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

January 28, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237

Daniel T. Roach, Esq.
Roach, Brown, McCarthy & Gruber, P.C .
1620 Liberty Bank Building
420 Main Street
Buffalo, New York 14202-3616

Mathew K. Alukal, M.D.
8282 Old Post Road, East
East Amherst, New York 14051

RE: In the Matter of Mathew K. Alukal, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-40) 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:cah
Enclosure

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

IN THE MATTER OF MATHEW K. ALUKAL, M.D.	**DETERMINATION AND ORDER** **BPMC # 02- 40**

A Commissioner's Order, Notice of Hearing and Statement of Charges, each dated July 3, 2001, was served upon the Respondent, **MATHEW K. ALUKAL, M.D. SHELDON H. PUTTERMAN, M.D.**, Chairperson, **DIANA E. GARNEAU, M.D.**, and **WILLIAM W. WALENCE, Ph.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 (12) of the Public Health Law. **JEFFREY ARMON, ESQ.** served as Administrative Law Judge for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Service of Commissioner's Order, Notice Of Hearing and Statement of Charges:	July 6, 2001
Pre-Hearing Conference:	July 16, 2001
Hearing Dates:	July 16, August 9, 29, September 10, 11, October 10, 11, 30 and 31, 2001
Department of Health appeared by:	**DONALD P. BERENS, JR., ESQ.,** General Counsel, New York State Department of Health 2509 Corning Tower Empire State Plaza Albany, New York 12237-0032 BY: **KEVIN C. ROE, ESQ. &** **AMY B. MERKLEN, ESQ.**

Respondent appeared by:	**ROACH, BROWN, McCARTHY & GRUBER, P.C.** 1620 Liberty Bank Building 420 Main Street Buffalo, New York 14202-3616 BY: **DANIEL T. ROACH, ESQ.**
Witnesses for Department of Health:	Patient A Patient C Patient B Employee G Mark A. Weissman, M.D. Patient D Madhav Deshmukh, M.D. Patient E Employee F Donald Wexler, M.D. Carolyn M. Zemko Thomas Hughes, M.D.
Witnesses for Respondent:	Mathew K. Alukal, M.D. (Respondent) Sharon A. Crahen Elaine Panzica Richard Romanowski, M.D. Mary Kathleen McGorray, M.D. Kenton Forte, M.D. Stephen Ornella Nancy Rainer Marcia Bryndle
Deliberations held:	December 6, 2001

LEGAL ISSUES

The Administrative Law Judge (ALJ) issued a ruling, in accordance with 10 NYCRR 51.9, that no evidence would be received related to Factual Allegation I, based on a conclusion that the prejudice to the Respondent in receiving evidence related to that Allegation would greatly exceed any probative value. The ALJ determined that, in order to prove such Factual Allegation, the Department would improperly raise issues before the Hearing Committee which could not be cross-examined by Respondent. Accordingly, no evidence was received and Factual Allegation I was not sustained.

The ALJ further excluded evidence related to allegations that Respondent had engaged in conduct on a number of earlier occasions which was similar to the unprofessional conduct which he was accused of in the Statement of Charges. Many of those allegations related to acts which allegedly occurred a decade or more earlier; none were specifically charged by the Department in this proceeding. The ALJ determined that it was improper for the Department to attempt to have the Committee infer that it was more likely that the Respondent had conducted the acts complained of in the Charges by raising unsubstantiated charges from many years earlier.

Respondent was permitted by the ALJ to present a limited number of patients and medical colleagues to testify as to his character and reputation based on a determination that the Department had put such traits in issue through its direct case.

The Committee was instructed to disregard any material set out in Factual Allegation I as well as to any statements made by counsel for either party that appeared in the hearing record related to those allegations of misconduct which the ALJ ruled were improper subjects of examination. The findings and conclusions made by the Committee in this Determination and Order were based exclusively on those witnesses appearing and testifying at this proceeding and on the documentation received into the record.

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's Exhibits are designated by Letters.
T. = Transcript

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

GENERAL FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on August 14, 1981 by the issuance of license number 147353 by the New York State Education Department.

2. Respondent is board certified in internal medicine and rheumatology and practiced from an office located at 1301 North Forest Road, Williamsville, New York. (Ex. P; T. 747)

3. An examination for a finding of trigger points in the chest or costochondral junction is conducted while the patient is lying supine and gowned and consists of an examination of the chest, sternum and costochondral joints by the physician using his fingers to put pressure on those areas and asking if those areas are tender. (T. 514-5, 522-3)

4. Pelvic pain is often associated with groin or hip pain. To examine for hip pain, the patient is supine and the physician is over the patient manipulating the legs. (T. 522-4)

5. A breast examination is commonly performed with the patient lying supine, with the arms either at the side or back behind the patient. A bimanual examination of all four quadrants of both breasts is conducted one breast at a time. Physical observation of the breast is important for the purpose of viewing possible abnormalities. (T. 456-8)

6. It is not appropriate for a physician to sit behind a patient and to examine the breasts from behind. It is also not appropriate for a physician to unfasten a female patient's brassiere himself if the patient is physically capable of doing so herself. (T. 565-6)

FINDINGS RELATED TO PATIENT A

7. Patient A, a 28 year old female, was hired as a temporary employee by Respondent. She worked in Respondent's office one week in March, 2001 and one day in April 2001. Patient A was to have worked at Respondent's office on a day preceding her final April, 2001 day of employment, but she did not because she was ill. (T. 20, 23-8)

8. When she next reported for work, Patient A informed Respondent that she had been absent because she had been ill with a cold. Respondent then offered to examine Patient A. (T. 31-2, 65)

9. Respondent examined Patient A in the fileroom in which she was working with the room lights off. He first examined her mouth and throat and then placed a stethoscope on her chest, initially above her clothing. He then lifted her clothing and while holding the stethoscope to her heart with one hand, reached inside her brassiere and cupped her left breast with his other hand. Respondent then moved the stethoscope, reached inside the patient's brassiere and cupped her right breast in the same manner. Respondent did not palpate, squeeze or apply pressure with his hand while touching her breasts. He then stepped away from the patient and offered her a decongestant before leaving the room. (T. 33-40)

10. Patient A took the cold medication and resumed her work. Approximately thirty minutes later, Respondent returned to the fileroom and again examined the patient in the same manner; while holding a stethoscope in one hand, he put his fingers inside her brassiere and touched first her left and then her right breast. Respondent then asked Patient A to turn around. Respondent stood behind her, placed his hand on her right breast above her clothing and examined the patient's back with the stethoscope. Patient A could feel Respondent pressing his pelvic area against her lower back and buttocks. Respondent thereafter left the fileroom. (T. 40-8)

11. After a few minutes, Patient A left the fileroom and went to the reception area where Employee F was working. At the time, Employee F was using Employee G's cellular telephone to talk to Employee G, who was out of town. Patient A told Employee F that she was leaving work because Respondent " ... is paying me to do paper work, not to touch my tits." Employee F repeated that statement to Employee G while the latter was listening on the telephone. Patient A then left Respondent's office and did not return. (T. 49-51, 196-7, 391-2)

FINDINGS RELATED TO PATIENT B

12. Patient B, a 51 year old female, was treated at Respondent's office on approximately fourteen occasions from on or about February 25, 1998, to on or about May 31, 2000. At the initial office visit, a female was in the room with the Respondent and a breast examination was not performed. Respondent documented diagnosis of inflammatory polyarthritis, possibly sacroilitis, rule out seronegative spondyloarthropathy. Respondent's office record contains documentation that Patient B's breasts were normal/cystic on January 29, 1999; normal on May 28, 1999; normal on January 21, 2000; and cystic on May 31, 2000. (Ex. 2, pp. 11, 17, 28, 34, 42-3)

13. On three or four occasions between February 25, 1998 and before May 31, 2000 Respondent touched Patient B's breasts. On those occasions, Patient B was not asked to undress and was not given a gown. On at least one of those occasions, Respondent sat behind Patient B with his legs astride her hips. Respondent unhooked Patient B's bra and felt her breasts with one hand on each breast. Respondent did not bimanually palpate Patient B's breast in a clockwise motion. (T. 147-152, 178)

14. On May 31, 2000, Patient B was seen by Respondent at his office with complaints of pain in her feet and ankles, low back, right hip, right buttock, the inner portion of the right leg and thigh, and shoulders. Although so documented by Respondent in his medical record for that office visit, Patient B did not, in fact, complain of pain or discomfort in her groin, pubic, or genital area. (Ex. 2, p. 11; T. 152, 171-173, 181-182)

15. During the May 31, 2000 office visit, Patient B remained dressed in street clothes and was not asked to disrobe or put on a gown. After examining her wrists, fingers, ankles, and feet, Respondent asked Patient B to stand. While standing behind Patient B, Respondent placed his right hand inside of Patient B's pants and underwear and touched her groin and pelvic area. The patient became uncomfortable and shifted and Respondent then pulled her back with his left hand on her rib cage and moved his right hand from her pubic area to Patient B's genitals. She asked Respondent what he was doing and got no response. He then placed his left hand beneath Patient B's bra and fondled her left breast. At that point, Respondent was standing behind Patient B with his left hand fondling her left breast and right hand touching her genitals. Patient B asked Respondent to stop and tried to pull away. He first pulled her back towards him and then let her go. Respondent did not give the patient any explanation for these actions. (T. 152-157, 173)

16. At some point after the May 31, 2000 examination, Patient B telephoned her gynecologist and spoke with his partner, Dr. Mark Weissman. The patient was anxious and upset and inquired as to the propriety of a breast examination performed on her by a rheumatologist. (T. 241-3)

FINDINGS RELATED TO PATIENT C

17. Respondent treated Patient C, a 53 year old female, from on or about March 2, 2000 to on or about June 7, 2000 at his office. Patient C was referred to Respondent by Thomas Hughes, M.D., her primary care physician, for rheumatological evaluation of her possible Sjogren's syndrome and musculosketal complaints. She was seen by Respondent at his office on three occasions. (Ex. 6, T. 102-103)

18. At the first office visit on March 2, 2000, Patient C was asked to disrobe and wore a gown. A female employee was present in the room with the Respondent during his physical examination of the patient and a breast examination was not performed. (Ex. 6, pp.14-5; T. 103-104, 1039-40)

19. Patient C was seen by Respondent for a second office visit on April 7, 2000, for follow-up and with complaints of swollen glands in her neck. During the physical examination, the patient wore street clothes and was not gowned and another female was not present. After examining Patient C's neck and jaw, Respondent lifted her t-shirt, placed his stethoscope at the bra line and listened to her heart. He then dropped the stethoscope, placed his hand inside Patient C's bra and touched her breast around the nipple area. While seated on Patient C's right side, Respondent then unfastened her bra with just his left hand and continued to feel her left breast area and under her arm with his right hand, touching her in the nipple area and side of the breast. Respondent did not bimanually palpate the breast in the customary fashion for a breast examination. He then re-hooked Patient C's bra using just his left hand and examined her right axila. Respondent did not touch Patient C's right breast. (T. 104-107)

20. Respondent documented in the patient's medical record for the April 7, 2000 office visit an impression that Patient C's breasts were cystic. (Ex. 6, p. 12)

21. Patient C returned to Respondent's office on June 7, 2000, with complaints of pain in the back of her legs. During this office visit, Respondent asked Patient C to perform several maneuvers (bend over forward and touch toes, deep knee bends) while he was seated in very close proximity to Patient C. She was unable to perform these movements as to do so would cause her buttocks to come in contact with Respondent's body. Patient C told Respondent that she could not perform the maneuvers because there was not enough space, but he did not move or speak (T. 108-109, 134-135, 137-9)

22. In July, 2000, Patient C discussed with her primary physician concerns about the manner in which Respondent had performed a breast examination on her and requested that she be referred to a different rheumatologist. (T. 109-110, 617-9)

FINDINGS RELATED TO PATIENT D

23. Respondent treated Patient D, a 44 year old female, from on or about July 23, 1998 to on or about February 1, 2000. Respondent's medical records for the patient documents approximately ten office visits during this period. His records for the patient contain no documentation of the performance or results of any breast exams of Patient D during the entire period of his treatment of her. (Ex. 4)

24. At the first office visit on July 23, 1998, Patient D was asked to undress and wore a gown during the physical examination by Respondent. No breast examination was performed at the initial visit. Respondent diagnosed mild inflammatory arthritis and fibromylagia. (Ex. 4; T. 256)

25. During an office visit in the Fall of 1999, Patient D wore street clothes. Respondent turned the patient so that he was standing behind her and she was facing forward. He then pulled Patient D's bra up over her breasts without asking her to remove it herself. Respondent then touched and felt both breasts, but did not palpate both breasts in a circular motion. Respondent did not inform Patient D why he was touching her breasts, nor did she ask. (T. 256-262, 282, 309)

26. Patient D returned to Respondent's office for treatment on February 1, 2000. After examining her hands, Respondent asked Patient D to stand up and then stood behind her with the patient facing forward. Patient D was not asked to undress, remove her bra, nor was she offered a gown. Respondent unhooked Patient D's bra with his right hand and then touched and felt Patient D's breast with that hand. He did not palpate all four quadrants of both breasts in a circular motion. While Respondent's right hand was touching and feeling Patient D's right breast, he placed his left hand inside her pants touching her lower abdomen just above her pubic hair Respondent moved his left hand around on Patient D's lower abdomen but did not palpate or press. The patient could feel Respondent's slacks touching her buttocks and his breathing on her neck. After removing his hands from her body, Respondent re-fasteneded Patient D's bra. He did not offer Patient D an explanation for his conduct before, during or after these actions. (T. 264-270, 286, 313)

27. On February 7, 2000, Patient D saw her primary care physician, Dr. Madhav Deshmukh and informed him that she was uncomfortable with Respondent's examination of her. Dr. Deshmukh noted in the patient's chart that Patient D told him that she was not comfortable returning to the Respondent for follow up and requested referral to another rheumatologist. (Ex. 5; T. 270, 289, 320-22)

FINDINGS RELATED TO PATIENT E

28. Respondent treated Patient E, a 44 year old female, from on or about May 22, 1998 to on or about August 1, 2000. Patient E was seen by Respondent on approximately seventeen occasions during that period for complaints of joint pain. Respondent diagnosed rheumatoid arthritis. (Ex. 3)

29. Respondent's office record for Patient E contains a notation, dated May 17, 1999, that Patient E's breasts were normal. (Ex. 3, p. 56)

30. On two office visits in the Spring of 1999, Respondent touched Patient E's breasts in a similar manner while she was wearing street clothes. The patient was not asked to undress or offered a gown on either occasion. While seated behind Patient E with the patient facing forward and his legs astride her hips, Respondent unfastened her bra. Patient E was not asked to unhook her bra, nor was she informed that a breast examination was to be conducted. On both occasions, Respondent placed his hands up and under Patient E's shirt and felt the underside of her breasts. Respondent did not bimanually palpate all four quadrants of both breasts in a circular motion. After touching Patient E's breasts, Respondent re-hooked her bra. On neither occasion did Patient E complain of chest or breast pain. (T. 332-341)

FINDINGS RELATED TO EMPLOYEE F

31. Employee F, a 22 year old female, was employed at Respondent's office from February 22, 2000 to June 15, 2001. During the course of her employment, Employee F attended college full time and

lived at home with her parents. Her duties at Respondent's office included answering the phones, scheduling appointments, typing, and transcription. Employee F's work hours were flexible to accommodate her college schedule. (T. 377-380)

32. On several occasions during the course of her employment, Respondent approached Employee F and told her she looked tense and rubbed her neck, shoulders, back and buttocks with his hands while standing or sitting behind her. These encounters were not invited by Employee F and took place in various locations in Respondent's office, often after hours when she was alone with Respondent. (T. 382-390, 417, 431-433, 435)

33. On a Friday afternoon or evening in the middle of April 2001, as Employee F was pulling out in her car and leaving work, Respondent stopped her and asked her to come back into the office. After calling her mother to ask her to call her in five minutes to give her an excuse to leave if necessary, Employee F returned to the office. After speaking with Respondent for several minutes regarding work, Employee F went to the bathroom to wash her hands and he followed. While standing behind Employee F in the bathroom, Respondent rubbed her shoulder, neck and back. Respondent reached under Employee F's shirt and unhooked her bra. Employee F's cellular phone then rang with a call from her mother as pre-arranged. While still on the phone, Employee F left the office with her bra unfastened. (T. 387-389)

34. On several occasions during her employment, Respondent engaged Employee F in conversations of a sexual nature. Respondent asked who she was dating, whether they were sleeping together, and advised Employee F not to engage in sexual relations with her boyfriend because she would be called a "slut". (T. 402-403)

35. On June 15, 2001, Respondent approached Employee F in a parking lot near his office and asked to talk in her car. Respondent told her that he was concerned about an investigation of his medical practice by the Office of Professional Medical Conduct and asked Employee F questions regarding her interview with that Office. Respondent asked Employee F to write a letter concerning his conduct with her in the office. (T. 393-5, 397)

36. Upon their return to the office on that same day, Respondent asked Employee F to type the letter immediately. Employee F typed a draft and showed it to Respondent. He requested changes and additions and she typed a second draft. After Employee F signed the letter, Respondent took it and left. Employee F made a copy of the second draft of the letter and provided it to the OPMC with a handwritten explanation which apparently retracted the statements in the typed letter. In her retraction, Employee F sets out the circumstances under which the original letter was created and signed. (Ex. 10; T. 393-400, 404-408, 420-421)

FINDINGS RELATED TO EMPLOYEE G

37. Employee G, a 26 year-old female, was employed by Respondent as an office manager from April 26, 1999, to May 23, 2001. On various occasions during her employment, Respondent engaged in conversations of a sexual nature with Employee G. Respondent asked Employee G who she was sleeping with and what type of sex she liked. These conversations usually occurred after regular office hours when Employee G was alone with Respondent in the office. (T. 190-3)

38. On one occasion following a conversation regarding the size of Employee G's breasts, Respondent chased his employee around the office. Respondent came up behind Employee G, cupped her left breast and asked "how much bigger do you want it to get?" Employee G told Respondent to get away from her or to stop it. Respondent replied that "the thrill is in the chase". (T. 191-2, 231-233)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. Unless otherwise noted, all conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concluded that the following Factual Allegations should be **SUSTAINED**. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraphs A. and A. 1., A. 2., A. 3. :	(8-11);
Paragraphs B. and B. 1., B. 2., B. 3. :	(12-16);
Paragraphs B. 4. through and including B.10. :	(12, 14-6);
Paragraphs C. and C. 1., C.2., C. 3. :	(17-22);
Paragraphs D. and D. 1. through and including D. 6. :	(23-27);
Paragraphs E. and E. 1., E. 2., E. 3. :	(28-30);
Paragraph F. :	(31-4);
Paragraph H. :	(37-38);

The Hearing Committee determined that all other Factual Allegations should **NOT** be sustained.

The Hearing Committee concluded that the following Specifications of Professional Misconduct should be **SUSTAINED** based on the Factual Allegations which were sustained as set out above:

First through and including Fifth Specifications;

Sixth through Tenth Specifications;

Eleventh Specification;

Twelfth Specification;

Thirteenth through Seventeenth Specifications;

Eighteenth through Twenty third and Twenty fifth Specifications.

The Hearing Committee determined that all other Specifications of Professional Misconduct should **NOT BE SUSTAINED.**

DISCUSSION

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories 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 certain types of professional misconduct.

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

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

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee 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 of medicine is the intentional misrepresentation or concealment of a known fact, made in connection with the practice of medicine.

The Committee relied upon these definitions in considering the Specifications of professional misconduct.

No witnesses were present at the time of the alleged acts of professional misconduct committed by Respondent. The Committee recognized that it was essential to evaluate the credibility of each of the complainants. The members of the Hearing Committee closely examined the testimony and demeanor

of the seven female patients and employees of the Respondent, each of whom personally appeared at this preceding, and of the Respondent to consider the consistency and persuasiveness of their statements. As was stated consistently throughout this proceeding, decisions as to whether to sustain the charges were based solely on the relevant evidence received into the record. Collateral matters that each party attempted to raise, but which were determined by the ALJ to be inadmissable, played no role in the final determination and were never considered by the Committee.

Patients B, C, D and E

The Committee found the testimony of these four female patients to be consistent and believable. Theories that were suggested by Respondent as motivating factors for the accusations were totally rejected as not being supported in the record. The fact that Patient E may have spoken with Patients C and D about Respondent's treatment was not seen as unusual and the Committee found no evidence of a "conspiracy" by the patients to fabricate accusations of mistreatment. It was considered to be reasonable for patients with a common physician to discuss the care being provided. The Committee did not conclude that Patients B, C, D and E colluded to falsely accuse Respondent and believed that their demeanor supported their testimony. The four women clearly did not enjoy recounting unpleasant and embarrassing information and it was apparent that they took no pleasure in making their accusations. Each patient gave every indication of being a typical middle-aged female with no motive in making a false report and whose trust in a physician had been betrayed.

The credibility of these four patients was strengthened by their similar descriptions of Respondent's behavior. In each case, Respondent unhooked the patient's brassiere himself, touched one or both breasts with only one hand without palpating all quadrants and thereafter provided no explanation, either prior to, or at the completion of, the purported examination, for his actions. He touched the breasts of Patients B, D and E while seated behind each woman and without being able to visualize the breasts. The Committee also found it significant that no breast examination was performed during the initial ofice visits of Patients B, C and D, when a female chaperone was present, but that subsequent breast "examinations" occurred in the absence of a female chaperone. These consistencies assisted the

Committee in its evaluation of the testimony of the witnesses.

The Hearing Committee considered Respondent to not be direct and straightforward and believed he unreasonably attempted to shift responsibility for his actions to others. His testimony was viewed as self-serving and unconvincing. The members of the Committee believed Respondent's recordkeeping to be substandard, with inadequate justification for the breast examinations he performed. His demeanor appeared flat and the justifications for his actions were inconsistent and inadequate. Respondent also demonstrated poor communication with his patients by failing to prepare them for the breast examinations or to explain his purpose in touching sensitive portions of the female anatomy. The Committee rejected his insinuations that the patients made their allegations because they may have been taking psychotropic medications or were denied documentation that would have supported a claim of disability and found his testimony to have no credibility.

The testimony of Dr. Wexler, the Department's expert and board certified in rheumatology, was accepted and relied upon by the Committee in establishing appropriate standards for both the manner in which a breast examination should be performed and for the occasions on which such an examination should be undertaken by a rheumatologist. He was considered to be both knowledgeable and objective in his answers. He honestly testified that he no longer conducted breast examinations because he felt uncomfortable in doing so as a result of having little need to perform them in his practice. The Committee did not conclude that this fact precluded him from testifying about his earlier experiences in conducting a breast examination that met acceptable medical standards. Based on his opinions, the Committee believed that a breast examination performed while the patient was upright and not supine was an exception to standard medical practice that required adequate documentation for its justification. The Committee also determined that touching a patient's breast while seated behind her for the purpose of conducting an examination of the breast constituted practice of the profession with gross incompetence as such an act demonstrated an unmitigated absence of medical skill and knowledge.

The Committee believed that Respondent's explanation that he performed the breast examinations to check for complaints of chest pain, to examine the costrochondral junction, to test for tender trigger points or to monitor potential side effects from medications such as methotrexate were actually excuses to fondle the patient's breasts. The members considered it important to note that Respondent was treating

the patients as a rheumatologist and not as a gynecologist. There was no evidence that he referred any of the four women to a gynecologist to follow up complaints of chest pain.

The medical records of the patients did not support performance of the examinations. Findings at one visit by Patient B of a "cystic" breast were followed by a finding of a "normal" breast at a subsequent visit with no explanation provided. She was not being seen by Respondent to be treated for a cystic breast condition. Complaints of chest pain, allegedly made by the patients, were not consistently recorded and there was no documentation that the Respondent actually asked the patients whether they were experiencing pain while he purportedly tested their tender trigger points. There was also no documentation of any findings of an examination of the axilla or lymph nodes which would have been relevant information obtained pursuant to a legitimate breast examination.

The Committee told strong exception to Respondent's characterization of Patient B's testimony as "unconvincing, crass and histrionic". She exhibited righteous indignation at being mistreated and her emotional explanation of personal indignities made her testimony most credible. Contrary to Respondent's assertions, it was determined that Respondent touched her breasts and pubic areas on more than one occasion in an inappropriate manner for no justifiable medical reason. The fact that Patient B, as well as Patients D and E, continued to see Respondent after the initial improper examinations was not considered to be significant by the Committee, which found it reasonable to believe that the patients may have been uncertain initially as to what had occurred or how to address the situation. It was also observed that each of the these three women discussed their discomfort with Respondent with either her primary physician or gynecologist. All of the women, including Patient C, ultimately stopped being treated by the Respondent because they believed that they had been improperly examined.

The June 7, 2000 office visit of Patient C, during which Respondent asked her to perform certain movements while he sat in such close proximity to her that she could not perform them without touching him, was considered to be so unusual that the Committee believed it must have occurred as described. This made her testimony more credible. It was that office visit which convinced Patient C to discontinue her treatment with Respondent. It was not considered significant that she complimented Respondent's care of her in a July 31, 2000 letter to his office in which she requested that her medical records be transferred to a different rheumatologist. The Committee reasoned that the patient intended to encourage Respondent to comply with the request to transfer her records by complimenting him on his care.

Patient A, Employee F and Employee G

The Hearing Committee concluded that the testimony of these three witnesses, each of whom was a young female employee of the Respondent, was consistent and credible. No motivation for falsely accusing the Respondent was apparent and it was obvious they did not enjoy reporting Respondent's improper conduct. The Committee members believed that Respondent initiated inappropriate conversations and actions with the three women and took advantage of his status as their employer. His behavior toward his employees served to support the allegations of Patients B, C, D and E and made those complaints more credible.

The testimony of Patient A was accepted as accurately relating Respondent's actions in purportedly examining her throat and chest to monitor the patient's recovery from a cold. Patient A only worked in Respondent's office for a few days and the Committee felt it unreasonable to expect her to accurately recall minor details about the physical layout of the office. The Committee felt it more significant that both Employees F and G confirmed that Patient A angrily left the office and did not return after stating that Respondent had improperly touched her breasts.

The Committee did not believe Respondent's testimony that Employee F regularly complained of neck and back pain and requested massages. She credibly testified that his rubbing of various parts of her body was not invited and was unwelcomed. The Committee also accepted her description of being cornered in an office bathroom after work hours by the Respondent who reached under her shirt and unhooked Employee F's brassiere. Employee G also testified about Respondent's inappropriate behavior, including his chasing her in his office. His actions were also not welcomed and she testified as to her attempts to avoid working alone with Respondent after regular business hours in the office.

Employee F's testimony concerning preparation of the June 15, 2001 letter about Respondent's treatment of her was less convincing. She contradicted herself several times on how the letter came to be written and about the manner in which she subsequently wrote a retraction on the reverse side. The Committee considered Factual Allegation G to be less significant than the other charges that were sustained and did not conclude that the Department had demonstrated by a preponderance of the evidence that Respondent knowingly and intentionally caused her to prepare a false statement. Accordingly, Factual Allegation G was not sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set out above, unanimously determined 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, and the imposition of monetary penalties.

The Committee sustained multiple Specifications of Respondent's having practiced with gross negligence, gross incompetence, negligence and incompetence on more than one occasion, having practiced in a manner evidencing moral unfitness and having willfully harassed, abused or intimidated patients. It was determined that the repetitive pattern of the conduct over a period of years was of such an egregious nature that Respondent could not be rehabilitated. Respondent used his position as a physician to take advantage of female patients for his personal sexual gratification which broke the trust his patients held in him and resulted in a loss of their dignity. He used his position as an employer to harass female employees causing them to fear to work alone with him. Respondent exhibited no remorse for his actions and, in fact, denied that anything improper had taken place.

The Committee members believed that Respondent demonstrated that he was aware that he was unfairly taking advantage of his female patients by his policy of having the presence of a female chaperone at each patient's initial office visit. It was noted that he never asked the patients if they wanted a chaperone present at subsequent visits and it was during those visits that the improper touching took place. The collective testimony of Patients A, B, C, D and E and Employees F and G was found to be credible and the Committee felt that Respondent's actions occurred as described by the witnesses. Notwithstanding testimony of other former patients and colleagues as to his medical skills and general character, the Committee unanimously concluded that nothing in Respondent's character indicated that he could be rehabilitated to prevent future improper acts from taking place and determined that Respondent is not morally fit to practice medicine in New York State.

ORDER

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

1. The following Specifications of professional misconduct as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED:**
    a. First through Fifth Specifications;
    b. Sixth through Tenth Specifications;
    c. Eleventh Specification;
    d. Twelfth Specification;
    e. Thirteenth through Seventeenth Specifications;
    f. Eighteenth through Twenty third;
    g. Twenty fifth Specification.

2. The license of Respondent to practice medicine in New York State be and hereby is **REVOKED.**

3. 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: Troy, New York

Jan 22, **2002**

Sheldon H. Putterman, MD

SHELDON H. PUTTERMAN, M.D., CHAIRPERSON

DIANA E. GARNEAU, M.D.
WILLIAM W. WALENCE, Ph. D.

TO:

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APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
	:	CHARGES
MATHEW K. ALUKAL, M.D.		

----------X

MATHEW K. ALUKAL, M.D., the Respondent, was authorized to practice medicine in New York State on August 14, 1981, by the issuance of license 147353 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (Patients are identified in the appendix) in or about April 2001 at his office, 1301 North Forrest Road, Williamsville, New York. Respondent's care and treatment of Patient A, who was also an office employee, failed to meet acceptable standards of medical care and/or professional conduct, in that:

1. In or about April 2001, Respondent touched Patient A's breasts without medical justification.
2. In or about April 2001, Respondent touched Patient A's breasts in a manner that was not medically appropriate.
3. In or about April 2001, Respondent touched Patient A's buttocks with his groin area for no legitimate medical purpose.

B. Respondent treated Patient B from on or about February 25, 1998, to on or about May 31, 2000, at his office. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care and/or professional conduct, in that:

1. Respondent failed to perform an adequate and/or appropriate breast examination.
2. Between February 25, 1998 and before May 31, 2000, Respondent touched Patient B's breasts without medical justification on approximately four occasions.
3. Between February 25, 1998 and before May 31, 2000, Respondent touched Patient B's breasts in a manner that was not medically appropriate on approximately four occasions.
4. On or about May 31, 2000, Respondent touched Patient B's breasts without medical justification.
5. On or about May 31, 2000, Respondent touched Patient B's breasts in a manner that was not medically appropriate.
6. On or about May 31, 2000, Respondent touched Patient B's lower abdomen and pubic area without medical justification.
7. On or about May 31, 2000, Respondent touched Patient B's lower abdomen and pubic area in a manner that was not medically appropriate.
8. On or about May 31, 2000, Respondent touched Patient B's genitals without medical justification.

9. On or about May 31, 2000, Respondent touched Patient B's genitals in a manner that was not medically appropriate.

10. On or about May 31, 2000, Respondent touched Patient B's buttocks with his groin area for no legitimate medical purpose.

C. Respondent treated Patient C from on or about March 2, 2000, to on or about June 7, 2000. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care and/or professional conduct, in that:

1. Respondent failed to perform an adequate and/or appropriate breast examination on or about April 7, 2000.

2. On or about April 7, 2000, Respondent touched Patient C's left breast without medical justification.

3. On or about April 7, 2000, Respondent touched Patient C's left breast in a manner that was not medically appropriate.

D. Respondent treated Patient D from on or about July 23, 1998, to in or about the Spring of 2000 at his office. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care and/or professional conduct, in that:

1. Respondent failed to perform an adequate and/or appropriate breast examination.
2. In or about the Spring of 2000, Respondent touched Patient D's breasts without medical justification on two occasions.
3. In or about the Spring of 2000, Respondent touched Patient D's breasts in a manner that was not medically appropriate on two occasions.
4. In or about the Spring of 2000, Respondent touched Patient D's lower abdomen and pubic area without medical justification.
5. In or about the Spring of 2000, Respondent touched Patient D's lower abdomen and pubic area in a manner that was not medically appropriate.
6. In or about the Spring of 2000, Respondent touched Patient D's buttocks with his groin area for no legitimate medical purpose.

E. Respondent treated Patient E from on or about May 22, 1998 to on or about September 2000 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care and/or professional conduct, in that:

1. Respondent failed to perform an adequate and/or appropriate breast examination.
2. In or about the Spring of 1999, Respondent touched Patient E's breasts without medical justification on two occasions.

3. In or about the Spring of 1999, Respondent touched Patient E's breasts in a manner that was not medically appropriate on two occasions.

F. From on or about February 2000 to on or about May 2001, Respondent sexually harassed Employee F by asking inappropriate sexual questions and initiating inappropriate sexual conversations; hugging; rubbing her shoulders; unhooking her bra; touching her buttocks with his hand(s); and/or touching her buttocks with his groin area.

G. On or about June 15, 2001, Respondent knowingly and intentionally caused Employee F to make a false statement regarding Respondent's behavior during her employment.

H. From on or about April 1999 to on or about February 2001, Respondent sexually harassed Employee G by asking inappropriate sexual questions; initiating inappropriate sexual conversations; attempting to touch; and/or hugging.

I. On or about June 30, 2000, Respondent falsely stated to Detective Gary Woods of the Amherst Police Department that he had never been accused of this type of incident (sexual abuse of patient) in the past when in fact Respondent knew that three patients had previously accused him of sexual misconduct.

SPECIFICATIONS

FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

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

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

SIXTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence on a particular occasion in violation of New York Education Law §6530(6), in that Petitioner charges:

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

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

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

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5), in that Petitioner charges two or more of the following:

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

THIRTEENTH THROUGH SEVENTEENTH SPECIFICATIONS

PHYSICAL ABUSE OR HARASSMENT OF PATIENTS

Respondent is charged with physically abusing or harassing patients in violation of New York Education Law §6530(31), in that Petitioner charges:

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

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

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

16. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5 and/or D.6.

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

EIGHTEENTH THROUGH TWENTY-SIXTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20), in that Petitioner charges:

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

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

20. The facts in Paragraphs C and C.1, C.2, and/or C.3.

21. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5 and/or D.6.

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

23. The facts in Paragraph F.

24. The facts in Paragraph G.

25. The facts in Paragraph H.

26. The facts in Paragraph I.

TWENTY-SEVENTH AND TWENTY-EIGHTH SPECIFICATIONS

FRAUD

Respondent is charged with practicing the profession fraudulently in violation of New York Education Law §6530 (2), in that Petitioner charges:

27. The facts in Paragraph G.

28. The facts in Paragraph I.

DATED: July 3, 2001
Albany, New York

BRIAN M. MURPHY
Chief Counsel
Bureau of Professional
Medical Conduct