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 6, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin A. Brousell, Esq.
26 Broadway
New York, New York

Daniel Guenzburger, Esq.
Assistant Counsel
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: In the Matter of Armand Di Nolfi, M.D.

Dear Mr. Brousell and Mr. Guenzburger :

Enclosed please find the Determination and Order (No. 94-165) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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	:	DETERMINATION
OF	:	AND
ARMAND DI NOLFI, M.D.	:	ORDER

NO. BPMC-94-165

Stanley L. Grossman, M.D., Chairperson, Thakor C. Rana, M.D. and Anthony Santiago, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 230 (1) of the Public Health Law, served as the Hearing Committee in 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 Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	January 31, 1994
Amended Statement of Charges dated:	April 4, 1993[1]
Pre-hearing conference:	February 23, 1994
Hearing dates:	March 1, 1994

[1] The date of 1993, rather than 1994, is clearly a typographical error, which was not discovered during the course of the hearing. A motion to amend the charges was granted on March 31, 1994, and the Amended Statement of Charges was admitted into evidence on April 12, 1994.

	March 31, 1994 April 12, 1994 April 19, 1994
Intra-Hearing Conference	May 9, 1994
Deliberation date:	July 13, 1994
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Daniel Guenzburger, Esq. Assistant Counsel
Respondent appeared by:	Kevin A. Brousell, Esq. 26 Broadway New York, N.Y. 10004

MOTIONS

1. Petitioner's motion on March 1, 1994 to amend the Statement of Charges by correcting certain dates in Allegation E was GRANTED.

2. Petitioner's motion on March 31, 1994 to further amend the Statement of Charges by withdrawing all allegations referring to Patient A; making certain changes in the dates contained in the allegations concerning Patient B; and deleting all references to the fact that Patient B was the sister of Patient A was GRANTED, and an Amended Statement of Charges was admitted into evidence on April 12, 1994.

WITNESSES

For the Petitioner:

1) Steven Heymsfield, M.D.

For the Respondent:

1) Armand Di Nolfi, M.D.

STATEMENT OF CHARGES

The Amended Statement of Charges essentially charges the Respondent with professional misconduct in that he was practicing with negligence on more than one occasion, gross negligence on a particular occasion, incompetence on more than one occasion, and gross incompetence on a particular occasion; that he failed to maintain adequate records for each patient; and that he failed to comply with State law and regulations concerning the maintenance of an inventory for controlled substances he purchased and dispensed. The charges are more specifically set forth in the Amended Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page 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. Armand Di Nolfi, M.D., the Respondent, was authorized to practice medicine in New York State on September 30, 1965 by

issuance of license number 095432 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, 1994 at 250 East 34th Street, New York, New York 10016 (Pet. Ex. 2).

2. For the past 25 years the Respondent has concentrated his medical practice in the area of weight loss and nutritional problems (T. 250). Respondent testified that he has treated over 8,000 patients for weight loss (T. 290).

3. On or about and between May 1, 1989 and February, 1992, the Respondent purchased approximately 465,000 units (tablets) of appetite suppressant medication, including but not limited to phentermine hydrochloride ("phentermine"), phendimetrazine tartrate ("phendimetrazine"), and diethylproprion hydrochloride (Pet. Ex. 3a and 3b).

4. The Respondent dispensed these appetite suppressant medications directly to patients B through J at his office located at 250 East 34th Street, New York, New York. (Pet. Exhs. 7-15).

5. Phentermine hydrochloride, phendimetrazine tartrate and diethylproprion hydrochloride are classified as controlled substances pursuant to Public Health Law Sec. 3306.

Public Health Law Section 3322(1) and (2) (McKinney 1985) and Department of Health regulations 10 NYCRR Sections 80.111 and 80.112 (1975) require that a physician maintain a report of the quantities of controlled substances that he purchases and dispenses (ALJ Ex.2 and 3).

6. The Respondent failed to keep an accurate inventory of controlled substances as required (T. 633-45).

7. Phentermine hydrochloride is a sympathomimetic medication. The medication suppresses appetite by activating the sympathetic nervous system. Phendimetrazine tartrate is another sympathomimetic drug that suppresses appetite in the same manner as phentermine hydrochloride (T. 28-29).

8. Phentermine hydrochloride and phendimetrazine tartrate have traditionally only been indicated for short term treatment of several weeks duration. However, several clinical studies reported in medical journals in 1992 and 1993 found that phentermine hydrochloride could be effective in the long term treatment of obesity. In spite of evolving applications for these medications, no legitimate medical authority supports prescribing either drug to patients who are not truly obese. Further, the medications should not be prescribed unless the patient has already demonstrated an inability to lose weight on a program consisting of diet and exercise (T. 29-32; 59).

9. A serious weight problem is defined as being a minimum of twenty per cent above the patient's ideal body weight (T.40).

10. The reasonably prudent physician who was considering prescribing appetite suppressant medication should first elicit certain information from the patient. First, the physician should take a thorough medical history to ensure that the patient did not have any contraindicated conditions, such as high blood pressure. Second, the physician should explore the patient's social

history. Since appetite suppressant medications have significant addiction potential, the physician should also thoroughly investigate whether the patient has any history of substance abuse. Finally, the physician should take a nutritional history including past attempts at losing weight through dieting. (T. 31-32, Pet. Ex. 7).

11. In addition, prior to prescribing appetite suppressant medication, a reasonably prudent physician should perform a baseline physical examination, which would include checking the eyes, ears, lungs, heart, as well as other vital signs. Since phentermine hydrochloride and phendimetrazine tartrate are known to elevate blood pressure, the patient's blood pressure should be taken prior to prescribing the medication and at each subsequent office visit. (T. 32-33).

12. Finally, prior to prescribing these medications, a reasonably prudent physician should perform certain laboratory tests for two reasons. First, laboratory tests should be performed to screen for conditions that may be related to obesity, such as diabetes. Second, laboratory tests should be performed to detect underlying conditions which would make the patient prone to adverse consequences from taking the medication. The performance of liver function tests is especially significant, since phentermine and phendimetrazine are drugs that are metabolized by the liver. (T. 43, 44, 46, 57).

13. Each of the medical records submitted as Pet. Exs. 7-15 was certified by the Respondent to be "complete true and exact copies/originals" of his medical records (Pet. Exs. 7-15).

14. Respondent testified that he computerized his medical records in 1990 (T. 273). The medical data from the patient files of Patients B through J was entered into the computer, but all information entered prior to September 1990 was subsequently lost when Respondent experienced problems with retrieving data from his computer at that time (T. 283-4).

FINDINGS OF FACT AS TO PATIENT B

1. According to Respondent's medical records, Respondent treated Patient B, a female, with appetite suppressant medication between June 11, 1992 and September 21, 1993. Respondent testified that he had treated Patient B from the early 80's for a variety of conditions including weight loss, but that he had lost the medical records for the period prior to June, 1992. (T. 479-480; Pet. Ex. 7).

2. The records for Patient B cover visits from June 12, 1991 to September 21, 1993 (T. 524-529).

3. Patient B was 45 years old, either 5 feet 2 inches or 5 feet 3 inches tall, and weighed between 127 pounds and 130 pounds during the period of treatment reflected in the medical records (Pet. Ex. 7, p. 5 through 11).

4. The medical records for Patient B do not contain any evidence of a physical examination, including blood pressure measurement. However, the patient's weight was recorded for each visit (Pet. Ex. 7).

5. Patient B's weight was never close to 20 per cent above her ideal body weight (T. 40).

6. On or about June 11, 1992, the Respondent prescribed Patient B "28 green caps and 28 yellow tabs" (Pet. Ex. 7). According to Respondent's method for recording prescriptions, green caps are phendimetrazine tartrate 35 mg. and yellow tabs are phentermine hydrochloride 37.5 mg. (Pet. Ex. 3a and 3b).

7. Respondent only noted in the patient's chart the quantity, color and shape of the pills he dispensed (Pet. Ex.7).

8. Respondent failed to document any past medical history when he started the patient on phentermine hydrochloride at the June 11, 1992 office visit (Pet. Ex. 7).

9. After the initial visit, the Respondent dispensed varying quantities of phentermine hydrochloride and/or phendimetrazine tartrate to Patient B at office visits, dated July 18, 1992, September 5, 1992, October 29, 1992, December 8, 1992, January 23, 1993, March 4, 1993, April 20, 1993, July 5, 1993, and September 21, 1993. (Pet. Ex. 7).

10. Respondent failed to document adequate histories at the subsequent visits and failed to document whether the patient was developing a tolerance to the medication, or experiencing side effects or other adverse reactions (T. 38).

11. Respondent failed to take the patient's blood pressure at each office visit. (T. 38).

12. Respondent failed to document that he treated the patient with nutritional management and an exercise program before dispensing appetite suppressant medication (T. 38-41).

CONCLUSIONS AS TO PATIENT B

1. Prior to dispensing appetite suppressing medication for Patient B, the Respondent failed to take an adequate medical history; failed to perform an adequate physical examination; failed to order appropriate laboratory studies and failed to order an appropriate regimen of diet and exercise. This constitutes a deviation from acceptable medical standards.

2. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

3. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient B.

4. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient B.

FINDINGS OF FACT AS TO PATIENT C

1. On or about and between February 7, 1990 and May 8, 1993, the Respondent treated Patient C, a male. At the onset of

treatment, Patient C was 31 years old, 5 feet 7 1/2 inches tall, and weighed 163 pounds. (Pet. Ex. 8).

2. Patient C was less than 20 per cent over his ideal weight (T. 56).

3. Respondent dispensed phentermine and/or phendimetrazine to Patient C at office visits dated February 5, 1990, March 12, 1990, April 6, 1991, May 9, 1991, May 16, 1991, June 2 and 18, 1992, July 16, 1992, August 18, 1992, September 22, 1992, October 20, 1992, November 14, 1992, December 10, 1992, January 7 and 21, 1993, April 8, 1993 and May 8, 1993. (Pet. Ex.. 8).

4. Patient C's record indicated in his response to the medical history questionnaire that he had experience with narcotics The record fails to document that Respondent explored this with Patient C (Pet. Ex. 8).

5. Because of the significant addiction potential of phentermine hydrochloride and phendimetrazine tartrate, the medications should not have been prescribed to Patient C (T. 56-8).

6. During the course of treatment, Respondent prescribed medications such as Tylenol with codeine, Fioricet, Esgic and other medications that are often abused by addicts (T. 600-604; Pet. Ex. 8).

7. Respondent failed to document an appropriate past medical and nutritional history, and failed to document whether Patient C was abusing and/or developing a dependence to the appetite suppressant medications during the course of treatment (T. 27, 55).

8. With the exception of taking periodic weights, Respondent

failed to document any physical examinations, including Patient C's blood pressure during the course of treatment (T. 56; Pet. Ex.8).

9. Respondent failed to document any laboratory studies for Patient C (T. 56).

10. Respondent failed to document treatment of the patient with nutritional management and an exercise program before administering appetite suppressant medication (Pet. Ex. 8).

11. Respondent failed to adequately record the name, dosage, and instructions for taking the medications he prescribed for Patient C (T. 27, 130).

CONCLUSIONS AS TO PATIENT C

1. Prior to dispensing appetite suppressing medication for Patient C, the Respondent failed to take an adequate medical history; failed to perform an adequate physical examination; failed to order appropriate laboratory studies and failed to order an appropriate regimen of diet and exercise. This constitutes a deviation from acceptable medical standards.

2. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

3. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient C, especially in light of the fact that Patient C had indicated past experience with narcotics.

4. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient C.

FINDINGS OF FACT AS TO PATIENT D

1. On or about and between July 25, 1991 and May 9, 1992, Respondent treated Patient D with appetite suppressant medication. Patient D, a female, was 27 years old, 5 feet 8 inches, and weighed 147 pounds at the onset of treatment (Pet. Ex. 9).

2. Respondent conceded that even Patient D's highest weight of 147 pounds was an acceptable weight. Nevertheless, Respondent treated Patient D with appetite suppressant medication (T. 619).

3. Patient D was not 20% above her ideal weight and not a candidate for appetite suppressant medication (T. 84).

4. Respondent dispensed varying quantities and dosages of phentermine to Patient D at office visits dated July 25, 1991, November 26, 1991, January 11, 1992, March 31, 1992, and May 9, 1992. (Pet. Ex. 9).

5. Respondent did not document a program of nutritional management and exercise before initiating treatment with appetite suppressant medications (Pet. Ex. 9).

6. Respondent failed to document that he had explored Patient D's past medical and nutritional history, and he failed to document whether he had investigated Patient D's response to the medical history questionnaire that she had past experience with narcotics (T. 82).

7. Respondent failed to document a baseline physical exam, and failed to document that he took the patient's blood pressure at each visit. (T. 82).

8. Respondent failed to document any laboratory studies for Patient D (T. 83).

9. Respondent failed to adequately record the name, dosage, and instructions for taking the medications he dispensed to Patient D (Pet. Ex. 9).

CONCLUSIONS AS TO PATIENT D

1. Prior to dispensing appetite suppressing medication for Patient D, the Respondent failed to take an adequate medical history; failed to perform an adequate physical examination; failed to order appropriate laboratory studies and failed to order an appropriate regimen of diet and exercise. This constitutes a deviation from acceptable medical standards.

2. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

3. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient D, especially in light of the fact that Patient D had indicated past experience with narcotics.

4. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient D.

FINDINGS OF FACT AS TO PATIENT E

1. Respondent treated Patient E between January 3, 1990 and October 15, 1991. Patient E, a female, was 34 years old, 5 feet 4 inches tall, and weighed 133 pounds at the initial visit (Pet. Ex. 10).

2. Respondent dispensed varying quantities and dosages of phentermine to Patient E at office visits dated January 3, 1990, January 18, 1990, September 17, 1991, and October 15, 1991. In addition, Respondent dispensed hydrochlorothiazide at office visits dated January 18, 1990, September 17, 1991, and October 15, 1991 (Pet. Ex. 10).

3. Patient E weighed considerably less than the 20 per cent over ideal body weight threshold for treatment with appetite suppressant medication (T. 69).

4. Respondent failed to document an appropriate regimen of weight reduction based on caloric restriction and exercise before treating the patient with appetite suppressant medication (T. 69; Pet. Ex. 10).

5. Respondent failed to document Patient E's past medical, nutritional, and social history, and failed to investigate Patient E's response to a patient history questionnaire that she had experience with narcotics. Further, Respondent failed to document whether the patient was experiencing adverse reactions or developing a tolerance to the medication (T. 38, 68).

6. Respondent failed to document any laboratory studies (Pet. Ex. 10).

7. Respondent inappropriately dispensed hydrochlorothiazide to Patient E. Hydrochlorothiazide is a diuretic which is indicated for congestive heart failure, high blood pressure, and other conditions in which the patient has an excessive amount of fluid T.66).

8. Respondent documented a physical examination of Patient E, however there are discrepancies between his "scratch notes" and the chart entries. Blood pressures and pulses differed, and although Respondent indicates a complete physical in his progress note, there was no indication of same on his scratch notes (Pet. Ex. 10) and Respondent could not provide an adequate explanation for this (T. 346-7).

9. Respondent failed to document the name, dosage and instructions for taking medications (T. 67).

CONCLUSIONS AS TO PATIENT E

1. Prior to dispensing appetite suppressing medication for Patient E, the Respondent failed to take an adequate medical history; failed to order appropriate laboratory studies and failed to order an appropriate regimen of diet and exercise. This constitutes a deviation from acceptable medical standards.

2. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

3. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient E, especially in light of the fact that Patient E had indicated past experience with narcotics.

4. Respondent also inappropriately prescribed hydrochlorothiazide for Patient E. Respondent's treatment of Patient E with diuretics was inappropriate because Respondent's physical examination indicated that her heart and blood pressures were normal, and she did not have any other condition that would justify prescribing a diuretic.

5. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient E.

FINDINGS OF FACT AS TO PATIENT F

1. On or about April 9, 1993, the Respondent dispensed 14 half tabs of phentermine to Patient F. Patient F was a 24 year old female. Respondent noted that Patient F weighed 134 pounds, but he did not record the patient's height (Pet. Ex. 11).

2. Patient F reported that she had been hospitalized, had experience with narcotics, smoked cigarettes, drank a glass of hard liquor a day, was tense and anxious, and had important problems in both her work and personal life (Pet. Ex. 11).

3. Phentermine hydrochloride could aggravate Patient F 's psychological problems because the medication stimulates the nervous system and has a tendency to increase agitation (T.89).

4. Respondent failed to document Patient F's nutritional history and medical history, including a history of a past hospitalization. Respondent also failed to document Patient F's response to a patient history questionnaire that she had experience with narcotics (T. 84; Pet. Ex. 11).

5. Respondent failed to document an adequate physical examination in that he did not perform a baseline physical, take the patient's blood pressure, or even measure the patient's height. (T. 90).

7. Respondent failed to document the name, dosage and instructions for taking medications (T. 67).

CONCLUSIONS AS TO PATIENT F

1. Because Respondent did not record the height of Patient F, who weighed 134 pounds, the Committee was unable to determine the need for appetite suppressant medication in this patient.

2. Prior to dispensing appetite suppressing medication for Patient F, the Respondent failed to take an adequate medical history and failed to perform an adequate physical examination. This constitutes a deviation from acceptable medical standards.

3. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

4. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient F, especially in light of the fact that Patient F had indicated past experience with narcotics.

5. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient F.

FINDINGS OF FACT AS TO PATIENT G

1. Respondent dispensed varying amounts of phentermine to patient G, a 34 year old female, on August 1, 1991, August 27, 1991, and September 2, 1991. Respondent noted that Patient G was 5 feet 4 inches tall, and weighed 155 pounds at the initial visit (Pet. Ex. 12).

2. Respondent failed to document Patient G's medical, nutritional, and social history. In addition, Respondent failed to document that he adequately investigated Patient G's response to a patient history questionnaire that she had experience with narcotics (T. 98).

3. Respondent failed to document appropriate laboratory studies (T. 98).

4. Respondent failed to document that he treated the patient with nutritional management and an exercise program before dispensing the medication (T. 99).

5. Respondent inappropriately dispensed a diuretic, since Patient G did not have congestive heart failure, high blood pressure, edema or other condition that indicated that the patient needed a diuretic (T. 67, 98).

6. Respondent failed to record the name, dosage and instructions for taking medications (T. 67).

CONCLUSIONS AS TO PATIENT G

1. Prior to dispensing appetite suppressing medication for Patient G, the Respondent failed to take an adequate medical history; failed to perform an adequate physical examination; failed to order appropriate laboratory studies and failed to order an appropriate regimen of diet and exercise. This constitutes a deviation from acceptable medical standards.

2. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

3. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient G, especially in light of the fact that Patient D had indicated past experience with narcotics.

4. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient G.

FINDINGS OF FACT AS TO PATIENT H

1. On or about and between March 28, 1991 and June 29, 1993, the Respondent treated Patient H, a 42 year old female. Patient H was 5 feet 3 inches and weighed 202 pounds at the initial visit (Pet. Ex. 13).

2. Respondent dispensed varying quantities and dosages of phentermine at office visits dated April 23, 1991, September 12, 1991, July 21, 1992, January 12, 1993, May 4, 1993, June 1, 1993 and June 29, 1993. Respondent dispensed phendimetrazine on June 23, 1992 (Pet. Ex. 13).

3. Prior to the initiation of treatment, Patient H indicated in her answer to a patient history questionnaire that she had been taking medicine for high blood pressure (Pet. Ex. 13, p.2). The record fails to document Patient H's blood pressure prior to January of 1993, except for a June 1992 visit (Pet. Ex. 13). High blood pressure is a contraindication to treatment with appetite suppressant medications (T. 107).

4. Respondent's testimony that Patient H did not have high blood pressure and was not being treated with anti-hypertensive medication is not credible (T. 539, 544). Dr. Alford Smith's medical record for Patient H indicates that Dr. Smith treated Patient H with Dyazide, an anti-hypertensive medication, from on or

about June 1989 through September 1993 (Pet. Exs. 23 and 24). Patient H was therefore on anti-hypertensive medication during the entire period that she was being treated by Respondent. Further, during the period that Patient H was being treated by Respondent, Dr. Smith noted the following elevated blood pressures for Patient H: February 20, 1991, 150/100; November 18, 1991, 130/90; March 9, 1992, 170/110; January 30, 1993, 140/96. (Pet. Ex. 23, pgs. 3, 4, 5.; T. 539).

5. Respondent failed to document Patient H's medical, nutritional and social history (T. 107).

6. Respondent failed to document an adequate baseline physical examination for Patient H and failed to take blood pressures at office visits dated April 23, 1991, September 12, 1991, July 21, 1992, May 4, 1993 and June 1, 1993 (Pet. Ex. 13; T. 32-33, 103).

7. Respondent failed to document sufficient laboratory blood studies for Patient H (T. 109; Pet. Ex. 13).

8. Respondent failed to document that he treated the patient with nutritional management and an exercise program before dispensing the medications (Pet. Ex. 13).

9. Respondent failed to note the name, dosage and instructions for taking medications (T. 67).

CONCLUSIONS AS TO PATIENT H

1. Prior to dispensing appetite suppressing medication for Patient H, the Respondent failed to take an adequate medical history; failed to perform an adequate physical examination; failed to order sufficient laboratory studies and failed to order an appropriate regimen of diet and exercise. This constitutes a deviation from acceptable medical standards.

2. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

3. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient H.

4. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient H.

FINDINGS OF FACT AS TO PATIENT I

1. On or about and between April 28, 1990 and January 16, 1993, Respondent treated Patient I with phentermine. Patient I, a female, was 23 years old, 5 feet 4 inches tall and weighed 147 pounds at the initial visit. Patient I reported that she had a history of "heart attack, angina or other heart problems" (Pet. Ex. 14, p. 2).

2. Prior to initiating treatment with appetite suppressant medication, Respondent failed to adequately document Patient I's

cardiac condition (Pet. Ex. 14). Since the stimulating affect of the medication may cause an adverse cardiac reaction, the Respondent should have performed a thorough cardiac evaluation, including an electrocardiogram and/or referral to a cardiologist (T. 112).

3. Respondent failed to document that he treated the patient with an appropriate regimen of weight reduction based on caloric restriction and exercise prior to dispensing the medication (T. 112).

4. At the second patient visit dated June 2, 1993, the Respondent failed to document a physical examination and electrocardiogram in response to the patient's complaint of chest discomfort (T. 113; Pet. Ex. 14).

5. At the third patient visit dated June 16, 1990, Patient I continued to complain of chest discomfort. Respondent failed to order an electrocardiogram (T. 118; Pet. Ex. 14).

6. Respondent inappropriately ordered diuretics at patient visits dated April 28, 1990, June 2, 1990, and January 16, 1993 (T. 118.

7. Respondent failed to document laboratory blood studies (Pet. Ex. 14).

8. Respondent failed to document an adequate history by failing to elaborate on Patient I's response to the patient questionnaire indicating that she had had a heart attack, angina, or other heart problems (T. 32; Pet. Ex. 14).

9. Respondent failed to note the name, dosage, and instructions for taking the medications (T. 27, 130).

CONCLUSIONS AS TO PATIENT I

1. Prior to dispensing appetite suppressing medication for Patient H, the Respondent failed to take an adequate medical history; failed to perform an adequate physical examination; failed to order laboratory studies and failed to order an appropriate regimen of diet and exercise. This constitutes a deviation from acceptable medical standards.

2. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

3. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient I, especially because of his failure to adequately evaluate Patient I's cardiac condition.

4. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient I.

FINDINGS OF FACT AS TO PATIENT J

1. On or about and between September 6, 1989 and December 12, 1991, the Respondent treated Patient J with phentermine hydrochloride. Patient J was 200 pounds at the first visit. (Pet. Ex. 15).

2. Respondent failed to note the patient's height (T. 121; Pet. Ex. 15).

3. Respondent failed to take an adequate history in that he failed to document and elaborate on Patient J's report that she had had a heart condition from birth, heart surgery, and had had a nervous breakdown (T. 124).

4. Respondent failed to document a cardiac examination in a patient with a congenital heart condition and failed to document a baseline physical examination (T. 124, 125; Pet. Ex. 15).

5. Respondent also failed to document blood pressures at office visits dated January 3, 1990, October 6, 1990, November 2, 1990, and November 12, 1991 (T. 124).

6. Respondent failed to document any laboratory blood studies (T. 125).

7. Respondent inappropriately ordered diuretics for Patient J (T. 125).

8. Respondent failed to note the name, dosage and instructions for taking the medications (T. 27, 130, Pet. Ex. 15).

CONCLUSIONS AS TO PATIENT J

1. Because Respondent did not record the height of Patient J, who weighed 200 pounds, the Committee was unable to determine the need for appetite suppressant medication in this patient.

2. Prior to dispensing appetite suppressing medication for Patient J, the Respondent failed to take an adequate medical history; failed to perform an adequate physical examination; failed to order appropriate laboratory studies and failed to order an appropriate regimen of diet and exercise. This constitutes a deviation from acceptable medical standards.

3. Respondent's failure to note the name of the medication, dosage dispensed, and instructions for taking the medication was also a deviation from acceptable medical accepted standards.

4. Respondent inappropriately prescribed and/or dispensed appetite suppressant medication to Patient J, especially because of his failure to adequately evaluate Patient J's cardiac condition.

5. Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient J.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous.)

FIRST SPECIFICATION:
(Practicing with negligence on more than one occasion)

SUSTAINED as to Paragraphs B and B1, B2, B3, B4, B5; C and C1, C2, C3, C4, C5, C6; D and D1, D2, D3, D4, D5, D6; E and E1, E2, E3, E4, E5, E6; F and F1, F2, F3, F5; G and G1, G2, G3, G5, G5, G6; H and H1, H2, H3, H5; I and I1, I2, I3, I4, I5, I6; J and J1, J2, J3, J4, J5, J6, J7.

NOT SUSTAINED as to Paragraphs F4, H4, and I7.

SECOND SPECIFICATION:
(Practicing with incompetence)

SUSTAINED as to Paragraphs B and B1, B2, B3, B4, B5; C and C1, C2, C3, C4, C5, C6; D and D1, D2, D3, D4, D5, D6; E and E1, E2, E3, E4, E5, E6; F and F1, F2, F3, F5; G and G1, G2, G3, G5, G5, G6; H and

H1, H2, H3, H5; I and I1, I2, I3, I4, I5, I6; J and J1, J2, J3, J4, J5, J6, J7.

NOT SUSTAINED as to Paragraphs F4, H4, and I7.

THIRD AND FOURTH SPECIFICATIONS:
(Practicing with gross negligence)

NOT SUSTAINED as to Paragraphs I and I1, I2, I3, I4, I5, I6, I7; and J and J1, J2, J3, J4, J5, J6, J7.

FIFTH AND SIXTH SPECIFICATIONS:
(Practicing with gross incompetence)

NOT SUSTAINED as to Paragraphs I and I1, I2, I3, I4, I5, I6, I7 and J and J1, J2, J3, J4, J5, J6, J7.

SEVENTH THROUGHT FIFTEENTH SPECIFICATIONS:
(Failing to maintain an adequate record)

SUSTAINED as to B and B6; C and C7; D and D7; E and E7; F and F6; G and G7; H and H6; I and I8; J and J8.

SIXTEENTH SPECIFICATION:
(Failing to comply with a state law and regulation governing the practice of medicine)

SUSTAINED as to Paragraphs A and A1.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee felt that the Respondent's testimony concerning his lost office records was not credible. It judged the Respondent's practice by the office records in evidence and by his testimony. Inasmuch as the Respondent confines his practice to bariatric medicine, the Hearing Committee expected him to have more

knowledge about diet, nutrition, and the prescription medications he was dispensing then he demonstrated.

Therefore, the Committee unanimously determines that the Respondent be suspended from the practice of medicine for three years, with the suspension stayed under the following terms of probation:

1. At Respondent's expense, Respondent shall complete the Phase 1 Evaluation of the Physician Prescribed Educational Program (PREP) of the Department of Family Medicine, SUNY Health Science Center of Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center, Syracuse, within ninety (90) days of the effective date of this Order; and

2. If the Phase I Evaluation indicates that he is a candidate for re-education, then Respondent must successfully complete Phase II of the PREP at Syracuse, the pilot New York State Physician Retraining Program (PRP) or an equivalent program, such as a residency or mini-residency, and Phase III, the post-training evaluation.

3. If as a result of the Phase I Evaluation, the Respondent is not a candidate for retraining, the Respondent shall be referred to this Committee for re-consideration of the penalty.

4. Following completion of the re-education required by this Order, the Respondent's practice of medicine shall be monitored by the Office of Professional Medical Conduct (OPMC) for three years.

5. During the period of probation, the Director of OPMC or his/her designee, may review the professional performance of the Respondent. This review may include but not be limited to a random selection of office records, patient records or hospital charts, interviews with or periodic visits to the Respondent at his office location or one of the offices of OPMC.

6. The Respondent will make available for review by OPMC, or a physician selected by the Respondent and approved by OPMC, complete copies of any and all medical and office records selected by OPMC.

7. Any deviation from accepted medical practice identified during any of the reviews will be discussed with the Respondent. Any pattern of substandard care identified during the probation period may result in an independent medical review and could lead to additional investigation or charges.

8. Respondent will maintain legible and complete medical records which accurately reflect evaluation and treatment of patients. Records will contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing or administering of controlled substances, the medical record will contain all information required by state rules and regulations regarding controlled substances.

ORDER

Based upon the foregoing IT IS HEREBY ORDERED THAT

1. Respondent's license to practice medicine in the State of New York is suspended for a period of three years, with the suspension stayed under the terms of probation set forth above.

Dated: New York, New York
August 29, 1994

STANLEY L. GROSSMAN, M.D.
Chairperson

THAKOR C. RANA, M.D.
ANTHONY SANTIAGO

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

IN THE MATTER	:	AMENDED STATEMENT
OF	:	OF
ARMAND DI NOLFI, M.D.	:	CHARGES

ARMAND DI NOLFI, M.D., the Respondent, was authorized to practice medicine in New York State on September 30, 1965 by the issuance of license number 095432 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 to December 31, 1994 at 250 East 34th Street, New York, New York 10016.

FACTUAL ALLEGATIONS

A. On or about and between May 1, 1989 and February, 1992 the Respondent purchased approximately 465,000 units (tablets) of controlled substances, including but not limited to phentermine hydrochloride, phendimetrazine tartrate, and diethylpropion hydrochloride. These controlled substances are indicated for use as appetite suppressants in the treatment of obesity. The Respondent dispensed the medications to

Patients B through J and others at offices located at 952 Second Avenue, New York, New York and 250 East 34th Street, New York, New York. (The identity of Patients B through J are set forth in the attached appendix.)

1. The Respondent grossly negligently failed to maintain an inventory of the controlled substances he purchased and dispensed to patients as required by Public Health Law Sections 3322(1) and (2) (McKinney 1985) and Department of Health regulations 10 NYCRR Sections 80.111 and 80.112 (1975).

B. According to Respondent's records, on or about and between June 1992 September 1993 the Respondent dispensed appetite suppressant medications to Patient B, including but not limited to phentermine hydrochloride. Patient B was 45 years old at the initial recorded visit. She was 5 feet 3 inches and weighed approximately 130 pounds throughout the period that she received appetite suppressant medication from Respondent.

Throughout this period regarding Patient B, Respondent:

1. Failed to ~~take~~ adequate histories.

2. Failed to perform adequate physical examinations.

3. Failed to order appropriate laboratory studies.

4. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

5. Inappropriately prescribed and/or dispensed appetite suppressant medications, including phentermine hydrochloride.

6. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

C. On or about and between February 7, 1990 and May 8, 1993, the Respondent treated Patient C. Patient C was 31 years old, male, 5 feet 7 1/2 inches and weighed 163 pounds in 1990. He reported that he had experience with narcotics. Respondent treated him with appetite suppressant medications, including phentermine hydrochloride and phendimetrazine tartrate.

Throughout this period regarding Patient C, Respondent:

1. Failed to take adequate histories.

2. Inadequately investigated Patient C's experience with narcotics prior to prescribing a medication which is contraindicated for patients with a history of drug abuse.

3. Failed to perform adequate physical examinations.

4. Failed to ~~order~~ appropriate laboratory studies.

5. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

6. Inappropriately prescribed and/or dispensed appetite suppressant medications, including phentermine hydrochloride and phendimetrazaine tartrate.

7. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

D. On or about and between ~~March 13, 1990~~ July 25, 1991 and ~~May 29, 1993~~ May 9, 1992, the Respondent treated Patient D with appetite suppressant medications, including phentermine hydrochloride and

phendimetrazine tartrate. Patient D, a female, was 27 years old, 5 feet 8 inches, and weighed 147 pounds at the onset of treatment. She reported that she had experience with narcotics.

Throughout this period regarding Patient D, Respondent:

1. Failed to take adequate histories.

2. Inadequately investigated Patient D's experience with narcotics prior to prescribing a medication which is contraindicated for patients with a history of drug abuse.

3. Failed to perform adequate physical examinations.

4. Failed to order appropriate laboratory studies.

5. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

6. Inappropriately prescribed and/or dispensed appetite suppressant medications, including

phentermine hydrochloride and phendimetrazine tartrate.

7. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

E. On or about and between January 3, 1990 and October 15, 1991, the Respondent treated Patient E, a 34 year old female with phentermine hydrochloride, hydrochlorothiazide, 50 mg., and fiber tablets. Hydrochlorothiazide is a diuretic. Patient E was 5 feet 4 inches and weighed 133 pounds at the initial visit. She reported that she had experience with narcotics.

Throughout this period regarding Patient E, Respondent:

1. Failed to take adequate histories.

2. Inadequately investigated Patient E's experience with narcotics prior to prescribing a medication which is contraindicated for patients with a history of drug abuse.

3. Failed to order appropriate laboratory studies.

4. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

5. Inappropriately prescribed and/or dispensed phentermine hydrochloride.

6. Inappropriately prescribed and/or dispensed hydrochlorothiazide.

7. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

F. On or about April 9, 1993, the Respondent treated Patient F, a 24 year old female. Patient F was 134 pounds. Respondent's records did not indicate Patient F's height. Patient F reported that she had experience with narcotics, smoked cigarettes, drank a glass of hard liquor a day, was tense and anxious, and had important problems in both her work and personal life. Respondent prescribed phentermine hydrochloride.

Throughout this period regarding Patient F, Respondent:

1. Failed to take adequate histories.

2. Inadequately investigated Patient F's experience with narcotics prior to prescribing a medication which is contraindicated for patients with a history of drug abuse.

3. Failed to perform adequate physical examinations.

4. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

5. Inappropriately prescribed and/or dispensed phentermine hydrochloride.

6. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

G. **Respondent** treated Patient G on August 1, 27, and September 2, 1991. Patient G, a 32 year old female, was five feet four inches and weighed 155 pounds. She reported that she had experience with narcotics. At the initial visit, Respondent dispensed phentermine hydrochloride and fiber

tablets. On August 27, 1991, Patient G complained that the medication was not strong enough. Respondent increased the dosage of phentermine hydrochloride to 37.5 mg. On September 2, 1991, Respondent once again complained that the medication was not strong enough.

Throughout this period regarding Patient G, Respondent:

1. Failed to take adequate histories.

2. Inadequately investigated Patient G's experience with narcotics prior to prescribing a medication which is contraindicated for patients with a history of drug abuse.

3. Failed to order appropriate laboratory studies.

4. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

5. Inappropriately prescribed and/or dispensed hydrochlorothiazide.

6. Inappropriately prescribed and/or dispensed phentermine hydrochloride.

7. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

H. On or about and between March 28, 1991, and June 29, 1993, the Respondent treated Patient H, a 42 year old female. Patient H was 5 feet 3 inches tall and weighed 202 pounds at the initial visit. She gave a history of having been treated for high blood pressure with anti-hypertensive medication. The Respondent treated Patient H with phentermine hydrochloride.

Throughout this period regarding Patient H, Respondent:

1. Failed to take adequate histories.

2. Failed to perform adequate physical examinations.

3. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

4. Inappropriately prescribed and/or dispensed hydrochlorothiazide.

5. Inappropriately prescribed and/or dispensed phentermine hydrochloride.

6. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

I. On or about and between April 28, 1990 and January 16, 1993, the Respondent treated Patient I, a female. Patient I was 23 years old, 5 feet 4 inches tall and weighed 147 pounds at the initial visit. Patient I reported that she had severe headaches and had a history of "heart attack, angina, or other heart problems." Respondent treated Patient I with phentermine hydrochloride, hydrochlorothiazide and fiber tablets.

Throughout this period regarding Patient I, Respondent:

1. Failed to take adequate histories.

2. Failed to order appropriate laboratory studies.

3. Inappropriately prescribed and/or dispensed hydrochlorothiazide.

4. Inappropriately prescribed and/or dispensed phentermine hydrochloride.

5. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

6. Failed to adequately evaluate Patient I's cardiac condition before prescribing and/or dispensing phentermine hydrochloride.

7. Failed to discontinue treatment with phentermine hydrochloride in response to Patient I's complaints of chest discomfort on or about and after June 2, 1990.

8. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

J. On or about and between September 6, 1989 and December 12, 1991, the Respondent treated Patient J, a female. Patient J was 200 pounds at the initial visit. Respondent did not record the patient's height. Patient J gave a history of a heart condition from birth, heart surgery, a nervous breakdown, and she complained of nervousness. Respondent treated Patient J with appetite suppressant medication, including but not limited to phentermine hydrochloride.

During the course of treatment Patient J's weight increased from 200 to 235 pounds.

Throughout this period regarding Patient J, Respondent::

1. Failed to take adequate histories.

2. Failed to perform adequate physical examinations.

3. Failed to order appropriate laboratory studies.

4. Inappropriately prescribed a diuretic.

5. Inappropriately prescribed phentermine hydrochloride.

6. Failed to order an appropriate regimen of weight reduction based on caloric restriction and exercise.

7. Failed to adequately evaluate Patient J's cardiac condition before prescribing and/or dispensing phentermine hydrochloride.

8. Failed to maintain a record which accurately reflected the evaluation and treatment of the Patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession 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 that Respondent committed two or more of the following:

1. The facts in Paragraphs B and B1, B2, B3, B4, B5; C and C1, C2, C3, C4, C5, C6; D and D1, D2, D3, D4, D5, D6; E and E1, E2, E3, E4, E5, E6; F and F1, F2, F3, F4, F5; G and G1, G2, G3, G4, G5, G6; H and H1, H , H3, H4, H5; I and I1, I2, I3, I4, I5, I6, I7; and/or J and J1, J2, J3, J4, J5, J6, J7.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE

Respondent is charged with professional misccnduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1994), in that Petitioner charges Respondent committed two or more of the following:

2. The facts in Paragraphs B and B1, B2, B3, B4, B5; C and C1, C2, C3, C4, C5, C6; D and D1, D2, D3, D4, D5, D6; E and E1, E2, E3, E4, E5, E6; F and F1, F2, F3, F4, F5; G and G1, G2, G3, G4, G5, G6; H and H1, H , H3, H4, H5; I and I1, I2, I3, I4, I5, I6, I7; and/or J and J1, J2, J3, J4, J5, J6, J7.

THIRD AND FOURTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence on a particular occasion within the meaning of N.Y.

Educ. Law Section 6530(4) (McKinney Supp. 1994), in that Petitioner charges:

3. The facts in Paragraphs I and I1 through I7.

4. The facts in Paragraphs J and J1 through J7.

FIFTH AND SIXTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence on a particular occasion within the meaning of N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1994) in that Petitioner charges:

5. The facts in Paragraphs I and I1 through I7.

6. The facts in Paragraphs J and J1 through J7.

SEVENTH THROUGH FIFTEENTH SPECIFICATIONS

FAILING TO MAINTAIN AN ADEQUATE RECORD

Respondent is charged with professional misconduct pursuant to N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1994), by reason of failing to maintain a record for each patient which adequately reflects the evaluation and treatment of the patient, in that Petitioner charges:

7. The facts in Paragraphs B and B6.

8. The facts in Paragraphs C and C7.

9. The facts in Paragraphs D and D7.

10. The facts in Paragraphs E and E7.

11. The facts in Paragraphs F and F6.

12. The facts in Paragraphs G and G7.

13. The facts in Paragraphs H and H6.

14. The facts in Paragraphs I and I8.

15. The facts in Paragraphs J and J8.

SIXTEENTH SPECIFICATION

FAILING TO COMPLY WITH A STATE LAW AND REGULATION GOVERNING THE PRACTICE OF MEDICINE

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(16) (McKinney Supp. 1994), by his grossly negligent failure to comply with substantial provisions of New York State Laws and Department of Health Regulations governing the practice of medicine, in that Petitioner charges:

16. The facts in Paragraphs A and A1.

DATED: New York, New York
April 4, 1993

Chris Stern Hyman
Counsel
Bureau of Professional
Medical Conduct