NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

September 29, 2021

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jeffrey J. Conklin, Esq.
NYS Department of Health
Corning Tower Room 2517
Empire State Plaza
Albany, New York 12237

Anthony Z. Scher, Esq.
800 Westchester Avenue
Suite N-641
Rye Brook, New York 10573

RE: In the Matter of Danielle Roberts, DO

Dear Parties:

Enclosed please find the Determination and Order (No. 21-206) 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. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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:

Jean T. Carney, 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 Ms. Carney 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]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: nm
Enclosure

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

IN THE MATTER	**DETERMINATION**
OF	**AND**
DANIELLE ROBERTS, D.O.	**ORDER**

A Notice of Hearing and Statement of Charges dated March 5, 2020, and Amended Statement of Charges dated April 27, 2020, were duly served pursuant to § 230(10)(d)(i) of the Public Health Law (PHL) upon Danielle Roberts, D.O. (Respondent). (Exhibits 1, 1a; Appendix I.) Steven Lapidus, M.D., Chair, Ramanathan Raju, M.D., and Joan Martinez McNicholas, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee, and Dawn MacKillop-Soller, served as the Administrative Law Judge. PHL § 230(10)(e). The Department of Health, Bureau of Professional Medical Conduct (Department), appeared by Jeffrey J. Conklin, Esq. The Respondent appeared and was represented by Anthony Z. Scher, Esq.

The Hearing Committee voted 3-0 to sustain 45 specifications among ten definitions of misconduct set forth in the Education Law: willfully abusing a patient §6530(31); conduct in the practice of medicine which evidences moral unfitness §6530(20); failing to use appropriate infection control practices §6530(47); practicing the profession of medicine fraudulently §6530(2); practicing the profession with gross negligence §6530(4); practicing the profession with negligence on more than one occasion §6530(3); practicing the profession with gross incompetence §6530(6); practicing the profession with incompetence on more than one occasion §6530(5); performing professional services which have not been authorized by the patient §6530(26); and failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient § 6530(32). The Hearing Committee also voted 2-1 to sustain two

additional specifications of misconduct: willfully failing to file a report required by law §6530(21) and willfully or grossly negligently failing to comply with substantial provisions of federal, state, or local laws, rules, or regulations governing the practice of medicine §6530(16).

The Hearing Committee unanimously determined to impose the penalty of revocation of the Respondent's medical license pursuant to PHL § 230-a(4).

Hearing Record

Pre-Hearing Conference:	May 28, 2020
Hearing Dates:	June 2, July 1 & 6, August 12 & 14, September 9, October 21, November 3, December 2 & 15, 2020. January 8, February 19, March 2, 2021.
Witnesses for Petitioner:	Vasco Bilbao (Transcript, p. 61-189.) Danielle Roberts, D.O. (Transcript, p. 199-440, 514-757.) Ariella Cepelinski (Transcript, p. 443-490.) Michael Menashy (Transcript, p. 492-511.) S.E. (Transcript, p. 769-942.) Robert T. Grant, M.D. (Transcript, p. 1056-1238.) Bruce F. Farber, M.D. (Transcript, p. 955-1045.)
Petitioner's Exhibits:	1, 1a, 2a, 2b, 3, 4, 6, 8d, 9, 14a, 15a, 16, 17, 35, 38, 45, 47-49
Witnesses for Respondent:	Danielle Roberts, D.O. (Transcript, p. 1247-1461, 2106-2150.) David Mayer, M.D. (Transcript, p. 1469-1594.) M.H. (Transcript, p. 1594-1666.) Jane Doe 1 (Transcript, p. 1675-1720.) Jane Doe 2 (Transcript, p. 1726-1755.) Steve Arthur Haworth (Transcript, p. 1758-1840, 2094-2097.) E. Carlson (Transcript, p. 1845-1855.) R. Wolle (Transcript, p. 1856-1867.) Jane Doe 3 (Transcript, p. 1878-1930.) Jane Doe 4 (Transcript, p. 1934-1993.) Jane Doe 5 (Transcript, p. 1996-2092.)
Respondent's Exhibit:	A
ALJ Exhibit:	I
Written Submissions received:	June 2, 2021
Deliberations held:	June 29, July 20, 2021

Findings of Fact

The Hearing Committee unanimously makes the following findings of fact:

1. Respondent Danielle Roberts, D.O., was authorized to practice medicine in New York State on October 5, 2009, by the issuance of license number 255075. (Exhibit 3.)

2. The Respondent's background includes board certification and completion of a residency in family practice in 2011 followed by working as a physician and medical director between 2011 and 2013 at a large family practice caring for patients of all ages and with various conditions. From 2013 to 2018, she worked as a hospitalist at St. Peter's Hospital in Albany providing medical care to hospital patients from admission to discharge. Her background also includes seven years of locum tenens work at a hospital in Wisconsin and one year at a large integrative medical practice in Manhattan. (Exhibit 38; Transcript, p. 202, 206-207, 1249-1250, 1424-1425.)

3. In 2013, the Respondent joined NXIVM, a personal development organization founded by Keith Raniere, also known as Vanguard. NXIVM is the parent company to several umbrella organizations, including ESP (Executive Success Programs), SOP (Society of Protectors), Ninth Media, DOS (dominus obsequious sororium, master/slave, master allegiance sisterhood), and Exo/Eso (fitness/exercise program), with multiple center locations in New York, California, Canada, and Mexico. (Exhibit 49; Transcript, p. 65, 184, 186-187, 224, 1255-1256, 1261, 1728.)

4. In 2016, the Respondent joined DOS, a secret women's group developed by eight "1st line" or original members in collaboration with Keith Raniere. The claimed purpose of DOS was to empower women to build character, strength, and discipline by overcoming fears and pain to experience growth. The Respondent's involvement in DOS was "2nd line member" behind the "1st line" members. (Exhibits 14a, 49; Transcript, p. 234, 246, 252-253, 411-412, 526, 785, 1426, 1938, 2003.)

5. Membership in DOS required a lifetime commitment or "vow of obedience" between master and slave, the exchange of collateral, a necklace or collar worn 24 hours every day to symbolize obedience and commitment, and a brand placed by an electrocautery device to the pelvic region as part of a branding ceremony. The vow required slaves to strictly follow their masters' orders and keep DOS completely secret. The goal of the branding was to overcome pain and create solidarity. (Exhibit 14a; Transcript, p. 240-243, 255-256, 358-359, 1265, 1268, 1730, 1747-1750, 1888, 1938-1939.)

6. The brandings of the women, including S.E., A.M., J.G., C.G., A.C., and L.S., occurred only after they committed to join DOS and submitted multiple forms of acceptable collateral. Acceptable collateral included titles to houses and cars, investment and bank accounts, businesses, nude photographs, incriminating letters and/or written confessions detailing sexual deviance, illicit drug use, extramarital affairs, and/or embarrassing family matters. The collateral coerced the women into keeping DOS secret and maintaining their commitment and was subject to public release if the women breached these requirements. (Exhibit 14a; Transcript, p. 243-246, 358-359, 781, 783, 796, 815, 859, 894, 1730, 1747-1748, 1967, 1969, 2054-2055.)

7. An electrocautery device generates electrical energy that is converted to heat for cutting through skin or solid organs, dissection, separating planes between tissues, hemostasis to stop or seal off bleeding blood vessels or lymphatics during procedures, and for electrocautery branding to place a scar on the body. While an electrocautery device can be used as a scalpel, it is not intended to be used directly on the skin surface because it can cause significantly more skin damage extending beyond the tip or point of contact. (Transcript, p. 1072, 1074, 1224, 1541.)

8. A smoke evacuator must be used with an electrocautery device to remove dangerous particulate matter such as viruses, infectious diseases, blood cells, and other antigens released from the

device upon contact with skin and tissue and prevent them from being absorbed or inhaled. (Transcript, p. 1074, 1082.)

9. Electrocautery branding is a form of body modification in which an electrical arch on the electrocautery device vaporizes the skin and leaves behind undamaged skin and tissue but not a 2nd degree burn. (Transcript, p. 1787-1788.)

10. Prior to performing the branding procedures on the women, including S.E., A.M., J.G., C.G., A.C., and L.S., the Respondent was required, under acceptable standards of medical conduct that apply to physicians, to complete training in the use of an electrocautery device. The training involves: (1) regulating the settings considering skin anatomy for the appropriate amount of energy transmitted through the tip; (2) grounding the device; (3) using personal protection equipment; and (4) safely operating and maintaining the device, including the use of a smoke evacuator. The Respondent never completed such training. (Transcript, p. 1070-1079, 1082-1087, 1125-1126, 1322-1325, 1327-1328.)

11. Beginning in January of 2017 and continuing through March of 2017, the Respondent used a Medline Valley Lab Surgistat electrocautery device and a stencil to brand "KAR," the initials of Keith Raniere, into the pelvic regions of 17 women, including S.E., A.M., J.G., C.G., A.C., and L.S., most of whom were nude. The brandings were done without anesthesia to intentionally cause them pain. (Exhibits 8D, 45, 47; Transcript, p. 313, 339, 416, 524, 584-585, 635-640, 692, 1331-1332, 1353, 2107-2108.)

12. The branding procedures occurred in a small room of a house and took between 20 and 45 minutes to complete. They were videotaped with a cell phone while a group of women used their bare hands and/or naked bodies to hold down the woman branded to keep her still and supine on the massage table. (Exhibit 8D; Transcript, p. 308, 313-314, 330, 524, 636, 804, 821, 827, 1333-1334, 1377, 1416, 1421.)

13. The Respondent's conduct in performing the brandings on S.E., A.M., J.G., C.G., A.C., L.S. and the other women constituted the practice of medicine by a physician. The Respondent relied on her medical training, education, and background when she performed the procedures to alter the skin and physical condition of their pelvic regions. (Transcript, p. 1110, 1115-1116, 1129, 1176.)

14. The brandings performed by the Respondent while licensed as a physician were medical procedures in which standards of medical practice apply. (Transcript, p. 1097, 1109, 1112, 1129, 1163.)

15. An electrocautery device must be properly grounded to ensure the safe return of the electrical energy from the person treated with the electrocautery device back to the grounding pad, which is affixed to that person. This process involves ensuring the operator and participants are properly insulated to prevent a burn by wearing gloves to avoid serving as the ground themselves. The women participants were not wearing gloves. (Transcript, p. 342, 638, 696, 1074, 1079-1080, 1082, 1154.)

16. Physicians using an electrocautery device to perform procedures must adhere to infection control standards applicable to physicians performing invasive procedures on the human body. They must maintain a sterile field and sterile environment by: (1) applying draping around the surgical site and as a barrier to block off unsterile areas; (2) using an antibacterial cleaning solution to clean the room, surfaces, table, and equipment between cases and terminally at the end of the day; and (3) requiring all participants wear personal protection equipment, including sterile gloves, masks, and eye shields. The purpose in these requirements is to prevent infection. The Respondent followed none of these infection control procedures. (Exhibit 8D; Transcript, p. 341-342, 522, 536, 638, 1097-1098, 1100-1105, 1125, 1130, 1160-1161.)

17. Physicians using electrocautery devices must also adhere to operational standards by performing and documenting routine testing and service of the electrocautery device and confirming sufficient electrical output in the room where the device is used. The purpose in these rules is to prevent a surgical or electrical fire during a procedure. (Transcript, p. 1071, 1097-1098, 1100.)

18. The Respondent's failures to maintain proper infection control standards and operational procedures while using an electrocautery device that inflicted 2nd degree burns on the women were severe deviations from the standard of care. (Transcript, p. 1124-1125, 1132.)

19. In using an electrocautery device to perform the brandings without anesthesia, the Respondent caused the women, including S.E., A.M., J.G., C.G., A.C., and L.S., significant physical pain, 2nd degree burns, and abnormal permanent and/or raised keloid and hypertrophic scarring, and placed them at risk for harm, including deeper 3rd and 4th degree burns and psychological trauma like post-traumatic stress disorder (PTSD) or anxiety. (Exhibits 14a, 45, 47; Transcript, p. 579, 1079-1090, 1124-1130, 1133-1146, 1154, 1209, 1377, 1403, 1421.)

20. In subjecting the women to significant pain from the electrocautery device, the Respondent was required to administer them, or at the very least offer, anesthesia, such as a local anesthetic, to alleviate the pain. The Respondent had no legitimate medical reason, such as an allergy or an emergency, for neither providing the women anesthesia nor presenting them with this treatment option. (Transcript, p. 339, 635, 1073, 1086.)

21. The Respondent's failure to administer or advise and offer anesthesia to the women was a severe deviation from the standard of care. Physicians are ethically prohibited from causing patients such extreme harm on purpose. (Transcript, p. 1073, 1124-1125, 1131-1132, 1210-1211.)

22. The Respondent never informed the women she branded that the brand was KAR to represent Keith Raniere's initials or that it would measure approximately two inches by two inches. The brand was intentionally placed upside down and backwards on most of the women to conceal Keith Raniere's initials. S.E., A.M., J.G., C.G., A.C. and others had falsely been told by their masters that the brand represented "a symbol of the sorority," "a line of the sun and the earth and certain elements," an "abstract symbol," "chakras," and/or "four elements," and that the size would be "little," "small," and/or

"dime sized." Only L.S., as a "1st line" member, knew prior to her branding that the brand represented Keith Raniere's initials. (Exhibit 14a; Transcript, p. 351, 541-542, 787, 797-802, 904, 1355, 1450, 1685-1686, 1739, 1882, 1939, 1941-1942.)

23. Prior to performing the branding procedures on the women, the Respondent was required to obtain their voluntary, verbal and/or written informed consent that reflected a discussion of the psychological and physical risks, benefits, and alternatives to the procedure, including the option not to proceed; the pain involved and the option of anesthesia; details of the brand symbol; and consideration of the individual's psychological and medical histories, comorbidities, and medications. The purpose of obtaining informed consent is to confirm the women have a complete understanding of the procedure and to avoid complications. The Respondent did not obtain such consent from any of the women. (Transcript, p. 435-437, 538-540, 1098, 1124-1125, 1164-1168, 1178-1182, 1985.)

24. The Respondent's infliction of the branding procedures on the women without obtaining their voluntary verbal and/or written informed consent was a severe deviation from the standard of care. Informed consent must be voluntary and not in connection with coercion under the threat of disclosure of personal and potentially damaging or destructive collateral. (Transcript, p. 1098, 1124-1125, 1132, 1178-1183.)

25. Physicians are obligated to provide proper care of 2nd degree burn wounds that includes application of antibacterial ointment and treatment plans that include follow-up physician monitoring. Providing this care is critical to ensure proper wound healing and to prevent infection. The Respondent failed to provide this care. (Transcript, p. 542-545, 624-625, 1164, 1166-1167, 1171, 1349, 2114.)

26. The Respondent's failure to provide proper treatment and follow-up care of the 2nd degree burn wounds was a severe deviation from the standard of care. (Transcript, p. 1093-1096, 1123-1124, 1128, 1164, 1166-1167, 1171, 1174.)

27. Following completion of the branding procedures, the Respondent instructed the women to submit photos of their brands to their masters every day for 30 days and then one time per week. The Respondent evaluated and kept the photos but never made them part of a medical record because she never prepared or maintained such records for the women. (Transcript, p. 377, 379, 540, 543, 547-549, 556.)

28. Physicians performing medical procedures involving the infliction of wounds are required to prepare, maintain, and document medical records that include photographs of the wound and details of the procedure, the equipment used, physical evaluations, diagnosis, treatment plans, and post-procedure instructions. The Respondent severely deviated from the standard of care by failing to prepare and maintain medical records to apprise outside providers of the treatment provided. (Transcript, p. 1173-1174.)

29. In 2016, the Respondent participated in a ten-day annual NXIVM corporate retreat known as "Vanguard week" at the Silver Bay YMCA Family and Retreat Center, located in Silver Bay, New York. The purpose of the event was to celebrate the birthday of Keith Raniere. The attendees included more than 400 NXIVM members. (Exhibit 17; Transcript, p. 80, 90-93, 451-452, 456, 478, 496, 708, 710.)

30. During the event and while attending it, the Respondent became aware of a gastrointestinal illness affecting many of the attendees. Among the attendees were children, a woman with end-stage cancer, and a pregnant woman. The symptoms of the illness included diarrhea, nausea, vomiting, dehydration, and fatigue. This illness placed the attendees and the public at risk for harm, including gastrointestinal morbidity and dehydration, which is a particular concern for people with comorbidities like cancer. (Transcript, p. 84-85, 454, 455, 485, 498-499, 505, 714-715.)

31. This illness constituted a disease outbreak because it involved a large group of people who developed similar symptoms while attending the same event in a confined environment. Physicians are required under Department of Health regulations to report a communicable disease or any disease outbreak

or unusual disease to public health officials. 10 NYCRR 2.10. The Respondent failed to take any steps to comply with these requirements. (Transcript, p. 972, 991.)

32. The Respondent's failure to report the infectious disease outbreak was a violation of public health regulations and a significant deviation from the standard of care for a physician. (Transcript, p. 991.)

Factual Allegations

By email correspondence dated March 1, 2021, the Petitioner withdrew factual allegations G.3 and G.4. (ALJ I.) The Hearing Committee sustained all the remaining Factual Allegations in the Statement of Charges.

The Hearing Committee sustained, by unanimous vote (3-0):

Factual Allegations A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, A.9, A.10, A.11, A.12, A.13, A.14, A.15, B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, B.13, B.14, B.15, C.1, C.2, C.3, C.4, C.5, C.6, C.7, C.8, C.9, C.10, C.11, C.12, C.13, C.14, C.15, D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12, D.13, D.14, D.15, E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, E.11, E.12, E.13, E.14, E.15, F.1, F.2, F.3, F.4, F.5, F.6, F.7, F.8, F.9, F.10, F.11, F.12, F.13.

The Hearing Committee sustained, by majority vote (2-1):

Factual Allegations G.1, G.2.

Evaluation of the Respondent's Testimony

The Respondent testified on her own behalf and as a witness for the Petitioner. Although considered incidental by the Hearing Committee in deciding central issues in this case, the Hearing Committee believes it is worth noting the Respondent's evasiveness, defiance, and inconsistencies on various points. For instance, she refused to disclose: (1) the circumstances of her becoming involved in NXIVM (Transcript, p. 218); (2) the initials of the women she branded (Transcript, p. 315-316); (3) the whereabouts of the branding videos and whether she maintained them (Transcript, p. 328, 331); (4) how it was determined the brandings would be videotaped (Transcript, p. 331); (5) who was present when she branded L.S. (Transcript, p. 333); (6) the roles of the women in the room with L.S. during the branding

(Transcript, p. 336); (7) whether L.S. was clothed during the branding (Transcript, p. 335); (8) what the brand represented (Transcript, p. 351); and (9) whether L.S.'s limbs were held down when she was branded (Transcript, p. 337). Despite being directed to answer these questions when they were asked, the Respondent never did. She also initially refused to disclose whether she was branded with Keith Raniere's initials (Transcript, p. 518-519) but then finally admitted — consistent with the other evidence — that she was branded and that the brand was KAR to represent his initials. (Exhibits 14a and 49; Transcript, p. 1312, 1352-1352, 1388, 1391-1393, 1396.)

Further inconsistencies include her initial testimony that she was unaware of the details of the electrocautery device she used, stating it was "purchased by the friend that invited me" (Transcript, p. 266, 269), and her later testimony that she purchased it, identifying the model and manufacturer. (Transcript, p. 2108.) She also initially testified that DOS was "a completely separate organization" from NXIVM and Keith Raniere was not its "leader" (Transcript, p. 253) and that L.S., a 1st line member, had "no master" (Transcript, p. 381), but then later admitted that Keith Raniere was the "grandmaster" to the 1st line members (Transcript, p. 1387), who were his "slaves." (Transcript, p. 1389.)

The Hearing Committee finds these factors significantly diminished the Respondent's credibility and evaluated her testimony accordingly.

The Practice of Medicine

The Hearing Committee was not persuaded by the Respondent's arguments that the Board lacks subject matter jurisdiction to bring charges against her because she "was not engaged in the practice of medicine" and that branding "is not a medical procedure." (Respondent's brief, p. 2.) The Hearing Committee finds the Petitioner correctly argues the Respondent "performed medical procedures when she branded the DOS women" and that "the brandings fell within the definition as to what constitutes the

practice of medicine" and agrees with its reliance on Courts having a long-standing history of interpreting Educ. Law §6521 broadly to support these positions. (Petitioner's brief, p. 12-13.)

The practice of the profession of medicine is defined as "diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition." Educ. Law § 6521. Whether conduct constitutes the practice of medicine is a determination to be made by the Hearing Committee based on the facts presented. Addei v. State Board for Professional Medical Conduct, 278 AD2d 551, 552 (3d Dept. 2000); *See also* Educ. Law §6504. This determination must be based solely on the facts "and not upon the name of the procedure, its origins or legislative lack of clairvoyance." People v. Amber, 76 Misc. 2d 267, 273 (Sup. Ct. Queens Co. 1973).

The reported decisions relied on by the Petitioner that the Hearing Committee finds convincing on this point include People v. Amber, *supra* at 273, in which the Court described its interpretation of Educ. Law §6521 as "a statute intended to regulate, limit or control the diagnosis and treatment of ailments must be read broadly to include the gamut of those known, whether or not recognized and even those not yet conjured." (Petitioner's brief, p. 12-13.) *See also*, People v. Mastromarino, 148 Misc. 454, 455 (Sup. Ct. Kings Co. 1933); People v. Rubin, 103 Misc.2d 227, 234 (N.Y. City Crim. Ct. Queens Co. 1979). The Respondent acknowledges that while branding "arguably involves operating," the operations were not "for a human disease, pain, injury, deformity or physical condition," and so did not fit the statute because the women were "perfectly healthy and normal in all respects" when they received the brands. (Respondent's brief, p. 3-4.)

The Respondent relies on Matter of Gross v. Ambach, 71 NY2d 859, 861 (1988), in which the Court of Appeals determined autopsies constitute the practice of medicine because they are "the ultimate diagnostic procedure" to diagnose the cause and manner of death. (Respondent's brief, p. 3-4.) The Hearing Committee finds the only similarity to be drawn between the two cases is that the statute somehow

does not fit. There because autopsies are not practicing medicine since medicine can only be practiced on "living" patients and here because the women were "normal and healthy" when they were branded. Gross, *supra* at 861. In any event, the Hearing Committee, like the Court of Appeals in Gross, declines to limit the statue in that regard. *Id.* (Respondent's brief, p. 4.) The Hearing Committee rejects the Respondent's claim that it is "blatantly obvious" that the Respondent's "operating" on the women was not for "a human disease, pain, injury, deformity or physical condition" to meet the criteria under the statute. (Respondent's brief, page 3.) To the contrary, it is glaringly obvious to the Hearing Committee that she was operating on the women to alter the skin, appearance, and physical condition of their pelvic regions regardless of whether they were "normal and healthy." (Transcript, p. 1110-1111, 1116.)

The Petitioner presented as a witness plastic surgeon Robert T. Grant, M.D. While Dr. Grant lacks branding experience, the Hearing Committee noted his expertise and credibility on the main issues in this case were established by his decades of experience as a board-certified specialist in general and plastic surgeries performing cosmetic procedures, such as body piercings and nipple and areola tattooing to complete a breast reconstruction, and as Chief of Plastic Surgery at NewYork-Presbyterian Hospital, program director for the residents training program, and Professor of Surgery at Columbia University. (Exhibit 4; 1060-1066, 1185-1186.)

The Respondent presented as a witness general surgeon David Mayer, M.D. The Hearing Committee noted Dr. Mayer's extensive and diverse background as a practicing healthcare attorney and board-certified surgeon with 40 years of experience, including current privileges at three ambulatory facilities, teaching at three medical colleges, and prior Chair of Surgery at Syosset Hospital, where he performed thousands of surgeries, directed a laparoscopic fellowship program, and trained residents. (Transcript, p. 1469-1471, 1505.) Despite his considerable medical and legal experience, the Hearing

Committee was not persuaded by his professional opinions on the issue of the practice of medicine due to contradictions in his testimony.

For instance, Dr. Mayer insisted the Respondent was a branding technician able to "put aside her white coat" as a physician when she performed the brandings, yet he described himself as "always a physician" who doesn't "stop being a physician...at different times." (Transcript, p. 1569, 1579-1580.) His position that she was acting as a branding technician was also inconsistent with his testimony that "you never forget your training and education" (Transcript, p. 1566-1567.) Another example is his testimony that physicians should not cause extreme pain while also refusing to discuss the "ethics" of the Respondent causing the women such pain and insistence that her osteopathic oath to do no harm and prevent pain did not apply. (Transcript, p. 1528, 1531.) The Hearing Committee considered such inconsistencies, noted his long-standing history of providing expert witness services in hundreds of civil cases to law firms and other private companies, and evaluated his testimony accordingly. (Transcript, p. 1499.)

While the Hearing Committee was not persuaded by Dr. Grant's professional opinion that the Respondent was practicing medicine because she addressed "psychic pain" the women were experiencing, it did agree with his testimony that the brandings are the practice of medicine under Educ. Law §6521 because they were "surgical," involving "violating the epidermis and getting into the deeper layers of skin," and performed to "alter the skin" or physical condition of the women. (Transcript, p. 1110-1111, 1114, 1116.) The Respondent attempted to contrast branding with plastic surgery such as a rhinoplasty on a "successful face model" on the grounds that branding does not treat "a physical condition" the patient seeks to change (brief, p. 12), but the Hearing Committee finds this comparison frustrates her cause. Just as a rhinoplasty to change the appearance of a nose alters the physical condition of the face, the Hearing

Committee finds the Respondent's branding to inflict a permanent and very visible scar alters the skin, appearance, and physical condition of the pelvic region.

Dr. Grant took the position that while brandings and other similar cosmetic procedures such as body piercing and tattooing can be performed by non-physicians, they constitute medical procedures when physicians perform them. (Transcript, p. 1108-1109, 1196-1197.) The Hearing Committee agrees with this view and rejects the Respondent's arguments against it. On the one hand, the Respondent claims that branding "is a form of commercial body art in the same manner as are tattooing and body piercing." (Respondent's brief, p. 8.) To that end, she argues that "aesthetic or ritual branding is outside the jurisdiction of the State Board for Professional Medical Conduct as branding is not regulated at all in New York." (Respondent's brief, p. 9.) On the other hand, the Respondent goes on to distinguish these activities on the basis that tattooing and body piercing require a license to perform, whereas branding does not. PHL §461. In doing so, she overlooks the exception to the tattoo and body piercing licensing requirement for physicians that is expressly stated in the statute. PHL §462. The Hearing Committee believes the Legislature specifically carved out that exception precisely because when a doctor and not a technician performs tattooing or body piercing, it is presumed that appropriate medical standards will apply. Consistent with this was Dr. Grant's testimony that he was unable to "imagine the scenario" involving a licensed physician performing these brandings acting as only a "technician." (Transcript, p. 1218.)

The Respondent's arguments that tattooing and body piercing are regulated — whereas branding is not — were deemed inconsequential to the Hearing Committee. The Committee's view is simple — all these activities are practicing medicine and become medical procedures when performed by a physician. Contrary to Dr. Mayer's testimony that the Respondent could obtain "a separate license as a tattoo artist or body piercer" and "not use" her medical license (Transcript, p. 1549), the Hearing Committee believes that as a physician, the Respondent cannot unilaterally pick and choose when the standards of medical

practice apply. (Transcript, p. 1107-1109, 1200, 1549.) Dr. Grant confirmed this when he testified: "given the privilege of being a physician that comes with responsibilities. You can't decide when you are going to enjoy the privileges, but not have the responsibilities." (Transcript, p. 1112.) The Hearing Committee considers the Respondent's attempt to use a double standard, compartmentalizing her life by ostensibly branding the women as a technician and not a doctor, an irresponsible attempt to cast aside her privileged status as a licensed physician with specialized knowledge.

The Hearing Committee was guided in reaching its determination by reported court decisions relying on various factors and circumstances in recognizing when activities performed by physicians fall within the definition of the practice of medicine. In Y.Y.B. ex rel. Barukh v. Rachminov, the court found that "while a circumcision performed by a physician would be the practice of medicine, a circumcision performed as a religious ritual by a qualified person (a 'mohel' in this case) does not constitute the practice of the profession of medicine within the meaning of the Education Law." Y.Y.B. ex rel. Barukh v. Rachminov, 11 N.Y.S.3d 808, 1059 (Sup. Ct. Queens Co. 2015); *See also* Zakhartchenko v. Weinberger, 605 N.Y.S.2d 205, 206 (Sup. Ct. Kings Co. 1993.) In relying on this same reasoning, the Court in Zakhartchenko applied negligence principles to a hospital where a circumcision performed by a Rabbi involved the hospital's trained medical staff. Zakhartchenko, *supra* at 413. The Petitioner also cites Zakhartchenko in its brief (p. 18) to correctly summarize the principle from these cases applicable to this matter: "Therefore, while the acts performed by a non-physician are not subject to the jurisdiction of the Board of Professional Medical Conduct, the brandings/medical procedures performed by Dr. Roberts on 17 DOS women are." The Hearing Committee follows the view of these reported cases that different standards apply when physicians perform procedures.

The Respondent claims that "several possible people were considered" to perform the brandings and that "(c)learly, the intent was not to select a physician but to pick amongst friends" (brief, p. 8), but

the Hearing Committee finds it more likely the Respondent was chosen based on her background, training, and knowledge as a physician. The Respondent acknowledged relying on her medical background in everything she does. (Transcript, p. 263, 423, 430-431, 488, 521, 547, 552-553, 1440-1442, 2134.) The evidence also confirms she was the only physician approached by the 1st line members to perform the brandings, her status as a physician was well-known in the NXIVM community, and she was the one chosen to do them. (Transcript, p. 182-183, 352, 797, 1853, 1950.) Her experience as a physician was obviously relevant to what they were seeking in a person to do the job, which Jane Doe 5 described as someone who was "willing," "calm," not "squeamish," and had "a steady hand" and "attention to detail." (Transcript, p. 2020-2021.) Jane Doe 4 also expressed how she hoped "someone skilled enough" would be chosen for the job and the relief she felt — consistent with S.E.'s testimony — knowing her branding would be done by the Respondent, who she knew was a doctor. (Transcript, p. 796, 1951, 1942-1943, 1975.)

Standards of Medical Practice

The Hearing Committee concluded the Respondent's lack of training in the use of an electrocautery device contributed to her improper technique in performing the branding procedures and exacerbated the harm to these women. The Hearing Committee was skeptical of Dr. Mayer's assertion that the Respondent took "great care to get special training in branding" (Transcript, p. 1476) because the evidence established she was woefully unskilled in performing the procedures. According to Dr. Grant, proper training in the safe and proper use of an electrocautery device includes attending "a series of didactic lectures" and using the device for a period of time "under direct observation of a mentor or preceptor," steps the Respondent never undertook. (Transcript, p. 517, 562-563, 1070-1071, 1327-1328, 1765, 1784.) The Hearing Committee finds her preparations for the brandings, which included undergoing branding herself by branding artist Brian Decker in Brooklyn, practicing on fruit and pigs' knuckles, and a few

communications by email and telephone with Mr. Decker and body modification artist Steve Arthur Haworth, fell short of demonstrating serious and proper training in using an electrocautery device. (Transcript, p. 273-274, 280-284.)

The Respondent presented body modification artist Steve Arthur Haworth as a witness to discuss her branding technique. The Hearing Committee was not convinced by Mr. Haworth's opinion that the Respondent used appropriate technique when she performed the brandings. (Transcript, p. 1779.) Mr. Haworth testified that in his almost 30 years of performing electrocautery brandings, he has never caused a 2nd degree burn. (Transcript, p. 1827.) He described such a burn as "significantly more painful" than a brand (Transcript, p. 1788), with a greater risk of infection. (Transcript, p. 1795.) Mr. Haworth's description of an electrocautery brand as "not a second-degree burn" and "more like a scrape" that heals "very quickly" (Transcript, p. 1763, 1789-1790, 1796) was contrary to all the evidence in this case. The Respondent's brandings resulted in 2nd degree burns, as was established by the brand photos (Exhibits 45 and 47), the branding video (Exhibit 8D), and the testimony of Dr. Mayer (Transcript, p. 1510-1511), Dr. Grant (Transcript, p. 1085), and the Respondent herself. (Transcript, p. 1377, 1420-1421.) The Hearing Committee attributed Mr. Haworth's seeming unawareness that the Respondent's brandings caused 2nd degree burns to his lack of a medical degree and his failure to review the brand wound photos showing the depth of the wounds or the testimony of the physician witnesses. (Exhibits 8D, 45, 47; Transcript, p. 1791-1792.)

The Respondent's poor technique was obvious to the Hearing Committee on S.E.'s branding video, which showed sparks and fire from the electrocautery device as she moved it across the skin to create the brand's "seven lines" and "touchups" (Exhibit 8D; Transcript, p. 366-367) and her multiple starts and stops, which Mr. Haworth commented on as "different" from his technique. (Transcript, p. 1778.) The Hearing Committee also recognized the Respondent's failure to mention the energy settings or the types

of tips she used, which suggested her unfamiliarity with how the device works, specifically that the electrical current from the device and the time in which it is applied directly affects the outcome. (Transcript, p. 283, 1224.) She also expressed no awareness of the danger in using an electrocautery device directly on the skin surface to make an incision because it can cause a more significant injury than intended, such as the abnormal scarring and deep 2nd degree burns that occurred in this case and the risk of deeper 3rd and 4th degree burns. (Transcript, p. 1215, 1224, 1510, 1581.) For these reasons, the Hearing Committee believes her lack of training in controlling the electrocautery device to predict the outcome meant she never understood that the time in which she applied the tremendous amount of electrical energy from the device caused the women substantial injuries, pain, and trauma. (Exhibits 14a, 45, 47; Transcript, p. 1085-1087, 1128.)

Dr. Grant described the Respondent's branding of these women as "excruciatingly" and "incredibly painful" for which she never even offered them a choice of anesthesia. (Transcript, p. 1086, 1162-1163.) In response to the pain, the evidence showed A.M. and S.E. cried and J.G. screamed and squealed, flipped off the table, and bit down on a towel. (Exhibit 14a; Transcript, p. 807, 819, 579, 689, 819, 846, 1404.) S.E. described her pain from the branding as "an acute fire in the most sensitive part of my body." (Transcript, p. 827.) L.S. described her experience of the branding as "incredibly painful." (Exhibit 14a.) While the evidence established the women desired pain as part of the branding process (Respondent's brief, p. 18), the Hearing Committee agreed with Dr. Grant that absent a legitimate medical reason, such as an allergy or an emergency, the Respondent was obligated to at least attempt to alleviate such pain, such as by administering a local anesthetic in the area where the cautery was applied. (Transcript, p. 1073, 1124, 1210-1211.)

This was necessary, Dr. Grant explained, because the level of pain the women endured was so intense that it risked causing the woman cauterized even deeper burns from not being able to remain still

during the procedure. Dr. Mayer also acknowledged this risk, as well as the risk of physical injuries to the women participants holding her down as she violently reacts to the electrocautery device. (Transcript, p. 1082-1083, 1087-1090, 1510.) Dr. Grant emphasized it is "unethical" for physicians to intentionally cause patients such harm because doing so violates "our ethical background in training and responsibility." (Transcript, p. 1116, 1228.)

The Respondent's lack of training was also established by her failure to prevent other risks of harm from occurring. She risked burns to the other women participants because they were not properly grounded by wearing gloves for insulation, instead using their bare skin to hold down the woman cauterized. Another risk was that the women could inhale or absorb harmful pathogens, such as viruses and infectious diseases, due to the failure to use a smoke evacuator to remove the debris plume released from the electrocautery device. She also risked burn wound infections by not maintaining a sterile field because she never properly cleaned the room, applied sterile draping, or required the women to wear personal protective equipment such as masks, sterile gloves, and eye protection. (Transcript, p. 1074, 1082, 1097-1098, 1104-1105, 1130.) The Hearing Committee disagreed with Dr. Mayer's opinion that these risks were "low," especially because the Respondent made no effort to mitigate them. (Transcript, p. 334-335, 532, 562, 1584.) Dr. Grant deemed the Respondent's failure to complete these steps serious deviations from the standard of care. (Transcript, p. 1124-1125, 1132.)

The Hearing Committee unanimously voted that the Respondent's conduct constituted professional misconduct as defined in Educ. Law §6530(4), practicing the profession with gross negligence on a particular occasion, professional misconduct as defined in Educ. Law §6530(6), practicing the profession with gross incompetence, and professional misconduct as defined in Educ. Law 6530(5), practicing the profession with incompetence on more than one occasion.

Gross negligence involves a significant deviation from acceptable medical standards that creates the risk of grave consequence to the patient. Such conduct may result in a single act of negligence in egregious proportions or multiple acts of negligence that cumulatively are egregious. Post v. N.Y.S. Dept. of Health, 245 A.D.2d 985, 986 (3d Dept. 1997.) Gross incompetence involves an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. This conduct may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct. Post, 245 A.D.2d at 986; Minielly v. Commissioner of Health, 222 A.D.2d 750, 752 (3d Dept. 1995). Incompetence includes a lack of the requisite knowledge or skill in the practice of the profession but does not require a showing of an act or omission constituting a breach of the duty of due care. Dhabuwala v. State Bd. For Professional Med. Conduct, 225 AD2d 209, 213 (3d Dept. 1996).

The Respondent deviated from the standard of care and demonstrated a lack of skill and knowledge to practice the profession of medicine. She dangerously operated the electrocautery device to perform the branding procedures without anesthesia or adhering to infection control standards, which subjected the women to extreme pain, deep 2nd degree burn wounds, and abnormal scarring, and risked them further 3rd and 4th degree burn wounds, infection, and other harm.

The Hearing Committee also voted 3-0 that the Respondent's conduct constituted professional misconduct as defined under Education Law §6530(47), failing to use appropriate infection control practices. The Respondent's failure to follow any infection control procedures risked the women burn wound infections and other harmful outcomes, representing to the Hearing Committee her disregard for their health and safety.

Informed consent requires a verbal or written discussion to evaluate risks so the patient can "prudently decide whether or not" to proceed with the procedure. (Transcript, p. 1098, 1178-1180.) It must

include a discussion of the psychological and physical risks, benefits, and alternatives to the procedure, including the option not to proceed, considering medical histories, comorbidities, and medications. (Transcript, p. 1124, 1179-1180.) The Respondent admits she never obtained such consent, which Dr. Grant deemed a serious deviation from the standard of care. (Respondent's brief, p. 8; Transcript, p. 436, 538-540, 1180.)

In failing to take medical histories and perform physical examinations, the Respondent risked missing a diagnosis or condition such as diabetes or connective tissue disorder, or a blood thinner medication like aspirin, that could affect clotting or wound healing. She also risked missing a cardiac condition that could trigger an arrythmia or pre-existing PTSD or anxiety that could become exacerbated by direct exposure to blood and trauma. (Transcript, p. 544-544, 1094-1095, 1171, 1418.) Other risks included burn wound infections and poor healing because she never provided treatment plans that included application of antibiotic ointment and follow-up physician monitoring. (Transcript, p. 377, 547, 556, 1362, 1168, 1171-1172.) In failing to document medical records, including the brand wound photos she collected and kept, she also risked depriving outside providers of important information about the procedures and the reason why they were performed. (Transcript, p. 1175.)

The Respondent, as a physician, was obligated to complete such tasks. The Hearing Committee believes she should have known to do so, especially considering her experience as a hospitalist following protocols that involve reading charts, assessing medications and medical histories to determine comorbidities, and treating patients with various injuries, including burn wounds. (Transcript, p. 206-207, 209, 291.) Although Mr. Haworth testified that his brandings never involve completing these steps, the Hearing Committee noted that he is not a doctor. The medical standards that apply to physicians with specialized medical training and knowledge performing these procedures do not also apply to branding technicians. (Transcript, p. 1770-1771.)

The Hearing Committee unanimously determined that the Respondent's conduct constituted professional misconduct as defined in Educ. Law §6530(32), failing to maintain records for each patient that "accurately reflect the evaluation and treatment of the patient." Physicians are required to maintain such records that include every interaction with the patient and, in cases such as this, photos of the injury. Mucciolo v. Fernandez, 195 A.D.2d 623, 625 (3d Dept. 1993).

Negligence means the "failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances." Bogdan v. State Bd. For Professional Med. Conduct, 195 A.D.2d 86, 88 (3d Dept. 1993). The Department is not required to prove harm to a patient. Youssef v. State Bd. For Professional Med. Conduct, 89 A.D.3d 824, 825 (3d Dept. 2004). Negligence can also be sustained when there is a relationship between inadequate medical records and patient treatment. Matter of Patin v. State Bd. For Professional Med. Conduct, 77 A.D.3d 1211, 1214 (3d Dept. 2010). The Hearing Committee sustains the negligence charge on both grounds. The Respondent failed to exercise the required level of care when she failed to take even the most basic steps to protect these women, such as by assessing medical and psychiatric histories, providing follow-up care considering the deeply traumatizing nature of the branding procedures, or assessing cross reactions, such as a medication that could worsen a preexisting psychiatric problem or a heart defect that could create a fatal condition. Her failure to maintain any medical records prevented subsequent providers from understanding the cause of the injuries and the reasons for them, which could adversely impact their future treatment decisions. As a physician, the Respondent was required to consider these matters before performing operations on the women that physically and permanently altered their bodies.

Of particular concern to the Hearing Committee in the circumstances here was that informed consent must be voluntary and not due to coercion (Transcript, p. 1182) and involves providing details of the procedure, all of which were missing in this case. The Respondent concedes she never obtained

"formal written" informed consent but claims the branding video of S.E. shows she gave "verbal" consent, which the Hearing Committee finds misleading at best. (Respondent's brief, p. 8, 17.) The Respondent denies the women were coerced, yet the brandings were performed upon women who had submitted collateral that would result in damaging and embarrassing consequences if released to the public. (Respondent's brief, p. 19; Exhibit 14a; Transcript, p. 388, 390, 424, 426, 530, 783-784, 1182, 1957.) S.E. described the involuntariness of the branding process in the pressure she felt to move forward with the procedure because of the collateral, which she characterized as a "gun" to her head. (Transcript, p. 802.) This is the very definition of coercion.

The collateral included titles to cars and houses, letters about illicit drug use and sexual deviance, and nude photos, some of which showed explicit images of genitalia. (Exhibit 14a; Transcript, p. 802, 857, 1353, 1941-1942, 1686, 1738, 1884.) Even Dr. Mayer acknowledged the women could view the collateral as coercive (Transcript, p. 1537), describing it as "a factor to consider in the voluntariness of their actions." (Transcript, p. 1528.) Dr. Grant confirmed that under these circumstances, there can be no informed consent. (Transcript, p. 1182.) The Hearing Committee was not persuaded by the Respondent's comparison of the branding process to the brandings in the "African American fraternity known as the Omegas" (Respondent's brief, p. 18-19) because while the fraternity members experience painful brands to symbolize their "bond" and "life-long membership in the fraternity," they are not coerced into being branded by having to submit potentially harmful collateral. (Respondent's brief, p. 18-19.)

Particularly troubling to the Hearing Committee was the evidence establishing the women were purposefully not told what symbol would be branded onto their bodies. (Exhibit 14a; Transcript, p. 798, 802, 1182, 1660, 1685, 1884, 1941.) S.E. confirmed this when she testified "(a)t no point did anyone say these are Keith's initials. It was only revealed to me later." (Transcript, p. 798.) The Respondent, however, did know that the symbol was KAR to represent Keith Raniere's initials. (Transcript, p. 1387-1388, 1353,

1355, 1392, 1394.) She claims she did not disclose it to the women because it wasn't her "business" or "responsibility" and doing so would have breached her "lifetime vow of obedience" to DOS. (Transcript, p. 541, 1353-1355.) The Hearing Committee rejects these excuses and finds that regardless of her commitment to DOS, she had a duty as a physician to disclose what she was doing in the same way a plastic surgeon would be required to describe the pigment, shape, and appearance of a nipple for a nipple areola tattooing procedure. (Transcript, p. 1107.) The Hearing Committee agrees with Dr. Grant that the Respondent's failure to disclose the brand symbol to the women deviated from the standard of care. (Transcript, p. 1178, 1182.)

The Hearing Committee unanimously determined that the Respondent's conduct constituted professional misconduct as defined in Educ. Law §6530(2), practicing the profession fraudulently. Fraudulent practice requires "proof of either an intentional misrepresentation or concealment of a known fact" and "intent or knowledge" can be inferred. Patin, *supra* at 1214. The Hearing Committee finds the Respondent's admission that she knew what the brand symbol was and her decision not to disclose it represents an intentional concealment of a known fact. The Respondent violated an important aspect of informed consent by branding the women without making them fully aware of what the brand symbol was or what it represented.

The Hearing Committee unanimously determined that this conduct also constitutes professional misconduct as defined in Educ. Law §6530(20), moral unfitness to practice medicine; professional misconduct as defined in Educ. Law 6530(31), willfully harassing, abusing, or intimidating a patient; and professional misconduct as defined in Educ. Law §6530(26), performing professional services which have not been duly authorized by the patient. Moral unfitness is conduct that "violat[es] the trust the public bestows on the medical profession and/or violate[es] the medical profession's moral standards." Such conduct is suggestive of, or would tend to prove, moral unfitness. Patin, *supra* at 1215 *citing* Matter of

Prado v. Novello, 301 A.D.2d 692, 694 (3d Dept. 2003). The Respondent's medically reckless performance of the brandings caused the women significant harm without apprising them of the brand symbol. Physicians are strictly prohibited from going above and beyond what the patient expects when performing a medical procedure.

Vanguard Week

The Petitioner also charges the Respondent with failing to report a communicable disease, an unusual outbreak, or a disease outbreak involving a gastrointestinal illness during the annual NXIVM retreat at the Silver Bay YMCA, as required under the New York State Sanitary Code. (Petitioner's brief, p. 72-73.) The Respondent admits she did not report the outbreak of the gastrointestinal illness during the event to public health officials but claims she was not required to because she was on vacation and since "garden variety" stomach viruses, which are "unpleasant but not lethal," are not "communicable" or "unusual" to meet the mandatory reporting requirements under the regulation. (Respondent's brief, p. 21-22; Transcript, p. 733, 1294.) Physicians are required to report a "communicable disease" or "(a)ny disease outbreak or unusual disease" to public health officials. 10 NYCRR 2.10(a)-(c). An outbreak is defined as "an increased incidence of disease above its expected or baseline level" 10 NYCRR 2.2(d).

In support of its charges, the Petitioner presented as a witness infectious disease specialist Bruce Frederick Farber, M.D., whose testimony the Respondent failed to refute. The Hearing Committee noted Dr. Farber's impressive background includes 30 years of experience as an infectious disease specialist, including head of infectious disease for Northwell Health and in charge of the infectious disease programs at North Shore University Hospital and LIJ Medical Center. (Exhibit 6; Transcript, p. 959.) The majority of the Hearing Committee agreed with his professional opinion that the Respondent's duty as a physician to report this illness applied to her even if she was on vacation. (Transcript, p. 993, 995.) The Committee decided 2-1 that while the illness fails to meet the criteria under the regulation as "communicable" or

"unknown" — presumably because it was never reported or investigated — it did constitute a "disease outbreak" that the Respondent as a physician was required to report regardless of whether or not she was on vacation. 10 NYCRR 2.1(c); 10 NYCRR 2.2. (Transcript, p. 993, 995, 998-999.) Dr. Farber made clear that her failure to fulfill this duty was a significant deviation from the standard of care. (Transcript, p. 991, 994.)

The evidence established this "obvious" illness affected a large group of people among the more than 400 attendees in a confined location, all of whom had similar symptoms. (Transcript, p. 990-991, 993, 999.) This is the precise definition of a "disease outbreak." 10 NYCRR 2.1(c), 10 NYCRR 2.2(d). The majority of the Hearing Committee agreed with Dr. Farber that the Respondent's failure to report it was especially egregious because it subjected the elderly and other vulnerable individuals, such as those with conditions or diseases like cancer, renal failure, and pregnancy, to potentially dangerous consequences like dehydration requiring hospitalization. (Transcript, p. 974-975.) The majority of the Hearing Committee also agreed with his opinion that based on her hospitalist experience that required her to complete an infection control course covering this subject, the Respondent should have known to report the illness. (Transcript, p. 972-973, 979.) Dr. Farber emphasized the importance in following this rule to "shut down" and properly "clean" the facility to prevent the illness from contaminating others and to determine its etiology. (Transcript, p. 980, 984.)

The Hearing Committee voted 2-1 that the Respondent's failure to report a disease outbreak constituted professional misconduct as defined in Educ. Law § 6530(21), a willful failure to file a report required by law; professional misconduct as defined in Educ. Law § 6530(16), a willful or grossly negligent failure to comply with substantial provisions of state laws governing the practice of medicine; professional misconduct as defined in Educ. Law § 6530(3), practicing the profession with negligence on

more than one occasion; and professional misconduct as defined in Educ. Law § 6530(5), practicing the profession with incompetence on more than one occasion.

Penalty

In considering the full spectrum of penalties under PHL § 230-a, including revocation, suspension, probation, censure and reprimand and the imposition of civil penalties, the Hearing Committee unanimously determined, by vote of 3-0, that the penalty of revocation of the Respondent's medical license is appropriate. The Hearing Committee determined that the Respondent engaged in 12 forms of professional misconduct, all of which it addressed in this hearing decision and sustained. The Respondent says she joined NXIVM with a goal to "enrich (her) skills as a doctor." (Transcript, p. 219.) The evidence shows, however, that she deliberately chose to adhere to her DOS "vows of obedience" instead of providing the women she branded with "all the things that a physician does" because to do so would have resulted in "breaking (her) vow" and "went quite the counter to what the whole purpose was." (Transcript, p. 1442-1443.) In other words, when faced with any conflict between NXIVM and her responsibilities as a physician, she chose NXIVM. For these reasons, the Hearing Committee believes she abdicated her values as a physician and failed her profession, herself, and everyone else involved.

The Hearing Committee recognizes the Respondent's tremendous future potential as a physician who excelled in every undertaking from becoming a skilled gymnast to graduating college with honors and earning dual degrees — osteopathic medicine and a master's in clinical nutrition — and then as an entrepreneur building a family medical practice and developing Exo/Eso, the physical fitness company within NXIVM she co-developed with Keith Raniere. (Transcript, p. 1255-1256.) The Hearing Committee is deeply troubled, however, by her unwillingness to admit regrets. (Transcript, p. 228, 1248-1249, 1252, 1255-1256, 1259, 1412, 1445, 1455-1456.) Instead of holding herself accountable for harming S.E., for example, she accused S.E. of victimizing herself. (Transcript, p. 1412-1413.) The only sadness she

expressed was that the branding "was twisted into something it wasn't" and that "it has been used to scare people." (Transcript, p. 1455-1456.) The Respondent denies being brainwashed, yet she expressed no real remorse, which represented to the Hearing Committee her distorted reality and the very real concern that others remain vulnerable to her future brandings. (Transcript, p. 1453, 1719, 1753.)

The Hearing Committee is hopeful that the Respondent will regard the volume of sustained charges in this hearing decision as an opportunity to reflect on her poor choices and reeducate herself professionally and personally.

Order

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The first through forty-seventh specifications of professional misconduct set forth in the Statement of Charges are Sustained.

2. The Respondent's license to practice medicine in the State of New York is hereby Revoked under PHL § 230-a(4).

3. This Determination and Order shall be effective upon service on the Respondent in compliance with PHL § 230(10)(h).

DATED: Albany, New York
September 27, 2021

[redacted]
Steven Lapidus, M.D., Chairperson

Ramanathan Raju, M.D.
Joan Martinez McNicholas

TO: Jeffrey J. Conklin, Associate Counsel
New York State Department of Health
Division of Legal Affairs
Corning Tower Building, Room 2517
Empire State Plaza
Albany, New York 12237

Anthony Z. Scher, Esq.
800 Westchester Avenue
Suite N-641
Rye Brook, New York, 10573

APPENDIX I

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

IN THE MATTER

OF

DANIELLE ROBERTS, D.O.

AMENDED

STATEMENT

OF CHARGES

DANIELLE ROBERTS, D.O., the Respondent, was authorized to practice medicine in New York State on or about October 5, 2009, by the issuance of license number 255075 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about March 9, 2017, the Respondent used a cauterizing pen as part of a medical procedure to scar the skin by branding Patient A, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR and/or KAR, in the pelvis region, thereby leaving a permanent scar. Respondent's conduct deviated from accepted standards of care as follows:

1. Respondent performed the medical procedure upon Patient A in an other than appropriately sterile environment, and/or without appropriate infection control, and/or without the use of sterile technique, including the surgical field, surgical procedure room, multiple use of a cautery pen tip and electrical grounding pad, and documented electrical testing and maintenance upkeep of the cautery device.
2. Respondent performed the medical procedure without the use of a local anesthetic or general anesthesia, thereby causing Patient A to suffer pain for no legitimate medical purpose.

EXHIBIT
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3. Respondent performed the medical procedure upon Patient A with non-medically trained personnel present, who were not wearing personal protective equipment.
4. Respondent performed the medical procedure upon Patient A with the assistance of non-medically trained personnel who physically restrained said patient.
5. Respondent failed to cease performing the medical procedure despite the fact that Patient A was suffering pain without medical justification.
6. Respondent, during the course of the medical procedure, willfully physically abused Patient A.
7. Respondent performed the medical procedure upon Patient A at the time when said patient was naked and while being held down by other individuals, who were also naked, contrary to any appropriate medical protocol or need.
8. Respondent inappropriately performed the medical procedure upon Patient A while an individual who was also naked utilized a cell phone to video said medical procedure.
9. Respondent failed to provide appropriate wound care for Patient A at the time of the medical procedure, and thereafter.
10. Respondent failed to provide appropriate follow-up medical care and treatment for Patient A's wound, and/or failed to refer Patient A to another medical provider for such post-medical procedure wound care.
11. Respondent inappropriately advised, or caused another individual to advise, Patient A to take photographs of the wound caused by the medical procedure on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual who shared all or some of said photographs with the Respondent.
12. Respondent failed to provide appropriate medical care and treatment for Patient A, including obtaining information regarding said patient's medical history and current medications.

13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of Patient A.
14. Respondent fraudulently failed to disclose to Patient A that the initials KR and/or KAR said Respondent branded into the pelvis region of Patient A represented the initials of Keith Alan Ranieri..
15. Respondent performed the medical procedure upon Patient A without having obtained the adequate informed consent of Patient A.

B. On or about March 9, 2017, the Respondent used a cauterizing pen as part of a medical procedure to scar the skin by branding Patient B, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR and/or KAR, in the pelvis region, thereby leaving a permanent scar. Respondent's conduct deviated from accepted standards of care as follows:

1. Respondent performed the medical procedure upon Patient B in an other than appropriately sterile environment, and/or without appropriate infection control and/or, without the use of sterile technique, including the surgical field, surgical procedure room, multiple use of a cautery pen tip and electrical ground pad, and documented electrical testing and maintenance upkeep of the cautery device.
2. Respondent, while performing the medical procedure without the use of a local anesthetic or general anesthesia, thereby causing Patient B to suffer pain for no legitimate medical purpose.
3. Respondent performed the medical procedure upon Patient B with non-medically trained personnel present, who were not wearing personal protective equipment.
4. Respondent performed the medical procedure upon Patient B with the assistance of non-medically trained personnel who physically restrained said patient.

5. Respondent failed to cease performing the medical procedure despite the fact that Patient B was suffering pain without medical justification.

6. Respondent, during the course of the medical procedure, willfully and physically abused Patient B.

7. Respondent performed the medical procedure upon Patient B at the time when said patient was naked and while being held down by other individuals, who were also naked, contrary to any appropriate medical protocol or need.

8. Respondent inappropriately performed the medical procedure upon Patient B while an individual who was also naked utilized a cell phone to video said medical procedure.

9. Respondent failed to provide appropriate wound care for Patient B at the time of the medical procedure, and thereafter.

10. Respondent failed to provide appropriate follow-up medical care and treatment for Patient B's wound, and/or failed to refer Patient B to another medical provider for such post-medical procedure wound care.

11. Respondent inappropriately advised, or caused another individual to advise Patient B to take photographs of the wound caused by the medical procedure on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual who shared all or some of said photographs with Respondent.

12. Respondent failed to provide appropriate medical care and treatment for Patient B, including obtaining information regarding said patient's medical history and current medications.

13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of Patient B.

14. Respondent fraudulently failed to disclose to Patient B that the initials KR and/or KAR said Respondent branded into the pelvis region of Patient B represented the initials of Keith Alan Ranieri.

15. Respondent performed the medical procedure upon Patient B without having obtained the adequate informed consent of Patient B.

C. On or about March 9, 2017, the Respondent used a cauterizing pen as part of a medical procedure to scar the skin by branding Patient C, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR and/or KAR, in the pelvis region, thereby leaving a permanent scar. Respondent's conduct deviated from accepted standards of care as follows:

1. Respondent performed the medical procedure upon Patient C in an other than appropriately sterile environment, and/or without appropriate infection control, and/or without the use of sterile technique, including the surgical field, surgical procedure room, multiple use of a cautery pen tip and electrical grounding pad; and documented electrical testing and maintenance upkeep of the cautery device.
2. Respondent, while performing the medical procedure without the use of a local anesthetic or general anesthesia, thereby causing Patient C to suffer pain for no legitimate medical purpose.
3. Respondent performed the medical procedure upon Patient C with non-medically trained personnel present, who were not wearing personal protective equipment.
4. Respondent performed the medical procedure upon Patient C with the assistance of non-medically trained personnel who physically restrained said patient.
5. Respondent failed to cease performing the medical procedure despite the fact that Patient C was suffering pain without medical justification.
6. Respondent, during the course of the medical procedure, willfully physically abused Patient C.

7. Respondent performed the medical procedure upon Patient C at the time when said patient was naked and while being held down by other individuals, who were also naked, contrary to any appropriate medical protocol or need.
8. Respondent inappropriately performed the medical procedure upon Patient C while an individual who was also naked utilized a cell phone to video said medical procedure.
9. Respondent failed to provide appropriate wound care for Patient C at the time of the medical procedure, and thereafter.
10. Respondent failed to provide appropriate follow-up medical care and treatment for Patient C's wound, and/or failed to refer Patient C to another medical provider for such post-medical procedure wound care.
11. Respondent inappropriately advised, or caused another individual to advise, Patient C to take photographs of the wound caused by the medical procedure on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual who shared all or some of said photographs with Respondent.
12. Respondent failed to provide appropriate medical care and treatment for Patient C, including obtaining information regarding said patient's medical history and current medications.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of Patient C.
14. Respondent fraudulently failed to disclose to Patient C that the initials KR and/or KAR said Respondent branded into the pelvis region of Patient C represented the initials of Keith Alan Ranieri.
15. Respondent performed the medical procedure upon Patient C without having obtained the adequate informed consent of Patient C.

D. On or about March 9, 2017, the Respondent used a cauterizing pen as part of a medical procedure to scar the skin by branding Patient D, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR and/or KAR, in the pelvis region, thereby leaving a permanent scar. Respondent's conduct deviated from accepted standards of care as follows:

1. Respondent performed the medical procedure upon Patient D in an other than appropriately sterile environment, and/or without appropriate infection control, and/or without the use of sterile technique, including the surgical field, surgical procedure room, multiple use of a cautery pen tip and electrical grounding pad, and documented electrical testing and maintenance upkeep of the cautery device.
2. Respondent, while performing the medical procedure without the use of a local anesthetic or general anesthesia, thereby causing Patient D to suffer pain for no legitimate medical purpose.
3. Respondent performed the medical procedure upon Patient D with non-medically trained personnel present, who were not wearing personal protective equipment.
4. Respondent performed the medical procedure upon Patient D with the assistance of non-medically trained personnel who physically restrained said patient.
5. Respondent failed to cease performing the medical procedure despite the fact that patient D was suffering pain without medical justification.
6. Respondent, during the course of the medical procedure, willfully physically abused Patient D.
7. Respondent performed the medical procedure upon Patient D at the time when said patient was naked and while being held down by other individuals, who were also naked, contrary to any appropriate medical protocol or need.

8. Respondent inappropriately performed the medical procedure upon Patient D while an individual who was also naked utilized a cell phone to video said medical procedure.

9. Respondent failed to provide appropriate wound care for Patient D at the time of the medical procedure, and thereafter.

10. Respondent failed to provide appropriate follow-up medical care and treatment for Patient D's wound, and/or failed to refer Patient D to another medical provider for such post-medical procedure wound care.

11. Respondent inappropriately advised, or caused another individual to advise Patient D to take photographs of the wound caused by the medical procedure on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual who shared all or some of said photographs with Respondent.

12. Respondent failed to provide appropriate medical care and treatment for Patient D, including obtaining information regarding said patient medical history and current medications.

13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of Patient D.

14. Respondent fraudulently failed to disclose to Patient D that the initials KR and/or KAR said Respondent branded into the pelvis region of Patient D represented the initials of Keith Alan Ranieri.

15. Respondent performed the medical procedure upon Patient D without having obtained the adequate informed consent of Patient D.

E. On or about March 9, 2017, the Respondent used a cauterizing pen as part of a medical procedure to scar the skin by branding Patient E, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR and/or KAR,

in the pelvis region, thereby leaving a permanent scar. Respondent's conduct deviated from accepted standards of care as follows:

1. Respondent performed the medical procedure upon Patient E in an other than appropriately sterile environment, and/or without appropriate infection control, and/or without the use of sterile technique, including the surgical field, surgical procedure room, multiple use of a cautery tip pen and electrical grounding pad, and documented electrical testing and maintenance upkeep of the cautery device.
2. Respondent performed the medical procedure without the use of a local anesthetic or general anesthesia, thereby causing Patient E to suffer pain for no legitimate medical purpose.
3. Respondent performed the medical procedure upon Patient E with non-medically trained personnel present, who were not wearing personal protective equipment.
4. Respondent performed the medical procedure upon Patient E with the assistance of non-medically trained personnel who physically restrained said patient.
5. Respondent failed to cease performing the medical procedure despite the fact that Patient E was suffering pain without medical justification.
6. Respondent, during the course of the medical procedure, willfully physically abused Patient E.
7. Respondent performed the medical procedure upon Patient E at the time when said patient was naked and while being held down by other individuals, ~~who were also naked~~, contrary to any appropriate medical protocol or need.
8. Respondent inappropriately performed the medical procedure upon Patient E while an individual who was also naked utilized a cell phone to video said medical procedure.
9. Respondent failed to provide appropriate wound care for Patient E at the time of the medical procedure, and thereafter.

10. Respondent failed to provide appropriate follow-up medical care and treatment for Patient E's wound, and/or failed to refer Patient E to another medical provider for such post-medical procedure wound care.

11. Respondent inappropriately advised, or caused another individual to advise, Patient E to take photographs of the wound caused by the medical procedure on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual who shared all or some of said photographs with Respondent.

12. Respondent failed to provide appropriate medical care and treatment for the Patient E, including obtaining information regarding said patient's medical history and current medications.

13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of Patient E.

14. Respondent fraudulently failed to disclose to Patient E that the initials KR and/or KAR said Respondent branded into the pelvis region of Patient E represented the initials of Keith Alan Ranieri.

15. Respondent performed the medical procedure upon Patient E without having obtained the adequate informed consent of Patient E.

F. During the period from on or about January 2017 through December 2017, the Respondent used a cauterizing pen as part of medical procedures to permanently scar the skin by branding one or more of the following: Patients F and G, female patients, hereinafter identified in the attached Appendix "A", with the initials KR and/or KAR, in their pelvis regions. Respondent's conduct deviated from accepted standards of care as follows:

1. Respondent performed the medical procedures upon one or more of the following: Patients F and G in an other than appropriately sterile environment,

and/or without appropriate infection control, and/or without the use of sterile technique, including the surgical field, surgical procedure room, multiple use of a cautery pen tip and electrical grounding pad, and documented electrical testing and maintenance upkeep of the cautery device.

2. Respondent performed the medical procedures without the use of a local anesthetic or general anesthesia, thereby causing one or more of the following: Patients F and G to suffer pain for no legitimate medical purpose.
3. Respondent performed the medical procedures upon one or more of the following: Patients F and G with non-medically trained personnel present, who were not wearing personal protective equipment.
4. Respondent performing the medical procedures upon one or more of the following: Patients F and G with the assistance of non-medically trained personnel who physically restrained said patients.
5. Respondent failed to cease performing the medical procedures despite the fact that one or more of the following: Patients F and G were suffering pain without medical justification.
6. Respondent, during the course of the medical procedures willfully physically abused one or more of the following: Patients F and G.
7. Respondent inappropriately performed the medical procedures upon one or more of the following: Patients F and G while an individual utilized a cell phone to video said medical procedures.
8. Respondent failed to provide appropriate wound care for one or more of the following: Patients F and G at the time of the medical procedures, and thereafter.
9. Respondent failed to provide appropriate follow-up medical care and treatment for one or more of the following: Patients F and G, and/or failed to refer the patients to other medical providers for such post-medical procedures wound care.

10. Respondent inappropriately advised, or caused another individual to advise, one or more of the following: Patients F and G to take photographs of the wounds caused by the medical procedures on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual who shared all or some of said photographs with Respondent.
11. Respondent failed to provide appropriate medical care and treatment for one or more of the following: Patients F and G, including obtaining information regarding said patients' medical histories and current medications.
12. Respondent failed to prepare and/or maintain appropriate medical records for the patients which accurately reflected the evaluation and treatment of one or more of the following: Patients F and G.
13. Respondent performed the medical procedures upon one or more of the following: Patients F and G without having obtained the adequate informed consents of said Patients F and G.

G. During the time from on or about June 2016 through August 2016, NXIVM and/or the Executive Success Program (ESP) conducted a conference and/or meeting at the Silver Bay Conference and Family Retreat Center (Conference Center), located in Silver Bay, New York. The Respondent and approximately 438 other individuals attended the conference, including approximately 76 children. During the course of the conference, hundreds of the attendees became severely ill with an undetermined communicable disease. The individuals who became ill suffered inter alia, flu-like symptoms, severe vomiting and diarrhea. The Respondent had knowledge of the fact that many individuals at the conference had become ill. The Respondent knew or should have known that the illness suffered by the attendees at the conference was a communicable disease, outbreak of a communicable disease, and/or an unusual disease or outbreak. Respondent's conduct deviated from accepted standards of care as follows:

1. Respondent failed to report a disease outbreak or unusual disease to the State Department of Health as required by Title 10 N,Y.C.R.R. Section 2.1(c).
2. Respondent failed to report the suspected or confirmed case of communicable disease, outbreak of communicable disease, and/or the unusual disease or outbreak to the city, county, or district health officer as required by Title 10 N.Y.C.R.R. Sections 2.10 and 2.1(b) and (c).
3. Respondent failed to report by telephone, facsimile, or other electronic communication, or in person the illness of the attendees at the conference suspected or confirmed to have been caused due to the consumption of spoiled or poisonous food to the city, county, or district health officer, in violation of Title 10 N.Y.C.R.R. Section 2.15.
4. Upon being made aware of the fact that attendees at the conference might have been suffering from a communicable disease, the Respondent failed to cause such individuals to be isolated in an appropriate environment, pending official action by the health officer, in violation of Title 10 N.Y.C.R.R. Section 2.27.

SPECIFICATIONS OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS
WILLFULLY ABUSING A PATIENT

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(31) by willfully abusing a patient as alleged in the facts of one or more of the following:

1. The facts in paragraphs A and A.2, A and A.4, A and A.5, A and A.6, and/or A and A.8.
2. The facts in paragraphs B and B.2, B and B.4, B and B.5, B and B.6, and/or B and B.8.
3. The facts in paragraphs C and C.2, C and C.4, C and C.5, C and C.6, and/or, C and C.8.
4. The facts in paragraphs D and D.2, D and D.4, D and D.5, D and D.6, and/or, D and D.8.
5. The facts in paragraphs E and E.2, E and E.4, E and E.5, E and E.6, and/or, E and E.8.
6. The facts in paragraphs F and F.2, F and F.4, F and F.5, F and F.6, and/or F and F.8.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(20) by engaging in conduct in the practice of medicine which evidences moral unfitness to practice medicine as alleged in the facts of one or more of the following:

7. The facts in paragraphs A and A.2, A and A.4, A and A.5, A and A.6, and/or A and A.8.
8. The facts in paragraphs B and B.2, B and B.4, B and B.5, B and B.6, and/or B and B.8.
9. The facts in paragraphs C and C.2, C and C.4, C and C.5, C and C.6, and/or C and C.8.
10. The facts in paragraphs D and D.2, D and D.4, D and D.5, D and D.6, and/or D and D.8.
11. The facts in paragraphs E and E.2, E and E.4, E and E.5, E and E.6, and/or E and E.8.
12. The facts in paragraphs F and F.2, F and F.4, F and F.5, F and F.6, and/or F and F.8.

THIRTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

FAILING TO USE APPROPRIATE STERILE ENVIRONMENT AND/OR WITHOUT APPROPRIATE INFECTION CONTROL AND/OR WITHOUT THE USE OF STERILE TECHNIQUE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(47) by failing to use scientifically accepted barrier precautions and infection control practices as established by the department of health as alleged in the facts of one or more of the following:

13. The facts in paragraphs A and A.1, A and A.3, A and A.4, and/or A and A.7.

14. The facts in paragraphs B and B.1, B and B.3, B and B.4, and/or B and B.7.

15. The facts in paragraphs C and C.1, C and C.3, C and C.4, and/or C and C.7.

16. The facts in paragraphs D and D.1, D and D.3, D and D.4, and/or D and D.7.

17. The facts in paragraphs E and E.1, E and E.3, E and E.4, and/or E and E.7.

18. The facts in paragraphs F and F.1, F and F.3, F and F.4, and/or F and F.7.

NINTEENTH SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY OR BEYOND ITS SCOPE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(2) by practicing the profession fraudulently or beyond its authorized scope as alleged in the facts of one or more of the following:

19. The facts in paragraphs A and A.2, A and A.3, A and A.8 and/or A and A.14; B and B.2, B and B.3, B and B.8, and/or B and B.14; C and C.2, C and C.3, C and C.8, and/or C and C.14; D and D.2, D and D.3, D and D.8, and/or D and D.14; E

and E.2, E and E.3, E and E.8, and/or E and E. 14; F and F.2, F and F.3, and/or F and F.7.

TWENTIETH THROUGH TWENTY-FIFTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(4) by practicing the profession with gross negligence as alleged in the facts of one or more of the following:

20. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, A and A.13, A and A.14, and/or A and A.15.

21. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, B and B.13, B and B.14, and/or B and B.15.

22. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.10, C and C.11, C and C.12, C and C.13, C and C.14, and/or C and C.15.

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

24. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, E and E.14, and/or E and E.15.

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

TWENTY-SIXTH SPECIFICATION

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(3) by practicing the profession with negligence on more than one occasion as alleged in the facts of the following:

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

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

TWENTY-SEVENTH THROUGH THIRTY-SECOND SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(6) by practicing the profession with gross incompetence as alleged in the facts of one or more of the following:

27. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, A and A.13, and/or A and A.15.

28. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, B and B.13, and/or A and A.15.

29. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.10, C and C.11, C and C.12, C and C.13, and/or C and C.15.

30. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, D and D.12, D and D.13, and/or D and D.15.

31. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, and/or E and E.15.

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

THIRTY-THIRD SPECIFICATION

PRACTICNG THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(5) by practicing the profession with incompetence on more than one occasion as alleged in the facts of the following:

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

C and C.10, C and C.11, C and C.12, C and C.13, and/or C and C.15; and/or D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, D and D.12, D and D.13, and/or D and D.15; and/or E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, and/or E and E.15; and/or F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, and/or F and F.13; and/or G and G.1, G and G.2, G and G.3, and/or G and G.4.

THIRTY-FOURTH SPECIFICATION

WILLFULLY FAILING TO FILE A REPORT REQUIRED BY LAW

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(21) by willfully failing to file a report required by law or by the Department of Health, or the Education Department as alleged in the facts of one or more of the following:

34. The facts in paragraphs G and G.1, G and G.2, G and G.3 and/or G. and G.4.

THIRTY-FIFTH SPECIFICATION

WILLFULLY OR GROSSLY FAILING TO COMPLY WITH FEDERAL, STATE, OR LOCAL LAWS RULES OR REGULATIONS GOVERNING THE PRACTICE OF MEDICINE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(16) by willfully or grossly negligently failing to comply with substantial provisions of federal, state, or local laws, rules, or regulations governing the practice of medicine as alleged in the facts of one or more of the following:

35. The facts in paragraphs G and G.1, G and G.2, G and G.3 and/or G and G.4.

THIRTY-SIXTH THROUGH FORTY-FIRST SPECIFICATIONS

PERFORMING PROFESSIONAL SERVICES WHICH HAVE NOT BEEN AUTHORIZED BY THE PATIENT

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(26) by performing professional services which have not been authorized by the patient as alleged in the facts of one or more of the following:

36. The facts in paragraphs A and A.14, and/or A and A.15.

37. The facts in paragraphs B and B.14, and/or B and B.15.

38. The facts in paragraphs C and C.14, and/or C and C.15.

39. The facts in paragraphs D and D.14, and/or D and D.15.

40. The facts in paragraphs E and E.14, and/or E and E.15.

41. The facts in paragraphs F and F.14, and/or F and F.15.

FORTY-SECOND THROUGH FORTY-SEVENTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in the facts of the following:

42. The facts in paragraphs A and A.13.

43. The facts in paragraphs B and B.13.

44. The facts in paragraphs C and C.13.

45. The facts in paragraphs D and D.13.

46. The facts in paragraphs E and E.13.

47. The facts in paragraphs F and F.12.

DATE: April 27, 2020
Albany, New York

[redacted]

TIMOTHY J. MAHAR, ESQ.
Deputy Counsel
Bureau of Professional Medical Conduct