PUBLIC

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

IN THE MATTER

OF

JEAN DEBORAH MILLER, DO

CONSENT
ORDER

BPMC No. 03-248

Upon the application of Jean Deborah Miller, D.O. (Respondent) in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and SO ORDERED, and it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, Whichever is first.

SO ORDERED.

DATED: 9/10/03

MICHAEL GONZALEZ, R.P.A.
Vice Chair
State Board for Professional Medical Conduct

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

IN THE MATTER

OF

JEAN DEBORAH MILLER, D.O.

CONSENT AGREEMENT AND ORDER

Jean Deborah Miller, D. O., representing that all of the following statements are true, deposes and says:

That on or about , July 1, 1986, I was licensed to practice as a physician in the State of New York, and issued License No. 166662 by the New York State Education Department.

My current address is 317 Madison Avenue, Suite1708, New York , New York 10017, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct has charged me with eight (8) specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I plead no contest to the First, Third and Eighth Specifications, in full satisfaction of all the charges against me, and agree to the following penalty:

1. A censure and reprimand.
2. A fifteen thousand ($15,000.00) dollar fine.
3. A two year probation in accordance with the terms set forth in paragraphs one through eleven of Exhibit B, hereto.

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees. This condition shall take effect thirty (30) days after the Consent Order's effective date and will continue so long as Respondent remains licensed in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Order shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding, to the extent permitted by law.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first.

I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

DATED 5/30/03

Jean Deborah Miller, D.O.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: Aug 21, 2003

Scott E. Einiger, ESQ.
of counsel to Hoffman, Einiger
& Poland, PLLC
Attorneys for Respondent

DATE: September 2, 2003

Timothy J. Mahar
Associate Counsel
Bureau of Professional Medical Conduct

DATE: September 9, 2003

DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

Exhibit A

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

IN THE MATTER OF JEAN D. MILLER, D.O.	STATEMENT OF CHARGES

JEAN D. MILLER, D.O., the Respondent, was authorized to practice medicine in New York State on or about July 1, 1986, by the issuance of license number 166662 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to patient A at her offices located at 15 W. 44th Street, New York, New York from approximately August 23, 1991 through April 17, 1997 for fatigue and acne, as documented in the medical record, among other conditions. Respondent's care of patient [redacted] deviated from accepted standards of medical care in the following respects:

1. Respondent, on various occasions, failed to take an adequate history from Patient A and/or failed to perform an adequate physical examination.

2. Respondent gave approximately 133 injections of vitamin C and B12 to patient A during a 68 month period, some or all of which were excessive and/or were given without an adequate medical indication.

3. Respondent, on various occasions, performed or ordered acne surgery for Patient A, some or all of which were performed without adequate medical indication; and/or without documenting an adequate medical indication.

4. Respondent failed to adequately document the location and/or severity of Patient A's acne; the progress of the acne condition following therapy; and/or take and document the history of the acne condition.

5. Respondent, on various occasions, administered trigger point injections to patient A without adequate medical indications and/or without maintaining an adequate medical record of those treatments.

6. Respondent failed to maintain a complete and/or accurate medical record for patient [redacted], including, but not limited to, failing to document the medical indications for various treatments.

B. Respondent provided medical care to patient B at her offices from approximately April 19, 1993 through April 4, 1995, for acne as documented in the medical record, among other conditions. Respondent's care of patient B deviated from accepted standards of medical care in the following respects:

1. Respondent, on various occasions, failed to take an adequate history from Patient B and/or failed to perform an adequate physical examination.

2. Respondent on approximately 58 occasions during a twenty-four month period (April 19, 1993 through April 4, 1995) performed "acne surgery/comedone extraction" on patient B, some or all of which were performed without adequate medical indication; and/or without documentation of an adequate medical indication.

3. Respondent failed to adequately document the location and/or severity of Patient B's acne; the progress of the acne condition following therapy; and/or the history of the acne condition.

4. Respondent performed acne surgery on Patient B which was excessive.

5. Respondent failed to maintain a complete and/or adequate medical record for patient B, including, but not limited to, failing to document the medical indication for treatment.

C. Respondent provided medical care to patient C at her offices from approximately December 9, 1990 through November 20, 1997 for fatigue and acne as documented in the medical record, among other conditions. Respondent's care of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent, on various occasions, failed to take an adequate history from Patient C and/or failed to perform an adequate physical examination.

2. Respondent gave approximately 143 injections of vitamin C and B12 to Patient C during a 60 month period (December 19, 1990 through December 2, 1995), some or all of which were excessive and/or were given without adequate medical indications.

3. Respondent on approximately 92 occasions performed "acne surgery/comedone extraction" on Patient C during an fifty-eight month period (December 19, 1990 through December 28, 1995), some or all of which were performed without adequate medical indication; and/or without documentation of an adequate medical indication.

4. Respondent failed to adequately document the location and/or severity of Patient C's acne; the progress of the acne condition following therapy; and/or the history of the acne condition.

5. Respondent prescribed Elocon to Patient C in the treatment of her acne which was not medically indicated and/or was contraindicated.

6. Respondent, on various occasions, administered trigger point injections to Patient C without adequate medical indications for some or all of the treatments and/or without adequately documenting an indication for the treatments.

7. Respondent failed to maintain a complete and/or accurate medical record for Patient C, including, but not limited to, failing to document the medical indications for various treatments.

D. Respondent provided medical care to Patient D at her offices from approximately August 28, 1990 through December 18, 1996 for acne as documented in the medical record, among other conditions. Respondent's care of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent, on various occasions, failed to take an adequate history from Patient D and/or failed to perform an adequate physical examination.

2. Respondent performed or ordered "acne surgery/comedone extraction" for Patient D on approximately 43 occasions, without adequate medical indication for some or all of such treatments, and/or without documentation of an adequate medical indication.

3. Respondent failed to adequately document the location and/or severity of Patient D's acne; the progress of the acne condition following therapy; and/or the history of the acne condition.

4. Respondent, on various occasions, administered trigger point injections to Patient D without an adequate medical indication and/or without adequately documenting an indication for those treatments.

5. Respondent failed to maintain a complete and/or accurate medical record for Patient D, including, but not limited to, failing to document the medical indication for treatments.

E. Respondent provided medical care to Patient E at her offices from approximately September 10, 1991 through February 24, 1997 for fatigue and acne as documented in the medical record, among other conditions. Respondent's care of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent, on various occasions, failed to take an adequate history from Patient E and/or failed to perform an adequate physical examination.

2. Respondent gave approximately 88 injections of vitamins C and B12 to Patient E during a 44 month period, some or all of which were excessive and/or which were given without adequate medical indication.

3. Respondent, on various occasions, performed "acne surgery/comedone extractions" on Patient E during a sixty-two month period (September 16, 1991 through November 7, 1996) without adequate medical indications for some or all of those treatments, and/or without documentation of an adequate medical indication.

4. Respondent failed to adequately document the location and/or severity of Patient E's acne; the progress of the acne condition following therapy; and/or the history of the acne condition.

5. Respondent prescribed Westcort cream to Patient E in the treatment of her acne which was not medically indicated and/or was contraindicated.

6. Respondent, on various occasions, administered trigger point injections to Patient E without adequate medical indications for some or all of such treatments and/or without adequately documenting the indication for such treatment.

7. Respondent failed to maintain a complete and/or accurate medical record for Patient E, including, but not limited to, failing to document the medical indications for treatments.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, and/or E and E.6.

SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E

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

THIRD THROUGH SEVENTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

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

3. The facts set forth in paragraphs A and A.2 and/or A and A.3.
4. The facts set forth in paragraphs B and B.2 and/or B and B.3.
5. The facts set forth in paragraphs C and C.2 and/or C and C.3.
6. The facts set forth in paragraphs D and D.2.
7. The facts set forth in paragraphs E and E.2 and/or E and E.3.

EIGHTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

8. The facts set forth in paragraphs A and A.3, A and A.4, A and A.5, A and A.6, B and B.2, B and B.3, B and B.5, C and C.2, C and C.3, C and C.4, C and C.6, C and C.7, D and D.2, D and D.3, D and D.4, D and D.5, E and E.2, E and E.3, E and E.4, E and E.6, and/or E and

E.7.

DATED: ~~May~~ Sept. 2, 2003

Albany, New York

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

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by New York State Education Law §6530 or §6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York State Public Health Law §230(19).

2. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that such information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty (30) days of each action.

3. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

4. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

5. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of thirty (30) consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive thirty (30) day period. Respondent shall then notify the Director again at least fourteen (14) days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period will resume and Respondent shall fulfill any unfulfilled probation terms.

6. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records and/or hospital charts; and interviews with or periodic visits with Respondent and Respondent's staff at practice locations or OPMC offices.

7. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

8. Respondent shall enroll in and complete a continuing education program in the area of medical record keeping subject to the Director of OPMC's prior written approval . Respondent shall complete this continuing education program within one year from the effective date of this order.

9. Within thirty days of the effective date of the order, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

   a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC. The review shall be conducted of patient care provided since the date of this consent order. The practice monitor may inspect records concerning care provided prior to this consent order as necessary to assess the care provided following the consent order.

   b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

   c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

   d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

10. Unless otherwise specified herein, the fine is payable in full within ninety (90) days of the effective date of this Order. Payment must be submitted to:

    Bureau of Accounts Management
    New York State Department of Health
    Empire State Plaza
    Corning Tower, Room 1245
    Albany, New York 12237

11. Respondent shall comply with this Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.