STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Public

July 13, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Francisco Javier Monreal, M.D.
4413 South Salina Street
Syracuse, New York 13205

Joel Abelove, Esq.
NYS Department of Health
Bureau of Professional Med. Conduct
Corning Tower, Room 2589
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Francisco Javier Monreal, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. BPMC-07-141) 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,

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER

OF

FRANCISCO JAVIER MONREAL, M.D.

DETERMINATION

AND

ORDER

BPMC-07-141

WALTER M. FARKAS, M.D. Chairperson, **CARMELITA V. BRITTON, M.D.** and **GAIL S. HOMICK**, duly designated members of the State Board for Professional Medical Conduct appointed by the Commissioner of Health of the State of New York pursuant to Sections 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) 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

Notice of Hearing/ Statement of Charges:	April 25, 2007
Personal Services of Notice & Charges:	April 30, 2007
Date of Hearing:	June 11, 2007
Department of Health appeared by:	**THOMAS G. CONWAY, ESQ.**, General Counsel, NYS Department of Health
	BY: JOEL ABELOVE, ESQ. NYS Department of Health Room 2589, Corning Tower Empire State plaza Albany, New York 12237
Respondent :	**NO APPEARANCE**
Deliberations held:	June 11, 2007

LEGAL ISSUES

Pursuant to Part 230 (10) (d) of the Public Health Law, Petitioner must obtain personal service in order to establish jurisdiction to proceed to take an action against Respondent's medical license. Respondent was personally served with the Notice of Hearing and Statement of Charges on April 30, 2007. (Ex. 1) The Administrative Law Judge (ALJ) spoke via telephone with Respondent on May 4, 2007 and the details of that conversation are set out in a certified letter sent to Respondent on May 8, 2007. (Ex. 2) Respondent returned such letter unopened and also sent a letter in response dated May 14, 2007 in which he indicated knowledge of the impending hearing and his unwillingness to participate or to recognize the authority of the Board for Professional Medical Conduct to take action against his license. (Ex. 2A) Exhibits for this proceeding were sent in advance to Respondent by Department's counsel, but were also returned unopened and additional correspondence was received from Respondent, dated June 3, 2007 which gave further evidence of Respondent's knowledge of this proceeding, scheduled for June 11, 2007.The Administrative Law Judge ruled that jurisdiction had been obtained and that the Petitioner could proceed in its proposed action in accordance with provisions of the Public Health Law.

The Respondent failed to file a written answer to any of the Allegations in the Statement of Charges as required by Public Health Law Section 230 (10) and the ALJ accordingly granted Petitioner's request to deem all such Allegations admitted. The members of the Hearing Committee were advised that the only issue to be addressed would be the determination of an appropriate penalty as a result of all Allegations having been admitted.

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

A copy of the Notice of Hearing and Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on or about January 1, 1973 by the issuance of license number 118576 by the New York State Education Department. (Ex. 3)

2. Respondent provided medical care to Patient A on July 22, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient A, a 7-year-old girl, for attention deficit/hyperactivity disorder, after Patient A began having difficulties in school.

b. Respondent had an EEG performed on Patient A, which was not indicated.

c. Respondent's diagnosis of attention deficit/hyperactivity disorder for Patient A was not supported by the medical record.

d. Respondent's recorded statements that Patient A possessed a severe learning disability and that the personality features of controlling oppositional/defiant character had Respondent worried about her being an independent and stable adult, probably not with peaceful and durable relationships, were without medical basis or support.

e. Respondent breached patient confidentiality when he discussed two prior patients with the patient's mother and grandmother.

f. Respondent made comments to Patient A's mother and grandmother regarding Patient A's father which had no bearing on Patient A's health and which were insulting, unnecessary and/or entirely unacceptable for pediatric neurology.

g. Respondent's letters to the president of SUNY and to OPMC were suggestive of a personality disorder.

3. Respondent provided medical care to Patient B on July 27, 2006, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient B, a 3-year-old boy, in the presence of Patient B's mother and 16-year-old brother.

b. Respondent repeatedly jabbed Patient B in the chest and stomach with his knee to keep Patient B from making physical contact.

c. Respondent grabbed Patient B and shoved him, causing Patient B to fall to the floor.

d. While Patient B's mother was attempting to place Patient B in a restraining hold on her lap at Respondent's request, Respondent shoved Patient B's brother.

e. Without performing any testing, Respondent stated that Patient B was hopeless and useless and would only sit on the couch and get fat.

f. Respondent told Patient B's mother to begin administering Risperdal to Patient B to "snow" him so that he would not require any care.

g. Respondent told Patient B's mother that he had audiotaped the appointment although she was never asked for consent to do so.

h. Respondent's diagnosis and interpretation of behavior of Patient B are incorrect.

i. Respondent's behavior toward Patient B and Patient B's brother was without diagnostic or other medical purpose.

j. It was inappropriate to involve Patient B's brother in the course of treatment of Patient B.

k. On 8/30/06, OPMC sent Respondent a letter requesting the medical records of Patient B. Respondent failed to provide Patient B's medical records, and indicated in writing that he was no longer in possession of the records and/or he would not provide the records. On 11/27/06, Respondent was ordered by a Supreme Court Judge to provide the records to OPMC within 10 days. On 12/6/06, Respondent provided the medical records of Patient B.

4. Respondent provided medical care to Patient C on February 25, 2004, and several weeks later, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient C failed to meet accepted standards of medical care in that:

a. Respondent evaluated and treated Patient C, a 2-year-old boy, for shaking spells, during two separate office visits.

b. Respondent told Patient C's mother that Patient C would be fine by the time he turned five years old, but stated that he did not have a diagnosis for Patient C.

c. Patient C's mother complained that no examination or studies had occurred, yet Respondent reassured her that nothing was wrong with Patient C.

d. Subsequent to Patient C's appointments with Respondent, another provider diagnosed Patient C with mental retardation, dystonia, cerebral palsy and dyspraxia.

e. Respondent ordered the performance of an EEG on Patient C, which was not indicated.

f. Respondent's interpretation of the EEG as "inconclusive" was inappropriate.

g. On 8/30/06, OPMC sent Respondent a letter requesting the medical records of Patient C. Respondent failed to provide Patient C's medical records, and indicated in writing that he was no longer in possession of the records and/or he would not provide the records. On 11/27/06, Respondent was ordered by a Supreme Court Judge to provide the records to OPMC within 10 days. Respondent stated that he could not locate the medical records of Patient C.

5. Respondent provided medical care to Patient D on or about December 6, 2002, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient D failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient D, a 10-year-old boy, after he had been diagnosed with ADHD and emotional disturbance at Benjamin Rush Psychiatric Center.

b. Respondent brought Patient D into an exam room alone, and upon his return stated to Patient D's mother that she had adopted a bad seed, and asked why she wanted to change him, or words to that effect. Respondent further stated that she should not have adopted Patient D, that he was from bad genes, and would never amount to anything, or words to that effect.

c. Respondent failed to provide a diagnosis, treatment plan, or medication for Patient D. He instead stated that Patient D's mother should do whatever Benjamin Rush Psychiatric Center told her.

d. Subsequent to Respondent's evaluation of Patient D, the patient was diagnosed with autism.

e. On 8/30/06, OPMC sent Respondent a letter requesting the medical records of Patient D. Respondent failed to provide Patient D's medical records, and indicated in writing that he was no longer in possession of the records and/or he would not provide the records. On 11/27/06, Respondent was ordered by a Supreme Court Judge to provide the records to OPMC within 10 days. On 12/6/06, Respondent provided the medical records of Patient D.

6. Respondent provided medical care to Patient E, on or about June 9, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient E failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient E, a 4-year-old female, for a history of peculiar behaviors or movements that she had since she was an infant, and for posturing her arms to the side with fisted hands as she was having a neuromuscular reaction.

b. Respondent ordered an EEG performed on Patient E, which was not indicated.

c. Respondent's interpretation of the EEG was not correct.

7. Respondent provided medical care to Patient F, on or about January 29, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient F failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient F, a 5-year-old female, for a history of not sleeping well, RSV, and febrile seizures.

b. Respondent ordered an EEG performed on Patient F, which was not indicated.

c. Respondent's interpretation of the EEG was not correct.

8. Respondent provided medical care to Patient G, on or about June 17, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient G failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient G, a 10-year-old female, for a history of seizures since infancy, which was being treated with Depakote, and frequent headaches. Two prior EEG's at SUNY on 1/29/03 and 3/29/04 were both negative for epilepsy.

b. Respondent ordered an EEG performed on Patient G, the indication for which was not clear.

c. Respondent's interpretation of the EEG was incorrect.

9. Respondent provided medical care to Patient H, on or about March 1, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient H failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient H, a 13-year-old male, for a history of daily morning headaches for two months.

b. Respondent failed to obtain any information regarding the characteristics of the patient's headache other than localizing it to the frontal region.

c. Respondent failed to obtain information regarding family history of headaches in either the patient's parents or family members.

d. Respondent failed to properly state in the record his diagnosis and treatment plan.

10. Respondent provided medical care to Patient I, on or about February 19, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient I failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient I, a 13-year-old male, for a history of headaches and dizziness, for which an MRI had shown bifrontal periventricular bright spots in front of both frontal horns, spots of different interpretation. Patient I also had a history of recurrent sinusitis and allergies and had a normal CT Scan of his sinuses.

b. Respondent ordered an EEG performed on Patient I, which was not indicated.

c. Respondent failed to obtain sufficient history regarding the frequency of the headaches and dizziness, or the characteristics of the headaches and dizziness.

d. Respondent's final diagnosis is not clear and the follow-up contains insufficient information other than waiting another winter or two to ascertain more about the child's headache history.

11. Respondent provided medical care to Patient J, on or about March 3, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient J failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient J, a 7-year-old male, for a history of possible Asperger's or PDD.

b. Respondent ordered an EEG performed on Patient J, which was not indicated.

12. Respondent provided medical care to Patient K, on or about May 26, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient K failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient K, a 3-year-old male, for a history of clumsy walking and his wearing out the inside of his sneaker heels, and for possible CP.

b. Respondent ordered an EEG performed on Patient K, which was not indicated.

13. Respondent provided medical care to Patient L, on or about February 19, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient L failed to meet accepted standards of medical care in that:

a. Respondent evaluated Patient L, an 8-year-old male, for a history of possible learning difficulties and possible ADD.

b. Respondent ordered an EEG performed on Patient L, which was not indicated.

c. Respondent's interpretation of the EEG was vague.

14. Respondent's communications with various agencies in New York State by letters and/or legal papers show evidence of being paranoid, grandiose and/or disorganized. Conditions that present this way may be Bipolar Disorder, or Delusional Disorder, or Depression with Psychotic Features and/or Personality Disorders.

CONCLUSIONS OF LAW

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

The Hearing Committee concluded that all Factual Allegations and all Specifications should be **SUSTAINED** as Petitioner met its burden of proof and Respondent did not file an answer to any of the Charges or make an appearance, thereby admitting to all Charges.

DISCUSSION AND DETERMINATION OF PENALTY

Respondent's correspondence and legal filings sent to numerous State agencies over a lengthy period of time provided substantial evidence for the Hearing Committee to conclude that his ability to practice medicine may be impaired by his having one or more psychiatric disorders. His writings

demonstrate indications of both a grandiose and paranoid personality and represent an obvious unwillingness to accept the Board's authority to regulate his practice of medicine in New York State. The admitted Charges represent a clear pattern of cursory examinations, incorrect diagnoses and inappropriate treatment modalities which were considered to be significant deviations from accepted standards of medical practice. The Hearing Committee considered Respondent's history of insensitive and inappropriate statements made to patient families to also be of great concern and a further indication of his lack of fitness to practice.

The fact that Respondent failed to appear or to file an Answer to the Charges was also considered to be a clear indication of his lack of desire to retain his license. The Committee determined that Respondent's conduct justified the most serious punishment and that the revocation of his license to practice medicine in New York was the only appropriate penalty that could be imposed to adequately protect the public. The Committee considers the threat to the public's health and safety presented by Respondent's continued practice of medicine to be so significant that it specifically requests the OPMC to take all possible action available to advise any other State Board that has issued a medical license to Respondent of the determination to revoke his New York medical license.

ORDER

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

1. The Specifications contained within the Statement of Charges (Ex. 1) are **SUSTAINED**, and;

2. Respondent's license to practice medicine in New York State be, and hereby is, **REVOKED**, and;

3. This Order shall be effective upon service on the Respondent by personal service or by certified or registered mail in accordance with the provisions o Public Health Law §12-a.

DATED: Troy, New York

July 16, 2007

Walter M. Farkas, M.D.

WALTER M. FARKAS, M.D., Chairperson

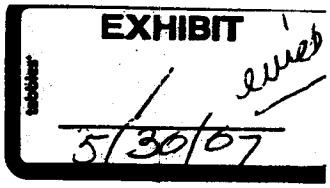
CARMELITA V. BRITTON, M.D.
GAIL S. HOMICK

TO:

Joel Abelove, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Room 2589, Corning Tower
Empire State Plaza
Albany, New York 12237

Francisco Javier Monreal, M.D.
4413 South Salina Street
Syracuse, New York 13205

APPENDIX I



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

IN THE MATTER

OF

FRANCISO JAVIER MONREAL, M.D.

NOTICE

OF

HEARING

TO: FRANCISCO JAVIER MONREAL
4413 South Salina Street
Syracuse, New York 13205

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on June 11, 2007, at 10:00 a.m., at the Holiday Inn Carrier Circle (Gemini Room), 6555 Old Collamer Road South, East Syracuse, New York 13057, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

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

ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A

DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
April 25 ,2007

Peter D. Van Buren

Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Joel Abelove, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower, Rm 2512
Albany, New York 12237
(518) 473-4282

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name_____Date of Proceeding_____

Name of person to be admitted_____

Status of person to be admitted_____
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

_____
Signature (of licensee or licensee's attorney)

This written notice must be sent to:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

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

IN THE MATTER

OF

FRANCISCO JAVIER MONREAL, M.D.

STATEMENT

OF

CHARGES

FRANCISCO JAVIER MONREAL, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 1, 1973, by the issuance of license number 118576 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A on July 22, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient A, a 7-year-old girl, for attention deficit/hyperactivity disorder, after Patient A began having difficulties in school.
2. Respondent had an EEG performed on Patient A, which was not indicated.
3. Respondent's diagnosis of attention deficit/hyperactivity disorder for Patient A is not supported by the medical record.
4. Respondent's recorded statements that Patient A possesses a severe learning disability and that the personality features of controlling oppositional/defiant character have Respondent worried about her being an independent and stable adult,

probably not with peaceful and durable relationships, are without medical basis or support.

5. Respondent breached patient confidentiality when he discussed two prior patients with the patient's mother and grandmother.
6. Respondent made comments to Patient A's mother and grandmother regarding Patient A's father which had no bearing on Patient A's health and which were insulting, unnecessary and/or entirely unacceptable for pediatric neurology.
7. Respondent's letters to the president of SUNY and to OPMC are suggestive of a personality disorder.

B. Respondent provided medical care to Patient B on July 27, 2006, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient B, a 3-year-old boy, in the presence of Patient B's mother and 16-year-old brother.
2. Respondent repeatedly jabbed Patient B in the chest and stomach with his knee to keep Patient B from making physical contact.
3. Respondent grabbed Patient B and shoved him, causing Patient B to fall to the floor.
4. While Patient B's mother was attempting to place Patient B in a restraining hold on her lap, at the request of Respondent, Respondent shoved Patient B's brother.
5. Without performing any testing, Respondent stated that Patient

B was hopeless and useless and would only sit on the couch and get fat.

6. Respondent told Patient B's mother to begin administering Risperdal to Patient B to "snow" him so that he would not require any care.

7. Respondent told Patient B's mother that he had audiotaped the appointment although she was never asked for consent to do so.

8. Respondent's diagnosis and interpretation of behavior of Patient B are incorrect.

9. Respondent's behavior toward Patient B and Patient B's brother was without diagnostic or other medical purpose.

10. It was inappropriate to involve Patient B's brother in the course of treatment of Patient B.

11. On 8/30/06, OPMC sent Respondent a letter requesting the medical records of Patient B. Respondent failed to provide Patient B's medical records, and indicated in writing that he is no longer in possession of the records and/or he will not provide the records. On 11/27/06, Respondent was ordered by a Supreme Court Judge to provide the records to OPMC within 10 days. On 12/6/06, Respondent provided the medical records of Patient B.

C. Respondent provided medical care to Patient C on February 25, 2004, and several weeks later, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient C failed to meet accepted standards of medical care in that:

1. Respondent evaluated and treated Patient C, a 2-year-old boy, for shaking spells, during two separate office visits.
2. Respondent told Patient C's mother that Patient C would be fine by the time he turned five years old, but stated that he did not have a diagnosis for Patient C.
3. Patient C's mother complained that no examination or studies had occurred, yet Respondent reassured her that nothing was wrong with Patient C.
4. Subsequent to Patient C's appointments with Respondent, another provider diagnosed Patient C with mental retardation, dystonia, cerebral palsy and dyspraxia.
5. Respondent had an EEG performed on Patient C, which was not indicated.
6. Respondent's interpretation of the EEG as "inconclusive" is inappropriate.
7. On 8/30/06, OPMC sent Respondent a letter requesting the medical records of Patient C. Respondent failed to provide Patient C's medical records, and indicated in writing that he is no longer in possession of the records and/or he will not provide the records. On 11/27/06, Respondent was ordered by a Supreme Court Judge to provide the records to OPMC within 10 days. Respondent stated that he could not locate the medical records of Patient C.

D. Respondent provided medical care to Patient D on or about December 6, 2002, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient D failed to meet accepted

standards of medical care in that:

1. Respondent evaluated Patient D, a 10-year-old boy, after he had been diagnosed with ADHD and emotional disturbance at Benjamin Rush Psychiatric Center.
2. Respondent brought Patient D into an exam room alone, and when he returned Respondent stated to Patient D's mother that she had adopted a bad seed, and asked why she wanted to change him, or words to that effect. Respondent further stated that she should not have adopted Patient D, that he is from bad genes, and will never amount to anything, or words to that effect.
3. Respondent failed to provide a diagnosis, treatment plan, or medication for Patient D. Respondent instead stated that Patient D's mother should do whatever Benjamin Rush Psychiatric Center told her.
4. Subsequent to Respondent's evaluation of Patient D, he was diagnosed with autism.
5. On 8/30/06, OPMC sent Respondent a letter requesting the medical records of Patient D. Respondent failed to provide Patient D's medical records, and indicated in writing that he is no longer in possession of the records and/or he will not provide the records. On 11/27/06, Respondent was ordered by a Supreme Court Judge to provide the records to OPMC within 10 days. On 12/6/06, Respondent provided the medical records of Patient D.

E. Respondent provided medical care to Patient E, on or about June 9, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient E failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient E, a 4-year-old female, for a history of peculiar behaviors or movements that she had since she was an infant, and for posturing her arms to the side with fisted hands as is she was having some sort of neuromuscular reaction.
2. Respondent had an EEG performed on Patient E, which was not indicated.
3. Respondent's interpretation of the EEG is not correct.

F. Respondent provided medical care to Patient F, on or about January 29, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient F failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient F, a 5-year-old female, for a history of not sleeping well, RSV, and febrile seizures.
2. Respondent had an EEG performed on Patient F, which was not indicated.
3. Respondent's interpretation of the EEG is not correct.

G. Respondent provided medical care to Patient G, on or about June 17, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient G failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient G, a 10-year-old female, for a history of seizures since infancy, which was being treated with Depakote, and frequent headaches. Two prior EEG's at SUNY on 1/29/03 and 3/29/04 were both negative for epilepsy.
2. Respondent had an EEG performed on Patient G, indication of which is not clear.
3. Respondent's interpretation of the EEG is incorrect.

H. Respondent provided medical care to Patient H, on or about March 1, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient H failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient H, a 13-year-old male, for a history of daily, morning headaches for a couple of months.
2. Respondent failed to obtain any information regarding the characteristics of the patient's headache other than just localizing it to the frontal region.
3. Respondent failed to obtain information regarding family history of headaches in either the patient's parents or family members.
4. Respondent failed to properly state in the record his diagnosis and treatment plan.

I. Respondent provided medical care to Patient I, on or about February 19, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient I failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient I, a 13-year-old male, for a

history of headaches and dizziness, for which an MRI had shown bifrontal periventricular bright spots in front of both frontal horns, spots of different interpretation. Patient I also had a history of recurrent sinusitis and allergies and had a normal CT Scan of his sinuses.

2. Respondent had an EEG performed on Patient I, which was not indicated.

3. Respondent failed to obtain sufficient history regarding the frequency of the headaches and dizziness, or the characteristics of the headaches and dizziness.

4. Respondent's final diagnosis is not clear and the follow-up contains insufficient information other than waiting another winter or two to ascertain more about the child's headache history.

J. Respondent provided medical care to Patient J, on or about March 3, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient J failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient J, a 7-year-old male, for a history of possible Asperger's or PDD.

2. Respondent had an EEG performed on Patient J, which was not indicated.

K. Respondent provided medical care to Patient K, on or about May 26, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient K failed to meet accepted

standards of medical care in that:

1. Respondent evaluated Patient K, a 3-year-old male, for a history of clumsy walking and his wearing out the inside of his sneaker heels, and the issue of possible CP.
2. Respondent had an EEG performed on Patient K, which was not indicated.

L. Respondent provided medical care to Patient L, on or about February 19, 2004, at his office at 4413 South Salina Street, Syracuse, New York 13205. Respondent's care and treatment of Patient L failed to meet accepted standards of medical care in that:

1. Respondent evaluated Patient L, an 8-year-old male, for a history of possible learning difficulties and possible ADD.
2. Respondent had an EEG performed on Patient L, which was not indicated.
3. Respondent's interpretation of the EEG is vague.

M. Respondent's communications with various agencies in New York State by letters and/or legal papers, show evidence of being paranoid, grandiose and/or disorganized. Conditions that present this way may be Bipolar Disorder, or Delusional Disorder, or Depression with Psychotic Features and/or Personality Disorders.

SPECIFICATION OF CHARGES

FIRST THROUGH TWELFTH SPECIFICATIONS
PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with Practicing the Profession with Negligence on More Than One Occasion, in violation of New York Education Law Section 6530(3), in that Petitioner charges two or more of the following:

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

and I.4.

10. The facts in Paragraphs J and J.1, and/or J and J.2.

11. The facts in Paragraphs K and K.1, and/or K and K.2.

12. The facts in Paragraphs L and L.1, L and L.2, and/or L and L.3.

THIRTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with Practicing the Profession with Incompetence on More Than One Occasion, in violation of N.Y. Education Law Section 6530(5), in that Petitioner charges two or more of the following:

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

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

15. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.5, and/or C and C.6.

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

17. The facts in Paragraphs E and E.1, E and E.2, and/or E and E.3.

18. The facts in Paragraphs F and F.1, F and F.2, and/or F and F.3.

19. The facts in Paragraphs G and G.1, G and G.2, and/or G and G.3.

20. The facts in Paragraphs H and H.1, H and H.2, H and H.3,

and/or H and H.4.

21. The facts in Paragraphs I and I.1, I and I.2, I and I.3, and/or I and I.4.
22. The facts in Paragraphs J and J.1, and/or J and J.2.
23. The facts in Paragraphs K and K.1, and/or K and K.2.
24. The facts in Paragraphs L and L.1, L and L.2, and/or L and L.3.

TWENTY-FIFTH THROUGH TWENTY-SEVENTH SPECIFICATIONS
CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE MEDICINE

Respondent is charged with Conduct in the Practice of Medicine Which Evidences Moral Unfitness to Practice Medicine, in violation of N.Y. Education Law Section 6530(20), in that Petitioner charges the following:

25. The facts in Paragraphs A and A.1, and/or A and A.6.
26. The facts in Paragraphs B and B.1, B and B.5, B and B.6, and/or B and B.9.
27. The facts in Paragraphs D and D.1, and/or D and D.2.

TWENTY-EIGHTH SPECIFICATION
FAILING TO MAINTAIN A RECORD FOR EACH PATIENT WHICH ACCURATELY REFLECTS THE EVALUATION AND TREATMENT OF THE PATIENT

Respondent is charged with Failing to Maintain a Record for Each Patient Which Accurately Reflects the Evaluation and Treatment of the Patient, in violation

of N.Y. Education Law Section 6530(32), in that Petitioner charges the following:

28. The facts in Paragraphs C and C.1, and/or C and C.7.

TWENTY-NINTH SPECIFICATION

REVEALING OF PERSONALLY IDENTIFIABLE FACTS, DATA, OR INFORMATION OBTAINED IN A PROFESSIONAL CAPACITY WITHOUT THE PRIOR CONSENT OF THE PATIENT

Respondent is charged with Revealing of Personally Identifiable Facts, Data, or Information Obtained in a Professional Capacity Without the Prior Consent of the Patient, in violation of N.Y. Education Law Section 6530(23), in that Petitioner charges the following:

29. The facts in Paragraphs A and A.1, and/or A and A.5.

THIRTIETH THROUGH THIRTY-SECOND SPECIFICATIONS

FAILING TO RESPOND WITHIN THIRTY DAYS TO WRITTEN COMMUNICATIONS FROM THE DEPARTMENT OF HEALTH AND TO MAKE AVAILABLE ANY RELEVANT RECORDS WITH RESPECT TO AN INQUIRY OR COMPLAINT ABOUT THE LICENSEE'S PROFESSIONAL MISCONDUCT

Respondent is charged with Failing to Respond Within Thirty Days To Written Communications From The Department Of Health And To Make Available Any Relevant Records With Respect To An Inquiry Or Complaint About The Licensee's Professional Misconduct, in violation of N.Y. Education Law Section 6530(28), in that Petitioner charges the following:

30. The facts in Paragraphs B and B.1, B and B.11.

31. The facts in Paragraphs C and C.1, C and C.7.

32. The facts in Paragraphs D and D.1, D and D.5.

THIRTY-THIRD THROUGH FORTY-FIRST SPECIFICATIONS
ORDERING OF EXCESSIVE TESTS, TREATMENT, OR USE OF TREATMENT FACILITIES NOT WARRANTED BY THE CONDITION OF THE PATIENT

Respondent is charged with Ordering Of Excessive Tests, Treatment, Or Use Of Treatment Facilities Not Warranted By The Condition Of The Patient, in violation of N.Y. Education Law Section 6530(35), in that Petitioner charges the following:

33. The facts in Paragraphs A and A.1, and/or A and A.2,

34. The facts in Paragraphs E and E.1, and/or E and E.2.

35. The facts in Paragraphs F and F.1, and/or F and F.2.

36. The facts in Paragraphs G and G.1, and/or G and G.2.

37. The facts in Paragraphs H and H.1, and/or H and H.2.

38. The facts in Paragraphs I and I.1, and/or I and I.2.

39. The facts in Paragraphs J and J.1, and/or J and J.2.

40. The facts in Paragraphs K and K.1, and/or K and K.2.

41. The facts in Paragraphs L and L.1, and/or L and L.2.

FORTY-SECOND SPECIFICATION
HAVING A PSYCHIATRIC CONDITION WHICH IMPAIRS THE LICENSEE'S ABILITY TO PRACTICE

Respondent is charged with Having A Psychiatric Condition Which Impairs The Licensee's Ability To Practice, in violation of N.Y. Education Law Section 6530(8), in that Petitioner charges the following:

42. The facts in Paragraphs A and A.1, and/or A and A.7, M.

DATE: April 25, 2007
Albany, New York

Peter D. VanBuren
Deputy Counsel
Bureau of Professional Medical Conduct