STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

May 21, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Gilbert J. Elian, M.D.
9976 Northwest 64th Court
Parkland, Fl 33076

Scott I. Einiger, Esq.
Fager & Amsler
2 Park Avenue 26th Floor
New York, New York 10016

Paul Stein, Esq.
NYS Department of Health
5 Penn Plaza Sixth Floor
New York, New York 10001

RE: In the Matter of Gilbert J. Elian, M.D.

Dear Dr. Elian, Mr. Einiger and Mr. Stein:

Enclosed please find the Determination and Order (No. 97-117) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:nm
Enclosure

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

COPY

IN THE MATTER

OF

GILBERT J. ELIAN, M.D.

DETERMINATION

AND

ORDER

BPMC - 97 - 117

CONRAD ROSENBERG, M.D., (Chair), **JACK SCHNEE, M.D.** and **CAROL LYNN HARRISON, Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, ("**ALJ**") served as the Administrative Officer.

The Department of Health appeared by **PAUL STEIN, ESQ.**, Associate Counsel.

Respondent, **GILBERT J. ELIAN, M.D.**, appeared personally and was represented by the law firm of **FAGER & AMSLER, SCOTT I. EINIGER, ESQ.**, of counsel.

A Hearing was held on April 15, 1997. Evidence was received and examined, including witnesses who were sworn or affirmed. A transcript of the proceeding was made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York. (§ 230 et seq. of the Public Health Law of the State of New York ["**P.H.L.**"]).

This case, brought pursuant to P.H.L. § 230(10)(p), is also referred to as an "expedited hearing". The scope of an expedited hearing is strictly limited to evidence or sworn testimony relating to the nature and severity of the penalty (if any) to be imposed on the licensee[1] (Respondent).

GILBERT J. ELIAN, M.D., ("**Respondent**") is charged with professional misconduct within the meaning of § 6530(9)(b) of the Education Law of the State of New York ("**Education Law**"), to wit: "professional misconduct ... by reason of having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state ..." (§ 6530[9][b] of the Education Law) and (Petitioner's Exhibit # 1 [First Specification]).

In order to find that Respondent committed § 6530(9)(b) misconduct, the Hearing Committee must determine: (1) whether Respondent was found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state and (2) whether Respondent's conduct on which the findings were based would, if committed in New York State, constitute professional misconduct under the laws of New York State.

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

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[1] P.H.L. § 230(10)(p), fifth sentence.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence or testimony was considered and rejected in favor of the cited evidence. All Findings and Conclusions herein were unanimous. The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was authorized to practice medicine in New York State on July 28, 1970 by the issuance of license number 106691 by the New York State Education Department (Petitioner's Exhibits # 1 & # 2)[2].

2. On December 30, 1996, Melvin A. Gross personally served on Respondent a copy of a "Notice of Referral Proceeding, Statement of Charges & Summary of Health Dept. Hearing Rules" (Petitioner's Exhibit # 1).

3. The State Board For Professional Medical Conduct has obtained personal jurisdiction over Respondent (Respondent was personally served and had no objection to the personal service effected on him); (P.H.L. § 230[10][d]); (Petitioner's Exhibit # 1); [P.H.T-14, 15]; [T-20][3].

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[2] Refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit) or exhibits submitted by Dr. Elian (Respondent's Exhibit).

[3] Numbers in brackets refer to Hearing transcript page numbers [T-]; OR to Pre-Hearing transcript page numbers [P.H.T-]. The Hearing Committee did not review the Pre-Hearing transcript but was advised of the relevant evidentiary legal decisions or rulings made by the ALJ. [P.H.T-6-7]. The Hearing Committee did not have access to the ALJ Exhibits which were marked for identification purposes [P.H.T-36].

4. The Division of Medical Quality of the Medical Board of the State of California ("**California Board**") is a state agency charged with regulating the practice of medicine pursuant to the laws of the State of California (Petitioner's Exhibits # 3, 4, 5 & 6); (Respondent's Exhibit # B of B[4]).

5. On October 11, 1989, the California Board charged (accusation # D--4090) Respondent with unprofessional conduct in the care and treatment of two patients. On April 9, 1990, a first supplemental accusation was issued and on September 14, 1990, a second supplemental accusation was issued (Petitioner's Exhibits # 3, 4 & 5); (Respondent's Exhibit # A).

6. In total, Respondent was charged in the accusations with unprofessional conduct in the care and treatment of six elderly patients during the period from January 1989 through August 1989 (Petitioner's Exhibits # 3, 4 & 5); (Respondent's Exhibit # A).

7. The charges by the California Board involve allegations of gross negligence, gross incompetence, repeated negligent acts, the alteration or falsification of medical records with fraudulent intent, dishonesty and excessive prescribing or administering of treatment as to the six patients indicated in the accusations (Petitioner's Exhibits # 3, 4 & 5); (Respondent's Exhibit # A).

8. After 24 days of hearings in California, Respondent (a board certified ophthalmologist since 1976) was found to have committed, by clear and convincing proof to a reasonable certainty, unprofessional conduct in that: (1) he was grossly negligent in the care and treatment he provided to four patients; (2) he committed acts of dishonesty as to the care and treatment he provided to four patients; (3) his conduct involved clearly excessive prescribing of treatment for four patients; and (4) he committed repeated acts of negligence in his conduct with six patients (Petitioner's Exhibit # 6); (Respondent's Exhibit # B of B); [T-59].

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[4] Respondent's Exhibit # B of B (the California Board and the California ALJ decision) was omitted from Respondent's Exhibit # B (which was partially admitted in evidence) since it was the same document as Petitioner's Exhibit # 6 [P.H.T-34-35, 91]; [T-7, 21].

9. The decision of the California Board states that (as to three patients) "Respondent's conduct in scheduling [name of patient] for cataract surgery was an extreme departure from the standard of practice of medicine." (Petitioner's Exhibit # 6); (Respondent's Exhibit # B of B).

10. In adopting the ALJ's July 31, 1991 decision, the California Board, on May 21, 1992, made an additional finding of fact and changed the penalty to outright revocation of Respondent's license to practice medicine with no stay of revocation and no probation. The California Board's decision reflected five separate revocations based on the five separate determinations made by the California ALJ (Petitioner's Exhibit # 6); (Respondent's Exhibit # B of B).

11. The California Board's May 21, 1992 decision was appealed through the California Courts (Respondent's Exhibits # A, C of B and C-1 of B).

12. The Court of Appeal of the State of California, Second Appellate District, Division Four, filed a decision on August 8, 1994 in which it essentially affirmed the California Board's May 21, 1992 decision, including the revocation sanctions (Respondent's Exhibit # C-1 of B).

13. On March 23, 1995 (effective April 21, 1995), a final Order was issued ("**Order**") by the California Board which revoked Respondent's certificate to practice medicine in California (Petitioner's Exhibit # 6); (Respondent's Exhibit # B of B).

14. Respondent's conduct constituted violations of California Business and Professions Code [§ 2234(b)[5]; § 2234(e)[6]; and § 725[7]]; (Petitioner's Exhibit # 6); (Respondent's Exhibit # B of B).

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[5] Gross Negligence.

[6] The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician or surgeon.

[7] Repeated acts of clearly excessive prescribing or administering of drugs or treatment ... as determined by the standard of the community of licenses is unprofessional conduct ...

15. The Hearing Committee accepts the 1995 Order of the California Board and adopts it, together with the 30 page Findings of Fact issued by the California ALJ, as amended, as part of its own Findings of Fact (Petitioner's Exhibit # 6); (Respondent's Exhibit # B of B).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the Factual Allegations (A.1 through A.5.), from the December 20, 1996 Statement of Charges, are SUSTAINED.

The Hearing Committee further concludes, based on the above Factual Conclusion, that the FIRST SPECIFICATION OF CHARGES in the Statement of Charges is SUSTAINED.

The Hearing Committee concludes that the Department of Health has shown by a preponderance of the evidence that Respondent was found guilty of improper professional practice and of professional misconduct by the State of California and his conduct in California would constitute professional misconduct under the laws of New York State. The Department of Health has met its burden of proof.

I Professional Misconduct under § 6530(9)(b) of the Education Law.

The California Board is a duly authorized professional disciplinary agency. In October 1989, April, 1990 and September 1990, the State of California, through the California Board, instituted disciplinary action against Respondent.

The 1995 (1992 prior to the court appeals) final Order of the California Board contains facts and conclusions which establish that Respondent's conduct constituted grounds for revocation of his California medical license. Respondent admitted to the New York Hearing Committee that the California Board has decided that misconduct by Respondent has occurred.

The final Order has findings, by the California Board, of guilt of violations of California Statutes. The California Board found by clear and convincing evidence to a reasonable certainty that Respondent committed unprofessional conduct in the practice of medicine by being grossly negligent on at least three (3) separate occasions in the care and treatment he provided to three (3) separate patients. In addition, Respondent committed unprofessional conduct in the practice of medicine by committing repeated acts of negligence; being dishonest in his care and treatment to his patients and prescribing cataract surgery which was excessive treatment for the particular patients and their circumstances. Respondent was found guilty of improper professional practice or professional misconduct by the California Board.

The record establishes that Respondent committed the New York equivalent of professional misconduct pursuant to at least § 6530(3)[8]; § 6530(4)[9] and § 6530(35)[10]; of the Education Law.

Respondent's acts constituted gross negligence and negligence on more than one occasion in that he scheduled patients for cataract surgery where it was not warranted and at least once where it was specifically contraindicated.

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[8] Each of the following is professional misconduct... Practicing the profession with negligence on more than one occasion;

[9] Each of the following is professional misconduct... Practicing the profession with gross negligence on a particular occasion;

[10] Each of the following is professional misconduct... Ordering of excessive tests, treatment, ... not warranted by the condition of the patient;

Respondent's acts and conduct also constituted dishonest and unethical practice in his attempts to persuade his patients to undergo cataract surgery where said surgery was not warranted and at least once where it was specifically contraindicated. The repeated scheduling of cataract surgery by Respondent, for patients where cataract surgery was not warranted and at least once where it was specifically contraindicated, constitutes the ordering of excessive treatment by Respondent.

Taking the findings of the California Board as true, the Hearing Committee finds that the record establishes that Respondent is guilty of (1) practicing the profession with gross negligence; (2) practicing the profession with negligence on more than one occasion; and (3) the ordering of excessive treatment where not warranted by the conditions of the patients.

Since the Hearing Committee has determined that Respondent's conduct, if committed in New York State, would constitute professional misconduct under § 6530(3); § 6530(4); and § 6530(35) of the Education Law, Respondent has therefore committed professional misconduct pursuant to § 6530(9)(b) of the Education Law.

DETERMINATION

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

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

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

Respondent testified on his own behalf and presented Dr. Lewis Gordonson as an expert (board certified) in the field of Ophthalmology and as a character witness. With regard to the testimony presented, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility.

Respondent admits to being disciplined in California. However Respondent strenuously and vehemently denies that his conduct and actions in California constitute professional misconduct in New York. Respondent misunderstands or is unwilling to understand that treating a patient negligently in California by departing from the standard of practice in California (whatever the standard of practice is or was in California) is no different than the failure to exercise the care that would be exercised by a reasonably prudent person under the circumstances in New York.

When a licensee has deviated from acceptable medical standards in the treatment of a patient, the licensee has breached the duty of care and is negligent. For example, Respondent asserts that multiple standards of care exist concerning offering cataract surgery to a patient. Respondent's assertion is misplaced. California has found and determined that Respondent has breached the standard of care for California and on more than one occasion has done so egregiously (extreme departure)[11]. This alone is sufficient for a finding of misconduct in New York.

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[11] This determination was made eventhough the California Board's decision indicates "There was three major differences of opinion between respondent's expert witnesses and some of complainant's experts. All three were resolved in favor of respondent, ..." (Petitioner's Exhibit # 6); (Respondent's Exhibit # B of B).

The California Board found that: Respondent pressured a patient to agree to surgery; Respondent scheduled cataract surgery where it was contraindicated; Respondent failed to reveal significant facts and even gave misinformation to a patient regarding the potential benefits and success of cataract surgery for that patient; and Respondent unethically continued to urge surgery after the patient had elected not to have the surgery. The findings of fact reported do not show one isolated incident but appear to be illustrative of Respondent's persistent unwillingness to follow established criteria and the safe practice of medicine (irrespective of liberal or conservative views or spectrum or continuum of care or organizational philosophical ideation).

Whether Respondent's position was supported by leading experts, whether there were raging debates and splits in the California Ophthalmologic community or whether all the experts agreed that there exists a tremendous amount of variability and subjectivity in grading cataracts is irrelevant to this New York expedited hearing as to whether Respondent's conduct in California constitutes professional misconduct in New York.

The California ALJ's report is replete with examples of Respondent's claims, testimony or assertions that the ALJ found lacked credibility. This lack of credibility was presented to the New York Hearing Committee by Respondent in person.

For example, Respondent testified "We told everybody, I never went out personally, my staff went out, but they were instructed to tell all patients if there were any problems about the eyesight, they were to go back to their own doctor." This is inconsistent with the findings of the California Board which indicates that Respondent pressured the patients in question to undergo the cataract surgery and was angry when confronted by a second opinion. Another example involves Respondent's belief that " I think if I'm guilty of anything I'm guilty of being in the liberal spectrum of ophthalmologists.". This belief fails to address all the other issues raised (or resolved by the California ALJ) by the decision of the California Board (ie: pressuring patients; failure to reveal

significant facts to patients; providing misinformation to patients; pressing for surgery where contraindicated). Respondent fails to see or admit there was more involved in California than the difference between a liberal spectrum versus a conservative spectrum.

Dr. Gordonson testified about the appropriateness of recommending cataract surgery as follows: " I tell my patients, I don't make the decision, they make the decision. I ask them, is this impairing your quality of life?" According to the record, Respondent did not leave that option to his patients, but he made the decision for them and apparently with insufficient information.

The Hearing Committee also notes that the California ALJ expressed that Respondent did not appear to have a concern for the welfare of his patients. The Hearing Committee further notes that the California Board added as a finding of fact that "the public needs to be adequately protected" and then the California Board amended the ALJ's recommendation to outright revocation of Respondent's California license to practice medicine with no stay of the revocation and no probation.

The record clearly establishes that Respondent committed significant misconduct in California. The fact that Respondent's license was revoked in California (where they heard all the experts) was significant to the Hearing Committee. With regard to the issue of sanctions, the Hearing Committee recognizes that it is a generally accepted principal that the State where Respondent lived and practiced medicine at the time of the offense has the greatest interest in the issue and the public policy considerations relevant to such disciplinary actions. However the Hearing Committee does not rubber stamp the California Board's decision but makes an independent evaluation of what the appropriate penalty should be in New York.

The Hearing Committee has considered the mitigation presented by Respondent, including the numerous attempts at relitigation of the findings of the California Board. Taken, *in toto*, and even if they were accepted as completely accurate, Respondent has not presented sufficient reasons to even tip the scale slightly against total and absolute revocation in New York.

In arriving at the severity of the penalty to be imposed, the Hearing Committee has reviewed all of the evidence presented by the parties, including: the California Board and California ALJ decision; the complete record, which indicates, inter alia, that Respondent has had the opportunity to fully contest the matter through the California system; the assertion that there was significant disagreement as to the beliefs of the experts presented by both sides; the no action (as of April 15, 1997) taken by the Medical Review Board of the State of Hawaii; the expert and character support of Dr. Richard D. Klotz and Dr. Kenneth J. Hoffer; the letter submitted by the President of the California Association of Ophthalmology; the numerous letters in support of Respondent; the testimony of Dr. Gordonson; and most importantly, the testimony and demeanor of Respondent himself.

The Hearing Committee cannot ignore the weight of the evidence. The California Board has indicated that any ONE of the five separate determinations of violations of the California Business and Professions Code sections is sufficient to revoke Respondent's license.

The Hearing Committee rejects Dr. Gordonson's belief that the penalty by the California Board "was outrageous, the result was egregious, a miscarriage of justice". Taken in the aggregate, the Hearing Committee concludes and determines that the only appropriate penalty, under the circumstances presented here, is the revocation of Respondent's license to practice medicine in New York. Based on all the evidence presented, the Hearing Committee determines that the same actions taken in the State of California are necessary in New York to adequately protect the People of the State of New York. Accordingly, Respondent's license to practice medicine in the State of New York should be revoked.

The Hearing Committee concludes that if this case had been held in New York, on the facts presented relative to Respondent's acts of gross negligence, repeated acts of negligence, dishonesty and excessive proposed treatments, the Hearing Committee would have voted unanimously for revocation of Respondent's license.

The Hearing Committee considers Respondent's misconduct to be very serious. With a concern for the health and welfare of patients in New York State, the Hearing Committee determines that revocation of Respondent's license is the appropriate sanction to impose under the totality of the circumstances presented.

All other issues raised have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The Specification of professional misconduct contained within the Statement of Charges (Petitioner's Exhibit # 1) is **SUSTAINED,** and

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

DATED: **New York, New York**
May 19, 1997

CONRAD ROSENBERG, M.D., (Chair),
JACK SCHNEE, M.D.
CAROL LYNN HARRISON, Ph.D.

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APPENDIX I

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

IN THE MATTER

OF

GILBERT J. ELIAN, M.D.

STATEMENT

OF

CHARGES

GILBERT J. ELIAN, M.D., the Respondent, was authorized to practice medicine in New York State on July 28, 1970 by the issuance of license number 106691 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. 1. On or about October 11, 1989, the Board of Medical Quality Assurance, State of California (hereinafter referred to as "the Board"), issued an Accusation alleging that Respondent was guilty of, inter alia, gross negligence, repeated negligent acts, and clearly excessive prescribing or treating in connection with the care and treatment of two patients at the San Jose Eye Center.

2. On or about April 9, 1990, the Board issued a First Supplemental Accusation alleging that Respondent was guilty of, inter alia, gross negligence, repeated negligent acts, and clearly excessive prescribing or treating in connection with the care and treatment of three additional patients at the San Jose Eye Center.

3. On or about September 14, 1990, the Board issued a Second Supplemental Accusation alleging that Respondent was guilty of, inter alia, gross negligence, repeated negligent acts, and

clearly excessive prescribing or treating in connection with the care and treatment of one additional patient at the San Jose Eye Center.

4. On or about March 23, 1995, the Board issued a Decision, which had been originally ordered on or about May 21, 1992, but had been delayed by an Order Delaying Decision issued on or about April 16, 1992. The Decision found Respondent guilty, inter alia, of gross negligence, repeated negligent acts, and clearly excessive prescribing or treating, in violation of sections 2234(b), 2234(c), and 725 of the California Business and Professions Code.

5. The Decision revoked Respondent's license to practice medicine in the state of California.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

HAVING BEEN FOUND GUILTY OF PROFESSIONAL MISCONDUCT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(b)(McKinney Supp. 1996) by having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state, namely:

a. Practicing the profession with gross negligence on a particular occasion (N.Y. Educ. Law sec. 6530 (4) (McKinney Supp. 1996));

b. Practicing the profession with negligence on more than one occasion (N.Y. Educ. Law sec. 6530 (3) (McKinney Supp. 1996)); and/or

c. Ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient (N.Y. Educ. Law sec. 6530 (35) (McKinney Supp. 1996)).

as Petitioner specifically alleges:

1. The facts in Paragraph A1 through A5.

Dated: New York, New York
December 20, 1996

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct