New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

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

Patrick F. Carone, M.D., M.P.H.
Chair
Ansel R. Marks, M.D., J.D.
Executive Secretary

July 24, 1998

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Rabin Chakraborty, M.D.
247 Golf Course Road
Amsterdam, New York 12010

RE: License No. 132909

Dear Dr. Chakraborty:

Enclosed please find Order #BPMC 98-152 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **July 24, 1998.**

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
Hedley Park Place, Suite 303
433 River Street
Troy, New York 12180

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure
cc: Cynthia Weiss Antonucci, Esq.
Lester, Schwab, Katz, & Dwyer
Law Offices
120 Broadway
New York, New York 10271-0071

Cindy Fascia, Esq.

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	CONSENT
OF	:	AGREEMENT
RABIN CHAKRABORTY, M.D.	:	AND ORDER
	:	BPMC #98-152

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STATE OF NEW YORK)

COUNTY OF)

RABIN CHAKRABORTY, M.D., deposes and says:

That on or about October 21, 1977, I was licensed to practice as a physician in the State of New York, having been issued license number 132909 by the New York State Education Department.

My current address is 247 Golf Course Road, Amsterdam, New York 12010 and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with twenty-one specifications of professional misconduct as set forth in the Statement of Charges, annexed hereto, made a part hereof, and marked as Exhibit A.

I agree not to contest the charges against me. I hereby agree to the following penalty:

My license to practice medicine shall be limited as follows:

I will not engage in the solo practice of medicine. I shall be restricted to the practice of gynecology in an outpatient setting only, and only under and in full compliance with the terms and conditions set forth in Exhibit B. I shall only provide such medical care and treatment as a reasonably prudent gynecologist would provide in an office setting, and I will perform only those procedures that would normally and customarily be performed by a reasonably prudent gynecologist in an office setting, and which can be performed safely and in accordance with accepted standards of medical care in an office setting.

I further agree that the Consent Order for which I hereby apply shall impose a condition that I maintain current registration of my license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees as long as I remain in active practice. This condition shall be in effect beginning thirty days after the effective date of the Consent Order. I hereby stipulate that any failure by me to comply with such condition shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that in the event that I am charged with professional misconduct in the future, this Consent Order and its Exhibits shall be admitted into evidence in that proceeding.

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

I understand that, in the event that this Application is not granted by the Board, 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 any appeals therefrom; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective as of the date of the personal service of this order upon me, upon mailing of this order to me at the address set forth in this agreement or to my attorney by certified mail, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

AFFIRMED:

RABIN CHAKRABORTY, M.D.
RESPONDENT

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 7/16/98

CYNTHIA WEISS ANTONUCCI, ESQ.
Attorney for Respondent

DATE: July 17, 1998

CINDY M. FASCIA
ASSOCIATE COUNSEL
Bureau of Professional
Medical Conduct

DATE: July 20 1998

ANNE F. SAILE
DIRECTOR
Office of Professional
Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER :

OF : CONSENT

RABIN CHAKRABORTY, M.D. : ORDER

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Upon the agreement of RABIN CHAKRABORTY, M.D. (Respondent) and the State Board for Professional Medical Conduct for a Consent Order, which agreement is made a part hereof, it is agreed to and

ORDERED, that the agreement and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective as of the date of the personal service of this order upon Respondent, upon mailing of this order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: July 22, 1998

Vice Chairperson

PATRICK F. CARONE, M.D., M.P.H.
Chairperson
State Board for Professional
Medical Conduct

EXHIBIT B

TERMS AND CONDITIONS OF CONSENT ORDER

1. Respondent shall conduct himself in all ways in a manner befitting his professional status as a physician, and shall conform fully to:

   a. the moral and professional standards of conduct and obligations imposed by law and by his profession;

   b. all civil and criminal laws, rules and regulations.

2. Respondent shall submit written notification to the New York State Department of Health (NYSDOH), addressed to the Director, Office of Professional Medical Conduct (OPMC), New York State Department of Health, Hedley Park Place, 4th Floor, 433 River Street, Troy, New York 12180-2299, of the following:

   a. any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility within thirty days of each action;

   b. a full description of any employment and practice, as well as Respondent's professional and residential addresses and telephone numbers. If there is any change in this information, Respondent will notify the Director of OPMC within 30 days of such change. This will include any change in practice location, within or without New York State.

   Failure to timely notify the Office of Professional Medical Conduct of any of the above will be considered a violation of the terms and conditions of this Consent Order.

3. Respondent's professional performance may be reviewed by the Director of OPMC or her designees. Said reviews shall occur on a quarterly basis. Reviews may include, but shall not be limited to, review of office records and/or hospital charts, interviews with and/or periodic visits with Respondent and his staff, at Respondent's office and/or OPMC's offices. OPMC shall reserve the right to require Respondent, on thirty (30) days written notice, to provide a list of all patients whom Respondent treated in the preceding year, including patient name, purpose of visit(s), and treatment rendered.

4. Respondent shall provide to OPMC, within ten (10) days of commencing any employment, a list of all procedures which Respondent proposes to perform in said setting. If OPMC, in the reasonable exercise of its discretion, determines that any procedure proposed by Respondent cannot be performed safely and in accordance with accepted standards of medical

practice in an office setting, Respondent will immediately cease performing said procedure.

5. Respondent will maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. In cases where the prescribing, dispensing, or administering of controlled substances is involved, the medical records shall contain all information required by State rules and regulations regarding controlled substances. Respondent's office records shall include, but not be limited to, documentation of all office visits and physical examinations, diagnosis, indications for treatment rendered, and all test results, including pathology. If a patient refuses a test or other treatment that is medically indicated, Respondent must specifically and contemporaneously document said refusal in the patient's medical record.

6. Respondent's practice of medicine shall be monitored by a licensed physician, board certified in Obstetrics and Gynecology, approved in advance, in writing, by the Director of Office of Professional Medical Conduct or her designee. It shall be Respondent's responsibility to locate a physician willing to serve in such a capacity and who is approved by the Director of Office of Professional Medical Conduct. The practice monitor shall not be a family member or personal friend of Respondent, or be or have been in a professional relationship with Respondent where that relationship could cause a conflict with monitoring responsibilities. Respondent may not practice medicine until an approved practice monitor and monitoring program are in place. Any practice of medicine prior to the submission and approval of a proposed monitor will be a violation of the terms and conditions of this Consent Order.

   a. Respondent shall make available to the practice monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's office on a quarterly basis and shall review no less than twenty (20) patient records maintained by Respondent, including but not limited to Respondent's notes of office visits and prescribing information. The practice monitor shall select these twenty records from the list of all patients treated by Respondent in his office. The practice monitor may select the records to be reviewed at random, or may request the records of specific named patients, at the discretion of the monitor and/or at the request of OPMC. The monitor's review shall be to determine whether Respondent's medical practice is being conducted in accordance with accepted standards of medical care. If any of the records indicate, or if the monitor otherwise ascertains or perceives Respondent to have deviated from accepted standards of medical care or to have otherwise committed professional misconduct of any

kind, or if Respondent fails to cooperate with or obstructs the monitor in any way, the monitor shall report said deviation and/or misconduct to OPMC within twenty-four (24) hours of the monitor's learning of said deviation and/or misconduct and/or failure to cooperate.

b. Respondent shall cause the practice monitor to submit written quarterly reports to OPMC regarding the patient charts reviewed by the monitor and any other means by which the monitor has evaluated Respondent's practice. The quarterly reports must include the patient's name, medical record number, and assessment of the quality of care provided by Respondent for each record reviewed. Failure of the practice monitor to submit required reports on a timely basis will constitute a violation of the terms and conditions of this Consent Order. OPMC, in its discretion, may accept late reports if good cause is shown for the delay.

c. If, at any time, Respondent's practice monitor is no longer willing, able, or approved to serve, Respondent must submit the name of a proposed successor monitor to OPMC within seven business days of Respondent learning that his monitor is no longer willing, able or approved to serve. Any proposed successor monitor is subject to approval by OPMC.

d. All expenses associated with practice monitoring, including the fees, if any, of the monitoring physician, shall be the sole responsibility of Respondent.

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

7. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

8. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms and conditions, or of the practice limitation in the Consent Order, the Director of OPMC and/or the Board may initiate any such other proceeding against Respondent as may be authorized pursuant to the law.

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
RABIN CHAKRABORTY, M.D.	:	CHARGES

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RABIN CHAKRABORTY, M.D., the Respondent, was authorized to practice medicine in New York State on October 21, 1977 by the issuance of license number 132909 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine through December 31, 1999, with a registration address of 247 Golf Course Road, Amsterdam, New York 12010.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A [Patients are identified in Appendix.] on various occasions from approximately January 19, 1989 through August 7, 1989 at the Total Female Care Center located at 347 West Main Street, Amsterdam, New York [hereinafter "Respondent's office"] and/or at St. Mary's Hospital, Amsterdam, New York [hereinafter "St. Mary's Hospital"]. Respondent, on August 1, 1989, admitted Patient A to St. Mary's Hospital for induction of labor.

1. Respondent, on or about August 1, 1989, ordered

Syntocinon Nasal Spray for Patient A, which was contraindicated.

2. Respondent failed to adequately document his use of Syntocinon Nasal Spray for induction of this patient.

3. Respondent induced labor in Patient A without adequate medical indication and/or diagnosed Patient A as having pre-eclampsia, which diagnosis was not medically justified.

B. Respondent provided medical care to Patient B from approximately January 20, 1989 through July 20, 1989, at his office and/or at St. Mary's Hospital. Respondent, on July 10, 1989, admitted Patient B to St. Mary's Hospital and on or about July 12, 1989, commenced an induction of labor for Patient B.

1. Respondent, on or about July 12 and/or July 13, 1989, ordered Syntocinon Nasal Spray for Patient B, which was contraindicated.

2. Respondent induced labor in Patient B without adequate medical indication.

3. Respondent performed an amniocentesis at approximately 38 weeks gestation which was not indicated.

C. Respondent provided medical care to Patient C from approximately March 28, 1989 through October 10, 1989 at his office and/or at St. Mary's Hospital. Respondent, on October 5, 1989, admitted Patient C to St. Mary's Hospital for preterm labor, and caesarean section of a known twin gestation.

1. Respondent, in a pre-term twin gestation, performed a caesarean section without adequate indication at the time it was performed and/or when Patient C was not in active labor.

D. Respondent provided medical care to Patient D on various occasions from approximately October 29, 1990 through March 26, 1991 at the Women's Health Center clinic at Amsterdam Memorial Hospital, Amsterdam, New York.

1. Respondent failed to offer to and/or order AFP testing for this patient in a timely manner.

E. Respondent provided medical care to Patient E on various occasions from approximately February 23, 1987 through October 5, 1987 at his office and/or at St. Mary's Hospital.

1. Respondent performed a caesarean section on Patient E on September 30, 1987, without medical indication.

2. Respondent performed a caesarean section on Patient E

for herpes without evidence and/or documentation of active disease.

F. Respondent provided medical care to Patient F from approximately April 28, 1987 through May 13, 1987 at St. Mary's Hospital. Respondent, on May 8, 1987, performed a total abdominal hysterectomy and bilateral salpingo oophorectomy on Patient F.

1. Respondent performed the above surgery on Patient F without adequate medical indication.

2. Respondent performed the above surgery on Patient F in the presence of pelvic abscess secondary to diverticulitis.

G. Respondent provided medical care to Patient G on various occasions from approximately September 16, 1992 through approximately May 13, 1993 at Respondent's office and at Amsterdam Memorial Hospital, Amsterdam, New York [hereinafter "Amsterdam Memorial Hospital"]. Respondent, on September 18, 1992, performed surgery on Patient G at Amsterdam Memorial Hospital. Respondent described said surgery in his operative note as a D&C, operative laparoscopy, lysis of adhesions, salpingostomy and partial right salpingectomy.

1. Respondent, on approximately January 13, 1993, performed surgery on Patient G at Amsterdam Memorial Hospital. Respondent described said surgery in his operative note as exploratory laparotomy, bilateral ovarian wedge resection, left cornual resection, lysis of adhesions and appendectomy.

   a. Respondent performed the above surgery on January 13, 1993 without adequate medical indication.

   b. Respondent performed a right ovarian wedge resection for hemostasis, when the blood loss for the entire surgery was estimated at 100 cc.

   c. Respondent performed an incidental appendectomy after having performed wedge resections of both

ovaries.

d. Respondent, despite Patient G's history of prolonged pain and the fact that he was performing an open abdominal surgery, failed to perform surgery which he could reasonably have expected to improve the patient's condition.

2. Respondent, on or about February 19, 1993 performed surgery on Patient G at Amsterdam Memorial Hospital. Respondent described said surgery in his operative note as D&C, operative laparoscopy and right ovariotomy.

a. Respondent performed the above surgery on February 19, 1993 without adequate medical indication.

b. Respondent considered and/or documented ectopic pregnancy as a differential diagnosis for said surgery, when Patient G had a negative serum HCG.

c. Respondent performed a laparoscopy on Patient G, despite the fact that in January 1993 Respondent had documented in Patient G's medical record that he felt it was too dangerous to do another laparoscopy on her, and had performed a laparotomy at that time.

d. Respondent subjected Patient G to surgery on February 19, 1993 which exposed her to risk because of her adhesions and/or which Respondent could not have reasonably expected would improve Patient G's condition.

e. Respondent failed to perform definitive surgery on Patient G in a timely manner and/or when indicated.

f. Respondent failed to properly evaluate Patient G's laboratory and testing data and/or to correlate said data to her symptoms.

3. Respondent, from approximately February 1993 through approximately May 1993, continued to treat Patient G with Lupron, despite the fact that previous doses of said medication had not alleviated her condition and/or failed to consider and/or discuss with Patient G definitive or extended treatment for her condition.

4. Respondent, on approximately May 12, 1993, again performed surgery on Patient G at Amsterdam Memorial Hospital. Respondent described said surgery in his operative note as EUA, video operative laparoscopy, right intestinal and omental adhesiolysis, and right salpingo-oophorectomy with cornual resection.

a. Respondent performed the above surgery without adequate medical indication.

b. Respondent subjected Patient G to repeated surgery without adequate medical indication.

c. Respondent failed to perform definitive surgery on Patient G in a timely manner and/or when indicated.

d. Respondent failed to properly evaluate Patient G's lab data and/or to correlate said data to her symptoms.

e. Respondent performed a laparoscopy on Patient G, despite the fact that in January 1993 Respondent had documented in Patient G's medical record that he felt it was too dangerous to do another laparoscopy on her, and had performed a laparotomy at that time.

H. Respondent provided medical care to Patient H on various occasions from approximately June 1983 through approximately January 1988 at Respondent's office and/or at St. Mary's Hospital and/or at Amsterdam Memorial Hospital.

1. Respondent, on approximately June 22, 1983, performed surgery on Patient H at Amsterdam Memorial Hospital.

Respondent described said surgery in his operative note as diagnostic laparoscopy and D&C, and aspiration of cul-de-sac. Respondent, despite his diagnosis of endometriosis at the time of surgery, failed to provide any treatment for said condition.

2. Respondent, on approximately June 22, 1984, again performed surgery on Patient H at Amsterdam Memorial Hospital. Respondent described said surgery in his operative note as a D&C. Respondent, despite his previous diagnosis of endometriosis in this patient, failed to consider and/or document consideration of endometriosis as the etiology for Patient H's condition.

3. Respondent, on approximately September 18, 1985, performed a D&C with endocervical curettement and biopsies on Patient H at St. Mary's Hospital. Respondent, on approximately October 14, 1985, performed cryocautery on Patient H in his office without a definitive diagnosis and/or without adequate medical indication for said procedure.

4. Respondent, on approximately November 19, 1986, performed surgery on Patient H at St. Mary's Hospital. Said surgery is described as a laparoscopy, D&C, and aspiration of right ovarian cyst.

a) Respondent failed to adequately evaluate Patient H and/or to consider and/or correlate her past medical history in making treatment choices.

b) Respondent subjected Patient H to surgery without adequate medical indication.

c) Respondent, despite his previous diagnosis of endometriosis in this patient, failed to consider and/or document consideration of endometriosis as the etiology for Patient H's condition.

5. Respondent, on approximately February 25, 1987, performed surgery on Patient H at St. Mary's Hospital. Respondent described said surgery in his operative note as a D&C, laparoscopy followed by laparotomy, right ovarian cystectomy, drainage of hemoperitoneum and appendectomy.

a) Respondent considered and/or documented ectopic pregnancy as a differential diagnosis for said surgery, when Patient H had a negative pregnancy test.

b) Respondent, after performing an ovarian cystectomy, and in the presence of a hemoperitoneum, performed an appendectomy.

c) Respondent subjected Patient H to surgery without adequate medical indication.

d) Respondent failed to consider and/or correlate Patient H's past medical history in making treatment choices.

e) Respondent saw Patient H in his office for medical care on or about February 24, 1987. Respondent failed at that time to develop and/or document a treatment plan for Patient H's care.

6. Respondent, on approximately August 12, 1987, again performed surgery on Patient H at St. Mary's Hospital. Respondent described said surgery in his operative note as laparoscopy, drainage of left ovarian cyst and posterior cul-de-sac fluid.

a) Respondent considered and/or documented a pre-operative diagnosis of ectopic pregnancy despite a negative serum pregnancy test.

b) Respondent subjected Patient H to surgery without adequate medical indication.

7. Respondent provided medical care to Patient H on approximately December 15, 1987 in Respondent's office, for complaints of amenorrhea and pain. Respondent

failed to consider and/or document a diagnosis of ectopic pregnancy.

8. Respondent, on approximately January 14, 1988, again performed surgery on Patient H at St. Mary's Hospital. Respondent described said surgery in his operative note as D&C, laparoscopy, laparotomy, drainage of hemoperitoneum, right salpingostomy, removal of products of conception, and a right tuboplasty. Respondent thereafter provided medical care to Patient H in February 1988 in Respondent's office. Respondent performed hydrotubation purportedly to ascertain patency of the repaired tube, when in fact said procedure would not have provided definitive information.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing medicine with gross negligence on a particular occasion in violation of New York Education Law § 6530(4) (McKinney Supp. 1997), in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3.
2. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3.
3. The facts in Paragraphs C and C.1.
4. The facts in Paragraphs D and D.1.
5. The facts in Paragraphs E and E.1 and/or E.2.
6. The facts in Paragraphs F and F.1 and/or F.2.
7. The facts in Paragraphs G and G.1(a) and/or G.1(b) and/or G.1(c) and/or G.1(d) and/or G.2(a) and/or G.2(b) and/or G.2(c) and/or G.2(d) and/or G.2(e) and/or G.2(f) and/or G.3 and/or G.4(a) and/or G.4(b) and/or G.4(c) and/or G.4(d) and/or G.4(e).
8. The facts in Paragraphs H and H.1 and/or H.2 and/or H.3 and/or H.4(a) and/or H.4(b) and/or H.4(c) and/or H.5(a) and/or H.5(b) and/or H.5(c) and/or H.5(d) and/or H.5(e) and/or H.6(a) and H.6(b) and/or H.7 and/or H.8.

NINTH THROUGH SIXTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing medicine with gross incompetence in violation of New York Education Law § 6530(6) (McKinney Supp. 1997), in that Petitioner charges:

9. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3.
10. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3.
11. The facts in Paragraphs C and C.1.
12. The facts in Paragraphs D and D.1.
13. The facts in Paragraphs E and E.1 and/or E.2.
14. The facts in Paragraphs F and F.1 and/or F.2.
15. The facts in Paragraphs G and G.1(a) and/or G.1(b) and/or G.1(c) and/or G.1(d) and/or G.2(a) and/or G.2(b) and/or G.2(c) and/or G.2(d) and/or G.2(e) and/or G.2(f) and/or G.3 and/or G.4(a) and/or G.4(b) and/or G.4(c) and/or G.4(d) and/or G.4(e).
16. The facts in Paragraphs H and H.1 and/or H.2 and/or H.3 and/or H.4(a) and/or H.4(b) and/or H.4(c) and/or H.5(a) and/or H.5(b) and/or H.5(c) and/or H.5(d) and/or H.5(e) and/or H.6(a) and H.6(b) and/or H.7 and/or H.8.

SEVENTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with negligence on more than one occasion in violation of New York Education Law § 6530(3) (McKinney Supp. 1997), in that Petitioner charges that Respondent committed two or more of the following:

17. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or B and B.1 and/or B.2 and/or B.3 and/or C and C.1 and/or D and D.1 and/or E and E.1 and/or E.2 and/or F and F.1 and/or F.2 and/or G and G.1(a) and/or G.1(b) and/or G.1(c) and/or G.1(d) and/or G.2(a) and/or G.2(b) and/or G.2(c) and/or G.2(d) and/or G.2(e) and/or G.2(f) and/or G.3 and/or G.4(a) and/or G.4(b) and/or G.4(c) and/or G.4(d) and/or G.4(e) and/or H and H.1 and/or H.2 and/or H.3 and/or H.4(a) and/or H.4(b) and/or H.4(c) and/or H.5(a) and/or H.5(b) and/or H.5(c) and/or H.5(d) and/or H.5(e) and/or H.6(a) and H.6(b) and/or H.7 and/or H.8.

EIGHTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with

incompetence on more than one occasion in violation of New York Education Law § 6530(5) (McKinney Supp. 1997), in that Petitioner charges that Respondent committed two or more of the following:

18. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or B and B.1 and/or B.2 and/or B.3 and/or C and C.1 and/or D and D.1 and/or E and E.1 and/or E.2 and/or F and F.1 and/or F.2 and/or G and G.1(a) and/or G.1(b) and/or G.1(c) and/or G.1(d) and/or G.2(a) and/or G.2(b) and/or G.2(c) and/or G.2(d) and/or G.2(e) and/or G.2(f) and/or G.3 and/or G.4(a) and/or G.4(b) and/or G.4(c) and/or G.4(d) and/or G.4(e) and/or H and H.1 and/or H.2 and/or H.3 and/or H.4(a) and/or H.4(b) and/or H.4(c) and/or H.5(a) and/or H.5(b) and/or H.5(c) and/or H.5(d) and/or H.5(e) and/or H.6(a) and H.6(b) and/or H.7 and/or H.8.

NINETEENTH THROUGH TWENTY-FIRST SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct under New York Education Law § 6530(32) (McKinney Supp. 1997) by reason of his failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

19. The facts in Paragraphs A and A.2.

20. The facts in Paragraphs E and E.2.

21. The facts in Paragraphs H and H.2 and/or H.4(c) and/or H.5(a) and/or H.5(e) and/or H.6(a) and/or H.7.

DATED: June 24, 1998
Albany, New York

Peter D. Van Buren

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