STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
*Commissioner*

Paula Wilson
*Executive Deputy Commissioner*

September 28, 1994

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Denise Lepicier, Esq.
Assistant Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001

Henry V. Chase, D.O.
87-24 Jamaica Avenue
Woodhaven, New York 11421

**RE: In the Matter of Henry V. Chase, D.O.**

Dear Ms. Lepicier and Dr. Chase :

Enclosed please find the Determination and Order (No. 94-204) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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), "(t)he 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 all action 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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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:mmn

Enclosure

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

| IN THE MATTER<br>OF<br>HENRY V. CHACE, D.O. | DETERMINATION<br>AND<br>ORDER<br><br>NO. BPMC-94-204 |
|---|---|

**WILLIAM W. FALOON, M.D.**, (Chair), **ALBERT B. ACCETTOLA, JR., M.D.** and **RANDOLPH MANNING**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10)(e) of the Public Health Law.

**MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The Department of Health appeared by **DENISE LEPICIER, ESQ.**, Assistant Counsel.

Respondent appeared personally at the Hearing on his own behalf and was not represented by counsel.

Evidence was received, witnesses were sworn or affirmed and examined. Transcripts of the proceedings were made. After consideration of the record, the Hearing Committee issues this Determination and Order pursuant to the Public Health Law and the Education Law of the State of New York

## PROCEDURAL HISTORY

| | |
|---|---|
| Date of Notice of Hearing: | May 24, 1994 |
| Date of Service of Notice of Hearing: | May 26, 1994 |
| Date of Statement of Charges: | May 24, 1993 |
| Date of service of Statement of Charges: | May 26, 1994 |
| Answer to Statement of Charges: | None Filed (but see below) (July 15, 1994) |
| Pre-Hearing Conference Held: | June 24, 1994 |
| Hearing Held: | June 28, 1994 |
| Received Petitioner's Summation, Proposed Findings and Conclusions of Law: | August 15, 1994 |
| Received Respondent's Answer to the Statement of Charges and Summary: | July 15, 1994 |
| Witnesses called by the Petitioner, Department of Health: | Jerome S. Greenholz, D.O.<br>Roger W. Steinhardt M.D. |
| Witnesses called by the Respondent, Henry V. Chace: | Henry V. Chase, D.O. |
| Deliberations Held: | August 23, 1994 |

## STATEMENT OF CASE

This case was brought pursuant to §230 of the Public Health Law of the State of New York (hereinafter P.H.L.). Respondent, HENRY V. CHASE, D.O., (hereinafter "Respondent") is charged with seven specifications of professional misconduct as delineated in §6530 of the Education Law of the State of New York (hereinafter Education Law).

In this case, the Respondent is charged with: (1) professional misconduct by reason of practicing the profession with negligence on more than one occasion[1]; (2) professional misconduct by reason of failing to maintain records for each patient which accurately reflects the evaluation and treatment of each patient[2]; and (3) professional misconduct by reason of practicing the profession of medicine fraudulently[3].

The charges concern the medical care and treatment provided by Respondent to five (5) patients (A through E)[4].

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

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[1] Education Law §6530(3) and First Specification of Petitioner's Exhibit # 1.

[2] Education Law §6530(32) and Second through Sixth Specifications of Petitioner's Exhibit #1.

[3] Education Law §6530(2) and Seventh Specification of Petitioner's Exhibit # 1.

[4] All patients are identified in Appendix B of the Statement of Charges, Petitioner's Exhibit # 1.

## FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence or testimony, if any, was considered and rejected in favor of the cited evidence. Unless otherwise noted, all Findings and Conclusions herein were unanimous.

1. Respondent was authorized to practice medicine in New York State on September 22, 1958, by the issuance of license number 81372 by the New York State Education Department. (Petitioner's Exhibits # 1 and # 2)[5]

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994. (Petitioner's Exhibits # 1 and # 2).

3. Robert Ramsey personally served a Notice of Hearing and a Statement of Charges, dated May 24, 1994 and May 24, 1993[6], respectively, on Respondent on May 26, 1994 at 87-24 Jamaica Avenue, Woodhaven, Queens, NY (Petitioner's Exhibit # 1)

4. Jerome S. Greenholz has been in family practice since 1958 and was certified in General Practice by the American Osteopathic Board of General Practice in 1985. Dr. Greenholz specializes in the treatment of adults with chronic pain and

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[5] refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit) or by Henry V. Chace, D.O. (Respondent's Exhibit).

[6] appears to be error, and should be May 24, 1994.

is experienced in the use of controlled substances for treatment of chronic pain. (Petitioner's Exhibits # 14) and [T-9-12][7]

5. According to accepted medical practice, a medical record includes: some demographics of the patient, such as, name and date of birth; the chief complaint; background of that complaint; its duration; detailed descriptions of symptoms, similar complaints in the past and if so what treatment was used; studies done for this complaint. For initial patient contacts: a general review of the patient's past health, including prior illnesses, operations or hospitalizations; drug allergies; smoking, alcohol or drug uses; current medication uses; family medical history. A medical record would also include a physical examination with findings; the physician's impressions; diagnosis; tests necessary and treatment plan, including medications or referral for further treatment. In subsequent visits, a medical record would also include: progress of the patient, if any; new or different complaints; effect of treatment, if any; further diagnostic steps; new or additional medication prescribed, including amount and strength. [T-13-18]

6. It is a deviation from accepted medical practice and standards for a physician to fail to maintain appropriate medical records for a patient. [T-17-18]

**Patient A**

7. Respondent treated Patient A, a 33 year old female (in 1988), from approximately 1983 through approximately 1990. (Petitioner's Exhibits # 3A and # 3B) and [T-20]

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[7] Numbers in brackets refer to transcript page numbers. [T- ]

8. The medical records of Patient A maintained by Respondent include a "sketchy" history and physical of the patient. Said records are lacking as to progress notes, symptoms and diagnoses of the patient. (Petitioner's Exhibits # 3A and # 3B) and [T-21-22]

9. Respondent prescribed Seconal (3 times), Tylenol 3 (1 time) and Valium (1 time) to Patient A which prescriptions do not appear in the patient's medical records, as maintained by Respondent. (Petitioner's Exhibits # 8 and # 9; # 3A and # 3B) and [T-38-42] Respondent issued numerous prescriptions to Patient A for Seconal, Valium, Tylenol, Dyazide and Tylenol 3.

10. Patient A had a past history of Qualude and Seconal abuse and treatment as an inpatient for substance detoxification. Respondent prescribed Seconal repeatedly for Patient A. (Petitioner's Exhibits # 3A; # 3B; # 8 and # 9) and [T-22-23]

11. The record indicates, based on the patient's complaints and the information listed in Respondent's medical records, that the treatment of Patient A with Seconal, Tylenol 3 and Valium was not appropriate for this patient and was contrary to accepted medical practice and standards of care. (Petitioner's Exhibits # 3A and # 3B); [T-22-38] and [T-41-42]

**Patient B**

12. Respondent treated Patient B, a 47 year old male (in 1990) in 1990. (Petitioner's Exhibits # 4A and # 4B)

13. The medical records of Patient B maintained by Respondent include no medical history and no physical examination results of the patient. Said records are also barren as to progress notes, symptoms and diagnoses of the patient. (Petitioner's

Exhibits # 4A and # 4B) and [T-61-63]

14. Respondent prescribed Ativan (1 time) and Valium (5 times) to Patient B which prescriptions do not appear in the patient's medical records, as maintained by Respondent. (Petitioner's Exhibits # 8 and # 12; # 4A and # 4B)

**Patient C**

15. Respondent treated Patient C, a 36 year old male (in 1984), from approximately 1984 through approximately 1992. (Petitioner's Exhibits # 5A and # 5B)

16. The medical records of Patient C maintained by Respondent include no medical history and no adequate physical examination of the patient. Said records are also lacking as to progress notes, symptoms and adequate diagnoses of the patient. (Petitioner's Exhibits # 5A and # 5B) and [T-68-70]

17. Respondent prescribed Tuinal (10 times) and Seconal (3 times) to Patient C which prescriptions do not appear in the patient's medical records, as maintained by Respondent. (Petitioner's Exhibits # 8 and # 11; # 5A and # 5B) Respondent issued numerous prescriptions to Patient C for Seconal and Tuinal.

18. The record indicates, based on the patient's complaints and the information listed in Respondent's medical records, that the treatment of Patient C with Tuinal and Seconal over the extended period of time and the large number of prescriptions indicated was not appropriate for this patient and was contrary to accepted medical practice and standards of care. (Petitioner's Exhibits # 5A and # 5B) and [T-70-74]

**Patient D**

19. Respondent treated Patient D, a 27 year old female (in 1974), from approximately 1974 through approximately 1991. (Petitioner's Exhibits # 6)

20. The medical records of Patient D maintained by Respondent does not include an adequate physical examination of the patient. (Petitioner's Exhibits # 6) and [T-82]

21. Respondent prescribed Tuinal (8 times) to Patient D which prescriptions do not appear in the patient's medical records, as maintained by Respondent. (Petitioner's Exhibits # 16 and # 6) Respondent issued numerous prescriptions to Patient D for Tuinal.

