STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D. M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

March 28, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Maximo Chua
373 Route 11
Smithtown, New York 11787

Robert C. Gottlieb, Esq.
353 Veterans Memorial Hwy.
Commack, New York 11725

James F. Farrell, Jr., Esq.
888 Veterans Memorial Hwy.
Hauppauge, New York 11788-2919

Ronald R. Sussman, Esq.
470 Park Avenue South
New York, New York 10016

RE: In the Matter of Maximo Chua, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 94-46) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon 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.

As prescribed by the New York State Public Health Law, §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the administrative review board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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 of the Hearing Committee's Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to the New York State Department of Health, Bureau of Adjudication, Corning Tower - Room 2503, Empire State Plaza, Albany, New York 12237-0030, **Attention: James F. Horan, Esq., Administrative Law Judge.** 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.

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:lar
Enclosure

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

IN THE MATTER : DETERMINATION
OF : AND
MAXIMO C. CHUA, M.D. : ORDER
No. BPMC 94-46

THEA GRAVES PELLMAN, Chairperson, ROBERT S. BERNSTEIN, M.D., and HILDA RATNER, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. ELLEN B. SIMON, ESQ., served as Administrative Officer for the Hearing Committee.

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

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with negligence and incompetence, each on more than one occasion, and with gross negligence and gross incompetence.

The charges are more specifically set forth in the

Statement of Charges, a copy of which is attached hereto and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Commissioner's Order and Notice of Hearing Dated:	November 16, 1993
Amendment to Statement of Charges date:	November 27, 1993
Prehearing Conference:	November 29, 1993
Hearing Dates:	December 9, 1993
	December 10, 1994
	December 17, 1993
	January 14, 1994
	January 28, 1994
Interim Report date:	January 14, 1994
Commissioner's Interim Report dated:	January 19, 1994
Deliberation date:	February 16, 1994
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner Appeared By:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Ann Hroncich, Esq. Associate Counsel Roy Nemerson, Esq. Deputy Counsel, Of Counsel

Respondent Appeared By:

Wortman, Fumuso, Kelly,
Deverna & Snyder

888 Veterans Mem. Hgwy.
Hauppauge, New York
By: James F.
Farrell, Jr., Esq.

Siegel, Sommers & Schwartz
470 Park Avenue South
New York, New York
By: Ronald R. Sussman, Esq.,
Of Counsel

Robert C. Gottlieb, Esq.,
Of Counsel
353 Veterans Mem. Hgwy.
Commack, New York

Motion:

November 29, 1993: Pre-hearing motion by Petitioner to amend the Statement of Charges to include an additional factual allegation to the existing charges of practicing with negligence and incompetence - GRANTED.

WITNESSES

For the Petitioner: Pairojn Umpuntang
David Tricamo
Howard Chester, M.D.

For the Respondent: Richard S. Blum, M.D.

FINDINGS OF FACT

Numbers in parentheses 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.

GENERAL FINDINGS

1. Maximo C. Chua, M.D. the Respondent, was authorized to practice medicine in New York state on September 16, 1974, by the issuance of license number 121419 by the New York State Education Department (Dept.'s Ex. 2).

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 to December 31, 1994, at 373 Route 111, Smithtown, New York 11787-4759 (Dept.'s Ex. 2).

3. According to Respondent's curriculum vitae (Dept.'s Ex. 10), between 1963 and 1983, Respondent practiced as an anesthesiologist and, in 1975, became a Fellow of the American College of Anesthesiology.

FINDINGS OF FACT AS TO PATIENT A

4. From approximately April 1993 to approximately July 1993, Respondent treated Patient A, who at the time was 14 years old, at his office, located at 373 Route 111, Smithtown, New York (Dept.'s Ex. 3).

5. On or about July 29, 1993, Respondent inappropriately administered to Patient A an intravenous mixture of vitamins (thiamine (B-1), pyridoxine (B-6), cyancobalamin (B-12), B complex, and liver-iron) and magnesium sulfate (Dept.'s Ex. 3, p. 1; Dept.'s Ex. 7, pp. 1-2; Transcript pp. (hereinafter T.) 47-49, 115-116, 145-146,316-328, 338-358].

6. The magnesium sulfate and the thiamine that Respondent administered to Patient A on or about July 29, 1993, had expired (Dept.'s Ex.6, p. 7).

7. The liver-iron vitamin that Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "for intramuscular use only" (Dept.'s Ex. 6, p. 7).

8. The cyancobalamin that Respondent intravenously administered to Patient A on or about July 29, 1993 was labelled "intramuscular or deep subcutaneous--not for intravenous use" (Dept.'s Ex. 6, p. 7).

9. The magnesium sulfate that Respondent administered to Patient A on or about July 29, 1993, was labelled "intravenous if diluted" (Dept.'s Ex. 6, p. 7).

10. The vitamin B complex that Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "anaphylactogenesis to parenteral thiamine has been reported" (Dept.'s Ex. 6, p. 7).

11. Upon receiving the above-described intravenous regimen, Patient A developed a severe acute allergic reaction and suffered respiratory arrest. Respondent did not take appropriate action in response to this event as follows (Dept.'s Ex. 3, pp. 1-2; Dept.'s Ex. 7; T. 366-371, 373-376, 445-447):

a. He failed to administer epinephrine;

b. he failed to establish a proper airway before administering oxygen or mouth-to-mouth resuscitation;

c. he failed to use an Ambu bag; and

d. he administered oxygen by an inappropriate means, e.g., through an oxygen tube in the mouth.

12. Patient A subsequently expired (Dept.'s Ex. 6).

13. Parenteral administration of vitamins, particularly intravenously, was clearly an inappropriate mode of administration, unjustifiably increasing the risk of an allergic reaction or anaphylaxis (T. 339-340, 345-346, 348-358, 501, 506-508, 521-523).

14. Particularly in light of this patient's allergies and asthma, the unacceptable risks of administering treatment in an unjustifiably risky manner were even greater (Dept.'s Ex. 3; T. 316-328, 338-358).

FINDINGS OF FACT AS TO PATIENT B

15. From approximately September 1992 to approximately August 1993, Respondent treated Patient B, who at the time was 65 years old, at his office, located at 373 Route 111, Smithtown, New York (Dept.'s Ex. 4).

16. On or about October 22, 1992, Respondent inappropriately administered to Patient B an intravenous mixture of 10 ml of B complex, liver iron, magnesium sulfate, potassium chloride, vitamin C, and pyroxidine (Dept.'s Ex. 4, p. 57; T. 344-345, 349, 352-353, 355, 525-535, 541-543).

17. On or about October 7, 1992, Respondent inappropriately administered a single isolated dose of 1 gm of streptomycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 67; T. 535-539, 543-545).

18. On or about December 1, 1992, Respondent inappropriately administered gentamycin intramuscularly to Patient B (Dept's. Ex. 4, p. 43; T. 539-541, 545-548).

19. On or about December 23, 1992, Respondent inappropriately administered both streptomycin and gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 35; T. 541, 550-551).

20. On or about December 1, 1992, Respondent inappropriately administered both streptomycin and gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 35; T. 541, 550-551).

21. On or about January 7, 1993, Respondent inappropriately administered gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 33; T. 539-541, 551-552).

22. On or about March 10, 1993, Respondent inappropriately administered both streptomycin and gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 21; T. 541, 552-553).

23. On or about March 12, 1993, Respondent inappropriately administered gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 19; T. 539-541, 553-557).

24. Respondent failed to perform or note adequate follow-up examinations relative to Patient B's condition and/or treatment in that, despite Respondent's use of multiple injections of intramuscular streptomycin and gentamycin on multiple occasions (T 535-557), Respondent failed to perform audiometry studies to ensure that no additional complications were being caused iatrogenically (Dept.'s Ex. 4; T. 538-541, 554-557).

25. Treatment with a single isolated dose of streptomycin was not indicated for Patient B's condition (Dept.'s Ex. 4; T. 535-539).

26. Treatment with gentamycin was not indicated for Patient B's condition (Dept.'s Ex. 4; T. 539-541).

27. Treatment with a combined dose of streptomycin and gentomycin was not indicated for Patient B's condition (Dept.'s Ex. 4; T. 541, 861-862).

28. Parenteral administration of vitamins, particularly intravenously, was clearly an inappropriate mode of administration, unjustifiably increasing the risk of an allergic reaction or anaphylaxis (T. 316-317, 319-325, 527-531, 532-535).

29. Particularly in light of this patient's asthma, the unacceptable risks of administering treatment in an unjustifiably risky manner were even greater (see Findings of Fact No's. 15 through 28 and the record citations therein).

FINDINGS OF FACT AS TO PATIENT C

30. From approximately September 1992 to approximately September 1993, Respondent treated Patient C, who at the time was 39 years old, at his office, located at 373 Route 111, Smithtown, New York (Dept.'s Ex. 5).

31. On or about February 9, 1993, Respondent inappropriately administered to Patient C an intravenous mixture of B vitamins, magnesium sulfate, and potassium chloride (Dept.'s Ex. 5, p. 70; T. 344, 355, 525, 527, 628-631).

32. On or about March 9, 1993, Respondent inappropriately administered a combined dose of streptomycin and gentamycin intramuscularly to Patient C (Dept.'s Ex. 5, p. 64; T. 631-633).

33. On or about March 23, 1993, Respondent inappropriately administered a single isolated dose of streptomycin intramuscularly to Patient C (Dept.'s Ex. 5, p. 62;

T. 633-634).

34. Parenteral administration of vitamins, particularly intravenously, was clearly an inappropriate mode of administration, unjustifiably increasing the risk of an allergic reaction or anaphylaxis (T. 321-323).

35. Treatment with a single isolated dose of streptomycin was not indicated for Patient C's condition (Dept.'s Ex. 5; T. 535-539).

36. Treatment with gentamycin was not indicated for Patient C's condition (Dept.'s Ex. 5; T. 539-541).

37. Treatment with a combined dose of streptomycin and gentamycin was not indicated for Patient C's condition (Dept.'s Ex. 5; T 541).

CONCLUSIONS

In reaching its findings, the Hearing Committee reasoned as follows:

As to charges A.2 and A.3, there is insufficient evidence to conclude that, on July 29, 1993, Respondent had available in his office appropriate emergency supplies and equipment in the event of respiratory arrest, considering his administration of intravenous therapy. If such supplies and equipment were not available, the Committee believes that they should have been; if they were available, the Committee believes that they should have been used, but they were not. In this

regard, the Committee placed great weight on the fact that Respondent was trained and experienced in anesthesiology and, therefore, should have been better prepared to respond to respiratory failure. Instead, he failed even to administer epinephrine.

As to charge A.3, it cannot be determined from the evidence that the injection itself caused Patient A's sever acute allergic reaction. Rather, it was one or more of the component ingredients in the injection that caused it, but it cannot be determined from the evidence which ingredient or ingredients it was.

As to charge B.3, the Hearing Committee could not sustain the charge that Respondent failed to perform any necessary laboratory studies to ensure that no additional complications were caused iatrogenically because the patient's record indicated that renal studies had been done (Dept.'s Ex. 4). However, as there is no indication in the record that any audiometric studies were done, the Committee sustained that part of the charge relating to such studies.

As to charge C.4, the evidence indicated that Respondent had advised Patient C to consult a hematologist and that the patient refused to do so (Resp.'s Ex. D, p. 2, paragraph 6). Accordingly, the Committee could not and did not sustain this charge.

In considering the charges of negligence and gross negligence, the Hearing Committee noted the testimony of Respondent's expert witness, Dr. Richard S. Blum, that Respondent's treatment of patients with vitamins and minerals was appropriate under the practice of homeopathic medicine (T. 750, 887, 888, et al). No evidence was presented that homeopathy is an accepted and recognized medical sub-specialty in New York state. Further, Dr. Blum himself admitted that he is not an expert on homeopathy, but, rather, that he had done "some independent review of various forms to get a feeling of the field of homeopathy" (T. 712). Moreover, there was no substantive evidence presented that Respondent is experienced in homeopathy medicine. His curriculum vitae (Dept.'s Ex. 10) does not reflect any specific training in its practice. It merely states Respondent's membership in 1989 in the Homeopathic Society of the State of New York (sic) and his 1990 Board certification in Naturopathic Medicine.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously as follows:

FIRST SPECIFICATION:
(Negligence on more than one occasion)

SUSTAINED as to Paragraphs A, A.1 and A.3 (except that it cannot be determined from the evidence what particular ingredient or ingredients in the intravenous injection caused Patient A's severe acute allergic reaction); B, B.1, B.2, and B.3 (except as to necessary laboratory studies); C, C.1, C.2, and C.3.

NOT SUSTAINED as to Paragraphs A.2, B.3 (as to necessary laboratory studies), and C.4.

SECOND THROUGH FOURTH SPECIFICATIONS:
(Gross negligence)

SUSTAINED as to Paragraphs A, A.1. and A.3 (except as noted under the FIRST SPECIFICATION).

NOT SUSTAINED as to paragraphs A.2, B, B.1-B.3, C, C.1-C.4.

FIFTH SPECIFICATION:
(Incompetence on more than one occasion)

SUSTAINED as to paragraphs A, A.1, and A.3 (except as noted under the FIRST SPECIFICATION); B, B.1, B.2, and B.3 (except as to necessary laboratory studies).

NOT SUSTAINED as to Paragraphs A.2, B.3 (necessary laboratory studies); C, C.1-C.4.

SIXTH THROUGH EIGHTH SPECIFICATIONS:
(Gross incompetence)

SUSTAINED as to paragraphs A, A.1, and A.3 (except as noted under the FIRST SPECIFICATIONS).

NOT SUSTAINED as to paragraphs A.2, B, B.1-B.3, C, C.1-C.4.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee unanimously determines that the medical license of Respondent should be restricted to the practice of acupuncture in accordance with the terms and conditions of the Interim Order of the Commissioner of Health dated January 19, 1994, a copy of which is attached to and made a part of this Determination and Order.

The Hearing Committee further unanimously determines that Respondent should be required to comply with the following terms and conditions:

1. That Respondent apply for and participate in an evaluation of his knowledge and ability to practice medicine at the Physician Prescribed Educational Program (PPEP) at the Health Science Center, Syracuse, New York;

2. That if Respondent's evaluation by the PPEP indicates that he can be retrained, he be accepted into the PPEP;

3. That if Respondent is accepted for retraining at the PPEP, the restriction of his license to practice medicine be modified only to the extent necessary for the PPEP evaluation and retraining;

4. That Respondent successfully complete such PPEP course of study and present proof of such completion to the New York State Department of Health; and

5. That upon Respondent's successful completion of evaluation and retraining and his presentation of proof thereof, he be placed on probation for a period of two years.

ORDER

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

1. Respondent's license to practice medicine in the state of New York is restricted to the practice of acupuncture in accordance with the terms and conditions of the Interim Order of the Commissioner of Health dated January 19, 1994, a copy of which is attached to and made a part of this Determination and Order; and

IT IS FURTHER HEREBY ORDERED THAT:

2. Respondent comply with the following terms and conditions:

a. That Respondent apply for and participate in an evaluation of his knowledge and ability to practice medicine at the Physician Prescribed Educational Program (PPEP) at the Health Science Center, Syracuse, New York;

b. That if Respondent's evaluation by the PPEP indicates that he can be retrained, he be accepted into the PPEP;

c. That if Respondent is accepted for retraining at the PPEP, the restriction of his license to practice medicine be modified only to the extent necessary for the PPEP evaluation and retraining;

d. That Respondent successfully complete such PPEP course of study and present proof of such completion to the New York State Department of Health; and

e. That upon Respondent's successful completion of his evaluation and retraining and his presentation of proof thereof, he be placed on probation for a period of two years.

Dated: West Hempstead, New York
March 23, 1994

THEA GRAVES PELLMAN (Chairperson)

Robert S. Bernstein, M.D.
Hilda Ratner, M.D.

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

IN THE MATTER

OF

MAXIMO C. CHUA, M.D.

: COMMISSIONER'S
: ORDER AND
: NOTICE OF HEARING

TO: MAXIMO C. CHUA, M.D.
373 Route 111
Smithtown, New York 11787

The undersigned, Mark R. Chassin, M.D., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by MAXIMO C. CHUA, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993), that effective immediately MAXIMO C. CHUA, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified

or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993), and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1993). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 30th day of November, 1993 at 10:00 a.m. at 5 Penn Plaza, 6th Floor, New York, New York 10001 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 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.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), 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. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

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 or sanction 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 FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1993). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
November 16, 1993

MARK R. CHASSIN, M.D.
Commissioner of Health

Inquiries should be directed to:

Ann Hroncich
Associate Counsel
N.Y.S. Department of Health
5 Penn Plaza, 6th Floor
New York, New York 10001
Tel. No.: 212-613-2615

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
MAXIMO C. CHUA, M.D.	:	CHARGES

----------X

MAXIMO C. CHUA, M.D., the Respondent, was authorized to practice medicine in New York State on September 16, 1974, by the issuance of license number 121419, by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 to December 31, 1994.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, who at the time was 14 years old, at his office, which is located at 373 Route 111, Smithtown, New York, from approximately April 1993 to approximately July 1993. (The identities of Patient A and the other patients are disclosed in the attached Appendix.) Patient A had a personal and family history of severe asthma, and a personal history of allergies to a variety of substances as well as multiple endocrinological problems.

1. On or about July 29, 1993, Respondent inappropriately administered an intravenous mixture of vitamins (thiamine (B-1), pyridoxine (B-6), cyancobalamin (B-12), B complex, and liver-iron), and magnesium sulfate.

   a. The magnesium sulfate and the two containers/bottles of thiamine which Respondent administered to Patient A on or about July 29, 1993, had expired.

   b. The liver-iron vitamin which Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "for intramuscular use only".

   c. The cyancobalamin which Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "intramuscular or deep subcutaneous - not for intravenous use".

   d. The magnesium sulfate which Respondent administered to Patient A on or about

July 29, 1993, was labelled "intravenous if diluted".

e. The vitamin B complex which Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "anaphylactogenesis to parenteral thiamine has been reported".

2. On or about July 29, 1993, Respondent failed to have available appropriate emergency care supplies and equipment in light of the fact that he was administering intravenous therapy.

3. Upon receiving the above-described intravenous regimen, Patient A developed a severe acute allergic reaction to the intravenous injection and suffered a respiratory arrest. Respondent failed to take appropriate action in response to this event, and Patient A subsequently expired.

B. Respondent treated Patient B, who at the time was 65 years old, at his office, which is located at 373 Route 111, Smithtown, New York, from approximately September 1992 to

approximately August 1993. Respondent was treating Patient B for asthma and other conditions.

1. On or about October 22, 1992, Respondent inappropriately administered an intravenous mixture of 10 ml of B complex, liver, iron, magnesium sulfate, potassium chloride, vitamin C, and pyridoxine to Patient B.

2. On several occasions from approximately October 1992 to March 1993, Respondent inappropriately administered streptomycin and/or garamycin/gentamycin as follows:

   a. On or about October 7, 1992, Respondent inappropriately administered streptomycin intramuscularly to Patient B.

   b. On or about December 1, 1992, January 7, 1993, and March 12, 1993, Respondent inappropriately administered garamycin/gentamycin intramuscularly to Patient B.

c. On or about December 23, 1992, December 31, 1992, and March 10, 1993, Respondent inappropriately administered both streptomycin and gentamycin intramuscularly to Patient B.

3. Respondent failed to perform or note adequate follow-up examinations relative to Patient B's condition and/or treatment, including but not limited to the following:

a. Despite Respondent's use of multiple injections of intramuscular streptomycin and gentamycin on multiple occasions, Respondent failed to perform any laboratory or audiometry studies to ensure that no additional complications were being caused on an iatrogenic basis.

C. Respondent treated Patient C, who at the time was 39 years old, at his office, which is located at 373 Route 111, Smithtown, New York, from approximately September 1992 to approximately September 1993. Respondent was treating Patient C for his history of Chronic Fatigue Syndrome.

1. On or about February 9, 1993, Respondent inappropriately administered an intravenous mixture of B vitamins, magnesium sulfate, and potassium chloride to Patient C.

2. On or about March 23, 1993, Respondent inappropriately administered streptomycin intramuscularly to Patient C.

3. On or about March 9, 1993, Respondent inappropriately administered streptomycin and gentamycin intramuscularly to Patient C.

4. Despite the fact that Respondent knew that Patient C was leukopenic and thrombocytopenic, Respondent conducted some evaluations but upon obtaining the results of those evaluations, he failed to appropriately follow up upon such conditions.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed at least two of the following:

1. The facts contained in paragraphs A., A.1., A.1.a-e, and/or A.2 and/or 3, and/or B., B.1. and/or B.2. and/or B.2.a-c, and/or B.3. and/or B.3.a. and/or C., C.1., C.2., C.3, and/or C.4.

SECOND THROUGH FOURTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed the following:

2. The facts contained in paragraphs A., A.1., A.1.a-e, and/or A.2 and/or 3.

3. The facts contained in paragraphs B., B.1. and/or B.2. and/or B.2.a-c, and/or B.3. and/or B.3.a.

4. The facts contained in paragraphs C., C.1., C.2., C.3., and/or C.4.

FIFTH SPECIFICATION

PRACTICING WITH INCOMPETENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed at least two of the following:

5. The facts contained in paragraphs A., A.1., A.1.a-e, and/or A.2 and/or 3, and/or B., B.1. and/or B.2. and/or B.2.a-c, and/or B.3. and/or B.3.a. and/or C., C.1., C.2., C.3., and/or C.4.

SIXTH THROUGH EIGHTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed the following:

6. The facts contained in paragraphs A., A.1., A.1.a-e, and/or A.2 and/or 3.

7. The facts contained in paragraphs and/or B., B.1. and/or B.2. and/or B.2.a-c, B.3. and/or B.3.a.

8. The facts contained in paragraphs C., C.1., C.2., C.3, and/or C.4.

DATED: New York, New York
November 16, 1993

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct