Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

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

C. Maynard Guest, M.D.
Executive Secretary

August 15, 1995

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Kolin Kolew, M.D.
125 Charles Colman Boulevard
Pauling, New York 12564

Re: License No. 126546
Effective Date: 08/22/95

Dear Dr. Kolew:

Enclosed please fine Order #BPMC 95-175 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

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

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

Sincerely,

C. Maynard Guest

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Jean Bresler, Esq.

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

IN THE MATTER

OF

KOLIN KOLEW, M.D.

SURRENDER

ORDER

BPMC #95-175

Upon the Application of KOLIN KOLEW, M.D. (Respondent) to Surrender his/her license as a physician in the State of New York, which application is made a part hereof, it is

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

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

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

SO ORDERED.

DATED: 9 August 1995

Charles J. Vacanti

CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

KOLIN KOLEW, M.D.

APPLICATION TO SURRENDER LICENSE

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

KOLIN KOLEW, M.D., being duly sworn, deposes and says:

In or about 1976, I was licensed to practice medicine as a physician in the State of New York having been issued License No. 126546 by the New York State Education Department.

My current address is 125 Charles Coleman Boulevard, Pauling, NY 12564, and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that I have been charged with twenty specifications of professional misconduct as set forth in the Statement of Charges, annexed hereto, made a part hereof, and marked as Exhibit "A".

I am applying to the State Board for Professional Medical Conduct for permission to surrender my license as a physician in the State of New York on the grounds that I do not contest the first and fourth specifications, in full satisfaction of the Statement of Charges.

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

I understand that, in the event that the application is not granted by the State Board for Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such application shall not be used against me in any way, and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the State Board for Professional Medical Conduct shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by a Committee on Professional Medical Conduct pursuant to the provisions of the Public Health Law.

I agree that, in the event the State Board for Professional Medical Conduct grants my application, an order shall be issued striking my name from the roster of physicians in the State of New York without further notice to me.

I am making this Application of my own free will and accord and not under duress, compulsion, or restraint of any kind or manner.

Kolin Kolew M.D.

KOLIN KOLEW, M.D.
Respondent

Sworn to before me this
2nd day of August, 1995

Frank McKeon

NOTARY PUBLIC

FRANK McKEON
Notary Public, State of New York
No. 24-4795[illegible]
Qualified in New York County
Commission Expires 10-31-96

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

IN THE MATTER

OF

KOLIN KOLEW, M.D.

APPLICATION TO SURRENDER LICENSE

The undersigned agree to the attached application of the Respondent to surrender his license.

Date: 8-2-, 1995

Kolin Kolew M.D.

KOLIN KOLEW, M.D.
Respondent

Date: 8-2-, 1995

I choose not to have Attorney.

(IF ANY)
Attorney for Respondent

Date: , 1995

JEAN BRESLER
Associate Counsel
Bureau of Professional
Medical Conduct

Date: August 7, 1995

Anne Saccà

for KATHLEEN M. TANNER
Director
Office of Professional Medical Conduct

Date: 9 August, 1995

Charles J. Vacanti

CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional Medical Conduct

EXHIBIT "A"

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

IN THE MATTER OF KOLIN KOLEW, M.D.	STATEMENT OF CHARGES

KOLIN KOLEW, M.D., the Respondent, was authorized to practice medicine in New York State on or about 1976, by the issuance of license number 126546 by the New York State Education Department.

FACTUAL ALLEGATIONS

PATIENT A

A. Respondent rendered care and treatment to Patient A on or about June 28, 1990, March 5, 1991 and undated home visit. Respondent diagnosed acute pharyngotonsillitis.

1. On or about June 28, 1990, Respondent's care and treatment of Patient A deviated from acceptable medical standards in that:

   a. He failed to obtain an adequate history.
   b. He failed to perform an adequate physical examination.

2. On or about March 5, 1991 Respondent's care and treatment of Patient A deviated from acceptable medical standards in that:

   a. He failed to obtain an adequate history.

   b. He failed to perform an adequate physical examination.

   c. He inappropriately prescribed tetracycline and Compazine.

3. Respondent records a home visit for Patient A. No date is recorded. On this date Respondent's care and treatment of Patient A deviated from acceptable medical standards in that he:

   a. He failed to obtain an adequate history.

   b. He failed to perform an adequate physical examination.

PATIENT B

B. Respondent treated Patient B on or about May 24, 1990, January 16, 1991, January 30, 1991, February 1, 15, 7, 12, 14, 1991. Respondent's care and treatment of Patient B deviated from acceptable medical standards in that:

1. He failed to obtain an adequate history at each of the visits.
2. Respondent failed to perform adequate physical examination.

3. Respondent ordered tests not justified by history or findings noted, including progesterone test, and estrogen test.
4. Respondent administered Vitamin B12 injections not justified by history or physical findings.

PATIENT C

C. Respondent treated Patient C on eight occasions between 1984 through 1990. Respondent diagnosed bronchial asthma on December 19, 1984. An EKG was performed on August 5, 1987 and PVC's are noted. Respondent prescribes steroids, muscle relaxants, Decadron Motrin and Nitroglycerin. Respondent's care and treatment of Patient C deviated from acceptable medical standards in that:

1. He failed to obtain an adequate past medical history.
2. He failed to obtain adequate histories related to the patient's presenting complaints.
3. Respondent failed to adequately work-up Patient C for bronchial asthma.
4. Respondent's diagnosis of bronchial asthma is not supported by adequate history or physical findings.
5. Respondent failed to adequately follow-up on abnormal post-exercise EKG.
6. Respondent's prescription of steroids, muscle relaxants, Decadron, Motrin and nitroglycerin is not supported by history or physical findings.

PATIENT D

D. Respondent rendered care and treatment to Patient D on March 14, May 23, 1990 and on February 6, 1991. During the course of these three visits Patient D complained of nausea and vomiting. Respondent diagnosed acute gastritis. On the second visit Patient D complained of headaches. Migraine headaches are diagnosed and Respondent treated her with cafegot, cyclic Premarin and Inderal. On the last visit Respondent diagnosed respiratory infection and treated her with Tetracycline, Dimetane and Tylenol. Respondent's care and treatment of Patient D deviated from acceptable medical standards in that:

1. Respondent failed to obtain an adequate past medical history.
2. Respondent failed to perform adequate physical examinations.
3. Respondent's treatment for menopausal syndrome is unsupported by appropriate history, and physical findings.

PATIENT E

E. Respondent rendered care and treatment to Patient E on nine occasions between June 2, 1990 and April 5, 1991. Respondent recorded a history of chest pressure, headaches and coronary arteriosclerosis disease. Respondent's records indicate that Patient C received Coumadin and takes 2 aspirin. Throughout the treatment, Respondent continued to prescribe Coumadin and nitroglycerin. Two

P/T determinations are performed without controls. Respondent's care and treatment of Patient E deviated from acceptable medical standards in that:

1. Respondent failed to obtain an adequate past medical history, social history and history related to his symptoms and complaints.
2. Respondent failed to perform adequate physical examinations.
3. Respondent failed to appropriately monitor Patient E's prothrombin time.
4. Respondent failed to curtail the patient's use of aspirin in the presence of maintained Coumadin therapy.
5. Respondent failed to appropriately adjust Coumadin doses in response to P/T determinations.

PATIENT F

F. The Respondent treated Patient F on or about December 7, 8 and 9, 1989 January 11, 1990, May 25, 1990, September 1, 1990 and January 15, 1991.

1. He failed to obtain an adequate past medical history, and history related to symptoms and complaints.
2. He failed to perform adequate physical examinations.
3. On or about January 11, 1990 Respondent prescribed Hydrodiuril, Tenex and Tenormin without adequate medical

justification for these prescriptions.

4. On or about May 25, 1990 Respondent recorded a "hypertensive episode" without recording adequate history and physical findings.
5. Respondent continued using Niacin therapy despite lack of change in the patient's serum cholesterol during therapy.
6. Respondent prescribed Inderal and Antevert without sufficient medical indication.

PATIENT G

G. Respondent treated Patient G, a 76 year old woman on March 13, 1991. On this visit, the Respondent notes a history of heart palpitations and a list of 4 medications. Respondent prescribed Digoxin and Inderal, ECG was performed. Respondent's care and treatment of Patient G deviated from acceptable medical standards in that:

1. Respondent failed to obtain an adequate history.
2. Respondent failed to perform an adequate physical examination.
3. Respondent failed to adequately describe a systolic heart murmur noted.
4. Respondent prescribed Digoxin and Inderal without an adequate work-up.

PATIENTS H THROUGH CC

H. Respondent issued prescriptions for one or more of the following controlled substances; Valium, Tylenol with Codeine, Perogoric, Fastin, Darvocet, Placidyle, Emprin with Codeine, Darvon, Vicodin, without maintaining any patient records and for other then a bona fide medical purpose of the following patients: Patients H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, and CC.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(3)(McKinney Supp. 1995) in that the Petitioner charges that Respondent committed two or more of the following:

1. The facts in Paragraphs A, 1a, 1b, A2a, A2b, A2c, A3a, B, B1, B2, B3, B4, C, C1, C2, C3, C4, C5, C6, D, D1, D2, D3, E, E1, E2, E3, E4, E5, F, F1, F2, F3, F4, F5, F6, G, G1, G2, G3, G4, the facts as related to Patient H, I, J, K, L, M, N. O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB and/or CC.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law §6530 (3)(McKinney Supp. 1995) in that Petitioner charges that Respondent committed two or more of the following:

2. The facts in Paragraphs A, 1a, 1b, A2a, A2b, A2c, A3a, B, B1, B2, B3, B4, C, C1, C2, C3, C4, C5, C6, D, D1, D2, D3, E, E1, E2, E3, E4, E5, F, F1, F2, F3, F4, F5, F6, G, G1, G2, G3, G4, the facts as related to Patient H, I, J, K, L, M, N. O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB and/or CC.

3.

THIRD SPECIFICATION

PRACTICING FRAUDULENTLY

The Respondent is charged with professional misconduct pursuant to

N.Y. Educ. Law §6530(2)(McKinney Supp. 1995) in that he practiced the profession fraudulently in that Petitioner charges:

4. The facts in paragraphs H as pertains to Patient H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, and/or Patient CC.

FOURTH SPECIFICATION

FAILING TO MAINTAIN RECORDS

Respondent is charged with unprofessional conduct under N. Y. Educ. Law Section 6530(32)(McKinney Supp. 1995), in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient in that Petitioner charges:

5. The facts in paragraph H as pertains to Patient H, I, J, K, L, M, N. O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, and/or Patient CC.

FIFTH THROUGH TWELFTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with unprofessional conduct under N.Y. Educ.

Law Section 6530(4)(McKinney Supp. 1995), in that he practiced the profession with gross negligence on a particular occasion in that Petitioner charges:

6. The facts in paragraph A, A1a, A1b, A2a, A2b, A2c, and/or A3a.
7. The facts in paragraph B, B1, B2, B3, and/or B4.
8. The facts in paragraph D, D1, D2 and/or D3.
9. The facts in paragraph E, E1, E2, E3, E4, and/or E5.
10. The facts in paragraph F, F1, F2, F3, F4, F5, and/or F6.
11. The facts in paragraph G, G1 G2, G3 and/or G4.
12. The facts in paragraph H as related to Patients H, I, J, K, L, M, N, O, P. Q, R, S, T, U, V, W, X, Y, Z, AA, BB, and/or Patient CC.

THIRTEENTH THROUGH TWENTY FIRST SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with unprofessional conduct under N. Y. Educ. Law Section 6530(6)(McKinney supp. 1995), in that he practiced the profession with gross incompetence in that Petitioner charges:

13. The facts in paragraph A, A1a, A1b, A2a, A2b, A2c, and/or A3a.
14. The facts in paragraph B, B1, B2, B3 and/or B4.
15. The facts in paragraph C, C1, C2, C3, C4, C5 and/or C6.
16. The facts in paragraph D, D1, D2 and/or D3.
17. The facts in paragraph E, E1, E2, E3, E4, and/or E5.
18. The facts in paragraph F, F1, F2, F3, F4, F5 and/or F6.

19. The facts in paragraph G, G1, G2, G3 and/or G4.

20. The facts in paragraph H as related to Patients H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB and/or CC.

DATED: August , 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct