STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

October 13, 1995

RECEIVED
OCT 16 1995
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ann Hroncich Gayle, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

Lee S. Goldsmith, Esq.
Rachelle Harz, Esq.
Goldsmith and Richman, P.C.
747 Third Avenue
New York, New York 10017

David Korman, M.D.
206 Albemarle Road
Brooklyn, New York 11218

RE: In the Matter of David Korman, M.D.

Dear Ms. Gayle, Mr. Goldsmith and Dr. Korman:

Enclosed please find the Determination and Order (No. 95-239) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

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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), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays 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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER

OF

DAVID KORMAN, M.D.

DETERMINATION

AND

ORDER

BPMC-95-239

A Commissioner's Order and Notice of Hearing, dated March 16, 1995, and a Statement of Charges, dated March 15, 1995, were served upon the Respondent, David Korman, M.D., on March 24, 1995. **BENJAMIN WAINFELD, M.D.**, Chairperson, **HILDA RATNER, 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 Section 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. **JEFFREY ARMON, ESQ.**, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Prehearing Conference:	April 6, 1995
Dates of Hearing:	April 7, 1995 May 31, 1995 June 26, 1995 June 27, 1995

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		July 10, 1995 July 27, 1995
Department of Health Appeared by:		Jerry Jasinski, Esq. Acting General Counsel NYS Dept. of Health
	BY:	Ann Hroncich Gayle, Esq. Associate Counsel
Respondent appeared by:		Lee S. Goldsmith, Esq. Rachelle Harz, Esq. Goldsmith and Richman, P.C. 747 Third Avenue New York, New York 10017
Witnesses for Department of Health:		Mark A. Fialk, M.D. Patient D Mitchell Scher, Senior Medical Conduct Investigator
Witnesses for Respondent:		David Korman, M.D. (Respondent) Barry H. Kaplan, M.D.
Hearing Committee's Report on Imminent Danger:		July 27, 1995
Date of Commissioner's Interim Order to Vacate the Summary Suspension:		August 15, 1995
Deliberations Held:		August 23, 1995

AMENDMENTS TO THE STATEMENT OF CHARGES

An Amended Statement of Charges (Ex. 1-A) dated June 23, 1995 was received in evidence on June 26, 1995. Exhibit 1-A included several significant amendments and deletions to the original Statement of Charges (Ex. 1) served upon the Respondent. A copy of Exhibit 1-A is attached to this Determination and Order as Appendix I.

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STATEMENT OF CASE

By an Order dated March 16, 1995, the Commissioner of Health summarily suspended the medical license of the Respondent, David Korman, M.D., upon a finding that his continued practice of medicine would constitute an imminent danger to the health of the people of this State. More specifically, the accompanying Statement of Charges alleged sixteen specifications of professional misconduct, including allegations of practicing the profession of medicine with gross negligence on a particular occasion, with negligence on more than one (1) occasion, with incompetence on more than one (1) occasion, practicing the profession fraudulently, in a manner evidencing moral unfitness and willfully harassing, abusing or intimidating patients. At the conclusion of this proceeding on July 27, 1995, the Hearing Committee determined its recommendation on the issue of imminent danger. The Hearing Committee recommended that the summary suspension of Respondent's license be vacated. By an Order dated August 15, 1995, the Commissioner ordered that the summary suspension be vacated.

FINDINGS OF FACT

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

NOTE: Petitioner's Exhibits are designated by Numbers.

Respondent's Exhibits are designated by Letters.

T.= Transcript

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GENERAL FINDINGS

1. The Respondent was authorized to practice medicine in New York State on or about October 27, 1965 by the issuance of license number 095729 by the New York State Education Department.

2. CMF is a combination of chemotherapy originally developed in the mid-1970's. It is a combination of cytoxan, methotrexate and 5-fluorouricil (5 FU). Respondent testified he used CMF therapy to treat essentially all of his patients. (T. 551, 611)

3. Dr. Kaplan testified that there is little data which indicates a difference in continuing to treat a cancer patient with CMF therapy over the course of a six month versus a two year period. He stated that if it is provided for a shorter period of time, it is administered in a greater dosage, resulting in more side effects. He testified that it is not a required standard of care to administer chemotherapy with high doses for shorter periods of time and that there is no evidence that the outcome of a patient is affected by the dosage level of the chemotherapy administered. Dr. Kaplan expressed the opinion that it is reasonable and within the standard of medical care to give protracted courses of CMF. (T. 613, 617-618, 621-622)

4. Dr. Kaplan testified that chemotherapy is used in a variety of ways to slowdown the progression of cancer, to provide emotional support and/or to actually cause the shrinkage of the disease. (T. 602-603, 648-650)

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FINDINGS RELATED TO PATIENT A

5. Respondent treated Patient A, age 65, for colon cancer from approximately May 1990 to January 1994, at Kingsbrook Jewish Medical Center, Brooklyn, New York and/or at his office, located at 206 Albemarle Road, Brooklyn, New York. (Ex. 3)

6. CEA is a tumor antigen on the cancer cell. In March, 1992, Patient A's CEA was reported as being 170. In May, 1992, the CEA was reported to be 480, in July, 1992, it was recorded as being 464 and in October, 1992, it was reported as being 651. Each of these results were reported as being an abnormal elevation of the patient's CEA. (Ex. 3, pp. 41, 44, 46, 48; T. 36, 41)

7. Dr. Fialk testified that the abnormal elevations of Patient A's CEA should have led the Respondent to conduct an aggressive evaluation of her clinical status. Such an evaluation would have included a CAT scan, a sonogram and possibly a colonoscopy or barium enema. (T. 41-42, 68)

8. Respondent ordered a sonogram for Patient A on or about January 11, 1993, the results of which were reported on or about February 17, 1993. (Ex. 3, p. 78; T. 69)

9. Dr. Kaplan testified that the treatment of Patient A's colon cancer with CMF and adriamycin would be within reasonable medical guidelines, in view of the advanced stage of the disease and the poor prognosis. (T. 643-644)

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FINDINGS RELATED TO PATIENT B

10. Respondent treated Patient B, age 72, for prostate cancer metastatic to the bone from approximately January 1991 to October 1994, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York. (Ex. 4)

11. Laboratory tests of Patient B's blood consistently indicated abnormally low hemoglobin and hematocrit results during the period in which Respondent provided treatment. During the six month period of December 21, 1992 through July 1, 1993, Patient B's hematocrit decreased from a reading of 33 to a reading of 28. Between July 1 and September 23, 1993, Patient B's hematocrit decreased from a reading of 28 to a reading of 21. (Ex. 4, pp. 26-68)

12. Between October 28, 1993 and September 15, 1994, Patient B received blood transfusions on at least four occasions. On or about October 28, 1993, Respondent began prescribing Epogen, a marrow stimulate, as treatment for Patient B's anemia. (Ex. 4, pp. 18-24; T. 705, 709-710)

13. Dr. Kaplan testified that Respondent's treatment of Patient B's prostate cancer with chemotherapy was appropriate and conformed with acceptable standards of medical practice. He further testified that the Respondent appropriately changed therapy while he treated the patient. (T. 638-641)

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FINDINGS RELATED TO PATIENT C

14. Respondent treated Patient C, age 62, for breast cancer from approximately August 1991 to December 1994, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York. (Ex. 5)

15. Respondent noted a four by five millimeter left supraclavicular lymph node in Patient C's medical record in an entry dated November 14, 1991. A biopsy of the lymph node was requested by Respondent and was performed on or about February 19, 1992. (Ex. 5, pp. 3, 38; T. 682)

16. Dr. Fialk testified that it was appropriate for Respondent to monitor a lymph node of the size noted by Respondent in November, 1991 and to wait for it to enlarge before ordering a biopsy. (T. 231-232)

17. Dr. Kaplan testified that Respondent's continued treatment of Patient C with CMF and adriamycin was appropriate in view of the advanced stage of the patient's disease. He stated that the objective of treatment in a patient with such a poor prognosis is to make the patient as comfortable and as free of symptoms from the metastic disease for as long as possible. (T. 637-638)

FINDINGS AS TO PATIENT D

18. Respondent treated Patient D, age 45, for breast cancer from approximately June, 1988 to November 1993, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

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19. Blood chemistry results performed on Patient D during the period of September 7, 1989 through August 2, 1990 indicated that her alkaline phosphate levels were slightly elevated above the upper limit of normal of 125. The levels of her alkaline phosphates were noted to be significantly elevated during the period of August 30, 1990 through March 7, 1991. Ex. 5, pp. 56-74)

20. Respondent ordered an abdominal sonogram, chest X-ray, mammogram and bone scan for the patient on or about June 7, 1989, which were performed on or about June 13, 1989. Respondent ordered a second bone scan for Patient D on or about October 18, 1990, which was performed on October 23, 1990. In February, 1991, Respondent ordered a liver spleen scan for the patient which was performed on or about March 5, 1991. (Ex. 5, pp 9, 18, 20-21, 29-31, 36-37)

21. Dr. Kaplan testified that the appropriate follow-up for a patient with an elevated alkaline phosphate level is to order and perform bone and liver scans. (T. 635-636)

22. Dr. Kaplan testified that Respondent's prolonged treatment of Patient D's breast cancer with CMF was within acceptable standards of care in view of her stage-3 classification and the advanced state of her disease. (T. 634-635)

23. Respondent noted in Patient D's medical record, in entries dated September 7, September 14 and October 5, 1989, that she complained of feeling pressure on her bladder and of cramps and tenderness in the lower right quadrant of her abdomen. (Ex. 5, p. 11)

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24. In an entry dated October 12, 1989, Respondent noted Patient D's complaints of suprapubic pain, urinary frequency and abdominal cramping. He also recorded the fact that she had a history of kidney stones. On that day, Respondent conducted a pelvic examination of the patient. (Ex. 5, p. 11; T. 454-455)

25. Respondent testified that the pelvic examination was bimanual, in that he placed one hand on the abdomen and the other hand in the pelvic area, and that he inserted a finger in Patient D's vagina to determine whether there was a mass in the pelvic area. He noted in the medical record that the examination was within normal limits. (Ex. 5, p. 11; T. 462-463)

FINDINGS AS TO PATIENT E

26. Respondent treated Patient E, age 59, for breast cancer from approximately April 1986 to November 1991, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York. (Ex. 7)

27. In an entry in Patient E's medical chart dated November 14, 1991, Respondent noted that the patient had had performed an excisional biopsy of a nodule in the left upper chest. In an entry dated November 21, 1991, Respondent recorded that the "biopsy of the supraclavicular nodule reveals metastasis." Respondent treated Patient E with CMF therapy on November 21 and November 27, 1991. (Ex. 7, p. 42; T. 664-665)

28. Respondent noted in an entry dated November 27, 1991 that the patient was to go for the performance of a bone scan and breast biopsy. He did not treat Patient E after November 27, 1991. (Ex. 7, p. 42; T. 665)

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29. Dr. Kaplan testified that it was not improper for Respondent to not change the type of therapy provided to Patient E within one week of learning of the positive results of the biopsy of the patient's nodule. (T. 633)

30. Dr. Kaplan testified that Respondent's treatment of Patient E with CMF for more than a five year period did not meet acceptable standards of medical care. He stated that because the patient's breast cancer was a stage 2-B classification, two years would have been the longest acceptable period of time for which the patient should have been treated with CMF. (T. 631-632)

FINDINGS RELATED TO PATIENT F

31. Respondent treated Patient F, age 65, for breast cancer from approximately September 1988 to March 1994, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York. (Ex. 8)

32. Dr. Kaplan testified that the Respondent's prolonged treatment of Patient F's disease with CMF therapy was not a deviation from acceptable standards of care based upon the advanced stage of the patient's cancer. He stated that a prolonged course of chemotherapy administered in an attempt to slow the course of the disease and to keep the patient comfortable for as long as possible was reasonable. (T. 628-630)

FINDINGS RELATED TO PATIENT H

33. Respondent treated Patient H, age 72, for breast cancer from approximately April 1990 to December 1992, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York. (Ex. 10)

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34. Dr. Kaplan testified that Respondent's treatment of Patient H with CMF therapy for approximately a two-year period was not a deviation from accepted standards of practice based on the 2-B classification of the staging of her disease. (T. 614-615)

35. In an entry in the patient's medical record dated June 4, 1992, Respondent noted that she was to have colon surgery in the following week. Respondent treated Patient H with CMF therapy on June 4, 1992. (Ex. 10, p. 14)

36. Respondent treated Patient H with CMF therapy on September 3 and November 13, 1992. Patient H had a left colostomy performed at some point in the period between those two dates. (Ex. 10, p. 14; T. 659)

37. Dr. Kaplan testified that it was not a deviation from accepted standards of care for the Respondent to have continued to treat the patient with low doses of CMF therapy prior to her colon surgery as long as there was no decrease in her blood count. (T. 615)

FINDINGS RELATED TO PATIENT J

38. Respondent treated Patient J, age 67, for pancreatic cancer from approximately August 1991 to December 1991, at Kingsbrook Jewish Medical Center, Brooklyn, New York and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

39. Dr. Kaplan testified that Respondent's treatment of Patient J's pancreatic cancer with CMF therapy met the minimum level of acceptable standards of medical care. He stated that the three agents comprising CMF are each used by some therapists to treat pancreatic cancer and that there is no good standard treatment for pancreatic cancer. (T. 602-603)

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40. Patient J also had a history of prostate cancer. On or about October 7, 1991, Respondent wrote a consultation letter to the urologist of Patient J, who had requested information about Patient J's status. In the letter, the Respondent indicated that the patient had surgery performed in July, 1991 and had "received a course of cancer chemotherapy postoperatively consisting of 5 FU, adriamycin and mitomycin," and that "presently is on maintenance chemotherapy with 5 FU and leucovoran once weekly." (Ex. 12, p. 9; T. 537)

41. In an entry in Patient J's medical record dated August 29, 1991, Respondent recorded that mitomycin and 5 FU were administered on two occasions; August 22 and August 29, 1991. In an entry in Patient J's medical record dated September 26, 1991, Respondent recorded that the patient had received four doses of leucovoran and 5 FU. In an entry in the record dated October 31, 1991, Respondent recorded "mitomycin, 5 FU, fifty times five". Respondent testified that this indicated a weekly dose of mitomycin and 5 FU were administered to Patient J. (Ex. 12, pp. 1-2; T. 533-536)

42. Dr. Kaplan testified that a urologist provides support for a patient's urinary tract symptoms and does not need to be provided with a detailed letter setting forth all chemotherapies administered to a patient. He further stated that low doses of chemotherapy would not impact on a patient's postoperative recovery. (T. 603-604, 608-609)

CONCLUSIONS OF LAW

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

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The Hearing Committee concluded that the following Factual Allegations set forth in the Department's Notice of Hearing and Statement of Charges (Ex. 1-A) should be **SUSTAINED**. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A.1.: (5-8)

Paragraph E.2.: (26, 30).

The Hearing Committee concluded that the following Factual Allegations should **NOT BE SUSTAINED:**

Paragraphs A.2., A.3. and A.4.;

Paragraphs B.1., B.2. and B.3.;

Paragraphs C.1. and C.2.;

Paragraphs D.1., D.2. and D.3.;

Paragraph E.1.;

Paragraph F.1.;

Paragraphs H.1. and H.2.;

Paragraphs J.1. and J.2.

The Hearing Committee concluded that the following Specifications of Charges should be **SUSTAINED** based upon the Factual Allegations which were sustained:

First Specification, as it relates to Paragraphs A.1. and E.2. only;

Eleventh Specification, as it relates to Paragraphs A.1. and E.2. only.

The Hearing Committee concluded that all other Specifications of Charges should **NOT BE SUSTAINED.**

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DISCUSSION

Respondent was charged with multiple specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. The document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence and incompetence.

The following definitions were utilized by the Hearing Committee during its deliberations:

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

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact.

Using the above definitions as a framework for its deliberations, the Hearing Committee determined that the Department had failed to establish, by a preponderance of the evidence, all Factual Allegations except those alleged in paragraphs A.1. and E.2. as set out in the Statement of Charges. The Committee further determined to not sustain all Specification of Charges, except the First and the Eleventh as related to Paragraphs A.1. and E.2. only.

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The Hearing Committee recognized that it was essential to establish what was the appropriate standard of medical care for each of the cases at issue. It was therefore necessary to closely evaluate the credentials and testimony of the two expert witnesses to determine the appropriate weight to be accorded to each.

The Committee noted that Dr. Fialk testified that since he completed his residency, his practice has consisted of approximately forty percent oncology with the balance of his time devoted to internal medicine. (T. 146-7) A review of his curriculum vitae indicates no current or recent research or teaching in the field of oncology. (Ex. 13) His responses on both direct and cross-examination were considered to be argumentative and often lacking in details. Dr. Fialk had difficulty in clearly articulating the dangers presented by Respondent's continuation of CMF therapy for prolonged periods. He criticized the prolonged administration of the therapy, yet failed to clearly state that the continuation of the therapy constituted a deviation from the accepted standards of practice. While he advocated a change in therapy upon the recurrence of the disease, he frequently could not specify what new therapy should have been administered. On several instances, he disagreed with the Department's Factual Allegations concerning Respondent's use of inappropriate chemotherapies. This led to significant amendments to the Department's original Statement of Charges. Several of Dr. Fialk's disagreements with Respondent's treatments were based on his misreading or inability to read the medical records of certain patients, including Patients C, D and J. The Hearing Committee accorded Dr. Fialk's testimony little weight for all of these reasons and believed that most of the charges of misconduct were not supported by his overall testimony .

In contrast, the Hearing Committee believed Dr. Kaplan to be well-qualified and extremely knowledgeable about the practice of oncology. His testimony was considered to be authoritative and based on solid reasoning. He was also viewed as being objective by expressing honest criticisms of Respondent's treatments of Patients A and E. The Hearing Committee found Dr. Kaplan's testimony to be persuasive as it related to the administration of chemotherapy for prolonged periods. His testimony that he currently was treating patients with CMF for up to five years was noted. (T. 613) The Committee also gave consideration to his testimony that the continued

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administration of chemotherapy in low doses has a positive psychological effect on a patient. (T. 648-50) The Hearing Committee accorded the testimony of Dr. Kaplan great weight in reaching its' determination.

CONCLUSION

The Factual Allegations of the Amended Statement of Charges (Ex. 1-A) may be grouped for discussion in the following manner:

1. Failure to follow up on abnormalities in lab data (A.1., B.1., C.1., D.1.);
2. Inappropriate chemotherapy administrations (A.2., B.2 , H.2., J.1.);
3. Failure to change therapies (A.3., B.3., C.2., E.1.);
4. Excessive duration of chemotherapies (A.4., D.2., E.2., F.1., H.1.);
5. Fraud (D.3., J.2.).

FAILURE TO FOLLOW UP ON ABNORMALITIES IN LABORATORY DATA

The Hearing Committee concluded that Respondent failed to follow up in a timely manner to determine the cause of Patient A's elevated CEA. The CEA was considerably elevated beyond normal limits by March, 1992 , yet Respondent failed to order a sonogram until January, 1993. The Committee agreed with Dr. Fialk's statement that the elevated CEA justified an aggressive evaluation of the patient's status and considered an appropriate response to include the immediate ordering of additional tests, which would have included a sonogram. The Committee determined the delay of almost three months following a CEA result of 651 in October, 1992 to be inappropriate. Factual Allegation A.1. was sustained.

The Respondent's treatment of Patient B's low hemoglobin and hematocrit with blood

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transfusions and Epogen was considered to be appropriate and to represent a follow up to that patients' abnormal laboratory result. Dr. Fialk's criticism of Respondent's treatment of Patient C was based on his misreading the November 14, 1991 entry in the patient's chart concerning the size of a lymph node. He testified that it was appropriate for the Respondent to monitor a node of four by five millimeters and to wait for it to enlarge before ordering a biopsy. Dr. Fialk admitted he also erred in alleging that Respondent failed to act after receiving results of Patient D's elevated alkaline phosphate levels. (T. 285) Respondent ordered two bone scans and a liver spleen scan in response to abnormalities in Patient D's laboratory data. In June, 1989, he also ordered an abdominal sonogram, mammogram and chest X-ray for the patient. The Committee did not sustain Factual Allegations B.1., C.1. and D.1.

ADMINISTRATION OF INAPPROPRIATE CHEMOTHERAPIES

The Hearing Committee was not persuaded by the testimony of Dr. Fialk that inappropriate chemotherapies were administered by Respondent in his treatment of Patients A, B, H and J. The Committee relied on Dr. Kaplan's's testimony that chemotherapy is administered to slow the progress of disease, to cause actual shrinkage of the cancer tumor and/or for emotional support to conclude that the administration of CMF to the four terminally ill patients was not inappropriate. Factual Allegations A.2., B.2., H.2. and J.1. were not sustained.

Both experts agreed that Patient A's colon cancer was in an advanced stage with a high expectation of recurrence and that the patient had a limited likelihood of survival. Dr. Fialk and Dr. Kaplan each testified that effective therapies for colon cancer are limited. (T. 42, 644) The Hearing Committee agreed with Dr. Kaplan's statement that, based on the patient's poor prognosis, the administration of CMF was appropriate.

Patient B had known metastatic prostate cancer to the bone. Dr. Fialk testified that the therapies administered to Patient B by the Respondent, which included CMF, leucovorin, mitomycin and megace, were not appropriate in that they are not effective in the treatment of prostate cancer.

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The Committee considered testimony by Dr. Kaplan to be more persuasive, in that he stated that all therapies tested against prostate cancer have been shown to have the same limited response rate and that almost no therapies work after the disease progresses. Dr. Kaplan testified that the use of CMF in treating prostate cancer will not harm a patient and could provide positive benefits, including emotional support. (T. 639)

Dr. Fialk testified that it was inappropriate for the Respondent to administer CMF chemotherapy to Patient H on June 4 and September 3, 1992 because the patient had scheduled surgeries pending. He considered the administration of chemotherapy shortly prior to surgery to be inappropriate because it could lessen the patient's ability to heal and fight a possible infection. (T. 338-9) However, he admitted that the doses of chemotherapy were at a low enough level to reduce any likelihood of complications. (T. 344) Respondent testified that he regularly measured the patient's blood count to monitor the effect of the chemotherapy on Patient H. (T. 655) Dr. Kaplan testified that it was not a deviation from accepted standards of care for the Respondent to administer chemotherapy prior to Patient H's scheduled surgeries as long as the blood counts were maintained.

Patient J suffered from an advanced stage of cancer of the pancreas. Dr. Fialk testified that CMF is not effective in treating pancreatic cancer. The Hearing Committee again found Dr. Kapl;an's testimony persuasive that CMF could be helpful as emotional support and that the treatment of pancreatic cancer with CMF was not a deviation from accepted standards of care.

FAILURE TO CHANGE THERAPIES

Dr. Fialk testified that as a general oncologic principle, if the disease recurs while a patient is being treated with a specific regimen of therapy, use of that regimen should cease and a new manner of therapy instituted. (T. 31) However, he was often vague as to what new modes of therapy were to be tried and could only state in several of the cases that CMF should have been discontinued once the disease recurred. The Hearing Committee relied on the testimony of Dr. Kaplan that there

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are not different treatments for patients that fail the first treatment. He stated that because of the limited number of effective alternatives, the first treatment should be continued until it is clear that it is not effective. (T. 618-9) The Committee considered the fact that Patients A, B and C were in advanced stages of cancer and that alternative therapies were limited. There was no evidence in the record that CMF was detrimental to the patients and the continuation of chemotherapy was considered to provide some palliative and emotional benefits. Factual Allegations A.3., B.3. and C.2. were not sustained for these reasons. Factual Allegation E.1. was considered to be without basis and the Committee felt that Dr. Fialk was unreasonable in testifying that Respondent improperly provided CMF therapy to Patient E for two visits within a two week period after the Respondent learned of a positive result of a biopsy. The record is clear that Respondent did not treat the patient after those two visits and he testified that another oncologist and surgeon assumed her care thereafter. (T. 665) The Committee did not sustain Factual Allegation E.1.

EXCESSIVE DURATION OF CHEMOTHERAPIES

The two experts disagreed in their testimony about the accepted standards of practice for the prolonged administration of chemotherapy as an adjuvant, or preventative, therapy. Dr. Fialk testified that the accepted standard of treatment had been shortened during the 1980's from about a two year period to about a six month period. (T. 277-8) He stated that studies had shown that chemotherapy administered in an adjuvant setting was no more effective in terms of the rate of patient survival when administered for a two year period than when administered for six months. (T. 29-30) Dr. Kaplan agreed that there was little difference in providing chemotherapy for a two year versus a six month period. (T. 617) However, he clearly stated that he believed it reasonable and within the standard of care to give protracted courses of chemotherapy for many years to slow the progression of disease or to provide emotional support.

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The Hearing Committee concluded that there is not a definitive standard for an acceptable period of time to administer chemotherapy. Dr. Fialk seemed to indicate that, based on a reasonable explanation, adjuvant chemotherapy administered for more than a two year period could be appropriate. (T. 310) The patients treated by the Respondent were essentially terminally ill with cancers of the breast, prostrate or colon and it is clear that treatment therapies were limited. Based on the expert testimony, the Hearing Committee felt that the practice of oncology is experimental to a large degree and that practice standards are not as defined as in other medical specialities. Dr. Fialk testified in general terms as to the potential side effects and cumulative toxicity of chemotherapy. However, he could point to no specific harm that any patient incurred as a result of the prolonged therapy and stated that his primary objection was that extended chemotherapy was no more effective than chemotherapy administered for a shorter period. The Committee agreed with Dr. Kaplan that chemotherapy administered in low doses to terminally ill patients as a form of a placebo can provide positive psychological and emotional benefits. Dr. Kaplan testified that there are many ways to administer chemotherapy, each of which may meet accepted standards of treatment. (T. 621) The Committee concluded that it was not proven by a preponderance of the evidence that the Respondent had deviated from the accepted standards of medical practice by providing chemotherapy over an extended period to Patients A, D, F and H. Factual Allegations A.4., D.2., F.1. and H.1. were not sustained.

Dr. Kaplan testified that Patient E's breast cancer would have been considered to have been a stage 2-B when she was initially treated by the Respondent in 1986. He expressed his opinion that the administration of CMF therapy to the patient for approximately a five year period was not within acceptable standards of care and that such therapy would have been acceptable for a maximum of two years. Because Patient E's disease was not as advanced as a stage 3, the Committee agreed and determined to sustain Factual Allegation E.2.

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FRAUD

It was not disputed that Patient D had complaints of abdominal pain, urinary frequency and urinary tract infections in September and October, 1989. (T. 407, 454) There is no evidence in the record to suggest that Respondent's determination to conduct a pelvic examination to investigate the source of those complaints was not appropriate. Patient D's allegation of Respondent's misconduct related to the manner in which the pelvic examination was conducted and not to whether it was appropriate to conduct such an examination. There was no medical evidence presented to suggest that a pelvic examination could not appropriately include the insertion of a physician's finger in a patient's vagina. Respondent testified that the purpose of such action would be to feel if there was a mass in the pelvic area. Factual Allegation D.3. contends that Respondent inappropriately touched Patient D by intentionally inserting his fingers in her vagina and moving his fingers around and his hand in and out. There is nothing in the record to suggest such actions could not be a part of the determination of the presence of a pelvic mass. The Hearing Committee believed that Patients D's complaint was actually that the vaginal examination lasted for a longer period of time than was medically necessary and that she perceived the extended examination was for Respondent's sexual gratification. While the Committee considered that the Department's charge did not address the patient's complaint and believed that that alone was sufficient to not sustain the Factual Allegation, it also concluded that Patient D's testimony was not credible. Respondent's medical records verify that the pelvic examination was conducted on or about October 12, 1989, at least one year earlier than alleged in the Department's Statement of Charges. (Ex. 6, p.11) The patient testified that she had no recollection of an abdominal sonogram ordered by the Respondent and performed on Patient D four months before the alleged improper pelvic examination. (T. 430-1) She stated that she continued her treatment with the Respondent for several years after October, 1989 and may have made approximately 122 visits with him after that date. (T. 425) She also testified that her husband would sometimes accompany her to Respondent's office, that he was in Respondent's waiting room during the October, 1989 examination and that she did not ask her husband to accompany her in the

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examination room during visits subsequent to October 12, 1989. (T. 412, 425-6) The Committee felt that Patient D sincerely believed that Respondent conducted an improper pelvic examination on that date, but concluded that she misperceived his actions. Factual Allegation D.3. was not sustained.

The Committee relied upon the definition above of the fraudulent practice of medicine to conclude that Respondent had no intent to misrepresent or conceal the treatment he had been providing Patient J in his consultation letter to the patient's urologist. It was bothered by the inability of the Department's expert witness to read entries in the patient's record as to therapies administered which otherwise appeared to be legible. It was further noted that the period of time that Respondent's treatment was at issue was for only about a six week period from August 22 to October 7, 1991. Respondent's explanation of his notes confirms that his weekly treatment of Patient J during that period included CMF and either 5 FU and leucovorin or 5 FU and mitomycin. (T. 533-6) Dr. Fialk testified that the treatment of pancreatic cancer with either 5 FU, adriamycin and mitomycin or 5 FU and leucovoran would be reasonable. (T. 367) The Department also alleged that Respondent misrepresented in the consultation letter that the patient had been treated with mitomycin while hospitalized following his July, 1991 surgery in that there was no evidence in Patient J's hospital record (Ex. 12A) that he had actually received such therapy. Respondent credibly testified that, while hospitalized, Patient J developed sepsis, an infection which was treated with antibiotics. He stated that mitomycin was contraindicated in the face of treatments for a blood infection. (T. 530-2) The record indicates that mitomycin was administered to the patient on or about August 22, 1991, shortly after his hospital discharge. The Committee concluded that allegations that Respondent intended to misrepresent Patient J's course of treatment were without any basis in fact. It also relied upon Dr. Kaplan's testimony that it would not be necessary to advise a urologist of all chemotherapies administered to a patient, particularly when those therapies were being administered in low dosages. Factual Allegation J.2. was not sustained.

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NEGLIGENCE AND INCOMPETENCE ON MORE THAN ONE OCCASION

The Hearing Committee sustained Factual Allegations A.1. and E.2. as having been proven by a preponderance of the evidence and determined that Respondent's actions as related to those Allegations constituted the practice of the professional with negligence and with incompetence on more than one occasion. It was concluded that neither Allegation rose to the level which would constitute the practice of medicine with gross negligence.

The Committee believed that the continued elevation of Patient A's CEA levels from March, 1992 necessitated some action by the Respondent to investigate the patient's condition. The October, 1992 result of a CEA level of 651 should have caused Respondent to immediately order appropriate diagnostic tests. The Committee considered Respondent's delay until January, 1993 in ordering a sonogram for Patient A to be unacceptable and below the reasonable standard of medical care. It also concluded that the failure to promptly investigate the patient's status represented a lack of skill or knowledge necessary to practice the profession.

The excessively prolonged treatment of Patient E with CMF therapy was mainly the result of Respondent's incorrect evaluation of the staging of the patient's breast cancer. Dr. Kaplan testified that the patient was accurately classified as a stage 2-B. He had testified that stage-3 and stage-4 breast cancers are generally considered terminal illnesses. (T. 612) Prolonged treatment with CMF for a five year period was not within acceptable standards of practice with such a staging. The Committee believed it necessary for an oncologist to accurately establish the stage of a cancer tumor and concluded that the failure to do so, thereby resulting in an inappropriate period of therapy, constituted negligence and incompetence in the practice of medicine.

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DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be suspended for a two year period, said suspension to be stayed, and that Respondent be placed on probation for said two year period. The Committee further determined that Respondent shall complete one year of medical practice in a supervised setting followed by one year of medical practice monitored by an approved physician monitor during the two year period of probation, in accordance with the conditions set forth in Appendix II of this Determination and Order. This determination was reached upon due consideration for the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

While the Committee sustained only two of the Factual Allegations in the Department's Statement of Charges, it was troubled by some of Respondent's practices in general as he testified to at this proceeding. In addition, Dr. Kaplan indicated that he had some reservations as to treatments administered to some of Respondent's patients. In his discussion of Patients A and J, Dr. Kaplan appeared to hint that CMF therapy, while continuing to be acceptable, has become outmoded as a treatment for certain forms of cancer. (T. 602-3; 643-4) The Committee was concerned by Respondent's testimony that he administered CMF therapy in low doses regardless of the type or stage of cancer and regardless of what other therapy was being provided. (T. 551-2, 663) It noted his testimony that he never took a formal fellowship in oncology and never took a course or educational program in oncology outside of any residency or fellowship. (T. 516, 568) The Hearing Committee concluded that Respondent would benefit from a practice in a supervised setting for an extended period to enable him to refresh his knowledge and update his skills. The Committee also had concerns about the manner by which Respondent administered chemotherapy to his patients. He testified that up to four patients would receive treatment intravenously at the same time for a period of about one hour and that he was the only person available who would remain "in the

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vicinity" to monitor them for possible adverse reactions. (T. 506-7) It was felt that this was a potentially harmful practice that also could be remedied through practice supervision and monitoring. Therefore, it was determined that the most appropriate penalty to protect the public would be to place Respondent's license on probation and to require that he continue his medical practice in a supervised setting and, subsequently, with a practice monitor.

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ORDER

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

1. The First and Eleventh Specification of Charges as set forth in the Amended Statement of Charges (Ex. 1-A) and, as they relate to Paragraphs A.1. and E.2. only, are **SUSTAINED;** and

2. All other Specification of Charges set forth in the Amended Statement of Charges (Ex. 1-A) are **NOT SUSTAINED** and are hereby **DISMISSED**; and

3. The license of Respondent to practice medicine in New York State be hereby **SUSPENDED** for a period of two years, said suspension to be **STAYED**; and

4. Respondent shall be placed on **PROBATION** during the period of the stayed suspension of his license, and he shall comply with all terms of probation as set forth in Appendix II, attached hereto and made a part of this Determination and Order.

DATED: Albany, New York

October 12, **1995**

BENJAMIN WAINFELD, M.D. (Chair)

HILDA RATNER, M.D.
ANTHONY SANTIAGO

NEW YORK STATE DEPARTMENT OF HEALTH 19

TO: Ann Hroncich Gayle, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

Lee S. Goldsmith, Esq.
Rachelle Harz, Esq.
Goldsmith and Richman, P.C.
747 Third Avenue
New York, New York 10017

David Korman, M.D.
206 Albemarle Road
Brooklyn, New York 11218

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APPENDIX I

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

IN THE MATTER

OF

DAVID KORMAN, M.D.

AMENDED STATEMENT OF CHARGES

DAVID KORMAN, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 27, 1965, by the issuance of license number 095729 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, age 65, for colon cancer from approximately May 1990 to February 1994, located at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York. (The identities of Patient A and the other patients are disclosed in the attached Appendix.)

1. Respondent failed to follow up on abnormalities in laboratory data obtained for this patient with regard to providing treatment and/or conducting additional diagnostic testing.

2. Respondent administered inappropriate chemotherapy such as cytoxan, methotrexate, 5 FU (CMF), ~~mitomycin~~, ~~leucovoran~~ and adriamycin to this patient given this patient's disease.

4/7/95

3. Despite progression in this patient's disease, Respondent failed to change the type of therapy, i.e., chemotherapy such as cytoxan, methotrexate, 5 FU (CMF), mitomycin, leucovoran, and adriamycin which this patient was receiving.

Petitioner's Ex 1-A
FN Evid.
6-28-95 JS

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4. Respondent provided adjuvant chemotherapy such as cytoxan, methotrexate, 5 FU (CMF), mitomycin, leucovoran, and adriamycin for too long a period of time for this patient given this patient's disease.

B. Respondent treated Patient B, age 72, for prostate cancer metastatic to the bone from approximately January 1991 to October 1994, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

1. Respondent failed to follow up on abnormalities in laboratory data obtained for this patient with regard to providing treatment and/or conducting additional diagnostic testing.

2. Respondent administered inappropriate chemotherapy such as cytoxan, methotrexate, 5 FU (CMF), mitomycin, leucovoran, and megace to this patient given this patient's disease.

3. Despite progression in this patient's disease, Respondent failed to change the type of therapy, i.e. [therapy such as diethylstilbestrol, and] chemotherapy such as cytoxan, methotrexate, 5 FU (CMF), mitomycin, leucovoran, and megace which this patient was receiving.

6/26 ja

[4. The diethylstilbestrol was given to this patient in an inappropriate manner.]

6/26 ja

C. Respondent treated Patient C, age 62, for breast cancer from approximately August 1991 to December 1994, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

1. Respondent failed to follow up on abnormalities in laboratory data obtained for this patient with regard to providing treatment and/or conducting additional diagnostic testing.

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2. Despite progression in this patient's disease, Respondent failed to change the type of therapy, i.e., cytoxan, methotrexate, 5 FU (CMF), and adriamycin, [nolvadex, and vincristine] which this patient was receiving.

6/26 ja

D. Respondent treated Patient D, age 45, for breast cancer from approximately June 1988 to November 1993, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

1. Respondent failed to follow up on abnormalities in laboratory data obtained for this patient with regard to providing treatment and/or conducting additional diagnostic testing.

2. Respondent provided adjuvant chemotherapy such as cytoxan, methotrexate, and 5 FU (CMF) for too long a period of time for this patient given this patient's disease.

3. In the course of a purported physical examination, but not for a proper medical purpose, Respondent touched Patient D inappropriately as follows:

In or about late 1990, Respondent intentionally inserted his fingers in Patient D's vagina, and moved his fingers around and his hand in and out.

E. Respondent treated Patient E, age 59, for breast cancer from approximately April 1986 to November 1991, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

1. Despite progression in this patient's disease, Respondent failed to change the type of therapy, i.e., cytoxan, methotrexate, and 5 FU (CMF), which this patient was receiving.

2. Respondent provided adjuvant chemotherapy such as cytoxan,

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methotrexate, and 5 FU (CMF) for too long a period of time for this patient given this patient's disease.

F. Respondent treated Patient F, age 65, for breast cancer from approximately September 1988 to March 1994, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

1. Respondent provided adjuvant chemotherapy such as cytoxan, methotrexate, 5 FU (CMF), and nolvadex for too long a period of time for this patient given this patient's disease.

G. Respondent treated Patient G, age 63, for breast cancer metastatic to the bone from approximately March 1987 to December 1990, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

ja deleted 6/26

1. Despite progression in this patient's disease with metastasis to the bone, and a malignant pleural infusion, Respondent failed to change the type of therapy, i.e., cytoxan, methotrexate, and 5 FU (CMF) which this patient was receiving.

H. Respondent treated Patient H, age 72, for breast cancer from approximately April 1990 to January 1993, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

1. Respondent provided adjuvant chemotherapy such as cytoxan, methotrexate, and 5 FU (CMF), [and therapy such as radiation] for too long a period of time for this patient given this patient's disease.

6/26 ja

2. Respondent inappropriately treated this patient with cytoxan, methotrexate, and 5 FU (CMF) prior to her colon surgery and proposed

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bowel surgery.

I. Respondent treated Patient I, age 44, for breast cancer from approximately November 1992 to May 1993, at Kingsbrook Jewish Medical Center, Brooklyn, New York.

deleted 6/26/95

1. In the course of a purported physical examination, but not for a proper medical purpose, Respondent touched Patient I inappropriately as follows:

   On three occasions in early 1993, Respondent, while purportedly examining Patient I's breast, intentionally pressed his body against the patient.

J. Respondent treated Patient J, age 67, for pancreatic cancer from approximately August 1991 to December 1991, at Kingsbrook Jewish Medical Center, Brooklyn, New York, and/or at his office, located at 206 Albemarle Road, Brooklyn, New York.

1. Respondent administered inappropriate chemotherapy such as cytoxan, methotrexate, and 5 FU (CMF) to this patient given this patient's disease.
2. On or about October 7, 1991, Respondent knowingly and intentionally falsely represented to another physician, involved in Patient J's care and/or treatment, the nature of Respondent's treatment of Patient J.

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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)(McKinney Supp. 1995) 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, 2, 3, and/or 4, B and B1, 2, 3 and/or 4, C and C1 and/or 2, D and D1, and/or 2, E and E1, and/or 2, F and F1, G and G1, H and H1and/or 2, J and J1 and/or 2.

SECOND THROUGH TENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1995) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

2. Paragraphs A and A1, 2, 3, and/or 4.
3. Paragraphs B and B1, 2, 3,and/or 4.
4. Paragraphs C and C1, and/or 2.
5. Paragraphs D and D1, and/or 2.
6. Paragraphs E and E1, and/or 2.

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7. Paragraphs F and F1.

8. Paragraphs G and G1.

9. Paragraphs H and H1 and/or 2.

10. Paragraphs J and J1 and/or 2.

ELEVENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1995) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

11. Paragraphs A and A1, 2, 3, and/or 4, B and B1, 2, 3, and/or 4, C and C1, and/or 2, D and D1, and/or 2, E and E1, and/or 2, F and F1, G and G1, H and H1 and/or 2, J and J1 and/or 2.

TWELFTH AND THIRTEENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1995) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

12. Paragraphs D and D3.

13. Paragraphs I and I1.

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FOURTEENTH AND FIFTEENTH SPECIFICATIONS

WILLFULLY HARASSING and ABUSING OR INTIMIDATING PATIENTS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(31)(McKinney Supp. 1995) by willfully harassing and abusing or intimidating patients either physically or verbally, as alleged in the facts of:

14. Paragraphs D and D3.

15. Paragraphs I and I1.

SIXTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1995) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

16. Paragraphs D and D3.

17. Paragraphs I and I1.

18. Paragraphs J and J2

DATED: June 23, 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

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APPENDIX II
TERMS AND CONDITIONS OF PROBATION

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

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

3. Respondent shall submit prompt written notification to the Board, addressed to the Director, Office of Professional Medical Conduct ("OPMC"), Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, addresses, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

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

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

7. Respondent's probation shall be supervised by the Office of Professional Medical Conduct.

8. During the first year of Respondent's probation, the Respondent shall work only in a supervised setting, which may include but not be limited to an institution licensed pursuant to Article 28 of the Public Health Law, and will advise the Office of Professional Medical Conduct of all such

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settings over the period of probation. Respondent may not practice medicine until the supervised setting is approved. Any practice of medicine prior to the submission and approval of a proposed practice setting will be determined to be a violation of probation. A supervised setting shall be a setting where an approved supervisor or administrator, board certified in oncology, is always on premises when Respondent is on premises.

a. The Respondent shall identify an appropriate supervisor or administrator in all settings, to be approved by the Office of Professional Medical Conduct, for submittal of reports regarding the Respondent's overall quality of medical practice.

b. The Respondent will provide the supervisor/administrator in all settings with this Order and terms of probation and authorize the supervisor/administrator in writing to comply with the Office of Professional Medical Conduct schedules and requests for information. Said Office shall determine the schedule for the submittal of all reports.

9. During the second year of Respondent's probation, Respondent's practice of medicine shall be monitored by a physician monitor ("practice monitor"), board-certified in oncology, who shall be approved in advance in writing by the Director of the Office of Professional Medical Conduct. Respondent may not practice medicine until an approved practice monitor and monitoring program is in place. Any practice of medicine prior to the submission and approval of the proposed practice monitor will be determined to be a violation of probation.

a. The practice monitor shall report in writing to the Director of the Office of Professional Medical Conduct or designee thereof, on a schedule to be determined by the Office. The practice monitor shall visit Respondent's medical practice at each and every location in New York State on a random basis and shall examine a random selection of records maintained by Respondent, including patient histories, treatment records and prescribing information. Respondent will make available to the practice monitor any and all records or access to the practice requested by the monitor, including on-site observation. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall immediately be reported to the Office of Professional Medical Conduct by the monitor.

b. Any change in practice monitors must be approved in writing, in advance, by the Office of Professional Medical Conduct.

c. It shall be the responsibility of the Respondent to ensure that the reports of the practice monitor are submitted in a timely manner. A failure of the practice monitor to submit required reports on a timely basis will be considered a possible violation of the terms of probation.

10. Respondent will maintain legible and complete medical records which accurately reflect evaluation and treatment of patients. Where

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appropriate, records will contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment.

11. 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.

12. All expenses, including but not limited to those of complying with these terms of probation and the Determination and Order, shall be the sole responsibility of the Respondent.

13. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Respondent pursuant to New York Public Health Law §340(19) or any other applicable laws.

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New York State Board for Professional Medical Conduct
Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

Charles J. Vacanti, M.D.
Chair

January 8, 1996

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

David C. Saunders, M.D.
Skyline Apartments - Suite 5
753 James Street
Syracuse, NY 13203

Re: License No. 092806

Effective Date: 01/15/96

Dear Dr. Saunders:

Enclosed please find Order #BPMC 96-3 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

Sincerely,

Charles J. Vacanti, M.D.
Chair
Board for Professional Medical Conduct

Enclosure
cc: Peter J. Cambs, Esq.
Smith, Sovick, Kendrick & Sugnet, P.C.
250 South Clinton Street, Suite 600
Syracuse, NY 13203-1252

Joseph Huberty, Esq.

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------x

IN THE MATTER :

OF : ORDER

DAVID C. SAUNDERS, M.D. : BPMC #96-3

----------x

Upon the application of DAVID C. SAUNDERS, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED,

DATED: 4 January 1996

Charles J. Vacanti, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER : APPLICATION

OF : FOR

DAVID G.SAUNDERS, M.D. : CONSENT ORDER

STATE OF NEW YORK)
COUNTY OF ONONDAGA) ss.:

Respondent, David G. Saunders, M.D., being duly sworn, deposes and says:

On or about August 12, 1964 I was licensed to practice as a physician in the State of New York, having been issued license number 092806 by the New York State Education Department.

I am currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through February 28, 1997. My address, as shown on my current registration with the New York State Education Department is Skyline Apartments--Suite 5, 753 James Street, Syracuse, New York 13203.

I understand that the New York State Board For Professional Medical Conduct has charged me with one Specification of professional medical misconduct as set forth in the Statement of Charges annexed hereto, made a part hereof, and marked Exhibit "A".

I do not contest the charge as set forth in the First Specification of the Statement of Charges annexed hereto.

I hereby agree to the penalty that my license to practice medicine in the State of New York be suspended for a period of two (2) years, that the execution of said suspension be stayed, and that I be placed on probation for a period of two (2) years under the Terms Of Probation annexed hereto, made a part hereof and marked Exhibit "B".

I hereby make this application to the Board For Professional Medical Conduct and request that it be granted.

I understand that in the event that this application is not granted by the Board For Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of professional misconduct alleged or charged against me, such application shall not be used against me in any way and shall be kept in strict confidence during the pendency of any disciplinary proceeding against me. Any such denial by the Board For Professional Medical Conduct shall be without prejudice to the continuance of any disciplinary proceeding and final determination by the Board For Professional medical Conduct.

I agree, that in the event the Board For Professional Medical Conduct grants my application, as set forth herein, an order of the Chairperson of the Board For Professional Medical Conduct may issue in accordance with the provisions herein.

No promises of any kind were made to me. I am making this application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

DAVID G. SAUNDERS, M.D.

Sworn to before me this
19 day of December, 1995

Notary Public, State of New York
My Comm. Expires 3/3/97

PETER J. CAMBS
Notary Public, State of New York
Qualified in Onon. Co., No. 4948045
My Commission Expires Mar. 03, 97

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

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IN THE MATTER	:	APPLICATION
OF	:	FOR
DAVID G. SAUNDERS, M.D.	:	CONSENT
	:	ORDER

----------X

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

Date: December 19, 1995

DAVID G. SAUNDERS, M.D.
RESPONDENT

Date: December 19 1995

PETER J. CAMBS
ATTORNEY FOR RESPONDENT

Date: December 21, 1995

JOSEPH HUBERTY, Asst. Counsel
BUREAU OF PROFESSIONAL MEDICAL CONDUCT

Date: ~~December~~ ~~1995~~ Jan 2 1996

ANN M. SAILE , Director
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

Date: ~~December~~ ~~1995~~ 4 January 1996

CHARLES J. VACANTI, M.D.
CHAIRPERSON, STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

TERMS OF PROBATION

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

2. Respondent shall submit written notification to the New York State Department of Health (NYDOH), addressed to the Director, Office of Professional Medical Conduct, New York State Health Department, Empire State Plaza, Tower Building Room 438, Albany, New York 12237, of any employment and practice, of Respondent's residence and telephone number, and of any change in Respondent's employment, practice, residence or telephone number within or without the State of New York.

3. Respondent shall submit written proof from the New York State Education Department, Division of Professional Licensing Services (DPLS), that Respondent has paid all registration fees due and owing to the New York State Education Department (NYSED) and Respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by Respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than at the end of the first three months of the period of probation.

4. Respondent shall submit written proof to NYSDOH, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) Respondent is currently registered with the NYSED, unless Respondent submits written proof that

Exhibit "B"

Respondent has advised DPLS, NYSED, that Respondent is not engaging in the practice of Respondent's profession in the State of New York and does not desire to register, and 2) that Respondent has paid any fines which may have previously been imposed upon Respondent by the Board For Professional Medical Conduct, said proof of the above to be submitted no later than at the end of the first two (2) months of Respondent's period of probation;

5) During the period of his probation Respondent shall be monitored in his practice by a licensed physician (hereinafter monitoring physician). The selection of said monitoring physician shall be made by Respondent subject to approval of the Director of the Office of Professional Medical Conduct.

6. Respondent shall secure the monitoring physician at his own expense. Said monitoring physician shall monitor Respondent's practice with respect to prescriptions for controlled substances written by Respondent during the period of his probation.

7. Said monitoring physician shall, at least once every three months during the period of Respondent's probation, review Respondent's medical charts with respect to prescriptions written by Respondent for controlled substances and evaluate the propriety and efficacy of the prescriptions so written.

8. Said monitoring physician shall, at least once every three months, or sooner if improprieties are found, make a written report to the Director of the Office of Professional Medical Conduct setting forth his opinion regarding the propriety and efficacy of the controlled substances prescribed by Respondent during the period of review.

9. The written reports of the monitoring physician referred to in paragraph "8" above shall be addressed to the Director, Office of Professional Medical Conduct, New York State Department of Health, Corning Tower Building, Room 438, Albany, New York 12237. It shall be the responsibility of Respondent to make certain of compliance with the provisions of paragraphs numbered "8" and "9" hereof.

I acknowledge receipt of a copy of the above Terms of Probation.

Dated: December 19 1995

DAVID C. SAUNDERS, M.D.

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
DAVID G. SAUNDERS, M.D.	:	CHARGES

----------X

DAVID G. SAUNDERS, MD., the Respondent, was authorized to practice medicine in the State of New York on August 12, 1964 by the issuance of license number 092806 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through February 28, 1997. Respondent's address, as shown on Respondent's last registration with the New York State Education Department is Skyline Apartments--Suite 5, 753 James Street, Syracuse, New York 13203.

FACTUAL ALLEGATIONS

A. Following an investigation by the New York State Department of Health, Bureau of Controlled Substances, on or about June 14, 1995 Respondent signed a stipulation resulting in order # CS 95-12 dated June 23, 1995.

B. By the terms and conditions of the aforesaid stipulation and order Respondent admitted and the Commissioner of Health found:

EXHIBIT "A"

1. Respondent had violated the provisions of New York Public Health Law Sec. 3332(3) in that between October 1990 and December 1990 on at least ten (10) occasions Respondent wrote prescriptions for Dilaudid 4mg for patient J.S. (all patients are identified in Appendix "A" annexed hereto) in amounts which exceeded a thirty (30) day supply if the drug was taken in accordance with the directions for use.

2. Respondent had violated the provisions of New York State Public Health Law Sections 3332(a) and 3335(2) in that on at least two (2) occasions between November 1990 and December 1990 and on at least one (1) occasion in March 1993, Respondent provided patient J.S. with prescriptions for controlled substances which were written by him on a date earlier than the date of the prescription.

3. Respondent had violated New York Public Health Law Sec. 3343(2) in that on at least twenty six (26) occasions between October 1990 and September 1991 Respondent prescribed controlled substances for patient J.S. for which Respondent failed to keep the required documentation of such prescribing.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

COMMISSIONER'S FINDING OF VIOLATIONS OF

ARTICLE THIRTY THREE OF THE PUBLIC HEALTH LAW

Petitioner charges Respondent with professional misconduct under N.Y. Educ. Law Sec. 6530(9)(e) (McKinney Supp.1995) in that Respondent was found by the New York State Commissioner of Health to have violated Article Thirty Three of the New York State Public Health Law in that Petitioner charges:

1. The facts in paragraphs A, B, B.1, B.2 and B.3.

Dated: Albany, New York
December 27 1995

PETER D. VAN BUREN, Deputy Counsel
Bureau of professional medical
Conduct