAINED**

FOURTEEN THROUGH SIXTEENTH SPECIFICATIONS:

(FAILING TO MAINTAIN RECORDS)

A(1) **SUSTAINED**

A(5) **SUSTAINED**

B(2) **SUSTAINED**

B(3) **SUSTAINED**

D(1) **SUSTAINED**

D(2) **SUSTAINED**

D(3) **SUSTAINED**

SEVENTEENTH SPECIFICATION:

(FALSE, FRAUDULENT OR DECEPTIVE ADVERTISING)

F **SUSTAINED**

EIGHTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS: (MORAL UNFITNESS)

A(3) **NOT SUSTAINED**

A(4) **NOT SUSTAINED**

A(6) **NOT SUSTAINED**

B(1) **NOT SUSTAINED**

B(4) **NOT SUSTAINED**

C(1) **NOT SUSTAINED**

C(2) **NOT SUSTAINED**

D(4) **NOT SUSTAINED**

D(5) **NOT SUSTAINED**

E(1) **NOT SUSTAINED**

E(2) **NOT SUSTAINED**

F **NOT SUSTAINED**

CONCLUSIONS OF THE HEARING COMMITTEE

During the course of his testimony, Aaron G. Meislin, M.D., the Petitioner's expert witness, made very similar observations in evaluating the Respondent's care of Patients A, B, C and D. These observations are supported by the evidence, and they accurately summarize the problems with the Respondent's medical practice.

PATIENT A: "I think that there seems to be such a preoccupation with pulmonary function, and ear function, it takes up the allotted time or the allotted interest of the doctor, to the exclusion of other presenting, and I would say more serious problems.

I would have gotten a blood pressure on the child also with this degree of a weight gain. There is sort of an unbalanced approach to patient's problems here that I don't quite follow." (Tr. 37-38)

PATIENT B: "My objection is that as a primary care physician, he does not have a broad conception of medical complaints that should be dealt with in the course of caring for a youngster.

And he has such a directed interest, and such a minute interest in one aspect of a patient's complaints, that it appears to me that he is losing sight of other areas of problems." (Tr. 167)

PATIENT C: "Third of all, you had a patient that you are concerned about hematuria, so there certainly are more important things to consider than a repeat evaluation, middle ear dynamics and respiratory function.

I don't see that this takes center stage over some of the other findings of interest.

Now, a blood workup was ordered later on, but certainly, if you are concerned about the hematuria, about the blood in the urine, I would think that an evaluation should have been done before a repeat pulmonary function evaluation, and a repeat middle ear evaluation."

"But presumably, the patient was referred to a laboratory on-and blood workup was done on 8/11, and we do have the laboratory report from 8/11, and that should include a complete urinalysis, which it does, and there are zero red cells in the report from the lab. And the sedimentation rate-there is no evidence of serious inflammatory disease. There is no evidence of a lupus, which was suspected-which was considered. I shouldn't say suspected. The blood count was normal. And the laboratory workup was appropriate, complete, and the patient was referred to a urologist before the laboratory work was done, but again, he did not escape his typanogram, acoustic reflex, audiogram, pulmonary function studies, which were all, again, normal." (Tr. 197-200)

PATIENT D: "The only objection I would say, however, I would say no matter what the presenting complaints from a contact dermatitis to arthritis, depression, she always was given the tympanogram, the pulmonary function studies, and this was done on almost each visit. There is sort of a preoccupation with these pulmonary function studies, as we have seen, or as I have seen in previous patients." (Tr. 277)

The Hearing Committee concurs with Dr. Meislin's evaluations and concludes that the Respondent, as a primary care physician, does not have the broad conception of medical complaints that should be dealt with in the course of caring for his patients and that he has a preoccupation with pulmonary and ear functions to the exclusion of other presenting and perhaps even more serious problems.

The Hearing Committee also concludes that the Respondent knowingly intended to mislead by false representations in his newspaper advertisement.

DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee has considered the full spectrum of available penalties, including revocation, suspension, probation, censure and reprimand or the imposition of civil penalties not to exceed $10,000 per violation.

The Hearing Committee determines: (1) that the Respondent's license to practice medicine should be suspended, that the suspension be partially stayed; and (2) that the Respondent be put on probation; the terms of probation to include reeducation and monitoring. The terms of suspension and probation are set forth hereinafter in the Hearing Committee's ORDER.

The Hearing Committee also determines that a civil penalty in the amount Five Thousand Dollars ($5,000) should be assessed against the Respondent because of his false advertising.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in the State of New York is **SUSPENDED** for a period of One (1) year, the last six (6) months of said suspension is **STAYED**, six (6) months actual suspension, with terms of probation as follows:

   During the six (6) months of actual suspension and the six (6) months of stayed suspension, (the one year SUSPENSION period), the Respondent shall successfully complete 100 hours of Continuing Medical Education appropriate to a primary care physician in the specialties of pediatrics and family practice and shall submit to the Office of Professional Medical Conduct certificates indicting successful completion of said courses. Such courses are

offered by the American Academy of Pediatrics, the American Academy of Family Practice and the University of Medicine and Dentistry of New Jersey (New Jersey Medical School-Newark).

If for some reason the Respondent is unable to attend the courses offered by these institutions, he may attend equivalent courses offered by other institutions, but he must obtain prior approval from the Office of Professional Medical Conduct.

2. For a two (2) year period after the six (6) months of actual **SUSPENSION**, the Respondent will be on probation and his practice shall be monitored by a practice monitor who is board certified in either pediatrics or family practice who is familiar with the terms of this **DETERMINATION AND ORDER;** who did not participate in this hearing; and who is approved by the Office of Professional Medical Conduct;

* The Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

* The Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

* The Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

* The Respondent shall maintain medical malpractice insurance coverage with limits no less that $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to the Respondent's practice after the effective date of this Order.

3. The period of probation shall be tolled during periods in which the Respondent is not engaged in the active practice of medicine in New York State. The Respondent shall notify the Director of OPMC, in writing, if the Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. The Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon the Respondent's return to practice in New York State.

4. A civil penalty in the amount of Five thousand Dollars ($5,000) is assessed against the Respondent for his false advertising.

5. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: North Bergen, New Jersey
June 8, **1998**

REDACTED

MICHAEL R. GOLDING, M.D.

HRUSIKESH PARIDA, M.D.
MS. OLIVE JACOB

APPENDIX I

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

IN THE MATTER OF JAY STANLEY SAUNDERS, M.D.	STATEMENT OF CHARGES

JAY STANLEY SAUNDERS, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 7, 1986, by the issuance of license number 165803 by the New York State Education Department.

At all times mentioned herein, Respondent was enrolled as a physician provider with the New York State Medical Assistance Program holding Provider # 00958705. Patients A through E were all recipients enrolled in the New York State Medical Assistance Program. (Patients A through E are identified in the attached Appendix A)

FACTUAL ALLEGATIONS

A. Between in or about April, 1993 and September, 1993, Respondent treated Patient A at his offices located at 341 Route 306, Monsey, New York 10952 (hereinafter "Office") for facial erythema and other medical conditions.

1. Throughout the period, Respondent failed to obtain an adequate medical history or note such history, if any.

2. Respondent inappropriately prescribed Mycolog cream.

3. On each visit, Respondent inappropriately performed or caused to be performed:

   a. Tympanography
   b. Acoustic reflex test
   c. Audiometry
   d. Throat culture

4. Respondent inappropriately ordered pulmonary function tests.

5. Patient A complained of Eczema but Respondent failed to evaluate, follow-up or treat such condition or note such evaluation, follow-up or treatment, if any.

6. The tests and/or treatment set forth in Paragraphs 3a-d and 4 above, were ordered or performed by Respondent knowingly and intentionally without a bona fide medical reason.

B. Between in or about March, 1991 and October, 1993, Respondent treated Patient B for rash and other medical conditions at his Office.

1. During each visit, Respondent inappropriately performed or caused to be performed:

   a. Tympanography
   b. Acoustic reflex test
   c. Audiometry

d. Throat culture

e. Peak flow rate test

2. Respondent diagnosed Enuresis and weight problems but Respondent failed to evaluate, follow-up or treat such conditions or note such evaluation, follow-up or treatment, if any.

3. Respondent diagnosed "tinea pedis" but failed to adequately follow-up or make a dermatological referral despite persistence of such condition or note such follow-up or referral, if any.

4. The tests set forth in Paragraphs 1a-e above, were ordered or performed by Respondent knowingly and intentionally without a bona fide medical purpose.

C. Between in or about December, 1989 and August, 1993, Respondent treated Patient C at his Office for sore throat and other medical conditions.

1. During each visit, Respondent inappropriately performed or caused to be performed:

a. Tympanography

b. Audiometry

c. Pulmonary function tests

2. The tests set forth in Paragraphs C1a-c above, were ordered or performed by Respondent knowingly and intentionally without a bona fide medical purpose.

D. Between in or about December, 1990 and November, 1993, Respondent treated Patient D at his Office for nasal congestion and other medical conditions.

1. Respondent failed to perform an adequate physical examination or note such examination, if any.

2. Respondent failed to obtain an adequate medical history or note such history, if any.

3. Patient D complained of arthritis and depression but Respondent failed to evaluate, follow-up or treat such conditions or note such evaluation, follow-up or treatment, if any.

4. Respondent inappropriately performed or caused to be performed:

   a. Tympanography
   b. Pulmonary function tests

5. The tests set forth in Paragraphs 4a-b above, were ordered or performed by Respondent knowingly and intentionally without a bona fide medical purpose.

E. On or about October, 1993, Respondent treated Patient E at his Office for intermittent abdominal pain and other medical conditions.

1. Respondent inappropriately and without legitimate medical purpose performed or caused to be performed:

   a. Tympanography
   b. Acoustic reflex test
   c. Audiometry
   d. Throat culture
   e. Spirometry

2. The tests set forth in Paragraphs 1a-e above, were ordered or performed by Respondent knowingly and intentionally without a bona fide medical purpose.

F. In or about April, 1991, Respondent deliberately, falsely and with intent to deceive advertised in a local newspaper as follows: "Subspecially trained in Allergy, Immunology and Rheumatology - Children and Adults". In fact, Respondent did not have adequate training in any of these fields.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1997) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1-5; B and B1-3; C and C1; D and D1-4; and/or E and E1.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1997) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A and A1-5; B and B1-3; C and C1; D and D1-4; and/or E and E1.

THIRD THROUGH EIGHTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1997) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A, A3, A4 and A6.
4. Paragraphs B, B1 and B4.
5. Paragraphs C, C1 and C2.
6. Paragraphs D, D4, and D5.
7. Paragraphs E, E1, and E2.
8. Paragraph F.

NINTH THROUGH THIRTEENTH SPECIFICATIONS

UNNECESSARY TESTS AND/OR TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1997) by ordering excessive tests and/or treatments not warranted by the condition of the patient, as alleged in the facts of:

9. Paragraphs A, A2-4.
10. Paragraphs B, B1.
11. Paragraphs C, C1.

12. Paragraphs D, D4.

13. Paragraphs E, E1.

FOURTEENTH THROUGH SIXTEENTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1997) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patients as alleged in the facts of:

14. Paragraphs A, A1 and A5.

15. Paragraphs B, B2, and B3.

16. Paragraphs D, D1-3.

SEVENTEENTH SPECIFICATION

FALSE, FRAUDULENT OR DECEPTIVE ADVERTISING

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(27)(a)(McKinney Supp. 1997) by engaging in advertising which is false, fraudulent or deceptive, as alleged in the facts of the following:

17. Paragraph F.

EIGHTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1997) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

18. Paragraphs A, A3, A4 and A6.
19. Paragraphs B, B1 and B4.
20. Paragraphs C, C1 and C2.
21. Paragraphs D, D4 and D5.
22. Paragraphs E, E1 and E2.
23. Paragraph F.

DATED: November 12, 1997
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct