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. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 12, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lee A. Davis, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237

Gregory S. Doria, M.D.
2118 83rd Street
Brooklyn, New York 11214

Carl E. Person, Esq.
Person & Reid
325 West 45th Street – Suite 201
New York, New York 10038-3603

RE: In the Matter of Gregory S. Doria, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-61) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

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

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

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

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

Sincerely,

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**
	:	
GREGORY S. DORIA, M.D.	:	**ORDER**

BPMC #01-61

A Commissioner's Order and Notice of Hearing, dated July 7, 2000, and a Statement of Charges, dated July 6, 2000, were served upon the Respondent, Gregory S. Doria, M.D. **RICHARD N. ASHLEY, M.D. (CHAIR), SHAHLA JAVDAN, AND JACK SCHNEE, M.D.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Lee A. Davis, Assistant Counsel. The Respondent appeared by Person & Reid, Carl E. Person, 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

The Commissioner of Health of the State of New York issued an Order summarily suspending the license of Dr. Doria. The accompanying Statement of Charges alleged that the Respondent is impaired for the practice of medicine due to a psychiatric condition. Respondent denied the allegation. Following the conclusion of the hearing, the Hearing Committee recommended that the summary suspension remain in effect, pending the final resolution of this matter. By an Interim Order, dated November 21, 2000, the Commissioner ordered that the summary suspension remain in effect, without modification. 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. Gregory S. Doria, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State on June 2, 1983 by the issuance of license number 154280 by the New York State Education Department. (Exh. 2).

2. A November 18, 1999 Order of the State Board for Professional Medical Conduct, ordered Respondent, pursuant to New York State Public Health Law §230(7) to appear and submit to a psychiatric examination. (Exh. 5, p. 1; T. 26-27).

3. Respondent was examined by Dr. Howard W. Telson for six and one-half hours on February 12, 2000. (T. 29-30).

4. The examination was a Board-ordered forensic evaluation. The purpose of the meeting was not for treatment. No physician-patient privilege attached and the communications between Dr. Telson and Respondent were not confidential, for the purposes of this proceeding. (T. 31-32).

5. The November 18, 1999 Order required Respondent to provide Dr. Telson a certified copy of the records of his care and treatment by Roland S. Parker, Ph.D. Respondent did not bring the records to the examination. (T. 33-34).

6. Dr. Telson's examination of Respondent included a review of his childhood history, educational history, social history, post-graduate training and employment history and

family history. Current functioning and mental status were also assessed. (T. 39-40).

7. Dr. Telson noted that the process of obtaining factual information was hampered by numerous contradictions. The information conveyed by Respondent during the course of the examination called into question the thought processes and psychiatric condition of Respondent. (T. 41).

8. Respondent related that he was exceptionally bright and talented in physics and computers while a high school student. He stated that he was recruited to work for the Department of Defense on a project that was a predecessor of the internet, and that he worked for approximately four months at Princeton University for minimum wage. (T. 42-43).

9. Respondent reported that he had been recruited to study physics at Princeton while in high school, but decided not to attend the college because it would mean that he would have been obligated to work for the Department of Defense for his entire career. This recruiting process was supposedly outside the usual admission process on the condition that Respondent would not have the right to change his major or choose a different employer in the future. (T. 42-43).

10. Details regarding Respondent's post-graduate training and employment history were also problematic. For

example, his residency application to the Bergen Pines County Hospital contained information that was inaccurate and unreliable regarding previous employment history. The resume listed as work experience "private practice" at 115 Bay 40, Brooklyn, from 1984 to 1988. (Exh. 9, p.1). Respondent admitted that this was his residence, and not a work address. Similarly, the address provided for private practice from "1988 to present" at 1035 Park Avenue, New York was not at the location at which Respondent claimed. (T. 46-48).

11. Respondent claimed that the inaccurate information on the resume submitted to the Bergen Pines residency program was caused by the a resume service that supposedly prepared the document. This explanation is contradicted by the residency application itself, which was typed by Respondent. One of the references cited by Respondent in his application, "R. Cilento, M.D.", lists the same address at which Respondent indicated that he had practiced as a *locum tenens* physician. Respondent also claimed that this physician treated him for an injured foot following an accident at the Bergen Pines County Hospital. (T. 46-49).

12. Respondent was similarly contradictory and vague regarding the means by which he had supported himself since the mid-1980s. He indicated that he was in an automobile accident

in 1984 which resulted in a sizable financial settlement and that he was also receiving social security disability income for periods of time from approximately 1986 through the present. The specifics of the automobile accident, settlement and disability were vague and contradictory. (T. 50-52).

13. Respondent's experience while in the residency program was also problematic. Pursuant to a memorandum dated February 10, 1994 by M.J. Iqbal, M.D., director of the residency program, Respondent was placed on probation as a result of deficiencies in his performance. The deficiencies included failing to complete histories and physicals, complaints from nursing staff finding Respondent difficult to reach and rarely in the unit, and failing to report to work without an excuse. Respondent denied the accuracy of this information, stating that the only relevant information was the "certificate of training" that he received when he left the residency program. (Exh. 9, pp. 40-42; T. 58-62).

14. Documents provided for the evaluation and information provided by Respondent indicate that he has previously undergone treatment for psychiatric problems. Respondent indicated that he had been treated for seizures and depression following the alleged automobile accident in 1984. Dr. Parker wrote a letter indicating that he had evaluated

Respondent and found a psychiatric-psychological impairment. (T. 51-55).

15. Respondent told Dr. Telson that he had been in treatment with Dr. Parker for psychiatric therapy from approximately 1984 through sometime in the 1990's, although details were not provided. Respondent also stated that he had received treatment from a Dr. Greenspan, starting in 1986 or 1987, and continuing into the late 1980's. Dr. Greenspan prescribed a large number of medications to Respondent, including anti-seizure medications, psychotropic medications, anti-psychotic medications, anti-depressants, and anti-anxiety medications. (T. 51-56).

16. Respondent reported that he was arrested in New Jersey and was found to be in possession of a large quantity of controlled substances. Respondent denied that there was a problem during his interview with Dr. Telson. Respondent told Dr. Telson that on the day of his arrest, he had been cleaning out boxes of medication while moving his possessions on a daily basis from a residence to a motel room. This explanation contradicted an earlier explanation provided by Respondent indicating he was transferring his possessions between a motel room and his car every day and unpacked them every night in the motel room. (T. 65-68).

17. On a number of occasions during the interview, Respondent requested that the tape recorder be turned off, such as when discussing recent work opportunities. During one such conversation, Respondent stated that he recently received an Executive-mail from the Department of Defense offering him a position, but that he decided not to accept it. During other conversations with the tape recorder off, Respondent made statements regarding employment for the Department of Defense, his involvement as a physicist, and issues of nuclear war and preparing for nuclear war. (T. 73-74).

18. Dr. Telson found Respondent's physical appearance to be noteworthy. The clothing worn was somewhat rumpled and appeared to be oversized. Respondent's affect had a strange quality with superficial friendliness and superficial cooperation. Respondent was preoccupied and submerged in his own language. There were episodes of a vigorous laugh that had a bizarre quality. (T. 74-75).

19. In his 1999 application for re-certification of social security disability benefits, Respondent represented that he was completely disabled and that the disability had been continuous since he first received benefits due to a brain injury. He reported problems with memory, concentration, an

inability to travel independently, and that he spent most of his time by himself or going to the park. (Exh. 10; T. 242).

20. During the course of his re-certification for disability benefits, Respondent was required to meet with a psychiatrist and a psychologist. (Exh. 10, pp. 3-34; T. 243).

21. The evaluation completed by the psychologist reported that Respondent had difficulty traveling alone and tended to get lost, and that he spent his days going to the park watching the birds, feeding the squirrels and watching television. (Exh. 10, p. 23; T. 250).

22. Psychological testing performed on Respondent indicated that his full scale IQ was 72 - in the range of mental retardation. The testing also indicated that Respondent demonstrated mild delay in abstract spatial organization and borderline skills in relation to visual acuity. (Exh. 10, pp. 23-24; T. 251).

23. Respondent's "Mental Residual Functional Capacity Assessment" demonstrated that Respondent was markedly limited in the following areas: ability to remember locations and worklike procedures; ability to understand and remember detailed instructions; ability to carry out detailed instructions; ability to maintain attention and concentration for extended periods; ability to perform activities within a schedule,

maintain regular attendance and be punctual within customary tolerances; ability to sustain an ordinary routine without special supervision; ability to work in coordination with or in proximity to others without being distracted by them; ability to complete a normal work day and work week without interruptions from psychologically-based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; ability to accept instructions and respond appropriately to criticism from supervisors; ability to travel in unfamiliar places or use public transportation; and ability to set realistic goals or make plans independently of others. (Exh. 10, pp. 17-18).

24. The assessment further indicated that Respondent was moderately limited in the following areas: ability to understand and remember very short and simple instructions; ability to make simple work related decisions; ability to interact appropriately with the general public; ability to get along with co-workers or peers without distracting them or exhibiting behavior extremes; and ability to respond appropriately to changes in the work setting. (Exh. 10, pp. 17-18; T. 252-253).

25. Based upon the review of Respondent's condition, the Social Security Administration (SSA) continued to classify

Respondent as totally disabled based upon a marked impairment resulting from a brain injury reported by him. (Exh. 10, pp. 2, 6-7; T. 253).

26. The primary diagnosis described by the SSA is organic mental disorders (chronic brain syndrome); the secondary diagnosis is border intellectual functions. (Exh. 10, p. 2; T. 254-255).

27. Based upon his February 12, 2000 evaluation, Dr. Telson opined that Respondent is impaired for the practice of medicine due to a psychiatric condition. Dr. Telson's working diagnosis was psychotic disorder, not otherwise specified. (T. 78).

28. Dr. Telson's diagnosis was based primarily on his clinical evaluation of Respondent. He found disorder of Respondent's thoughts indicating illogical, circumstantial and circular reasoning. Respondent's preoccupation with the Department of Defense and family members who had connections with the Department of Defense, demonstrated delusional, grandiose thinking. (T. 84-87).

29. Dr. Telson identified additional information which could possibly aid in developing a more specific diagnosis of Respondent's condition. This included information relating

to the events of the 1984 automobile accident, records of treatment with Dr. Parker and Dr. Greenspan. (T. 79-82).

30. Dr. Telson opined that Respondent's impairment would interfere with his ability to practice medicine, in that Respondent does not have the capacity to relate appropriately with patients or to evaluate a clinical situation appropriately. Information regarding Respondent's arrest in 1995 and statements made by Respondent about nuclear war call into question his ability to adequately handle controlled substances. (T. 89-90, 205-208).

31. The diagnosis of psychotic disorder, not otherwise specified, is not inconsistent with that made by the SSA. (T. 256).

32. The discrepancies between the SSA diagnosis and Dr. Telson can be attributed to the fact that different information was provided to them by Respondent. In both evaluations there is clear evidence of impaired concentration and of psychological difficulty. (T. 256-258).

33. The two diagnoses are consistent in that they both reflect an individual with a chronic condition who has been unable to maintain employment. The different profiles presented by Respondent demonstrate evidence of both a thinking disorder

and a willful effort to provide misleading information. (T. 259-260, 292-295).

34. The conflicting information provided to different sources is partly a function of a willful act on the part of Respondent to attain different goals, and also a function of a disease process and thinking disorder that impairs Respondent's ability to work. (T. 291-293).

CONCLUSIONS OF LAW

Respondent is charged with one specification alleging professional misconduct within the meaning of Education Law §6530. More specifically, he is charged with professional misconduct under New York Education Law §6530(8) by reason of having a psychiatric condition which impairs his ability to practice medicine. The Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

At the outset, the Hearing Committee assessed the credibility of the witnesses presented by both sides.

Petitioner presented Howard Telson, M.D. Dr. Telson is a board certified psychiatrist, with a sub-specialty certification in forensic psychiatry. Dr. Telson interviewed Respondent for 6½ hours and produced a detailed report following

his examination. Dr. Telson indicated that he was leaning toward a diagnosis of schizophrenia, but was hampered by his inability to verify his opinion with any of Respondent's clinical records. Dr. Telson clearly had no stake in the outcome of the hearing, and testified in a forthright manner.

Respondent presented Richard B. Krueger, M.D. Dr. Krueger is also a board certified forensic psychiatrist, with no stake in the outcome of the case. He also interviewed Respondent, for approximately 5 hours, and prepared a report. Dr. Krueger concluded that Respondent was not suffering from either a psychotic disorder or a thought disorder, and that he was not impaired for the practice of medicine.

However, Dr. Krueger's report is based, at least in part, on inaccurate information. Based upon information provided by Respondent, Dr. Krueger reported that Respondent had returned to practice in 1989, and worked as a physician until 1994. In fact, Respondent has been able to demonstrate only eighteen months of medical practice since obtaining his license in 1983.

Most troubling to this Hearing Committee was the fact that Dr. Krueger's report did not address the SSA determination that Respondent was totally disabled. Dr. Krueger testified on cross-examination that he had never reviewed the SSA file prior

to his testimony. He was not aware of the claims made by Respondent that he easily became confused, or that he is unable to take public transportation because he gets lost easily. (T. 358-359, 371).

After reviewing the SSA file, Dr. Krueger testified that the history which Respondent presented to the SSA was disturbing, and reflected badly on his credibility. He further testified that, based upon the history presented to the SSA, he now had a "great concern" that Respondent may be suffering from dementia. (T. 372). Dr. Krueger agreed that Respondent may be impaired, differing with Dr. Telson only on the nature of the impairment. He expressed the opinion that Respondent's impairment may be neuropsychological in nature rather than psychotic. (T. 374).

Respondent also testified on his own behalf. Rather than help his own cause, Respondent's testimony helped seal his fate. On cross examination, Respondent denied providing many of the answers to the SSA which he was credited with making, and was extremely evasive in his answers. He virtually acknowledged defrauding the government, while claiming that it was necessary to obtain the benefits he desired.

The record clearly demonstrates that Petitioner has met its burden of proof in this matter. Respondent is impaired for the practice of medicine. Even Dr. Krueger acknowledged that, based upon the SSA records, Respondent may be impaired due to an organic brain disorder. His opinion was qualified only as to the possible root of the impairment; whether it is neuropsychological or psychotic in origin. (*See*, T. 374).

In essence, at least three different Respondents were identified during the course of the hearing. Respondent presented a different face to Dr. Telson, Dr. Krueger, and to the SSA. However, the apparent discrepancies between their respective evaluations of Respondent can be reconciled.

Since obtaining his license in 1983, Respondent has demonstrated no more than 18 months of work history as a physician. Exhibit 10 indicates that Respondent has been receiving SSI disability benefits since 1985. While Respondent has offered anecdotal reasons for his lack of work at various times during the course of the proceeding, he has presented no evidence to substantiate any of his claims. There are no medical records to substantiate the alleged head injury from the alleged 1984 car accident. There are no medical records to substantiate the claim that Respondent broke his foot in 1993.

The Hearing Committee concluded that the most likely explanation for the lack of a substantial work history is the existence of a significant psychiatric impairment. Respondent's own testimony and his statements to Dr. Telson reveal that he started receiving treatment for psychiatric ailments in 1985. While the SSA diagnosis of an organic mental disorder is not on its face consistent with that provided by Dr. Telson, the discrepancy may be explained by the limited records provided to both reviewers, and to Respondent's intent to present himself differently to each reviewer.

Respondent could not receive SSI benefits, unless he were found to be totally incapable of working. Therefore, Respondent skewed his presentation to ensure the receipt of the desired benefits. Respondent needed to show a capacity to practice medicine to Dr. Telson (and later to Dr. Krueger). Accordingly, he presented to them in a more capable fashion. Despite his impairment, Respondent is capable of presenting differently to different people, although his condition interferes with his ability to respond in a consistently rational manner.

Respondent's testimony demonstrated examples of his grandiose and delusional thinking. For example, Respondent testified that he was an attending psychiatrist at Kings County

Hospital in 1983-1984. When asked to explain his qualifications for this position, Respondent listed his experience of psychiatry rounds in medical school and his fifth pathway year. To Respondent, this minimal experience made him a qualified psychiatrist. Respondent similarly demonstrated grandiose and delusional thinking when he critiqued Dr. Telson's evaluation. This critique demonstrated Respondent's implied belief that he possessed superior knowledge of the subject than Dr. Telson.

Respondent's description of his efforts to receive SSI benefits further highlights the extent of his impairment. Respondent described himself as two people - "Dr. Doria" and "Mr. Doria". He described his situation as a desperate fight for survival. (T. 521-523). Respondent admitted that he would do or say whatever it took to get what he believed he needed. It is clear that Respondent's willingness to do or say anything, if he perceived it to be to his advantage, would present a grave risk to any patients, were Respondent to be allowed to return to practice

Ultimately, it is not necessary for the Hearing Committee to determine an exact diagnosis for Respondent's condition. That can only be determined following an extensive psychiatric evaluation. It is sufficient that the Committee has concluded, based upon the testimony of both experts, as well as

that of Respondent, that he is impaired for the practice of medicine due to a psychiatric condition which has rendered him unfit to practice the profession.

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 in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The record overwhelmingly established that Respondent's judgement is significantly impaired and that his impairment has extended over a period of many years. His demonstrated lack of insight into his problems makes his prognosis poor. The Committee's determination to revoke Respondent's license was reached without rancor. The members of the Hearing Committee recognize that the situation represents a personal tragedy for Respondent. Nevertheless, the Committee's primary obligation is to protect the people of this state.

Revocation of Respondent's license to practice medicine is the only sanction which will accomplish that purpose.

The Hearing Committee strongly recommends that, in the event that Respondent should ever seek reinstatement of his license, he be required to demonstrate that he has undergone a complete psychiatric evaluation, has entered into a long-term therapeutic relationship, and that he is fully compliant with any treatment recommendations. The Hearing Committee also recommends that Respondent be required to undergo psychometric testing in the event that he seeks reinstatement of his license. The Committee further recommends that Respondent be required to undergo significant retraining, in the event that he is ever found to be mentally fit to practice.

ORDER

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

1. The First Specification of professional misconduct, as set forth in the Statement of Charges, (Petitioner's Exhibit #1) be and hereby is **SUSTAINED**;

2. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order;

3. 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
March, 7, 2001

RICHARD N. ASHELY, M.D. (CHAIR)

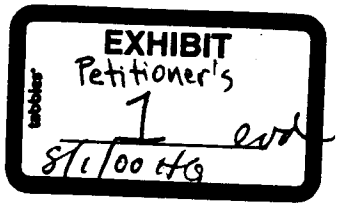
SHAHLA JAVDAN
JACK SCHNEE, M.D.

TO: Lee A. Davis, Esq.
Assistant Counsel
New York State Department of Health
Corning Tower Building - Room 2509
Empire State Plaza
Albany, New York 12237

Gregory S. Doria, M.D.
2118 83rd Street
Brooklyn, New York 11214

Carl E. Person, Esq.
Person & Reid
325 West 45th Street - Suite 201
New York, New York 10038-3603

APPENDIX I



STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER : COMMISSIONER'S

OF : ORDER AND

GREGORY S. DORIA, M.D. : NOTICE OF HEARING

----------X

TO: GREGORY S. DORIA, M.D.
2118 83rd Street
Brooklyn, New York 11214

The undersigned, Dennis P. Whalen, Executive Deputy Commissioner of the New York State Department of Health, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by Gregory S. Doria, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12), that effective immediately Gregory S. Doria, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230, and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing

will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 19th day of July, 2000 at 10:00 a.m. at 5 Penn Plaza, 6th Floor, Room D, New York, New York and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 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.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Hedley Park Place, 433 River Street, 5th Floor, Troy, New York 12180

(518-402-0751), 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. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

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 or sanction 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 FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
July 7, 2000

DENNIS P. WHALEN
Executive Deputy Commissioner

Inquiries should be directed to:

Lee A. Davis, Esq.

Assistant Counsel
NYS Department of Health
Division of Legal Affairs
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
GREGORY S. DORIA	:	CHARGES

----------X

GREGORY S. DORIA, M.D., the Respondent, was authorized to practice medicine in New York State on June 2, 1983 by the issuance of license number 154280 by the New York State Education Department. The Respondent is not currently registered with the New York State Education Department to practice medicine.

FACTUAL ALLEGATIONS

A. On or about February 12, 2000 Respondent presented to Howard Telson, M.D. for a psychiatric examination, pursuant to the November 18, 1999 Order of the Board for Professional Medical Conduct. In a report dated February 25, 2000, Dr. Telson concluded that:

1. Respondent is impaired for the practice of medicine due to a psychiatric condition.

SPECIFICATIONS

FIRST SPECIFICATION

IMPAIRMENT DUE TO A PSYCHIATRIC CONDITION

Respondent is charged with professional misconduct under New York Education Law §6530 (8) by reason of having a psychiatric condition which impairs his ability to practice medicine, in that Petitioner charges:

1. The facts in paragraphs A and A.1.

DATED: July 6, 2000
Albany, New York

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