These charges are only allegations which may be contested by the licensee in an administrative hearing.

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

IN THE MATTER

OF

FRANCES ILOZUE, M.D.

STATEMENT

OF

CHARGES

FRANCES ILOZUE, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 22, 2007, by the issuance of license number 243530 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified only in the attached confidential index), a 34-year-old male, from December 31, 2013, to October 20, 2015, at Rapha Family Medicine. Patient A had a history of low back pain, anxiety and drug dependence, and was prescribed Suboxone treatment for Lortab dependency. Respondent provided Patient A medical care and managed Patient A's Suboxone therapy. On December 31, 2013, Patient A complained of a left leg mass. On October 15, 2015, Patient A was diagnosed with liposarcoma of the left leg with metastases to subcutaneous tissue/muscles, and later succumbed to his disease. Respondent's care and treatment of Patient A deviated from accepted standards, in that:

1. Respondent failed to document the history of the leg mass Patient A presented with, nor did Respondent develop a plan to evaluate and treat the condition.
2. Respondent failed to document a follow-up plan or workup for Patients A's leg mass.
3. Respondent failed to order additional diagnostic tests, imaging studies or biopsy of the mass on Patient A's leg
4. Respondent failed to refer Patient A for a surgical or interventional radiology consultations for a diagnostic biopsy.
5. Respondent failed to adequately and completely document Patient A's office visits. A mass is described on physical examination with no documentation of how long it has been there or where it was located on the leg.

B. Respondent provided medical care to Patient B, a 34-year-old male, at Rapha Family Medicine. Patient B had a history of diabetes, hypertension, Stage IV chronic kidney disease, and sleep apnea. Respondent's care and treatment of Patient B deviated from accepted standards, in that:

1. Respondent failed to properly manage Patient B's renal disease. Respondent did not obtain blood work as a baseline from the initial visit in January of 2014 until April of 2014, and Respondent wrote several prescriptions without knowing or commenting on baseline lab work. Respondent failed to mention the BUN and Creatinine elevations to 72 and 3.6, respectively, on the April blood work. Respondent, after the lab abnormalities were noted, failed to conduct a complete medication review, nor did Respondent refer Patient B for a nephrology consultation.
2. Respondent prescribed Belviq (lorcaserin) without reviewing lab work and without discussing with Patient B the risks/benefits of using this drug.
3. Respondent failed to appropriately address or comment on Patient Bs blood work from April 16, 2014. Specifically,the chart does not document Patient B's anemia and his significant chronic renal insufficiency, and Respondent did not make any medication changes, adjustments or referrals.
4. Respondent failed to refer Patient D to nephrology for consultation and long-term care.
5. Respondent failed to appropriately manage Patient B's anemia. Specifically, Respondent failed to document anemia on the problem list, nor was it documented or addressed in any of the office notes.
6. Respondent failed to document why Zolpidem was indicated, given that the drug is for short term use in insomnia, and is not recommended for patients with sleep apnea.
7. Respondent failed to document any coordination of care and hypertensive management with Patient B's cardiologist, and failed to document any coordination of care with Patient B's endocrinologist.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts in paragraphs A and A1, A and A2, and A and A3, and/or A and A4.

FOURTH THROUGH SIXTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

2. The facts in paragraphs A and A1, A and A2, and A and A3, and/or A and A4.

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

3. The facts in paragraph A and A1, A and A2, and A and A3, and/or A and A4, and B and B1, B and B2, B and B3, B and B4, B and B5, B, and B7 and B and/or B8.

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

4. The facts in paragraph A and A1, A and A2, A and A3, and/or A and A4, and B and B1, B and B2, B and B3, B and B4, B and B5, B and B7, and/or B and B8.

NINTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

5. The facts in paragraph A and A1, A and A2, and/or A and A5, and B and B3, B and B5, and/or B and B6.

DATE: January 24, 2024
Albany, New York

[redacted]

JEFFREY J. CONKLIN
Deputy Counsel
Bureau of Professional Medical Conduct