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.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 3, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe, Esq.
NYS Department of Health
Corning Tower – Room 2509
Empire State Plaza
Albany, New York 12237

Megaly C. Lucas, Esq.
403 West 38th Street
New York, New York 10018

RE: In the Matter of Luis Fernando Rivas, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-135) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

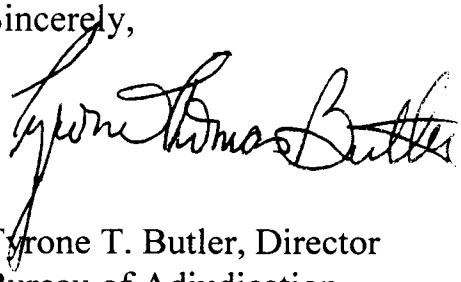
The notice of review served on the Administrative Review Board should be forwarded to:

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

COPY

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

IN THE MATTER

OF

LUIS FERNANDO RIVAS, M.D.

DETERMINATION

AND

ORDER

BPMC- -00-135

DAVID T. LYON, M.D., Chairperson, **ROBERT A. MENOTTI, M.D.**, and **JOHN D. TORRANT**[1], duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **SUSAN S. PATTENAUDE, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee. 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.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges Served:	August 16, 1999
Answer to Statement of Charges:	August 31, 1999

[1]Initially, Rev. Robert Eggenschiller was appointed to the Hearing Committee in this case and attended all hearing dates. Shortly after the last hearing date but prior to the Committee's deliberations, Rev. Eggenschiller retired out of state. Mr. Torrant, who is a duly designated member of the State Board for Professional Medical Conduct and attended all hearing dates and affirms that he read all transcripts in this case, was substituted for Rev. Eggenschiller.

Amended Statement of Charges:	September 15, 1999
Amended Answer:	October 6, 1999
Hearing Dates:[2]	September 13, 1999 October 6, 1999 December 22, 1999
Post-Hearing Briefs Served:[3]	January 20, 2000
Deliberation Date:	February 10, 2000
Places of Hearing:	Office of Professional Medical Conduct 433 River Street Hedley Building Troy, New York 5 Penn Plaza New York, New York Empire State Plaza Corning Tower Albany, New York
Petitioner Appeared By:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health By: Kevin C. Roe, Associate Counsel
Respondent Appeared By:	Magaly C. Lucas, Esq.

WITNESSES

For the Petitioner:	Joseph Cain Luis F. Rivas, M.D. Salvatore Galante, M.D.
For the Respondent:	None

[2]The one-hundred-twenty day time period for the completion of a hearing set forth in Public Health Law Section 230.10(f) was waived by Respondent.

[3]Respondent did not serve any post-hearing submissions.

STATEMENT OF CHARGES

Respondent was authorized to practice medicine in New York State on January 15, 1982 by the issuance of license number 149034 by the New York State Education Department. Respondent was served with a Notice of Hearing and Statement of Charges on August 16, 1999, and an Amended Statement of Charges, dated September 15, 1999. Respondent was charged with misconduct under New York Education Law Sec. 6530.

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

The charges are more specifically set forth in the Amended Statement of Charges (hereinafter referred to as "Statement of Charges"), a copy of which is attached hereto and made a part hereof.

GENERAL FINDINGS OF FACT

Having heard testimony and considered evidence presented by the Department of Health and the Respondent, the Hearing Committee hereby makes the following findings. Citations in parentheses refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

1. Respondent Luis Fernando Rivas, M.D. was licensed as a physician in New York State on January 15, 1982, by the issuance of license number 149034 by the New York State Education Department. (Ex. 1-A, A).

2. Respondent practiced at the Padre Billini Medical Office (PBMO), 40 Wadsworth Avenue and/or 599 190th Street, New York, New York from September 1995 to May 1999. (T. 86-87).

3. Respondent saw patients A through H at PBMO between February 1997 and April 1998 (Ex. 2-9).

4. Medical records of the eight patients named in this proceeding were altered by "whiting out" certain entries, changing certain dates and/or entries, and adding new information to the reports of office visits. None of the changes made was dated, thus making it appear that all of the information was placed in the record at or about the time of the office visits reflected therein (Ex. 2-9, 14; T 45-47, 49-51, 97, 123, 126).

5. At the initial office visit for each of the patients in question, the treatment plan, or letters provided to employers for each of the patients, included bed rest, "absolute repose," and/or a period of disability from work. (Exs. 2-9).

GENERAL CONCLUSIONS

With respect to the allegations of misconduct, the Hearing Committee found the Petitioner's expert witness, Dr. Salvatore Galante, to be both qualified and credible. While his testimony supported many of the Petitioner's factual allegations, Dr. Galante could not or would not simply

agree to them all. Rather, he was careful to answer questions very specifically and thoughtfully, and qualify such answers where appropriate to do so.

The Hearing Committee also found Dr. Rivas to be a credible, although perhaps somewhat confused, witness. He was forthcoming regarding several incidents of his own misconduct about which he was specifically questioned, and appeared to make efforts to cooperate throughout the proceeding, at least until the December 22nd hearing date, as discussed below. It is quite unfortunate that we did not have an opportunity to hear more from the Respondent.

Finally, we must address the unusual procedural issues which arose in this case. Originally, the third hearing day was scheduled for November 19, 1999 and was to be held via teleconference so that the Respondent's witnesses could testify from New York City. On November 15th, Respondent requested an adjournment of several weeks to allow time for him to regroup following a serious fire in the home he shared with his mother. In support of the request, Respondent asserted that the fire made it difficult, if not impossible, for him to assist in his own defense at that time. The request was granted over Petitioner's objections, and the hearing was adjourned until December 22, 1999. Arrangements for teleconferencing were once again made. Despite being duly notified of the hearing date and arrangements for teleconferencing, neither Respondent nor his attorney appeared on December 22nd. Numerous unsuccessful attempts were made to reach them via telephone, and no voice mail messages, correspondence or other communications were received on that day, or at any time subsequent, regarding their whereabouts or failure to appear. As a result, at the December 22nd hearing, the Administrative Law Judge found that the Respondent defaulted and waived his opportunity to complete his testimony or cross examination and granted the Petitioner's motion to close the hearing. (T. 371-372).

FINDINGS OF FACT - PATIENT A

1. Patient A was seen by Respondent on January 30, 1998, February 25, 1998, March 5, 1998, and March 13, 1998. (Ex. 2).

2. A minimally acceptable history for a complaint of back pain should include: mechanism of injury; relationship to work; duration of pain; nature of pain; and history of previous treatment. (T. 210-212).

3. At the initial office visit on January 30, 1998, Respondent obtained and recorded a history of severe back pain over the lower back, mostly in the morning and when the patient bends or lies down. (Ex. 2).

4. A minimally acceptable physical examination of a patient with complaints of back pain should include: range of motion of the lower back; detailed examination and report of reflexes in the lower extremities; muscle strength in the lower extremities; gait; and straight leg raising sign. (T. 212-215).

5. At the initial office visit, Respondent performed and recorded a physical examination with normal findings of the head and neck, eyes, ears, nose, throat, mouth, skin, lymph nodes, lungs, heart, abdomen, genitalia, extremities, general appearance, edema, and reflexes. Respondent later added notes under extremities which included decreased range of motion of the hip, both frontal and flexion, pain on motion of the lower back, and severe muscle spasm. Under reflexes, Respondent later added bilateral reflex response, no neuromotor deficit. (Ex. 2).

6. At the initial office visit, Respondent ordered bed rest or "absolute repose" until March 16, 1998, a period of approximately six weeks. (Ex. 2; T. 113, 123, 127-128).

7. When bed rest or "absolute repose" is medically appropriate, it should be prescribed for only a few days; at most, one week without interval examination. (T. 217, 256).

CONCLUSIONS - PATIENT A

We find that Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

- Respondent failed to perform and/or record an adequate physical examination.
- Respondent failed to obtain and/or record an adequate history.
- Respondent ordered "absolute repose" without adequate medical justification.
- Respondent ordered "absolute repose" for an inappropriate period of time without adequate follow-up..
- Respondent altered the medical record by adding and changing information in the reports of office visits.

First, it is clear from Petitioner's expert witness' testimony that the requisite minimal elements of patient history and physical examination, given the nature of the complaints, were not recorded and/or performed by the Respondent.

In reaching our findings, we also conclude that based on the information contained in the medical record, bed rest or "absolute repose" was not medically justified for this patient. At the very least, interval follow-up must be conducted within a short period of time; no such follow-up was

conducted in this case. Bed rest or "absolute repose" for five to six weeks was not medically justified and was excessive.

As to the changes made to the medical records, the Respondent admits he made such changes to the reports of office visits, although he denies he was responsible for changes made to the dates of office visits. While there is ample evidence to indicate that such dates were changed, the Petitioner has failed to meet its burden of proving that the Respondent, rather than other office staff as suggested by Dr. Rivas, was in fact responsible for such changes to the dates on Patient A's records or, in fact, to the dates of any of the subject patients' records..

DETERMINATIONS - PATIENT A

1. Allegations A.1 through A.6 are sustained.
2. Allegation A.7 is not sustained.

FINDINGS OF FACT - PATIENT B

1. Patient B was seen by Respondent at PBMO on January 24, 1998, February 14, 1998 and March 7, 1998 (Ex. 3).

2. A minimally acceptable history for a complaint of palpitations and chest pain should include onset and duration of the complaints, and further description of the palpitations and chest pain complained of. (T. 260-261).

3. At the initial office visit on January 24, 1998, Respondent reported a history which did not include the onset or duration of the complaints nor a further description of Patient B's palpitations and chest pain. (Ex. 3).

4. A minimally acceptable physical examination for complaints of palpitations and chest pain should include mental status, presence or absence of suicidal ideation, and a detailed examination and report of the heart and lungs. (T. 260-261).

5. At the initial office visit, Respondent reported a physical examination with normal findings of the head and neck, eyes, ears, nose, throat, mouth, skin, lymph nodes, lungs, heart, breast, abdomen, extremities, general appearance, edema, and reflexes. Pelvic examination was reported as deferred. Respondent "whited out" the original report of his examination of the heart and added "NRS S1 S2 MGR." Respondent did not include findings for all of the minimally accepted elements set forth above. (Ex. 3).

6. Respondent reported a diagnostic impression of anxiety disorder/depression, ordered laboratory studies, and prescribed Paxil. Respondent prescribed bed rest or "absolute repose" until March 9, 1998, a period of five weeks. (Ex. 3; T. 113, 123, 127-128).

CONCLUSIONS - PATIENT B

We find that Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

- Respondent failed to perform and/or record an adequate physical examination.
- Respondent failed to obtain and/or record an adequate history.
- Respondent altered the medical record by adding and changing the reports of office visits.

As with Patient A, Respondent admitted to having made changes to the medical records of Patient B. Further, it is clear from Petitioner's expert witness' testimony that the requisite minimal elements of patient history and physical examination, given the nature of the complaints, were not recorded and/or performed by the Respondent.

We cannot, however conclude with any reasonable certainty that absolute repose was ordered for this patient by the Respondent. A letter addressed to "whom it may concern" and signed by Dr. Billini indicates that such treatment was ordered, but we cannot say by a preponderance of the evidence that Respondent was responsible for this directive. We also note that while the Petitioner pointed out the identical nature of the handwriting in the Billini letters and the handwriting in the patient records that was admitted by Dr. Rivas to be his, we are unwilling to conclude that they were definitively written by the same person based solely on appearance and without expert handwriting testimony. While we concede that this may in fact be the case, it was simply not proved by a preponderance of the evidence and thus the allegations cannot be sustained.

DETERMINATIONS - PATIENT B

1. Allegations B.1, B.2, B.5 and B.6 are sustained.
2. Allegations B.3, B.4 and B.7 are not sustained

FINDINGS OF FACT - PATIENT C

1. Patient C was seen at PBMO by Respondent on December 16, 1997 and January 31, 1998. (Ex. 4).

2. A minimally acceptable history for a complaint of a painful lump in the right inguinal area should include mechanism of injury, duration of condition, and whether or not trauma was involved. (T. 285-286).

3. At the initial office visit on December 16, 1997, Respondent obtained and reported a chief complaint and history of a lump in the right inguinal area with pain, lump increased when increased pressure of the abdomen. (Ex. 4).

4. A minimally acceptable physical examination for a complaint of a painful lump in the right inguinal area should include the size of the lump or hernia, presence or absence of bowel sounds, and the presence or absence of any other problems in the abdomen. (T. 286-288).

5. At the initial office visit, all categories of physical examination were reported as normal except the abdomen, which was reported as "lump - right inguinal area, right inguinal hernia." Information originally entered in the medical record regarding physical examination of the head an

neck and of the heart were "whited out" and information was added. Respondent did not include findings for all of the minimally accepted elements set forth above. (Ex. 4).

6. At the initial office visit, Respondent reported a diagnostic impression of right inguinal hernia. Under patient instructions, Respondent reported that the patient was scheduled for surgery on December 29, 1997, was advised to bring description of surgical procedure to his office visit, and was advised to go back to work on February 2, 1998. (Ex. 4).

CONCLUSIONS - PATIENT C

We find that Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

- Respondent failed to perform and/or record an adequate physical examination.
- Respondent failed to obtain and/or record an adequate history.

Once again, the Petitioner's expert testimony indicated that the requisite minimal elements of patient history and physical examination, given the nature of the complaints, were not recorded and/or performed by the Respondent.

With respect to the fraud allegations, we can conclude that the records were in fact changed, but not that the Respondent was the one responsible for such changes. We did not hear Respondent testify specifically as to Patient C. Given Dr. Rivas' testimony regarding changes he made to the records of Patients A and B, it may be reasonable to infer that records of some of the remaining patients (C through H) were changed by him. However, the Petitioner must prove these allegations by a preponderance of the evidence, and given the Respondent's denials that he was responsible for

changing all of the records, coupled with the lack of any further evidence regarding patients C through H, we simply cannot sustain the fraud charges for Patient C or for Patients D through H.

We also note that there is nothing in the record to indicate that Respondent ordered bed rest or absolute repose, and there was no testimony to this fact by Respondent. As with Patient B, a letter addressed to "whom it may concern" and signed by Dr. Billini indicates that it was recommended to the patient that he "stay in repose for a period of five weeks," but we cannot determine with the requisite probability that Respondent was responsible for this recommendation.

DETERMINATIONS - PATIENT C

1. Allegations C.1 and C.2 are sustained.
2. Allegations C.3, C.4, C.5, C.6 and C.7 are not sustained.

FINDINGS OF FACT - PATIENT D

1. Patient D was seen by Respondent at PBMO on February 18, 1997, March 8, 1997, March 29, 1997, April 19, 1997, January 1, 1998, January 26, 1998, February 20, 1998 and February 28, 1998. (Ex. 5).

2. A minimally acceptable history for a complaint of back pain should include: mechanism of injury; relationship to work; duration of pain; nature of pain; and history of previous treatment. (T. 210-212, 304).

3. At the initial office visit on February 18, 1997, Respondent obtained and recorded a history of lower back pain for one week, mostly when he bends down, with exercise, cannot sleep at night due to pain, and cough and stuffy nose for two days. (Ex. 5).

4. A minimally acceptable physical examination of a patient with complaints of back pain should include: range of motion of the lower back; detailed examination and report of reflexes in the lower extremities; muscle strength in the lower extremities; gait; and straight leg raising sign (T. 212-215, 304-306).

5. At the initial office visit, Respondent performed and/or reported a physical examination with normal findings in all categories. A notation of decreased range of motion of the hip with frontal extension was added by Respondent in June 1998. Other entries in the report of physical examination were "whited out" and information was added. Respondent did not include findings for all of the minimally accepted elements set forth above.(Ex. 5; T. 97, 123).

6. At the initial office visit, Respondent reported a diagnostic impression of bronchial asthma, lower back ache-rule out herniated disc. Among other treatment, respondent ordered bed rest, "absolute repose," and/or disability from work until April 7, 1997, a period of eight weeks. (Ex. 5; T. 113, 123, 127-128).

7. Patient D was seen again by Respondent in January 1998, diagnosed with lower back pain, and placed on disability for eight weeks. (Ex. 5).

8. Where bed rest or "absolute repose" is medically appropriate, it should be prescribed for only a few days; at most, one week without interval examination (T. 217, 256).

CONCLUSIONS - PATIENT D

We find that Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

- Respondent failed to perform and/or record an adequate physical examination.
- Respondent failed to obtain and/or record an adequate history.
- Respondent ordered "absolute repose" for an inappropriate period of time without adequate follow-up.

In reaching our findings, we conclude that based on the information contained in the medical record, while bed rest may have been appropriate for some length of time, bed rest or absolute repose, for eight weeks, without appropriate follow-up, was not medically justified and was most certainly excessive.

Further, it is clear that the requisite minimum elements of patient history and physical examination, given the nature of the complaints, were not recorded and/or performed by the Respondent.

DETERMINATIONS - PATIENT D

1. Allegations D1, D.2, D.4 and D.5 are sustained.
2. Allegations D.3, D.6 and D.7 are not sustained.

FINDINGS OF FACT - PATIENT E

1. Patient E was seen by Respondent at PBMO on March 9, 1998, March 19, 1998 and April 7, 1998. (Ex. 7).

2. A minimally acceptable history for a complaint of back pain should include: mechanism of injury; relationship to work; duration of pain; nature of pain; and history of previous treatment. (T. 210-212, 311-312).

3. At the initial office visit on March 9, 1998, Respondent obtained and recorded a history of lower back pain for one week, mostly when he walks or lies down, worse when he bends down. (Ex. 7).

4. A minimally acceptable physical examination of a patient with complaints of back pain should include: range of motion of the lower back; detailed examination and report of reflexes in the lower extremities; muscle strength in the lower extremities; gait; and straight leg raising sign. (T. 212-215, 313).

5. At the initial office visit, Respondent performed and/or reported a physical examination with normal findings in all categories. A notation of decreased range of motion of the hip with frontal extension was added in June 1998. Other entries in the report of physical examination were "whited out" and information was added. Respondent did not include findings for all of the minimally accepted elements set forth above.(Ex. 7; T. 97, 123).

6. At the initial office visit, Respondent reported a diagnostic impression of lower back ache. Among other treatment, Respondent ordered bed rest, "absolute repose," and/or disability from work until April 6, 1998, a period of four weeks. (Ex. 5, T. 113, 123, 127-128).

7. When bed rest or "absolute repose" is medically indicated, it should be prescribed for only a few days; at most, one week without interval examination. (T. 217, 256).

CONCLUSIONS - PATIENT E

We find that Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

- Respondent failed to perform and/or record an adequate physical examination.
- Respondent failed to obtain and/or record an adequate history.
- Respondent ordered "absolute repose" for an inappropriate period of time without adequate follow-up.

Once again, we must conclude that based on the information contained in Patient E's medical record, bed rest or "absolute repose" for a period of four weeks, without any interval follow-up within a week or so, was excessive and unjustified.

Additionally, as with other patients, the requisite minimal elements of patient history and physical examination, given the nature of Patient E's complaints, were not recorded and/or performed by the Respondent.

DETERMINATIONS - PATIENT E

1. Allegations E.1, E.2, E.4 and E.5 are sustained.
2. Allegations E.3 and E.6 are not sustained.

FINDINGS OF FACT - PATIENT F

1. Patient F was seen by Respondent at PBMO on March 25, 1998 and April 8, 1998. (Ex. 8).

2. A minimally acceptable history for a complaint of back pain should include: mechanism of injury; relationship to work; duration of pain; nature of pain; and history of previous treatment. (T. 210-212, 317).

3. At the initial office visit on March 28, 1998, Respondent obtained and recorded a history of lower back pain for one week, mostly in the morning, and cannot walk properly. (Ex. 8).

4. A minimally acceptable physical examination of a patient with complaints of back pain should include: range of motion of the lower back; detailed examination and report of reflexes in the lower extremities; muscle strength in the lower extremities; gait; and straight leg raising sign. (T. 212-215, 318).

5. At the initial office visit, Respondent performed and/or reported a physical examination with normal findings in all categories. A notation of decreased range of motion of the hip with frontal extension was added by Respondent in June 1998. Other entries in the report of physical

examination were "whited out" and information was added. Respondent did not include findings for all of the minimally accepted elements set forth above. (Ex. 8; T. 97, ,123).

6. At the initial office visit, Respondent reported a diagnostic impression of lower back ache. Among other treatment, Respondent ordered bed rest, "absolute repose," and/or disability from work until April 20, 1998, a period of four weeks. (Ex. 8; T. 113, 123, 127-128).

6. When bed rest or "absolute response" is medically indicated, it should be prescribed for only a few days; at most, one week without interval examination. (T. 217, 256).

CONCLUSIONS - PATIENT F

We find that Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

- Respondent failed to perform and/or record an adequate physical examination.
- Respondent failed to obtain and/or record an adequate history.
- Respondent ordered "absolute repose" for an inappropriate period of time without adequate follow-up.

Petitioner's expert testimony again supports our conclusion that the requisite minimal elements of patient history and physical examination, given the nature of Patient F's complaints, were not recorded and/or performed by the Respondent.

Further, based on the information contained in the medical record, bed rest or "absolute repose" for a period of four weeks without interval follow-up was not medically justified and was excessive.

DETERMINATIONS - PATIENT F

1. Allegations F.1, F.2, F.4 and F.5 are sustained.
2. Allegations F.3 and F.6 are not sustained.

FINDINGS OF FACT - PATIENT G

1. Patient G was seen by Respondent at PBMO on March 9, 1998, March 28, 1998 and April 10, 1998. (Ex. 6).

2. A minimally acceptable history for a complaint of back pain should include: mechanism of injury; relationship to work; duration of pain; nature of pain; and history of previous treatment. (T. 210-212, 330-331).

3. At the initial office visit on March 9, 1998, Respondent obtained and recorded a history of lower back pain, mostly in the evening, difficulty walking with some (illegible) over the legs for two days. (Ex. 6).

4. A minimally acceptable physical examination of a patient with complaints of back pain should include: range of motion of the lower back; detailed examination and report of reflexes in the lower extremities; muscle strength in the lower extremities; gait; and straight leg raising sign. (T. 212-215, 331-332).

5. At the initial office visit, Respondent performed and/or reported a physical examination with normal findings in all categories. A notation of decreased range of motion of the hip with frontal extension was added in June 1998. Other entries in the report of physical examination were

"whited out" and information was added. Respondent did not include findings for all of the minimally accepted elements set forth above.(Ex. 6; T. 97, 123).

6. At the initial office visit, Respondent reported a diagnostic impression of lower back ache. Among other treatment, Respondent ordered bed rest, "absolute repose," and/or disability from work until April 13, 1998, a period of four weeks. (Ex. 6; T. 113, 123, 127-128).

7. When bed rest or "absolute repose" is medically indicated, it should be prescribed for only a few days; at most, one week. (T. 217, 256).

CONCLUSIONS - PATIENT G

We find that Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care, in that:

- Respondent failed to perform and/or record an adequate physical examination.
- Respondent failed to obtain and/or record an adequate history.
- Respondent ordered "absolute repose" for an inappropriate period of time without adequate follow-up.

Based on information contained in Patient G's records, bed rest or "absolute repose" for five to six weeks without any interval follow-up was not medically justified and was excessive.

As with all the subject patients, the requisite minimal elements of patient history and physical examination, given the nature of Patient G's complaints, were not recorded and/or performed by the Respondent.

DETERMINATIONS - PATIENT G

1. Allegations G.1, G.2, G.4, and G.5 are sustained.
2. Allegations G.3, G.6 and G.7 are not sustained.

FINDINGS OF FACT - PATIENT H

1. Patient H was seen by Respondent at PBMO on 12 occasions between September 12, 1997 and March 2, 1998. (Ex. 9).

2. A minimally acceptable history for a complaint of back pain should include: mechanism of injury; relationship to work; duration of pain; nature of pain; and history of previous treatment. (T. 210-212, 337-338).

3. At the initial office visit on September 12, 1998, Respondent obtained and recorded a history of lower back pain for one week, mostly when she bends down; pain in the cervical area (history of trauma, car accident March 1996); excessive worry, tension, cannot sleep, difficulty concentrating, chest pain, headaches, and feels sad. (Ex. 9).

4. A minimally acceptable physical examination of a patient with complaints of back pain should include: range of motion of the lower back; detailed examination and report of reflexes in the lower extremities; muscle strength in the lower extremities; gait; and straight leg raising sign. (T. 212-215, 338-339).

5. At the initial office visit, Respondent performed and/or reported a physical examination with normal findings in all categories. A notation of decreased range of motion of the hip with

frontal extension was added in June 1998. Other entries in the report of physical examination were "whited out" and information was added. Respondent did not include findings for all of the minimally accepted elements set forth above. (Ex. 9; T. 97, 123).

6. At the initial office visit, Respondent reported a diagnostic impression of lower back ache, anxiety disorder and depression. Among other treatment, Respondent ordered bed rest, "absolute repose," and/or disability from work until November 10, 1997, a period of eight weeks. The period of disability was later extended to 24 weeks. (Ex. 9; T. 113, 123, ,127-128).

7. When bed rest or "absolute repose" is medically indicated, it should be prescribed for only a few days; at most, one week. (T. 217, 256).

CONCLUSIONS - PATIENT H

We find that Respondent's care and treatment of Patient H failed to meet acceptable standards of medical care, in that;

- Respondent failed to perform and/or record an adequate physical examination.
- Respondent failed to obtain and/or record an adequate history.
- Respondent ordered "absolute repose" for an inappropriate period of time without adequate follow-up.

Clearly, "absolute repose" or bed rest for a period of eight to twenty-four weeks with no interval follow-up, was extremely excessive and not justified by the Patient H's record. In addition, Respondent failed to record and/or perform the requisite minimal elements of patient history and physical examination in this case, given the nature of Patient H's complaints.

DETERMINATIONS - PATIENT H

1. Allegations H.1, H.2, H.4 and H.5 are sustained.
2. Allegations H.3, H.6 and H.7 are not sustained.

VOTES OF THE HEARING COMMITTEE

The Hearing Committee voted unanimously as follows:

FIRST THROUGH EIGHTH SPECIFICATIONS (GROSS NEGLIGENCE)

A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7.	NOT SUSTAINED
B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7.	NOT SUSTAINED
C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7.	NOT SUSTAINED
D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7.	NOT SUSTAINED
E and E.1, E.2, E.3, E.4, E.5 and/or E.6.	NOT SUSTAINED
F and F.1, F.2, F.3, F.4, F.5 and/or F.6.	NOT SUSTAINED
G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7.	NOT SUSTAINED
H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.	NOT SUSTAINED

NINTH THROUGH SIXTEENTH SPECIFICATIONS (GROSS INCOMPETENCE)

A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7.	NOT SUSTAINED
B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7.	NOT SUSTAINED
C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7.	NOT SUSTAINED
D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7.	NOT SUSTAINED
E and E.1, E.2, E.3, E.4, E.5 and/or E.6.	NOT SUSTAINED
F and F.1, F.2, F.3, F.4, F.5 and/or F.6.	NOT SUSTAINED
G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7.	NOT SUSTAINED
H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.	NOT SUSTAINED

SEVENTEENTH SPECIFICATION (NEGLIGENCE ON MORE THAN ONE OCCASION)

A and A.1, A.2, A.3, A.4, A.5, A.6, A.7; B and B.1, B.2, B.3, B.4, B.5, B.6, B.7; C and C.1, C.2, C.3, C.4, C.5, C.6, C.7; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7; E and E.1, E.2, E.3, E.4, E.5, E.6; F and F.1, F.2, F.3, F.4, F.5, F.6; G and G.1, G.2, G.3, G.4, G.5, G.6, G.7; and/or H and H.1, H.2, H.3, H.4, H.5, H.6, H.7.	SUSTAINED

EIGHTEENTH SPECIFICATION (INCOMPETENCE ON MORE THAN ONE OCCASION)

A and A.1, A.2, A.3, A.4, A.5, A.6, A.7; B and B.1, B.2, B.3, B.4, B.5, B.6, B.7; C and C.1, C.2, C.3, C.4, C.5, C.6, C.7; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7; E and E.1, E.2, E.3, E.4, E.5, E.6; F and F.1, F.2, F.3, F.4, F.5, F.6; G and G.1, G.2, G.3, G.4, G.5, G.6, G.7; and/or H and H.1, H.2, H.3, H.4, H.5, H.6, H.7.	SUSTAINED

NINETEENTH THROUGH TWENTY-SIXTY SPECIFICATIONS (FRAUD)

A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7.	SUSTAINED
B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7.	SUSTAINED
C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7.	NOT SUSTAINED
D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7.	NOT SUSTAINED
E and E.1, E.2, E.3, E.4, E.5 and/or E.6.	NOT SUSTAINED
F and F.1, F.2, F.3, F.4, F.5 and/or F.6.	NOT SUSTAINED
G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7.	NOT SUSTAINED
H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.	NOT SUSTAINED

TWENTY-SEVENTH THROUGH THIRTY-FOURTH SPECIFICATIONS (MORAL UNFITNESS)

A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7.	NOT SUSTAINED
B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7.	NOT SUSTAINED
C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7.	NOT SUSTAINED
D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7.	NOT SUSTAINED
E and E.1, E.2, E.3, E.4, E.5 and/or E.6.	NOT SUSTAINED
F and F.1, F.2, F.3, F.4, F.5 and/or F.6.	NOT SUSTAINED
G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7.	NOT SUSTAINED
H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.	NOT SUSTAINED

CONCLUSIONS OF LAW

The Respondent is charged with thirty-four Specifications alleging professional misconduct within the meaning of Education Law Sec. 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does 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 Henry M. Greenberg, Esq., 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.

As enumerated below, using the above-referenced memorandum as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the Petitioner has sustained its burden of proof regarding four of the Specifications and did not prove thirty Specifications.

1. The First through Eighth Specifications charge the Respondent with practicing medicine with gross negligence, based upon factual allegations A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7; B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7; C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7; D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7; E and E.1, E.2, E.3, E.4, E.5 and/or E.6; F and F.1, F.2, F.3, F.4, F.5 and/or F.6; G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7; and H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7. of the Statement of Charges. The Hearing Committee does not sustain the allegations and finds that Respondent's treatment of Patients A through H was not grossly negligent within the meaning of New York State Education Law § 6530 (4) in that it did not fail to conform to the standard of care that would be exercised by a reasonably prudent physician under the same circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. **The First through Eighth Specifications are NOT SUSTAINED.**

2. The Ninth through Sixteenth Specifications charge the Respondent with practicing medicine with gross incompetence, based upon factual allegations A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7; B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7; C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7; D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7; E and E.1, E.2, E.3, E.4, E.5 and/or E.6; F and F.1, F.2, F.3, F.4, F.5 and/or F.6; G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7; and H and

H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7 of the Statement of Charges. The Hearing Committee does not sustain the allegations and finds that Respondent's treatment of Patients A through H was not grossly incompetent within the meaning of New York State Education Law § 6530 (6) in that it did not constitute an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the Respondent in the practice of medicine.

The Ninth through Sixteenth Specifications are NOT SUSTAINED.

3. The Seventeenth Specification charges the Respondent with practicing with negligence on more than one occasion, based upon factual allegations A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7; B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7; C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7; D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7; E and E.1, E.2, E.3, E.4, E.5 and/or E.6; F and F.1, F.2, F.3, F.4, F.5 and/or F.6; G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7; and H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7 of the Statement of Charges. The Hearing Committee sustains this specification and finds that Respondent's treatment of Patients A through H was negligent within the meaning of New York State Education Law § 6530 (3) in that it did not conform to the standard of care of a reasonably prudent physician under the same circumstances. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Seventeenth Specification is SUSTAINED.

4. The Eighteenth Specification charges the Respondent with practicing with incompetence on more than one occasion, based upon factual allegations A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7; B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7; C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7; D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7; E and E.1, E.2, E.3, E.4, E.5 and/or E.6; F and F.1, F.2, F.3, F.4, F.5 and/or F.6; G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7; and H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7 of the Statement of Charges. The Hearing Committee sustains this specification because it finds that on more than one occasion the Respondent was incompetent within

the meaning of New York State Education Law § 5630 (5) in that Respondent demonstrated a lack of requisite skill and knowledge. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Eighteenth Specification is SUSTAINED.

5. The Nineteenth through Twenty-Sixth Specifications charge the Respondent with practicing the profession of medicine fraudulently, based upon factual allegations A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7; B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7; C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7; D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7; E and E.1, E.2, E.3, E.4, E.5 and/or E.6; F and F.1, F.2, F.3, F.4, F.5 and/or F.6; G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7; and H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7 of the Statement of Charges. The Hearing Committee sustains specifications Nineteen and Twenty but does not sustain Specifications Twenty-One through Twenty-Six and finds that the Respondent did practice the profession of medicine fraudulently within the meaning of New York State Education Law § 6530(2), with respect to Patients A and B, in that he made a misrepresentation or concealed a known fact with the intention to mislead by altering the medical records of Patients A and B.

The Nineteenth through Twenty-Second Specifications are SUSTAINED.

The Twenty-Third through Twenty-Sixth Specifications are NOT SUSTAINED.

6. The Twenty-Seventh through Thirty-Fourth Specifications charge the Respondent with being morally unfit to practice the profession of medicine, based upon factual allegations A and A.1, A.2, A.3, A.4, A.5, A.6 and/or A.7; B and B.1, B.2, B.3, B.4, B.5, B.6 and/or B.7; C and C.1, C.2, C.3, C.4, C.5, C.6 and/or C.7; D and D.1, D.2, D.3, D.4, D.5, D.6 and/or D.7; E and E.1, E.2, E.3, E.4, E.5 and/or E.6; F and F.1, F.2, F.3, F.4, F.5 and/or F.6; G and G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7; and H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7 of the Statement of Charges. The Hearing Committee does not sustain the allegations and finds that Respondent did not evidence

moral unfitness to practice the profession within the meaning of New York State Education Law § 6530(20).

The Twenty-Seventh through Thirty-Fourth Specifications are NOT SUSTAINED

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that the Respondent should have his license to practice medicine revoked. This determination was reached upon due consideration of the full range of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The evidence produced during this hearing indicated, at the very least, a pattern of negligence and incompetence with respect to obtaining adequate patient medical histories and conducting thorough physical examinations and, on at least several occasions, ordering excessively long periods of bed rest without proper follow-up.

While the record also demonstrates that Respondent conducted fraud on at least two occasions, we are not willing at this time to conclude that he knowingly participated in a systematic scheme to defraud by making false medical diagnoses and ordering inappropriate and excessive treatment. While that is certainly one possible explanation, and the one offered by the Petitioner, we cannot conclude that the Petitioner proved this theory by a preponderance of the evidence.

Regardless of explanation, however, the fact that Respondent was negligent and incompetent with respect to each and every one of the eight patients who were the subjects of this proceeding compels us to impose such a strict penalty. We have no choice but to conclude that the Respondent

potentially poses a threat to the safety of the citizens of New York State by his inability to conduct such fundamental tasks with even a minimally requisite level of skill.

ORDER

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

1. The Seventeenth, Eighteenth, Nineteenth and Twentieth Specifications of professional misconduct are **SUSTAINED**;

2. The First through Sixteenth and the Twenty-First through Thirty-Fourth Specifications are **DISMISSED**;

3. The Respondent's license to practice medicine is hereby **REVOKED**; and

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

DATED: April 26, 2000

DAVID T. LYON, M.D.
Chairperson

ROBERT A. MENOTTI, M.D.
JOHN D. TORRANT

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
FRANCISCO JOSE BILLINI, M.D. AND LUIS FERNANDO RIVAS, M.D.	:	CHARGES

----------X

FRANCISCO JOSE BILLINI, M.D., the Respondent, was authorized to practice medicine in New York State on April 15, 1993, by the issuance of license number 191919 by the New York State Education Department.

LUIS FERNANDO RIVAS, M.D., the Respondent, was authorized to practice medicine in New York State on January 15, 1982, by the issuance of license number 149034 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondents treated Patient A (patients are identified in the attached appendix) in 1996, 1997, and/or 1998, at his offices, 140 Wadsworth Avenue and/or 599 West 190th Street, New York, New York. Respondents' care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondents failed to perform and/or record an adequate physical examination.
2. Respondents failed to obtain and/or record an adequate history.
3. Respondents ordered "absolute repose" without adequate medical justification.

4. Respondents ordered "absolute repose" for an inappropriate period of time.

5. Respondents failed to order and/or schedule appropriate follow-up.

6. Respondents inappropriately billed and/or charged the patient directly.

B. Respondents treated Patient B in 1996, 1997, and/or 1998, at his offices. Respondents' care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondents failed to perform and/or record an adequate physical examination.

2. Respondents failed to obtain and/or record an adequate history.

3. Respondent ordered "absolute repose" without adequate medical justification.

4. Respondents ordered "absolute repose" for an inappropriate period of time.

5. Respondents failed to order and/or schedule appropriate follow-up.

6. Respondents inappropriately billed and/or charged the patient directly.

C. Respondents treated Patient C in 1996, 1997, and/or 1998, at his offices. Respondents' care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondents failed to perform and/or record an adequate physical examination.

2. Respondents failed to obtain and/or record an adequate history.

3. Respondents ordered "absolute repose" without adequate medical justification.

4. Respondents ordered "absolute repose" for an inappropriate period of time.

5. Respondents failed to order and/or schedule appropriate follow-up.

6. Respondents inappropriately billed and/or charged the patient directly.

D. Respondents treated Patient D in 1996, 1997, and/or 1998, at his offices. Respondents' care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondents failed to perform and/or record an adequate physical examination.

2. Respondents failed to obtain and/or record an adequate history.

3. Respondents ordered "absolute repose" without adequate medical justification.

4. Respondents ordered "absolute repose" for an inappropriate period of time.

5. Respondents failed to order and/or schedule appropriate follow-up.

6. Respondents inappropriately billed and/or charged the patient directly.

E. Respondents treated Patient E in 1996, 1997, and/or 1998, at his offices. Respondents' care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondents failed to perform and/or record an adequate physical examination.

2. Respondents failed to obtain and/or record an adequate history.

3. Respondents ordered "absolute repose" without adequate medical justification.

4. Respondents ordered "absolute repose" for an inappropriate period of time.

5. Respondents failed to order and/or schedule appropriate follow-up.

6. Respondents inappropriately billed and/or charged the patient directly.

F. Respondents treated Patient F in 1996, 1997, and/or 1998, at his offices. Respondents' care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

1. Respondents failed to perform and/or record an adequate physical examination.

2. Respondents failed to obtain and/or record an adequate history.

3. Respondents ordered "absolute repose" without adequate medical justification.

4. Respondents ordered "absolute repose" for an inappropriate period of time.

5. Respondents failed to order and/or schedule appropriate follow-up.

6. Respondents inappropriately billed and/or charged the patient directly.

G. Respondents treated Patient G in 1996, 1997, and/or 1998, at his offices. Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care, in that:

1. Respondents failed to perform and/or record an adequate physical examination.

2. Respondents failed to obtain and/or record an adequate history.

3. Respondents ordered "absolute repose" without adequate medical justification.

4. Respondents ordered "absolute repose" for an inappropriate period of time.

5. Respondents failed to order and/or schedule appropriate follow-up.

6. Respondents inappropriately billed and/or charged the patient directly.

H. Respondents treated Patient H in 1996, 1997, and/or 1998, at his offices. Respondents' care and treatment of Patient

H failed to meet acceptable standards of medical care, in that:

1. Respondents failed to perform and/or record an adequate physical examination.

2. Respondents failed to obtain and/or record an adequate history.

3. Respondents ordered "absolute repose" without adequate medical justification.

4. Respondents ordered "absolute repose" for an inappropriate period of time.

5. Respondents failed to order and/or schedule appropriate follow-up.

6. Respondents inappropriately billed and/or charged the patient directly.

SPECIFICATIONS

FIRST THROUGH EIGTH SPECIFICATIONS
GROSS NEGLIGENCE

Respondents are charged with gross negligence in violation of New York Education Law §6530(4) in that, Petitioner charges:

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

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

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

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, E.3, E.4, E.5, and/or E.6.

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

7. The facts in Paragraphs G and G.1, G.2, G.3, G.4, G.5, and/or G.6.

8. The facts in Paragraphs H and H.1, H.2, H.3, H.4, H.5, and/or H.6.

NINTH THROUGH SIXTEENTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondents are charged with gross incompetence in violation of New York Education Law §6530(6) in that, Petitioner charges:

9. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, and/or A.6.

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

11. The facts in Paragraphs C and C.1, C.2, C.3, C.4, C.5, and/or C.6.

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

13. The facts in Paragraphs E and E.1, E.2, E.3, E.4, E.5, and/or E.6.

14. The facts in Paragraphs F and F.1, F.2, F.3, F.4, F.5, and/or F.6.

15. The facts in Paragraphs G and G.1, G.2, G.3, G.4, G.5, and/or G.6.

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

SEVENTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondents are 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:

17. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6; B and B.1, B.2, B.3, B.4, B.5, B.6; C and C.1, C.2, C.3, C.4, C.5, C.6; D and D.1, D.2, D.3, D.4, D.5, D.6; E and E.1, E.2, E.3, E.4, E.5, E.6; F and F.1, F.2, F.3, F.4, F.5, F.6; G and G.1, G.2, G.3, G.4, G.5, G.6; H and H.1, H.2, H.3, H.4, H.5, H.6.

EIGHTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondents are 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:

18. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6; B and B.1, B.2, B.3, B.4, B.5, B.6; C and C.1, C.2, C.3, C.4, C.5, C.6; D and D.1, D.2, D.3, D.4, D.5, D.6; E and E.1, E.2, E.3, E.4, E.5, E.6; F and F.1, F.2, F.3, F.4, F.5, F.6; G and G.1, G.2, G.3, G.4, G.5,

G.6; H and H.1, H.2, H.3, H.4, H.5, H.6.

NINETEENTH THROUGH TWENTY-SIXTH SPECIFICATIONS

FRAUD

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

19. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, and/or A.6.

20. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, and/or B.6.

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

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

23. The facts in Paragraphs E and E.1, E.2, E.3, E.4, E.5, and/or E.6.

24. The facts in Paragraphs F and F.1, F.2, F.3, F.4, F.5, and/or F.6.

25. The facts in Paragraphs G and G.1, G.2, G.3, G.4, G.5, and/or G.6.

26. The facts in Paragraphs H and H.1, H.2, H.3, H.4, H.5, and/or H.6.

TWENTY-SEVENTH THROUGH THIRTY-FOURTH SPECIFICATIONS

MORAL UNFITNESS

Respondents are 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:

The allegations of the nineteenth through twenty-sixth specifications are repeated as if fully set forth herein.

DATED: , 1999
Albany, New York

PETER D. VANBUREN
Deputy Counsel
Bureau of Professional
Medical Conduct