STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Public

February 17, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Martin Kosich, M.D.
Fluss-Heim
Hamburg Road
Catskill, New York 12414

Sheila Galvin, Esq.
Galvin & Morgan
217 Delaware Avenue
Delmar, New York 12054

Kevin C. Roe, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237-0032

RE: In the Matter of Martin Kosich, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-30) 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 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,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

IN THE MATTER **OF** **MARTIN KOSICH, M.D.,** **Respondent**	**DETERMINATION** **AND** **ORDER** BPMC #06-30

A Notice of Hearing and Statement of Charges dated May 9, 2005, were served upon the Respondent, MARTIN KOSICH, M.D. **REV. THOMAS KORNMEYER (Chair), JAMES T. ADAMS, M.D. and ROGER L. SPARK, 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 KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Kevin C. Roe, Esq., Associate Counsel. The Respondent appeared by Galvin & Morgan, Madeline S. Galvin and James E. Morgan 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 Notice of Hearing & Statement of Charges:	May 9, 2005
Dates of Hearing:	June 30, 2005 September 2, 2005 September 8, 2005 September 29, 2005 October 31, 2005 November 7, 2005 November 8, 2005
Date of Deliberations:	January 3, 2006

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated the following four categories of professional misconduct: gross negligence, negligence on more than one occasion, gross incompetence and incompetence on more than one occasion. The Statement of Charges was amended on September 28, 2005. A copy of the Amended Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are the unanimous

determination of the Committee. 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. 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.

1. Martin Kosich, M.D., (hereinafter "Respondent"), was authorized to practice medicine in New York State on or about June 22, 1971 by the issuance of license number 108834 by the New York State Education Department. (Exs. 1 & 1B)

PATIENT A:

2. The Respondent treated Patient A, a 36 year old male, on or about March 1992 to March 2002 (T. 78; Ex.2).

3. Patient A presented to the Respondent with a history of hypertension. When a Patient presents to a physician for the first time, the physician should obtain a history of the present illness or reason for the visit, and any

therapies that have been tried; a past medical and surgical history; a social history; any allergies and which current medications the patient may be taking. The Respondent did not obtain this information about Patient A (T. 78-81, 83-84; Ex. 2).

4. When a patient presents to a physician for an initial visit as Patient A did in March of 1992, the physician should perform a complete physical assessment of the patient to obtain a baseline, including a thorough head and neck evaluation, cardiac evaluation, pulmonary evaluation, GI evaluation, GU evaluation, evaluation of the extremities, vascular evaluation, neurological evaluation and a skin evaluation. The Respondent did not perform such a physical on Patient A (T. 81-83; Exs. 2, 2A).

5. The Respondent made an initial diagnosis for Patient A of hypertension. When a physician makes such an initial diagnosis, medical test results, including CBC, BUN, creatinine, potassium levels, cholesterol and glucose levels and an EKG should be obtained. The Respondent did not do this for Patient A (T. 84, 86-88; Ex. 2).

6. When a physician initiates treatment of a patient for hypertension, the physician should begin with a drug from a particular class of drugs, continue with that drug until it's shown to be ineffective or not tolerated,

and then a drug from a different class should be tried. The Respondent did not follow that regimen in his treatment of Patient A's hypertension (T. 84-86; 298, 304, 355-356; Ex. 2).

7. On a number of office visits Patient A had an abnormally elevated pulse rate. When a patient presents with such a symptom, it should be addressed and treated. The Respondent did not treat Patient A's abnormally elevated pulse rate (T. 89-92; Ex. 2).

8. Respondent diagnoses Patient A with atrial fibrillation and prescribed Lanoxin for treatment of that condition. Patient A returned two days after the initial diagnosis of atrial fibrillation and had a normal sinus rhythm . The Respondent discontinued the Lanoxin. To adequately diagnose a patient with atrial fibrillation an EKG must be obtained. The Respondent did obtain an EKG for Patient A. When a patient with atrial fibrillation is given Lanoxin and converts to a regular sinus rhythm the physician should maintain the patient on Lanoxin. The Respondent did not do this (T. 98-100; Ex. 2).

9. Respondent was treating Patient A for back pain of the lumbar spine. Patient A had an MRI, which indicated he had a retro-pulsed fragment causing relative spinal stenosis. When a physician obtains the findings

from an MRI of the lumbar spine for a patient which indicates the patient has a retro-pulsed fragment causing relative spinal stenosis, the physician should refer the patient to an orthopedic surgeon for possible surgical intervention. The Respondent did not refer Patient A to an orthopedic surgeon (T.102-104; Ex. 2).

10. The Respondent concurrently prescribed Oxycontin and Norco for Patient A. A physician should not prescribe Oxycontin and Norco together due to the potential for overdosing (T.107-109, 280, 319-320, 356; Ex. 2).

11. The Respondent concurrently prescribed Oxycontin, Norco and Darvocet. A physician should not concurrently prescribe Oxycontin, Norco and Darvocet due to the potential for overdosing and the possibility of taking too much acetaminophen (T. 110-112, 312; Ex. 2).

12. The Respondent prescribed a number of analgesic narcotics for Patient A, including Oxycontin, Norco, Darvocet, Valium, Ativan and Vicodin. If a physician prescribes a number of analgesic narcotics for a patient, the physician should adequately monitor the dosage and frequency of these medications. The Respondent did not adequately monitor Patient A's use of these analgesic narcotics (T. 111-115; Ex. 2).

PATIENT B:

13. The Respondent treated Patient B from on or about January 2001 through April 2003 (Ex. 3).

14. Patient B presented with a chief complaint of nervousness and depression. The Respondent's diagnosis was substance abuse. Patient B was noted to be HIV positive, with a history of compound fracture of the fibula and tibia. When a Patient presents to a physician for the first time, the physician should obtain a history of the present illness or reason for the visit, any therapies that have been tried, a past medical and surgical history; a social history; any allergies and which current medications the patient may be taking. The Respondent did not obtain this information about Patient B. (T.359-362; 689-692, Ex. 3).

15. When a patient presents to a physician for an initial visit as Patient B did in January of 2001, the physician should perform a complete physical assessment of the patient to obtain a medical baseline, including a thorough head and neck evaluation, cardiac evaluation, pulmonary evaluation, GI evaluation, GU evaluation, evaluation of the extremities, vascular evaluation and a skin evaluation. The Respondent did not perform such a physical on Patient B (T. 363-364, 696-701; Ex. 3).

16. When a patient who is HIV positive presents to a physician for the first time, the physician should obtain information such as what HIV related medications the patient is taking, physical findings, laboratory results, and if and where the patient is being monitored for his HIV status elsewhere, so as to coordinate the care. The Respondent did not obtain this information (T. 365-367, 703-704; Ex. 3).

17. When a physician uses methadone for a patient as part of the patient's methadone maintenance/detoxification program for treatment of substance abuse, the physician should, as part of the program, obtain a past history of drug detoxification; what other methods have been tried to treat to the condition; he should also determine whether the patient has been on a methadone maintenance program before, and what occurred; he should know what other drugs the patient is using; the physician should perform routine urine screening tests and should have a specific treatment plan, including behavioral therapy and a treatment contract. The Respondent did not do this when treating Patient B's substance abuse with methadone (T. 368-374, 712-716; Ex. 3).

18. Patient B who was HIV positive was noted to have a sty. Although a referral could have been made for treatment of the sty, the Respondent did adequately treat this condition (T. 970; Ex. 3.).

19. When an HIV positive patient upon physical examination is noted to have an enlarged lymph node, the patient should be referred to a specialist for this condition since HIV positive patients are more prone to developing malignancies and infections. The Respondent did not refer Patient B to a specialist even though the patient was noted to have an enlarged lymph node (T. 379-380; Ex. 3).

20. A physician cannot legally prescribe methadone to a patient for the treatment of opioid addiction. The Respondent prescribed methadone for Patient B's substance abuse treatment (T. 368, 707-709, 839-841; Ex. 3).

PATIENT C:

21. The Respondent treated Patient C from on or about January 2001 through July 2002 (Ex. 4).

22. Patient C initially presented to the Respondent with a chief complaint of addiction to heroin. She was noted to be allergic to codeine, had a history of anemia until age 6, arrhythmia at age 18, a surgical history of a plate and rod in her left leg which was removed in 1990. When a physician initially

sees a patient, he should obtain a history which includes a history of the present illness or reason for the visit, and any therapies that have been tried; a past medical and surgical history; a social history; any allergies and which current medications the patient may be taking. The Respondent did not obtain this information about Patient C (T. 688-693, Exs. 4 & 4A).

23. When a patient presents to a physician for an initial visit with an opiate addiction as Patient C did in January 2001, the physician should perform a complete physical assessment of the patient including a review of systems, a mental health psychosocial assessment; tests for the presence of infectious diseases, a neurological workup; an assessment of drug intoxication or withdrawal; laboratory studies including complete blood work; urinalysis and urine drug screening, EKG and chest X-rays. The Respondent did not do this for Patient C. (T. 694, 696, 699-700; Ex. 4 & 4A).

24. When a patient who is an opioid user such as Patient C presents to a physician, the physician should order and obtain HIV tests for the patient. The Respondent did not do this for Patient C. (T. 701, 705; Exs. 4 & 4A).

25. When a physician uses methadone for a patient as part of the patient's methadone maintenance/detoxification program for treatment of substance abuse, the physician should, as part of the program, obtain a past history of

drug detoxification; ascertain what other methods have been tried to treat the condition; he should also determine whether the patient has been at a methadone maintenance program before, and what occurred; he should know what other drugs the patient is using; additionally the physician should perform routine urine screening tests and should have a specific treatment plan, including behavioral therapy and a treatment contract. The Respondent did not do this when treating Patient C's substance abuse with methadone (T. 712-717; Exs. 4 & 4A).

26. A physician cannot prescribe methadone. Respondent prescribed methadone to Patient C. (T. 708, 711; Exs. 4 & 4A).

PATIENT D:

27. The Respondent treated Patient D from on or about January 2000 through July 2002. (Ex. 5)

28. Patient D presented to the Respondent with a chief complaint of "consultation," a listing of medications, medical and surgical history both negative. No physical examination was performed, vital signs were not taken. When a patient initially presents to a physician, he should obtain a history which includes a history of the present illness or reason for the visit, and any therapies that have been tried to treat the condition; a past medical

and surgical history; a social history; any allergies and which current medications the patient may be taking. The Respondent did not obtain this information about Patient D. (T. 688-693; Exs. 5 & 5A)..

29. When a patient presents to a physician for an initial visit with an opiate addiction as Patient D did in January 2000, the physician should perform a complete physical assessment of the patient including a review of systems, a mental health psychosocial assessment; tests for the presence of infectious diseases; a neurological workup; an assessment of drug intoxication or withdrawal; laboratory studies including complete blood work; urinalysis and urine drug screening, an EKG and chest X-rays. The Respondent did not do this for Patient D (Exs. 5 & 5A).

30. When a patient who is an opioid user such as Patient D presents to a physician, the physician should order and obtain HIV tests for the patient. The Respondent did not do this for Patient D. (T. 701, 705; Ex.s. 5 & 5A.).

31. When a physician uses methadone for a patient as part of the patient's methadone maintenance/detoxification program for treatment of substance abuse, the physician should, as part of the program, obtain a past history of drug detoxification; what other methods have been tried to treat the condition; he should also determine whether the patient has been at a

methadone maintenance program before, and what occurred; he should know what other drugs the patient is using; the physician should perform routine urine screening tests and should have a specific treatment plan, including behavioral therapy and a treatment contract. The Respondent did not do this when treating Patient D's substance abuse with methadone (T. 712-717; Exs. 5 & 5A3).

32. A physician cannot prescribe methadone. Respondent prescribed methadone to Patient D (. 708, 711; Exs. 5 & 5A).

PATIENT E:

33. The Respondent treated Patient E from on or about February 1998 through April 2003 (Ex. 6).

34. Patient E presented to the Respondent at his initial visit with chronic knee pain, shoulder pain, a history of multiple fractures of right clavicle, ACL knee reconstruction, chronic shoulder dislocation, fractured vertebrate. A surgical history on his shoulder and knee and a diagnosis of degenerative arthritis. When a patient presents to a physician for the first time, the physician should obtain a history of the present illness or reason for the visit and any treatment therapies that have been tried; a past medical and surgical history; a social and family history, any allergies and which current

medications the patient may be taking. The Respondent did not obtain this information about Patient E. (T. 549-550; Exs. 6 & 6A).

35. When a patient presents to a physician for an initial visit such as Patient E did in February of 1998, the physician should perform a complete physical assessment of the patient to obtain a medical baseline including a thorough head and neck evaluation, cardiac evaluation; pulmonary evaluation, GI evaluation, GU evaluation, evaluation of the extremities, vascular evaluation, neurological evaluation and a skin evaluation. The Respondent did not perform such a physical on Patient E (T. 551-553; Exs. 6 & 6A).

36. When a patient initially presents to a physician as Patient E did, the physician should obtain and review records of previous treatments and/or surgeries of that patient. The Respondent did not do this for Patient E. (T. 552-553; Exs. 6 & 6A).

37. When a patient presents to a physician for an initial visit, as Patient E did, the physician should order and obtain appropriate laboratory/radiological studies to evaluate the patient's arthritis. The Respondent did not do this. (T. 553-554; Exs. 6 & 6A).

38. When beginning treatment for degenerative arthritis, a physician should start a course of treatment with a non-steroidal anti-inflammatory medication

and physical therapy. The Respondent did not do this. The Respondent initially prescribed Percocet for the treatment of this patient's degenerative arthritis (T. 555-556; Exs. 6 & 6A).

39. On or about May 12, 2000 to October 31, 2000, the Respondent prescribed Halotestin for Patient E. Halotestin is an anabolic steroid used to treat delayed puberty or diminished levels of testosterone. There was no indication that this patient had diminished levels of testosterone. Prior to and during the course of prescribing Halotestin, a physician should conduct various laboratory tests. The Respondent did not do this. (T. 557-561; Exs. 6 & 6A).

40. On or about July 6, 2000, the Respondent prescribed Ionamin for Patient E. This was during the same time period when the patient was on Halotestin. Ionamin is used for weight reduction. Although Patient E had gained weight, taking Halotestin can cause weight gain. The proper course of action would have been to discontinue the Halotestin and observe Patient E's weight before prescribing Ionamin in conjunction with diet and exercise. The Respondent did not do this (T. 561-562; Exs. 6 & 6A).

41. On or about December 28, 2000 Patient E was seen by the Respondent. His blood pressure was 160/100. That blood pressure reading is elevated When

a patient's blood pressure is elevated the patient should be made aware of this and counseled regarding the elevated pressure and how to lower it, and scheduled for a return office visit in the near future. The Respondent did not do this. (T. 562-565; Exs. 6 & 6A).

42. On or about April 17, 2001 the patient was noted to have vascular headaches. As part of Patient E's medical treatment for his vascular headaches, he had an MRI/MRA. A physician should obtain the results of such tests for his patients and follow-up his treatment of this condition. The Respondent did not do this (T. 569-570, Exs. 6 & 6A).

PATIENT G:

43. The Respondent treated Patient G from on or about January 2002 through April 2003.

44. Patient G presented on the initial office visit with a chief complaint of "drug control, wants to detox, wants off." Current medication was methadone 115 mg/qid. When a patient presents for an initial visit, the physician should obtain a history of the present illness or the reason for the visit, and any therapies that have been tried; a past medical and surgical history; a social history; any allergies and which current medications the patient may be

taking. The Respondent did not obtain this information about Patient G. (T. 688-693, Exs. 8 & 8A).

45. When a patient presents to a physician for an initial visit with an opiate addiction as Patient G did in January 2002, the physician should perform a complete physical assessment of the patient including a review of systems, a mental health psychosocial assessment; testing for the presence of infectious diseases, a neurological workup; an assessment of drug intoxication or withdrawal; laboratory studies including complete blood work; urinalysis and urine drug screening, an EKG and chest X-rays. The Respondent did not do this for Patient G. (T. 694, 696, 699-700; Exs. 8 & 8A).

46. When a patient who is an opioid user such as Patient G presents to a physician, the physician should order and obtain HIV tests for the patient. The Respondent did not do this for Patient G (T. 701, 705;Exs. 8 & 8A).

47. When a physician uses methadone for a patient as part of the patient's methadone maintenance/detoxification program for treatment of substance abuse, the physician should, as part of the program, obtain a past history of drug detoxification and determine what other methods have been tried. He should also determine whether the patient has been at a methadone

maintenance program before, and what occurred; he should know what other drugs the patient is using; the physician should perform routine urine screening tests and should have a specific treatment plan, including a behavioral therapy program and a treatment contract. The Respondent did not do this when treating Patient G's substance abuse with methadone T. 368-374, 712-716; Exs. 8 & 8A).

48. A physician cannot prescribe methadone. Respondent prescribed methadone to Patient G. (T. 708, 711; Exs. 8 & 8A).

CONCLUSIONS

Based on the Findings of Fact noted 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);
Paragraph A.3.: (5, 6);

Paragraph A.4.: (7);

Paragraph A.5.: (8);

Paragraph A.6.: (9);

Paragraph A.7.: (10);

Paragraph A.8.: (11);

Paragraph A.9.: (12);

Paragraph B.: (13);

Paragraph B.1.: (14);

Paragraph B.2.: (15);

Paragraph B.3.: (16);

Paragraph B.4.: (17);

Paragraph B.6.: (19);

Paragraph B.7.: (20);

Paragraph C.: (21);

Paragraph C.1.: (22);

Paragraph C.2.: (23);

Paragraph C.3.: (24);

Paragraph C.4.: (25);

Paragraph C.5.: (26);

Paragraph D.: (27);

Paragraph D.1.: (28);

It is noted that the Amended Statement of Charges contained a typographical error in that the initiation of treatment was in January 2000, not 2001;

Paragraph D.2.: (29)

Paragraph D.3.: (30);

Paragraph D.4.: (31);

Paragraph D.5.: (32);

Paragraph E.: (33);

Paragraph E.1.: (34);

Paragraph E.2.: (35);

Paragraph E.3.: (36);

Paragraph E.4.: (37);

Paragraph E.5.: (38);

Paragraph E.7.: (39);

Paragraph E.8.: (39);

Paragraph E.9.: (40);

Paragraph E.10.: (41);

Paragraph E.11.: (42);

Paragraph G.: (43);

Paragraph G.1.: (44);

Paragraph G.2.: (45);

Paragraph G.3.: (46);

Paragraph G.4.: (47);

Paragraph G.5.: (48).

The Committee notes that Factual Allegations B.5. and E.6 were not proven by a preponderance of the evidence.

Accordingly, the Committee found that the following Specifications of Misconduct as set forth in the Amended Statement of Charges were sustained. The citations in parentheses refer to the Factual Allegations from Amended the Statement of Charges, which support each specification:

NEGLIGENCE ON MORE THAN ONE OCCASION

Thirteenth Specification: (Paragraphs A., A.1. – A.9., B., B.1. – B.4., B.6. – B.7, C., C.1. – C.5., D., D. 1 – D.5., E., E.1. – E.5., E. 7. – E. 11., G. and G.1. – G-5);

INCOMPETENCE ON MORE THAN ONE OCCASION

Fourteenth Specification: (Paragraphs A., A.1. – A.9., B., B-1. – B.4., B.6. – B.7., C., C.1. – C.5., D., D.1. – D.5., E., E.1- E.5., E.7. – E .11., G. and G.1. – G.5);

The Committee found that the First through Twelfth Specifications were not sustained.

DISCUSSION

Respondent was charged with fourteen alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct that constitute professional misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by 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, among other conduct, gross negligence, negligence, and fraud in the practice of medicine.

The following definitions were utilized by the 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.

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.

Using the above-referenced specifications as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the thirteenth specification of Negligence on More than One Occasion and fourteenth specification of Incompetence on More than One Occasion should be sustained.

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

The Petitioner presented as their expert witnesses Dr. Irene Snow and Dr. Bruce Maslack. Dr. Snow is Board Certified in internal medicine. Dr. Maslack is Board Certified in family practice. There was no evidence of any bias on the part of either expert. The Committee found both witnesses to be qualified and credible.

The Respondent presented no expert on his behalf and offered no testimony to refute the Petitioner's expert opinions, nor did the Respondent testify on his own behalf. In the administrative hearing setting where the Respondent does not testify on his own behalf, the Committee may take a negative inference and in this case they took such an inference.

Given that the Committee found the Petitioner's experts credible and there was no testimony or documentary evidence presented to refute their conclusion, the Committee concurred with their findings.

RECURRING PATIENT CHARGES:

There were a number of charges that applied to all or most of the patients in this case. These charges included inadequate histories and physicals, failure to obtain information about a patient's HIV status or treatment, failure to appropriately manage the patient's methadone detoxification program and inappropriately prescribing methadone.

The record established that for all of the patients charged the Respondent's initial history and physical examinations did not meet accepted standards of care. The Petitioner's witnesses testified that for the most part, these histories and physicals were cursory and inadequate and sometimes incomprehensible.

In all the cases charged, Respondent failed to take an adequate history of immediate complaints and of past history. That failure was particularly noticeable on initial visits, where a complete history is an essential element of standard care. An initial history ought to include an elaboration of the immediate complaint, previous treatment and response if any, previous illnesses and medications, social history, and family history. There is no credible evidence that the Respondent performed adequate initial histories on the six patients. Also, on subsequent visits, history-taking is essential. Details of new complaints must be elicited, progress and possible side effects of present treatment must be monitored. There is no evidence that Respondent engaged in adequate history-taking on an ongoing basis during the extensive periods of time that he treated these patients.

Respondent failed to perform adequate physical examinations on initial office visits and on a follow-up basis. In addition to an examination directed at the immediate area of complaint, physical examinations on an initial office visit should include, at a minimum, an examination of heart, lungs, abdomen, eyes, ears, and extremities. On a follow-up basis, further examination should be done relevant to the particular problem for which the patient is being treated. Respondent consistently failed to follow these indications. Respondent's ongoing physical examinations were substandard.

For those patients seeking help with their substance abuse problem, the Respondent should have either tested for HIV, or inquired into treatment they were receiving, but didn't for any of these patients. Nor did he manage their methadone maintenance program in a professionally acceptable manner. The records with respect to the patients' methadone maintenance program paint a picture of haphazard treatment with no plan or regimen, no patient accountability and no oversight on the part of the physician. This was a dangerous practice.

Additionally, the Respondent prescribed methadone for 4 of the 6 patients in question. Methadone cannot be prescribed legally unless a physician-specific waiver is obtained. The Respondent had no such waiver. He could not prescribe methadone legally for these four patients charged in this case, nevertheless he did just that. Although Respondent's counsel alluded that the Respondent possessed such a waiver, no

document was ever produced or offered in evidence. Since this would have exonerated the Respondent with respect to that charge, it is assumed that the Respondent had no such waiver.

PATIENT A:

Patient A was diagnosed with hypertension, yet the Respondent took no steps to ascertain the underlying status of the patient, a possible etiology of the condition and the extent to which it had affected the patient's health. The Respondent then proceeded to treat the condition with a number of different medications simultaneously, thus hindering the treatment process.

The patient also presented with an elevated pulse rate, but there is no record the Respondent ever addressed this fact. Nor did he appropriately treat the patient who he diagnosed with an atrial fibrillation without first conducting an EKG. After two days of pharmaceutical treatment for his atrial fibrillation, the patient's sinus rhythm was recorded as normal and the Respondent discontinue the treatment, thus inappropriately concluding that the patient no longer needed the medication.

This patient was being treated for back pain. The Respondent's records contain the results of an MRI which indicate there was a retro-pulsed fragment causing relative spinal stenosis. In layman's terms, there was a bone chip pressing against the patient's

spine. Yet the Respondent did not act upon this information. He should have referred the patient to an orthopedic surgeon for evaluation.

The Committee concluded that the Respondent's prescribing practices were inappropriate and did not meet acceptable standards of medical care. The record indicates he initially prescribed two opiate analgesics with a potential for overdosing. The Respondent then added Darvocet which increased the potential for harm to the patient. The Respondent then added to this potentially harmful mix an additional opiate with acetaminophen. Yet he did not monitor the patient's use of these potentially harmful medications in combination.

PATIENT B:

The Committee found the Respondent's care of Patient B with respect to this patient's sty to be adequate. There was conflicting testimony from the Petitioner's witnesses as to whether the Respondent's treatment of this condition met the standard of care. This was a matter of judgment. The record indicates that the Respondent did take steps to treat the problem with an antibiotic. It was not established that a referral to a specialist was warranted.

The patient was HIV positive. The Committee concurred with the Petitioner's expert that when the patient presented with an enlarged left lymph node a referral should have been made, given the patient's HIV status.

PATIENTS C, D, & G:

The Committee's reasoning with respect to the " Recurring Patient Charges" is applicable to these patients.

PATIENT E:

The evidence was clear that the Respondent failed to appropriately evaluate and treat the patient's arthritis. There was no inquiry into past treatments, tests were not conducted to ascertain the extent of the patient's condition and then he started treatment with narcotic medication instead of a non-steroidal anti-inflammatory agent.

The record indicates that the Respondent prescribed Halotestin, an anabolic steroid used to treat patient with diminished levels of testosterone. The Respondent prescribed this medication without any indicated evaluation such as relevant history or physical examination, laboratory tests or endocrine studies. Nor did the Respondent monitor the effect of the administration of the Halotestin with laboratory tests.

The Respondent then concurrently prescribed Ionamin, a weight reduction drug for the patient, notwithstanding that taking Halotestin may cause weight gain. This concurrent prescribing was inappropriate. The standard of care warranted that the Holotestin be discontinued first to determine whether the Ionamin was needed.

This patient also presented with an elevated blood pressure. The Respondent took no action with respect to this physical finding, nor did he obtain the results or follow-up on the patient's MRI test conducted in response to the patient's vascular headaches. This was substandard care.

Overall the care provided by the Respondent to these six patients was slipshod and unprofessional. The record established there was no defined treatment goal. Often each office visit was an isolated event, lacking any continuity of care.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent's license to practice medicine in New York State should **be revoked.** 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.

The record in this case clearly established that Respondent consistently failed to obtain adequate histories or conduct adequate physicals, did not order appropriate tests when needed, illegally prescribed methadone, inappropriately issued prescriptions for potentially dangerous substances, and failed to address a number of his patients medical

conditions or refer to an appropriate specialist. By doing so, he put his patients at risk. Respondent demonstrated negligence and incompetence in the practice of medicine.

Any individual who receives a license to practice medicine is placed into a position of public trust. Respondent essentially forfeited his right to that public trust, by his prescribing practices and the manner in which he conducted his practice. Respondent abdicated his responsibility to exercise his skill and judgment for the benefit of his patients.

The Committee unanimously determined that no sanction short of revocation would adequately protect the public.

ORDER

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

1. The **Thirteenth and Fourteenth Specifications** of professional misconduct, as set forth in the Amended Statement of Charges (Appendix I,

attached hereto and made a part of this Determination and Order) are

SUSTAINED;

2. The Respondent's license to practice medicine in New York State is

REVOKED.

DATED: Saranac Lake, New York
Feb 16th **, 2006**

Rev. THOMAS KORNMEYER (Chair)
JAMES T.ADAMS, M.D.
ROGER L. SPARK, M.D.

Martin Kosich, M.D.
Fluss-Heim
Hamburg Rd
Catskill, NY 12414

Sheila Galvin, Esq.
Galvin & Morgan
217 Delaware Ave.
Delmar, New York 12054

Kevin C. Roe, Esq.
Associate Counsel
NYS-DOH
BPMC
Corning Tower - Rm. 2509
Albany, New York 12237-0032

APPENDIX I

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

IN THE MATTER

OF

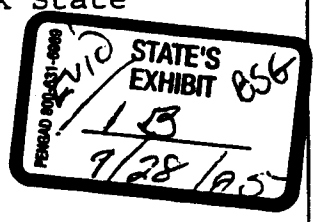
MARTIN KOSICH, M.D.

AMENDED STATEMENT

OF

CHARGES

MARTIN KOSICH, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 22, 1971, by the issuance of license number 108834 by the New York State Education Department.



FACTUAL ALLEGATIONS

A. Respondent treated Patient A(patients are identified in the attached Appendix) at his office Greenville Health Center, Greenville, New York from March 1992 to March 2002. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent failed to adequately evaluate, manage and/or treat persistent hypertension.

4. Respondent failed to adequately evaluate, manage and/or treat intermittent elevated heart rates.

5. Respondent failed to adequately diagnose, evaluate and/or treat atrial fibrillation.

6. Respondent failed to refer Patient A to an orthopedic/neurosurgical specialist for consideration of surgery after an MRI showed

"retropulsed fragment causing relative spinal stenosis."

7. Respondent inappropriately prescribed Oxycontin and Narco in combination.

8. Respondent inappropriately prescribed Darvocet, in addition to Oxycontin and Narco.

9. Respondent failed to adequately monitor the prescribing of narcotics regarding appropriate dosage and frequency.

B. Respondent treated Patient B at his office from January 2001 through April 2003. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent failed to obtain information regarding HIV treatment.

4. Respondent failed to appropriately manage methadone maintenance program.

5. Respondent failed to refer Patient B to a specialist for evaluation of recurrent/persistent "left eyelid stye" given the patient's known HIV status.

6. Respondent failed to refer Patient B to a specialist for evaluation of "enlarged left lymph node in the neck" given the patient's known HIV status.

7. Respondent inappropriately prescribed methadone.

C. Respondent treated Patient C at his office January 2001 through April 2003. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent failed to recomend/order/obtain HIV testing.

4. Respondent failed to appropriately manage methadone maintenance/detoxification program.

5. Respondent inappropriately prescribed methadone.

D. Respondent treated Patient D at his office from January 2001 through July 2002. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent failed to recomend/order/obtain HIV testing.

4. Respondent failed to appropriately manage methadone maintenance/detoxification.

5. Respondent inappropriately prescribed methadone.

E. Respondent treated Patient E at his office from February 1998 through April 2003. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent failed to obtain and review records of previous treatments/surgeries to evaluate nature of arthritis.

4. Respondent failed to order/obtain appropriate laboratory/radiographic studies to evaluate arthritis.

5. Respondent failed to prescribe a regimen of non-narcotic treatments (nonsteroidal anti-inflammatories, physical therapy, etc.) prior to treatment with narcotics.

6. Respondent failed to provide and/or document adequate instructions for follow-up on February 9, 1998.

7. Respondent prescribed Halotestin without adequate medical justification.

8. Respondent failed to order/obtain appropriate laboratory studies during Halotestin treatment.

9. Respondent prescribed Ionamin without adequate medical justification.

10. Respondent failed to adequately evaluate/manage elevated blood pressure.

11. Respondent failed to adequately follow up neurologist's recommendations to obtain MRI/MRA to evaluate vascular headaches.

G. Respondent treated Patient G at his office from January 2002 through April 2003. Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent failed to recommend/order/obtain HIV testing.

4. Respondent failed to appropriately manage methadone maintenance/detoxification.

5. Respondent inappropriately prescribed methadone.

SPECIFICATIONS

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Laws §6530(4) in that, Petitioner charges:

1. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, and/or A.9.

2. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7.

3. The facts in Paragraphs C and C.1, C.2, C.3, C.4 and/or C.5.

4. The facts in Paragraphs D and D.1, D.2, D.3, D.4, and/or D.5.

5. The facts in Paragraphs E and E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, and/or E.11.

6. The facts in Paragraphs G and G.1, G.2, G.3, G.4, and/or G.5.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law §6530(6) in that, Petitioner charges:

7. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, and/or A.9.

8. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7.

9. The facts in Paragraphs C and C.1, C.2, C.3, C.4 and/or C.5.

10. The facts in Paragraphs D and D.1, D.2, D.3, D.4, and/or D.5.

11. The facts in Paragraphs E and E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, and/or E.11.

12. The facts in Paragraphs G and G.1, G.2, G.3, G.4, and/or G.5.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Education Law §6530(3) in that, Petitioner charges two or more of the following:

13. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, A.9; B and B.1, B.2, B.3, B.4, B.5, B.6, B.7; C and C.1, C.2, C.3, C.4, C.5; D and D.1, D.2, D.3, D.4, D.5; E and E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, E.11; and/or G and G.1, G.2, G.3, G.4, G.5.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5) in that, Petitioner charges two or more of the following:

14. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, A.9; B and B.1, B.2, B.3, B.4, B.5, B.6, B.7; C and C.1, C.2, C.3, C.4, C.5; D and D.1, D.2, D.3, D.4, D.5; E and E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, E.11; and/or G and G.1, G.2, G.3, G.4, G.5.

DATED: September 21, 2005

Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct