NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 18, 2019

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Christine M. Radman
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

Clarisse Clemons, M.D.
[redacted]

Clarisse Clemons, M.D.
3250 Westchester Avenue
Suite 101
Bronx, New York 10461

RE: In the Matter of Clarisse Clemons, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.19-090) 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

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

IN THE MATTER OF CLARISSE CLEMONS, M.D.	DETERMINATION AND ORDER 19-090

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("Department"). A Notice of Hearing ("NOH") and Statement of Charges ("SOC"), both dated August 9, 2018, were served on Clarisse Clemons, M.D. ("Respondent"), and a hearing was held pursuant to N.Y. Public Health Law ("PHL") §230 and New York State Admin. Proc. Act §§301-307 and 401 on December 14, 2018, at the Department's offices at 90 Church Street, New York, New York. A copy of the NOH and SOC is attached to this Determination and Order as Appendix 1. Jeffrey Perry, D.O., Chair, Ramanathan Raju, M.D., and Curtis Hart, M. Div., duly designated members of the State Board for Professional Medical Conduct ("Board"), served as the Hearing Committee ("Committee" or "Hearing Committee") in this matter. Ann H. Gayle served as the Administrative Officer. The Department appeared by Richard J. Zahnleuter, General Counsel, by Christine M. Radman, Associate Counsel. The Respondent appeared *pro se*. A transcript (pages 1-207) of the proceedings was made and is part of the record.

All Hearing Committee findings, conclusions, and determinations are unanimous. The citations in brackets refer to transcript page numbers ["T"] and exhibits ["Ex"] that were accepted into evidence. Any testimony or exhibit not cited was considered and rejected by the Committee in favor of what was cited.

PROCEDURAL HISTORY

Service of NOH and SOC:	September 4, 2018
Answer Filed:	None
Pre-Hearing Conference:	December 3, 2018
Hearing Date:	December 14, 2018
Witness for Petitioner:	David Prince, M.D.
Witness for Respondent:	Respondent
Deliberations Dates:	February 19 and March 4, 2019

STATEMENT OF THE CASE

The Department charged Respondent with fourteen specifications of professional misconduct under N.Y. Education ("Educ.") Law §6530. Due to Respondent's failure to file a written answer to the SOC at least ten days prior to the first day of hearing, the charges and allegations were deemed admitted (PHL §230.10(c)(2)), and the factual allegations and fourteen charges were sustained. The Committee must determine only what penalty should be imposed.

FINDINGS OF FACT

1. Respondent was authorized to practice medicine in New York State on May 21, 1982, by the issuance of License Number 150089 by the New York State Education Department. [Ex 2]
2. In 2010-2011, Respondent treated Patients A through F at her solely owned Cautious Care Medical, P.C. office in Bronx, New York, for injuries sustained in motor vehicle accidents. [Ex 3 through Ex 8]
3. Respondent: (1) failed to perform and document adequate histories and physical examinations for Patients A through F; (2) performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary for Patients A

through F; (3) provided and billed for excessive treatment and/or supplies not warranted by Patients A through F's conditions; (4) failed to adequately follow up on Patients A through F's conditions and/or treatment plans; and (5) failed to maintain a record that accurately reflected the evaluation and treatment of Patients A through F. [Ex 1 (Department's SOC); Ex 3 through Ex 8]

CONCLUSIONS OF LAW

Respondent was charged with the following fourteen Specifications of professional misconduct under Educ. Law §6530: First: practicing medicine with negligence on more than one occasion –§6530(3); Second: practicing medicine with incompetence on more than one occasion –§6530(5); Third through Eighth: ordering unwarranted tests/treatment –§6530(35); and Ninth through Fourteenth: failing to maintain a record which accurately reflects the evaluation and treatment of the patient –§6530(32).

Pursuant to PHL §230.10(c)(2), by failing to file an answer at least ten days prior to the first day of hearing, the First through Fourteenth Specifications of Charges were deemed admitted; all fourteen Specifications are sustained.

DISCUSSION

With the charges against Respondent deemed admitted and the specifications of misconduct sustained, the Committee considered the testimony of Respondent and the Department's expert witness in reaching a determination about what if any penalty should be imposed. Upon finding that Dr. Prince provided credible testimony about the allegations and charges that were deemed admitted, the Committee then focused on Respondent's testimony and presentation of her case.

Respondent's repeated outbursts during the hearing gave the Committee great cause for

concern. The Committee also found that Respondent did not respond to their questions with any clarity. Respondent didn't say *I did this or I ordered this or I didn't do this or follow up on this because* ... Instead, Respondent said throughout the hearing, including in her cross examination of Dr. Prince and in her testimony and presentation of her case, that she did what she did because no-fault required it or that this is how no-fault is, but she is not doing no-fault anymore. Respondent did not or could not adequately explain any rationale for her treatment of these patients. This showed the Committee that Respondent did not understand her actions and treatment or the impact on the patients. This lack of insight and understanding of the seriousness of the charges and the incoherent nature of Respondent's answers to the Committee's questions as evidenced by her not answering their questions with clarity or precision, coupled with her "cookie cutter" treatment of these six patients, caused the Committee to seriously question Respondent's ability to treat patients.

The Committee found that Respondent has a sincere empathy for cancer patients, however, the Committee could not ignore that Respondent did not at any time during the hearing articulate a rationale for the care and treatment of the six patients. The Committee is gravely concerned about her ability to safely treat patients, particularly cancer patients who are extremely vulnerable.

The Committee found that Respondent's "cookie cutter" treatment of these six patients resulted in: inadequate physical examinations, inadequate documentation, poor or no justification for tests ordered, lack of follow up on test results, and lack of referral to specialists as required. The evidence demonstrated that the tests Respondent ordered were not based on the patients' histories, and Respondent did not articulate why she thought they were indicated. In fact, Respondent's repeated statements that she ordered the tests because no-fault required them was

an outright admission of the charges and not the defense or attempted explanation Respondent intended those statements to be. (T 89-92, 161, 179-183, 185-186, 188, 189-190, 197-198, 199-200). The Committee believes Respondent did not order the tests to impact care or treatment of these patients because many of the tests were not indicated, she did not utilize the tests to make diagnoses or treat the patients, she did not follow up on tests when the results dictated follow up, and even when there were abnormal findings there was no indication that she reevaluated the patient to determine the need for referral to specialists or modification to treatment. The Committee found that the evidence showed that Respondent engaged in a dangerous pattern of providing substandard care and treatment that was not for the benefit of all six patients.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

The Department, in its opening statement, stated that it "trusts of this panel to sanction the respondent accordingly" [T 8], and in closing, suggested "a sanction that the entitlement program of no-fault be unavailable" [T 203]. Respondent "would suggest community service by creating guidelines to improve the no-fault business. My submitting resolution for the medical society going forward. What I think this panel would want me to do is set up some parameters so that patients won't be subjected with the no-fault business. It is like an open faucet. There's no second opinion. There's no call up and do prior approval like I have to do now. Use what I know to make the system better. I would say a community service request of my time to write that up and …I'm even willing to make sure that people in private practice get the TB test." [T 202-203].

The Committee, having considered the full range of penalties available pursuant to PHL §230-a, determined that the appropriate penalty for Respondent's misconduct is a revocation of her license. Any penalty short of a revocation would not address Respondent's substandard, poor

quality of care of these six patients, her lack of insight and understanding of the seriousness of her misconduct, her failure to explain her rationale for the treatment of these patients, and her lack of remorse.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following charges of misconduct under Educ. Law §6530 are sustained:

   §6530(3) – practicing medicine with negligence on more than one occasion
   §6530(5) – practicing medicine with incompetence on more than one occasion
   §6530(35). – ordering unwarranted tests/treatment
   §6530(32) – failing to maintain a record

2. Pursuant to PHL §230-a(4) Respondent's license to practice medicine in New York State is revoked.

DATED: New York, New York
April , 2019

[redacted]

JEFFREY PERRY, D.O., Chair
RAMANATHAN RAJU, M.D.
CURTIS HART, M. DIV.

To: Christine M. Radman
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

Clarisse Clemons, M.D.
[redacted]

Clarisse Clemons, M.D.
3250 Westchester Avenue
Suite 101
Bronx, New York 10461

APPENDIX 1

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

IN THE MATTER

OF

CLARISSE CLEMONS, M.D.

NOTICE,

OF

HEARING

TO: CLARISSE CLEMONS, M.D.
[redacted]

CLARISSE CLEMONS, M.D.
3250 Westchester Avenue
Bronx, New York 10461

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on November 8, 2018, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, New York 10007, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York State. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to

require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here [redacted]

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Riverview Center,150 Broadway - Suite 510, Albany, NY 12204-2719, ATTENTION: HON. JAMES HORAN, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

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 or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose

name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATE: August 9, 2018

[redacted]

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct

Inquiries should be directed to:
Christine M. Radman
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street
4th Floor
New York, New York 10007
(212)417-4450

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

IN THE MATTER OF CLARISSE CLEMONS, M.D.

STATEMENT

OF

CHARGES

CLARISSE CLEMONS, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 21, 1982, by the issuance of license number 150089 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about August 2, 2010 through on or about November 29, 2010, Respondent treated Patient A at her solely owned Cautious Care Medical, P.C. office for alleged injuries reportedly sustained in a July 30, 2010 motor vehicle accident. Patient A's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Failed to perform and document adequate histories and physical examinations,
2. Performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
3. Provided and billed for excessive treatment and/or supplies not warranted by the patient's condition.
4. Failed to adequately follow up on Patient A's condition and/or treatment plan and

5. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient A.

B. From on or about July 12, 2010 through on or about December 9, 2010, Respondent treated Patient B at her solely owned Cautious Care Medical P.C. office for alleged injuries reportedly sustained in an July 5, 2010 motor vehicle accident. Patient B's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Failed to perform and document adequate histories and physical examinations,
2. Ordered and/or performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
3. Ordered excessive treatment and/or supplies not warranted by the patient's condition.
4. Failed to adequately follow up on Patient B's condition and/or treatment plan and
5. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient B.

C. From on or about June 7, 2010 through on or about December 22, 2010, Respondent treated Patient C at her solely owned Cautious Care Medical P.C. office for alleged injuries reportedly sustained in an June 5, 2010 motor vehicle accident. Patient B's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Failed to perform and document adequate histories and physical examinations,

2. Ordered and/or performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
3. Ordered excessive treatment and/or supplies not warranted by the patient's condition.
4. Failed to adequately follow up on Patient C's condition and/or treatment plan and
5. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient C.

D. From on or about October 25, 2010 through on or about January 4, 2011, Respondent treated Patient D at her solely owned Cautious Care Medical P.C. office for alleged injuries reportedly sustained in an October 22, 2010 motor vehicle accident. Patient D's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Failed to perform and document adequate histories and physical examinations,
2. Ordered and/or performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
3. Ordered excessive treatment and/or supplies not warranted by the patient's condition.
4. Failed to adequately follow up on Patient D's condition and/or treatment plan and
5. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient D.

E. From on or about September 20, 2010 through on or about December 28, 2010, Respondent treated Patient E at her solely owned Cautious Care Medical

P.C. office for alleged injuries reportedly sustained in an September 15, 2010 motor vehicle accident. Patient E's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Failed to perform and document adequate histories and physical examinations,
2. Ordered and/or performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
3. Ordered excessive treatment and/or supplies not warranted by the patient's condition.
4. Failed to adequately follow up on Patient E's condition and/or treatment plan and
5. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient E.

F. From on or about September 27, 2010 through on or about December 30, 2010, Respondent treated Patient F at her solely owned Cautious Care Medical P.C. office for alleged injuries reportedly sustained in an September 25, 2010 motor vehicle accident. Patient F's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Failed to perform and document adequate histories and physical examinations,
2. Ordered and/or performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
3. Ordered excessive treatment and/or supplies not warranted by the patient's condition.

4. Failed to adequately follow up on Patient F's condition and/or treatment plan and
5. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient F.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraph A and each of its subparagraphs, except 3; and/or Paragraph B and each of its subparagraphs, except 3; and/or Paragraph C and each of its subparagraphs, except 3; and/or Paragraph D and each of its subparagraphs, except 3; and/or Paragraph E and each of its subparagraphs, except 3; and/or Paragraph F and each of its subparagraphs, except 3.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. Paragraph A and each of its subparagraphs, except 3; and/or Paragraph B and each of its subparagraphs, except 3; and/or Paragraph C and each of its subparagraphs, except 3; and/or Paragraph D and each of its subparagraphs, except 3; and/or Paragraph E and each of its subparagraphs, except 3; and/or Paragraph F and each of its subparagraphs, except 3.

THIRD THROUGH EIGHTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

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

3. Paragraphs A and A (3).
4. Paragraphs B and B (3).
5. Paragraphs C and C (3).
6. Paragraphs D and D (3).
7. Paragraphs E and E (3).
8. Paragraphs F and F (3).

NINTH THROUGH FORTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

9. Paragraphs A and A (5).
10. Paragraphs B and B (5).
11. Paragraphs C and C (5).
12. Paragraphs D and D (5).
13. Paragraphs E and E (5).
14. Paragraphs F and F (5).

DATE: August 9, 2018
New York, New York

[redacted]

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct