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

PUBLIC

April 24, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Leni S. Klaimitz, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

Michael John Mazzeo, M.D.
115 Crescent Road
Piermont, New York 10968

RE: In the Matter of Michael John Mazzeo, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-117) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

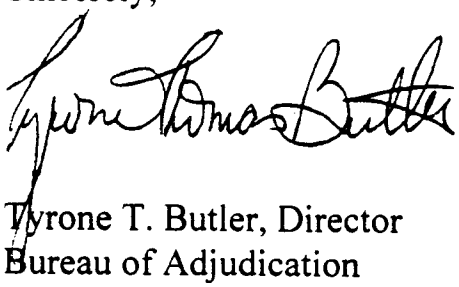
The notice of review served on the Administrative Review Board should be forwarded to:

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:nm
Enclosure

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

IN THE MATTER	:	HEARING COMMITTEE
OF	:	DETERMINATION
MICHAEL JOHN MAZZEO, M.D.	:	AND ORDER

_____X

BPMC-00-117

Richard N. Ashley, M.D., Chairperson, **Linda D. Lewis, M.D.**, and **Daniel W. Morrissey, O.P.**, duly designated members of the State Board of Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230 (1) of the Public Law, served as the Hearing Committee in this matter pursuant to Sections 230 (10) (e) and 230 (12) of the Public Health Law. **Stephen Bermas, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	December 21, 1999
Statement of Charges dated:	December 21, 1999

Hearing Date:	January 31, 2000
Deliberation Date:	March 10, 2000
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner Appeared By:	Leni S. Klaimitz, Esq. Attorney Bureau of Professional Medical Conduct NYS Department of Health

STATEMENT OF CHARGES

The Statement of Charges has been marked as Petitioner's Exhibit 1 and attached hereto as Appendix A.

CREDIBILITY OF WITNESSES

The Committee found Dr. Robert Sunshine and Dr. Lawrence Damkoff, Petitioner's expert witnesses, to be fully credible witnesses.

FINDINGS OF FACT

It should be noted that inasmuch as Respondent has failed to appear or file any answer to the Charges, pursuant to NY Public Health Law Sec. 230 (10) (c) the Hearing Officer ruled that the charges and allegations in the Statement of Charges were deemed admitted by Respondent. Nonetheless, the Hearing Committee has found support in the evidence for its findings and has referred to such evidence in the parentheses at the end of each Finding. The numbers in parentheses refer to transcript page numbers or exhibits.

1. On January 4, 2000, Michael John Mazzeo, M.D., the Respondent, was personally served with the Statement of Charges, Notice of Hearing and Summary of Hearing Regulations. (Exhibit 1; T. 77-80).

2. Although properly served in the manner set forth in N.Y. Public Health Law, Respondent did not appear in person or by counsel in this hearing, nor did he file a written answer to any of the charges and allegations in the Statement of Charges.

3. Michael John Mazzeo, M.D. was authorized to practice medicine in New York State on or about April 7, 1993, by the issuance of license number 191848 by the New York State Education Department (Exhibit 2). As of January 27, 2000, the Respondent was not currently registered to practice the profession in New York State (Exhibit 2A).

4. On or about May 11, 1995, the Respondent was interviewed at the Office of Professional Medical Conduct at 5 Penn Plaza, New York, New York. During the course of that interview, Respondent stated that he treated approximately eighty to one hundred twenty patients for impotence per year. (Exhibit 5).

5. In the 1994 NYNEX Yellow Pages Physicians Guide, Respondent placed an advertisement, which stated that he specialized in several areas, including "Impotence". (Exhibit 6A).

6.. On August 21, 1996, the Board for Professional Medical Conduct voted to recommend that a Comprehensive Medical Review (hereinafter a "CMR") of the patient and office records of Respondent be conducted. (Exhibit 7) A CMR order dated September 3, 1996, was signed by the then-acting Director of the Office of Professional Medical Conduct, Anne F. Saile. (Exhibit 8) Respondent received written notification of the CMR order and the plan to conduct the review on November 26, 1996. (Exhibit 9).

7. On November 26, 1996, investigators from the Office of Professional Medical Conduct attempted to conduct the review of records. They were not permitted to do so by Respondent's office manager. Respondent was notified in writing that his failure to reschedule the CMR would be

considered a failure to cooperate with the investigation and would be referred for further legal action. Respondent failed to comply with or reschedule the CMR. (Exhibit 10)

8. The Office of Professional Medical Conduct sought and on September 29, 1997, obtained, an order from Justice Frederic S. Berman of the Supreme Court of the state of New York compelling Respondent to fully comply with the order for the CMR. (Exhibit 11)

9. Respondent received written notice of the judicial order (Exhibits 12, 13 and 14) and at the request of Respondent the scheduled date of the CMR was changed twice. (Exhibits 14 and 15)

10. On the appointed date of the CMR, December 25, 1997, two investigators from the Office of Professional Medical Conduct were given entry to the office. Respondent remained seated in the area where the file cabinet was located during the CMR. Respondent was asked if he could identify any patients with a diagnosis of impotence and responded that he could not. Respondent was asked whether the files were arranged by year or alphabetically and he replied that he did not know. Copies of twenty-one patient records were obtained by the investigators. (Exhibit 16)

11. Respondent failed to comply with the CMR order in that he failed to identify any patients whom he had treated for impotence and failed to produce any records during the CMR which reflected a complaint of and/or treatment for impotence. (Exhibit 16)

12. Roy Nemerson, Deputy Counsel of the Bureau of Professional Medical Conduct, sent Respondent a certified letter dated May 28, 1998, directing him to produce to the Executive Secretary of the State Board for Professional Medical Conduct no fewer than one hundred medical records relating to patients seeking or receiving treatment for impotence. Those records were to be produced no later than June 12, 1998. Respondent was advised that his failure to produce the records would be viewed as a failure to comply with the CMR order and would be prosecuted as such. (Exhibit 17)

13. Respondent failed to produce any records to the Executive Secretary, Ansel R. Marks, M.D., J.D., nor has Respondent responded to Mr. Nemerson's letter with any communication to either Mr. Nemerson or Dr. Marks. (Exhibits 19 and 20)

Patient A

14. On or about May 26, 1994 Patient A, a sixty-three year old man, had an initial consultation with Respondent. Patient A was self-referred to Respondent with a complaint of impotence. (Exhibit 22 p. 13)
15. Respondent obtained a medical history from Patient A through a written questionnaire. This was inadequate in both scope and methodology. (Exhibit 22 p. 13-14; T.14-18, 55-56)
16. Respondent failed to perform an adequate physical examination of Patient A, omitting an examination of the patient's penis, prostate and secondary sexual characteristics, relevant reflexes, peripheral pulse, penile and perineal sensation and blood pressure. Because of the limited scope of this examination on this self-referred patient, underlying diseases may have gone undetected. (T.18-21, 54-59; Exhibit 22)
17. Respondent failed to appropriately and adequately evaluate the etiology of Patient A' s erectile dysfunction though urinalysis, blood tests, hormone level testing, nocturnal studies and/or thyroid studies. (T22-23, 41-42; Exhibit 22)
18. Respondent attributed Patient A's erectile dysfunction to vascular causes, although no support for the determination is contained in the patient's medical record. (Exhibit 5 p.3: T.21-22)
19. Respondent administered a penile injection for the treatment of erectile dysfunction to Patient A at the initial consultation. The medical record provides unclear information as to what medication Patient A was given and no information as to the concentration of the substance. Respondent evaluated Patient A's response utilizing an idiosyncratic rating scale which has no medical significance. (T.24-26; Exhibit 22)
20. Respondent indicated during his interview at the Office of Professional Medical Conduct that the treatment which he gave to Patient A consisted of an injection of Prostaglandin and Persantin. Respondent referred to this treatment as the "Peniteen Program". (Exhibit 5)
21. Penile injection of Prostaglandin is a recognized treatment for impotence; the injection of Persantin is not. (T.25-26)
22. According to the medical record maintained by Respondent for Patient A, Respondent failed to advise the patient of the various options which were available for the treatment of his impotence. (Exhibit 22; T.43-44)
23. Respondent began treating Patient A with the "Peniteen Program" as of the date of the initial consultation. Respondent began this treatment without first obtaining an adequate informed consent from Patient A. The form signed by Patient A and labeled "Peniteen Consent Form" is a disclaimer, not an adequate consent. (T.29-30, 43)

24. Respondent failed to inform Patient A of possible risks and side-effects of the self injection treatment including burning at the injection site, bleeding, the formation of scar tissue, infection and priapism. (T.30)
25. Respondent failed to adequately instruct Patient A on the proper self-administration of injections including sites to be avoided, sterile technique, the frequency with which the patient could avail himself of the treatment, and proper handling of the medication. (T. 32-34)
26. Respondent failed to adequately inform Patient A of and prepare him for potential complications and emergencies which might arise from treatment, including priapism, a prolonged, painful erection which requires emergency treatment and may result in permanent impotence. (T. 30-31, 46-47)
27. Respondent lacked the training to treat the complication of priapism should it have occurred. (T. 47)
28. Respondent's failings in his treatment of Patient A posed the risk of serious harm to the patient. (T. 45-46)
29. Respondent conducted neurological testing on Patient A subsequent to the initiation of the self-injection treatment. These included somatosensoroy evoked potentials of the bilateral upper and lower extremities and electromyography nerve conduction studies of the bilateral upper and lower extremities. The tests involved some discomfort and possibly pain. (Exhibit 22; T. 62-65)
30. The tests which Respondent performed were not warranted by Patient A's history, complaint or examination and were excessive and unnecessary. (T. 37-39, 48, 62-65)

Patient B

31. On or about April 8, 1996, Patient B, a ninety-one year old man, consulted Respondent. The patient had a chief complaint of difficulty walking on his left leg and reported a resting tremor, memory difficulty and left hip pain. On examination Respondent noted a mild resting tremor, without bradykinesia or cogwheel rigidity, mild lumbosacral tenderness and a left Patrick's sign. (Exhibit 23)
32. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient B. (Exhibit 23, T. 72)
33. Respondent failed to adequately evaluate Patient B's complaints and condition. (T. 70-71)

Patient C

34. On or about October 8, 1996, two days subsequent to having been injured in a motor vehicle accident, Patient C, a seventeen year old woman, consulted Respondent. Patient C complained of

headaches, an unsteady gait and neck pain. Respondent conducted various tests upon her. (Exhibit 24)

35. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient C. (T. 72)

Patient D

36. On or about October 8, 1996, Patient D, a thirty-four year old woman who had been involved in a motor vehicle accident four days earlier, consulted Respondent complaining of headaches and neck pain. Respondent conducted various tests upon Patient D in his medical office. Respondent administered a series of lidocaine and robaxin injections to Patient D from October 1996 through April 1997. (Exhibit 25)
37. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient D. (T. 72)
38. Respondent inappropriately treated Patient D with lidocaine and robaxin injections. (T. 72)
39. Respondent failed to formulate and pursue an adequate treatment plan for Patient D. (T 70-72)
40. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient D. (T. 70-72)

Patient E

41. On or about June 30, 1997, Patient E, a fifty year old man who had been in an automobile accident on or about May 19, 1997, consulted Respondent complaining of pain in his neck, arm, ankle and back, as well as dizziness and problems with concentration and sleep. Respondent conducted various tests upon Patient E. (Exhibit 25)
42. Respondent caused excessive testing, unwarranted by the condition of patient, to be conducted upon Patient D. (T. 70-72)

Patient F

43. On or about July 29, 1996, Patient F, a fifty-eight year old man, consulted Respondent. The patient complained of headaches and neck and back pain which had begun after an automobile accident which had occurred on about May 14, 1996. Respondent conducted various tests upon Patient F

and treated him with injections of lidocaine and robaxin. Respondent treated Patient F through on or about October 14, 1996. (Exhibit 27)

44. Respondent caused excessive testing, unwarranted by the condition of patient, to be conducted upon Patient F. (T. 70-72)
45. Respondent failed to adequately assess and/or note in his medical record the effects of treatment on Patient F. (T. 70-72)
46. Respondent failed to maintain a medical record which accurately reflects the evaluation and treatment of Patient F. (T. 70-72)

Patient G

47. On or about October 1, 1996 , Patient G, a forty-nine year old man, consulted Respondent with chief complaints of headaches and back and neck pain which had developed after a work-related fall in or about May 1995. Respondent conducted various tests upon Patient G. Respondent treated Patient G with lidocaine trigger point injections, medications and spinal manipulation. (Exhibit 28)
48. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient G. (T70-72)
49. Respondent failed to adequately assess and/or note in medical record the effects of treatment on Patient G. (T. 70-72)
50. Respondent failed to maintain a medical record which accurately reflects the evaluation and treatment of Patient G. (T. 70-72)

Patient H

51. On or about October 27, 1997, Patient H, a fifty-seven year old man who had been in an automobile accident on or about October 4, 1997, consulted Respondent. Patient H complained of radiating back and neck pain, unsteadiness on his feet and headaches. Respondent conducted various tests upon Patient H in his medical office. (Exhibit 29)
52. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient H. (T. 70-72)

Patient I

53. On or about November 29, 1993, Patient I, a thirty-three year old man, who had been in an automobile accident on or about November 17, 1993, consulted Respondent. Patient I had chief complaints of neck and back pain and headaches. Respondent conducted various tests upon Patient I and treated him with medication, trigger point injections and robaxin and lidocaine-steroid nerve blocks. In or about November 1996 Patient I experienced an "idiosyncratic reaction" to a nerve block which had been administered to him by Respondent on or about November 25, 1996, and which required hospital evaluation. Respondent's treatment of Patient I ended in or about June 1997. (Exhibit 30)
54. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient I. (T. 70-72)
55. Respondent failed to formulate and pursue an adequate treatment plan for Patient I. (T. 70-72)
56. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient I. (T. 70-72)

Findings Relating To Patients A Through I

57. Respondent utilized a template for obtaining patient histories without regard to the patient's particular complaint. (T. 70-72)
58. Respondent worked-up patients and gave them the same tests, irrespective of complaint. (T. 70-72)

Patient J

59. In or about 1995 and 1996 Patient J, a women, consulted with and was treated by Respondent for back pain. Respondent conducted various tests upon Patient J, for which Patient J directly paid Respondent approximately four thousand five hundred eighty-four dollars ($4584.00). In or about October 1998, Patient J's insurer paid Respondent approximately three thousand one hundred forty-four ($3144.00) for a number of the tests conducted by him upon Patient J. When Patient J became aware, in or about October 1998, of that payment to Respondent, she made numerous attempts in writing, via telephone and in person to secure repayment from Respondent. (Exhibit 31)
60. Respondent acknowledged to Patient J that the money paid by her insurer to him was owed to Patient J and repeatedly assured Patient J that he would reimburse her. (Exhibit 31)

61. Respondent has failed to repay to Patient J the amount of money paid to him by her insurer, despite promises by Respondent that he would do so. (Exhibit 31)

62. In or about August 1999 Patient J filed suit in Small Claims Court, County of New York against Respondent. On January 11, 2000 following an inquest based on Respondent's default, a judgment in Patient J's favor in the amount of three thousand five hundred fifty-five dollars ($3555.00) was issued. (Exhibit 31)

63. On or about October 6, 1999 Nurse Investigator Marthajean Caesar, R.N. of the Office of Professional Medical Conduct sent a written request pursuant to Public Health Law Section 230 for a certified copy of the medical records, including billing records, of Patient J. The letter was not returned to Ms. Caesar. (Exhibit 21)

64. Respondent has failed to provide the requested records and has failed to respond in any way to Ms. Caesar's letter. (Exhibit 21)

CONCLUSIONS OF LAW

FIRST: Respondent is found to have engaged in professional misconduct by reason of practicing medicine with gross negligence within the meaning of N.Y. Education Law Sec. 6530 (4) (McKinney Supp. 1999) as set forth in Findings of Fact 14 through 30, supra.

SECOND: Respondent is found to have engaged in professional misconduct by reason of practicing medicine with negligence on more than one occasion within the meaning of N.Y. Education Law Sec. 6530 (3) (McKinney Supp. 1999) as set forth in Findings of Fact 14 through 58, supra.

THIRD: Respondent is found to have engaged in professional misconduct by reason of practicing medicine with gross incompetence within the meaning of N.Y. Education Law Sec. 6530 (6) (McKinney Supp. 1999) as set forth in Findings of Fact 14 through 30, supra.

FOURTH: Respondent is found to have engaged in professional misconduct by reason of practicing medicine with incompetence on more than one occasion within the meaning of N.Y. Education Law Sec. 6530 (5) (McKinney Supp. 1999) as set forth in Findings of Fact 14 through 58, supra.

FIFTH : Respondent is found to have engaged in professional misconduct by reason of practicing medicine fraudulently within the meaning of N.Y. Education Law Sec. 6530 (2) (McKinney Supp. 1999) as set forth in Findings of Fact 4 through 13, and 59 through 62, supra.

SIXTH: Respondent is found to have engaged in professional misconduct by reason of practicing medicine with moral unfitness within the meaning of N.Y. Education Law Sec. 6530 (20) (McKinney Supp. 1999) as set forth in Findings of Fact 4 through 13, and 59 through 62, supra.

SEVENTH: Respondent is found to have engaged in professional misconduct by reason of ordering excessive tests not warranted by patients' conditions within the meaning of N.Y. Education Law Sec. 6530 (35) (McKinney Supp. 1999) as set forth in Findings of Fact 29, 30, 32, 35, 37, 42, 44, 48, 52 and 54, supra.

EIGHTH: Respondent is found to have engaged in professional misconduct by reason of his failing to comply with orders issued pursuant to N.Y. Public Health Law Sec. 230 (10) within the meaning of N.Y. Education Law Sec. 6530 (15) McKinney Supp. 1999) as set forth in Findings of Fact 6 through 13, supra.

NINTH: Respondent is found to have engaged in professional misconduct by reason of his failings to respond within the thirty days to written communications from the N.Y. State Department of Health and failing to make available any records relevant to an inquiry or complaint about a licensee's professional misconduct, within the meaning of N.Y. Education Law Sec. 6530 (28) (McKinney Supp. 1999) as set forth in Findings of Fact 12, 13, 63 and 64, supra.

TENTH: Respondent is found to have engaged in professional misconduct by reason of failing to maintain patient records which accurately reflect the care and treatment of the patients within the meaning of N.Y. Education Law Sec. 6530 (32) (McKinney Supp. 1999) as set forth in Findings of Fact 40, 46, 50 and 56 supra.

ORDER

The Hearing Committee determines and orders that the Respondent's license to practice medicine be revoked. The Committee further orders that Respondent pay a penalty of Twenty thousand ($20,000) dollars.

Dated: New York, NY
March 31, 2000

Richard N. Ashley, M.D.
Chairperson

Linda D. Lewis, M.D.
Daniel W. Morrissey, O.P.

MAIL PAYMENT TO

New York State Department of Health
Bureau of Accounts Management
Corning Tower Building-Room 1258
Empire State Plaza
Albany, New York 12237

Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes, but is not limited to, the imposition of interest, late payment charges and collection fees; and non renewal of permits or licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32).

APPENDIX I

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

IN THE MATTER

OF

MICHAEL JOHN MAZZEO, M.D.

STATEMENT

OF

CHARGES

MICHAEL JOHN MAZZEO, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 7, 1993, by the issuance of license number 191848 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about May 26, 1994, Patient A , a sixty-three year old man, had an initial consultation with Respondent at Respondent's medical office located at 686 Lexington Avenue, New York, New York 10022 (hereafter referred to as Respondent's "medical office"). (The names of patients are contained in the attached appendix.) Patient A complained of impotence and Respondent prescribed as a treatment self-administered injections of Prostaglandin E-1. Respondent saw Patient A again on or about June 7, 1994, for a follow-up visit. Patient A underwent various tests at Respondent's medical office on four dates between on or about May 26, 1994, and on or about June 27, 1994.

1. Respondent failed to obtain an adequate history from Patient A.

2. Respondent failed to perform and/or note in his medical reco adequate physical examination of Patient A.

3. Respondent failed to appropriately and adequately evaluate the etiology of Patient A's erectile dysfunction.

4. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient A.

5. Respondent failed to obtain an adequate informed consent from Patient A prior to prescribing the self-injection treatments to Patient A.

6. Respondent failed to adequately instruct Patient A on the proper self-administration of the medication and to adequately prepare Patient A for potential complications and emergencies prior to prescribing the self-injection treatments to him.

B. On or about May 11, 1995, Respondent was interviewed at the Office of Professional Medical Conduct at 5 Penn Plaza, New York, New York. During the course of that interview Respondent stated that he treated approximately eighty to one hundred patients for impotence per year. On August 21, 1996, the Board for Professional Medical Conduct voted to recommend that a Comprehensive Medical Review (hereinafter a "CMR") of the patient and office records of Respondent be conducted. A CMR order dated September 3, 1996, was signed by the then-acting Director of the Office of Professional Medical Conduct, Anne F. Saile. Respondent received written notification of the CMR order and the plan to conduct the review on a

particular date.

1. Investigators from the Office of Professional Medical Conduct attempted to conduct the review on the appointed date. They were not permitted to do so by Respondent's office manager. Respondent was notified in writing that his failure to reschedule the CMR would be considered a failure to cooperate with the investigation and would be referred for further legal action. Respondent failed to comply with or reschedule the CMR.

2. The Office of Professional Medical Conduct sought and, on September 29, 1997, obtained an order from Justice Frederic S. Berman of the Supreme Court of the State of New York compelling Respondent to fully comply with the order for the CMR. When the Office of Professional Medical Conduct again attempted to perform a CMR at Respondent's medical office on or about December 25, 1997, Respondent failed to comply with the CMR order in that he failed to identify patients whom he had treated for impotence and failed to produce any medical records during the CMR which reflected a complaint of and/or treatment for impotence.

3. Respondent has failed to respond to a certified letter sent on or about May 28, 1998, by Roy Nemerson, Deputy Counsel of the

Bureau of Professional Medical Conduct, directing Respondent to produce to the Executive Secretary of the State Board for Professional Medical Conduct no fewer than one hundred patient medical records relating to patients seeking or receiving treatment for impotence. Respondent has also failed to produce such records.

4. Respondent acted with intent to deceive in that having stated that he treated approximately eighty to one hundred patients for impotence per year, Respondent intentionally concealed and/or failed to produce, as obligated to do, the medical records of those patients, as set forth in Paragraphs B.1, B.2,and B.3.

C. On or about April 8,1996, Patient B, a ninety-one year man, consulted Respondent. Patient B had a chief complaint of difficulty walking on his left leg and reported a resting tremor, memory difficulty, and left hip pain. On examination Respondent noted a mild resting tremor, without bradykinesia or cogwheel rigidity, mild lumbosacral tenderness and a left Patrick's sign. Respondent conducted various tests upon Patient B.

1. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient B.

2. Respondent failed to adequately evaluate Patient B's complaints and condition.

D. On or about October 8, 1996, two days subsequent to having been injured in motor vehicle accident, Patient C, a seventeen year old woman, consulted Respondent. Patient C complained of headaches, an unsteady gait and neck pain. Respondent conducted various tests upon Patient C.

1. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient C.

E. On or about October 8, 1996, Patient D, a thirty-four year old woman who had been involved in a motor vehicle accident four days earlier, consulted Respondent complaining of headaches and neck pain. Respondent conducted various tests upon Patient D in his medical office. Respondent administered a series of lidocaine and robaxin injections to Patient D from October 1996 through April 1997.

1. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient D.

2. Respondent inappropriately treated Patient D with lidocaine and robaxin injections.

3. Respondent failed to formulate and pursue an adequate treatment plan for Patient D.

4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient D.

F. On or about June 30, 1997, Patient E, a fifty year old man who had been in an

automobile accident on or about May 19, 1997, consulted Respondent complaining of pain in his neck, arm, ankle and back, as well as dizziness a problems with concentration and sleep. Respondent conducted various tests upon Patient E.

1. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient E.

G. On or about July 29, 1996, Patient F, a fifty-eight year old man, consulted Respondent complaining of headaches and neck and back pain which had begun after an automobile accident that had occurred on or about May 14, 1996. Respondent conducted various tests upon Patient F and treated him with injections of lidocaine and robaxin. Respondent treated Patient F throug on or about October 14, 1996.

1. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient F.
2. Respondent failed to adequately assess and/or note in his medical record the effects of treatment on Patient F.
3. Respondent failed to maintain a medical record which accurately reflects the evaluation and treatment of Patient F.

H. On or about October 1, 1996, Patient G, a forty-nine year man, consulted Respondent with chief complaints of headaches and back and neck pain which had developed after a work-related fall in or about May 1995.

Respondent conducted various tests upon Patient G. Respondent treated Patient G with lidocaine trigger point injections, medications and spinal manipulation. Patient G was last seen by Respondent on or about January 28, 1997.

1. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient G.
2. Respondent failed to adequately assess and/or note in his medical record the effects of treatment on Patient G.
3. Respondent failed to maintain a medical record which accurately reflects the evaluation and treatment of Patient G.

I. On or about October 27, 1997, Patient H, a fifty-seven year old man who had been in an automobile accident on or about October 4, 1997, consulted Respondent. Patient H complained of radiating back and neck pain, unsteadiness on his feet and headaches. Respondent conducted various tests upon Patient H in his medical office.

1. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient H.

J. On or about November 29, 1993, Patient I, a thirty-three year old man who had been in an automobile accident on or about November 17, 1993, consulted Respondent. Patient I had chief complaints of neck and back pain and headaches. Respondent conducted various tests upon Patient I and

treated him with medications, trigger point injections and robaxin and lidocaine-steroid nerve blocks. In or about November 1996, Patient I experienced an "idiosyncratic reaction" to a nerve block which had been administered to him by Respondent on or about November 25, 1996, and which required hospital evaluation. Respondent's treatment of Patient I ende in or about June 1997.

1. Respondent caused excessive testing, unwarranted by the condition of the patient, to be conducted upon Patient I.
2. Respondent failed to formulate and pursue an adequate treatment plan for Patient I.
3. Respondent failed to adequately investigate and assess the "idiosyncratic reaction" to treatment which Patient I experienced in November 1996.
4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient I.

K. In or about 1995 and 1996, Patient J, a twenty-year old woman, consulted with and was treated by Respondent for back pain. Respondent conducted various tests upon Patient J, for which Patient J directly paid Respondent approximately four thousand five hundred eighty-four dollars ($4584.00). In o about October 1998, Patient J's insurer paid Respondent approximately three thousand one hundred forty-four dollars ($3144.00) for a number of the tests

conducted by him upon Patient J. When Patient J became aware, in or about October 1998, of that payment to Respondent, she made numerous attempts in writing, via telephone, and in person to secure repayment from Responder Respondent acknowledged to Patient J that the money paid by her insurer to him was owed to Patient J and repeatedly assured Patient J that he would reimburse her. On or about October 6, 1999, the Office of Professional Medical Conduct sent a written request to Respondent pursuant to Public Health Law Section 230 for the certified medical records, including billing records, of Patient J.

1. Respondent has failed to repay to Patient J the amount of money paid to him by her insurer, despite promises by Respondent that he would do so..
2. Respondent has failed to provide certified copies of the medical records, including billing records, of Patient J to the Office of Professional Medical Conduct.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined ir

N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A(1) through A(6).

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined N.Y. Educ. Law §6530(3)(McKinney Supp. 1999) 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:

2. Paragraphs A and A(1) through A(6) ; Paragraphs C and C(1)and C(2 Paragraphs D and D(1); Paragraphs E and E(1) through E(3); Paragraphs F and F(1); Paragraphs G and G(1)and G(2); Paragraphs and H(1) and H(2); Paragraphs I and I(1); Paragraphs J and J(1) through J(3).

THIRD SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

3. Paragraphs A and A(1) through A(6).

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined N.Y. Educ. Law §6530(5)(McKinney Supp. 1999) 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:

4. Paragraphs A and A(1) through A(6) ; Paragraphs C and C(1) and C(2); Paragraphs D and D(1); Paragraphs E and E(1) through E(3); Paragraphs F and F(1); Paragraphs G and G(1) and G(2); Paragraphs H and H(1) and H(2); Paragraphs I and I(1); and Paragraphs J and J(1 through J(3).

FIFTH AND SIXTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined b N.Y. Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

5. Paragraphs B and B(4).

6. Paragraphs K and K(1).

SEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined N.Y. Educ. Law §6530(20)(McKinney Supp. 1999) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

7. Paragraphs B and B(1) through B(4); and Paragraphs K and K(1) and K(2).

EIGHTH THROUGH SIXTEENTH SPECIFICATIONS

ORDERING EXCESSIVE TESTS AND/OR TREATMENT

Respondent is charged with committing professional misconduct as defined i N.Y. Educ. Law §6530(35)(McKinney Supp. 1999) 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:

8. Paragraphs A and A(4).

9. Paragraphs C and C(1).

10. Paragraphs D and D(1).

11. Paragraphs E and E(1).

12. Paragraphs F and F(1).

13. Paragraphs G and G(1).

14. Paragraphs H and H(1).

15. Paragraphs I and I(1).

16. Paragraphs J and J(1).

SEVENTEENTH AND EIGHTEENTH SPECIFICATIONS

FAILURE TO COMPLY WITH AN ORDER FOR A COMPREHENSIVE REVIEW

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(15)(McKinney Supp. 1999) by failing to comply with an order issued pursuant to N.Y. Public Health Law Sect. 230(10)(a) as alleged in the facts of:

17. Paragraphs B and B(1).

18. Paragraphs B and B(2).

NINETEENTH AND TWENTIETH SPECIFICATIONS

FAILURE TO RESPOND WITHIN THIRTY DAYS AND TO MAKE RECORDS AVAILABLE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(28)(McKinney Supp. 1999) by failing to respond within thirty days to written communications from the Department of Health and to make available any relevant records with respect to an inquiry or complaint about the licensee's professional misconduct, as alleged in the facts of:

19. Paragraphs B and B(3).

20. Paragraphs K and K(2).

TWENTY-FIRST THROUGH TWENTY-FOURTH SPECIFICATIONS

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined ir N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) by failing to maintain records which accurately reflect the evaluation and treatment of patients, as alleged in the facts of:

21. Paragraphs E and E(4).

22. Paragraphs G and G(3).

23. Paragraphs H and H(3).

24. Paragraphs J and J(4).

DATED: December 21, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct