Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

C. Maynard Guest, M.D.
Executive Secretary

January 30, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Robert Filardi, M.D.
39 Dogwood Road
Searlingtown, New York 11507

RE: License No. 077012
Effective Date: 2/6/95

Dear Dr. Filardi:

Enclosed please find Order #BPMC 95-20 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

Sincerely,

C. Maynard Guest

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Michael Kelton, Esq.
Lippman, Krasnow & Kelton
711 Third Avenue
New York, New York 10017

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

IN THE MATTER :

OF : ORDER
BPMC #95-20

ROBERT FILARDI, M.D. :

Upon the application of Robert Filardi, M.D., Respondent, for Consent Order, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED,

DATED: 23 January 1995

Charles J. Vacanti, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER OF ROBERT FILARDI, M.D.	APPLICATION FOR CONSENT ORDER

STATE OF NEW YORK)
ss.:
COUNTY OF NEW YORK)

ROBERT FILARDI, M.D., being duly sworn, deposes and says:

That on or about September 12, 1955 I was licensed to practice as a physician in the State of New York, having been issued License No. 077012 by the New York State Education Department.

I am currently registered with the New York State Education Department to practice as a physician in the State of New York for the period January 1, 1995 through August 31, 1997.

I understand that the New York State Board for Professional Medical Conduct has charged me with five Specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I admit guilt to the Third Specification (Practicing with Negligence on More Than One Occasion) and the Fifth

Specification (Failing to Maintain Accurate Records), and the related Factual Allegations, in full satisfaction of the charges against me.

I hereby agree to the limitation of my license pursuant to N.Y. Pub. Health Law Sec. 230-a(3) to the following activities at St. John's Queens Hospital, 90-02 Queens Blvd., Elmhurst, N.Y. 11373: interpreting electrocardiograms for the Department of Electrocardiography and writing related reports; and lecturing to podiatry and osteopathy students in a course on "Internal Medicine." I hereby also agree to a two year period of probation, with terms and conditions as set forth in the "Terms of Probation," a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B".

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

Robert Filardi M.D.

ROBERT FILARDI, M.D.
RESPONDENT

Sworn to before me this
day of , 19 .

NOTARY PUBLIC

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

IN THE MATTER OF ROBERT FILARDI, M.D.	APPLICATION FOR CONSENT ORDER

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

Date: 1/11/95

Robert F Filardi M.D.

ROBERT FILARDI, M.D.
RESPONDENT

Date: _____

_____

MICHAEL KELTON, ESQ.
ATTORNEY FOR RESPONDENT

Date: _____

_____

MARCIA KAPLAN
ASSOCIATE COUNSEL
BUREAU OF PROFESSIONAL
MEDICAL CONDUCT

Date: Jan. 19, 1995

KATHLEEN M. TANNER
DIRECTOR
OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

Date: 23 January 1995

CHARLES J. VACANTI, M.D.
CHAIRPERSON
STATE BOARD FOR
PROFESSIONAL MEDICAL CONDUCT

EXHIBIT "A"

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ROBERT FILARDI, M.D.	:	CHARGES

----------X

ROBERT FILARDI, M.D., the Respondent, was authorized to practice medicine in New York State on September 12, 1955 by the issuance of license number 077012 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 from 33-54 83rd St., Jackson Hts., New York 11372.

FACTUAL ALLEGATIONS

A. Between on or about February 4, 1974 and on or about January 2, 1990, Respondent treated Patient A in his office, (address unspecified; hereinafter referred to as "his office.") Patient A, who was 46 when first seen, was treated by Respondent for a variety of complaints and conditions, including hypertension, for which he prescribed medications including Corgard 40 mg. and Tenormin 50 mg. On or about January 2, 1990,

Respondent saw Patient A in his office and recorded a diagnosis of pneumonitis. He sent Patient A to the emergency room of St. John's Queens Hospital, 90-02 Queens Blvd, Elmhurst, N.Y. 11373 (hereafter "St. John's") with a prescription that read "Please admit. Dx Pneumonitis. RLL. 103. Kyphoscoliosis orthopnea dyspnea." Patient A presented to the the emergency room of St. John's on or about January 2, 1990 at 4:58 p.m. with complaints of fever, coughing, shortness of breath and indigestion. Patient A was not seen until 9:30 p.m., at which time she had a fever of 104.4. At or about 11:50 p.m., Patient A was admitted to the hospital, under Respondent's name. At or about 8:07 a.m. on January 3, 1990, she died. Respondent never saw Patient A at the hospital, either in the emergency room or after her admission to the hospital. Thereafter, Respondent countersigned the Medical History and Physical Examination note as well as progress notes, and entered an undated discharge summary into the hospital record. (The identities of Patients A - L are disclosed in the attached Appendix.)

1. Respondent failed to take or note an adequate history.

2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.

3. On or about January 2, 1990 - January 3, 1990, Respondent failed to see Patient A in a timely manner at St. John's and/or failed to initiate timely treatment.

4. On or after January 3, 1990, knowing that he had not seen Patient A after her arrival at St. John's on or about January 2, 1990, Respondent countersigned notes

written by other physicians in the St. John's record for Patient A, specifically the Medical History and Physical Examination note, and progress notes.

B. From on or about March 14, 1988 through in or about May 10, 1993, Respondent treated Patient B in his office for complaints and conditions which included ones he diagnosed as cardiomyopathy and cirrhosis of the liver.

1. Respondent failed to take or note an adequate medical history.

2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.

3. Respondent failed to order and/or perform appropriate laboratory and diagnostic tests, or to note such tests.

4. Respondent failed to evaluate, diagnose and treat appropriately Patient B's cardiac condition and/or failed to note such evaluation, diagnosis and treatment.

5. Respondent made a diagnosis of cirrhosis of the liver which was not supported by appropriate history and findings.

6. Respondent repeatedly failed to treat Patient B's congestive heart failure appropriately.

7. On or about January 28, 1991, Respondent prescribed Inderal inappropriately.

8. On or about August 20, 1992 and/or October 8, 1992, Respondent prescribed Atenolol inappropriately, given Patient B's congestive heart failure.

9. On or about October 8, 1992, Respondent diagnosed cholesystitis and failed to perform confirmatory tests and/or failed to treat appropriately.

C. From in or about July 23, 1987 through in or about March 23, 1993, Respondent treated Patient C in his office for complaints and conditions which included ones he diagnosed as allergic dermatitis and hypertension.

1. Respondent failed to take or note an adequate medical history.

2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.

3. Respondent made multiple diagnoses, including allergic dermatitis and hypertension, which were not supported by appropriate history or findings.

4. Respondent repeatedly prescribed anti-hypertensive medications inappropriately.

5. On or about January 10, 1992, Respondent prescribed Meprobamate inappropriately.

6. On or about April 30, 1992, Respondent prescribed Seldane inappropriately.

7. Respondent failed to identify the S-T wave depressions on the electrocardiogram of December 7, 1990, and noted in his record that the S-T segment was normal.

8. Respondent failed to follow up appropriately on an abnormality on Patient C's electrocardiogram on December 7, 1990 when Q-waves were present in leads 2 and 3, S-T-wave depressions were present in lead 1 and leads V2 to V6, and an R-wave was present in lead V-1.

D. From on or about August 19, 1983 through on or about January 14, 1991, Respondent treated Patient D at his office for various complaints and conditions, and made diagnoses including osteoarthritis, sinusitis, hypertension, vertigo, atherosclerotic heart disease, obstipation and bursitis.

1. Respondent failed to take or note an adequate medical history.

2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.

3. Respondent made multiple diagnoses which were not supported by appropriate history or findings.

4. Respondent failed to follow up to ascertain the results of multiple electrocardiograms ordered by him or to ascertain whether the tests were even performed.

5. Respondent failed to follow up to ascertain the results of a chest x-ray ordered by him on or about September 18, 1984 or to ascertain whether the test was even performed.

6. Respondent failed to follow up to ascertain the results of a barium enema ordered by him on or about January 3, 1985 or to ascertain whether the test was even performed.

7. Respondent failed to follow up appropriately on Patient D's fluctuations in weight, which ranged from 156 1/2 lbs on November 17, 1983 to 127 1/2 lbs on February 14, 1985 to 152 lbs on January 14, 1986.

8. On or about April 14, 1988, Respondent prescribed Inderal inappropriately.

9. Respondent repeatedly failed to note the dosages of medications he prescribed.

E. From on or about January 19, 1990 through on or about May 10, 1993, Respondent treated Patient E at his office for various complaints and conditions including labyrinthitis, gastritis, cardiac arrhythmias, hypertension, atherosclerotic heart disease, polymyalgia rheumatica, and/or osteoarthritis.

1. Respondent failed to take or note an adequate medical history.

2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.

3. Respondent repeatedly diagnosed hypertension without noting appropriate findings supporting the diagnosis.

4. On or about January 1, 1990, Respondent diagnosed labrynthitis without noting appropriate findings supporting the diagnosis.

5. On or about August 20, 1990, Respondent diagnosed an arrhythmia without appropriate electrocardiogram data and/or without noting appropriate findings supporting the diagnosis.

6. Respondent failed to follow up appropriately on an electrocardiogram done on or about May 16, 1991 which was interpreted as showing poor R-wave progression, suggestive of pulmonary disease.

7. Respondent failed to evaluate and/or treat Patient E appropriately for polymyalgia rheumatica or osteoarthritis, which he diagnosed on or about June 16, 1992.

8. Respondent failed to follow up appropriately on a drop in patient's weight from 135 lbs on or about January 29, 1990 to 115 lbs on or about March 22, 1993.

9. Respondent prescribed Capoten inappropriately on November 19, 1990.

10. Respondent failed to follow up appropriately to ascertain the results of an upper gastro-intestinal series ordered by him on February 3, 1992, and/or failed to ascertain whether the test was ever performed.

11. Respondent failed to follow up appropriately to ascertain the results of an EKG ordered by him on December 28, 1992, and/or failed to ascertain whether the test was ever performed.

F. From on or about February 5, 1991 to on or about July 23, 1991, Respondent treated Patient F in his office. On or about February 5, 1991, Patient F had a 4+ urinary glucose.

1. Respondent failed to take or note an adequate history.
2. Respondent failed to perform or note an adequate initial physical examination, including a comprehensive neurological evaluation, and/or failed to perform or note adequate follow-up examinations relative to Patient F's presenting complaints or condition.
3. Respondent failed to enter appropriate notes in the office record regarding Patient F's laboratory and diagnostic tests, specifically whether the blood tests for glucose were taken fasting or postprandially.
4. Respondent failed to treat Patient F appropriately for diabetes, and/or failed to note such treatment.

G. From in or about March 24, 1986 through on or about May 11, 1993, Respondent treated Patient G in his office for complaints and conditions which included ones he diagnosed as oral candidiasis, dermatitis, allergies, hypertension, cardiac arrhythmia, sinus tachycardia, bronchitis, depression and osteoarthritis.

1. Respondent failed to take or note an adequate medical history.
2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.
3. Respondent made diagnoses which were not supported by appropriate history and findings.

4. Respondent repeatedly diagnosed cardiac arrhythmia inappropriately.

5. Respondent prescribed medications inappropriately, including Keflex, Hygrotone, Ativan and Inderal.

6. Respondent repeatedly failed to note appropriately the dosages of medications he prescribed.

H. From in or about October 26, 1984 through in or about March 30, 1993, Respondent treated Patient H in his office for complaints and conditions which included ones he diagnosed as hypertension, vertigo, osteoarthritis, bronchitis, esophagitis, coronary insufficiency and peptic ulcer disease. On or about February 15, 1993, Patient H was hospitalized at St. John's from Respondent's office for coronary insufficiency.

1. Respondent failed to take or note an adequate medical history.

2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.

3. Respondent repeatedly diagnosed hypertension inappropriately upon a finding of blood pressure within normal limits.

4. Respondent repeatedly prescribed anti-hypertensive medications inappropriately.

5. Respondent failed to follow up to ascertain the results of EKGs which he ordered on or about January 25, 1985, December 23, 1985, July 2, 1987, August 28, 1989, June 19, 1990, and or October 1, 1992 or to determine whether the tests had even been performed.

6. Respondent repeatedly failed to note appropriately the dosages of medications ordered.

I. On or about June 26, 1987 and September 22, 1987, Respondent treated Patient I, a 45 year old female, in his office. On or about June 26, 1987, Respondent diagnosed an upper respiratory infection and prescribed erythromycin.

1. Respondent failed to take or note an adequate history.
2. Respondent failed to perform or note an adequate initial physical examination.
3. On or about June 26, 1987, Respondent made a diagnosis of an upper respiratory infection which was not supported by appropriate history or findings.
4. Respondent prescribed erythromycin inappropriately and/or failed to note appropriate indication for erythromycin.
5. Respondent failed to note the dosage of erythromycin which he prescribed to Patient I.

J. From in or about June 30, 1980 through in or about April 12, 1993, Respondent treated Patient J in his office for complaints and conditions which included ones he diagnosed as osteoarthritis of the left hip, labyrinthitis, acute sinusitis, peptic ulcer disease, esophagitis, spinal stenosis, myositis and radiculitis, prostatitis, angina pectoris, pruritus, carcinoma of the prostate and metastases to the bone.

1. Respondent failed to take or note an adequate medical history.
2. Respondent failed to perform or note an adequate physical examination and/or failed to perform or note

adequate follow-up examinations relative to presenting complaints.

3. Respondent repeatedly failed to note appropriately the dosages of medications prescribed.

4. On or about May 30, 1989, Respondent noted "prostatic oncology" and thereafter failed to communicate with any specialist concerning Patient J's prostatic cancer.

K. From on or about February 7, 1971 through in or about March 4, 1993, Patient K, a male, was treated by Respondent in his office for a variety of complaints and conditions which he diagnosed as gastrointestinal spasm, allergic rhinitis, spastic duodenitis, acute gastritis, lumbar muscle spasm, sciatica and irritable bowel syndrome.

1. Respondent failed to take or note an adequate medical history.

2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.

3. Respondent made multiple diagnoses which were not supported by appropriate history or findings.

4. Respondent failed to evaluate and/or treat appropriately Patient K's gastrointestinal symptoms.

5. On or about August 18, 1988, Respondent prescribed Naprosyn and/or Depro Medrol to Patient K inappropriately in that he failed to prescribe antacid medications concurrently.

L. From in or about May 20, 1980 through in or about March 1, 1993, Respondent treated Patient L in his office for complaints and conditions which included ones he diagnosed as

chronic bronchitis, hiatus hernia, subendocardial necrosis and infarction, hypertension, cardiac arrhythmia, atherosclerotic heart disease, peripheral vascular disease and osteoarthritis. On April 15, 1983, Patient L was hospitalized at St. John's from Respondent's office for an acute myocardial infarction.

1. Respondent failed to take or note an adequate medical history.

2. Respondent failed to perform or note an adequate initial physical examination and/or failed to perform or note adequate follow-up examinations.

3. Respondent failed to order or perform appropriate laboratory or diagnostic tests, or to note such tests.

4. Respondent repeatedly made diagnoses which which were not supported by appropriate history and findings.

5. Respondent repeatedly prescribed Pronestyl inappropriately on or after September 28, 1981.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

FRAUDULENT PRACTICE

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

The facts in paragraph A.4.

SECOND SPECIFICATION

GROSS NEGLIGENCE

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

The facts in paragraph B.8.

THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

3. 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 Respondent with having committed at least two of the following:

The facts in paragraphs A, A.1, A.2, A.3, A.4, B, B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, C, C.1, C.2, C.3, C.4, C.5, C.6, C.7, C.8, D, D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, E, E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, E.11, F, F.1, F.2, F.3, F.4, G, G.1, G.2, G.3, G.4, G.5, G.6, H, H.1, H.2, H.3, H.4, H.5, H.6, I, I.1, I.2, I.3, I.4, I.5, J, J.1, J.2, J.3, J.4, K, K.1, K.2, K.3, K.4, K.5, L, L.1, L.2, L.3, L.4, and/or L.5.

FOURTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

4. 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 Respondent with having committed at least two of the following:

The facts in paragraphs A, A.1, A.2, A.3, A.4, B, B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, C, C.1, C.2, C.3, C.4, C.5, C.6, C.7, C.8, D, D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, E, E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, E.11, F, F.1, F.2, F.3, F.4, G, G.1, G.2, G.3, G.4, G.5, G.6, H, H.1, H.2, H.3, H.4, H.5, H.6, I, I.1, I.2, I.3, I.4, I.5, J, J.1, J.2, J.3, J.4, K, K.1, K.2, K.3, K.4, K.5, L, L.1, L.2, L.3, L.4, and/or L.5.

FIFTH SPECIFICATION

FAILING TO MAINTAIN ACCURATE RECORDS

5. Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1994), in that he failed to maintain a record for each of patients A-L which accurately reflects his evaluation and treatment of the patient, in that Petitioner charges:

The facts in paragraphs A, A.1, A.2, A.4, B, B.1, B.2, B.3, B.4, C, C.1, C.2, D, D.1, D.2, D.9, E, E.1, E.2, E.3, E.4, E.5, F, F.1, F.2, F.3, F.4, G, G.1, G.2, G.6, H, H.1, H.2, H.6,

I, I.1, I.2, I.4, I.5, J, J.1, J.2, J.3, K, K.1, K.2, L, L.1, L.2, and/or L.3.

DATED: November 23, 1994
New York, New York

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

TERMS OF PROBATION

1. ROBERT FILARDI, M.D., during the period of probation, shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

2. That Respondent shall submit written notification to the New York State Department of Health (NYSDOH), addressed to the Director, Office of Professional Medical Conduct, New York State Health Department, Corning Tower Building, 4th Floor, Empire State Plaza Albany, New York 12237 of any employment and practice, of Respondent's residence and telephone number, of any change in Respondent's employment, practice, residence, or telephone number within or without the State of New York;

3. Respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that Respondent has paid all registration fees due and owing to the NYSED and Respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by Respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation;

4. Respondent shall submit written proof to the NYSDOH, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) Respondent is currently registered with the NYSED, unless Respondent submits written proof that Respondent has advised DPLS, NYSED, that Respondent is not engaging in the practice of Respondent's profession in the State of New York and does not desire to register, and that 2) Respondent has paid any fines which may have previously been imposed upon Respondent by the Board or by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

5. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the order of the Board;

6. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is

not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non renewal of permits or licenses (Tax Law section 171(27); State Finance Law section18; CPLR section 5001; Executive Law section 32).

7. Respondent's interpretation of electrocardiograms, and related written reports, shall be reviewed on a monthly basis by the chief of the Department of Electrocardiography at St. John's Queens Hospital, or his designee, as approved by the Director of the Office of Professional Medical Conduct, who shall certify to the Director of OPMC on a quarterly basis that he has performed said review, met with Respondent to discuss his review, and that Respondent's work has successfully met with accepted standards of the profession, and/or who shall report immediately to the Director of OPMC any non-compliance with this term of probation or any failure of Respondent's work to meet with accepted standards of the profession.

8. Respondent shall meet on a quarterly basis with a Medical Coordinator or other physician designated by the Director of OPMC. Said physician may review Respondent's records and reports.

9. So long as there is full compliance with every term herein set forth, Respondent may continue to practice his or her aforementioned profession in accordance with the terms of probation; provided, however, that upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the Public Health Law.