STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

February 15, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Barry C. Plunkett, Esq.
NYS Department of Health
Corning Tower Room 2509
Empire State Plaza
Albany, New York 12237

Sue Anne McCarthy, R.P.A.
c/o James McCarthy
9920 Grace Drive Apt. 5
Port Richey, Florida 34668-3520

Sue Anne McCarthy, R.P.A.
2344 Colvin Extension Apt. 8
Tonawanda, New York 14150

Sue Anne McCarthy, R.P.A.
c/o Karen Teresi
474 Starin Avenue
Buffalo, New York 14150

Sue Anne McCarthy, R.P.A.
c/o James McCarthy
114 Wrexham Court South
Tonawanda, New York 14150

RE: In the Matter of Sue Anne McCarthy, R.P.A.

Dear Parties:

Enclosed please find the Determination and Order (No.00-45) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

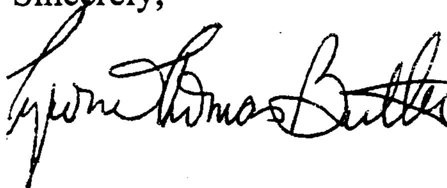
The notice of review served on the Administrative Review Board should be forwarded to:

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

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

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

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER OF SUE ANNE MCCARTHY, R.P.A.	DETERMINATION AND ORDER

BPMC-00-45

LEMUEL A. ROGERS, JR., M.D., Chairperson, **DIANA E. GARNEAU, M.D.** and **MS. JEAN KRYM**, duly designated members of the State Board for Professional Medical Conduct appointed by the Commissioner of Health of the State of New York pursuant to Sections 230(1) and (12) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ESQ.**, served as Administrative Officer for the Hearing Committee. After consideration of the entire record, the Hearing Committee submits this Determination.

SUMMARY OF PROCEEDINGS

Commissioner's Order/Notice of Hearing/ Statement of Charges:	December 20, 1999
Date of Hearing:	January 27, 2000
Department of Health appeared by:	**HENRY M. GREENBERG, ESQ..** General Counsel, NYS Department of Health **BY: BARRY C. PLUNKETT, ESQ. JOSEPH H. CAHILL, ESQ.** NYS Department of Health Corning Tower, Room 2509 Albany, New York 12237
Respondent :	**NO APPEARANCE**
Deliberations held:	January 27, 2000

LEGAL ISSUES

Pursuant to Part 230 (10) (d) of the Public Health Law, Petitioner must obtain personal service upon Respondent in order to establish jurisdiction over her. However, jurisdiction can be established where the Notice of Hearing and Statement of Charges is sent to Respondent by registered or certified mail. Service by mail is available where personal service cannot be obtained after due diligence. The due diligence must be certified under oath. The address to which the documents must be mailed is the last known address by the Board. (Public Health Law Part 230(10)(d)

Petitioner obtained jurisdiction through service by mail. The record established that Petitioner made a number of unsuccessful attempts to locate and personally serve Respondent on December 21 and December 22, 1999 and thereafter mailed the Commissioner's Order, Notice of Hearing and Statement of Charges to several locations, including her last known address, addresses of her father in both the Buffalo area and in Port Richey, Florida and the address of Respondent's sister in Buffalo. (Ex. 57, 59, 61) The Notice of Hearing indicated an address and telephone number for Respondent to contact to request an adjournment.

The record also demonstrated that staff of the Petitioner's Buffalo Area Office had made attempts as early as October, 1999 to locate Respondent in relation to an interview scheduled for November 1, 1999 to address allegations of professional misconduct. (Ex. 3-7) Evidence was obtained which indicated that Respondent had moved from her last known residence and that her telephone service had been discontinued. Furthermore, Petitioner provided evidence that on January 13, 2000, Respondent had signed certified mail receipts for certain documents sent her by Petitioner relating to the ongoing investigation into her medical practice. (Ex. 63)

Fundamental due process requires that an accused have notice of a pending proceeding and a reasonable opportunity to be heard. It was the ruling of the Administrative Law Judge that Petitioner did far more than is required by the controlling statutes and due process concepts. It was clear from the record that family members were aware of the action by Petitioner to summarily suspend Respondent's license and that they would have had the opportunity to inform her of such fact. In this case, Respondent was given every opportunity to answer the charges. Based on the exhibits presented which clearly demonstrated that Petitioner had exercised due diligence in attempting to locate and personally serve

Respondent, the Administrative Law Judge ruled that jurisdiction had been obtained and that the Petitioner could proceed in its proposed action.

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's exhibits are designated by Letters.
T = Transcript

A copy of the Commissioner's Order, Notice of Hearing and Statement of Charges (Ex. 1-2) is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on February 25, 1997 by the issuance of license number 005829 by the New York State Education Department. (Ex. 52)

2. Between approximately October 1998 and the first week of July 1999, Respondent was, at times, impaired for the practice of medicine and/or practiced medicine while impaired at Sheehan Memorial Hospital and associated health care facilities/clinics. (Ex. 22; 34-41; 43)

3. Respondent, between approximately June 17, 1999 and July 10, 1999, prescribed controlled substances and non-controlled substances for herself and an individual KT. These prescriptions included the following controlled substances: hydrocodone, zolpidem, phentermine, and a non-controlled substance prescription for carisoprodol.

a. Respondent prescribed the above stated medications for herself and KT without adequate medical justification.

b. Respondent prescribed the above stated medications without formulating and/or documenting an adequate treatment plan.

c. Respondent prescribed the above stated medications without performing and/or documenting an initial medical assessment.

d. Respondent prescribed the above listed medications without providing and/or documenting adequate medical treatment. (Ex. 2, Appendix B; 22; 24A-B; 27)

4. Respondent fraudulently issued prescriptions using Dr. AD's name on or about June 17, 1999 and July 10, 1999. Said prescriptions were issued without the consent, knowledge and authorization of Dr. AD.

a. Respondent fraudulently obtained the prescription drugs that were fraudulently prescribed by her on June 17, 1999 and July 10, 1999 in concert with KT. (Ex. 2, Appendix B; 35-6; Supp. Ex. 1)

5. Respondent fraudulently issued bulk stock orders for controlled substances. Such orders included 1000 phentermine 37.5 Cap Blk on October 9, 1998 and 500 hydrocodone 10 mg tablets on or about August 5, 1999. Respondent's employment with Sheehan Memorial Hospital had been previously terminated on or about July 7, 1999. (Ex. 24-5; 29-30)

6. Respondent provided medical care to Patient A, a female, on or about June 11, 1999, at Sheehan Memorial Hospital Family Care Center. Respondent's care of Patient A was below accepted standards of medical practice as follows:

a. Respondent treated Patient A, who has a history of hypertension, by inappropriately prescribing Plavix.

b. Respondent failed to adequately document the medical justification for the use of Plavix, if any. (Ex. 67)

7. Respondent provided medical care to Patient B, a female, at Sheehan Memorial Hospital Family Care Center, on or about April 17, 1998 through June 17, 1999. Respondent's care of Patient B was below accepted standards of medical practice as follows:

a. Respondent treated Patient B by inappropriately prescribing the drug Plavix on April 1, 1999 and June 17, 1999.

b. Respondent failed to adequately document the medical justification for the ordering of Plavix, if any. (Ex. 68)

8. Respondent provided medical care to Patient C, a female, at Sheehan Memorial Hospital Family Care Center, from on or about June 1997 through April 26, 1999. Respondent's care of Patient C was below accepted standards of medical practice as follows:

a. Respondent inappropriately prescribed Plavix on April 2, 1999, without adequate medical justification and/or failed to document such justification. (Ex. 69)

9. Respondent provided medical care to Patient D, a female, at Sheehan Memorial Hospital Family Care Center, from on or about July 27, 1998 through at least April 28, 1999. Respondent's care of Patient D was below accepted standards of medical practice as follows:

a. Respondent failed to obtain and/or document a change in blood pressure for Patient D on January 27, 1999.

b. Respondent failed to note the medical justification, if any, to substantiate the change in blood pressure medication for Patient D on January 27, 1999. (Ex. 70)

10. Respondent provided medical care to Patient E, a male, at Sheehan Memorial Hospital Family Care Center, on or about August 3, 1998 through June 27, 1999. Respondent's care of Patient E was below accepted standards of medical practice as follows:

a. Respondent, on or about 8/24/98, and/or 10/14/98, and/or 1/11/99, and/or 1/27/99, and/or 2/18/99, and/or 4/1/99, and/or 5/13/99, and/or 6/11/99, and/or 6/17/99, failed to perform adequate physical examinations to substantiate a diagnosis of sinusitis and/or failed to document such examinations. (Ex. 71)

11. Respondent provided medical care to Patient F, a male, at Sheehan Memorial Hospital Family Care Center on or about April 13, 1999. Respondent's care of Patient F was below accepted standards of medical practice as follows:

a. Respondent, on or about April 13, 1999, inappropriately prescribed and administered Toradol IM without adequate medical justification and/or failed to document such justification.

b. Respondent failed to appropriately perform or take reasonable steps to obtain a neurological examination of Patient F. (Ex. 66)

12. Respondent provided medical care to Patient G, a female, at Sheehan Memorial Hospital Family Care Center on or about April 22, 1999. Respondent's care of Patient G was below accepted standards of medical practice as follows:

a. Respondent, on April 22, 1999, failed to perform an adequate physical examination to substantiate a diagnosis of sinusitis and/or failed to document such examination for Patient G.

b. Respondent, on or about April 22, 1999, inappropriately prescribed the medication Celebrex to Patient G, age 13 at the time, without setting forth in the patient's medical record the reason why the prescription was written for Patient G or justification for the use of this medication on a patient 13 years of age. (Ex. 72)

13. Respondent provided medical care to Patient H, a female, at Sheehan Memorial Hospital Family Care Center from September 17, 1998 through June 7, 1999. Respondent's care of Patient H was below accepted standards of medical practice as follows:

a. Respondent, on 9/17/98, and/or 11/9/98, and/or 3/11/99, and/or 4/15/99, and/or 6/7/99, failed to adequately perform physical examinations despite the patient's complaints of knee pain and/or failed to document such examinations so as to support the diagnosis listed and the use of medications listed to treat same. (Ex. 73)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee determined that Petitioner had demonstrated that Respondent's continued practice of medicine constituted an imminent danger to the health of the people of New York as set forth in the Commissioner's Order dated December 20, 1999.

The Hearing Committee concluded that all Factual Allegations and all Specifications should be **SUSTAINED** as Petitioner met its burden of proof and Respondent did not make an appearance thereby, in effect, waiving her right to a hearing to contest such Factual Allegations and Specifications.

DISCUSSION AND DETERMINATION OF PENALTY

Respondent was found to have committed serious acts of professional misconduct, including practicing while impaired, inappropriately prescribing controlled substances for herself and others, fraudulently issuing presciptions in the name of another physician and fraudulently issuing bulk orders for controlled substances. The Committee considered such actions to be not only professional misconduct, but also potentially criminal activities. The fact that Respondent failed to respond to any notice of the Petitioner's investigation into her practice or to this impending proceeding, despite extensive attempts made by numerous individuals over several months to locate her, was viewed as a clear indication of Respondent's lack of desire to retain her Physician Assistant's license. The Committee concluded that the revocation of that license was the only appropriate penalty that could be imposed.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

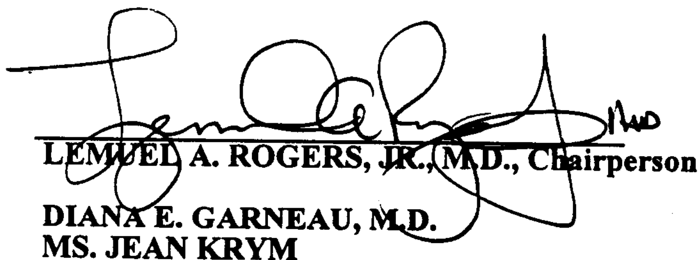
1. The Specifications contained within the Statement of Charges (Ex. 2) are **SUSTAINED**, and;

2. Respondent's license to practice medicine in New York State be, and hereby is, **REVOKED,** and;

3. This Order shall be effective upon service on the Respondent by personal service or by certified or registered mail.

DATED: Troy, New York

, 2000



LEMUEL A. ROGERS, JR., M.D., Chairperson
DIANA E. GARNEAU, M.D.
MS. JEAN KRYM

TO:

Barry C. Plunkett, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2509
Empire State Plaza
Albany, New York 12237-0032

Sue Anne McCarthy, R.P.A.
2344 Colvin Extension, Apt. 8
Tonawanda, New York 14150

c/o Karen Teresi
474 Starin Avenue
Buffalo, New York 14150

c/o James McCarthy
9920 Grace Drive, Apt. 5
Port Richey, Florida 34668-3520

c/o James McCarthy
114 Wrexham Court South
Tonawanda, New York 14150

APPENDIX 1

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

IN THE MATTER OF SUE ANNE MCCARTHY, R.P.A.	COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: SUE ANNE MCCARTHY, R.P.A.
2344 Colvin Extension, Apt. 8
Tonawanda, New York 14150

The undersigned, Antonia C. Novello, M.D., M.P.H., Commissioner of the New York State Department of Health, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by Sue Anne McCarthy, Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12), that effective immediately Sue Anne McCarthy, Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230, and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of

the State Board for Professional Medical Conduct on the 29th day of December, 1999, at 10:00 a.m., at the Buffalo Regional Office, 584 Delaware Avenue, Buffalo, New York and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

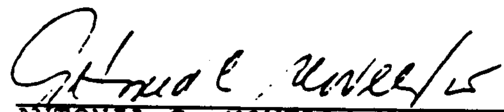
The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Hedley Park Place, 433 River Street, 5th Floor, Troy, New York 12180 (518-402-0751), upon notice to the attorney for the Department of

Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
December 30, 1999



ANTONIA C. NOVELLO, M.D., M.P.H.
Commissioner

Inquiries should be directed to:

Barry C. Plunkett
Associate Counsel
NYS Department of Health
Division of Legal Affairs
Room 2509,Corning Tower Building
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

EXHIBIT 2

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

---X

IN THE MATTER OF SUE ANNE MCCARTHY, R.P.A.	STATEMENT OF CHARGES

---X

SUE ANNE MCCARTHY, R.P.A., Respondent, was authorized to practice medicine in New York State on February 25, 1997, by the issuance of license number 005829, by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine, with a registration address of 2344 Colvin Extension, Apt. 8, Tonawanda, New York 14150.

FACTUAL ALLEGATIONS

A. During the period, between approximately October 1998 and the first week of July 1999, Respondent was, at times, impaired for the practice of medicine and/or practiced medicine while impaired at Sheehan Memorial Hospital and associated health care facilities/clinics.

B. Respondent, between approximately June 17, 1999 and July 10, 1999, prescribed controlled substances and non-controlled substances for herself and an individual KT (Patients are identified in Appendix A.). These prescriptions included the following controlled substances: hydrocodone, zolpidem,

phentermine, and a non-controlled substance prescription for carisoprodol. (Annexed hereto as Appendix B, is a tabulation of controlled substance prescriptions for Respondent and KT for this time period.)

1. Respondent prescribed the above stated medications for herself and KT without adequate medical justification.

2. Respondent prescribed the above stated medications without formulating and/or documenting an adequate treatment plan.

3. Respondent prescribed the above stated medications without performing and/or documenting an initial medical assessment.

4. Respondent prescribed the above listed medications without providing and/or documenting adequate medical treatment.

C. Respondent fraudulently issued prescriptions using Dr. AD's name (The Doctor is identified in Appendix A.)(The said prescriptions are listed in Appendix B.) on or about June 17, 1999 and July 10, 1999. Said prescriptions were issued without the consent, knowledge and authorization of Dr. AD.

1. Respondent fraudulently obtained the prescription drugs that were fraudulently prescribed by her on June 17,

1999 and July 10, 1999 in concert with KT.

D. Respondent fraudulently issued bulk stock orders for controlled substances. Such orders included 1000 phentermine 37.5 Cap Blk on October 9, 1998 and 500 hydrocodone 10 mg tablets on or about August 5, 1999. Respondent's employment with Sheehan Memorial Hospital had been previously terminated on or about July 7, 1999.

E. Respondent provided medical care to Patient A, a female, on or about June 11, 1999, at Sheehan Memorial Hospital Family Care Center. Respondent's care of Patient A was below accepted standards of medical practice as follows:

1. Respondent treated Patient A, who has a history of hypertension, by inappropriately prescribing Plavix.

2. Respondent failed to adequately document the medical justification for the use of Plavix, if any.

F. Respondent provided medical care to Patient B, a female, at Sheehan Memorial Hospital Family Care Center, on or about April 17, 1998 through June 17, 1999. Respondent's care of Patient B was below accepted standards of medical practice as follows:

1. Respondent treated Patient B by inappropriately prescribing the drug Plavix on April 1, 1999 and

June 17, 1999.

2. Respondent failed to adequately document the medical justification for the ordering of Plavix, if any.

G. Respondent provided medical care to Patient C, a female, at Sheehan Memorial Hospital Family Care Center, from on or about June 1997 through April 26, 1999. Respondent's care of Patient C was below accepted standards of medical practice as follows:

1. Respondent inappropriately prescribed Plavix on April 2, 1999, without adequate medical justification and/or failed to document such justification.

H. Respondent provided medical care to Patient D, a female, at Sheehan Memorial Hospital Family Care Center, from on or about July 27, 1998 through at least April 28, 1999. Respondent's care of Patient D was below accepted standards of medical practice as follows:

1. Respondent failed to obtain and/or document a change in blood pressure for Patient D on January 27, 1999.

2. Respondent failed to note the medical justification, if any, to substantiate the change in blood pressure medication for Patient D on January 27, 1999.

I. Respondent provided medical care to Patient E, a male,

at Sheehan Memorial Hospital Family Care Center, on or about August 3, 1998 through June 27, 1999. Respondent's care of Patient E was below accepted standards of medical practice as follows:

1. Respondent, on or about 8/24/98, and/or 10/14/98, and/or 1/11/99, and/or 1/27/99, and/or 2/18/99, and/or 4/1/99, and/or 5/13/99, and/or 6/11/99, and/or 6/17/99, failed to perform adequate physical examinations to substantiate a diagnosis of sinusitis and/or failed to document such examinations.

J. Respondent provided medical care to Patient F, a male, at Sheehan Memorial Hospital Family Care Center on or about April 13, 1999. Respondent's care of Patient F was below accepted standards of medical practice as follows:

1. Respondent, on or about April 13, 1999, inappropriately prescribed and administered Toradol IM without adequate medical justification and/or failed to document such justification.

2. Respondent failed to appropriately perform or take reasonable steps to obtain a neurological examination of Patient F.

K. Respondent provided medical care to Patient G, a female, at Sheehan Memorial Hospital Family Care Center on or about

April 22, 1999. Respondent's care of Patient G was below accepted standards of medical practice as follows:

1. Respondent, on April 22, 1999, failed to perform an adequate physical examination to substantiate a diagnosis of sinusitis and/or failed to document such examination for Patient G.

2. Respondent, on or about April 22, 1999, inappropriately prescribed the medication Celebrex to Patient G, age 13 at the time, without setting forth in the patient's medical record the reason why the prescription was written for Patient G or justification for the use of this medication on a patient 13 years of age.

L. Respondent provided medical care to Patient H, a female, at Sheehan Memorial Hospital Family Care Center from September 17, 1998 through June 7, 1999. Respondent's care of Patient H was below accepted standards of medical practice as follows:

1. Respondent, on 9/17/98, and/or 11/9/98, and/or 3/11/99, and/or 4/15/99, and/or 6/7/99, failed to adequately perform physical examinations despite the patient's complaints of knee pain and/or failed to document such examinations so as to support the diagnosis listed and the use of medications listed to treat same.

SPECIFICATIONS

FIRST SPECIFICATION
PRACTICING WHILE IMPAIRED

Respondent is charged with professional misconduct under N.Y. Education Law §6530(7) by reason of her having practiced the profession of medicine while impaired by drugs, physical and/or mental disability, in that Petitioner charges:

1. The facts in Paragraphs A; B and B.1, B.2, B.3, B.4; C and C.1; and/or D.

SECOND SPECIFICATION
HABITUAL USE

Respondent is charged with professional misconduct under N.Y. Education Law §6530(8) by reason of her being a habitual abuser of alcohol or dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens or other drugs having similar effects of having a psychiatric condition which impairs Respondent's ability to practice medicine, in that Petitioner charges:

2. The facts in Paragraphs A; B, and B.1, B.2, B.3, B.4; C and C.1; and/or D.

THIRD SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with professional misconduct under N.Y. Education Law §6530(2) by reason of her having practiced the profession of medicine fraudulently, in that Petitioner charges:

3. The facts in Paragraphs A; B and B.1, B.2, B.3, B.4; C and C.1; and/or D.

FOURTH THROUGH ELEVENTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Education Law §6530(3) by reason of her having practiced the profession of medicine with negligence on more than one occasion, in that Petitioner charges:

4. The facts in Paragraphs E and E.1 and/or E.2.
5. The facts in Paragraphs F and F.1 and/or F.2.
6. The facts in Paragraphs G and/or G.1.
7. The facts in Paragraphs H and H.1 and/or H.2.
8. The facts in Paragraphs I and/or I.1.
9. The facts in Paragraphs J and J.1 and/or J.2.
10. The facts in Paragraphs K and K.1 and/or K.2.
11. The facts in Paragraphs L and/or L.1.

TWELFTH THROUGH NINETEENTH SPECIFICATIONS

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Education Law §6530(5) by reason of her having practiced the profession of medicine with Incompetence on more than one occasion, in that Petitioner charges:

12. The facts in Paragraphs E and E.1 and/or E.2.
13. The facts in Paragraphs F and F.1 and/or F.2.
14. The facts in Paragraphs G and/or G.1.
15. The facts in Paragraphs H and H.1 and/or H.2.
16. The facts in Paragraphs I and/or I.1.
17. The facts in Paragraphs J and J.1 and/or J.2.
18. The facts in Paragraphs K and K.1 and/or K.2.
19. The facts in Paragraphs L and/or L.1.

TWENTIETH THROUGH TWENTY-SEVENTH SPECIFICATIONS

INADEQUATE RECORD KEEPING

Respondent is charged with professional misconduct under N.Y. Education Law §6530(32) by reason of her having failed to maintain a record for each patient that accurately reflects the care and treatment given to each patient, in that Petitioner charges:

20. The facts in Paragraphs E and/or E.2.
21. The facts in Paragraphs F and/or F.2.

22. The facts in Paragraphs G and/or G.1.

23. The facts in Paragraphs H and H.1 and/or H.2.

24. The facts in Paragraphs I and/or I.1.

25. The facts in Paragraphs J and/or J.1.

26. The facts in Paragraphs K and K.1 and/or K.2.

27. The facts in Paragraphs L and/or L.1.

TWENTY-EIGHTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Education Law §6530(20) by reason of her having practiced the profession of medicine which evidences moral unfitness, in that Petitioner charges:

28. The facts in Paragraphs A; B and B.1, B.2, B.3, B.4; C and C.1; D.

DATED: , 1999
Albany, New York

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct