STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

February 18, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Howard Marshal Bezoza, M.D.
24 West 57th Street, Suite 701
New York, New York 10019

Howard Marshal Bezoza, M.D.
8 Old Farms Road
Saddle River, New Jersey 07954

Paul Stein, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional
Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

RE: In the Matter of Howard Marshal Bezoza, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-041) 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.

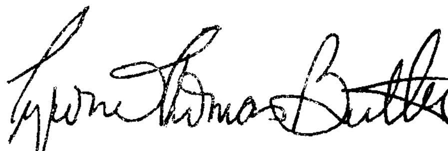
The notice of review served on the Administrative Review Board should be forwarded to:

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,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:djh

Enclosure

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

COPY

IN THE MATTER OF HOWARD MARSHAL BEZOZA, M.D.	DETERMINATION AND ORDER

RUTH HOROWITZ, Ph.D., Chairperson, **ALLAN GIBOFSKY, M.D.** and **DANA O. MONACO, 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 Section 230(10(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **DONALD P. BERENS, Jr.**, General Counsel, **PAUL STEIN, ESQ.**, Associate Counsel, of Counsel. The Respondent made no appearance at the hearing and was not represented by counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged thirty (30) specifications of professional misconduct, including allegations of negligence, incompetence, gross negligence, gross incompetence, excessive treatment, fraudulent practice and failure to maintain accurate medical records. The charges are more specifically set forth in the Statement of Charges dated October 24, 2002, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	October 24, 2002
Pre-Hearing Conference	November 20, 2002
Hearing Dates:	December 4, 2002

WITNESSES

For the Petitioner:	Pearl Howard Robert Matz, M.D. Jahon Soltani, M.D.
For the Respondent:	None

FINDINGS OF FACT

1. Howard Marshal Bezoza, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 20, 1978 by the issuance of license number 136435 by the New York State Education Department. (P's Ex. 2 at 1)

2. Petitioner made extensive and legally sufficient good faith efforts to locate Respondent and to serve Respondent with Notice of Hearing, Statement of Charges, and Summary of Department of Health Hearing Rules. (P's Ex. 3, 4, 5, 6, 7, and 22, Tr. 7-13)

3. Robert Matz, M.D., Petitioner's medical expert, was a well-qualified and credible expert witness. (P's Ex. 19, Tr. 25-27 and *passim*)

4. Pearl Howard, former Office of Professional Medical Conduct health program aide who participated in the investigation of Respondent, was a credible witness. (Tr. 20-24)

5. Jahon Soltani, M.D., Chief of the Division of Emergency Medicine at Coney Island Hospital at the time of Respondent's employment there, was a credible witness. (Tr. 138-41)

Patient A

A. From on or about January 8, 1985 through on or about May 28, 1996, Respondent treated Patient A, (Patient A and all other patients are identified in Appendix A) who initially presented with a history of recurrent depression and thyroid disease, in his office in New York City. Toward the end of Respondent's course of treatment of Patient A, Patient A was diagnosed with acute leukemia. (P's Ex. 8 at 2-22, 12, Tr. 29-30, 56-57)

A1. Respondent failed to take an adequate history of Patient A. (P's Ex. 8 at 12, Tr. 31-33)

A2. Respondent failed to order mammography of Patient A or document that mammography of Patient A was performed elsewhere. (P's Ex. 8, Tr. 33-34)

A3. Respondent failed to conduct an adequate work up or make a referral for Patient A's anemia, leucopenia, and high MCV. (P's Ex. 8 and specifically P's Ex. 8 at 199, Tr. 34-40)

A4 Respondent failed to conduct appropriate laboratory tests for Patient A. (P's Ex. 8 and specifically P's Ex. 8 at 199, Tr. 34-40)

A5. Respondent failed to appropriately evaluate and treat Patient A's thyroid condition. (P's Ex. 8 at 199, 238, 162, 219, 3, 4, Tr. 40-49)

A6. Respondent failed to adequately monitor the treatment of Patient A's thyroid condition. (P's Ex. 8 at 199, 238, 162, 219, 3, 4, Tr. 40-49)

A7. Respondent treated Patient A with megadoses of amino acids without adequate medical indication. (P's Ex. 8 at 13, 140, Tr. 49-51, 54-55)

A8. Respondent treated Patient A with megadoses of vitamins without adequate medical indication. (P's Ex. 8 at 140, 11, 13, 14, 15, 17, Tr. 51-54)

A9. Respondent failed to keep an adequate record for Patient A. (P's Ex. 8 *passim*, Tr. 54-58)

A10. As a result of Respondent's treatment of Patient A with thyroid extract, she suffered from iatrogenic hyperthyroidism. (P's Ex. 8 at 199, 238, 162, 219, 3, 4, Tr. 45-46, 40-49)

A11. As a result of Respondent's treatment of Patient A with very high doses of the amino acid tryptophan, she suffered from the eosinophilic myalgic syndrome. (P's Ex. 8 at 118, 13, 140, Tr. 55, 49-51, 54-55)

A12. Respondent failed to diagnose leukemia from which Patient A ultimately died. (Tr. 56-57)

Patient B

B. From on or about March 29, 1995 through on or about May 31, 1995, Respondent treated Patient B in his office in New York City. Patient B initially presented with a longstanding mental illness. (P's Ex. 9 at 4-8, Tr. 72-73)

B1. Respondent failed to perform an adequate physical examination of Patient B. (P's Ex. 9 at 4, 6, Tr. 73-74)

B2. Respondent failed to take a Pap smear from Patient B or refer her to another practitioner for a Pap smear. (P's Ex. 9, Tr. 74-75)

B3. Respondent prescribed estrogen treatment for Patient B, who was 38 years old, without adequate medical indication. (P's Ex. 9 at 5-8, 31, Tr. 75-77, 80-83)

B4. Respondent failed to appropriately monitor Patient B's estrogen levels during the course of her treatment with estrogen. (P's Ex. 9 and specifically at 31, Tr. 79, 81-83)

B5. Respondent prescribed Naltrexone for Patient B without adequate medical indication. (P's Ex. 9 at 5-8, 31, Tr. 77-83)

B6. Respondent failed to appropriately monitor or document Patient B's response to the Naltrexone during the course of her treatment with Naltrexone. (P's Ex. 9, Tr. 79)

B7. Respondent failed to keep an adequate record for Patient B. (P's Ex. 9 *passim*, Tr. 79-80)

B8. Respondent's treatment of Patient B with estrogen presented potential harm to Patient B. (P's Ex. 9 at 5-8, 31, Tr. 76-77)

Patient C

Petitioner hereby withdraws all allegations regarding Patient C from the Statement of Charges.

Patient D

Petitioner hereby withdraws the word "hypoglycemia" from allegation D4 and withdraws allegation D7 in its entirety from the Statement of Charges.

D. From on or about February 8, 1993 through on or about June 14, 1994, Respondent treated Patient D in his office in New York City. Patient D initially presented with a history of hypertension and complaints of fatigue, muscle weakness, immobility, and poor stamina. (P's Ex. 12 at 3, 8-11, Tr. 115-17)

D1. Respondent failed to take an adequate history of Patient D. (P's Ex. 12 at 3, Tr. 118)

D2. Respondent failed to perform an adequate physical examination of Patient D. (P's Ex. 12 at 3 reverse, Tr. 118-20)

D3. Respondent failed to perform appropriate laboratory tests on Patient D (P's Ex. 12 and specifically P's Ex. 12 at 26, Tr. 125-126)

D4. Respondent treated Patient D for adrenal insufficiency with the steroid Cortef without adequate medical indication. (P's Ex. 12 and specifically P's Ex. 12 at 8 reverse, 9, 9 reverse, 10,10 reverse, 26, Tr. 117,125-30)

D5. Respondent treated Patient D with DHEA without adequate medical indication. (P's Ex. 12 at 8, 8 reverse, 10 reverse, Tr. 126-30)

D6. Respondent treated Patient D with Dilantin without adequate medical indication. (P's Ex. 12 at 9, 9 reverse, 10, Tr. 130-32)

D7. [Withdrawn]

D8. Respondent failed to keep an adequate record for Patient D. (P's Ex. 12 *passim*, Tr. 132-35)

Patient E

E. From on or about September 21, 1998 through on or about January 6, 1999, Respondent treated Patient E, a twenty-year old male, in his office in New York City. Patient E presented with symptoms that mimic irritable bowel syndrome. (P's Ex. 14 at 6-11, 23, Tr. 143-50)

E1. Respondent failed to take an adequate history of Patient E. (P's Ex. 14 at 8, Tr. 151-55)

E2. Respondent failed to perform an adequate physical examination of Patient E. (P's Ex. 14, Tr. 155)

E3. Respondent failed to conduct an adequate work up for Patient E's gastro-intestinal complaints. (P's Ex. 14 and specifically P's Ex. 14 at 8, Tr. 154-57)

E4. Respondent failed to refer Patient E for a consultation with a gastro-intestinal specialist. (P's Ex. 14, Tr. 156-57)

E5. Respondent failed to appropriately diagnose Patient E's condition. (P's Ex. 14 and specifically P's Ex. 14 at 14-16, 19, 23, Tr. 157-61)

E6. Respondent failed to keep an adequate record for Patient E. (P's Ex. 14 *passim*, Tr. 161-63)

Patient F

Petitioner hereby withdraws allegations F4 and F6 from the Statement of Charges.

F. From on or about July 17, 1997 through on or about March 22, 1999, Respondent treated Patient F, a 50 year old male, who initially presented with Hepatitis C and liver function test irregularities, in his office in New York City. (P's Ex. 15 at 7-11, 40, Tr. 166-67)

F1. Respondent failed to take an adequate history of Patient F. (P's Ex. 15 at 7, Tr. 167-68)

F2. Respondent failed to perform an adequate physical examination of Patient F. (P's Ex. 15 at 7, Tr. 168-70 177-78)

F3. Respondent failed to perform an adequate examination of Patient F's thyroid gland. (P's Ex. 15 at 5, 58, Tr. 168-71)

F4. [Withdrawn]

F5. Respondent failed to adequately treat Patient F's hepatitis C. (P's Ex. 15 at 10, Tr. 173-175)

F6. [Withdrawn]

F7. Respondent treated Patient F for hypothyroidism without adequate medical indication. (P's Ex. 15 at 7, 58, Tr. 168-71, 175-76)

F8. Respondent treated Patient F with coffee enemas without adequate medical indication. (P's Ex. 15 at 5, Tr. 176)

F9. Respondent treated Patient F with peroxide soaks of his feet without adequate medical indication. (P's Ex. 15 at 5, Tr. 176-78)

F10. Respondent failed to keep an adequate record for Patient F. (P's Ex. 15 *passim*, Tr.178-79)

F11. Respondent's treatment of Patient F for hypothyroidism presented risk of harm to Patient F. (P's Ex. 15 at 7, 58, Tr. 168-71, 175-76)

Patient G

Petitioner hereby withdraws allegation G3 from the Statement of Charges.

G. From in or about January 25, 2000 through in or about April, 2000, Respondent treated Patient G, a 77 year old women, who presented initially with multiple complaints including chills, pain, itching, and occasional irregular heartbeat, in his offices in New York City. (P's Ex. 16 at 3, 11-14, Tr. 182)

G1. Respondent failed to perform an adequate physical examination of Patient G. (P's Ex. 16 and 17 and specifically P's Ex. 16 at 12, Tr. 182-84)

G2. Respondent failed to perform an adequate laboratory work up of Patient G for his impression of chronic rickettsial disease. (P's Ex. 16 and 17and specifically P's Ex. 16 at 13-14, 21-23, Tr. 183-88)

G3. [Withdrawn]

G4. Respondent failed to appropriately treat Patient G for his diagnosis of chronic rickettsial disease. (P's Ex. 16 and 17 and specifically P's Ex. 16 at 13-14, Tr. 183-91)

G5. Respondent failed to keep an adequate record for Patient G. (P's Ex. 16 and 17 *passim*, Tr. 191-92)

C.V. FRAUD

H. From in or about September of 1978 through in or about March of 1980, Respondent held an appointment to Coney Island Hospital in Brooklyn, New York as a session physician in Emergency Services with the rank of assistant physician in the Department of Community Medicine. (P's Ex. 20 at 1, 4, 10, 11, 18, 33, Tr. 139-40)

H1. In or about July of 1997, Respondent, in the Curriculum Vitae that he provided to the Office of Professional Medical Conduct and to others, intentionally and with intent to deceive, held himself out in writing as "Associate Director Coney Island Hospital Emergency Room" from "1978-1980", although he knew this written statement to be false and misleading. (P's Ex. 19 at 3 [not numbered], Tr. 21-23, 140-41)

H2. At no time while Respondent was employed at Coney Island Hospital was he ever the associate director of the emergency room. (P's Ex. 20, Tr. 140-41)

H3. At no time while Respondent was employed at Coney Island Hospital was he ever any kind of director of the emergency room. (P's Ex. 20, Tr. 141)

H4. Respondent did not finish his emergency medicine residency and was not board-certified in emergency medicine. (P's Ex. 20 at 29, 30, Tr. 140)

H5. Jahon Soltani, M.D. was the Chief of the Division of Emergency Medicine at Coney Island Hospital during the years 1978 to 1980. In that capacity he was responsible for the administration of the Emergency Division and maintaining quality of care. (Tr. 139)

CONCLUSIONS OF LAW

Respondent is charged with thirty (30) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on

these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Fraudulent practice is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine. The Hearing Committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false

representation. The licensee's knowledge and intent may properly be inferred from facts found by the Hearing Committee, but the Committee must specifically state the inferences it is drawing regarding knowledge and intent.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that twenty-five (25) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below. At the outset of deliberations, the Hearing Committee made a determination as to the credibility of the expert witness, Robert Matz, M.D. The Hearing Committee found Dr. Matz to be a credible and accurate witness. They note that he has a very knowledgeable background to assess the various practices of Respondent.

PATIENT A

Factual Allegations A, A.1 through A.9: SUSTAINED

PATIENT B

Factual Allegations B, B.1, B.2, B.3, B.5, B.6 and B.7: SUSTAINED

Factual Allegations B.4: NOT SUSTAINED

PATIENT C

All Charges for Patient C WITHDRAWN by Department

PATIENT D

Factual Allegations D, D.1 through D.6 and D.8 : SUSTAINED

Factual Allegations D.7: WITHDRAWN by the Department

PATIENT E

Factual Allegations E, E.1 through E.6: SUSTAINED

PATIENT F

Factual Allegations F, F.1, F.2, F.3, F.5, F.7 through F.10: SUSTAINED

Factual Allegations F.4 and F.6: WITHDRAWN by Department

PATIENT G

Factual Allegations G, G.1,G.2, G.4 and G. 5: SUSTAINED

Factual Allegations G.3: WITHDRAWN by the Department

PATIENT H

Factual Allegations H, and H.1: SUSTAINED

DISCUSSION

The Hearing Committee concurs in all aspects of Dr. Matz's opinion. They find a consistent pattern of Respondent making wrong diagnoses and inappropriate treatments for Patients A,B,D,E,F and G. They further find that in all instances, Respondent's actions rose to the level of gross negligence and gross incompetence. This is in addition to negligence and incompetence on more than one occasion as well as excessive testing for several patients. They also sustained all specifications for failing to maintain accurate records and for fraudulent practice for misrepresenting his credentials on his C.V.

More significantly, the Hearing Committee finds that Respondent did nothing for Patient A. He failed to do an adequate physical examination and adequate testing. He totally failed to diagnose her with acute myelogenous leukemia. The Committee notes that it was not diagnosed until Patient A was admitted to White Plains Hospital. (T. 56)

The Hearing Committee finds that Respondent failed to monitor Patient B in general from any vantage point. They note particularly that when he tested Patient B's estrogen level, the test was insufficient, yet Respondent prescribed estrogen without repeating the test. (T. 81-82) They further find that Respondent grossly deviated from standard care by prescribing naltrexone, a drug typically used in the treatment of narcotic addicts. Here, the Committee finds that there was no history in the patient's record of any type of substance abuse. (T. 78)

For Patient D, the Hearing Committee concurs with Dr. Matz that there is no elaboration in the patient's history of the potential severity of the diseases like adrenal insufficiency, immune insufficiency and hypertension. (T. 118) Likewise, they find the prescribed treatments of Cortef, DHEA and Dilantin to all be without medical indication as well as excessive. (T. 123,127, 132)

The Hearing Committee notes again that Respondent made the wrong diagnosis for Patient E whose symptoms appeared to be irritable bowel syndrome. Here, Respondent diagnosed intestinal parasitism, for parasites that are benign intestinal parasites, i.e. E. hermanii and E. coli. (T. 158-159)

The Hearing Committee notes that Patient F was not treated as a normal office visit because this patient mentioned he had Hepatitis C during the course of a business meeting with Respondent. (T. 167) They find that Respondent's history and treatment of Patient F's hepatitis C was inadequate. They further find that he inappropriately treated Patient F for hypothyroidism based solely on a borderline TSH test without a repeat exam, adequate history or examination of the thyroid. (T.169-170) The Hearing Committee concurs with Dr. Matz that there is nothing in the patient's record to justify Respondent's treatment of coffee enemas or peroxide soaks. (T. 176-178)

For Patient G, the Hearing Committee agrees with Dr. Matz that there is no adequate medical indication to treat the patient for chronic rickettsial disease. The Hearing Committee finds that Respondent made the wrong diagnosis and then treated Patient G inappropriately for the wrong diagnosis. Even if Respondent suspected an

infectious disease, tetracycline and referral to an infectious disease expert was the appropriate treatment according to Dr. Matz. (T. 190-191)

The Hearing Committee also sustains Charge H, the fraudulent practice of medicine. The Hearing Committee finds that Respondent intentionally misrepresented that he was an Associate Director of the emergency room at Coney Island Hospital. At that time, Respondent was only an assistant attending physician in the ER. Respondent did not complete his residency and was not board certified in emergency medicine. (T. 139-141)

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for revocation because it is the only effective penalty to protect the public from obviously bad medical practice. The Hearing Committee believes that Respondent had a total disregard for his patients. Everything he did for his patients was wrong. Respondent failed to adequately test, diagnose or treat his patients. Respondent offered the worst of all worlds in patient care and cannot be allowed

to practice in the State of New York. Under the totality of the circumstances, the Hearing Committee concludes that revocation is the only appropriate penalty.

ORDER

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

1. The First, Second , Fourth through Ninth, the Eleventh through Eighteenth, the Twentieth, the Twenty-Second through Twenty-Fifth and Twenty Seventh through Thirtieth of the Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

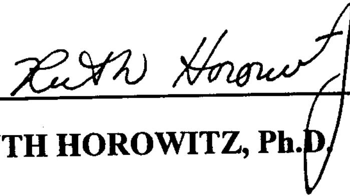
2. The Third, Tenth, Nineteenth, Twenty-First and Twenty-Sixth of the Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;**

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

4. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: New York, New York

Feb. 12 **2003**



RUTH HOROWITZ, Ph.D.

(Chairperson)

ALLAN GIBOFSKY, M.D.

DANA M. MONACO, M.D

TO: Paul Stein Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza- 6th Fl.
New York, NY 10001

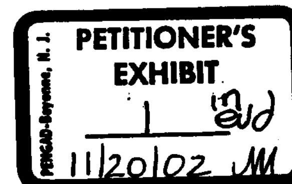
Howard Marshal Bezoza, M.D.
24 West 57th Street, Suite 701
New York, N.Y. 10019

Howard Marshal Bezoza. M.D.
8 Old Farms Rd.
Saddle River, New Jersey 07954

APPENDIX I

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

IN THE MATTER OF HOWARD MARSHAL BEZOZA, M.D.	NOTICE OF HEARING



TO: HOWARD MARSHAL BEZOZA, M.D.
24 West 57th Street
New York, NY 10019

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 December 4, 2002, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, 6th Floor, New York, NY 10001, 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. TYRONE BUTLER, 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: New York, New York
October 24, 2002

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to:
Paul Stein
Associate Counsel
Bureau of Professional Medical Conduct
New York State Department of Health
5 Penn Plaza, 6th Floor
New York, NY 10001
(212) 268-6806

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

Paul Stein
Associate Counsel
New York State Department of health
5 Penn Plaza, 6th Floor
New York, NY 10001
Fax: 212-268-6735

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

IN THE MATTER OF HOWARD MARSHAL BEZOZA, M.D.	STATEMENT OF CHARGES

Howard Marshal Bezoza, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 20, 1978 by the issuance of license number 136435 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about January 8, 1985 through on or about May 28, 1996, Respondent treated Patient A, (Patient A and all other patients are identified in Appendix A) who initially presented with a history of recurrent depression and thyroid disease, in his office in New York City. Toward the end of Respondent's course of treatment of Patient A, Patient A was diagnosed with acute leukemia.

1. Respondent failed to take an adequate history of Patient A.

2. Respondent failed to order mammography of Patient A or document that mammography of Patient A was performed elsewhere.

3. Respondent failed to conduct an adequate work up or make a referral for Patient A's anemia, leucopenia, and high MCV.

4. Respondent failed to conduct appropriate laboratory tests for Patient A.

5. Respondent failed to appropriately evaluate and treat Patient ~~B~~A's thyroid condition.

6. Respondent failed to adequately monitor the treatment of Patient A's thyroid condition.

7. Respondent treated Patient A with megadoses of amino acids without adequate medical indication.

8. Respondent treated Patient A with megadoses of vitamins without adequate medical indication.

9. Respondent failed to keep an adequate record for Patient A.

B. From on or about March 23, 1995 through on or about May 31, 1995, Respondent treated Patient B in his office in New York City. Patient B initially presented with a longstanding mental illness.

1. Respondent failed to perform an adequate physical examination of Patient B.

2. Respondent failed to take a Pap smear from Patient B or refer her to another practitioner for a Pap smear.

3. Respondent prescribed estrogen treatment for Patient B without adequate medical indication.

4. Respondent failed to appropriately monitor Patient B's estrogen levels during the course of her treatment with estrogen.

5. Respondent prescribed Naltrexone for Patient B without adequate medical indication.

6. Respondent failed to appropriately monitor or document Patient B's response to the Naltrexone during the course of her treatment with Naltrexone.

7. Respondent failed to keep an adequate record for Patient B.

withdrawn by Dept.

C. ~~From in or about May 28, 1997 through on or about January 5, 1999, Respondent treated Patient C in his office in New York City. Patient C initially presented for a general check up.~~

1. ~~Respondent failed to adequately work up Patient C's abnormal and discrepant urine mercury readings.~~

2. ~~Respondent performed multiple laboratory tests on Patient C without adequate medical indication.~~

3. ~~Respondent treated Patient C with multiple IV therapies without adequate medical indication.~~

4. ~~Respondent failed to keep an adequate record for Patient C.~~

D. From on or about February 8, 1993 through on or about June 14, 1994, Respondent treated Patient D in his office in New York City. Patient D initially presented with a history of hypertension and complaints of fatigue, muscle weakness, immobility, and poor stamina.

1. Respondent failed to take an adequate history of Patient D.

2. Respondent failed to perform an adequate physical examination of Patient D.

3. Respondent failed to perform appropriate laboratory tests on Patient D

4. Respondent treated Patient D for hypoadrenia/hypoglycemia with the steroid Cortef without adequate medical indication.

5. Respondent treated Patient D with DHEA without adequate medical indication.

6. Respondent treated Patient D with Dilantin without adequate medical indication.

7. Respondent treated Patient D with a hypoglycemia diet without adequate medical indication.

8. Respondent failed to keep an adequate record for Patient D.

E. From on or about September 21, 1998 through on or about January 6, 1999, Respondent treated Patient E, a twenty-year old male, in his office in New York City. Patient E presented with symptoms that mimic irritable bowel syndrome.

1. Respondent failed to take an adequate history of Patient E.

2. Respondent failed to perform an adequate physical examination of Patient E.

3. Respondent failed to conduct an adequate work up for Patient E's gastro-intestinal complaints.

4. Respondent failed to refer Patient E for a consultation with a gastro-intestinal specialist.

5. Respondent failed to appropriately diagnose Patient E's condition.

6. Respondent failed to keep an adequate record for Patient E.

F. From on or about July 17, 1997 through on or about March 22, 1999, Respondent treated Patient F, a 50 year old male, who initially presented with Hepatitis C and liver function test irregularities, in his office in New York City.

1. Respondent failed to take an adequate history of Patient F.

2. Respondent failed to perform an adequate physical examination of Patient F.

3. Respondent failed to perform an adequate examination of Patient F's thyroid gland.

withdrawn ~~4. Respondent failed to perform an adequate examination of Patient F's liver.~~

5. Respondent failed to adequately treat Patient F's hepatitis C.

withdrawn ~~6. Respondent failed to perform adequate confirmatory laboratory studies of Patient F.~~

7. Respondent treated Patient F for hypothyroidism without adequate medical indication.

8. Respondent treated Patient F with coffee enemas without adequate medical indication.

9. Respondent treated Patient F with peroxide soaks of his feet without adequate medical indication.

10. Respondent failed to keep an adequate record for Patient F.

G. From in or about ~~March, 1999~~ Jan, 25, 200 through in or about April, 2000, Respondent treated Patient G, a 77 year old women, who presented initially with multiple complaints including chills, pain, itching, and occasional irregular heartbeat, in his offices in New York City.

1. Respondent failed to perform an adequate physical examination of Patient G.

2. Respondent failed to perform an adequate laboratory work up of Patient G for his impression of chronic rickettsial disease.

3. Respondent treated Patient G for chronic rickettsial disease without adequate medical indication.

4. Respondent failed to appropriately treat Patient G for his diagnosis of

chronic rickettsial disease.

5. Respondent failed to keep an adequate record for Patient G.

H. From in or about September of 1978 through in or about March of 1980, Respondent held an appointment to Coney Island Hospital in Brooklyn, New York as a session physician in Emergency Services with the rank of assistant physician in the Department of Community Medicine.

1. In or about July of 1997, Respondent, in the Curriculum Vitae that he provided to the Office of Professional Medical Conduct and to others, intentionally and with intent to deceive, held himself out in writing as "Associate Director Coney Island Hospital Emergency Room" from "1978-1980", although he knew this written statement to be false and misleading.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A1-9.
2. Paragraphs B and B1-7.

3. Paragraphs C and C1-4.
4. Paragraphs D and D1-8.
5. Paragraphs E and E1-6.
6. Paragraphs F and F1-10.
7. Paragraphs G and G1-5.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

8. Paragraphs A and A1-9.
9. Paragraphs B and B1-7.
10. Paragraphs C and C1-4.
11. Paragraphs D and D1-8.
12. Paragraphs E and E1-6.
13. Paragraphs F and F1-10.
14. Paragraphs G and G1-5.

FIFTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

15. Paragraphs A and A1-9; B and B1-7; C and C1-4; D and D1-8; E and E1-6; F and F1-10; and/or G and G1-5.

SIXTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

16. Paragraphs A and A1-9; B and B1-7; C and C1-4; D and D1-8; E and E1-6; F and F1-10; and/or G and G1-5.

SEVENTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(35) by the ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient as alleged in the facts of the following:

17. Paragraphs A and A7-8.
18. Paragraphs B and B3 and 5.
19. Paragraphs C and C2-3.
20. Paragraphs D and D4-7.
21. Paragraphs F and F7-9.
22. Paragraphs G and G3

TWENTY-THIRD SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession fraudulently as alleged in the facts of the following:

23. Paragraphs H and H1.

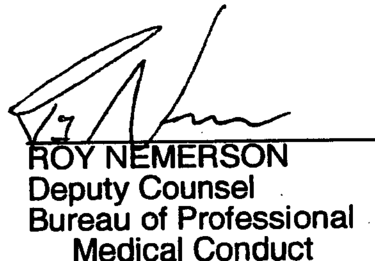
TWENTY-FOURTH THROUGH THIRTIETH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in the facts of the following:

24. Paragraphs A and A9.
25. Paragraphs B and B7.
26. Paragraphs C and C4.
27. Paragraphs D and D8.
28. Paragraphs E and E6.
29. Paragraphs F and F10.
30. Paragraphs G and G5.

DATED: New York, New York
October 24, 2002



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct