STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

August 2, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dwayne Wilson, M.D.
388 S. Main Street
Apartment 56
Providence, Rhode Island 02903

Cindy Fascia, Esq.
NYS Department of Health
Division of Legal Affairs
Corning Tower – Room 2512
Empire State Plaza
Albany, New York 12237-0032

RE: In the Matter of Dwayne Wilson, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 07-165) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure

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

COPY

IN THE MATTER

OF

DWAYNE WILSON, M.D.

DETERMINATION

AND

ORDER

BPMC NO. 07-165

A Notice of Hearing and a Statement of Charges, dated May 1, 2007, were served upon the Respondent, Dwayne Wilson, M.D. **ARTHUR S. HENGERER, M.D.** (Chair), **ALEXANDER E. KUEHL, M.D.** and **HEIDI B. MILLER, M.P.H., R.P.A.-C**, duly designated members of the State Board for Professional Medical Conduct ("**SBPMC**"), served as the Hearing Committee (herinafter the Committee)in this matter pursuant to §230(10) of the Public Health Law ("**P.H.L.**").

JEFFREY W. KIMMER, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health ("**Department**") appeared by **CINDY M. FASCIA, ESQ.**, Associate Counsel.

DWAYNE WILSON, M.D., ("**Respondent**") appeared ***pro se***.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the entire record, the Committee issues this Determination and Order in accordance with the Public Health Law and the Education Law of the State of New York.

PROCEDURAL HISTORY

Date of Notice of Hearing:	May 1, 2007
Date of Statement of Charges:	May 1, 2007
Pre-Hearing Conference Held:	May 22, 2007
Date of Hearing:	June 14, 2007
Deliberations Held:	June 14, 2007

A prehearing conference for this matter was originally scheduled May 14, 2007. On May 11, 2007, the Respondent called the ALJ requesting that the prehearing conference be rescheduled. During a conference call between the Respondent, the Department's attorney and the ALJ, held that same day, the Department's attorney agreed to reschedule the prehearing conference and May 22, 2007 was set as the new date for the prehearing conference. On May 15, 2007, the ALJ sent a letter the parties confirming that the prehearing conference was scheduled for May 22, 2007. In the letter of May 15, 2007, Respondent was informed that he must file an answer to the charges no later than 10 days prior to the hearing or all the charges would be deemed admitted. (ALJ Ex. 1)

On May 22, 2007, the Respondent failed to appear at the prehearing conference. The ALJ delayed the start of the prehearing conference in anticipation of the Respondent appearing. During

that delay the ALJ telephoned the Respondent in an attempt to find out if he was en route to the prehearing conference. The ALJ was able to contact the Respondent via telephone. The Respondent informed the ALJ that he was in Providence, RI, and that he thought the prehearing conference was on either Thursday May 24, 2007 or Friday May 25, 2007. The ALJ reminded the Respondent of the conference call on May 11, 2007, when the May 22, 2007 date was set. The ALJ informed the Respondent in that May 22, 2007, phone call that the prehearing conference would go forward that day, that the hearing was scheduled for June 14, 2007 and that he needed to file an answer no later than 10 days prior to the date of the hearing or all charges would be deemed admitted.

In a letter dated May 25, 2007, the ALJ informed the parties by letter, that the hearing was scheduled to commence on June 14, 2007, the location of the hearing and that an answer must be filed no later than 10 days prior to the start of the hearing or the charges will be deemed admitted. (ALJ Ex. 2)

In a letter dated June 5, 2007, the Department's attorney wrote to the ALJ with a copy to the Respondent stating that an answer had not been filed within the statutory time period and asked that the charges be deemed admitted. (ALJ Ex. 3)

On the afternoon of June 12, 2007, an attorney contacted the Department's attorney who initiated a conference call with the ALJ and that attorney. The attorney did not state that he was representing the Respondent other than to request an adjournment of the first hearing day. The ALJ informed the parties that statutorily whether or not to grant an adjournment of the first hearing day was a decision for the Committee to make. A conference call was held between the ALJ and the Committee. The Committee denied Respondent's request for an adjournment.

On the June 14, 2007, hearing day the Respondent appeared *pro se* and renewed his request for an adjournment. The Committee reconsidered the Respondent's request and denied an adjournment. (T. 14)

The ALJ ruled that Respondent had received ample notice and opportunity to submit an answer. The Notice of Hearing (Ex. 1) at page 2 states:

> Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge and allegation not so answered shall be deemed admitted. (Underline in original)

The Public Health Law to which Respondent was repeatedly referred by the ALJ, clearly indicates that the failure to file a written answer will result in the charges and allegations being deemed admitted. Respondent was informed of this in the telephone conversation of May 22, 2007 and in the 3 letters noted above. (ALJ Exs. 1-3) Based on the Respondent's failure to submit a written answer, the ALJ ruled that the factual allegations and specifications of misconduct contained in the Statement of Charges (Ex. 1) (with the exception of factual allegation B.6, which was withdrawn) were deemed admitted by Respondent. (T. 3-4)

STATEMENT OF CASE

The Respondent is charged with fourteen (14) specifications of professional misconduct within the meaning of §§6530 (2), (3), (4), (5), (6), (20), (21) and (32) of the Education

Law of the State of New York including: (1) Gross Negligence; (2) Gross Incompetence; (3) Negligence on more than one occasion; (4) Incompetence on more than one occasion; (5) Fraudulent practice; (6) Filing a False report; (7) Moral unfitness; and (8) Failure to maintain accurate records. The Charges involve Respondent's treatment of Patients A through F for a period of time between 1999 and 2003, and the Respondent's application for a license to practice medicine in Indiana.

The Statement of Charges is attached hereto, and made a part of this Decision and Order.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These findings are based on the application of Public Health Law §230 (10)(c) to the Statement of Charges.

1. Dwayne Wilson, M.D. (Hereinafter 'Respondent') was licensed to practice medicine in New York State on April 21, 1998, by the issuance of license number 210137 by the New York State Education Department. (Ex. 1)
2. On or about May 23, 2006,, the Respondent completed an application for a State of Indiana medical license which was received by the Indiana Medical Licensing Board on or about June 6, 2006, wherein the Respondent answered "No" to the question "Have you ever been the subject of an investigation by a regulatory agency concerning your license?". The Respondent had in fact been the subject of an investigation by the New York State Department of Health, Office of Professional Medical Conduct as of July 2005, and the Respondent had knowledge of this. (Exs. 13A, 13B, 15A and 15B)

PATIENT A:

3, On or about September 18, 2003, the Respondent provided medical care to Patient A at Highland Hospital in Rochester, New York. (Ex. 6)

4. A physician who provides care to a patient, as the Respondent did for Patient A, should obtain and record an adequate history. The Respondent did not to this. (Ex. 6)

5. A physician who provides care to a patient, as the Respondent did for Patient A, should perform and record an adequate physical examination. The Respondent did not do this. (Ex. 6)

6. As part of the medical care for Patient A, an EKG should have been ordered. The Respondent did not do this. (Ex. 6)

7. When a physician who is providing care to a patient such as Patient A is requested by nursing staff to re-evaluate the patient, the physician should do so in a timely manner. The Respondent did not do this. (Ex. 6)

8. Patient A needed to be intubated in a timely manner. The Respondent failed to do this. (Ex. 6)

PATIENT B:

9. On or about December 31, 1999, the Respondent provided medical care to Patient B at St. Luke's Hospital (hereinafter SLH), in Newburgh, New York. (Ex. 7)

10. A physician who provides care to a patient, as the Respondent did for Patient B, should obtain and record an adequate history. The Respondent did not do this. (Ex. 7)

11 A physician who provides care to a patient, such as Patient B, should obtain and record the patient's history regarding prior anemia, and should adequately investigate and address the patient's current anemia. The Respondent did not do this. (Ex. 7)

12. The Respondent should have adequately addressed Patient B's hypertension. The Respondent did not do this. (Ex. 7)

13 The Respondent should have adequately addressed Patient B's tachychardia. The Respondent did not do this. (Ex. 7)

14. The Respondent should have adequately addressed Patient B's abnormal vital signs and obtained repeat vital signs. The Respondent did not do this. (Ex. 7)

15. The Respondent should have ordered clotting studies for Patient B. The Respondent did not do this. (Ex. 7)

16. A physician providing medical care to Patient B, should have adequately considered and adequately ruled out intra-abdominal bleeding. The Respondent did not do this. (Ex. 7)

17. A physician providing medical care to Patient B should have adequately considered and adequately ruled out pregnancy or pregnancy-related complications, including an ectopic pregnancy. The Respondent did not do this. (Ex. 7)

PATIENT C:

18. On or about November 27, 1999, the Respondent provided care to Patient C at SLH. (Ex. 8)

19. A physician treating a patient such as Patient C, should have adequate indications before intubating such a patient. The Respondent intubated Patient C without such adequate indications. (Ex. 8)

PATIENT D:

20. On or about November 9, 1999, the Respondent provided care to Patient D at SLH. (Ex. 9)

21. A physician who provides care to a patient, as the Respondent did for Patient D, should obtain and record an adequate history. The Respondent did not do this. (Ex. 9)

22. A physician providing care to Patient D should have adequately assessed Patient D's chest pain and/or adequately assessed the patient for cardiac risk factors and/or adequately assessed Patient D for biliary disease. The Respondent did not do this. (Ex. 9)

23. The Respondent should have adequately attempted to relieve Patient D's pain in the Emergency Department. The Respondent did not to this,. (Ex. 9)

24. A physician should have an adequate medical justification for making a diagnosis of gastritis. The Respondent made this diagnosis for Patient D without such adequate medical justification. (Ex. 9)

25. When a diagnosis of gastritis has been made, Naprosyn, a pain medication which can exacerbate gastritis, should not be recommended by a physician. The Respondent recommended Naprosyn for Patient D. (Ex. 9)

26. A physician who provides care to a patient, as the Respondent did for Patient D, should contact the physician's primary physician. The Respondent did not do this. (Ex. 9)

PATIENT E:

27. On or about October 28, 1999, the Respondent provided care to Patient E at SLH. (Ex. 10)

28. A physician treating a patient, such as Patient E, should obtain a digoxin level in a timely manner. The Respondent did not do this. (Ex. 10)

29. A physician treating a patient, such as Patient E, should obtain a dilantin level in a timely manner. The Respondent did not do this. (Ex. 10)

30. A physician treating a patient, such as Patient E, should obtain pulse oximetry in a timely manner. The Respondent did not do this. (Ex. 10)

31. A physician treating a patient, such as Patient E, should re-evaluate the patient in a timely manner. The Respondent did not do this. (Ex. 10)

32. A physician treating a patient, such as Patient E, should have an indication for ordering ketamine. The Respondent did not have such an indication, yet ordered ketamine. (Ex. 10)

33. After administering ketamine to a patient, the patient should be appropriately monitored and supervised. The Respondent did not do tis for Patient E after administering ketamine. (Ex. 10)

PATIENT F:

34. On or about June 16, 2003, the Respondent provided medical care to Patient F at the Champlain Valley Physicians Hospital in Plattsburgh, New York.

35. A physician who provides care to a patient, as the Respondent did for Patient F, should obtain and record an adequate history, including the history of the accident and mechanism of the injury. The Respondent did not do this. (Ex. 12)

36. A physician who provides care to a patient, as the Respondent did for Patient F, should perform an adequate physical examination and order adequate x-rays. The Respondent did not do this. (Ex. 12)

ALLEGATIONS AND SPECIFICATIONS

Based on the application of PHL §230(10)(c), all factual allegations and specifications in the Statement of Charges (except for factual allegation B.6) are SUSTAINED.

DISCUSSION

Respondent, by virtue of P.H.L. §230(10)(c), admitted the allegations and specifications filed against him by the Department. The Committee then heard evidence from the Respondent regarding the appropriate penalty, if any, which should be assessed on Respondent's license to practice medicine in the State of New York. The Committee did allow limited testimony by the Respondent regarding his treatment of some of the patients who were the subject of the Statement of Charges.

The Committee's sole responsibility was to determine the appropriate penalty, if any, to assess.

With the above understanding, the Committee concludes the Respondent committed significant professional misconduct under the laws of New York State.

Respondent is guilty of: (a) committing professional misconduct by practicing the profession of medicine with gross negligence in the care and treatment of four (4) patients; and (b) committing professional misconduct by practicing the profession of medicine with gross incompetence in the care and treatment of four (4) patients; and (c) committing professional misconduct by practicing the profession of medicine with negligence on more than one occasion in the care and treatment of four (4) patients; and (d) committing professional misconduct by practicing the profession of medicine with incompetence on more than one occasion in the care and

treatment of six (6) patients; and (e) committing professional misconduct by practicing the profession of medicine fraudulently, and (f) committing professional misconduct in the practice of the profession of medicine by wilfully making or filing a false report, and (g) committing professional misconduct in the practicing of the profession of medicine by engaging in conduct that evidences moral unfitness to practice the profession.

The Committee wishes to note that if the charges were not deemed admitted, some of said charges and the corresponding specifications may not have been sustained.

The Respondent testified that his practice of medicine has changed in the four years since the most recent charged patient. The Committee questioned him on how his practice of medicine is different today.

The Committee was not convinced that his practice had improved. The Committee also found his behavior in dealing with this legal proceeding against him carried over to how he practices medicine. From an emergency medicine perspective, the Committee concluded that he does not demonstrate the proper understanding on how to deliver medical care in that setting. Additionally, the Committee concluded he had a serious medical information deficit which the Committee did not foresee as improving. There was no mitigating evidence presented. The Committee found significant shortcomings in the medical care that the Respondent provided.

The Committee's role is to protect the citizens of this State. The Respondent displayed cognitive deficiencies in his delivery of medical care. The Committee felt that in carrying out its duty to protect those citizens, revocation of the Respondent's license to practice medicine in the State of New York is appropriate.

DETERMINATION AS TO PENALTY

The Hearing Committee unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

The numerous acts of misconduct committed by Respondent are of such magnitude and severity that no penalty other than revocation would be appropriate.

The Committee was disappointed that the Respondent failed to submit an Answer as required by the Public Health Law. The Committee would have preferred to hear from witnesses for both sides; however the Committee was bound by the application of Public Health Law §230(10)(c), and the ALJ's ruling. The testimony of Respondent was troubling, especially from a medical quality of care standpoint.

Once the allegations and specifications were deemed admitted by the ALJ in accordance with the Public Health Law, the Committee's function became one of determining the appropriate penalty, if any, to be assessed against Respondent.

Each licensed New York State physician must meet certain minimum standards. A physician who undertakes the care and treatment of an individual must provide safe treatment in compliance with minimally accepted standards of medical practice. These minimum standards must be followed regardless of the licensed physician's specialty or calling. Respondent's representation that he is a medical doctor, licensed and registered in New York State, obligates him to practice

medicine within the appropriate medical standard of care which apply to all physicians. The Respondent has not met those standards.

ORDER

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

1. The FIRST through FOURTEENTH Specifications of professional misconduct from the Statement of Charges are **SUSTAINED,** and;

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

3. This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: Rochester, New York
July 30, 2007

ARTHUR S. HENGERER, M.D. (Chair),
ALEXANDER E. KUEHL, M.D.
HEIDI B. MILLER, M.P.H., R.P.A.-C

Dwayne Wilson, M.D.
388 S. Main St.
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Cindy Fascia, Esq.
NYS Department of Health
Div of Legal Affairs
Empire State Plaza
Corning Tower - Room 2512
Albany, New York 12237-0032

APPENDIX I

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

IN THE MATTER

OF

DWAYNE WILSON, M.D.

STATEMENT

OF

CHARGES

Dwayne Wilson, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 21, 1998, by the issuance of license number 210137 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, on or about May 23, 2006, completed an application for an Indiana medical license, which application was received by the Medical Licensing Board on or about June 6, 2006. Respondent answered "No" to the following question:

> **Have you ever been the subject of an investigation by a regulatory agency concerning your license?**

In fact, Respondent had been the subject of an investigation by the New York State Department of Health, Office of Professional Medical Conduct, and Respondent knew such fact.

B. Respondent provided medical care to Patient A on or about September 18, 2003, at Highland Hospital in Rochester, New York. Respondent's care of Patient A did not meet the standard of care, in that:

1. Respondent failed to obtain and/or record an adequate history.

2. Respondent failed to perform and/or record an adequate physical examination.

3. Respondent failed to order an EKG.

4. Respondent failed to timely re-evaluate Patient A after being requested to do so by nursing staff.

5. Respondent failed to intubate Patient A in a timely manner.

6. Respondent failed to use appropriate defibrillations in his attempt to resuscitate Patient A.

C. Respondent provided medical care to Patient B on or about December 31, 1999 at St. Luke's Hospital in Newburgh, New York. Respondent's care of Patient B did not meet the standard of care, in that:

1. Respondent failed to obtain and/or record an adequate history.

2. Respondent failed to obtain and/or record any history regarding prior anemia, and/or failed to adequately investigate and/or address the patient's current anemia.

3. Respondent failed to adequately address Patient B's hypotension.

4. Respondent failed to adequately address Patient B's tachycardia.

5. Respondent failed to adequately address abnormal vital signs and/or failed to obtain repeat vital signs.

6. Respondent failed to order clotting studies.

7. Respondent failed to adequately consider and/or adequately rule out intrabdominal bleeding.

8. Respondent failed to adequately consider and/or adequately rule out pregnancy and/or pregnancy related complications, including ectopic pregnancy.

D. Respondent provided medical care to Patient C on or about November 27, 1999 at St. Luke's Hospital in Newburgh, New York. Respondent's care of Patient C did not meet the standard of care, in that:

1. Respondent intubated Patient C without adequate indication.

E. Respondent provided medical care to Patient D on or about November 9, 1999 at St. Luke's Hospital in Newburgh, New York. Respondent's care of Patient D did not meet the standard of care, in that:

1. Respondent failed to obtain and/or record an adequate history.

2. Respondent failed to adequately assess Patient D's chest pain and/or failed to assess the patient for cardiac risk factors and/or failed to adequately assess the patient for biliary disease.

3. Respondent failed to adequately attempt to relieve Patient D's pain in the Emergency Department.

4. Respondent made a diagnosis of gastritis without adequate medical justification.

5. Respondent recommended a pain medication (Naprosyn) which could exacerbate gastritis, when Respondent had made a diagnosis of gastritis in Patient D.

6. Respondent failed to contact Patient D's PMD.

F. Respondent provided medical care to Patient E on or about October 28, 1999 at St. Luke's Hospital in Newburgh, New York. Respondent's care of Patient E failed to meet the standard of care, in that:

1. Respondent failed to obtain a digoxin level in a timely manner.

2. Respondent failed to obtain a dilantin level in a timely manner.

3. Respondent failed to obtain pulse oximetry in a timely manner.

4. Respondent failed to re-evaluate the patient in a timely manner.

5. Respondent ordered ketamine for Patient E, which was not indicated.

6. Respondent failed to appropriately monitor Patient E after administering ketamine to him.

7. Respondent failed to appropriately supervise Patient E after administering ketamine to him.

G. Respondent provided medical care to Patient F on or about June 16, 2003, at Champlain Valley Physician's Hospital in Plattsburgh, New York. Respondent's care of Patient F failed to meet the standard of care, in that :

1. Respondent failed to obtain and/or record an adequate history.

2. Respondent failed to obtain and/or record an adequate history of Patient F's rollover accident on an all terrain vehicle, and/or of the mechanism of injury.

3. Respondent failed to conduct and/or record an adequate physical examination and/or to order adequate x-rays.

SPECIFICATION OF CHARGES
FIRST SPECIFICATION
CONDUCT EVIDENCING MORAL UNFITNESS

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

1. The facts in Paragraph A.

SECOND SPECIFICATION
WILLFULLY MAKING OR FILING A FALSE REPORT

Respondent is charged with professional misconduct by reason of willfully making or filing a false report in violation of New York Education Law §6530(21), in that Petitioner charges:

2. The facts in Paragraph A.

THIRD SPECIFICATION
FRAUDULENT PRACTICE

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

3. The facts in Paragraph A.

FOURTH THROUGH SEVENTH SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of his practicing the profession with gross negligence on a particular occasion in violation of New York Education Law §6530(4), in that Petitioner charges:

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

5. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7 and/or C.8.

6. The facts in Paragraphs D and D.1.

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

EIGHTH THROUGH ELEVENTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of his practicing the profession with gross incompetence in violation of New York Education Law §6530(6), in that Petitioner charges:

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

9. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7 and/or C.8.

10. The facts in Paragraphs D and D.1.

11. The facts in Paragraphs F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6 and/or F.7.

TWELFTH SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

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

12. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6; C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7 and/or C.8; D and D.1; E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6; F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6 and/or F.7; G and G.1 and/or G.2 and/or G.3.

THIRTEENTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

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

13. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6; C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7 and/or C.8; D and D.1; E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6; F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6 and/or F.7; G and G.1 and/or G.2 and/or G.3.

FOURTEENTH SPECIFICATION
FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with professional misconduct by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of New York Education Law §6530(32), in that Petitioner charges:

14. The facts in Paragraphs B and B.1 and/or B.2; C and C.1 and/or C.2; E and E.1; G and G.1 and/or G.2 and/or G.3.

DATE: May 1, 2007
Albany, New York

Peter D. Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct