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

September 28, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Denise Lepicier, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

Said Dounel, M.D.
102-10 66th Road
Forest Hills, New York 11375

Michael S. Kelton, Esq.
Lippman, Krasnow & Kelton, LLP
711 Third Avenue
New York, New York 10017

RE: In the Matter of Said Dounel, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-269) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:cah
Enclosure

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

COPY

IN THE MATTER	:	**DETERMINATION**
	:	
OF	:	**AND**
	:	
SAID DOUNEL, M.D.	:	**ORDER**
		BPMC #00-269

A Notice of Hearing and Statement of Charges, both dated March 4, 1999, were served upon the Respondent, Said Dounel, M.D. **SHARON C.H. MEAD, M.D. (Chair), FRED LEVINSON, M.D., and MS. LOIS A. JORDAN**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Denise Lepicier, Esq., Associate Counsel. The Respondent appeared by Lippman, Krasnow & Kelton, LLP, Michael S. Kelton, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CASE

Petitioner has charged Respondent, an obstetrician/gynecologist, with seven specifications of professional misconduct concerning his medical care and treatment

of four patients. More specifically, Respondent has been charged with willfully harassing, abusing or intimidating a patient either physically or verbally, moral unfitness, negligence on more than one occasion, incompetence on more than one occasion, fraud, exercising undue influence on a patient, and ordering excessive tests. Respondent has denied the allegations.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Said Dounel, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State by the issuance of license number 133845 by the New York State Education Department on or about March 23, 1978. (Pet. Ex. #1).

PATIENT A

2. On April 30, 1993, Patient A presented to Respondent's office as a new patient, with a complaint of vaginal

bleeding during and after intercourse. (T. 1313; Pet. Ex. #5).

3. Patient A was very nervous. (T. 925, 958).

4. Respondent's medical assistant at the time, Olga Yusupova, testified that she was present in the examination room with Respondent and Patient A on April 30, 1993. (T. 925, 930-931, 1315, 1328).

5. Respondent performed an examination upon Patient A which included a breast examination, upon her unclothed breasts. (T. 1316-1317; Pet. Ex. #5).

6. Respondent then performed a pelvic examination upon Patient A, with examination gloves on. (T. 1318) In performing the pelvic examination, Respondent testified that he first performed a visual examination of the outer vaginal area and then visualized and touched the labia minora, the labia majora and the clitoris in order to determine if there was any abnormality in the outer areas of the vagina. Respondent thereafter performed an internal vaginal examination of Patient A, using a speculum. (T. 1318-1319) Respondent stated that he did not find any blood in the vagina upon examination. (T. 1366). Respondent also performed a rectal examination, with gloves on. (T. 1322) Ms. Yusupova testified that on completion of the pelvic examination of Patient A, Respondent left the examination room first, leaving her and Patient A alone in the room. (T. 927).

7. It is never appropriate for a physician to instruct a patient to try to have an orgasm while the physician is examining the patient internally. (T. 357).

8. Respondent suggested that Patient A have intercourse over the weekend to see if she bled again and told her to make an appointment to come back for blood work. (T. 196).

10. It is never appropriate for a physician to rub a patient's clitoris while he is conducting an internal examination. (T. 357).

11. Patient A understood that she either had to pay more money at this visit to have the blood work performed or that she should return for another appointment with more money. (T. 196).

12. Patient A returned to Respondent's office on May 3, 1993 with complaints of abdominal pain, weakness and a vaginal discharge. Patient A also complained of breast pain. (T. 931, 1328, 1330; Pet. Ex. #5).

13. Upon her arrival, Patient A paid one hundred and fifty dollars for the testing. (T. 192, 196).

14. Patient A was taken to the examining room and told to disrobe from the waist down. (T. 201-202).

15. Ms. Yusupova testified that she was present during Respondent's examination of Patient A on May 3, 1993. (T. 930-

931, 1428).

16. Patient A testified that Respondent entered the examining room and stated, "Hello beautiful, how is my beautiful patient today?" (T. 277).

17. There is conflicting documentation as to whether Respondent examined the patient's breasts, and of the manner in which such examination took place. (Pet. Ex. #3 and Pet. Ex. #5).

18. Respondent performed a pelvic examination upon Patient A on May 3, 1993, based upon her complaint of abdominal pain. Respondent testified that upon performing this examination, he felt what he believed to be an ovarian cyst, measuring approximately 3 x 4 centimeters. (T. 1332, 1352; Pet. Ex. #3).

19. Respondent told Patient A that someone would come in to collect her blood and that she should get dressed and go to his consultation office. (T. 204, 282).

20. In the consultation office, Respondent told Patient A that he thought she had an ovarian cyst and that she should have a sonogram. (T. 207, 289).

21. Respondent also asked Patient A if she had sexual intercourse over the weekend and whether there was any bleeding. (T. 205, 289).

22. Patient A told Respondent that she had not had

sexual intercourse. (T. 205).

23. Patient A testified that Respondent told her that he had forgotten to check for bleeding and asked her to return to the examination room in order for him to examine her again. (T. 205).

24. Patient A disrobed for a second time on May 3, 1993. (T. 205).

25. Following the examination, Respondent then asked Patient A to sit up on the examining table and to move down to the end of the table. (T. 207).

26. Respondent told Patient A that she could have an ovarian cyst and that she should have a sonogram. (T. 208).

27. Respondent told Patient A not to worry and to come to his consultation room again. (T. 208).

28. Respondent left the examining room and Patient A quickly dressed. (T. 208).

29. Patient A intended to leave Respondent's office immediately, but was concerned because she had paid for all of the blood testing and now believed she needed a sonogram. (T. 209).

30. Respondent told Patient A that she could have the sonogram performed in his office. (T. 209).

31. While Patient A was speaking to Respondent's receptionist, the sonogram technician told her that she could

perform the sonogram right away. (T. 211, 300).

32. Patient A believed that she would not have to see Respondent again and thought it was best to have the sonogram done to determine what was wrong. (T 211).

33. Patient A's bladder was not sufficiently full for the sonogram and she was instructed to drink water in the waiting room and that she would be checked again. (T. 211).

34. Patient A was checked by the sonogram technician three or four times. (T. 211).

35. Respondent walked into the room a number of times when Patient A was being checked for her readiness to have the sonogram. (T. 212).

36. After the sonogram was complete, Patient A was stopped on her way out of the office to make another appointment for the results of her testing. (T. 213-214).

37. Patient A had no intention of keeping the appointment. (T. 214).

38. There was not a single note written by Respondent in the medical records for Patient A produced for the Office of Professional Medical Conduct on July 26, 1996. (T. 616-617; Pet. Ex. #3).

39. There is no indication in the medical records provided by Respondent on July 26, 1996 of the need for a pelvic sonogram for Patient A. (T. 616-617; Pet. Ex. #3).

40. There is no indication in the single page of notes provided by Respondent on or about September 5, 1996 for a pelvic sonogram. (T. 618-619; Pet. Ex. #4).

41. On April 30, 1993, Respondent noted that Patient A refused a sonogram. (Pet. Ex. #5, p. 13).

42. If Respondent's notes are accepted as true, Respondent clearly intended to order a sonogram at the first office visit with no documentation that a sonogram was necessary. (Pet. Ex. #5).

43. On the subsequent office visit of May 3, 1993, Respondent noted a three by four centimeter cyst on the right ovary which was apparently not noted previously. (Pet. Ex. #5, p. 13).

44. The report of the sonogram reveals that there was no ovarian cyst. (Pet. Ex. #5, p.21).

45. None of the gynecologists that have examined Patient A since her visits to Respondent have ever told her that she has an ovarian cyst. (T. 310).

46. A chemical screen profile was indicated for Patient A on May 3, 1993 based upon her presenting condition and complaints. (T. 1333-1334).

47. Patient A paid fifty dollars as an office visit fee before she ever saw Respondent on April 30, 1993. (T. 184-185).

48. Patient A was told that Respondent would not see her without payment in advance. (T. 184).

49. Respondent told Patient A that she should return to his office for blood testing and that it would cost one hundred fifty dollars more. (T. 192, 19, 200).

50. Respondent admitted in his answer to the charges in this matter that "Patient A complained of abdominal pain and pain and burning on urination. Respondent failed to perform a urinalysis." (Resp. Ex. A, p. 2).

51. If Respondent's office notes produced on September 17, 1996 for Patient A are deemed to be true, Respondent noted on May 3, 1993 that Patient A complained of abdominal pain. (Pet. Ex. #5, p. 13).

52. Patient A noted in her check off forms that she had a current complaint of "Painful urination (burning)." (Pet. Ex. #5, p. 4).

53. Patient A testified at hearing that she made a mistake in checking off "Painful urination (burning)" as a current complaint. (T. 240-241; Pet. Ex. #3).

54. Respondent was apparently unaware that the complaint of painful urination was not a current complaint. (T. 350-353; Pet. Ex. #4; Pet. Ex. #5, p. 15).

55. Respondent failed to address Patient A's complaint of "painful urination" in his history and physical information at

either the April 30, 1993 or May 3, 1993 office visits. (T. 350-351, 356-357; Pet. Ex. #3, p. 8; Pet. Ex. #5, pp. 13-14).

56. If Respondent's record is deemed true regarding Patient A's complaint of abdominal pain, and given the fact that Respondent apparently believed that Patient A's complaint of painful urination was a current complaint, Respondent should have ordered a urinalysis. (T. 363-364).

57. Patient A was not asked to provide a urine specimen. (T. 197, 217, 309).

58. Respondent failed to order a urinalysis for Patient A. (T. 353-356; Pet. Ex. #3; Pet. Ex. #5).

59. A reasonably prudent physician should record notes in a patient's medical record concerning a patient's immediate medical complaints and the history of these complaints, current medications, a past medical history including diseases, illnesses, surgeries and treatments, history of personal habits including smoking, alcohol use, drug use, dietary and activity issues, a family medical history, an allergy history including medications, a review of organ systems, and a physical examination. (T. 338-339).

60. Patient A noted a past history of anemia, diabetes and hemorrhoids in her check-off history which Respondent should have investigated in greater detail. (T. 340-341; Pet. Ex. #5, p. 4).

61. Respondent failed to take and adequate history with respect to Patient A's diabetes, whether he intended to treat her diabetes or not, because the condition may have had some relationship to the patient's presenting complaint. (T. 342-343, 375-378).

62. Respondent failed to take an adequate history concerning Patient A's anemia, whether he intended to assume care for the anemia or not. (T. 343-345).

63. Patient A indicated in her check-off form that she used alcohol. (Pet. Ex. #3, p. 5).

64. A reasonably prudent physician should have inquired about the nature and quantity of the alcohol use. (T. 347-348, 407-408).

65. Respondent failed to record any information concerning Patient A's frequency and quantity of alcohol use. (T. 347-348).

66. The failure to take or record any further information concerning Patient A's alcohol use was a significant deviation from minimally accepted standards of care. (T. 621-622).

67. Patient A indicated in her check-off form that she used tobacco. (Pet. Ex. #3).

68. A reasonably prudent physician would have inquired about the amount of tobacco use and the length of time the

patient had been smoking. (T. 348, 408).

69. Respondent failed to record any information concerning Patient A's frequency and quantity of tobacco use. This was a significant deviation from minimally accepted standards of care. (T. 621-622; Pet. Ex. ##4, 4 and 5).

70. Respondent first produced the medical records of Patient A on or about July 26, 1996. (Pet. Ex. #3).

71. The medical records produced at that time include only forms completed by Patient A, and a note and letter written by the patient. The records do not contain a single notation recorded by Respondent. (Pet. Ex. #3).

72. On or about September 5, 1996, Respondent's then attorney sent the Office of Professional Medical Conduct a page of undated notations by Respondent allegedly "inadvertently [sic] left out of the record of [Patient A] that was previously provided." (Pet. Ex. #4).

73. The page of notes by Respondent was created by him at some time after he saw Patient A on May 3, 1993, because the notes document a blood glucose level of 282. Patient A's blood was drawn on May 7, 1993, and the laboratory reported the results on May 11, 1993. (T. 352; Pet. Ex. #4; Pet. Ex. #5, p.16).

74. On September 17, 1996, Respondent came to the Office of Professional Medical Conduct and produced a third copy of his medical records which included two additional pages of

office notes, the blood test results, the pap smear results, the report of the pelvic sonogram, some insurance information and forms, and a billing record. (Pet. Ex. #5, pp. 13-14, 16-25).

75. Respondent also provided a copy of his office records as part of a civil suit on or about October 27, 1997, and this copy of Respondent's records does not contain the page of notes initially provided to the Office of Professional Medical Conduct on or about September 5, 1996. Moreover, this record contains a different insurance billing form for the May 3, 1993 office visit. (T. 613-614; Pet. Ex. #4, Pet. Ex. #5, Pet. Ex. #8, Pet. Ex. #22).

76. Respondent told a medical coordinator and nurse investigator from the Office of Professional Medical Conduct that the single page of notes was written nearly contemporaneously with Patient A's office visits. (T. 1360-1362, 1404-1405).

77. At the hearing, Respondent testified that he prepared a written summary of his examination, treatment and diagnosis of Patient A for his former attorney, and that he told the attorney to send it to the Office so that they would have a clear record of Respondent's interaction with the patient. (T. 1312, 1344-1346, 1369).

Patient B

78. Patient B sought treatment at Respondent's office in June, 1995 complaining of a "genital yeast infection". (T.

461).

79. Respondent admitted that he advised Patient B about and HIV test, STD testing, and the patient's genital rash. (T. 1269-1270, 1274-1275).

80. Respondent did not conduct a physical examination of Patient B at a visit on June 14, 1995. (T. 468; Pet. Ex. #9).

81. Instead, Respondent told Patient B to return for a number of tests which Respondent suggested were indicated. (T. 468).

82. On June 15, 1995, Respondent ordered a number of tests for Patient B, including an automated chemistry panel, a coronary risk profile, a blood count, thyroid testing, magnesium testing, blood group testing, rubella testing, and a candida culture. (Pet. Ex. #9, pp. 11-13).

83. One of the groups of tests that Respondent ordered for Patient B, a male, was a prenatal profile. (T. 1280-1281; Pet. Ex. #9, p. 8).

84. A reasonably prudent physician orders testing where there is a specific history or problem that may be clarified by performing the tests, or, as in the case of cholesterol and glucose, as a part of screening tests on healthy people. (T. 644-647).

85. There was insufficient indication in Patient B's medical record for the entire automated chemistry profile that

Respondent ordered for the patient. (T. 646).

86. A reasonably prudent physician would order sexually transmitted disease testing when there was a history or physical finding which would raise the suspicion of a sexually transmitted disease. (T. 647).

87. Patient B's complaint of "yeast infection (penis)" is the only indication of a relevant history by Respondent in the record. (Pet. Ex. #9).

88. Respondent's physical examination on June 15, 1995 indicated that Patient B's testes and penis were "OK". (T. 642; Pet. Ex. #9).

89. A reasonably prudent physician would want to note the type of rash the patient had before ordering testing and then would order limited testing as indicated by the findings. (T. 641-642).

90. There is no indication in the record of what type of rash Patient B had. (T. 642).

91. A genital yeast infection is generally not considered to be a sexually transmitted disease. (T. 672).

92. A reasonably prudent physician would want some medical history or physical findings indicative of a thyroid problem before ordering thyroid testing. (T. 648).

93. There was insufficient indication in the record for the thyroid testing ordered for Patient B. (T. 648).

94. A reasonably prudent physician would order magnesium testing generally when the patient has an illness, or is taking medication, which might affect serum magnesium levels. (T. 648).

95. There was insufficient indication in the record for the magnesium testing ordered for Patient B. (T. 648-649).

96. Respondent ordered blood group testing for Patient B, which was part of a prenatal profile. (T. 669-671).

97. A reasonably prudent physician would order blood group testing when there was some specific indication that the patient needed to be typed, such as pregnancy. (T.645).

98. There was insufficient indication in the record for the blood group testing ordered for Patient B. (T. 645-646).

99. A reasonably prudent physician would generally order rubella testing for females when there is a possibility of pregnancy, or in a healthcare worker when there is a possibility of contact with pregnant females. (T. 649).

100. There was insufficient indication in the record for the rubella testing ordered for Patient B. (T. 649).

101. A reasonably prudent physician would order a candida culture for a male only when the history and physical examination suggest that the patient may be prone to Candida infection. (T. 649-650).

102. There was insufficient documentation in the record

on June 15, 1995 for the candida culture testing ordered for Patient B. (T. 650, 1274-1275).

103. When Patient B first arrived at Respondent's office, he was given a form to complete. Subsequently, Patient B wrote on this form that his present complaint was a yeast infection. (T. 463, 465; Pet. Ex. #9, pp. 2-4).

104. When Respondent reviewed the form with Patient B in his consultation room, Respondent encouraged the patient to add the following words to his present complaint: "weakness, check for syphilis, cholesterol, sugar". Respondent told the patient that this would facilitate Patient B's claim for insurance reimbursement. (T. 465).

105. Respondent admitted that he suggested that Patient B write down additional complaints. (T. 1271).

106. Patient B did not submit a claim to his insurance carrier. (T. 465).

107. Respondent did not ask Patient B is he was sexually active. (T. 467).

108. Respondent noted in Patient B's medical record that Patient B complained of herpes. (Pet. Ex. #9, p. 5).

109. Patient B testified that he never told Respondent that he had herpes, and had no reason to believe that he was at high risk to contract a sexually transmitted disease. (T. 467).

110. The tests Respondent ordered for Patient B

indicated that Patient B did not have herpes. (Pet. Ex. #9, p. 13).

111. Respondent told Patient B at his first office visit that his rash could be connected to a variety of diseases, such as diabetes or sexually transmitted diseases. He told the patient that he should undergo a number of tests to rule out those possibilities. (T. 461-462, 476-477, 492-493).

112. Patient B's test results revealed that he had none of these illnesses. (Pet. Ex. #9, pp. 11-13).

113. Respondent did not conduct a physical examination of Patient B at his first visit. (T. 468, 499).

114. Respondent told Patient B at the first visit that he could offer the patient a very good deal. For three hundred and fifty dollars Patient B would have a comprehensive physical examination and all the tests which Respondent stated were needed. (T. 468-471, 474, 499-500).

115. Respondent persuaded Patient B to return for another office visit for the testing without having first examined the patient. (T. 499).

116. When Patient B returned to Respondent's office for his second visit, Patient B paid ninety-five dollars at the outset, and was told by Respondent that three hundred fifty dollars would cover all of the laboratory testing. (T. 513; Pet. Ex. #11).

117. Respondent conducted a brief examination of Patient B on the second visit, listening briefly to Patient B's heart and lungs, and tapping various parts of Patient B's body. (T. 473).

118. Respondent told Patient B that a rectal examination was not a very pleasant experience, and that he was sure Patient B would not want to have a rectal performed. (T. 473, 539-540).

119. Patient B never specifically refused a rectal examination. (T. 473).

120. Respondent did not examine Patient B's eyes, ears, nose or throat. (T. 473).

121. Respondent never told Patient B that he would be doing rubella testing, Rh antibody testing, thyroid testing or blood group testing. (T. 474).

122. Respondent never discussed the form Patient B signed relating to a separate fee for the laboratory services. (T. 472; 514-515).

123. Patient B testified that he believed that he could trust the various forms that he signed in Respondent's office would be for his benefit. (T. 511).

124. Patient B ultimately received a bill form the laboratory which actually performed the tests. (Pet. Ex. #9, pp. 8-10).

125. Subsequent to the June 15, 1995 office visit, Patient B telephoned Respondent's office for the results of his tests. Respondent informed Patient B that he had received the results of all of the tests, other than the yeast culture, and that they were all satisfactory. (T. 478).

126. Patient B's tests revealed that his cholesterol (273) was significantly elevated, his LDL was elevated, and that his total cholesterol to HDL ratio was low. (T. 652-653; Pet. Ex. #9, p. 11).

127. Respondent never informed Patient B that he had any problems with his cholesterol levels. (T. 478-479).

128. Eighteen months to two years prior to the date of Patient B's testimony at this hearing, another physician found that Patient B's cholesterol was elevated, and instituted treatment. (T. 479).

129. Patient B had an elevated thyroid result, yet Respondent failed to apprise him of the results of the thyroid testing. (T. 478; Pet. Ex. #9, p. 12).

130. Respondent's failure to address the medically significant results of Patient B's cholesterol testing, coupled with his failure to perform a thorough physical examination, evidences the fact that his intent in ordering testing for Patient B was simply to inflate the bill. (Pet. Ex. #11).

131. Respondent persuaded Patient B to return for a

second office visit without having first examined the patient. (T. 499).

132. Respondent told Patient B that he would not treat Patient B's yeast infection until he had ruled out all the other possibilities, including diabetes, gonorrhea and syphilis. (T. 466).

133. Patient B was alarmed when Respondent told him that his yeast infection could be caused by diabetes or a sexually transmitted disease, and felt pressured to have the additional testing done. (T. 480, 505, 523).

Patient C

134. Patient C went to Respondent's office seeking treatment on or about June 3, 1996. (T. 95; Pet. Ex. #12).

135. Patient C complained of vaginal and/or abdominal pain. (T. 95, 135; Pet. Ex. #12, pp. 2, 8).

136. Patient C reported a last menstrual period of May 24, 1996. (T. 676; Pet. Ex. #12, p. 3).

137. Patient C reported that her next previous menstrual period was April 22, 1996. (T. 676; Pet. Ex. #12, p. 3).

138. Respondent told Patient C that her uterus was inflamed and swollen and that she could be pregnant. (T. 100, 141).

139. Patient C did not believe that she could be

pregnant because she had not been able to become pregnant in the past without medical assistance. (T. 100).

140. The least expensive and simplest test for pregnancy is a urine pregnancy test. (T. 677).

141. Respondent never suggested that Patient C provide a urine specimen, nor does the record indicate that a urine test was ordered. (T. 100, 105, 107, 677).

142. Patient C's medical record indicates in the physical examination portion that Patient C's uterus was enlarged consistent with a five week pregnancy. (T. 678; Pet. Ex. #12, p. 8).

143. Given that the office visit recorded in the medical record is approximately ten days after Patient C's last menstrual period, it was unlikely that Patient C was five weeks pregnant. (T. 679).

144. Patient C's serum pregnancy test indicated that she was not pregnant. (T. 679; Pet. Ex. #12, p. 9).

145. Patient C's pelvic sonogram was not consistent with a five week pregnancy. (T. 681; Pet. Ex. #12; Pet. Ex. #14).

146. When Patient C told Respondent that she could not be pregnant because she had not been able to become pregnant in the past, he told her that she might have a tumor developing. (T. 101, 141-143).

147. Respondent had a section on his pre-printed consent to testing form which indicated that Patient C had refused a urine pregnancy test. (Pet. Ex. #12, p.6).

148. Ms. Abramova's testimony about that portion of the form concerning a urine pregnancy test was confusing. Initially, she seemed to say that if the patient did not sign that portion of the form she was refusing all pregnancy testing. Subsequently, she seemed to say that the patient refused only the urine pregnancy test. Finally, she seemed to say the exact opposite, i.e., if the patient did not want the urine test, the patient would sign the form. (T. 1036-1041).

149. Although Patient C signed other portions of the consent form, the portion referring to the urine pregnancy test has the word "Refused" typed in. (Pet. Ex. #12, p. 6).

150. There is insufficient indication in the record for the serum pregnancy testing ordered for Patient C. (T. 677).

151. Respondent ordered hormonal testing for Patient C. At the time, the patient was thirty-seven years old, and had not reported any weight gain or hot flashes to Respondent. (T. 98, 132-133).

152. Patient C's check-off history form in the medical record is not consistent with a complaint of hot flashes and weight gain. (Pet. Ex. #12, pp.4, 8).

153. Respondent's notes for Patient C, indicating that

she experienced hot flashes and weight gain are not credible. (Pet. Ex. #12, p. 8).

154. There is insufficient indication in the record for the hormonal testing ordered for Patient C. (T. 682).

155. A reasonably prudent physician complying with minimal standards of care would not have ordered hormonal testing for Patient C. (T. 682).

156. Respondent ordered thyroid testing for Patient C. (T. 682).

157. A complaint of constipation alone is insufficient indication to order thyroid testing. (T. 684).

158. There is insufficient indication in the record for the thyroid testing ordered for Patient C. (T. 684).

159. A reasonably prudent physician complying with minimal standards of care would not have ordered thyroid testing for this patient. (t. 684).

160. Respondent told Patient C that she needed a mammogram. Patient C had a mammogram within the two years previous to her visit to Respondent. There is no indication in the record that Patient C needed a mammogram. (T. 102, 108, 110).

161. Patient C and her husband identified Respondent as a physician by looking in the Yellow Pages. (T. 95, 557-559; Pet. Ex. #25).

162. The Yellow Pages advertisement indicated that Spanish was spoken in Respondent's office. (Pet. Ex. #25).

163. Patient C and her husband called the office to ask if the doctor was a gynecologist and to inquire about the cost of the visit. (T 95, 559).

164. They were told that Respondent was a gynecologist and that the cost of the visit was seventy-five dollars. (T. 95, 560).

165. Patient C's husband accompanied her to Respondent's office for the visit. (T. 96).

166. Patient C's husband helped her to complete the forms she was given when she first arrived at Respondent's office. (T. 96, 121, 560).

167. After Patient C and her husband completed the forms and before Patient C was taken to the examining room, they paid the seventy-five dollar fee for the office visit. (T. 97, 103, 561, 572).

168. Patient C was then taken to an examining room where she disrobed. (T. 97).

169. Patient C testified that she had allergies to dust, pollen and certain flavors and liquids. (T.98).

170. Respondent's medical record for Patient C indicated that she had no allergies. (Pet. Ex. #12, p. 8).

171. Patient C never told Respondent that she had a

sexually transmitted disease or that she had ever missed a period. (T. 116).

172. Respondent asked Patient C how long she had been married and she told him that she had been married for a long time and had not had sexual relations with anyone but her husband. (T. 99).

173. Patient C stated that there was no female present in the examining room when Respondent was conducting the physical examination. (T. 99-100, 139).

174. Patient C stated that she was very upset and scared by the information that she might be pregnant or might have a tumor. (T. 145-146, 584).

175. While Patient C was in the examining room, Respondent had her sign the form concerning the laboratory fees, although at that time, Patient C was so upset that she did not know what she was signing and no one translated the form for her. (T. 101-102; Pet. Ex. #12, p. 7).

176. Respondent had Patient C add the words "STD test no HIV" to the presenting complaint portion of her medical record. (T. 122-123, 1224-1225; Pet. Ex. #12, p. 2).

177. When Patient C was initially brought back to the examining room she had asked if her husband could come with her because she did not understand English, but her request was denied. (T. 126, 156, 545-546, 561-562).

178. Patient C testified that Respondent did not permit her husband to accompany her to the examining room. She indicated that Respondent told her that he and his nurse spoke Spanish. (T. 555, 562, 581).

179. At hearing, Respondent denied that he or any of his employees spoke Spanish. (T. 1123-1125).

180. Respondent's Yellow Pages advertising (in both 1992 and 1995) indicated that Spanish was spoken in Respondent's office. (Pet. Ex. ##24 and 25).

181. After Patient C signed the form concerning the laboratory fees, Respondent called in a staff member who drew some blood from the patient. (T. 102).

182. Respondent told Patient C that he needed to draw the blood to determine whether there was any possibility of disease. (T. 102).

183. Respondent told Patient C that everyone should have sexually transmitted disease testing. (T. 123).

184. Respondent told Patient C that she should have HIV testing performed, but she refused because she had been tested at the Strang Clinic. (T. 124).

185. Respondent also told Patient C that she should have a mammogram and a sonogram. (T. 102).

186. After Patient C had dressed, Respondent accompanied her to the waiting room. (T. 102, 105-106).

187. Patient C told her husband that Respondent told her that she was either pregnant or had a tumor and that she needed a sonogram. (T. 562).

188. Respondent told Patient C's husband that his wife was having blood testing and that the husband should have the tests as well. (T. 102, 105-106, 562-563, 586).

189. Patient C's husband told Respondent that he had HIV testing a few months previous to the visit and that he did not feel he needed any other tests. Respondent insisted that Patient C's husband should still undergo the testing. (T. 563).

190. After Respondent left the waiting room, the receptionist also told Patient C's husband that he should have blood testing. (T. 107, 563).

191. Patient C's husband testified that he felt that he was being pushed by Respondent and his receptionist to have the blood testing done. (T. 585).

192. Patient C testified that she felt that she and her husband were being pushed to consent to the blood tests. (T. 107).

193. Patient C's husband paid an additional three hundred dollar fee to the receptionist. He stated that he was not sure what testing the money was for, but that he paid the fee because he wanted to find out what was wrong with Patient C. (T. 566-567).

194. Patient C testified that she believed the fee was for the mammogram and sonogram. (T. 103-105).

195. Patient C and her husband did not believe the seventy-five dollar fee was for blood collection, because of what they had been told, and because she had not yet been examined when she paid the fee. (T. 105, 572).

196. Patient C later received an additional bill from the laboratory for four hundred eighty dollars. (Pet. Ex. #14).

197. Patient C's sonogram was scheduled for approximately five in the afternoon on the same day as her office visit. (T. 106-107).

198. When Patient C was called for the sonogram, the technician told her that she also needed to have a mammogram. (T. 108).

199. Patient C did not believe the mammogram was necessary because she had one within the previous two years and refused to have it performed. (T. 108, 110).

200. Generally, a reasonably prudent physician would not order any radiologic procedure if a pregnancy is suspected. (T. 683).

201. Patient C's husband paid an additional one hundred fifty dollars to the sonogram technician, which surprised Patient C since she believed she had already paid for it. (T. 108-109, 565-566; Pet. Ex. #13).

202. Patient C's husband requested a receipt for the fees he paid before they left the office on June 3, 1996, and the receipt included some codes which were unintelligible to him. (T. 567; Pet. Ex. #13).

203. The receipt indicates that Patient C paid three hundred dollars for the office visit. (Pet. Ex. #13).

204. The receipt indicates an additional fee of fifty dollars for collection of a specimen. (Pet. Ex. #12).

205. Patient C did not recall paying an additional fifty dollar fee. (T. 104).

206. The technician performing the sonogram told Patient C that the results would be available in about one week. (T. 104).

206. Patient C returned in a week to obtain the results of the sonogram and her blood tests, but was told that the results were not yet available. (T. 110, 150-151).

207. Patient C's husband called many times to obtain the results of her tests. (T. 151, 155, 576).

208. Respondent never called or wrote to Patient C to tell her the results of her tests. (T. 576-578).

209. Patient C was unaware, until she received the bill from the laboratory, that she had been tested for so many things. (T. 112).

210. On or about August 19, 1996, Patient C went to

Respondent's office to obtain a copy of her sonogram results, but was told the results were not available. (Pet. Ex. #12).

211. Patient C's husband made numerous requests to receive the laboratory report and the sonogram results and mentioned not receiving the sonogram report in a letter dated August 21, 1996. (T. 579; Pet. Ex. #12).

212. Patient C's husband understood from a woman who worked in Respondent's office that she was going to request a copy of the sonogram report from the company who did the sonogram. (T. 579-580; Pet. Ex. #12).

213. Although Patient C finally obtained a copy of her laboratory results, she was never given the results of her sonogram. (T. 111, 114, 116, 577-578; Pet. Ex. #15).

214. Subsequent to her visit to Respondent, Patient C visited another physician who diagnosed a vaginal inflammation and prescribed some medicine which resolved her problem within two days. (T. 111, 159).

215. The subsequent treating physician did not find evidence of either a pregnancy or a tumor. (T. 159, 597, 599).

216. The results of Patient C's blood tests and pelvic sonogram revealed that she was not pregnant and did not have a tumor. (Pet. Ex. #12, pp. 9-12, 14).

Patient D

217. Patient D went to the offices of Respondent on or

about March 3, 1997, seeking treatment for a vaginal discharge. (T. 18; Pet. Ex. #17).

218. Respondent gave Patient D advice about additional testing he believed was indicated, provided her with some samples of medication, and prescribed additional medication for her. (Pet. Ex. #17, pp. 13-14; Pet. Ex. #17A).

219. Patient D went to Respondent's office in the company of her friend, Ms. L.A. (T. 18; Pet. Ex. #17, pp. 14-15).

220. Upon arrival, Patient D filled in some forms concerning personal data and paid a seventy-five dollar fee for the office visit. (T. 19).

221. After Patient D had paid the fee and completed the forms, she was escorted to an examining room where she was given a gown and told to disrobe. (T. 19-20).

222. Patient D testified that Respondent entered the examination room, but did not ask her any questions about her health history. (T. 20, 48-50, 77).

223. Respondent told Patient D before the physical examination that HIV was widely spread through kissing and that she should have an HIV test even though she told him that she had not been sexually active and that she was a blood donor. (T. 21-22, 34, 41-42, 80-81).

224. Respondent also told Patient D that she should

have a battery of tests for sexually transmitted diseases. (T. 22, 60).

225. Patient D testified that Respondent did not ask her any questions about her sexual history. (T. 22, 81).

226. Patient D admitted at the hearing that she had had one venereal disease ten years previously, but that she was asked no specifics about the disease. (T. 34).

227. Patient D had visited a gynecologist for an annual physical and Pap test approximately five months prior to her visit to Respondent and had been told that was fine. (T. 22).

228. Patient D testified that Respondent performed a physical examination and upon removing the speculum told her that there was blood on the speculum. He told her that this meant that she had cancer. (T. 23, 52).

229. Respondent subsequently told an investigator for the Office of Professional Medical Conduct in an interview that "[t]hey [the patient and her friend] got very nervous because [Respondent] told Patient D that she would have to come back for a biopsy to rule out cancer." (T. 1390-1391).

230. Patient D was upset when she was told that she might have a sexually transmitted disease, and very upset when she was told that she had cancer. (T. 23, 41).

231. Patient D testified that she then went to the Respondent's office or consultation room. However, when she

tried to ask him questions, Respondent gave only vague answers. He did tell her that one-third of her cervix was missing due to the cancer. (T. 23-24, 53-54, 58).

232. Patient D signed permission slips for the HIV and other sexually transmitted disease testing while she was in the examining room. (T. 27).

233. Patient D also was required to sign a credit card slip for three hundred eighty dollars to pay for this testing while she was still in the examining room. (T. 27-28, 59; Pet. Ex. #18).

234. Respondent told Patient D that the three hundred and eighty dollar fee was for all of the sexually transmitted disease testing. (T. 63).

235. Respondent prescribed a vaginal douche and Cleocin for the her vaginal discharge. (T. 24).

236. Patient D testified that she was extremely upset at this point. (T. 24).

237. Patient D left Respondent's consultation room or office and went into the waiting room where her friend was waiting. (T. 24).

238. Patient D's friend asked her what was wrong. (T. 25).

239. Patient D's friend did not believe that what Respondent told Patient D could be true and she asked the

receptionist to see the doctor immediately. (T. 25).

240. Respondent repeated to both Patient D and her friend that one-third of the patient's cervix was missing and that she had cancer. (T. 25).

241. Patient D and her friend both stated at the hearing that Respondent offered to Ms. L.A. to view Patient D's cervix herself. (T. 25, 28, 66-67).

242. Although at the hearing Respondent denied that he would have let Patient D's friend view the patient's cervix, in an interview with an OPMC investigator about this patient, he stated that if the patient had signed a release, he would have permitted the friend to view Patient D's cervix. (T. 1203, 1389).

243. When Ms. L.A. asked Respondent about his credentials, he showed them a photo album of women holding new-born infants in the hospital. (T. 28).

244. After discussing the matter with her friend, Patient D decided to revoke her consent to the testing and to have the charge for the testing removed from her credit card. (T. 26; Pet. Ex. #17, p. 16).

245. Respondent added a note to Patient D's medical record which confirms that she refused all testing. (Pet. Ex. #17, p. 15).

246. Patient D visited another gynecologist within

approximately three days of her visit to Respondent. (T. 26; Pet. Ex. #19).

247. This subsequent gynecologist performed a complete gynecological examination and told Patient D that her cervix was "100 percent intact" and that there was no cancer of any sort. (T. 26).

248. The office records of the subsequent treating physician confirm these findings. (Pet. Ex. #19).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

Respondent is charged with seven specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Henry M. Greenberg, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence,

and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Fraudulent Practice of Medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

At the outset, the Hearing Committee made an assessment of the various witnesses called by the parties. Petitioner presented testimony by Patients A, B, C and D, Patient C's husband, and Richard J. Bonanno, M.D. Petitioner also presented testimony by a friend of Patient A's.

The Hearing Committee found the testimony of Patient A regarding Respondent's alleged sexual misconduct to be not entirely credible. There were several instances where her testimony at hearing differed from her original statement. However, where he testimony reflected a pattern of Respondent's

behavior consistent with that reported by the other patients, the Committee gave it greater weight.

The Committee found Patient B to be a credible and accurate witness. The Committee also found Patient C and her husband to be generally credible, although there was some confusion as to the exact nature of the patient's command of the English language. Despite a tendency to hyperbole, the Committee found Patient D to be generally credible, as well. The Hearing Committee considered the testimony of Petitioner's expert, Dr. Bonanno, to be generally credible. He has excellent credentials, and was an independent observer, with no stake in the outcome of the proceeding.

Respondent presented several fact witnesses, a number of character witnesses, and testified on his own behalf. He did not present an independent medical expert.

Respondent presented the testimony of Olga Yusupova, a former employee. She testified as to her recollection of events, particularly with regard to Patient A. She is not currently employed by Respondent, and no credible motivation for fabrication of her testimony was presented. The Committee found her to be a generally credible witness.

Respondent also presented the testimony of Dora Abramova. Ms. Abramova's responsibilities in the office mainly pertain to billing and bookkeeping. As a current employee of

Respondent, she clearly has a stake in the outcome of this case. Nevertheless, the Hearing Committee found her direct, and to the point testimony to be generally credible. However, her testimony was not dispositive of the issues at hand. Respondent presented the testimony of Hosneara Begum, another employee, as to the custom and practice in the office. Her testimony was not given great weight by the Hearing Committee.

Respondent also presented a number of character witnesses. They were very supportive of Respondent, and the Hearing Committee believes that they are quite sincere in their support. Nevertheless, their testimony did not really address the substance of the allegations raised against Respondent. Accordingly, the Committee did not give any weight to their testimony when evaluating the validity of the charges.

As noted above, Respondent testified on his own behalf. The Hearing Committee was concerned by the fact that he did not present an independent medical expert. Respondent obviously has the greatest stake in the outcome of the case, and clear motivation to attempt to shade his testimony in the most favorable way possible.

The Committee was very troubled by the Respondent's attempts to manipulate the medical records concerning Patient A. On at least two occasions, copies of supposedly complete medical records for the patient were turned over to the Office of

Professional Medical Conduct. However, the records were significantly different. In addition, Respondent submitted an additional page of records (Petitioner's Exhibit #4) which he first claimed to have been inadvertently left out of the record. Only at the hearing, did Respondent acknowledge that in fact, this page of notes was created more than three years after the patient's visit to Respondent's office. He also claimed that the notes were not part of the record, but really intended to explain his thinking to the Petitioner. The Hearing Committee finds his testimony in this regard to be completely unbelievable. We find that instead Respondent falsified the medical record in order to affect the outcome of this case. As a result, the Hearing Committee found that Respondent was not a credible witness.

Based upon the credibility determinations made above, and the record as a whole the Hearing Committee will not set forth its conclusions regarding each of the Specifications of professional misconduct set forth in the Statement of Charges.

First Specification: Willfully Harassing, Abusing or Intimidating a Patient Either Physically or Verbally

Petitioner has alleged that Respondent engaged in improper sexual conduct with Patient A. After careful review of the testimony, the Hearing Committee is not convinced that a preponderance of the evidence supports these allegations. As

noted above, there were several significant differences between the patient's pre-hearing statements and her testimony at hearing. Moreover, Ms. Yusupova testified that she directly recalled Respondent's encounters with Patient A, and that she was present in the examination room during his examinations of the patient. She testified that she saw Respondent make no inappropriate comments to the patient, nor did he touch her in an impermissible manner. Accordingly, the Hearing Committee did not sustain the First Specification with regard to Patient A.

The record concerning Patients B through D, however, is clear. Each of the patients testified that Respondent pressured them to undergo a battery of tests which were generally not indicated by the patient's condition. Respondent would suggest to the patients that his examination findings suggested dire results, and then preyed upon their fears to induce them to agree to the tests "to rule out any abnormalities".

The Hearing Committee concluded that Respondent willfully harassed and intimidated these patients verbally, for his own financial gain, in violation of Education Law §6530(31). As a result, the Committee sustained the First Specification, with regard to Patients B, C and D.

Second Specification: Moral Unfitness

In many respects, Respondent's conduct resembles a classic "bait and switch" scheme. Respondent enticed patients to

his office through various advertisements. When prospective patients called for information, they were told that the examination would cost a certain amount (either $75.00 or $95.00). After arriving at Respondent's office, and paying in advance, the patients would finally see Respondent. Following a cursory "consultation" with Respondent, it always developed that he recommended an expensive battery of tests. At this point, Respondent began the pressure tactics to frighten his patients into undergoing the procedures. Respondent and his staff attempted to minimize the cost, glossing over the fact that the patients would also be billed by the laboratory as well.

Respondent repeatedly misrepresented the patients' medical condition in order to induce them to undergo unnecessary tests for his own financial gain. He falsified Patient A's medical records, and encouraged Patient B to record non-existent patient complaints in order to increase insurance reimbursement.

Respondent has repeatedly disregarded the moral and ethical standards of the medical profession for his own financial gain. As a result, the Hearing Committee unanimously concluded that Respondent has engaged in conduct in the practice of the profession of medicine that evidence moral unfitness to practice medicine, in violation of Education Law § 6530(20). Therefore, the Hearing Committee voted to sustain the Second Specification.

Third Specification: Negligence on More Than One

Occasion

Fourth Specification: Incompetence on More Than One Occasion

The record established that Respondent repeatedly performed inadequate physical examinations, and took inadequate histories. He ordered numerous laboratory tests for his patients without adequate medical indication. One of the most egregious examples was the order for pre-natal testing for Patient B, a male patient. Moreover, when some of the tests actually produced abnormal results, such as in the case of Patient B's cholesterol and thyroid tests, Respondent made no attempt to follow-up with the patient.

The Hearing Committee unanimously concluded that Respondent's conduct demonstrated both negligence and incompetence as defined above. Accordingly, the Committee voted to sustain the Third and Fourth Specifications of professional misconduct.

Fifth Specification: Fraudulent Practice

As noted previously, Respondent repeatedly misrepresented his patients' medical condition in order to induce them to undergo unnecessary tests for his own financial gain. He falsified Patient A's medical records, and encouraged Patient B to record non-existent patient complaints in order to increase insurance reimbursement. His patients legitimate medical

problems were ignored or subsumed into Respondent's practice of separating them from their money. The Hearing Committee unanimously concluded that Respondent's conduct constituted the fraudulent practice of medicine in violation of Education Law §6530(2), and voted to sustain the Fifth Specification.

Sixth Specification

The record established that Respondent repeatedly sought to induce his patients to undergo unnecessary and expensive laboratory tests. He scared and intimidated the patients by suggesting to them that they had serious and potentially catastrophic diseases, and that the tests were necessary to "rule out any abnormalities". The four patients at issue in this case did not know each other. They all presented to Respondent with different complaints. Nevertheless, each recounted strikingly similar efforts by Respondent to induce them to agree to the laboratory tests.

The Hearing Committee concluded that Respondent has committed professional misconduct in violation of Education Law § 6530(17) by exercising undue influence over these patients. As a result, the Committee voted to sustain the Sixth Specification.

Seventh Specification: Ordering Excessive Tests

Respondent repeatedly ordered extensive panels of tests which were not medically indicated. He needlessly ordered a

sonogram for Patient A, mammography for Patient C, and a pre-natal profile for Patient B, a male patient. The Hearing Committee concluded that Respondent ordered excessive tests, in violation of Education Law §6530(35). Therefore, the Committee voted to sustain the Seventh Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be suspended for a period of two years. The second year of the suspension shall be stayed and the Respondent placed on probation, with Respondent's practice monitored by a physician selected by Respondent and approved in advance by the Director of the Office of Professional Medical Conduct. In addition, Respondent shall be required to successfully complete continuing medical education courses in history-taking, medical record-keeping, and ethics. These courses, which must be approved by the Director of the Office of Professional Medical Conduct, must be completed before Respondent can return to practice. The complete terms of probation are attached to this Determination and Order in Appendix II and incorporated herein. Further, a fine in the amount of $40,000.00 shall be imposed upon Respondent. This determination was reached

upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

ORDER

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

1. The First through Seventh Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 2 are **SUSTAINED**;

2. Respondent's license to practice medicine as a physician in New York State be and hereby is **SUSPENDED** for a period of two (2) years commencing on the effective date of this Determination and Order;

3. The second year of the above-ordered suspension shall be stayed, and Respondent placed on probation. The complete terms of probation are contained in Appendix II of this Determination and Order and incorporated herein;

4. A fine in the amount of **$40,000.00** be and hereby is assessed against Respondent. Payment of the aforesaid sum shall be made to the Bureau of Accounts Management, New York State Department of Health, Erastus Corning Tower Building, Room 1258, Empire State Plaza, Albany, New York 12237 within thirty (30) days of the effective date of this Order;

5. 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, referral to the New York State Department of Taxation and Finance for collection, and non-renewal of permits or licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32);

6. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: **Troy, New York**
23 September **2000**

SHARON C.H. MEAD, M.D. (Chair)
Fred Levinson, M.D.
Lois A. Jordan

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

Said Dounel, M.D.
102-10 66th Road
Forest Hills, New York 11375

Michael S. Kelton, Esq.
Lippman, Krasnow & Kelton, LLP
711 Third Avenue
New York, New York 10017

APPENDIX I

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

IN THE MATTER

OF

SAID DOUNEL, M.D.

NOTICE

OF

HEARING

TO: SAID DOUNEL, M.D.
102-10 66TH Road
Forest Hills, NY 11375

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1999) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1999). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on May 19, 1999, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, 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. 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.

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, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, 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 (McKinney Supp. 1999) 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 (McKinney Supp. 1999). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
March 4, 1999

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Denise Lepicier
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

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

IN THE MATTER OF SAID DOUNEL, M.D.	STATEMENT OF CHARGES

SAID DOUNEL, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 24, 1978, by the issuance of license number 133845 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A from on or about April 30, 1993, to on or about May 3, 1993. Patient A complained at her first visit of bleeding during and after sexual intercourse.

1. On or about April 30, 1993, Respondent instructed Patient A to try to have an orgasm while he was examining her. Respondent rubbed Patient A's clitoris while his finger was inside her vagina. Respondent committed these acts purportedly, but not in fact, in the good faith practice of medicine.
2. Patient A returned to Respondent's office for additional testing on or about May 3, 1993. Respondent instructed Patient A to lie down on the examining table and put her feet in the stirrups. Patient A was fully dressed from the waist up. Respondent touched Patient A's breasts through her clothing. Respondent placed his finger in Patient A's vagina and he rubbed her clitoris. Respondent rubbed his erect penis against her leg. Respondent

kissed Patient A on her cheek. Respondent committed these acts purportedly, but not in fact, in the good faith practice of medicine.

3. Respondent ordered the following tests without indication: a pelvic sonogram, and a chemical screen profile.

   a. Respondent ordered these tests knowing they were unnecessary and with the intent to deceive Patient A about the necessity for the tests.

4. Patient A complained of abdominal pain and pain and burning on urination. Respondent failed to perform a urinalysis.

5. Respondent failed to perform or record adequate histories, physicals, diagnoses, testing or treatment.

6. Respondent produced Patient A's medical record on July 26, 1996. On September 5, 1996, Respondent's attorney produced an additional page purportedly "inadvertently left out of the record . . . that was previously provided." On September 17, 1996, Respondent provided another copy of Patient A's record which included additional information not previously provided. Respondent inappropriately added information to Patient A's medical record after July 26, 1996, in an attempt to make his medical records for Patient A appear adequate and/or justify the testing he ordered.

   a. Respondent created this information knowing the information was not part of Patient A's original medical record with the intent that the added material be taken as part of Patient A's original record.

B. Respondent treated Patient B from on or about June 14, 1995, to on or about June 15, 1995. Patient B complained of a yeast infection at his first office

visit.

1. Respondent ordered the following tests without indication: an automated chemistry panel; sexually transmitted disease testing; ~~coronary risk testing~~; ~~a complete blood count~~; thyroid testing; magnesium testing; blood group testing; rubella testing; and a candida culture.

withdrawn by Pet. 7/27/99 JGS

   a. Respondent ordered these tests knowing they were unnecessary and/or not indicated with the intent to deceive Patient B about the necessity for the tests.

2. Respondent and/or his staff made inappropriate and/or inaccurate statements to Patient B in an effort to persuade Patient B to undergo the testing Respondent recommended for Respondent's own financial gain.

   a. Respondent knowingly made and/or had his staff make these statements with the intent to deceive.

3. Respondent failed to adequately follow-up on abnormal test results.

C. Respondent treated Patient C on or about June 3, 1996. Patient C complained of abdominal pain.

1. Respondent ordered the following tests without indication: pregnancy testing; hormonal testing; thyroid testing; mammography; and hepatitis testing.

   a. Respondent ordered these tests knowing they were unnecessary and/or not indicated with the intent to deceive Patient C about the necessity for the tests.

2. Respondent and/or his staff made inappropriate and/or inaccurate statements to Patient C and her husband in an effort to persuade

Patient C to undergo the testing Respondent recommended for Respondent's own financial gain.

a. Respondent knowingly made and/or had his staff make these statements with the intent to deceive.

D. Respondent treated Patient D on or about March 3, 1997. Patient D complained of a vaginal discharge.

1. Respondent ordered the following test without indication: hepatitis testing.

a. Respondent ordered this test knowing it was unnecessary and/or not indicated with the intent to deceive Patient D about the necessity for the test.

2. Respondent and/or his staff made inappropriate and/or inaccurate statements to Patient D and her friend in an effort to persuade Patient D to undergo the testing Respondent recommended for Respondent's own financial gain.

a. Respondent knowingly made and/or had his staff make these statements with the intent to deceive.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT EITHER PHYSICALLY OR VERBALLY

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(31)(McKinney Supp. 1999) by willfully harassing, abusing or intimidating a patient either physically or verbally as alleged in the facts of:

amended by Jet 5/19/99 JJS

1. Paragraphs A, A1 and/or A2, and/or
2. Paragraphs B, B2 and/or B2a, and/or
3. Paragraphs C, C2 and/or C2a, and/or
4. Paragraphs D, D2 and/or D2a.

SECOND SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educe. 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:

2. Paragraphs A, A1, A2, A3 and A3a, and/or A6 and A6a; and/or B, B1 and B1a, and/or B2 and B2a; and/or C, C1 and C1a, and/or C2 and C2a; and/or D, D1 and D1a, and/or D2 and D2a.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educe. 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:

3. Paragraphs A, A3, A4 and/or A5; and/or B, B1, B2 and/or B3; and/or C, C1 and/or C2; and/or D, D1 and/or D2.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in

N.Y. Educe. 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, A3, A4 and/or A5; and/or B, B1, B2 and/or B3; and/or C, C1 and/or C2; and/or D, D1 and/or D2.

FIFTH SPECIFICATION

FRAUDULENT PRACTICE

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

5. Paragraphs A, A1, A2, A3 and A3a, and/or A6 and A6a; and/or B, B1 and B1a, and/or B2 and B2a; C, C1 and C1a, and/or C2 and C2a; and/or D, D1 and D1a, and/or D2 and D2a.

SIXTH SPECIFICATION

EXERCISING UNDUE INFLUENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educe. Law §6530(17)(McKinney Supp. 1999) by exercising undue influence on a patient, as alleged in the facts of:

6. Paragraphs A, A3 and A3a; and/or B, B1 and B1a, and/or B2 and B2a; and/or C, C1 and C1a, and/or C2 and C2a; and/or D, D1 and D1a, and/or D2 and D2a.

SEVENTH SPECIFICATION

ORDERING EXCESSIVE TESTS

Respondent is charged with committing professional misconduct as defined in N.Y. Educe. Law §6530(35)(McKinney Supp. 1999) by ordering excessive tests, treatment, or use of treatment facilities, as alleged in the facts of:

7. Paragraphs A and A3; and/or B and B1; and/or C and C1; and/or D and D1.

DATED: March 4, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

APPENDIX II
TERMS OF PROBATION

1. Dr. DOUNEL shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Dr. DOUNEL shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Dr. DOUNEL shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical conduct, 433 River Street - Suite 303, Troy, New York 12180, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Dr. DOUNEL leaves New York to reside or practice outside the State, Dr. DOUNEL shall notify the Director of the Office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of her departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. DOUNEL shall be required to successfully complete continuing medical education courses in history-taking, medical record-keeping, and ethics. These courses, which must be approved in advance by the Director of the Office of Professional Medical Conduct, must be completed before Respondent can return to practice.

6. Dr. DOUNEL shall have quarterly meetings with an employee or designee of the Office of Professional Medical Conduct during the period of probation. During these quarterly meetings Dr. DOUNEL's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed.

7. Dr. DOUNEL shall have quarterly meetings with a monitoring physician who shall review Dr. DOUNEL'

practice. This monitoring physician shall review randomly selected medical records and evaluate whether Dr. DOUNEL's practice comports with generally accepted standards of medical practice. This monitoring physician shall be selected by Dr. DOUNEL and is subject to the approval of the Director of the Office of Professional Medical Conduct. Dr. DOUNEL shall not practice medicine until an acceptable monitoring physician is approved by the Director.

8. Dr. DOUNEL shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the Office of Professional Medical Conduct at the address indicated above.

9. Dr. DOUNEL shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If Dr. DOUNEL elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

10. If there is full compliance with every term set forth herein, Dr. DOUNEL may practice as a physician in New York State in accordance with the terms of probation; provided, however, that upon receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Dr. DOUNEL pursuant to New York Public Health Law §230(19) or any other applicable laws.