STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Karen Schimke
Executive Deputy Commissioner

January 26, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David W. Smith, Esq.
Associate Counsel
NYS Dept. of Health
5 Penn Plaza-6th Floor
New York, New York 10001

Rachel D. Danielov, Esq.
63-61 99th Street
Suite #G1
Rego Park, New York 11374

Moshe Mirilashvilli, M.D.
90 Woodcrest Drive
Syosset, New York 11791

RE: In the Matter of Moshe Mirilashvilli, M.D.

Dear Mr. Smith, Ms. Danielov and Dr. Mirilashvilli :

Enclosed please find the Determination and Order (No. 96-12) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 all action 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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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:rlw
Enclosure

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

IN THE MATTER

OF

MOSHE MIRILASHVILLI, M.D.

DETERMINATION

AND

ORDER

BPMC-96-12

A Notice of Hearing and a Statement of Charges, dated August 31, 1995, were served upon the Respondent, Moshe Mirilashvilli, M.D. **KENNETH KOWALD, (Chair), STEVEN M. LAPIDUS, M.D. and MARVIN L. SHELTON, M.D.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by David W. Smith, Esq., Associate Counsel. The Respondent appeared by Rachel D. Danielov, Esq. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	August 31, 1995
Date of Prehearing Conference:	October 24, 1995
Dates of Hearing:	October 26, 1995
	November 30, 1995

Witness for Department of Health: Ramesh H. Gudimal, M.D.

Witness for Respondent: Subramaniam E.Khanthan,M.D.

Deliberations Held: December 18, 1995

STATEMENT OF CASE

The Respondent was charged with thirteen specifications of professional misconduct. The specifications include practicing with gross negligence, practicing with negligence on more than one occasion , failure to maintain records and violating a State regulation. The charges arose from the Respondent's treatment of six patients from 1990 through 1992 and a determination by the State Department of Social Services that he violated that agency's regulations relating to the Medicaid Program. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all Findings and Conclusions herein are the

unanimous determination of the Hearing Committee. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Hearing Committee hereby makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

GENERAL FINDINGS

1. MOSHE MIRILASHVILLI, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on December 1, 1986, by the issuance of license number 168778 by the New York State Education Department. (Department's Exhibit [hereinafter "Dept.Ex."] 3)

PATIENT A

2. Respondent treated Patient A during July of 1992 in his office at 3049 Brighton 6th Street, Brooklyn, New York (hereinafter "office"). The patient's initial complaints were pain in the lumbosacral area radiating to both lower extremities and numbness in the toes. (Transcript, page 24[hereinafter "T."]; Dept.Ex. 4)

3. This patient's medical history should have included a record of what prior treatment, if any, was provided by another physician, any medication the

patient was taking and the dosage and a comprehensive investigation of the numbness in the toes and the bilateral nature of the radiating pain to the lower extremities. The Respondent's medical history only contained a cursory reference to prior treatment and noted what medication the patient was currently taking but not the dosage. (T. 24, 51, 53, 129, 132-133; Dept.Ex. 4)

4. A physical examination of this patient should have included an investigation of the patient's numbness in the toes, whether or not normal reflexes were present and whether or not the numbness was associated with any weakness in the extremities. The Respondent's physical examination of this patient did not include this. (T. 26, 54, 119; Dept.Ex. 4)

5. Over a two week period the Respondent gave this patient six sciatic nerve blocks which treated this patient's symptoms but did not address the etiology of her condition. A sciatic nerve block does not relieve pain in the lumbosacral area nor does it have any effect on degenerative changes in the lumbar spine area. (T. 25-27, 36, 40, 42, 44, 51, 55, 157-158, 165-167; Dept.Ex. 4)

PATIENT B

6. Respondent treated Patient B during September and October of 1990 in his office. The patient's initial complaints were severe pain in the posterior cervical area, left shoulder, left arm and lumbosacral area. (T. 59; Dept.Ex. 5)

7. This patient's medical history should have included a record of whether the patient had any motor deficit, any sensory deficit, any bowel or bladder dysfunction, whether the patient's reflexes were normal, what prior treatment was provided by another physician and a prior x-ray and/or x-ray report. The Respondent's medical history did not include this information. (T. 60, 65, 197, 223-225, 245-246; Dept.Ex. 5)

8. A physical examination of this patient should have included a neurological examination and an investigation to determine if there were any deficits in the C-5, C-6 or C-7 nerves, a check of the wrist flexors and extensors, the finger reflexes and a biceps jerk sensory examination. The Respondent's physical examination of this patient did not include this. (T. 66, 203-204; Dept.Ex. 5)

9. Respondent injected Patient B with steroids in the brachial plexus area although her presenting symptoms indicated her medical problem was originating in her neck and such treatment would have no effect on the patient's neck. (T. 61, 218; Dept.Ex. 5)

10. Respondent gave Patient B a brachial plexus block although her presenting symptoms indicated her medical problem was originating in her neck and such treatment would have no effect on the patient's neck. (T. 61, 218; Dept.Ex. 5)

PATIENT C

11. Respondent treated Patient C from August 1990 through February 1991 in his office. The patient's initial complaints were severe pain and discomfort in the posterior cervical area radiating to both upper extremities, dizziness, headaches and episodes of loss of consciousness. (T. 69, 248; Dept.Ex. 6)

12. This patient's medical history should have included a record of where specifically the pain was located, if there was any numbness or weakness associated with the pain, if there was any bowel or bladder dysfunction and an inquiry into the loss of consciousness in an attempt to determine a possible cause. The Respondent's medical history did not contain this information. (T. 70, 254; Dept.Ex. 6)

13. A physical examination of this patient should have included an investigation of the patient's motor strength, the condition of his senses, an examination of his reflexes and his bowel and bladder function. The Respondent's physical examination of this patient did not include this. (T. 70; Dept.Ex. 6)

14. This patient complained of loss of consciousness. This a complaint required further investigation to determine the underlying cause. The Respondent had a Doppler study done which although it showed a reduction in the peripheral blood flow to both carotid arteries did not provide an explanation for the loss of consciousness. Other than an electrocardiogram the Respondent did not order or perform any other follow-up studies or tests nor did he refer this patient to another physician to determine the etiology of this complaint. (T. 70-71,73, 254-256; 262-263; Dept.Ex. 6)

15. Respondent gave Patient C approximately 33 brachial plexus blocks although his initial complaint indicated his medical problem was originating in his neck and such treatment would have no effect on the condition of the patient's neck. (T. 72, 256, 261; Dept.Ex. 6)

PATIENT D

16. Respondent treated Patient D from December 1990 through January 1991 in his office. The patient's initial complaints were severe pain and discomfort in the posterior cervical area with radiation and numbness in both upper extremities. (T. 76, 278; Dept.Ex. 7)

17. This patient's medical history should have included a record of where specifically the pain was located, where the numbness was located, if there was any bowel or bladder dysfunction and a copy of an existing x-ray report. The Respondent's medical history did not contain this information. (T. 77, 281; Dept.Ex. 7)

18. A physical examination of this patient should have included an investigation of the patient's numbness, his motor strength, the condition of his senses, an examination of his reflexes and his bowel and bladder function. The Respondent's physical examination of this patient did not include such an investigation. (T. 77, 282 ; Dept.Ex. 7)

19. This patient's initial complaint included pain and numbness in both upper extremities. This complaint required follow-up on the part of the Respondent, which at a minimum would include a sensory examination. The Respondent did not investigate, follow-up or treat this symptom. (T. 77; Dept. 7)

PATIENT E

20. Respondent treated Patient E from December 1990 through January 1991 in his office. The patient's initial complaints were severe pain and discomfort in the lumbosacral area with radiation into both lower extremities. (T. 80, 289; Dept.Ex. 8)

21. This patient's medical history should have included a record of where specifically the pain was located and a copy of an existing x-ray report. The Respondent's medical history did not contain this information. (T. 80, 291-292; Dept.Ex. 8)

22. A physical examination of this patient should have included an investigation of the patient's motor strength, an examination of his reflexes and whether there was any numbness associated with his symptoms. The Respondent's physical examination of this patient did not include this. (T. 80-81, 291-292 ; Dept.Ex. 8)

23. The Respondent administered 16 sciatic nerve blocks to this patient. All of these nerve blocks also included injections of Cortisone. The patient's history

and physical examination did not include enough information about the etiology of his medical condition to justify administering sciatic nerve blocks and injections of cortisone. (T. 81-82; Dept.Ex. 8)

PATIENT F

24. Respondent treated Patient F from April 1990 through April 1991 in his office. The patient's initial complaints were severe pain and discomfort in the lumbosacral area radiating into a numbness sensation in both legs and toes of both feet, cool feelings in both feet and pain or discomfort while walking 1 or 2 blocks. (T. 85; Dept.Ex. 9)

25. This patient's medical history should have included a record of what prior medical treatment was tried, a detailed description of the patient's numbness and a copy of an existing x-ray report. The Respondent's medical history did not contain this. (T. 86, 309; Dept.Ex. 9)

26. A physical examination of this patient should have included an investigation of the numbness and the patient's motor strength associated with his condition, an examination of his reflexes and an x-ray of his knee joint. The Respondent's physical examination of this patient did not include this. (T. 87, 309, 313; Dept.Ex. 9)

27. This patient's initial complaint included numbness in his feet. Follow-up of this complaint should have included a complete neurological examination including a Doppler study providing written evaluation of all the major arteries to the feet. The Respondent's follow-up for this patient did not include this. (T. 87, 314-315; Dept.Ex. 9)

28. The Respondent conducted an Electromyography (EMG) on this patient which showed abnormalities requiring further investigation, evaluation or

treatment. The Respondent did not take any action regarding these abnormal findings. (T. 85, 87-91, 307; Dept.Ex. 9)

29. The EMG performed on this patient indicated this patient's problem was not located in the sciatic nerve, nevertheless the Respondent gave this patient sciatic nerve blocks. (T. 88; Dept.Ex. 9)

MEDICAID PROGRAM

30. On or about November 8, 1993, Respondent was expelled from further participation in the New York State Medicaid Program for a period of five (5) years because he committed fraud and such conduct was a violation of the applicable New York State regulations. This determination was upheld on appeal. (Dept.Exs. 10 and 11)

Conclusions

The following conclusions were made pursuant to the Findings of Fact listed above. The Hearing Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A: (2);

Paragraph A.1: (3);

Paragraph A.2: (4);

Paragraph A.4: (5);

Paragraph B: (6);

Paragraph B.1: (7);

Paragraph B.2: (8);

Paragraph B.3: (9);

Paragraph B.4: (10);

Paragraph C: (11);

Paragraph C.1: (12);

Paragraph C.2: (13);

Paragraph C.3: (14);

Paragraph C.4: (14);

Paragraph C.5: (15) except for that part of the factual allegation which alleges that the Respondent diagnosed the patient with a cervical disc;

Paragraph D: (16);

Paragraph D.1: (17);

Paragraph D.2: (18);

Paragraph D.3: (19);

Paragraph E: (20);

Paragraph E.1: (21);

Paragraph E.2: (22);

Paragraph E.3: (23);

Paragraph E.4: (23); except for that part of the factual allegation which alleges that the Respondent diagnosed the patient with a disc problem;

Paragraph F.: (24);

Paragraph F.1: (25);

Paragraph F.2: (26);

Paragraph F.3: (27);

Paragraph F.4: (28);

Paragraph F.5: (29);

Paragraph F.6: (28);

Paragraph G.: (30).

The Hearing Committee further concluded that the following Specifications should **be sustained**. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

First Specification: (Paragraphs A., A.1. 2. and 4; B., B.1.-4.; C., C.1.-5.[except as noted above]; D., D.1.-3.; E., E.1.-4.[except as noted above]; F., F.1.-6.);

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Second Specification: (Paragraphs A., A.1. 2. and 4.);

Third Specification: (Paragraphs C., C.1.-5.[except as noted above]);

Fourth Specification: (Paragraphs D., D.1.-3.);

Fifth Specification: (Paragraphs E., E.1.-4.[except as noted above]);

Sixth Specification: (Paragraphs F., F.1.-6.);

FAILURE TO MAINTAIN RECORDS

Seventh Specification: (Paragraphs A., A.1. 2. and 4.);

Eighth Specification: (Paragraphs B., B.1.-2.);

Ninth Specification: (Paragraphs C., C.1.-4.);

Tenth Specification: (Paragraphs D., D.1.-3.);

Eleventh Specification: (Paragraphs E., E.1.-2.);

Twelfth Specification; (Paragraphs F., F.1.-4.,6.);

VIOLATION OF A STATE REGULATION

Thirteenth Specification: (Paragraph G.)

DISCUSSION

Respondent was charged with thirteen specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, 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 negligence and gross negligence in the practice of medicine.

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 physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, based on a preponderance of the evidence, that the first through sixth specifications of professional misconduct should be sustained. The Committee also unanimously determined that a preponderance of the evidenced supported a conclusion that the seventh through thirteenth specification should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Ramesh H. Gidumal, M.D. as its expert witness. Dr. Gidumal is a physician whose specialty is orthopedic surgery and is currently an Attending Assistant Professor in orthopedic surgery at the New York University-University Hospital.. There was no evidence of any bias on the part of Dr. Gidumal or of his unsuitability as an expert witness. The Hearing Committee found him to be a credible witness. Dr. Gidumal repeatedly testified

that the Respondent's treatment of Patients A through F did not meet acceptable standards of medical care. The Hearing Committee found his testimony to be convincing and accurate and agrees with his assessment of the Respondent's quality of care delivered to the patients in question. The Respondent presented an independent expert witness in an attempt to refute Dr. Gidumal's testimony. In many instances the Respondent's own expert witness found his medical practices to be lacking. Of particular significance was this witness' testimony that he would not have provided the same treatment as the Respondent. Additionally, the Respondent's records were of such poor quality that the witness could not testify as to what treatment was actually administered to a number of patients.

The Committee found the Respondent's records do not indicate that he ever did a minimal neurological evaluation of these patients. There was no indication that he even performed reflex tests on any of these patients. The Respondent's pattern of practice was such that he did not identify clinical entities nor did he collect enough historical and analytical data to support a diagnosis. Respondent only treated symptoms and never sought nor treated causes. The care Respondent provided was inadequate and did not meet acceptable standards of practice.

Patient A was continually given inappropriate sciatic nerve blocks while the numbness of which she complained was never investigated or evaluated. Patients B and C received a number of brachial plexus blocks without either a proper medical history or physical examination. Patient C initially complained of losing consciousness but that was never investigated or evaluated. Respondent's own expert believed the Respondent should have investigated this symptom more thoroughly.

All of the patients in question had inadequate physical examinations and medical histories. The numbness complaints of Patients D and F were neither investigated nor evaluated and nerve blocks administered to these patients were

medically inappropriate. In all but one case these patients also had prior medical records which Respondent did not obtain.

The patient notes, themselves, are incomplete or inaccurate. Parts of them appear to be pre-written or "canned." Thus certain entries are identical for all six (6) patients without there being any way of telling if that information is correct. As noted above, because of the way the notes were written, it appears that nerve blocks were continually administered even though they are not expressly noted.

Respondent's own expert found fault with the Respondent. He does not administer sciatic nerve blocks; he would have investigated certain patient complaints more closely; written better patient notes; and in some cases, changed the entire format of the patient notes.

From the testimony of his own expert it appears that a major reason for the poor care provided by Respondent is that he would not spend enough time with these patients because they were on Medicaid and the low rate of reimbursement necessitated this high volume-piecework practice. The Committee rejects that reasoning as a justification for providing substandard care. Medicaid patients are entitled to adequate care as are all other patients.

The Committee notes that although the Respondent did not testify on his behalf it **did not** take a negative inference from his silence. Additionally, it should be noted that the Respondent was informed prior to the commencement of the hearing of his right to be represented by an attorney and was advised by the Chair and the Administrative Officer that it would be in his interest to retain such representation.

Based on the definitions set out above and the evidence in the record, the Hearing Committee voted to sustain all the Specifications.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions set forth 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 record in this case clearly established that Respondent inappropriately administered nerve blocks and failed to diagnose his patients before administering potentially dangerous treatment. By doing so, he put his patients at risk. Respondent demonstrated gross negligence and negligence on more than one occasion in the practice of medicine.

Any individual who receives a license to practice medicine is placed into a position of public trust. Respondent essentially forfeited his right to that public trust, by the manner in which he conducted his practice. Respondent abdicated his responsibility to exercise his skill and judgment for the benefit of his patients.

The Hearing Committee unanimously determined that no sanction short of revocation would adequately protect the public.

ORDER

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

1. The First through Thirteenth Specifications of professional misconduct,

as set forth in the Statement of Charges (Appendix I) are **SUSTAINED**;

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

DATED: New York, New York
January 22, 1996

KENNETH KOWALD (CHAIR)

STEVEN M. LAPIDUS, M.D.
MARVIN L. SHELTON, M.D.

TO: David W. Smith, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Rachel D. Danielov, Esq.
63-61 99th Street
Suite #G1
Rego Park, New York 11374

Moshe Mirilashvilli, M.D.
90 Woodcrest Drive
Syosset, New York 11791

APPENDIX I

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

IN THE MATTER OF MOSHE MIRILASHVILLI, M.D.	STATEMENT OF CHARGES

MOSHE MIRILASHVILLI, M.D., the Respondent, was authorized to practice medicine in New York State by the issuance of license number 168778 in 1986 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. In or about July, 1992, Respondent treated Patient A for lumbosacral pain and other medical conditions at Respondent's office at 3049 Brighton 6th Street, Brooklyn, New York. (All patients are identified in the attached Appendix)

1. Respondent failed to obtain an adequate medical history or failed to note such history, if any.

2. Respondent failed to perform an adequate physical examination or failed to note such examination, if any.

3. Respondent caused x-rays to be taken of the lumbar spine area of Patient A. Such x-rays showed a degenerative change, but Respondent failed to adequately follow-up or treat such condition or note such follow-up or treatment, if any.

4. Respondent inappropriately gave Patient A six sciatic nerve blocks.

B. Between in or about September, 1990 and in or about October, 1990, Respondent treated Patient B for neck pain and other medical conditions at Respondent's office at 3049 Brighton 6th Street, Brooklyn, New York.

1. Respondent failed to obtain an adequate medical history or failed to note such history, if any.

2. Respondent failed to perform an adequate physical examination or failed to note such examination, if any.

3. Respondent inappropriately injected Patient B with steroids.

4. Respondent inappropriately gave Patient B a brachial plexus block .

C. Between in or about August, 1990 and in or about February, 1991, Respondent treated Patient C for cervical pain and other medical conditions at Respondent's office at 3049 Brighton 6th Street, Brooklyn, New York.

1. Throughout the period, Respondent failed to obtain an adequate medical history or failed to note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate

physical examination or failed to note such examination, if any.

3. Patient C complained of loss of consciousness but Respondent failed to adequately follow-up or treat such condition or note such follow-up, if any.

4. Respondent caused a Doppler to be done which showed a reduction of peripheral flow in both arteries carotid. Nevertheless, Respondent failed to adequately follow-up or treat such condition or obtain an appropriate consult or note such follow-up, treatment or consult, if any.

5. Respondent diagnosed Patient C with a cervical disc and inappropriately treated it with a brachial plexus block.

D. Between in or about December, 1990 and in or about January, 1991, Respondent treated Patient D for pain in the posterior cervical area and other medical conditions at Respondent's office at 3049 Brighton 6th Street, Brooklyn, New York.

1. Respondent failed to obtain an adequate medical history or failed to note such history, if any.

2. Respondent failed to perform an adequate physical examination or failed to note such examination, if any.

3. Patient D complained of pain in his shoulder joints from cervical problems and numbness. Nevertheless, Respondent failed to adequately evaluate, follow-up or treat such condition or note such evaluation, follow-up or treatment, if any.

E. Between in or about December, 1990 and in or about January, 1991, Respondent treated Patient E for lower back pain and other medical conditions at Respondent's office at 3049 Brighton 6th Street, Brooklyn, New York.

1. Respondent failed to obtain an adequate medical history or failed to note such history, if any.

2. Respondent failed to perform an adequate physical examination or failed to note such examination, if any.

3. Between in or about December, 1990, and in or about January, 1991, Respondent gave Patient E sixteen (16) shots of Cortisone. At least thirteen (13) of those shots were inappropriately given.

4. Respondent diagnosed Patient E with a disc problem and inappropriately gave him a sciatic nerve block.

F. Between in or about April, 1990 and in or about April, 1991, Respondent treated Patient F for lumbosacral pain and other medical conditions at Respondent's office at 3049 Brighton 6th Street, Brooklyn, New York.

1. Throughout the period, Respondent failed to obtain an adequate medical history or failed to note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate physical examination or failed to note such examination, if any.

3. Patient F complained of numbness in his feet, but Respondent failed to conduct an adequate neurologic examination or note such examination, if any.

4. Respondent conducted an Electromyography (EMG) of Patient F which showed peripheral neuropathy and which Respondent knew was becoming more severe. Nevertheless, Respondent failed to adequately evaluate, follow-up or treat such condition or obtain an appropriate consult or note such evaluation, follow-up, treatment or consult, if any.

5. Respondent inappropriately gave Patient F sciatic nerve blocks.

6. One of the EMGs Respondent caused to be performed showed abnormality of the upper extremities. Respondent failed to adequately follow-up or treat such abnormality or note such follow-up or treatment, if any.

G. On November 8, 1993, Respondent, after a hearing at which he was represented by Counsel, was disqualified by the New York State Department of Social Services from further participation in the New York State Medicaid

Program. Respondent was found guilty of violating 18 NYCRR 515.2 of the Medicaid Regulations (filing claims for unfurnished medical care and making false statements in a claim for payment), in that Respondent delegated the provision of medical care to an unlicensed person and then billing Medicaid as if he, himself, had provided it. Such activities constitute professional misconduct under N.Y. Educ. Law §§§§6530(2) (practicing the profession fraudulently), 6530(25) (delegating the medical responsibility to an unlicensed person), 6530(21) (filing a false claim), and 6530(11) (aiding and abetting an unlicensed person to provide medical care).

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law §6530(5) (McKinney Supp. 1995), in that Petitioner charges two or more of the following:

1. Paragraphs A and A1-4; Paragraphs B and B1-4; Paragraphs C and C1-5; Paragraphs D and D1-3; Paragraphs E and E1-4; and/or Paragraphs F and F1-6.

SECOND THROUGH SIXTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with practicing the profession with gross negligence on a particular occasion within the meaning of N.Y. Educ. Law §6530(4) (McKinney Supp. 1995). Specifically, Petitioner charges:

2. The facts in Paragraphs A and A1-4.
3. The facts in Paragraphs C and C1-5.
4. The facts in Paragraphs D and D1-3.
5. The facts in Paragraphs E and E1-4.

6. The facts in Paragraphs F and F1-6.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with failure to maintain a record for each patient which accurately reflects the evaluation and treatment of each patient within the meaning of §6530(32) of the N.Y. Educ. Law (McKinney Supp. 1995). Specifically, Petitioner charges:

7. The facts in Paragraphs A and A1-3.
8. The facts in Paragraphs B and B1-2.
9. The facts in Paragraphs C and C1-4.
10. The facts in Paragraphs D and D1-3.
11. The facts in Paragraphs E and E1-2.
12. The facts in Paragraphs F and F1-4, 6.

THIRTEENTH SPECIFICATION

VIOLATION OF STATE REGULATION

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6530(9)(c) (McKinney Supp. 1995) by having been found guilty in an adjudicatory proceeding of violating a State regulation, pursuant to a final determination, when no appeal is pending and when the violation constitutes professional misconduct under such section Specifically, Petitioner charges:

13. The facts in Paragraph G.

DATED: August 31, 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct