STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

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

Dennis P. Whalen
Executive Deputy Commissioner

October 28, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jack Schweitzer, M.D.
241 Rockaway Avenue
Valley Stream, NY 11580

David Smith, Esq
NYS Department of Health
5 Penn Plaza - 6th Floor
New York, NY 10001

T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy & Schoppmann
2120 Lakeville Road
Lake Success, NY 11044

RE: In the Matter of Jack Schweitzer, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.98-251) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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 penalties **other than suspension or revocation** 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Tyrone Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

COPY

IN THE MATTER

OF

JACK SCHWEITZER, M.D.

DETERMINATION

AND

ORDER

Order #98-251

A Notice of Hearing and a Statement of Charges, dated April 30, 1998, were served upon the Respondent, Jack Schweitzer, M.D. **THEA GRAVES PELLMAN (Chair), DAVID HARRIS, M.D. and RALPH LUCARIELLO, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the Committee) in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by David W. Smith, Esq., Associate Counsel. The Respondent appeared by Kern, Augustine, Conroy & Schoppmann, T. Lawrence Tabak, Esq., of counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	April 30, 1998
Amended Statement of Charges Entered in evidence:	July 9, 1998
Dates of Hearing:	May 12, 1998 June 9, 1998 June 23, 1998 June 25, 1998 July 9, 1998
Witnesses for Department of Health:	Ramesh Gidumal, M.D. Patient B Barry S. Gloger, M.D.

Witnesses for Respondent: Jack Schweitzer, M.D.
Martin Kobak
Harvey Klein, M.D.

Deliberations Held: August 28 ,1998

STATEMENT OF CASE

The Statement of Charges alleged twelve specifications of professional misconduct, including allegations of gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, fraudulent practice, false advertising and failure to maintain accurate records.

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

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all Findings and Conclusions herein are the unanimous determination of the Committee. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence.

1. JACK SCHWEITZER, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on September 20, 1966, by the issuance of license number 097591 by the New York State Education Department. (Petitioner's Exhibit 3 {hereinafter "Pet.Ex."})

PATIENT A:

2. Respondent saw Patient A at his office for the first time on June 4, 1993, and diagnosed him with osteoarthritis of the hip and degenerative changes of the knee. Respondent saw Patient A again on June 11, 1993 and the same diagnosis was made. (Pet. Ex. 4)

3. Patient A returned on June 18, 1993 and was diagnosed by Respondent with a right calcaneal nerve entrapment. A diagnosis of calcaneal nerve entrapment should be based on a history, physical examination and diagnostic tests results which suggest that condition. The record for Patient A does not contain such a history, physical examination or diagnostic tests results. Those diagnostic tests would include an X-ray and an EMG. (T. 17-19, 36-37; Pet. Ex. 4)

4. On June 18, 1993, the Respondent performed a medial calcaneal nerve release on Patient A to treat his medial calcaneal nerve entrapment. (T. 18-19; Pet. Ex. 4)

5 Prior to surgery on a patient for release of a medial calcaneal nerve entrapment a complete history must be obtained, an appropriate physical examination must be done, diagnostic test results confirming the diagnosis must be obtained and less invasive treatment measures must be attempted. Subsequent to the surgery post-operative notes should be made. Respondent did not do this prior to operating on Patient A on June 18, 1993, or subsequently. (T. 17-20, 36-37; Pet. Ex. 4)

6. On June 25, 1993, the Respondent performed a synovectomy on Patient A's right ankle to treat his synovitis. (T. 22; Pet. Ex. 4)

7. Prior to performing a synovectomy on a patient a complete history must be obtained, an appropriate physical examination must be done, diagnostic test results confirming the diagnosis must be obtained and less invasive treatment measures must be attempted. Subsequent to the surgery post-operative notes should be made. Respondent did not do this prior to operating on Patient A on June 25, 1993 or, subsequently. (T. 19-23, 38-39; Pet. Ex.. 4)

8. Prior to performing a synovectomy on a patient who had surgery one week prior for release of a medial calcaneal nerve on other side of the foot, a physician should rule out any adverse affects from the prior operation. The Respondent did not do this. (T. 20-21; Pet. Ex. 4)

9. On June 18, 1993, Respondent diagnosed Patient A with peripheral neuritis. A physician should base a patient diagnosis on indications from a physical examination and diagnostic test results which confirm the diagnosis. These findings should be recorded in the medical record. The Respondent did not do this. (T. 28-29; Pet. Ex. 4)

10. On July 2, 1993, Respondent performed capsulotomies of the 2nd, 3rd, 4th and 5th MP joints on the left foot of Patient A. Prior to performing a capsulotomy on a patient a complete history must be obtained, an appropriate physical examination must be done and diagnostic test results confirming the diagnosis must be obtained. Subsequent to the surgery post-operative notes should be made. Respondent did not do this prior to operating on Patient A on July 2, 1993, or subsequently. (T. 29, 33-35, 39-41; Pet. Ex. 4)

11. On July 6, 1993, Respondent performed capsulotomies of the 2nd, 3rd, 4th and 5th MP

joints on the right foot of Patient A. Prior to performing a capsulotomy on a patient, a complete history must be obtained, an appropriate physical examination must be done and diagnostic test results confirming the diagnosis must be obtained. Subsequent to the surgery post-operative notes should be made. Respondent did not do this prior to operating on Patient A on July 6, 1993, or subsequently. (T. 29, 33-35, 39-41; Pet. Ex. 4)

PATIENT B:

12. Patient B presented to Respondent in his office on April 5, 1996, after she suffered trauma to her left hand when it was caught in an elevator door the previous day. (T. 79-80; Pet. Ex. 12)

13. On April 5, 1996, Respondent performed capsulotomies of the 2nd, 3rd, 4th and 5th MP joints on the left hand of Patient B. The medical justification for performing a capsulotomy are dislocation of the joint or a persistent limitation of motion. Neither of these factors were present in the patient's medical condition or history. Subsequent to the surgery post-operative notes should be made. Respondent did not do this. (T. 80-83, 722-723; Pet. Ex. 12)

14. On April 5, 1996, Respondent diagnosed Patient B with an ulnar nerve dysfunction. Upon diagnosing a patient with Patient an ulnar nerve dysfunction a physician should follow up such diagnosis with either appropriate treatment or a referral to an appropriate specialist and note the action taken in the medical record. Respondent failed to do this. (T. 83-88; Pet. Ex. 12)

PATIENT C:

15. Patient C, a 42 year old woman, came to Respondent at his office on November 26, 1991, with a complaint of pain in back of the left knee. (T. 54; Pet. Ex. 11)

16. Respondent made diagnosis of Baker's Cyst and removed it on December 3, 1991. Prior to operating on a patient for the removal of a Baker's Cyst a physician should obtain a complete history of the patient and note this in the medical record and should perform an adequate physical examination which should include a patella femoral examination, a determination of whether effusion was present, was there any joint line pain and any evidence of meniscal pathology. The Respondent did not do this. (T. 54-65; Pet. Ex. 11)

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact listed above. The Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A.: (2);

Paragraph A.1.: (3);

Paragraph A.2.: (4&5);

Paragraph A.3.: (6.7&8);

Paragraph A.4.: (9);

Paragraph A.5.: (10);

Paragraph A.7.: (11);

Paragraph B.: (12);

Paragraph B.1.: (13);

Paragraph B.2.: (14);

Paragraph C.: (15);

Paragraph C.1.: (16);

Paragraph C.2.: (16);

Paragraph C.3.: (16).

The Hearing Committee further concluded that the following Specifications should **be sustained**. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Fifth Specification: (Paragraphs A.,A.1.-5.,7.; B., B.1.-2.; C.. C.1.-3.);

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Sixth Specification: (Paragraphs A.,A.1.-5.,7.; B., B.1.-2.; C.. C.1.-3.);

FAILURE TO MAINTAIN RECORDS

Seventh Specification: (Paragraphs A.,A.2.-3.,5.,7.);

Eighth Specification: (Paragraphs B.,B.1.-2.);

Ninth Specification: (Paragraphs C.,C.1-3);

The Hearing Committee voted to **not sustain** the **first through fourth and tenth through sixteenth** specifications.

DISCUSSION

Respondent was charged with sixteen specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, gross incompetence, negligence, incompetence and fraud in the practice of medicine.

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.

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

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.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

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

Using the above-referenced definitions as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the fifth through ninth specifications of professional misconduct should be sustained . The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Ramesh Gidumal, M.D. as its expert witness. Dr. Gidumal is board certified in Orthopedic Surgery. There was no evidence of any bias on the part of Dr. Gidumal or his unsuitability as an expert witness. The Committee found him to be a credible witness. Dr. Gidumal's testimony was based solely on the records he was provided with. The Committee agreed with his assessment of the Respondent's substandard care of Patients A, B and C. As a board certified orthopedic surgeon the Committee conclude his testimony should be given more weight than that of the Respondent's expert. For all three patients the Respondent's records were deficient in the history recorded, the adequacy of the physical examination performed and the basis for the diagnosis upon which the treatment was based. The Committee concluded that these failures were more than record keeping errors but represented real shortcomings in the care provided.

The Committee found the Respondent's witnesses unpersuasive. Both of them worked with the Respondent and their opinions could not be viewed as disinterested. Furthermore, Martin Kobak, who is not a physician, was primarily a fact witness. His opinions with respect to the quality of medical care provided were accorded the appropriate weight by the Committee in the course of its deliberations.

The Committee concluded that the Respondent's actions did not amount to gross negligence or gross incompetence based on the definitions set out above. Nor did the Committee find that the Respondent's conduct amounted to the fraudulent practice of medicine. With respect to the charge of false advertising the evidence did not support sustaining this charge. The Committee concluded that the Respondent has not held himself out to be an orthopedist.

The Committee found the Respondent's medical record keeping to be quite inadequate.The Respondent himself admitted this. The maintaining of complete and accurate notes is crucial in the event that another physician has to assume the care of the patient. The Respondent's failure to keep complete and accurate medical records led the Committee to conclude that complete histories were not obtained, adequate physicals were not performed and unsupported diagnosis were made leading the Committee to sustain the charges of neglect and incompetence.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent should be **suspended** for 18 months with 12 months of said suspension stayed. Additionally the Respondent's license to practice medicine is placed on **probation** under the terms set forth in Appendix II, attached to this Determination and Order. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

ORDER

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

1. The Fourth through Ninth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I) are **SUSTAINED**;

2. Respondent license to practice medicine is **suspended for 18 months,** however 12 months of this suspension is stayed. The Respondent's license is placed on **probation** for the entire 18 months of the suspension in accordance with the terms set forth in Appendix II, attached to this Determination and Order and made a part thereof.

DATED: New York, New York
October 26, 1998

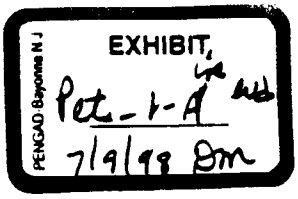
THEA GRAVES PELLMAN (Chair)
DAVID HARRIS, M.D.
RALPH LUCARIELLO, M.D.

TO: David W. Smith, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy & Schoppmann
2120 Lakeville Rd.
Lake Success, New York 11044

Jack Schweitzer, M.D.
241 Rockaway Ave.
Valley Stream, New York 11580

APPENDIX I



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

IN THE MATTER

OF

JACK SCHWEITZER, M.D.

AMENDED STATEMENT OF CHARGES

JACK SCHWEITZER, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 20, 1966, by the issuance of license number 097591 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between in or about June, 1993 and July, 1993, Respondent treated Patient A for knee pain and other medical conditions at his office at 241 Rockaway Avenue, Valley Stream, New York. (Hereinafter "Office") (All patients are identified in the Appendix attached hereto.)

1. Respondent inappropriately diagnosed Patient A with a medial calcaneal nerve entrapment.

2. As a result of such diagnosis, Respondent inappropriately operated on Patient A on or about June 18, 1993 and failed to make any post-operative patient notes.

3. On or about June 25, 1993, Respondent inappropriately performed a right ankle synovectomy and failed to record any post-operative patient notes.

4. Respondent inappropriately diagnosed Patient A with peripheral neuritis of the left hip.

5. On or about July 2, 1993 Respondent inappropriately performed a capsulotomy on the toes of the left foot of Patient A and failed to record in his patient notes where the incision was made or any post-operative notes.

6. In the alternative, such procedure was never performed by Dr. Schweitzer, but nevertheless Respondent knowingly and with intent to deceive billed the insurance carrier of Patient A for such procedure.

7. On or about July 6, 1993 Respondent inappropriately performed capsulotomies on the toes of the right foot of Patient A and failed to make any post-operative notes.

8. In the alternative, such procedure was never performed by Dr. Schweitzer, but nevertheless Respondent knowingly and with intent to deceive billed the insurance carrier of Patient A for such procedure.

B. In or about April, 1996, Respondent treated Patient B for injury to her left hand and other medical conditions at his Office.

1. Respondent inappropriately performed a capsulotomy of the 2nd, 3rd, 4th and 5th fingers of the left hand and failed to make any

post-operative notes.

a. In the alternative, such procedure was never performed by Dr. Schweitzer but, nevertheless, Respondent knowingly and with intent to deceive billed the insurance carrier of PatientB for such procedure.

2. Respondent diagnosed Patient B with a dysfunction in the ulnar nerve distribution but failed to follow-up, evaluate or treat such condition or note such follow-up, evaluation or treatment, if any.

C. On or about November 26, 1991, Patient C was treated by Respondent for pain behind her knee and other medical conditions at his office.

1. Respondent failed to perform an adequate physical examination or note such examination, if any.

2. Respondent failed to obtain an adequate medical history or note such history, if any,

3. Respondent inappropriately removed a cyst from the back of Patient C's knee.

D. Respondent advertised himself on his letterhead as being proficient in orthopedics.

1. Such advertising was knowingly false and done with intent to deceive.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A1-5, 7.
2. Paragraphs B and B1-2.

THIRD AND FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

3. Paragraphs A and A1-5, 7.
4. Paragraphs B and B1-2.

FIFTH 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. 1998) 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:

5. Paragraphs A and A1-5, 7; B and B1-2; and/or C and C1-3.

SIXTH 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. 1998) 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:

6. Paragraphs A and A1-5, 7; B and B1-2; and/or C anc C1-3.

SEVENTH THROUGH NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1998) by failing to maintain a record which reflects the treatment, evaluation and follow-up of each patient as alleged in

the facts of:

7. Paragraphs A and A2, 3, 5 and 7.

8. Paragraphs B and B1-2.

9. Paragraphs C and C1-2.

TENTH THROUGH TWELFTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1998) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

10. Paragraphs A and A6 and 8.

11. Paragraphs B and B1, 1a.

12. Paragraphs D and D1..

THIRTEENTH SPECIFICATION

FALSE ADVERTISING

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(27)(a)(McKinney Supp. 1998) by engaging in advertising which is false, deceptive or misleading as alleged in the facts of the following:

13. Paragraph D and D1.

FOURTEENTH THROUGH SIXTEENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1998) 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:

14. Paragraphs A and A6 and 8
15. Paragraphs B and B1, 1a..
16. Paragraph D and D1.

DATED: June 24, 1998
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

TERMS OF SUSPENSION

Dr. Schweitzer's license to practice medicine in the State of New York shall be suspended for 18 months with 12 months of that period stayed. During the 6 months of actual suspension of his license the Respondent shall take and successfully complete a course in Medical Record Keeping. Prior to enrolling in a Medical Record Keeping course the Respondent shall get written approval of the acceptability of such course for fulfilling the terms of his suspension, from the New York State Department of Health, Office of Professional Medical Conduct (OPMC). The cost of taking said course if any, shall be the responsibility of the Respondent. Prior approval and determination of successful completion of the course will be in the sole discretion of OPMC.

TERMS OF PROBATION

1. Respondent shall conduct himself at all times 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 written notification to the Board addressed to the Director, Office of Professional Medical Conduct ("OPMC"), Hedley Park Place, 433 River St., Troy, New York 12180, 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. In the event that Respondent leaves New York to reside or practice outside the State, Respondent shall notify the Director of the OPMC in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. The probation periods shall be tolled until the Respondent returns to practice in New York State.

6. Respondent shall have quarterly meetings with an employee or designee of OPMC during the periods of probation. In these quarterly meetings, Respondent's professional performance may be reviewed by inspecting selections of office records, patient records and hospital charts.

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

he has notified the New York State Education Department of that fact.

8. Respondent's practice of medicine shall be monitored by a physician monitor, board certified in an appropriate specialty, ("Practice monitor") approved in advance, in writing, by the Director of the Office of Professional Medical Conduct or designee. 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 a 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, on a schedule to be determined by the office. The practice monitor shall visit Respondent's medical practice at each and every location, on a random basis at least monthly and shall examine a random selection of no less than 15 records maintained by Respondent, including patient histories, prescribing information and billing records. Respondent will make available to the 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 monitor must be approved in writing, in advance, by the Office of Professional Medical Conduct.

c. All expenses associated with monitoring, including fees to the monitoring physician, shall be the sole responsibility of the Respondent.

d. It is 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.

e. Respondent must maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director or designee prior to the placement of a practice monitor.