STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

May 26, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ralph J. Bavaro, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

James G. Eberz, Esq.
118 North Bedford Road
P.O. Box 151
Mt. Kisco, New York 10549

Benjamin I. Dyett, M.D.
200 Maple Avenue
White Plains, New York 10606

RE: In the Matter of Benjamin I. Dyett, M.D.

EFFECTIVE DATE: 06/02/95

Dear Mr. Bavaro, Mr. Eberz and Dr. Dyett:

Enclosed please find the Determination and Order (No. 95-109) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 all action 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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER

OF

BENJAMIN I. DYETT, M.D.

DETERMINATION

AND

ORDER

BPMC-95-109

A Notice of Hearing and a Statement of Charges, dated November 30, 1994, were served upon the Respondent, Benjamin I. Dyett, M.D. **ANTHONY SANTIAGO (Chair), RALPH J. LUCARIELLO, M.D. and HILDA RATNER, 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)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Ralph J. Bavaro, Esq., Associate Counsel. The Respondent appeared by Meiselman, Farber, Packman & Eberz, James G. Eberz, 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.

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	December 14, 1994
Answer to Statement of Charges:	None
Pre-Hearing Conference:	January 6, 1995
Dates of Hearings:	January 17, 1995 February 28, 1995 March 7, 1995
Witness for Department of Health:	Jerome Greenholz, M.D.
Witness for Respondent:	Benjamin I. Dyett, M.D.

Received Petitioner's Proposed Findings of Fact and Conclusions	April 4, 1995
Received Respondent's Brief and Requested Instructions of Law	April 7, 1995
Deliberations Held:	April 20, 1995

STATEMENT OF CASE

The Statement of Charges alleged seventeen specifications of professional misconduct, including allegations of the fraudulent practice of medicine, gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion and failure to maintain adequate records.

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

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all Findings and Conclusions herein are the unanimous determination of the Hearing Committee. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Hearing Committee hereby makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. 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. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. BENJAMIN I. DYETT, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on September 23, 1957, by the issuance of license number 079907 by the New York State Education Department. (Petitioner's Exhibit 2[hereinafter "Pet.Ex."])

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995, through September 30, 1996, with a registration address of 200 Maple Avenue, White Plains, New York 10606-2606. (Pet. Ex. 25)

GENERAL FINDINGS

3. A physician's initial history of a patient should include a description of the patient's complaint, any previous treatment and the response thereto, the patient's past health including previous illnesses or surgery, if any, the patient's occupation and whether or not the patient smokes, drinks or uses drugs. (Transcript pp. 19-20 [hereinafter "T.19-20 " e.g.].)

4. A physician's initial physical examination of a patient should include an examination of the basic physical condition of the patient such as the patient's weight, blood pressure, status of the heart, lungs and abdomen, the general physical condition of the patient, any abnormalities. The results of the examination should be noted in the patient's record. (T.22-23)

5. To be of value to the treating physician or any other physician who subsequently treats the patient, the ongoing patient history should include a record of the condition or conditions for which he is treating the patient, the effectiveness and side effects,

if any, of the treatment and whether there is a need for follow up or referral elsewhere as part of the treatment. (T.25-26,42)

6. A physician's ongoing physical examination should include a record of physical findings relating to the complaint or problem for which the patient has come to the physician and any other pertinent findings. (T.27)

7. Preludin, Desoxyn and Ionamin are appetite suppressants which pose a danger of habituation and drug dependency. (T. 31,40-41)

8. Fastin is a stimulant related to the amphetamines. It is used as a diet pill. The risk of this drug is that it can be addictive. (T.67)

9. The concomitant prescribing of appetite suppressants and sedatives presents a danger to a patient. (Pet.Ex.24)

10. Long-term use of appetite suppressants alone, but especially in combination with sedatives, is contraindicated (T.86-90, 93-94; Pet.Ex.24).

11. Appetite suppressants rapidly produce tolerance and are potentially addictive. Their use can be detrimental to the central nervous and cardiovascular systems. (Pet.Ex.24)

12. Patients who are prescribed appetite suppressants on a long-term basis should be monitored for possible drug dependency. (T.40-41)

PATIENT A

13. Respondent treated Patient A, in his office from August 7, 1958

through September 14, 1994, for a total of approximately 246 visits. (Pet.Ex.2,24)

14. Patient A's initial complaint on August 7, 1958, was vaginal discharge for several days duration. (T.19; Pet.Ex.2)

15. Respondent's initial history notes are limited to patient's sensitivity to penicillin and a past history of hysterectomy. (T.19; Pet.Ex.2)

16. Physical examination notes are limited to "evidence of hysterectomy, irritated vaginal wall with marked (illegible)." (T.19; Pet.Ex.2)

17. The vast majority of subsequent office visit notes consist of one or two lines containing weight, blood pressure, and occasionally a prescription with no immediate history or other physical findings or indications for medications. (T.24-25,27; Pet.Exs.2,24)

18. Respondent prescribed appetite suppressants Preludin on October 30, 1964, Desoxyn on March 20, 1967 and Ionamin from November 11, 1980 to approximately March 26, 1982 for Patient A, without any indication for the initial necessity or the continuation of the medications, particularly the Ionamin, since Patient A's weight remained approximately constant from November 11, 1980 through March 20, 1982. (T.28-30; Pet.Exs.2,24).

19. Respondent's record contain no evidence that he addressed the problem of possible drug dependency. (T.40; Pet.Ex.2)

20. Respondent's records contain frequent notations of edema of the legs on various dates from 1972 through 1993, however, there is no evidence that Respondent evaluated that symptom or attempted to determine its cause. (T.24,36-40; Pet.Exs.2,24)

21. Patient A was hospitalized on March 8, 1983, but Respondent's office record does not state what the diagnosis or treatment was. A hospital record obtained by Respondent the week before he testified, disclosed that Patient A had been hospitalized for congestive heart failure . There are practically no progress notes regarding that condition in Respondent's record

subsequent to March 1983. (T.24; Pet.Ex.2; Res.Ex. Q)

22. On February 20, 1985, Patient A complained of pre-cordial chest pain with a normal EKG, and Respondent prescribed Procardia. However, the records of the following office visits contain no evidence of follow-up evaluation of the chest pain. (T.24-25; Pet.Ex.2)

23. Starting in January 1971, Patient A was prescribed diuretics on a near continuous basis throughout her period of treatment, . In some instances more than one diuretic was prescribed at the same time. The indicated monitoring for Patient A with regard to her use of diuretics was periodic testing every 3 to 4 months, of her electrolytes, blood sugar, and kidney function. Respondent ordered blood tests only twice, on June 7, 1988 and March 23, 1990. (T.34-36; Pet.Ex 2; Res.Ex. Q).

PATIENT B

24. Respondent treated Patient B in his office from January 30, 1971 through September 17, 1993 for a total of approximately 238 visits. (Pet.Ex. 3)

25. Respondent's initial medical history notes are limited to "Allergic to Penicillin." (Pet.Ex.3)

26. On the first office visit on January 30, 1971, Patient B complained of "signs and symptoms of the flu". (Pet.Ex.3)

27. Respondent's physical examination of this patient revealed a "temperature of 101 degrees, infected ears, nose and throat, harsh breath sounds in both lungs, soreness of all muscles". There is no evidence that Respondent took weight or blood pressure, or examined for lymphadenopathy, heart sounds, larynx exudate, or any other physical examination indicated for an initial office visit. (T.69-71; Pet.Ex.3)

28. In subsequent office visits through February 1992, Respondent's office entries contain primarily weight, blood pressure, and prescriptions, without any evidence of ongoing medical history, progress notes or physical examinations. Except for a few office visits, there is no indication as to why Patient B was being seen on a frequent basis, or what Respondent's treatment plan was. (T.73-74; Pet.Ex.3)

29. On September 24, 1971, Patient B was found to have glycosuria and a fasting blood sugar of 210, and was started on DBI-II. Subsequently, Patient B was placed on antidiabetic medications Dymelor, Tolinase, and Diabinase. The patient was then prescribed insulin. The record contains no explanation for the changes. (T.72, Pet.Exs. 3,24).

30. Respondent's record contains no mention of the presence or absence of diabetic symptoms. Respondent did not monitor Patient B for anticipated complications of diabetes. There is no evidence of evaluation or examination of Patient B's heart, peripheral pulses, kidneys, or eyes. The record contains no evidence of any discussion of exercise or foot care in relation to the treatment of diabetes. (T.72-73; Pet.Ex.3)

PATIENT C

31. Respondent treated Patient C from June 14, 1976 until September 18, 1993, for a total of approximately 236 visits. (Pet.Ex.4)

32. Respondent's initial medical history notes consist of the patient's social security number. (Pet.Ex.4)

33. On the initial office visit of June 14,1976, the "Present ailment" is noted to be "weight reduction" with "Penicillin Sensitivity." (Pet.Ex.4).

34. Respondent's initial physical examination consisted of recording the patient's weight, height and blood pressure. (T.85; Pet.Ex.4)

35. The vast majority of subsequent office visit entries through 1992 consist of one line containing the patient's weight, blood pressure, and a prescription. Throughout the record there is no evidence of ongoing medical history and physical examinations. (T.87; Pet.Ex.4).

36. Patient C's weight dropped to 156 lbs. on August 10, 1977, then steadily rose to the 195-205 lb. range by 1981, where it remained for over 12 years. (Pet.Ex.4).

37. Respondent alternatively prescribed the appetite suppressants Didrex, Dexosin, Ionamin, and Preludin throughout Patient C's period of treatment. Concomitantly, Patient C also received long-term prescriptions for the sedatives, Quaalude, Doriden, Restoril, and Placydil, respectively. (Pet.Ex.4)

38. Monitoring of this patient's heart rate was indicated on each visit. Also indicated were frequent physical examinations for possible side effects of medication such as the presence or absence of edema and tremors. (T.88)

39. Respondent's record contains no evidence that the patient's heart rate was monitored or that sufficient physical examinations were performed to detect possible side effects of the medications the patient was receiving. (T.87-88; Pet.Ex.4)

40. Respondent's records contain no evidence that he addressed the possible dependency as indicated, in view of Patient C being on amphetamines and sedatives. (T.91-94, Pet.Ex.4)

41. Patient C while being prescribed appetite suppressants and sedatives also received prescriptions for the diuretics Lasix and Hygroton, sometimes together. There is no evidence in the record of indications for the prescription of diuretics. (T.274; Pet.Ex.4)

42. Patient C also received prescriptions for thyroid medications Cytomel and Synthroid, in combination with the appetite suppressants. Those thyroid medications are particularly dangerous, and may produce life threatening toxicity when given in combination with sympathomimetic amines. Respondent

received a letter from Hudson Valley Blood Services on May 24, 1992, informing him that Patient C's liver function studies were elevated. However there is no evidence that Respondent investigated or conducted any follow laboratory tests. (T.90: Pet.Ex.4)

PATIENT D

43. Respondent treated Patient D from April 28, 1978 to September 13, 1993, for a total of approximately 225 visits.

44. Respondent's initial history note consists of the patient's medicare number and the effective date. (T.107. Pet.Ex.5)

45. Respondent's initial physical examination consisted of ascertaining the patient's blood pressure. (T.108, Pet.Ex.5)

46. On the patient's initial visit of April 28, 1978,.the Respondent noted under "Present ailment" an injury to the right knee 20 years ago; the fact that patient has taken several anti-arthritic medications and has developed a gastric ulcer; and that his symptoms are relieved by Percocet. (T.106; Pet.Ex.5)

47. Respondent's record of this patient' initial visit contained no past history or family history. (T.108; Pet.Ex.5)

48. The vast majority of subsequent office visit notes consisted of a the patient's blood pressure reading, weight and a prescription. (Pet.Ex. 5)

49. Patient D received monthly injections of Testosterone from November 11, 1980 to August 3, 1993. The record contains no diagnosis or rationale for this treatment. (T.109-110; Pet.Ex.5,24)

50. Respondent did not conduct any tests to ascertain whether the patient developed any side effects from the testosterone. (T.344; Pet.Ex.5)

51. Respondent did not determine whether Patient D's impotence had a physical or psychological etiology, nor did he in any clinical way attempt to determine this. (T. 352-355; Pet.Ex.5)

PATIENT E THROUGH PATIENT T

52. Respondent treated Patients E through T starting from November 11, 1978 for Patient E through September 21, 1993 for Patient K, with the initial and last treatment date for each patient falling within those dates. (Pet.Exs.6-21,24)

53. Respondent's initial history note for these patients, with one exception, consisted of either the patient's social security number, their health insurance I.D. number or in some instances there was no notation in the patient's initial history. (T.115-116, Pet.Exs.6-21,24)

54. Respondent's record of his initial physical for these patients, with two exceptions, consisted of recording the patient's weight and blood pressure. In one exception the patient's height was noted and in the other a notation regarding the patient's lungs was made. There is no evidence of any further physical examination on the initial visit. (Pet.Exs.6-21,24)

55. Respondent's record of the initial visit for each patient contained the notation "weight reduction" next to the pre-printed words "Present ailment". (Pet.Exs.6-21)

56. The vast majority of subsequent office visit notes for Patients E through T consisted of a recording of the patient's weight, blood pressure and a prescription. (Pet.Exs.6-21,24)

57. Respondent's records for these patients contained no evidence of further history such as past medical history, current medications if any, family history, occupation, social history such as exercise habits, smoking, drinking or past efforts at weight loss. (Pet.Exs.6-21)

58. Respondent's records for these patients contain no evidence of ongoing physical examination. (Pet.Exs.6-21)

59. Respondent prescribed appetite suppressants for Patients E through T

over a prolonged period of time (T.114-115, Pet.Exs.6-21)

60. Respondent's records for Patients E through T contain no evidence of clinical data or other indications to justify the long term prescribing of appetite suppressants. (Pet.Exs.6-21,24; Res.Ex. T)

61. Respondent's records for these patients contain no evidence that he provided or discussed diet counseling, exercise programs or behavior modification as a method of weight reduction.. (Pet.Exs.6-21,24)

62. The Respondent while prescribing appetite suppressants concomitantly prescribed Placidyl for Patients J, M and S. (T.123, Pet.Exs.6-21,24)

63. Respondent's records for Patients J, M and S contain no indication or justification for the prescribing of Placydil and the prolonged use of Placydil is contra indicated. (T.122-123; Pet.Exs.11,14 and 20; Res.Ex. T)

64. Respondent's records contain no evidence that he monitored Patients E through T for possible drug dependency as indicated. (Pet.Exs.6-21,24; Res.Ex.T)

PATIENT E

65. Respondent treated Patient E from October 7, 1978 through August 2, 1993 for a total of approximately 186 visits. (Pet.Ex. 6)

66. Respondent prescribed appetite suppressants for this patient throughout this period. Other than laboratory studies done on three occasions, the record contains no evidence of an initial medical history, initial or ongoing adequate physical examination, diagnosis or treatment plan. (T.115-116: Pet.Exs. 6,24)

PATIENT F

67. Respondent treated Patient F from July 20, 1979 through March 23, 1987 for a total of approximately 30 visits. (Pet.Ex.7)

68. Respondent prescribed appetite suppressants for Patient F for continuous and extended periods of time throughout the duration of his treatment. (Pet.Exs.7,24)

69. Patient F received injections of Testosterone and/or Deca-Durobolin throughout his treatment, without any medical history or clinical data to justify it. (T. 119-120; Pet.Exs. 7,24)

70. One known potential danger from receiving injections of Testosterone and Deca-Durobolin is liver disease. (T.110; Pet.Ex.24)

71. Respondent performed one laboratory test on Patient F on February 2, 1984, which showed an elevated SGOT and SGPT. No further investigation or treatment was implemented. (Pet.Ex.7)

PATIENT G

72. Respondent treated Patient G from November 4, 1980 through September 14, 1993 for a total of approximately 112 visits. (Pet.Ex.8)

73. Patient G was prescribed appetite suppressants throughout the period of treatment. (Pet.Ex.8)

74. Respondent while prescribing appetite suppressants for this patient, concomitantly prescribed the thyroid medication Cytomel on January 17, 1984 and from April 13, 1987 to at December 20, 1988. Respondent's records contain no evidence of an investigation regarding a thyroid condition. (Pet.Ex.8)

75. The use of Cytomel in combination with sympathomimetic amines is dangerous. (Pet.Ex.24)

PATIENT H

76. Respondent treated Patient H from April 16, 1983 through August 28, 1993, for a total of approximately 28 visits. (Pet.Ex.9)

77. Patient H was prescribed appetite suppressants throughout the period of treatment. (Pet.Exs.9,24)

78. Respondent while prescribing appetite suppresants for this patient, concomitantly prescribed the thyroid medication Cytomel throughout this patient's period of treatment. (Pet. Ex.9)

79. The use of Cytomel in combination with sympathomimetic amines is dangerous.

(Pet.Ex.24)

PATIENT I

80. Respondent treated Patient I from November 16, 1985 through September 18, 1993 for a total of approximately 55 visits. (Pet.Ex.10)

81. Her weight on the initial visit was 101 pounds. (Pet.Exs.10,24)

82. Respondent prescribed appetite suppressants for Patient I throughout her treatment period. (Pet.Exs.10,24)

83. With the exception of three office visits, the Respondent's records contain no evidence of the performance of a physical exam. (Pet.Ex.10)

84. Respondent performed one laboratory test and two urine pregnancy

tests during the approximately 8 years of treatment. (Pet.Ex.10).

PATIENT J

85. Respondent treated Patient J from April 30, 1986 through July 16, 1993, for a total of approximately 65 visits. (Pet.Ex.11)

86. Respondent prescribed appetite suppressants throughout Patient J's period of treatment. (Pet.Ex.11)

87. Respondent while prescribing appetite suppressants for this patient, concomitantly prescribed the sedatives Placydil and/or Meprobamate from approximately January 4, 1989 through March 7, 1990, on July 28, 1990, March 4, 1992 through September 9, 1992 and May 5, 1993 through July 16, 1993, and administered 11 injections of Testosterone in the course of his treatment of this patient, without any medical history or clinical data to justify it. (T.120-121; Pet.Ex.11)

PATIENT K

88. Respondent treated Patient K from October 21, 1986 through September 21, 1993, for a total of approximately 21 visits. (Pet.Ex.12)

89. Respondent prescribed an appetite suppressant throughout Patient K's period of treatment. (Pet.Ex.12)

PATIENT L

90. Respondent treated Patient L from October 10, 1988 to September 17, 1993, for a total of approximately 57 visits. (Pet.Ex.13)

91. Patient L's initial weight was 145 pounds. (Pet.Ex.13)

92. Respondent prescribed Plegine, a sympathomimetic amine, throughout her period of treatment. (Pet.Exs.13,24)

93. Respondent's records for this patient contain no justification for the continuous prescribing of Plegine. (Pet.Ex.13)

PATIENT M

94. Respondent treated Patient M from April 12, 1989 to August 9, 1993 for a total of approximately 50 visits. (Pet.Ex.14)

95. Respondent prescribed an appetite suppressant throughout Patient M's period of treatment. (Pet.Exs.14,24)

96. Respondent while prescribing an appetite suppressant for Patient M, concomitantly prescribed Placydil 750mg. throughout her period of treatment. (Pet.Ex.14)

97. A prescription dosage of 750mg. for Placidyl is the strongest dose available, and is only indicated as short term hypnotic therapy for periods of up to one week. (Pet.Ex.24)

PATIENT N

98. Respondent treated Patient N from October 27, 1989 to August 6, 1993, for a total of approximately 24 visits. (Pet.Ex.15)

99. Patient N was prescribed appetite suppressants throughout her period of treatment. (Pet.Ex.15)

100. Respondent while prescribing appetite suppressants for Patient N concomitantly prescribed Cytomel. (Pet.Ex.15)

PATIENT O

101. Respondent treated Patient O from April 5, 1991 to September 13, 1992, for a total of approximately 29 visits. (Pet.Ex.16)

102. Patient O was a 35-year old male, with an initial weight of 143 pounds and a height of 5 feet 6 inches. (T. 290; Pet.Ex16)

103. Patient O was within the acceptable weight range for a person of his height. (Pet.Ex.16; Res.Ex. X)

104. Throughout his period of treatment the patient's weight was within the 140-150 lbs. range. (Pet.Ex.16)

105. Respondent prescribed an appetite suppressant throughout this patient's period of treatment. (Pet.Ex.16)

PATIENT P

106. Respondent treated Patient P from April 17, 1991 to September 1, 1993 for a total of approximately 24 visits. (Pet.Ex.17)

107. Patient P was a female, whose initial weight was 146 pounds, and who is 5 feet 51/2 inches in height. (Pet.Ex. 17)

108. With the exception of her initial weight, throughout her period of treatment Patient P was within her acceptable weight range for a person of her height. (Pet.Ex. 17; Res.Ex. X)

109. Respondent prescribed appetite suppressants for Patient P throughout her period of treatment. (Pet.Exs.17,24)

PATIENT Q

110. Respondent treated Patient Q from August 16, 1991 to September 1, 1993, for a total of approximately 16 visits. (Pet.Ex.18)

111. Respondent prescribed a sympathomimetic amine throughout Patient Q's period of treatment. (Pet.Ex.18).

PATIENT R

112. Respondent treated Patient R from December 9, 1981 to September 13, 1993 for a total of approximately 126 visits. (Pet.Ex.19)

113. Respondent prescribed a sympathomimetic amine throughout this patient's period of treatment. (Pet.Exs.19,24)

PATIENT S

114. Respondent treated Patient S from January 1, 1993 to September 4, 1993 for a total of approximately 8 visits. (Pet.Ex.20)

115. Respondent prescribed a sympathomimetic amine throughout this patient's period of treatment. (Pet.Ex. 20)

116. Respondent while prescribing sympathomimetic amines for Patient S, concomitantly prescribed Placydil from April 12, 1993 to September 4, 1993. (Pet.Ex.20)

PATIENT T

117. Respondent treated Patient T from July 12, 1985 to September 13, 1993 for a total of approximately 81 visits. (Pet.Ex.21)

118. Respondent prescribed sympatomemathic amines throughout this patient's period of treatment. (Pet.Ex. 21)

PATIENT U

119. Respondent treated Patient U from November 14, 1968, to September 17, 1993, for a total of approximately 248 visits. (Pet.Ex.22)

120. Respondent's initial office visit record consists of the notation "URI" and a reference to the patient's ears, nose and throat. The record contains no past history or family history and no further physical examination. (Pet.Ex.22)

121. Respondent's records for Patient U's visits consist primarily of a notation of her weight, blood pressure and a prescription. (Pet.Exs.22,24)

122. Respondent's records indicate the patient was hospitalized from January 19, 1977 to January 27, 1977, on December 6, 1983 and from December 14, 1987 to December 19, 1987. With the respect to the first two hospitalizations, the Respondent's records contain no information regarding the reason for the hospitalization, findings, treatment or any follow-up care that may have been provided. With respect to the last hospitalization, Respondent's records do not contain any information regarding the treatment or any follow-up care that may have been provided. (Pet.Ex.22; Res.Ex. U)

PATIENT V

123. Respondent treated Patient V from February 6, 1969 to September

13, 1993, for a total of approximately 101 visits. (Pet.Ex.23)

124. Respondent's initial office record for this patient consisted of a notation regarding "URQ every 2 weeks" and a physical examination which "revealed marked tenderness URQ" The record contains no past history or family history notation and no further physical examination. (Pet.Ex.23)

125. Respondent's office visit records consist primarily of one line entries of either a weight, blood pressure and prescription or a present complaint and a prescription with no diagnosis. (Pet.Ex.23)

126. This patient was hospitalized in February 1969 and from January 25, 1977 to January 29. 1977. The Respondent's records do not contain any evidence of any follow up treatment relating to these hospitalizations. (Pet.Ex.23; Res.Ex. V)

Conclusions

The following conclusions were made pursuant to the Findings of Fact listed above. The Hearing Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A: (13);
Paragraph A.1: (15,17);
Paragraph A.2: (16,17,20,22,23);
Paragraph A.3: (18);
Paragraph A.5: (20);
Paragraph A.6: (23);
Paragraph A.7: (19);
Paragraph A.8: (16-18,20-22);
Paragraph B: (24);
Paragraph B.1: (25,28);
Paragraph B.2: (27,28,30);
Paragraph B.3: (30);
Paragraph B.4: (25,27-30);
Paragraph C: (31);
Paragraph C.1: (32,35)
Paragraph C.2: (34,35,39,42)
Paragraph C.3: (36,37,40,41);
Paragraph C.4: (36,37,40,42);
Paragraph C.6: (38,39,42);
Paragraph C.7: (40);
Paragraph C.8: (34,35,39,41,42);
Paragraph D: (43);

Paragraph D.1: (44,47,48);

Paragraph D.2: (45,48,50,51);

Paragraph D.3: (49-51);

Paragraph D.4: (49-51);

Paragraph D.5: (44,45,47-49,51);

Paragraph E: (52,55);

Paragraph E.1: [with the exception of the initial history (53,57)];

Paragraph E.2: (54,58,68,69,71,74,83);

Paragraph E.3: (59,60.61,66,68,73-75,77-79,82,86,87,89,91-93,95-97,99,100,102-105,107-109,111,113,115,116,118);

Paragraph E.5: (64);

Paragraph E.6: (53-58,60,63,66,69,74,93);

Paragraph E.7: (69,87);

Paragraph E.8: (62,63,87,96,97,116)

Paragraph F.: (119-122);

Paragraph G.: (123-126).

The Hearing Committee further concluded that the following Specifications should **be sustained**. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

First Specification: (Paragraphs A.,A.1-3,A.5-8,B.,B.1-4,C.,C.1-

4,C.6-8,D.,D.1-5,E.,E.1-3,E.5-8,F.,G.);

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Second Specification: (Paragraphs A.,A.1-3,A.5-8,B.,B.1-4,C.,C.1-4,C.6-8,D.,D.1-5,E.,E.1-3,E.5-8,F.,and G.);

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Third Specification: (Paragraphs A.,A.1-3 and A.5-8.);

Fourth Specification: (Paragraphs B. and B.1-4.);

Fifth Specification: (Paragraphs C., C.1-4 and C.6-8.);

Sixth Specification: (Paragraphs D. and D.1-5.);

Seventh Specification: (Paragraphs E.1-3 and E.5-8.);

FAILURE TO MAINTAIN ACCURATE RECORDS

Seventeenth Specification: (Paragraphs A.,A.8.,B.,B.,B.4.,C.,C.8,D.,D.5.,E.,E.6,F. and G.);

The Hearing Committee voted to **not sustain** specifications **eight** through **sixteen.**

DISCUSSION

Respondent was charged with seventeen 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 Peter J. Millock, 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:

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.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the

practice of medicine.

Fraudulent Practice of the Profession is an intentional misrepresentation or concealment of a know 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.

The Respondent in his post hearing brief requested the Hearing Committee be instructed to disregard all charges relating to conduct prior to July 26, 1991, the effective date of Chapter 606 of the Laws of 1991, which revised the definitions of misconduct applicable to physicians. However, that chapter stated that its provisions are applicable to cases in which a statement of charges has not been served prior to July 26, 1991, as was the case in this instance. (Section 32, Chapter 606 of the Laws of 1991) The Respondent alternatively requested the Hearing Committee be instructed to disregard all charges relating to record keeping which were based on conduct prior to August 2, 1977, since the predecessor to Ed. Law §6530 did not include the failure to maintain adequate records as an act of misconduct until that date. The Hearing Committee was instructed to alternatively base their determinations regarding all of the Specifications of Charges on the entire record of conduct, irrespective of the date of occurrence and with respect to specifications relating to record keeping, to only post-August 2, 1977 conduct, as set forth in the Findings of Fact herein. The determinations set forth above reflect those instructions.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that eight of the seventeen specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Jerome Greenholz, O.D., as its expert witness. Dr. Greenholz is a physician whose specialty is family practice. In

addition to being part of a group practice of family practitioners, Dr. Greenholz is currently the chairman of the Department of Family Practice at Brunswick Hospital, Amityville, New York and serves as a preceptor for third year students from SUNY-Stony Brook Medical School, who are interested in specializing in family practice medicine. This witness testified that the Respondent's initial and ongoing history-taking and initial and ongoing physical examinations did not meet acceptable standards of medical practice. There was no evidence of any bias on the part of Dr. Greenholz or his unsuitability as an expert witness. Dr. Greenholz also testified that the Respondent's prescribing practices for the Patients A through T was inappropriate and did not meet acceptable standards of medical care. The evidence regarding Respondent's care of Patients A through T -the 20 patients that are the subject of substantive charges -demonstrates a clear pattern of substandard medical practice. Among Respondent's departures from acceptable standards were his failures to obtain and/or perform adequate histories and physical examinations, appropriately prescribe medications, and maintain adequate records.

The Hearing Committee largely disregarded the testimony of Respondent as evidence because it did not find it credible.

Petitioner presented testimony as to the need for careful monitoring of diabetics, especially f or early signs of cardiovascular problems and that careful history taking and regular EKGs are essential. All of that was lacking in Respondent's care of Patient B.

The record indicates the Respondent's prescribing of Testosterone was done without the indicated evaluation such as history, physical examination, laboratory tests and endocrine studies. Similarly, the record contains no evidence justifying the prescribing of diuretics nor did the Respondent perform the indicated laboratory tests of electrolytes, blood sugar, and kidney function.

The record also indicates that for a great majority of the patient's

whose records were presented to the Hearing Committee, amphetamine or amphetamine-like substances were prescribed on a long term basis yet there is no evidence that Respondent ascertained whether the patients were suffering from nervousness, sleep loss, social or occupational disfunction, or other symptoms of psychological dependence despite the dangers associated with the prolonged use of amphetamines. The fact that Patients E through T were on sympathomimetic amines for extensive periods of time suggests that they were in fact habituated. That is especially true with respect to the patients, who despite long term use, did not lose weight or were already within their normal weight range. This long term prescribing of amphetamines was compounded and made more dangerous in those instances of concomitant prescribing of sedatives.

In all cases Respondent failed to take an adequate history of immediate complaints and of past history. That failure was particularly noticeable on initial visits, where applicable, where a complete history is an essential element of standard care. An initial history ought to include an elaboration of the immediate complaint, previous treatment and response if any, previous illnesses and medications, social history, and family history. There is no credible evidence that the Respondent performed adequate initiate histories on Patients A through D. Also on subsequent visits, history taking is essential. Details of new complaints must be elicited, progress and possible side effects of present treatment must be monitored. There is no evidence that Respondent engaged in adequate history taking on an ongoing basis during the extensive periods of time that he treated Patients A through T.

Respondent failed to perform adequate physical examinations on initial office visits and on a follow-up basis. In addition to an examination directed at the immediate area of complaint, physical examinations on an initial office visit should include, at a minimum, an examination of heart, lungs,

abdomen, eyes, ears, and extremities. On a follow-up basis further examination should be done relevant to the particular problem for which the patient is being treated. Respondent consistently failed to follow these indications. Respondent's ongoing physical examinations, with only a relatively few exceptions, consisted of weight and blood pressure only.

Respondent's recordkeeping for Patients A through T, U and V was such that a subsequent treating physician could not obtain sufficiently meaningful or accurate information about the condition of those patients.

Petitioner's exhibits 2 through 23 are Respondent's office records for patient's A through V respectively. Those records were certified by Respondent as complete, true and exact copies of the originals and were provided to the Department of Health in approximately April 1994. However, during the hearing Respondent produced additional folders consisting of ancillary documents such as laboratory and hospital reports for Patients A, B, D, S, U and V. Respondent testified that those ancillary documents corresponded to notations already contained in the previously certified records, i.e. exhibits 2, 3, 5, 20, 22 and 23 respectively. However, those folders did not contain evidence of history, physical examinations, diagnoses, treatment, progress notes or justifications for medication. They therefore did not change the Hearing Committee's findings with respect to the substantive charges against Respondent. They were also not significant in terms of elevating the quality of Respondent's recordkeeping to generally acceptable standards.

Practicing with Negligence on More Than One Occasion

As noted above, the Hearing Committee voted to sustain Five specifications of gross negligence on the part of the Respondent. Therefore, his conduct also constituted negligence on more than one occasion. As a result, the Hearing Committee voted to **sustain** the First Specification.

Practicing with Incompetence on More Than One Occasion

The Hearing Committee relied on the General Counsel's memorandum, as noted above, to define "incompetence." That memorandum citing the case of Storrs v. State Medical Board, 664 P.2d 547 (Alaska 1983), defined professional incompetence as the lack of sufficient knowledge or skills or both in the field of practice to a degree likely to endanger patients. Based on that definition and applying it to the evidence the Hearing Committee concluded the Respondent's treatment of Patient's A through T exhibited the attributes cited in the definition of incompetence. The Petitioner's expert testified that both in his prescribing practices and in his failure to adequately treat his patients, the Respondent's patients were endangered. Therefore the Hearing Committee voted to **sustain** the Second Specification.

Practicing the Profession with Gross Negligence

Gross negligence has been defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. The record clearly established the fact that Respondent repeatedly failed to meet the appropriate standards of care with respect Patients A through T. As was noted Respondent prescribing practices were inappropriate and posed a risk to his patients. Respondent's gross negligence was also manifested on the numerous occasions where he failed to perform initial and appropriate follow-up physical examinations and tests.

The Hearing Committee unanimously concluded that Respondent's conduct regarding Patients A through T constituted an egregious failure to exercise the care that would be exercised by a reasonably prudent physician. As a result, the Committee voted to **sustain** the Third through Seventh Thirteenth Specifications.

Practicing the Profession with Gross Incompetence

Gross incompetence has been determined to be a complete lack of ability necessary to perform an act in connection with a professional practice. The term has not been specifically defined by the New York courts. However, it has been defined by the Court of Appeals of North Carolina using Webster's Third New International Dictionary (unabr. 1968), as a complete, utter and unmitigated lack of physical, intellectual or moral ability. Applying that definition to this matter, the Hearing Committee concluded that the Respondent's conduct as set out in the record did not fall within that definition. The Hearing Committee felt that it could not impute that the Respondent's actions as presented by the Petitioner represented a complete lack of ability to practice the profession. Accordingly the Hearing Committee voted to **not sustain** Specifications Eight through Twelve.

Practicing the Profession Fraudulently

The fraudulent practice of medicine, as noted above, is an intentional misrepresentation or concealment of a known fact. The individual's knowledge can be inferred. In this case the Hearing Committee concluded that although the Respondent's prescribing practices were inappropriate they did not constitute the fraudulent practice of the profession since they could not infer from the evidence presented that the Respondent had the requisite knowledge or intent to support the charge. Based on the record the Hearing Committee did not feel it could infer that the Respondent was acting in a fraudulent manner when he prescribed for Patients A through T.

Therefore the Hearing Committee voted to **not sustain** Specifications Thirteen through Sixteen.

Failure to Maintain Adequate Records

The Department also alleged that Respondent failed to maintain accurate medical records for Patients A through V. The evidence clearly established that Respondent did not maintain a adequate medical record for these patients. The Petitioner's expert witness testified that for each patient the medical record did not meet the accepted standard of care in that they would not be of use to a subsequent treating physician. The Hearing Committee reviewed the record, in particular the exhibits which represented the Respondent's medical records for the patient's in question and concurred with the Petitioner's expert. Based on that conclusion the Hearing Committee voted to sustain Specification Thirteen.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions 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 in this case clearly established that Respondent inappropriately issued prescriptions for potentially dangerous substances. By doing so, he put his patients at risk. Respondent demonstrated gross negligence and incompetence practice of medicine.

Any individual who receives a license to practice medicine is placed into a position of public trust. Respondent essentially forfeited his right to that public trust, by his prescribing practices and the manner in which he conducted his practice. Respondent abdicated his responsibility to exercise his skill and

judgment for the benefit of his patients.

The Hearing Committee unanimously determined that no sanction short of revocation would adequately protect the public.

ORDER

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

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

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

DATED: New York, New York
May 25, 1995

ANTHONY SANTIAGO (CHAIR)
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APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
BENJAMIN I. DYETT, M.D.	:	CHARGES

----------X

BENJAMIN I. DYETT, M.D., the Respondent, was authorized to practice medicine in New York State on September 23, 1957 by the issuance of license number 079907 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 at 200 Maple Avenue, White Plains, New York 10606.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (all patients mentioned herein are more fully identified in Appendix A) at his office at 200 Maple Avenue, White Plains, N.Y., from on or about August 7, 1958 through September 14, 1993. During that time Respondent:

1. Failed to adequately elicit initial and on-going history.

2. Failed to perform adequate or sufficiently frequent physical examinations.

3. Inappropriately continued prescriptions for appetite suppressants without justification.

4. Inappropriately continued prescriptions for appetite suppressants without good faith medical purpose.

5. Failed to evaluate frequent symptoms of edema.

6. Failed to perform adequate laboratory monitoring despite frequent prescribing of diuretics.

7. Failed to perform and/or document evaluation regarding possible drug dependence.

8. Failed to document sufficiently meaningful information regarding evaluation and treatment.

B. Respondent treated Patient B in his office from on or about January 30, 1971 through September 17, 1993. During that time Respondent:

1. Failed to adequately elicit initial and on-going history.

2. Failed to perform adequate or sufficiently frequent physical examinations.

3. Failed to adequately evaluate diabetes.

4. Failed to document sufficiently meaningful information regarding evaluation and treatment.

C. Respondent treated Patient C in his office from on or about June 14, 1976 through September 18, 1993. During that time Respondent:

1. Failed to adequately elicit initial and on-going history.

2. Failed to perform adequate or sufficiently frequent physical examinations.

3. Inappropriately prescribed appetite suppressants, sedatives, and diuretics, in combination, without justification.

4. Inappropriately prescribed appetite suppressants on a long term basis without justification.

5. Inappropriately prescribed appetite suppressants and sedatives without good faith medical purpose.

6. Failed to perform adequate laboratory monitoring.

7. Failed to perform and/or document evaluation regarding possible drug dependence.

8. Failed to document sufficiently meaningful information regarding evaluation and treatment.

D. Respondent treated Patient D in his office from on or about April 28, 1978 through September 13, 1993. During that time Respondent:

1. Failed to adequately elicit initial and on-going history.

2. Failed to perform adequate or sufficiently frequent physical examinations.

3. Inappropriately administered testosterone from on or about November 3, 1980 through August 3, 1993 without justification.

4. Inappropriately administered testosterone from on or about November 3, 1980 through August 3, 1993 without good faith medical purpose.

5. Failed to document sufficiently meaningful information regarding evaluation and treatment.

E. Respondent treated Patients E through T, in his office for "weight reduction", (Dates of treatment are set forth in Appendix A). Respondent:

1. Failed to adequately elicit initial and on-going history.

2. Failed to perform adequate or sufficiently frequent physical examinations.

3. Inappropriately prescribed appetite suppressants without justification.

4. Inappropriately prescribed appetite suppressants without good faith medical purpose.

5. Failed to perform and/or document evaluation regarding possible drug dependence.

6. Failed to document sufficiently meaningful information regarding evaluation and treatment.

7. With respect to Patients F and J, Respondent administered testosterone without justification.

8. With respect to Patients J, M, and S, Respondent inappropriately prescribed Placidyl without justification.

F. Respondent treated Patient U in his office from on or about November 14, 1968 to September 17, 1993. Respondent failed to document sufficiently meaningful information regarding evaluation and treatment.

G. Respondent treated Patient V in his office from on or about February 8, 1969 through September 13, 1993. Respondent failed to document sufficiently meaningful information regarding evaluation and treatment.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1994) in that Petitioner charges two or more of the following:

1. The facts contained in Paragraphs A and A1-A8, B and B1-B4, C and C1-C8, D and D1-D5, E and E1-E8, F, and/or G.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1994), in that Petitioner charges two or more of the following:

2. The facts contained in Paragraphs A and A1-A8, B and B1-B4, C and C1-C8, D and D1-D5, E and E1-E8, F and/or G.

THIRD THROUGH SEVENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1994), in that Petitioner charges:

3. The facts contained in Paragraphs A and A1-A8.

4. The facts contained in Paragraphs B and B1-B4.

5. The facts contained in Paragraphs C and C1-C8.

6. The facts contained in Paragraphs D and D1-D5.

7. The facts contained in Paragraphs E and E1-E8.

EIGHTH THROUGH TWELFTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1994), in that Petitioner charges:

8. The facts contained in Paragraphs A and A1-A8.

9. The facts contained in Paragraphs B and B1-B4.

10. The facts contained in Paragraphs C and C1-C8.

11. The facts contained in Paragraphs D and D1-D5.

12. The facts contained in Paragraphs E and E1-E8.

THIRTEENTH THROUGH SIXTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1994), in that Petitioner charges:

13. The facts contained in Paragraphs A and A1-A8.

14. The facts contained in Paragraphs C and C1-C8.

15. The facts contained in Paragraphs D and D1-D5.

16. The facts contained in Paragraphs E and E1-E8.

SEVENTEENTH SPECIFICATION

FAILURE TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32)(McKinney Supp. 1994), in that he failed to maintain records for patients which accurately reflected the evaluation and treatment of the patients. Petitioner charges:

17. The facts contained in Paragraphs A and A8, B and B4, C and C8, D and D5, E and E6, F and G.

DATED: New York, New York
November 30, 1994

CHRIS STERN HYMAN
COUNSEL
Bureau of Professional Medical Conduct