22. The record indicates that the treatment of Patient D with Tuinal was not documented (no reason provided) within the medical records of the patient and therefore was contrary to accepted medical practice and standards of care. (Petitioner's Exhibits # 6) and [T-84-87]

**Patient E**

23. Respondent treated Patient E, a 32 year old male (in 1986), from approximately 1986 through approximately 1991. (Petitioner's Exhibits # 7)

24. The medical records of Patient E maintained by Respondent include no medical history and no physical examination of the patient. Said records are also barren as to progress notes, symptoms and diagnoses of the patient. (Petitioner's Exhibit # 7) and [T-89-90]

25. Respondent prescribed Percodan (7 times) to Patient E which prescriptions do not appear in the patient's medical records, as maintained by Respondent. (Petitioner's Exhibits # 8 and # 10; # 7) and [T-90-91] Respondent issued numerous

prescriptions to Patient E for Percodan.

26. Exhibits # 3 through and including # 7 have all been certified by Respondent to be "complete, true and exact copies/originals of the records of (each patient), kept on file during the regular course of business and were made at the time of such events as recorded or written."

27. Respondent prepared, at least a portion if not all, the medical records of Patient E several years subsequent to the patient's visits. [T-134-135] and [107-108]

## CONCLUSIONS OF LAW

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

The Hearing Committee concludes that the following Factual Allegations, from the May 24, 1993 (1994), Statement of Charges, are **SUSTAINED:**[8]

| | | |
|---|---|---|
| Paragraph A. | : | ( 7 ) |
| Paragraph A.1 | : | ( 8 ) |
| Paragraph A.2 | : | ( 8 ) |
| Paragraph A.3 | : | ( 8 ) |
| Paragraph A.4 | : | ( 9 ) except for Dyazide |
| Paragraph A.5 | : | ( 7 - 11 ) except for Dyazide |
| | | |
| Paragraph B. | : | ( 12 ) |
| Paragraph B.1 | : | ( 13 ) |
| Paragraph B.2 | : | ( 13 ) |
| Paragraph B.3 | : | ( 13 ) |
| Paragraph B.4 | : | ( 14 ) |

[8] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation.

Paragraph C. : ( 15 )
Paragraph C.1 : ( 16 )
Paragraph C.2 : ( 16 )
Paragraph C.3 : ( 16 )
Paragraph C.4 : ( 17 )
Paragraph C.5 : ( 15 - 18 )

Paragraph D. : ( 19 )
Paragraph D.2 : ( 20 )
Paragraph D.4 : ( 21 )
Paragraph D.5 : ( 19 - 22 )

Paragraph E. : ( 23 )
Paragraph E.1 : ( 24 )
Paragraph E.2 : ( 24 )
Paragraph E.3 : ( 24 )
Paragraph E.4 : ( 25 )

The Hearing Committee concludes that the following Factual Allegations, from the May 24, 1993 (1994) Statement of Charges, are **NOT SUSTAINED:**

Paragraph B.5 : ( 12 - 14 )
Paragraph D.1 : ( 19 - 22 )
Paragraph D.3 : ( 19 - 22 )
Paragraph E.5 : ( 23 - 27 )
Paragraph E.6 : ( 23 - 27 )

**Based on the above,** the Hearing Committee concludes that the following Specifications of Charges are **SUSTAINED:**[9]

FIRST SPECIFICATION: (Paragraphs: A, A.1, A.2, A.3, A.4 and A.5 )

(Paragraphs: C, C.1, C.2, C.3, C.4 and C.5 )

[9] The citations in parentheses refer to the Factual Allegations which support each Specification.

(Paragraphs: D, D.2, D.4 and D.5 )

SECOND SPECIFICATION: (Paragraphs: A, A.1, A.2, A.3, A.4 and A.5 )

THIRD SPECIFICATION: (Paragraphs: B, B.1, B.2, B.3 and B.4 )

FOURTH SPECIFICATION: (Paragraphs: C, C.1, C.2, C.3, C.4 and C.5 )

FIFTH SPECIFICATION: (Paragraphs: D, D.2, D.4 and D.5 )

SIXTH SPECIFICATION: (Paragraphs: E, E.1, E.2, E.3 and E.4 )

Based on the above, the Hearing Committee concludes that the following Specification of Charges is **NOT SUSTAINED:**

SEVENTH SPECIFICATION

## DISCUSSION

The Respondent is charged with seven specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitutes professional misconduct. However, §6530 of the Education Law does not provide definitions for two (2) of the types of misconduct charged in this matter, to wit: §6530(2), practicing the profession fraudulently and §6530(3), practicing the profession with negligence on more than one occasion.

During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum, prepared by Peter J. Millock, General Counsel for the New York State Department of Health, dated February 5, 1992. This document, entitled: Definitions of Professional Misconduct under the New York Education Law,

(hereinafter "Misconduct Memo"), sets forth suggested definitions for inter alia practicing the profession with negligence and fraudulent practice.

The following definitions from the Misconduct memo were used by the Hearing Committee during its deliberations:

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

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

With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to his training, experience, credentials, demeanor and credibility.

Dr. Jerome S. Greenholz, as the Petitioner's expert, presented an impartial approach with no professional association with the Respondent. Dr. Roger W. Steinhardt presented brief but credible testimony. The Respondent, Dr. Chace, offered mostly credible testimony, although he obviously had the greatest amount of interest in the results of these proceedings.

With regard to a finding of medical misconduct, the Hearing Committee first assessed Respondent's medical care of the patient, without regard to outcome but rather as a step-by-step assessment of patient situation, followed by medical response. Where medical misconduct has been established, the outcome may be, but need not be, relevant to penalty, if any. Patient harm need not be shown to establish

negligence in a proceeding before the Board for Professional Medical Conduct.

Using the above definitions and understanding, including the remainder of the Misconduct memo, the Hearing Committee, unanimously concludes that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State. The Department of Health has met its burden of proof as to six of the seven specifications of misconduct contained in the May 24, 1993 (1994) Statement of Charges and the Hearing Committee, unanimously votes to sustain the first six Charges.

The rationale for the Hearing Committee's conclusions is set forth below.

**Service of Charges and of Notice of Hearing.**

P.H.L. §230(10)(d) requires that the Charges and Notice of Hearing be served on the licensee personally, at least twenty (20) days before the Hearing. If personal service cannot be made, due diligence must be shown and certified under oath. After due diligence has been certified, then, the Charges and Notice of Hearing must be served by registered or certified mail to the licensee's last known address, at least fifteen (15) days before the Hearing.

From the affidavit submitted, personal service of the Notice of Referral Proceeding and the Statement of Charges on Respondent was proper and timely. In addition, Respondent appeared at the Hearing and had no objection to service of the Statement of Charges and the Notice of Referral Proceeding.

**Negligence on more than one occasion**

In 1991, Respondent had been authorized to practice medicine in New York State for approximately 33 years. The record clearly establishes that Respondent failed to meet the appropriate standards of care with respect to Patients A, C and D. The Hearing Committee determines that those patients received inappropriate treatment from Respondent.

There is ample evidence in the record that establishes that Respondent prescribed a variety of controlled substances and medications (Seconal, Valium, Tylenol 3, and Tuinal [hereinafter "drugs"]), for Patients A, C and D, without doing the minimally necessary exams and history of the patients to properly diagnose and treat the patients' symptoms, complaints and illnesses.

Patient A received drugs which were too many, too high in dosage and dangerous in their combined effects. Some of the drugs prescribed were contraindicated for this patient's past history and complaints. Patient C received enormous doses of addictive drugs which were contraindicated to the patient's complaint and proper treatment. Patient D was prescribed drugs by Respondent, although there is a lack of indication as to the reason or the necessity of those prescriptions over a three year period.

As Petitioner's expert testified, if dangerous or addicting medications are given, it's very important to justify their use in progress notes and to specify when they are prescribed, the dosage, the number of pills, whether or not there are refills and to their good or bad effects on the patient. Respondent did very little justification, if any, and follow up report or review.

Accepted standards of medical practice require that a physician be or become

familiar with the drugs that he prescribes, including their proper uses and side effects. A reasonably prudent physician does not prescribe drugs which are contraindicated to his patients' maladies and past history. A reasonably prudent physician does not prescribe drugs which he has not justified within the medical records of each patient.

Respondent's deviation from accepted medical standards in his treatment of Patients A, C and D was more than errors in judgment or medical mistakes, it was intentional and negligent.

Respondent was negligent in his medical care of Patient A.

Respondent was negligent in his medical care of Patient C.

Respondent was negligent in his medical care of Patient D.

Therefore, Respondent was negligent on more than one occasion and is guilty of professional misconduct under the laws of the State of New York.

**Failure to Maintain Adequate Records**

§ 6530(32) of the Education Law requires a licensee (physician) to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Respondent was charged with five counts of failing to take or note an adequate history in his patients' records. A review of the medical records provided by Respondent indicates, except for Patient D, sketchy history on one occasion and no history otherwise. It is a deviation from accepted medical standards not to have an adequate history recorded in each patient's medical records. The Hearing Committee concludes that the medical records of Patient A, B, C and E did not adequately or accurately reflect the medical history of each patient.

Respondent was charged with five counts of failing to do an adequate physical exam or note same in his patients' records. A review of the medical records provided

by Respondent indicates no physical exam performed or results thereof. It is a deviation from accepted medical standards not to do a physical exam and not to record that exam or its results in each patient's medical records. The Hearing Committee concludes that the medical records of Patient A, B, C, D and E did not adequately or accurately reflect a medical examination of the patient in the medical record of each patient.

Respondent was charged with five counts of failing to adequately note symptoms, diagnoses and/or progress notes in his patients' records. A review of the medical records provided by Respondent indicates, except for Patient D, bare, if any, symptoms, diagnoses and/or progress notes in each patient's medical records. It is a deviation from accepted medical standards not to have an adequate indication of each patient's symptoms, diagnoses and/or progress recorded in each patient's medical records. The Hearing Committee concludes that the medical records of Patients A, B, C and E did not adequately or accurately reflect the symptoms, diagnoses and/or progress of each patient. The medical records of Patient D did include a list of some symptoms and diagnoses and some indication of treatment. The Hearing Committee concludes that Patient D's medical records reflects Respondent's evaluation and treatment for that patient.

Respondent was charged with five counts of prescribing various drugs for each patient[10] and failing to record those prescriptions in each patient's records. A review of the medical records provided by Respondent and the exhibits which include the originals of the triplicate forms obtained by Petitioner from the dispensing pharmacies

[10] Patient A = Seconal, Tylenol 3 and Valium. Patient B = Valium and Ativan. Patient C = Tuinal and Seconal. Patient D = Tuinal. Patient E = Percodan.

indicates numerous prescriptions written by Respondent and not listed within the medical records of each patient. The Hearing Committee does note that many of the prescriptions written were listed within Patients A, C and D's medical records. However, it is a deviation from accepted medical standards for a physician to write prescriptions, especially for controlled substances, and not record these prescriptions in each patient's medical records. The Hearing Committee concludes that the medical records of Patients A, B, C, D and E did not adequately or accurately reflect the prescriptions written by Respondent for each patient.

Respondent was charged with five counts of inappropriate treatment for five separate patients. As discussed above (under the negligence heading), the Hearing Committee determines that Patients A, C and D received inappropriate treatment from Respondent.

The Hearing Committee determines, based on the evidence presented and the entire record that insufficient information was available regarding the treatment of Patients B and E to determine that Respondent's treatment of those patients were inappropriate. A prescription of Percodan for Patient E may or may not have been justified. However, Respondent made no real, or apparent, effort to treat the underlying diagnosis of Osteomyelitis. Although, Respondent's treatment of Patients B and E through various drug prescriptions may not have been the finest medical care for those patients, the Hearing Committee can not find, by a preponderance of the evidence, that said treatment was inappropriate or negligent.

**Fraudulent practice**

It is undisputed that Respondent certified the records of Patient E to be true and accurate and recorded contemporaneously. Respondent has also admitted, to a limited extent, that he recreated some of Patient E's records. However, the Hearing Committee does not believe that Respondent intended to mislead the reliance of those records. Eventhough Respondent's actions were knowing and intentional, the Hearing Committee determines that misrepresentation, concealment or misleading is not present here. Therefore, the charge of practicing the profession fraudulently, within the meaning of §6530(2) and as defined by the misconduct memo is not sustained.

## DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, unanimously determines as follows:

1. Respondent shall be placed on probation for a period of three (3) years from the effective date of this Determination and Order and comply with the terms of probation contained in Appendix II; and

2. Respondent must complete an evaluation and re-training in the proper use of Controlled Substances by attending and completing appropriate courses acceptable to the Office of Professional Medical Conduct (hereinafter "OPMC"); and

3. Respondent's authority to issue prescriptions for Controlled Substances shall be suspended for three (3) months and until satisfactory completion of the above re-training course(s); and

4. Respondent shall be required to obtain a practice monitor, acceptable to OPMC, to review and help Respondent in proper record keeping practices and appropriate circumstances for prescriptions of Controlled Substance for six (6) months; and

5. Respondent shall perform one hundred (100) hours of public service in a substance abuse rehabilitation center, approved by OPMC. Said public service must be completed within one (1) year from the effective date of this Determination and Order.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to §230-a of the P.H.L., including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service and (10) probation.

The record in this case clearly establishes that Respondent committed negligence in the care and treatment of at least three of his patients. Whether Respondent inherited these patients from another physician or not, they became his responsibility and it was his duty to deal with each patient's medical issues appropriately. Respondent demonstrated deficiencies in his knowledge, skills and judgment in providing medical care to Patients A, C and D. Respondent also demonstrated deficiencies in his skills in maintaining adequate and accurate medical records. However, the Hearing Committee believes that Respondent is capable of learning from his errors and is capable of rehabilitation.

The Hearing Committee considers Respondent's misconduct to be very serious and is concerned for the health and welfare of patients in New York State. Therefore, the Hearing Committee determines the above to be the appropriate sanctions under the circumstances.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

## ORDER

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

1. The First and Second through Sixth Specifications of professional misconduct contained in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The Seventh Specification of professional misconduct contained in the Statement of Charges (Petitioner's Exhibit #1) is **NOT SUSTAINED**; and

3. Respondent shall be on probation for a period of three (3) years from the effective date of this Determination and Order and comply with the terms of probation contained in Appendix II; and

4. Respondent must complete an evaluation and re-training in the proper use of Controlled Substances by attending and completing appropriate courses acceptable to the Office of Professional Medical Conduct (hereinafter "OPMC"); and

5. Respondent's authority to issue prescriptions for Controlled Substances is suspended for three (3) months and until satisfactory completion of the above re-training course(s); and

6. Respondent shall obtain a practice monitor, acceptable to OPMC, to review and help him in proper record keeping practices and appropriate circumstances for prescriptions of Controlled Substance for six (6) months; and

7. Respondent shall perform one hundred (100) hours of public service in a substance abuse rehabilitation center, approved by OPMC. Said public service must be completed within one (1) year from the effective date of this Determination and Order; and

8. The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein; and

9. Respondent's re-training and probation shall be supervised by the Office of Professional Medical Conduct.

**DATED:** **Albany, New York**
**September, 26, 1994**

**WILLIAM W. FALOON, M.D.**, (Chair),

**ALBERT B. ACCETTOLA, JR., M.D.**
**RANDOLPH MANNING**

To: Denise Lepicier, Esq.,
Assistant Counsel,
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

Dr. Henry V. A. Chase
87-24 Jamaica Avenue
Woodhaven, NY 11421

# APPENDIX I

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

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| | | |
|---|---|---|
| IN THE MATTER | : | STATEMENT |
| OF | : | OF |
| HENRY V. CHACE, D.O. | : | CHARGES |

----------X

HENRY V. CHACE, D.O., the Respondent, was authorized to practice medicine in New York State on September 22, 1958, by the issuance of license number 81372 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993, through December 31, 1995. He is registered to practice from 87-24 Jamaica Avenue, Woodhaven, New York.

## FACTUAL ALLEGATIONS

### PATIENT A

A. Respondent treated Patient A, a 33 year old female in 1983, at his office at 87-24 Jamaica Avenue, Woodhaven, New York, from sometime in or about 1983, through on or about October 8, 1990. (All patients are identified in Appendix B attached hereto.)

1. Respondent failed to take or note an adequate history.

2. Respondent failed to do or note adequate physical exams.

3. Respondent failed to adequately note symptoms, diagnoses and/or progress notes.

4. Respondent prescribed Seconal, Tylenol 3, Valium and Dyazide for Patient A, as is more fully enumerated in the chart attached hereto in Appendix A, and failed to record these prescriptions in her medical records.

5. Respondent's treatment of Patient A with Seconal, Tylenol 3, Valium and Dyazide was inappropriate.

PATIENT B

B. Respondent treated Patient B, a male who was 47 in 1990, at his office at 87-24 Jamaica Ave., New York, New York, from on or about January 13, 1990, to on or about November 19, 1990.

1. Respondent failed to take or note an adequate history.

2. Respondent failed to do or note adequate physical exams.

3. Respondent failed to adequately note symptoms, diagnoses and/or progress notes.

4. Respondent prescribed Valium and Ativan for Patient B, as is more fully enumerated in the chart attached hereto in Appendix A, and failed to record these prescriptions in his medical records.

5. Respondent's treatment of Patient B with Valium and Ativan was inappropriate.

PATIENT C

C. Respondent treated Patient C, a 36 year old male in 1984, at his office at 87-24 Jamaica Avenue, Woodhaven, New York, from on or about November 24, 1984, through February 21, 1992.

1. Respondent failed to take or note an adequate history.

2. Respondent failed to do or note adequate physical exams.

3. Respondent failed to adequately note symptoms, diagnoses and/or progress notes.

4. Respondent prescribed Tuinal and Seconal for Patient C, as is more fully enumerated in the chart attached hereto in Appendix A, and failed to record these prescriptions in his medical records.

5. Respondent's treatment of Patient C with Tuinal and Seconal was inappropriate.

PATIENT D

D. **Respondent** treated Patient D, a 27 year old female in 1974, at his office at 87-24 Jamaica Avenue, Woodhaven, New York, from on or about August 29, 1974, through on or about March 27, 1991.

1. Respondent failed to take or note an adequate history.

2. Respondent failed to do or note adequate physical exams.

3. Respondent failed to adequately note symptoms, diagnoses and/or progress notes.

4. Respondent prescribed Tuinal for Patient D, as is more fully enumerated in the chart attached hereto in Appendix A, and failed to record these prescriptions in her medical records.

5. Respondent's treatment of Patient D with Tuinal was inappropriate.

PATIENT E

E. Respondent treated Patient E, a 32 year old male in 1986, at his office at 87-24 Jamaica Avenue, Woodhaven, New York, from on or about July 14, 1986, through on or about January 10, 1991.

1. Respondent failed to take or note an adequate history.

2. Respondent failed to do or note adequate physical exams.

3. Respondent failed to adequately note symptoms, diagnoses and/or progress notes.

4. Respondent prescribed Percodan for Patient E, as is more fully enumerated in the chart attached hereto in Appendix A, and failed to record these prescriptions in her medical records.

5. Respondent's treatment of Patient E with Percodan was inappropriate.

6. Respondent knowingly and intentionally created the medical record for Patient E long after the office visits recorded. Respondent intended that it be relied on as a contemporaneous representation of the office visits recorded.

## SPECIFICATIONS

### FIRST SPECIFICATION

PRACTICING THE PROFESSION WITH NEGLIGENCE

ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion, within the meaning of N.Y. Educ. Law Section 6530 (3) (McKinney Supp. 1994), in that Petitioner charges:

1. The facts in two or more of the following paragraphs: A and A1, A2, A3, A4 and/or A5; B and B1, B2, B3, B4 and/or B5; C and C1, C2, C3, C4 and/or C5; D and D1, D2, D3, D4 and/or D5; and/or E and E1, E2, E3, E4 and/or E5.

### SECOND THROUGH SIXTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with professional misconduct by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, within the

meaning of N.Y. Educ. Law Section 6530 (32) (McKinney Supp. 1994), in that Petitioner charges:

2. The facts in paragraphs A, A1, A2, A3 and/or A4.

3. The facts in paragraphs B, B1, B2, B3 and/or B4.

4. The facts in paragraphs C, C1, C2, C3 and/or C4.

5. The facts in paragraphs D, D1, D2, D3 and/or D4.

6. The facts in paragraphs E, E1, E2, E3, E4 and/or E6.

## SEVENTH SPECIFICATION

PRACTICING FRAUDULENTLY

Respondent is charged with professional misconduct by reason of practicing the profession of medicine fraudulently, within the meaning of N.Y. Educ. Law Section 6530 (2) (McKinney Supp. 1994), in that Petitioner charges:

7. The facts in paragraph E6.

DATED: New York, New York
May 24, 1993

Chris Stern Hyman
Counsel
Bureau of Professional
Medical
Conduct

# APPENDIX A

Re: Henry Chace, D.O.

Patient A

| CHARTED VISITS | PRESCRIPTIONS |
|---|---|
| 01/07/88 | Seconal #30 |
| 02/06/88 | Seconal #60; Tagamet #300 |
| | 03/05/88-Seconal #60 |
| 03/12/88 | Seconal#60 |
| | 04/06/88-Seconal #60 |
| 04/08/88 | Seconal #60 |
| 05/07/88 | Seconal #60 |
| 05/07/88 | Seconal #60; Tetracycline |
| 06/18/88 | Seconal #60 |
| 08/01/88 | Seconal #60 |
| | 08/28/88-Seconal #60 |
| 09/03/88 | Seconal #60 |
| | 09/30/88-Seconal #60 |
| | 11/08/88-Seconal #60 |
| 01/14/89 | Seconal #60; Pennicillin; Keflex |
| 02/27/89 | Seconal #60 |
| 05/20/89 | Valium #120 |
| 06/23/89 | Valium #120 |
| 08/28/89 | Valium #120 |
| 09/08/89 | Valium #120 |
| 11/29/89 | Valium #120; Keflex |
| | 01/08/90-Tylenol 3 |
| | 01/15/90-Seconal #60; Valium #120 |
| | 01/25/90-Tylenol 3 #50; Valium #120; Seconal #60 |
| 02/22/90 | Valium #90; Tylenol 3 #100 |
| 03/16/90 | Valium #120 |
| | 10/08/90-Dyazide #30 |

Re: Henry Chace, D.O.

Patient B

| CHARTED VISITS | PRESCRIPTIONS |
|---|---|
| | 01/30/90-Valium #90 |
| | 02/22/90-Valium #90 |
| | 03/06/90-Ativan #90 |
| | 03/26/90-Valium #90 |
| | 05/07/90-Valium #90 |
| 06/14/90 | Valium #90 |
| | 08/13/90-Valium #90 |
| | 09/13/90-Valium #90 |
| | 11/19/90-Valium #90 |

Re: Henry Chace, D.O.

Patient C

| CHARTED VISITS | PRESCRIPTIONS |
|---|---|
| 11/24/84 | Phenergan with Codeine |
| 04/08/85 | Tuinal |
| 11/18/85 | Tuinal; Amoxil |
| 01/18/86 | Tuinal |
| 12/27/86 | Tuinal |
| 12/26/87 | Tuinal |
| | 08/17/88-Tuinal #60 |
| | 10/22/88-Tuinal #60 |
| 05/13/89 | Tuinal |
| 08/14/89 | Tuinal |
| | 12/13/89-Tuinal #60 |
| | 03/01/90-Tuinal #60 |
| | 04/07/90-Tuinal #60 |
| | 05/12/90-Tuinal #60 |
| | 06/21/90-Tuinal #30 |
| | 06/21/90-Tuinal #30 |
| | 07/26/90-Tuinal #60 |
| | 08/29/90-Tuinal #60 |
| 10/06/90 | Seconal #60; Phenergan with Codeine |
| | 11/05/90-Seconal #60 |
| | 12/07/90-Seconal #60 |
| 07/13/91 | Seconal #30 |
| 08/17/91 | Seconal #30 |
| 09/19/91 | Seconal #30 |
| | 09/20/91-Seconal #30 |
| 10/18/91 | Seconal |
| 11/27/91 | Seconal |
| 12/26/91 | Robitussin with codeine; Amoxil; Seconal |
| 01/21/92 | Seconal |
| 02/21/92 | Seconal |

Re: Henry Chace, D.O.

Patient D

| CHARTED VISITS | PRESCRIPTIONS |
|---|---|
| 08/29/74 | Penicillin; Dimetane; |
| 09/05/74 | Keflex; |
| 09/11/74 | Keflex |
| 12/13/74 | Lomotil; Tetra |
| 01/15/75 | Cleocin; Tetra |
| 02/24/75 | AVC |
| 04/01/75 | |
| 06/19/75 | Vibracin; |
| 10/08/76 | Valium; Donnatal |
| 03/04/77 | |
| 05/13/77 | Flosene |
| 09/23/77 | Tuinal; Tetra |
| 10/31/77 | Flosene |
| 12/03/77 | Lomotil; Terra |
| 12/23/77 | Terra |
| 03/28/78 | Tuinal |
| 06/02/78 | Tuinal |
| 08/01/78 | Keflex; |
| 09/06/78 | Tuinal |
| 10/06/78 | Tuinal |
| 11/07/78 | |
| 02/09/79 | Tuinal #30 |
| 03/09/79 | Tuinal #30 |
| 04/09/79 | Tuinal; Flosene |
| 06/11/79 | Tuinal #30 |
| 07/11/79 | Tuinal #30 |
| 09/13/79 | Tuinal #30 |
| 10/09/79 | Tuinal #30 |
| 11/06/79 | Tuinal #30 |
| 12/06/79 | Tuinal #30 |
| 01/02/80 | Tuinal #30; Tylenol 4 #20 |
| 03/04/80 | Tuinal #30 |
| 05/05/80 | Bactrim |
| 05/06/80 | |
| 07/03/80 | Tuinal #30 |
| 07/14/80 | Erythromycin |
| 08/04/80 | Tuinal #30 |
| 09/05/80 | Tuinal #30 |
| 10/06/80 | Tuinal #30 |
| 11/05/80 | Tuinal |
| 12/04/80 | Tuinal |
| 01/02/81 | Tuinal |
| 02/12/81 | Lomotil |

| | |
|---|---|
| | 12/14/89-Tuinal #30 |
| | 1/12/90-Tuinal #30 |
| | 02/10/90-Tuinal #30 |
| 02/19/90 | Phenergan with codeine; Keflex |
| 02/25/90 | |
| | 03/14/90 Tuinal #30 |
| | 04/09/90 Tuinal #30 |
| 05/11/90 | Tuinal #30 |
| 06/07/90 | Tuinal #30 |
| 07/09/90 | Tuinal #30 |
| | 09/07/90-Tuinal #30 |
| | 10/16/90-Tuinal #30 |
| | 12/06/90-Tuinal #30 |
| 03/27/91 | |

Re: Henry Chace, D.O.

Patient E

| CHARTED VISITS | PRESCRIPTIONS |
|---|---|
| 07/14/86 | Percodan #30 |
| 08/08/86 | Percodan #30 |
| 08/18/86 | Percodan #30 |
| 08/22/86 | Percodan |
| | 04/15/87-Percodan-#30 |
| | 02/06/88-Phenergan with Codeine |
| | 03/15/88-Percodan #25 |
| | 03/21/88-Percodan #20 |
| | 05/17/88-Percodan #30 |
| | 06/08/88-Percodan #30 |
| | 07/06/88-Percodan #30 |
| | 07/25/88-Percodan #30 |
| 01/10/91 | Percodan; Amoxil |

# APPENDIX II

## TERMS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Respondent leaves New York to reside or practice outside the State, Respondent shall notify the Director of the Office of Professional Medical Conduct (hereinafter "OPMC") in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Respondent shall have quarterly meetings with an employee or designee of the OPMC during the period of probation. During these quarterly meetings Respondent's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed.

6. Respondent shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the OPMC at the address indicated above.

7. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Respondent elects not to practice medicine as a physician in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

8. If there is full compliance with every term set forth herein, and the terms of the annexed Determination and Order, Respondent may practice as a physician in New York State in accordance with the terms of probation; provided, however, that on receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.