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., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Public

May 31, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Bruce M. Brady, Esq.
Callan, Koster, Brady & Brennan LLP
One Whitehall Street
New York, New York 10004

Paul Stein, Esq.
NYS Department of Health
90 Church Street- 4th Floor
New York, New York 10007

Milton Alan Pereira, M.D.
7 East 93rd Street
New York, New York 10128

RE: In the Matter of Milton Alan Pereira, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-124) 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.

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 Respondent or the Department may seek a review of a committee determination.

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,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

PUBLIC

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

IN THE MATTER OF MILTON ALAN PEREIRA, M.D.	DETERMINATION AND ORDER BPMC #06-124

COPY

CAROLYN C. SNIPE, ROBERT BRUCE BERGMANN, M.D., and C. DEBORAH CROSS, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230 (1) of the Public Health Law, served as the Hearing Committee for this matter pursuant to Sections 230(10) (e) and 230 (12) of the Public Health Law. JANE B. LEVIN, ESQ., Administrative Law Judge, served as the Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Commissioner's Order and Notice of Hearing dated:	November 28, 2005
Statement of Charges dated:	November 28, 2005
Answer dated:	January 4, 2006

Hearing Dates:	January 25, 2006 February 16, 2006 March 4, 2006 March 16, 2006 April 4, 2006
Deliberation Date:	May 17, 2006
Place of Hearing:	NYS Department of Health 90 Church Street New York, N.Y.
Petitioner appeared by:	Donald P. Berens, Jr. General Counsel NYS Department of Health By: Paul Stein, Esq. Associate Counsel
Respondent appeared by:	Callan Koster Brady & Brennan LLP One Whitehall Street New York NY 10004 By: Bruce M. Brady, Esq.

WITNESSES

For the Petitioner:

1) Norman Weiss, M.D.
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3) Leslie Fisher
4) Patient F

For the Respondent:

1) Milton Alan Pereira, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct in that he practiced with negligence by failing to maintain adequate records

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

FINDINGS OF FACT

Numbers in parentheses refer to transcript pages or numbers of exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. Milton Alan Pereira, the Respondent, was authorized to practice medicine in the State of New York on or about July 8, 1963 by the issuance of license number 90679 by the New York State Education Department (P's Ex. 2).

2. The Respondent is 69 years old and was board certified in psychiatry in 1963. Until 1997, in addition to a private practice, he had staff appointments and teaching responsibilities, and maintained privileges, at several local hospitals. Currently he only maintains a private practice, located at 7 East 93rd Street, New York NY 10128 (P's Ex. 14; Tr. 30, 35). He is a solo practitioner and has no employees (Tr. 86).

3. The Respondent testified that he also had had psychoanalytic training which requires a different kind of record keeping than standard hospital records (Tr. 35).

4. Respondent testified that he is in the process of retiring and that he has cut his case load from 40 patients to 18 (Tr. 67).

5. On August 3, 2004 OPMC nurse investigator Leslie Fisher visited Respondent's office to do a comprehensive medical review. She testified, and Respondent acknowledged, that his records were kept in a two-drawer file cabinet and in piles of manila envelopes with various pieces of paper in two or three piles on the floor of his office, as well as in a closet. Of the original thirteen records that were requested with specific patient names, Respondent was only able to find two at this visit, although others were produced subsequent to that visit (Tr. 38, 83-85,420-22). Respondent has been unable to locate records for Patients H, I, and J although pharmacy records for prescriptions written by Respondent for those patients exist (P's Exs. 10, 11, 11A, 11B, 12, 12A).

6. Respondent testified that since he saw his patients on a regular basis, he relied on his memory to monitor their medications (Tr. 65).

7. Respondent has readily admitted his deficiencies in record keeping (R's Ex. A; Tr. 38). He testified that after Ms. Fisher's visit, there was "a distinct realization on my part that I had been wrong in terms of how I had kept records or how I had created records...my organizational skills in this area were abominable" (Tr. 38).

8. He further testified that he asked Ms. Fisher to appoint someone to teach him these skills (Tr. 39), and independently undertook to improve his note taking and patient summaries shortly after the problem was brought to his attention (Tr. 38-40, 66), and the State's expert agreed that his newer records have improved (Tr. 374, 379, 465, 513-14, 517, 529, 536-7, 543, 548, 535).

9. There is no allegation of patient harm as a result of Respondent's record keeping deficiencies. The State's expert acknowledged that all of the prescriptions written by the Respondent were continuous, did not overlap and were not duplicative (Tr. 361-62, 467,510-11,525-26).

FINDINGS OF FACT as to PATIENT A

10. Respondent treated Patient A at a minimum from on or about July 29, 1997, to on or about December 19, 2001 (P's Ex. 3, 3A, 3B, Tr. 345-357).

11. Respondent failed to record notes which adequately and/or accurately reflected the patient's complaints, care, and/or treatment (P's Ex. 3, 3A, 3B, Tr. 345-357).

12. The State's expert testified that it is a departure from the standard of care for Respondent to have written twelve prescriptions for Adderall, a controlled substance, for Patient A and not to have an office note for each of these prescriptions. It is important to know why the prescription was written, especially when written for the first time. With subsequent prescriptions it's useful to know whether the medication is helping or is not helping or whether the patient is experiencing side effects (P's Ex. 3, 3A, 3B, Tr. 347-348, 353).

13. Respondent's initial evaluation for Patient A does not meet the standard of care. It is inadequate in terms of noting any complaints, suicidal history, substance abuse, family background, mental status, medications being taken, social history, and history of individual or family therapy (P's Ex. 3 at 2-3, Tr. 348-353).

14. Adderall is used to treat hyperactive disorder or attention deficit disorders, but Respondent's record for Patient A does not indicate that Patient A suffered from either disorder (P's Ex. 3, Tr. 353-54).

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient A because his records were inadequate and failed to note critical data.

2. Factual allegations A. and A.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS OF FACT as to PATIENT B

15. Respondent treated Patient B at a minimum from on or about July 9, 1998, to on or about May 31, 2005 (P's Ex. 4, 4A, Respondent's Exhibit B, Tr. 372-383).

16. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment. (P's Ex. 4, 4A, R's Ex. B, Tr. 372-383)

17. Respondent's initial note for Patient B does not meet the standard of care for record keeping. There is no indication of why the patient is there at that time to seek treatment, what the problems are, what treatment history had preceded, what history of symptoms may have been ongoing in the past. Questions and answers concerning dangerousness to self or others are not present. There are no notes regarding medications the patient may have taken or is currently taking. Family background and a mental status exam, both critical factors, are absent (P's Ex. 4 at 2-4, Tr. 372-73).

18. It is a departure from standard practice to write an intake note several years after the patient was initially seen. The original note should be written contemporaneously (R's Ex. B at 1-2, Tr. 373-75).

19. The subsequent visit notes of Respondent for Patient B do not meet the standard of care for record keeping. It is not possible to get a sense of what the treatment is, what medications are being used, how those medications are prescribed, and whether they are effective and/or causing side effects. The record does not note whether the individual is improving in terms of the initial symptomatic complaints (R's Ex. B at 4-5, Tr. 377-78).

20. Respondent's record for Patient B does not adequately reflect the prescription of controlled substances for Patient B and the monitoring of the treatment with these medications. It is important to monitor and note the action of these drugs on the patient, as in some cases the side effects may overweigh the benefits (P's Ex. 4, 4A, Respondent's Exhibit B, Tr. 381-83).

CONCLUSIONS AS TO PATIENT B

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient B because his records were inadequate and failed to note critical data.

2. Factual allegations B. and B.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS of FACT as to PATIENT C

21. Respondent treated Patient C at a minimum from on or about February 15, 1990, to on or about February 8, 2000 (P's Ex. 5, Tr. 469-472).

22. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment (P's Ex. 5, Tr. 469-472).

23. From Respondent's record for Patient C, it is not clear why the patient came for treatment. There is no note as to complaints or symptoms (P's Ex. 5, Tr. 470).

24. There is a reference in Respondent's record for Patient C concerning "suicide", but it is not possible to tell from this note whether the patient is or is not suicidal, or the current mood of the patient. This note is not sufficient to inform another physician of the status of Patient C (P's Ex. 5 at 4, Tr. 470-71).

25. A reference by Respondent to a prescription for Effexor for Patient C is recorded in Respondent's record for Patient C, but one cannot tell which symptoms this medication was intended to address, or whether the medication alleviated any particular symptoms (P's Ex. 5 at 4-6, Tr. 472. 476-77).

CONCLUSIONS as to PATIENT C

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient C because his records were inadequate and failed to note critical data.

2. Factual allegations C. and C.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS of FACT as to PATIENT D

26. Respondent treated Patient D at a minimum from on or about November 11, 1997, to on or about November 12, 1998 (P's Ex. 6, R's Ex. C, Tr. 478-484).

27. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment. It is not possible from Respondent's records for Patient D to determine what Patient D's complaints are, how serious they are, or how they have been treated (P's Ex. 6, R's Ex. C, Tr. 478-484).

28. There are notes relating to various medications in the record. There is a reference to the antidepressant Wellbutrin, but it's not clear what the rationale is for the medication (R's Ex. C at 1, Tr. 481-82).

29. Respondent's record is devoid of a rationale for treatment, the severity of the symptoms, the level of functioning of the patient, and the response to treatment over time (P's Ex. 6, R's Ex. C, Tr. 483-84).

CONCLUSIONS as to PATIENT D

1. Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient D because his records were inadequate and failed to note critical data.

2. Factual allegations D. and D.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS of FACT as to PATIENT E

30. Respondent began treating Patient E from on or about June 10, 1998 to a time unknown (P's Ex. 7, Tr. 491-94).

31. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment. The chief complaint consists of a single statement and no symptoms are listed. It is not possible to determine, based on this, what treatment is recommended or indicated (P's Ex. 7 at 2-4, Tr.491-94).

CONCLUSIONS as to PATIENT E

1. Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient E because his records were inadequate and failed to note critical data.

2. Factual allegations E. and E.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS of FACT as to PATIENT F

32. Respondent treated Patient F at a minimum from on or about sometime in 1992, to on or about October 24, 2002 (P's Ex. 8, 8A, 8B, 8C, 15, Tr. 502-507).

33. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment (P's Ex. 8, 8A, 8B, 8C, 15, Tr. 502-507).

34. Respondent prescribed Celexa, Prozac, and Valium for Patient F without maintaining an adequate record (P's Ex. 8B, Tr. 504-06).

35. Patient F suffered from chronic fatigue syndrome and also suffered from depression and anxiety associated with her abusive marriage and difficult childhood (Tr. 569-571).

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CONCLUSIONS as to PATIENT F

1. Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient F because his records were inadequate and failed to note critical data.

2. Factual allegations F. and F.1 are sustained with respect to negligence and failure to maintain records.

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FINDINGS of FACT as to PATIENT G

43. Respondent treated Patient G at a minimum from on or about December 18, 2002, to on or about October 16, 2005 (P's Ex. 9, 9A, 9B, R's Ex. D, Tr. 513-17).

44. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment (P's Ex. 9, 9A, 9B, R's Ex. D, Tr. 513-17).

45. It is a violation of the standard of care for Respondent, in his record for Patient G, to refer to substance use or abuse without any detail as to the length of the abuse, what substances are involved, and why the patient is coming for treatment at this particular time (R's Ex. D at 27-28, Tr. 515-17).

CONCLUSIONS AS TO PATIENT G

1. Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient G because his records were inadequate and failed to note critical data.

2. Factual allegations G. and G.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS of FACT as to PATIENT H

46. Respondent treated Patient H at a minimum from on or about January 3, 2000, to on or about January 31, 2002 (P's Ex. 10, Tr. 521-22, 524).

47. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment (P's Ex. 10, Tr. 521-22, 524).

48. Respondent prescribed Ativan, a controlled substance, for Patient H (P's Ex. 10 at 2-7, Tr. 522, 524).

49. It is a violation of the standard of care by Respondent that he is unable to locate records for Patient H (Tr. 524).

CONCLUSIONS as to PATIENT H

1. Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient H because he cannot produce a patient record.

2. Factual allegations H. and H.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS OF FACT as to PATIENT I

50. Respondent treated Patient I at a minimum from on or about May 29, 2001, to on or about April 21, 2004 (P's Ex. 11. 11A, 11B, Tr. 521-24).

51. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment (P's Ex. 11, 11A, 11B, Tr. 521-24).

52. Respondent prescribed Xanax (generic name alprazolam), a controlled substance, for Patient I (P's Ex. 11, 11A, 11B, Tr. 522-24).

53. It is a violation of the standard of care by Respondent that he is unable to locate records for Patient I (Tr. 524).

CONCLUSIONS as to PATIENT I

1. Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient I because he cannot produce a patient record.

2. Factual allegations I. and I.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS of FACT as to PATIENT J

54. Respondent treated Patient J at a minimum from on or about December 11, 2000, to on or about June 21, 2002 (P's Ex. 12, 12A, Tr. 521-528).

55. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment (P's Ex. 12. 12A, Tr. 521-528).

56. Respondent prescribed Adderall, a controlled substance, for Patient J. (P's Ex. 12, 12A, Tr. 523-34).

57. It is a violation of the standard of care by Respondent that he is unable to locate records for Patient J (Tr. 524).

CONCLUSIONS as to PATIENT J

1. Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient J because he cannot produce a patient record.

2. Factual allegations J. and J.1 are sustained with respect to negligence and failure to maintain records.

FINDINGS of FACT as to PATIENT K

58. Respondent treated Patient K at a minimum from on or about June 23, 2000, to on or about March 3, 2003 (P's Ex. 13, R's Ex. E, Tr. 528-552).

59. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment (P's Ex. 13, R's Ex. E, Tr. 531-32, 553-55).

60. Some of Respondent's notes for Patient K are inadequate, fail to meet the standard of care, and fail to reflect the patient's complaints, care and/or treatment (R's Ex. E at 91, 106, 107, 140, Tr. 531-32, 553-55).

CONCLUSIONS as to PATIENT K

1. Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient K because his records were inadequate and failed to note critical data.

2. Factual allegations K. and K.1 are sustained with respect to negligence and failure to maintain records.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous, unless specified.)

FIRST SPECIFICATION:
(Negligence)

All allegations are sustained, with the exception of factual allegation F.2 which is not sustained.

SECOND THROUGH TWELFTH SPECIFICATIONS:
(Failure to maintain records)

All allegations are sustained.

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CREDIBILITY OF WITNESSES

The Respondent testified in a credible manner without guile. He readily acknowledged his deficiencies in record keeping; MATERIAL REDACTED He presented himself in a likeable manner, and on some occasions responded using unsophisticated language that seemed more social than professional in style.

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Both and Leslie Fisher were highly credible.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee votes to place the Respondent on probation for a period of two years, dating from the time of this Order, under the supervision of a records monitor.

In reaching this conclusion, the Committee considered the full range of penalties available, including revocation.

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With regard to the record keeping allegations, the Respondent readily acknowledged that his office records are inadequate, and indicated that he had already taken steps to improve them. In the early years of his practice, when he had both a private practice and medical staff appointments, the Respondent was monitored and interacted with other physicians. He indicated that his patient notes were more organized and more frequent as required by the hospital environment. He indicated that his office notes were very different, and offered that he was not sure of the protocol for making patient notes and maintaining

office records. He was very quick to indicate his willingness to remediate this problem and his more recent records reviewed by the State's expert demonstrated that he is attempting to improve. A record monitor will ensure that he follows through on his stated good intentions and the Committee feels strongly that no other penalty is indicated in this situation.

ORDER

Based upon the foregoing **IT IS HEREBY ORDERED THAT**:

1. Respondent is hereby placed on probation for a period of two (2) years dating from the time of this Order, during which time he shall be under the supervision of a records monitor.

2. The terms of probation are annexed hereto and made a part hereof.

Dated: New York, New York
May 22, 2006

CAROLYN C. SNIPE
Chairperson

ROBERT BERGMANN, M.D.
C. DEBORAH CROSS, M.D.

TERMS OF PROBATION

1. Respondent shall conduct himself/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

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 Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law Section 32]

5. 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.

6. 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/her staff at practice locations or OPMC offices.

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

8. Respondent shall practice medicine only when his records are monitored by a licensed physician, board certified in psychiatry, ("records monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Respondent shall make available to the records monitor any and all records or access to the practice requested by the monitor, including on-site observation. The records monitor shall monitor Respondent's medical records on a random unannounced basis at least quarterly and shall examine a selection of no less than five (5) records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical records are kept 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.

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

10. Respondent shall cause the records monitor to report quarterly, in writing, to the Director of OPMC.

11. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(180(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.

12. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon 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.

APPENDIX I

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

IN THE MATTER OF MILTON ALAN PEREIRA, M.D.	NOTICE OF HEARING

TO: MILTON ALAN PEREIRA, M.D.
45 East 89th Street
New York, New York 10128

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on January 25, 2006, at 10:00 a.m., at the Offices of the New York State Department of Health, 4th floor, 90 Church Street, New York, New York, 10007, and at such other adjourned dates, times and places as the committee may direct.

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. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF

ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), 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. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §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. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

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 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 OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: NewYork, New York
November 29 ,2005

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Denise Lepicier
Associate Counsel
Bureau of Professional Medical Conduct
4th floor, 90 Church Street
New York, New York 10007
212-417-4450

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

IN THE MATTER
OF
MILTON ALAN PEREIRA, M.D.

STATEMENT
OF
CHARGES

MILTON ALAN PEREIRA, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 8, 1963, by the issuance of license number 90679 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A at a minimum from on or about July 29, 1997, to on or about December 19, 2001.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

B. Respondent treated Patient B at a minimum from on or about July 9, 1998, to on or about May 31, 2005.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

C. Respondent treated Patient C at a minimum from on or about February 15, 1990, to on or about February 8, 2000.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

D. Respondent treated Patient D at a minimum from on or about November 11,

1997, to on or about November 12, 1998.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

E. Respondent treated Patient E at a minimum from on or about June of 1998 to a time unknown.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

F. Respondent treated Patient F at a minimum from on or about sometime in 1992, to on or about October 24, 2002.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

MATERIAL REDACTED

G. Respondent treated Patient G at a minimum from on or about December 18, 2002, to on or about October 16, 2005.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

H. Respondent treated Patient H at a minimum from on or about January 3, 2000, to on or about January 31, 2002.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

I. Respondent treated Patient I at a minimum from on or about May 29, 2001, to on or about April 21, 2004.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

J. Respondent treated Patient J at a minimum from on or about December 11, 2000, to on or about June 21, 2002.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

K. Respondent treated Patient K at a minimum from on or about June 23, 2000, to on or about March 3, 2003.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraphs A and A1; and/or B and B1; and/or C and C1; and/or D and D1; and/or E and E1; and/or F and F1 *MATERIAL REDACTED* and/or G and G1; and/or H and H1; I and I1; and/or J and J1;

and/or K and K1.

SECOND THROUGH TWELFTH 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:

2. Paragraphs A and A1;
3. Paragraphs B and B1;
4. Paragraphs C and C1;
5. Paragraphs D and D1;
6. Paragraphs E and E1;
7. Paragraphs F and F1;
8. Paragraphs G and G1;
9. Paragraphs H and H1;
10. Paragraphs I and I1;
11. Paragraphs J and J1;
12. Paragraphs K and K1.

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MATERIAL REDACTED

DATE: November 28, 2005
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct