Public

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

IN THE MATTER OF MELVIN BOSKIN, D.O.	DETERMINATION AND ORDER BPMC 05-88

COPY

Ralph Levy, D.O. (Chairperson), Cassandra E. Henderson, M.D., and Gary Schwall, R.P.A.-C., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law. Marc P. Zylberberg, Esq., Administrative Law Judge, ("ALJ") served as the Administrative Officer.

The Department of Health appeared by David W. Smith, Esq., Associate Counsel. Respondent, Melvin Boskin, D.O., appeared personally and was represented by Furey, Kerley, Walsh, Matera & Cinquemani, P.C. by Raymond J. Furey, Esq. of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	October 19, 2004
Date of Answer to Charges:	November 4, 2004
Pre-Hearing Conference Held:	November 18, 2004

Hearings Held: - (First Hearing day):	December 14, 2004 February 10, 2005 February 17, 2005
Intra-Hearing Conference Held:	None
Location of Hearings:	Offices of New York State Department of Health 5 Penn Plaza, 6th Floor New York, NY 10001
Witnesses called (in the order they testified) by the Petitioner, Department of Health:	Richard Bonanno, M.D.
Witnesses called (in the order they testified) by the Respondent, Melvin Boskin, D.O.	Patient E[1] Melvin Boskin, D.O.
Department's Summation, Findings of Fact and Conclusions of Law:	Received March 28, 2005
Respondent's Summation:	Received March 29, 2005
Deliberations Held: (last day of Hearing)	Wednesday, April 6, 2005

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 *et seq.* of the Public Health Law of the State of New York ["P.H.L."]). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("Petitioner" or "Department") pursuant to §230 of the P.H.L. Melvin Boskin, D.O. ("Respondent") is charged with eight (8) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York ("Education Law").

---

[1] The record and this Determination and Order refers to the patients by letter to protect patient privacy. All Patients are identified in the Appendix annexed to the Statement of Charges (Department's Exhibit #1).

Respondent is charged with professional misconduct by reason of:

MATERIAL REDACTED ; and (3) failing to maintain a record for each patient (six patients) which accurately reflected the evaluation and treatment of the patient[4].

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct towards six (6) patients at various times between 1972 and 1998. Respondent admits to treating the patients but denies all other allegations and Specifications of misconduct contained in the Statement of Charges. A copy of the Statement of Charges and the Answer is attached to this Determination and Order as Appendix 1 and Appendix 2.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

MATERIAL REDACTED

[4] Education Law §6530(32) - (Third through Eighth Specification of the Statement of Charges [Department's Exhibit # 1]).

1. Respondent was licensed to practice medicine in New York State on September 26, 1960 by the issuance of license number 84958 by the New York State Education Department (Department's Exhibit # 3)[5].

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's license and this disciplinary proceeding (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d] & §230[7] & §230[10]); (Department's Exhibit # 2); [P.H.T-8-9][6].

Patient A

3. Patient A was treated for depression and other medical conditions by Respondent and his associates from 1982 through 1998 (Department's Exhibits # 1 and # 4); (Respondent's Exhibit # A); [T-274-77].

4. From 1995 through 1997 there is no note in the medical records of Patient A that indicates that Respondent performed (documented) a physical examination of the patient (Department's Exhibit # 4); [T-15-16, 18, 39-40].

5. There is information in the medical records of Patient A which indicates that at some point Respondent did perform a physical examination of the patient (medical clearance noted by Respondent for surgery) (Department's Exhibit # 4); [T-225-287].

6. From 1995 through 1997 there is no note in the medical records of Patient A that indicates that Respondent obtained (documented) a medical history of the patient (Department's Exhibit # 4); [T-15-19].

---

[5] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Boskin (Respondent's Exhibit #).

[6] Numbers in brackets refer to Hearing transcript page numbers [T-] or to Pre-Hearing transcript page numbers [P.H.T-]. The Hearing Committee did not review the Pre-Hearing transcript but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

7. There is information in the medical records of Patient A which indicates that at some point Respondent did obtain a medical history of the patient (medical diagnoses made by Respondent) (Department's Exhibit # 4); [T-225-287].

8. Based on Respondent's diagnoses for Patient A the prescriptions he wrote were justified (Department's Exhibit # 4); [T-225-287].

9. Based on Respondent's diagnoses for Patient A and Patient A's needs, the prescriptions he wrote were justified (Department's Exhibit # 4); [T-225-287].

Patient B

10. Patient B was treated by Respondent and his associates for various medical conditions from 1981 through 1997 (Department's Exhibit # 5); (Respondent's Exhibit # A).

11. In 1995 Patient B was diagnosed with non-insulin diabetes. Patient B was treated with sulfonylurea and insulin treatments during her hospitalizations (Department's Exhibit # 5); [T-58-83].

12. There is information in the medical records of Patient B which indicates that Respondent did evaluate, follow-up, and treat Patient B's diabetes (Department's Exhibit # 5).

Patient C

13. Patient C was treated by Respondent and his associates for multiple medical conditions from 1978 through 1997 (Department's Exhibit # 6); (Respondent's Exhibit # A); [T-317-318, 319].

14. From 1985 through 1997 there is no note in the medical records of Patient C that indicates that Respondent performed (documented) a physical examination of the patient (Department's Exhibit # 6); [T-84].

15. There is information in the medical records of Patient C which indicates that at some point Respondent did perform a physical examination of the patient (Department's Exhibit # 6); [T-319-366, 373-389].

16. From 1985 through 1997 there is no note in the medical records of Patient C that indicates that Respondent obtained (documented) a medical history of the patient (Department's Exhibit # 6); [T-84].

17. There is information in the medical records of Patient C which indicates that at some point Respondent did obtain a medical history of the patient (medical diagnoses made by Respondent) (Department's Exhibit # 6); [T-319-366, 373-389].

18. Based on Respondent's diagnoses for Patient C and Patient C's needs, the prescriptions he issued to Patient C were justified (Department's Exhibit # 6); [T-319-366, 373-389].

19. Patient C's medical diagnoses included renal insufficiency and hydronephrosis. The _minimum_ acceptable standard of care involves the use of opiates and Valium for Patient C's condition (Department's Exhibit # 6); [T-88, 99-100, 104-105, 319-366, 373-389].

20. Respondent did try on a number of occasions to wean Patient C off the narcotics that she was being treated with (Department's Exhibit # 6).

21. In 1993 Patient C developed renal insufficiency and was diagnosed with kidney stones. Patient C was treated by a urologist and at Brunswick Hospital for her kidney stones (Department's Exhibit # 6).

22. There is information in the medical records of Patient C which indicates that Respondent did evaluate, follow-up, and treat Patient C's renal insufficiency (Department's Exhibit # 6).

__Patient D__

23. Patient D was treated by Respondent and his associates for various medical conditions from 1973 through 1996 (Department's Exhibit # 7); (Respondent's Exhibit # A); [T-108, 392].

24. There is no note in the medical records of Patient D that indicates that Respondent performed (documented) a physical examination of the patient (Department's Exhibit # 7); [T-108, 110].

25. There is information in the medical records of Patient D which indicates that at some point Respondent did perform a physical examination of the patient (Department's Exhibit # 7); (Respondent's Exhibit # D); [T-392-432].

26. There is no note in the medical records of Patient D that indicates that Respondent obtained (documented) a medical history of the patient (Department's Exhibit # 4); [T-110-111].

27. There is information in the medical records of Patient D which indicates that at some point Respondent did obtain a medical history of the patient (medical diagnoses made by Respondent) (Department's Exhibit # 7); (Respondent's Exhibit # D); [T-392-432].

28. Patient D had hypothyroidism. Based on Respondent's diagnoses for Patient D, the thyroid medication he provided to the patient were justified (Department's Exhibit # 7); [T-392-432].

29. Beginning in 1984 Patient D was diagnosed with diabetes. Patient D's glucose levels were checked by Respondent repeatedly during her numerous office visits (Department's Exhibit # 7); (Respondent's Exhibit # D); [T-392-432].

30. There is information in the medical records of Patient D which indicates that Respondent did evaluate, follow-up, and treat Patient D's diabetes (Department's Exhibit # 7); (Respondent's Exhibit # D).

Patient E

31. Patient E was treated by Respondent and his associates for various medical conditions from 1972 through 1998 (Department's Exhibit # 8A); (Respondent's Exhibit # A); [T-130, 434].

32. Patient E was diagnosed with anxiety and depression. Patient E was monitored by a neurologist (Department's Exhibit # 8A); [T-450].

33. Respondent did not note or document his evaluation, follow-up, or treatment of Patient E' anxiety and depression in Patient E's medical records (Department's Exhibit # 8A); [T-130-134].

34. There is information in the medical records of Patient E which indicates that Respondent did evaluate, follow-up, and treat Patient E's anxiety and depression (Department's Exhibit # 8A); [T-434-471].

35. In 1987 Patient E was diagnosed with asthma. Patient E was monitored by pulmonary specialists (Department's Exhibit # 8A); (Respondent's Exhibit # C-1); [T-147-150, 434-471].

36. Respondent did not note or document his evaluation, follow-up, or treatment of Patient E's asthma in the medical records of Patient E (Department's Exhibit # 8A); [T-130-134].

37. There is information in the medical records of Patient E which indicates that Respondent did evaluate, follow-up, and treat Patient E's asthma (Department's Exhibit # 8A); [T-434-471].

38. In 1996 Patient E was diagnosed with diabetes. Patient E was put on a diet by Respondent, given hypoglycemic agents and monitored appropriately (Department's Exhibit # 8A); [T-434-471].

39. There is information in the medical records of Patient E which indicates that Respondent did evaluate, follow-up, and treat Patient E's diabetes (Department's Exhibit # 8A); [T-434-471].

Patient F

40. Patient F was treated by Respondent and his associates for various medical conditions from 1974 through 1998 (Department's Exhibit # 9); (Respondent's Exhibit # A); [T-472].

41. In 1998 Patient F was diagnosed with diabetes. Patient F was counseled about a diet by Respondent and monitored appropriately (Department's Exhibit # 9); [T-472-481].

42. Respondent did not note or document his evaluation, follow-up, or treatment of Patient F's diabetes in the medical records of Patient F (Department's Exhibit # 9); [T-478-479].

43. There is information in the medical records of Patient F which indicates that Respondent did evaluate, follow-up, and treat Patient F's diabetes (Department's Exhibit # 9); [T-472-481].

CONCLUSIONS OF LAW

The Hearing Committee, pursuant to the Findings of Fact listed above, makes the conclusion by a unanimous vote, that the following Factual Allegations, contained in the October 19, 2004 Statement of Charges are SUSTAINED: A., A.1., A.2., B., C., C.1., C.2., D., D.1., D.2., E., E.1., E.2., F., and F.1. (these factual allegations are sustained as to the failure to note in the medical records of the individual patients).

MATERIAL REDACTED

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee, by a unanimous vote, concludes that: (1) the Third, and the Fifth through Eighth Specifications of Misconduct contained in the Statement of Charges are SUSTAINED

MATERIAL REDACTED

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

DISCUSSION

Respondent is charged with eight (8) 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 constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of some of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were obtained from a memoranda entitled: Definitions of Professional Misconduct under the New York Education Law[7].

During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

MATERIAL REDACTED

[7] A copy was made available to both parties at the Pre-Hearing conference [P.H.T-5-7]; [T-4].

MATERIAL REDACTED

The ALJ also instructed the Hearing Committee of the following commonly understood concepts:

Failure to Maintain Records

A physician must record meaningful and accurate information in a patient's medical records which accurately reflects the care and treatment of the patient for a number of reasons. These reasons include: (1) for the physician's own use; (2) for the use of the treatment team; (3) for the use of subsequent care providers; (4) for the use of the patient.

Preponderance of the Evidence

The burden of proof in these proceedings rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred. The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim. The Charges of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence.

The Hearing Committee used ordinary English usage and understanding for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. We considered whether the testimony was supported or contradicted by other independent objective evidence The Hearing Committee understood that as the trier of fact we may accept so much of a witnesses' testimony as is deemed true and disregard what we find and determine to be false.

Credibility

Richard Bonanno is the Program Director of Family Practice Residency at Southside hospital. Dr. Bonanno was a credible witness. He answered questions knowledgeably, directly and without evasion. The committee found Dr. Bonanno to be credible. Patient E was a credible witness but with no direct knowledge of the alleged charges. She expressed satisfaction with the care and attention she received from the Respondent.

Respondent has the most at stake in this proceeding. Dr. Boskin's testimony was at times self- serving and sometimes evasive. His answers were sometimes contradictory. He offered no independent expert witnesses on his behalf. The Hearing Committee is pleased that Dr. Boskin has become more sensitive to the requirements by the HMOs, insurance companies and Government Agencies and has taken two eight-hour courses in Risk Management, including medical documentation. Despite Respondent's claim that hospital records contain materials which if presented would exonerate him, Respondent failed to present such alleged evidence for the Hearing Committee's review and consideration.

Summary

Patient A

After a careful review of the testimony and the medical records of each patient the Hearing Committee determined that we can only sustain charges which relate to Respondent's failure to adequately note or document patient information within the patient's medical records.

MATERIAL REDACTED

MATERIAL REDACTED

MATERIAL REDACTED

Patient C

Patient C was a difficult patient for a physician. She had a complex history of abuse, tragedy, addiction and psychiatric problems that interfered with and impacted her medical conditions. As indicated in the discussion of Patient A, the Hearing Committee can only sustain charges which relate to Respondent's failure to adequately note patient information within the

patient's medical records. Patient notes must accurately and completely reflect the care and treatment of the patient. They are not just to remind the treating physician of what he's doing but also to inform a subsequent treating physician of what has gone before. Respondent had been criticized by his own HMO for poor record-keeping. His record keeping did not meet minimal acceptable medical standards.

MATERIAL REDACTED

MATERIAL REDACTED

Patient D

As indicated in the discussion of Patient A, the Hearing Committee can only sustain charges which relate to Respondent's failure to adequately note patient information in the patient's medical records.

As indicated in the discussion of Patient A, the Hearing Committee can only sustain charges which relate to Respondent's failure to adequately note patient information within the patient's medical records.

MATERIAL REDACTED

Patient F

As indicated in the discussion of Patient A, the Hearing Committee can only sustain charges which relate to Respondent's failure to adequately note patient information within the patient's medical records. Respondent admitted that he had nothing in his medical records for Patient F regarding evaluations of her blood sugars in 1998. In 1998 Respondent saw Patient F 10 times.

MATERIAL REDACTED

Based on the above the Hearing Committee can only sustain the charges that Respondent committed professional misconduct by failing to maintain adequate medical records for Patients A, C, D, E, and F.

In accordance with the above understanding, the Hearing Committee unanimously determined that all of the allegations of failure to maintain a record for each patient (except Patient B) which accurately reflects the care and treatment of the patient as contained in the Statement of Charges were established by a preponderance of the evidence.

MATERIAL REDACTED

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee determines that Respondent's license to practice medicine in New York State should be suspended for one (1) year. The one (1) year suspension should be stayed and Respondent shall be required to be on probation for one (1) year and have a Practice Monitor review his medical records as indicated in the annexed Terms of Probation. During the one year term of stayed suspension/probation Respondent must successfully complete at least eight (8) hours of Continuing Medical Education ("CME") in medical documentation and/or medical record keeping. These 8 hours of CME are in addition to any other required CME (which are taken to stay current in the practice of medicine) and must be pre-approved by the Director of the Office of Professional Medical Conduct (or his designee).

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, 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 Hearing Committee discussed the appropriate penalties necessary to address Respondent's misconduct in this case. The Hearing Committee believes that Respondent is a family practitioner who takes care of his patients by treating the whole person. Respondent's lapses in documentation had no impact on the medical care actually provided to his patients. It is true however that Respondent will not always be available in the future to interpret the medical records of his patients.

The Hearing Committee believes that the penalty imposed should help prevent future lapses in record keeping practices by Respondent. Respondent's medical record keeping practices must be monitored for a period of time in order to verify that he can practice medicine in compliance with generally accepted standards of record keeping practices. The medical records maintained by Respondent should be reviewed by the Practice Monitor for accuracy and completeness.

The Hearing Committee believes that Respondent is basically a good physician who needs to be up-to-date with the requirements of medical record keeping for patients. He can continue to provide benefits to his patients with his medical license and with appropriate safeguards.

No additional fines or sanctions were deemed appropriate under the circumstances presented. Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action 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.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

Based on the foregoing, IT IS HEREBY ORDERED THAT:

1. The THIRD, FIFTH, SIXTH, SEVENTH, and EIGHTH SPECIFICATIONS contained in the Statement of Charges (Department's Exhibit # 1) are SUSTAINED; and

MATERIAL REDACTED

3. Respondent's license to practice medicine in the State of New York is hereby SUSPENDED for ONE (1) YEAR; and

4. The ONE (1) YEAR SUSPENSION is STAYED; and

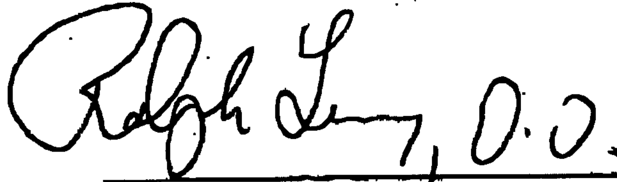
5. Respondent shall be on PROBATION for ONE (1) YEAR and have a Practice Monitor review his medical records as indicated in the annexed terms of probation (Appendix 3) which terms are fully incorporated in this Determination and Order; and

6. The period of probation shall begin when this Determination and Order becomes effective (as described in paragraph # 8 below); and

7. During the one year term of suspension Respondent must successfully complete at least eight (8) hours of Continuing Medical Education ("CME") including courses in medical documentation and/or medical record keeping. These 8 hours of CME are in addition to any other required CME (which are taken to stay current in the practice of medicine) and must be pre-approved by the Director of the Office of Professional Medical Conduct (or his designee); and

8. This Order shall be effective on personal service on the Respondent or seven (7) days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: New York, April 29, 2005



Ralph Levy, D.O. (Chairperson)
Cassandra E. Henderson, M.D.
Gary Schwall, R.P.A.-C.,

Melvin Boskin, D.O.
900 Straight Path Road
West Babylon, NY 11704.

Furey, Kerley, Walsh, Matera & Cinquemani, P.C.
Raymond J. Furey, Esq.
2174 Jackson Avenue
Seaford, NY 11783

David W. Smith, Esq.
Associate Counsel
New York State Department of Health
Office of Professional Medical Conduct
90 Church Street, 4th Floor
New York, NY 10007-2919

APPENDIX 1

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

IN THE MATTER OF MELVIN BOSKIN, D.O.	STATEMENT OF CHARGES

MELVIN BOSKIN, D.O., the Respondent, was authorized to practice medicine in New York State on or about September 26, 1960, by the issuance of license number 084958 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A for depression and other medical conditions from in or about 1982 to in or about 1997.

1. From in or about 1995 through in or about 1997, Respondent failed to MATERIAL REDACTED note such examination, if any.

2. Between in or about 1995 through in or about 1997, Respondent failed to MATERIAL REDACTED note such history, if any.

MATERIAL REDACTED

MATERIAL REDACTED

B. Respondent treated Patient B from in or about 1981 through in or about 1997 for various medical conditions.

MATERIAL REDACTED

C. Respondent treated Patient C for multiple medical conditions from in or about 1978 through in or about 1997.

1. Beginning in or about 1985 and throughout the period, Respondent failed to MATERIAL REDACTED note such examination, if any.

2. Beginning in or about 1985 and throughout the period, Respondent failed to MATERIAL REDACTED note such history, if any.

MATERIAL REDACTED

MATERIAL REDACTED

D. From in or about 1986 through in or about 1996, Respondent treated Patient D for various medical conditions.

1. Throughout the period, Respondent failed to

MATERIAL REDACTED note such examination, if any.

2. Throughout the period, Respondent failed to

MATERIAL REDACTED note such history, if any.

MATERIAL REDACTED

MATERIAL REDACTED

E. From in or about 1972 through in or about 1998, Respondent treated Patient E for various medical conditions.

1. Throughout the period, Respondent diagnosed Patient E with anxiety and depression but failed MATERIAL REDACTED note such evaluation, follow-up or treatment, if any.

2. In or about 1987, Respondent diagnosed Patient E with asthma but failed to MATERIAL REDACTED note such evaluation, follow-up or treatment, if any.

MATERIAL REDACTED

F. From in or about 1974 through in or about 1998, Respondent treated Patient F for various medical conditions.

1. In or about 1998, Respondent diagnosed Patient F with diabetes Respondent failed to MATERIAL REDACTED note such evaluation, follow-up or treatment, if any.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

MATERIAL REDACTED

SECOND SPECIFICATION

MATERIAL REDACTED

THIRD THROUGH EIGHTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

3. Paragraphs A and A1-4.

MATERIAL REDACTED

5. Paragraphs C and C1-4.
6. Paragraphs D and D1-4.
7. Paragraphs E and E1-3.
8. Paragraphs F and F1.

DATED: October 19, 2004
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX 2

RC/dab

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

IN THE MATTER
OF
MELVIN BOSKIN, D.O.

ANSWER TO STATEMENT OF CHARGES

MELVIN BOSKIN, D.O., by his attorneys, Furey, Kerley, Walsh, Matera & Cinquemani, P.C., sets forth the following as and for his Answer to the Statement of Charges upon information and belief:

1. Denies each and every allegation in paragraphs designated A.1, A.2, A.3, A.4, B.1, C.1, C.2, C.3, C.4, D.1, D.2, D.3, D.4, E.1, E.2, E.3, F.1 of the Factual Allegations claimed herein.

MATERIAL REDACTED

MATERIAL REDACTED

4. Denies each and every allegation in paragraph designated 3 through 8 of the Specification of Charges, Failure to Maintain Records.

Dated: Seaford, New York
November 4, 2004

Yours, etc.

FUREY, KERLEY, WALSH, MATERA & CINQUEMANI, P.C.

By:

ROSEMARY CINQUEMANI, ESQ.

Attorneys for Respondent
MELVIN BOSKIN, D.O.
2174 Jackson Avenue
Seaford, NY 11783
(516) 409-6200

TO: David Smith
Deputy Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

Marc, Zylberberg,
Administrative Law Judge
NYS Department of Health
Bureau of Adjudication
433 River Street, 5th Floor
Troy, New York 12180-2299

APPENDIX 3

Terms of Probation for Melvin Boskin, D.O.

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 and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Determination and Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

7. Respondent shall enroll in and successfully complete at least eight (8) hours of a Continuing Medical Education program in the area of medical documentation and/or medical record keeping. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the first year prior to the beginning of probation.

8. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("Practice Monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

9. Respondent shall make available to the Practice Monitor any and all records or access to the practice requested by the monitor, including on-site observation. The Practice Monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 10) of records maintained by Respondent, including patient records and prescribing information. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

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

11. Respondent shall cause the Practice Monitor to report quarterly, in writing, to the Director of OPMC.

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

13. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. On receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.