Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

September 9, 2022

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Nathanial C. White, Esq.
Bureau of Professional Medical Conduct
Division of Legal Affairs
NYS Department of Health
Corning Tower, Room 2512
Empire State Plaza
Albany, New York 12237

Dennis A. First, Esq.
O'Connor, O'Connor, Bresee & First, P.C.
20 Corporate Woods Boulevard
Albany, New York 12211

RE: In the Matter of Ronald Monson, P.A.

Dear Parties:

Enclosed please find the Determination and Order (No. 22-196) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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 <u>other than suspension or revocation</u> 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.

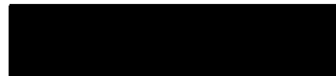
The notice of review served on the Administrative Review Board should be forwarded to:

Jean T. Carney, Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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 Ms. Carney 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,



Sean D. O'Brien
Acting Chief Administrative Law Judge
Bureau of Adjudication

SDO: cmg
Enclosure

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

COPY

IN THE MATTER OF RONALD MONSON, P.A.	DETERMINATION AND ORDER BPMC-22-196

Pursuant to New York State Public Health Law (PHL) § 230(10)(d)(i), the New York State Department of Health, Bureau of Professional Medical Conduct (Department) served Ronald Monson, P.A. (Respondent) with a Notice of Hearing and Statement of Charges. The hearing was held via videoconference. **LYON M. GREENBERG, M.D.**, Chairperson, **GREGORY ALLEN THREATTE, M.D.**, and **ELENA M. COTTONE, P.A.-C**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to PHL § 230(10)(e). **TINA M. CHAMPION**, Administrative Law Judge, served as the Administrative Officer.

The Department appeared by Nathanial C. White, Esq. The Respondent appeared by Dennis A. First, Esq. Evidence was received, witnesses were sworn or affirmed, and a transcript of the proceeding was made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Notice of Hearing and Statement of Charges:	August 28, 2020
Pre-Hearing Conference:	September 23, 2020
Hearing Dates:	September 30, 2020 December 9, 2020 January 14, 2021 January 27, 2021 February 25, 2021[1] April 29, 2021 June 10, 2021 September 30, 2021[2] November 3, 2021 December 2, 2021
ALJ Exhibits:	I and II
Witnesses for Department:	Patient A Patient B Patient C Patient D Patient E Patient F Robert Lesser, M.D.
Department Exhibits:	1-3, 4A, 5A, 6A, 6B, 7, 7A, 8A, 9A, 10, 13-16
Witnesses for Respondent:	Respondent Hal Blatman, M.D. Rebekah Ann Mauck Paul D. Clarke, P.A.-C
Respondent Exhibits:	A, F[3]
Written Submissions Received:	December 31, 2021
Deliberations Held:	January 20, 2022

[1] The transcript has been corrected to replace patient names with initials.

[2] The transcript has been corrected to replace patient names with initials.

[3] Exhibit F is the CV Hal Blatman, M.D. (T. 55, 1770-1773.)

STATEMENT OF CASE

The Department charged the Respondent with nineteen specifications of professional misconduct under NY Educ. Law § 6530 involving the Respondent's care of six patients.

The Department recommends that the Respondent's license to practice as a physician's assistant be revoked. The Respondent requests that any penalty imposed not exceed a probationary period with a practice monitor and continuing medical education on sensitivity or related training as he would like to continue practicing as a physician's assistant.

FINDINGS OF FACT

The following findings are the unanimous determinations of the Hearing Committee. Numbers in parentheses refer to exhibits (Ex.) or transcript page numbers (T.).

1. The Respondent was licensed as a physician's assistant in New York State on September 1, 1987 by issuance of license number 003350. (Ex. 3, p. 13.)

2. The standard of care for physician's assistants is the same as it is for supervising physicians.

3. The Respondent worked as a physician's assistant at Arthritis Care, PC (Arthritis Care) in Troy, New York for approximately six years from early 2012 to late 2017, which are the years relevant to this proceeding. (T. 1407, 1650.)

4. While working at Arthritis Care, the Respondent practiced in the field of rheumatology under the supervision of Dr. Christopher Huyck. (T. 1650.)

5. The Respondent had previously worked as a physician's assistant in various areas of medicine other than rheumatology, and in various settings, including surgery at Albany Memorial Hospital (1987-1990), geriatric care at Eden Park Nursing Home (1990-1999), geriatrics and rehabilitation at Northwoods at Troy (1999-2000), primary and family medicine at Prime Care Physicians (2000-2002), psychiatry and medication management at

Psychopharmacology Consultant (2002-2007), and pain management at New York Pain Management (2007-2012). (T. 1394-1407, 1635-1649.)

6. The Respondent's employment at Arthritis Care was his first experience working in the field of rheumatology. (T. 1650-1651.)

7. Arthritis Care patients treated by the Respondent were also treated periodically by other providers at the practice. (T. 1655.)

8. The Respondent's care of six Arthritic Care patients (Patients A - F) was reviewed in this proceeding. (Exs. 1, 4A, 5A, 6A, 6B, 7, 7A, 8A, 9A.)

9. One Arthritis Care patient's (Patient B) medical record contains documentation on October 12, 2017 of a complaint by the patient that she did not want to see the Respondent again because he had inappropriately touched her and that her visits with the Respondent were creepy and uncomfortable. (Ex. 5A, p. 304.)

10. Dr. Huyck subsequently met with the Respondent to discuss the patient's complaint. (T. 1712, 1716.)

11. Shortly thereafter, on October 23, 2017, Dr. Huyck issued the Respondent a letter documenting a review of Respondent's work performance and log of multiple complaints by several different patients that Arthritis Care had received about the Respondent. (Exs. 13-14.)

12. The October 23, 2017 letter from Dr. Huyck set forth several requirements including that the Respondent engage in counseling/sensitivity training; refrain from further inappropriate physical exams or comments such as communications that are inappropriately sexual, intimate, hyper-religious, nonclinical, or unprofessional; ask each female patient if she wishes to have an attendant present for the history and physical; and use a chaperone for all procedures. (Ex. 13.)

13. The Respondent refused to sign the letter and did not agree with the remediation plan set forth therein. (Ex. 13; T. 1728, 1736, 1741.)

14. On October 25, 2017, the Respondent issued a letter resigning from Arthritis Care with his last day planned to be January 24, 2018. (Ex. 15; T. 1714, 1717.)

15. On October 26, 2017, Dr. Huyck implemented a policy at Arthritis Care specific to using chaperones during patient encounters and procedures. (Ex. 16; T. 1742-1743.)

16. The Respondent left Arthritis care on December 30, 2017. (T. 1714, 1717.)

Patient A

17. Patient A was first treated at Arthritis Care on February 1, 2017, at the age of 42, and saw the Respondent as her care provider that day. (Ex. 4A, p. 6; T. 99-100.)

18. Patient A was referred to Arthritis Care by her primary doctor for a rheumatology consult for complaints of wrist pain and a positive Antinuclear Antibody (ANA) level. (Ex. 4A, p. 6; T. 99.)

19. Patient A's wrist pain was bilateral and presented as joint pain in her wrists and weakness in her hands. She had been experiencing wrist pain and wrist swelling for a couple months prior to her February 1, 2017 appointment. (Ex 4A, p. 6; T. 100, 104, 147.)

20. Patient A reported having hives, heartburn, morning stiffness, joint pain, neck pain, back pain, muscle weakness, an elevated Sedimentation Rate (SED rate), and an elevated ANA level. (Ex. 4A, p. 32.)

21. Patient A's hives had been located on her trunk, extremities, and face six weeks prior to her February 1, 2017 appointment. However, she was not experiencing hives at the start of her appointment. (Ex. 4A, p. 6; T. 104, 106.)

22. Patient A reported to the Respondent that she also experienced chronic neck and back pain, although she was not referred to Arthritis Care for her neck and back pain. (Ex. 4A, p. 6; T. 107.)

23. In May 2014, almost three years prior to her appointment on February 1, 2017, Patient A fractured her left fibula and developed a deep vein thrombosis (DVT) in her lower left leg. Those issues had resolved prior to her appointment and Patient A had no residual pain. (Ex. 4A, p. 6; T. 163, 194-195.)

24. Patient A had no symptoms or concerns regarding her upper legs, thighs, breasts, or chest at her appointment on February 1, 2017. (Ex. 4A, p. 7; T. 107-108, 115, 118.)

25. Patient A changed into a medical gown with her bra, underwear, and socks on underneath the gown prior to the Respondent entering the exam room. (T. 100-101.)

26. The Respondent performed a physical exam of Patient A on February 1, 2017. (Ex. 4A, pp. 6-11; T. 108.)

27. The Respondent advised Patient A that he was going to perform an exam focused on her joints. (T. 160.)

28. The Respondent documented no observable abnormalities from Patient A's physical exam. (Ex. 4A, pp. 7-9; T. 749-750.)

29. During the exam, while Patient A was lying on the exam table, and the Respondent removed Patient A's socks in a way that felt sensual and sexual to her. (T. 109-110, 113.)

30. Patient A had no pain or skin abnormalities on her feet and was otherwise not symptomatic in her feet. (T. 113.)

31. The Respondent slowly and softly massaged Patient A's calves in a way that felt sexual to her. (T. 110, 115.)

32. The Respondent adjusted Patient A's gown up to her pubic area to expose her thighs. The Respondent did not offer Patient A a sheet or other covering to minimize her exposure or protect her privacy. (T. 117-118.)

33. The Respondent examined Patient A's upper legs with a touch that felt massage-like to her. (T. 116.)

34. The Respondent grabbed both of Patient A's upper and inner thighs in a manner that felt forceful to her and without any explanation from the Respondent as to the purpose thereof. (T. 110, 116, 119.)

35. The Respondent forcefully grabbed both of Patient A's breasts above her bra and gown for a period of approximately five seconds. (T. 110-111, 120-122.)

36. The Respondent did not explain to Patient A the purpose for grabbing her breasts and it did not feel like a medical exam to Patient A. (T. 110-111, 123.)

37. The Respondent then touched Patient A's arms in a manner that felt massage-like, starting at the top and moving down her arms for approximately twenty seconds. (T. 111, 124-125.)

38. The Respondent instructed Patient A to stand up and bend over for him to examine her back. Patient A's gown was open in the back. (Ex. 4A, p. 9; T. 112, 125-126.)

39. Patient A remained bent over in front of the Respondent while he sat behind her for ten to twenty seconds. (T. 125-127.)

40. The entirety of the Respondent's examination of Patient A on February 1, 2017 lasted approximately five to ten minutes, at which point the Respondent instructed Patient A to get dressed and he exited the examination room. (T. 128-130.)

41. A few seconds after exiting the examination room, the Respondent reentered without knocking or announcing himself, stated to Patient A that it was nice to meet her, and exited again. Patient A was unclothed. (T. 130-132.)

42. The Respondent ordered blood work and a wrist x-ray (Ex. 4A, p. 10-11, T. 129).

43. The Respondent's encounter with Patient A on February 1, 2017 made Patient A feel shaky, elicited her hives to appear, and made her feel like she was being molested. (T. 110.)

44. The scope of an initial Rheumatology exam is to examine the patient's skin, head, lungs, heart, and abdomen, and examine for swelling in the peripheral joints (T. 746).

45. The objective of palpating an area of the body during a Rheumatology exam is to see whether the examination will elicit pain, and whether there is swelling, associated rash, or any abnormality of movement or function, or pain elicited by movement and function, whether there is swelling of the joints and whether the range of motion of the joints is normal. (T. 745-746.)

46. Massage is a therapeutic modality and should not be part of a Rheumatology exam. Massage differs from palpation in that palpation is for examination and massage is intended to be therapeutic. (T. 746, 760-761.)

47. Fibromyalgia falls under the purview of Rheumatology and findings of Fibromyalgia on a physical exam would include discrete tender points generally along the paraxial spine and peripheral areas as well as tender points in the chest where the clavicle meets the sternum. (T. 752-754.)

48. Patient A did not present with symptoms consistent with Fibromyalgia. (T. 755)..

49. The standard of care requires that a physician's assistant document the use of a massage technique during evaluation or treatment, and the justification for using a massage. (T. 759.)

50. Touching a patient in a manner that serves no legitimate medical purpose is a violation of the patient's privacy. (T. 763-764.)

51. Patient A's medical record contains no documentation that the Respondent massaged Patient A's lower extremities or information to justify the Respondent's use of massage. (Ex. 4A; T. 758-759).

52. There is no useful medical purpose for the Respondent grabbing Patient A's thighs or documentation in Patient A's medical record to support that conduct. (T. 761-761.)

53. The Respondent's examination of Patient A's lower extremities was not performed in accordance with accepted standards of care. (T. 764).

54. Patient A's history of DVT did not provide medical justification for the manner in which the Respondent touched Patient A's legs. (T. 766-767.)

55. The Respondent's conduct during the examination of Patient A's legs constituted a moderate to severe deviation from the standard of care. (T. 766).

56. The Respondent's conduct during the examination of Patient A's legs created a risk of harm to Patient A, including a risk of impacting the trust relationship between the patient and the provider, and a risk of emotional harm and post-traumatic stress disorder. (T. 765-766.)

57. There is no legitimate medical purpose for the Respondent to grab Patient A's breasts, or documentation in Patient A's medical record to support that conduct. (Ex. 4A; T. 767-770.)

58. Accepted standards of care require a physician's assistant to document the performance of a breast exam and the justification for doing a breast exam. (T. 768.)

59. The Respondent's grabbing Patient A's breasts constituted a severe violation of the standard of care. (T. 769-771.)

60. The Respondent's grabbing Patient A's breasts created a risk of harm to the patient, including damage to the trust relationship and the risk of emotional harm including post-traumatic stress. (T. 766, 771.)

61. There is no legitimate medical purpose for the Respondent to massage Patient A's arms or documentation in Patient A's medical record to support that conduct. (Ex. 4A; T. 772-773.)

62. The Respondent's conduct during the examination of Patient A's upper extremities constituted a moderate deviation from the standard of care. (T. 766, 777.)

63. The Respondent's conduct during the examination of Patient A's upper extremities created a risk of harm to the patient including detriment to the trust relationship and emotional harm to the patient (T. 766, 777.)

64. Accepted standards of care when examining a patient's spine require that a physician's assistant ensure that the patient's exposure is limited and that the patient is appropriately gowned to protect the patient's privacy. Patient exposure should be limited, patients should have confidence that they are being modestly examined, and patients should not be left exposed or uncovered. (T. 778-779.)

65. The Respondent's examination of Patient A's spine failed to protect her privacy, was not performed in accordance with accepted standards of care and constituted a moderate deviation from the standard of care. (T. 779-780.)

66. The Respondent's manner of examination of the Respondent's spine created a risk of harm to the patient, including a risk to the trust relationship with her provider, and the risk of emotional harm and/or post-traumatic stress disorder. (T. 766, 780.)

67. The Respondent failed to protect Patient A's privacy when he reentered the exam room without knocking or announcing himself when he knew or should have known that Patient A was likely in a state of undress. (T. 782).

68. The Respondent's conduct of reentering the exam room while Patient A was a mild to moderate deviation from the standard of care with a potential risk of harm to the patient, including harm to the trust relationship, emotional harm, and harmful to the patient in that it could dissuade her from seeking out medical care. (T. 766, 782-783.)

69. Patient A had a follow-up appointment with Arthritis Care on February 15, 2017, where she again saw the Respondent as her provider. (Ex. 4A, p. 15; T. 134-35.)

70. Patient A attended the second appointment to review blood work. The Respondent did not perform a physical exam. (T. 135.)

71. On February 15, 2017, the Respondent recommended that Patient A follow up with Dr. Huyck in four to six weeks. (Ex. 4A, p. 20; T. 136.)

72. Patient A did not return to Arthritis Care and is not being treated by a Rheumatologist despite the continued presence of her symptoms. (T. 138, 189-190.)

Patient B

73. Patient B was first treated at Arthritis Care on April 3, 2013, at the age of 29. (Ex. 5A, p. 24-27; T. 213.)

74. Between April 2013 and May 2018, Patient B had approximately 35 office visits at Arthritis Care, 15 of which were with the Respondent. (Ex. 5A, T. 218.)

75. Patient B was referred to Arthritis Care by her primary doctor for a rheumatology consult for a positive ANA level. (Ex. 5A, p. 24; T. 215-216.)

76. Patient B had a documented history of generalized myalgias which worsened after she was hospitalized with H1N1 influenza in December of 2012. (Ex. 5A, p. 24; T. 216.)

77. At Patient B's first visit to Arthritis Care on April 3, 2013, she had a documented history of neck pain, lower back pain, joint pain, and morning stiffness. She denied muscle pain, spasms, joint stiffness, tenderness, and muscle weakness. She reported that she was in constant, severe pain all over her body, including a burning sensation in her lower back and pain in her neck, that interfered with her quality of life. (Ex. 5A, p. 25; T. 217.)

78. Patient B was not symptomatic in her breasts. She denied problems with her breasts, and she did not seek treatment at Arthritis Care for any issues with her breasts. (Ex. 5A, pp. 24-25, 29; T. 219, 233, 236.)

79. Patient B was often symptomatic in her chest and documented symptoms include chest wall pain, rib pain usually on the left side, chronic pain in the chest, thoracic chest wall pain, chest pain described as locking for several minutes or days, and spasm in the left thorax. (Ex. 5A, p. 51, 55, 150, 153, 159; T. 235-236.)

80. The costal cage area is relevant in a Rheumatology exam because a patient could have tenderness and/or inflammation on the costochondral margins immediately adjacent to the sternum. (T. 750-751.)

81. The Respondent performed a physical examination of Patient B on May 1, 2015 and noted that Patient B's costal cage had tenderness to palpation with trigger points in the area of the superior left breast (above the left breast) and left upper back. (Ex. 5A, pp. 51-54; T. 838-839.)

82. In September 2016, Dr. Huyck documented tenderness in Patient B's left sternum, inferior chest wall, lower ribs, and lateral rib cage, and documented Chondrocostal Junction Syndrome (costochondritis) on the Respondent's assessment list. (Ex. 5A, p. 98-101.)

83. In June 2017, the Respondent documented costochondritis on Patient B's assessment list. (Ex. 5A, p. 126.)

84. Costochondritis is inflammation where the sternum in the center of the chest meets the rib cartilage. The location of costal cartilage is one to one-and-one-half centimeter, or as much as an inch, lateral to the midline where the cartilage meets the rib in the diarthrodial joint. (T. 849-850.)

85. The chest wall is anatomically separate from breast tissue and does not include dependent breast tissue. (T. 816-817, 860.)

86. An appropriate evaluation of the costal cage or chest wall does not require contact with the dependent soft breast tissue or for breasts to be exposed. (T. 868-869.)

87. Rheumatological care may evaluate and treat anatomy peripheral to the breast area but not the formal breast tissue itself or dependent soft breast tissue. A breast exam is not within the scope of Rheumatological care. (T. 857-858, 864.)

88. Appropriate standards of care required that an evaluation of the chest wall be done in a modest, discreet manner to protect the patient's privacy and with the patient's explicit consent. (T. 935.)

89. The Respondent performed a physical examination of Patient B at nearly every encounter with her, no less than 12 times, and Patient B was always alone the examination room with the Respondent. (Ex. 5A, T. 221, 225-226.)

90. The Respondent instructed Patient B to wear a gown during their appointments and to remove "everything," which she understood to include her bra and underwear. (T. 223-224.)

91. Patient B removed her bra on some occasions, but more often she left on her bra and underwear. She wore the medical gown that she was provided with the opening in the back. (T. 223-225.)

92. The Respondent touched Patient B's breasts on approximately 12 of their 15 appointments, and always in a similar manner. (T. 233.)

93. The Respondent used a soft, sensual rubbing motion, similar to a soft massage, on both Patient B's breasts, including her nipple on one occasion. Each encounter with her breasts lasted approximately 30 to 45 seconds. (T. 228, 229-230.)

94. On the occasions where Patient B kept her bra on, the Respondent touched her breasts underneath the fabric of her bra by pulling down the strap of the bra and moving the fabric to the side. (T. 230-231.)

95. On the occasions where Patient B removed her bra, the Respondent touched her breasts with skin-to-skin contact and caused Patient B's breasts to be exposed by moving Patient B's gown or causing the gown to fall away from her body. (T. 227, 231.)

96. Patient B's breasts were regularly exposed during her appointments with the Respondent. (T. 228.)

97. The Respondent did not offer Patient B a sheet or covering to minimize her exposure. (T. 228.)

98. The manner that the Respondent touched Patient B's breasts is not consistent with an appropriate rheumatological exam. (T. 860.)

99. The contact that the Respondent made on Patient B's breasts served no legitimate medical purpose and had no diagnostic value. (T. 864.)

100. The appropriate standard of care requires that a physician's assistant who believes there is a legitimate medical purpose for touching a patient's breasts to explain the reason to the patient. (T. 869.)

101. The Respondent never explained to Patient B the purpose or medical rationale for touching her breasts. (T. 232.)

102. The appropriate standard of care requires a physician's assistant to document that a breast exam was conducted and to document the medical justification for touching a patient's breasts. (T. 855, 862.)

103. The Respondent failed to document any medical rationale for repeatedly touching Patient B's breasts. (Ex. 5A; T. 855-857.)

104. The Respondent infringed on Patient B's privacy on repeat occasions by touching her breasts. (T. 865.)

105. The Respondent's physical examinations where he contacted Patient B's breasts constituted a severe deviation from the standard of care. (T. 865-866.)

106. The severe deviation created a risk of harm to the patient of damaging the trust relationship between the patient and her healthcare providers causing the patient to become reluctant to seek medical care, and a risk of emotional harm and post-traumatic stress disorder to the patient. (T. 766, 866-867.)

107. No other provider at Arthritis Care performed an evaluation of Patient B wherein they touched her breasts. (T. 236-237.)

108. Patient B also presented with symptoms of low back and buttocks pain which she described as a burning sharp pain making it hard to sit or stand for a period of time, and hip pain and pain in her upper back for many years qualified as a burning, deep, sharp pain. (Ex. 5A, p. 34, 150, T. 238.)

109. Patient B's low back pain ranged from above her butt to her lower back and concentrated around the spine, and she experienced a sore tailbone at times. (T. 238-239.)

110. The Respondent regularly (no fewer than 10 times), performed physical examinations of the pain in Patient B's lower back and buttocks. (T. 239, 247.)

111. An imaging study on January 29, 2014 showed mild to moderate neural foraminal narrowing on the right with mild general cervical spondylosis. (Ex. 5A, p. 146-149.)

112. Patient B was assessed by the Respondent as having cervical and lumbar spondylosis on August 25, 2014, and a suspicion of Ankylosing Spondylosis on September 25, 2014. (Ex. 5A, pp. 150-152, 158.)

113. On September 25, 2014, Patient B had documented tenderness in her upper and lower back, particularly over her sacroiliac joints. (Ex. 5A, p. 154.)

114. On September 25, 2014 and April 9, 2015, the Respondent documented a positive Schober's Test with +3 centimeters flexion. (Ex. 5A, pp. 154, 176).

115. When performing a Schober's Test, the buttocks should be exposed minimally if at all, and the portion of the spine not being measured should be covered. (T. 826.)

116. On October 27, 2014, Patient B had a documented positive HLA-B27, a test that is commonly positive in Caucasian patients that have Ankylosing Spondylitis, and the Respondent recommended that Patient B consider bilateral sacroiliac injections. (Ex. 5A, p. 159, 163; T. 827.)

117. On November 3, 2014, the Respondent performed Arthrocentesis of the bilateral sacroiliac joint for Patient B. (Ex. 5A, pp. 163-167.)

118. The sacroiliac joint is located lateral to the spine in the upper buttocks and injections of the bilateral sacroiliac joint should be done in a way that limits exposure of the patient's body to an area of about two centimeters around the injection location. (T. 834-835.)

119. On August 28, 2015, the Respondent performed a physical exam of Patient B and documented tenderness in the upper and lower back particularly in the region of her sacroiliac joints and coccyx, and significant tenderness of the left and right greater trochanter. (Ex. 5A, p. 67.)

120. The coccyx is two to three inches from the anus and an appropriate evaluation of the coccyx does not require a physician's assistant to touch the patient's anus or perianal area. (T. 875-879.)

121. The Respondent's examinations of Patient B's lower back typically lasted approximately one minute, and the portion focused on the tailbone lasted approximately 15 to 20 seconds. (T. 245.)

122. During examinations of her lower back, the Respondent instructed Patient B to lie on her side or stand, and the Respondent slowly pushed down on her back progressing downward toward her anus. (T. 239-240, 244, 342.)

123. Patient B felt the Respondent touch her perianal area during the Respondent's multiple examinations of her lower back. (T 239-240, 244, 342.)

124. Patient B described the examination as the Respondent softly and slowly rubbing his gloveless fingers down her back past her tailbone to her anus to the point where Patient B moved away or told the Respondent it was painful in order to stop the Respondent from touching her further. (T. 240-246, 343.)

125. An appropriate Rheumatological examination should not cause a physician's assistant to touch a patient's perianal area. (T. 882.)

126. When examining the coccyx, the standard of care requires a physician's assistant to explicitly inform the patient of the purpose and scope of the exam, and obtain verbal consent, because an exam of the coccyx is close to the patient's sensitive and private area. (T. 876-877.)

127. An appropriate evaluation of the coccyx or buttocks should be performed with limited exposure of the patient and by affording the patient as much cover as possible. (T. 879.)

128. The standard of care requires that a physician's assistant document justification for contacting a patient's perianal area. (T. 882-883.)

129. The Respondent did not document any medical justification to justify his contact with Patient B's perianal or anal area on repeated occasions. (T. 883.)

130. During the encounters where Patient B was lying down for an exam of her lower back, her backside was exposed, and she was not adequately covered by the medical gown and the Respondent did not offer or provide a cover to minimize Patient B's exposure. (T. 241-242, 248.)

131. On every occasion that the Respondent examined Patient B's lower back, he pulled, or folded down, Patient B's underwear exposing her buttocks. (T. 241-242, 245-247, 248.)

132. Patient B never asked the Respondent for assistance to take down her underwear and she never consented to the Respondent adjusting her underwear. (T. 243.)

133. The Respondent regularly evaluated Patient B's back while she was in a standing position by requiring the patient to bend over which caused her gown to fall to the side and expose her backside. (T. 251, 255, 260.)

134. While bending, the Respondent would adjust Patient B's underwear down exposing some or all of her buttocks and did not ask Patient B to adjust her underwear or tell Patient B he was going to do so. (T. 255-256.)

135. At the multiple appointments where Patient B removed her bra, her breasts were exposed while bending over in the gown. (T. 254-255.)

136. While Patient B was bending and exposed, the Respondent stood closely behind Patient B so that she could feel the fabric of the Respondent's clothes. (T. 253-254, 258.)

137. While Patient B was bending and exposed, the Respondent softly and sensually rubbed, massaged, or touched down Patient B's spine. (T. 256-257.)

138. While Patient B was bending and exposed, the Respondent would touch Patient B's hips in a way that felt sexual. (T. 257.)

139. On repeat occasions, Patient B remained exposed and bending in front of the Respondent for approximately one minute. (T. 259-260.)

140. The Respondent did not explain to Patient B the objective of this portion of the exams. (T. 257, 260.)

141. At 10 or more of Patient B's 15 encounters with the Respondent, the Respondent touched Patient B's buttocks using a soft, sensual massage, adjusted her underwear to expose her buttocks, and touched her perianal area. (T. 245, 247.)

142. The Respondent never explained to Patient B the purpose of softly rubbing her buttocks. (T. 246.)

143. Patient B felt that the Respondent's exam failed to protect her privacy. (T. 248, 260.)

144. The Respondent's multiple examinations of Patient B's coccyx and/or buttocks were not performed in accordance with accepted standards of care. (T. 882, 884.)

145. The Respondent's repeated contact with Patient B's perianal area was a violation of the patient's privacy. (T. 884.)

146. Each encounter that the Respondent contacted Patient B's perianal area constituted a severe deviation from the standard of care. (T. 884.)

147. Each encounter that the Respondent massaged Patient B's buttocks was a moderate to severe deviation from the standard of care. (T. 885.)

148. The Respondent's repeated exposure of Patient B's buttocks and/or breasts was not in accordance with accepted standards of care. (T. 885-886.)

149. Each encounter that the Respondent exposed Patient B's buttocks or breasts was a severe deviation from the standard of care. (T. 886.)

150. While evaluating complaints in Patient B's upper back, shoulders, or neck, the Respondent sensually rubbed, or massaged, Patient B's back. (T. 240.)

151. The Respondent never documented performing a massage on Patient B's back, shoulders, neck, or buttocks. (Ex. 5A, T. 873.)

152. The standard of care required the Respondent to document the performance of a massage if he felt it was appropriate for the evaluation or treatment of Patient B. (T. 873-874.)

153. Other providers at Arthritis Care also evaluated and examined Patient B but did not touch her the way the Respondent touched her, and never touched her near her anus, and did not expose her. (T. 249-251, 261.)

154. Patient B felt the Respondent's examinations did not protect her privacy. (T. 260.)

155. The Respondent made Patient B feel very exposed, embarrassed, and trashy. (T. 260-261.)

156. On regular occasions, at the start of the appointment between the Respondent and Patient B, the Respondent sat close to Patient B so her legs were between his legs. (T. 262-265.)

157. On one occasion, outside the context of a physical exam, the Respondent used his finger to touch Patient B from the top of her thigh down to her knee and rub her leg through a hole in her pants. (T. 262-266.)

158. Touching Patient B's legs and sitting such that her legs were in between his own, did not serve a legitimate medical purpose. (T. 886-887.)

159. The Respondent's contact with Patient B without a legitimate medical purpose constituted a moderate deviation from the standard of care creating a risk of harm to Patient B, including a risk of damaging the trust relationship between patient and provider, and a risk of emotional harm and post-traumatic stress disorder. (T. 766, 866-867, 887.)

160. The Respondent hugged Patient B on approximately 10 occasions, sometimes outside the exam room and sometimes while alone in the exam room with the door closed. (T. 262, 269, 357.)

161. On one occasion, while alone in an exam room, the Respondent positioned himself very close to Patient B where their knees were touching, grabbed her hands, and said a prayer. (T. 264, 270-271.)

162. Patient B never indicated to the Respondent that she would like to pray with him. (T. 271-272.)

163. Patient B asked a staff member at Arthritis Care to not see the Respondent for appointments anymore, and upon Patient B later being contacted by staff from Arthritis Care she informed the practice about her experiences with the Respondent. (T. 273, 275-276.)

164. Patient B's medical record contains an entry on October 12, 2017 summarizing her complaint about the Respondent. (Ex. 5A, p. 304.)

165. The documented complaint was viewed and later closed by Dr. Christopher Huyck. (Ex. 5A, p. 304, T. 276-277.)

166. Patient B was called to a meeting with Dr. Huyck and discussed her complaints about the Respondent including that the Respondent repeatedly touched her breasts and perianal area, among other issues. (T. 279-282.)

167. Dr. Huyck advised Patient B that she no longer had to see the Respondent for appointments. (T. 283.)

168. Patient B did not see the Respondent for an appointment after her meeting with Dr. Huyck. (T. 283.)

169. As of September 30, 2020, Patient B continued to experience symptoms but was not engaged with a Rheumatology practice. (T. 285.)

170. Patient B's experiences with the Respondent have made her apprehensive with male healthcare providers. Patient B felt that every physical exam performed by the Respondent was inappropriate and made her feel embarrassed, degraded, exposed, and trashy. (T. 226, 361.)

Patient C

171. Patient C was first treated at Arthritis Care on November 25, 2014, at the age of 27. (Ex. 6A, pp. 19-23, T. 377, 383-384.)

172. Patient C's intake paperwork at Arthritis Care listed her chief complaint as Sjogren's Syndrome, Fibromyalgia, Fibromatosis, and "very sick." (Ex. 6A, p. 16; T. 378.)

173. Patient C reported a past medical history of autoimmune disorder, depression, lung problems, stomach ulcers, questionable Thyroid Disease, and Sjogren's Syndrome. (Ex. 6A, p. 16; T. 379.)

174. Patient C's intake paperwork listed symptoms of morning stiffness, joint pain, joint swelling, neck pain, back pain. (Ex. 6A, p. 18; T. 380-381.)

175. Patient C reported having short-term memory problems described as difficulty with short-term recall such as details of a conversation. She has never had issues with hallucinations of delusions. (Ex. 6A, p. 18; T. 381-382.)

176. On November 25, 2014, Dr. Huyck documented that Patient C was referred to Arthritis Care for evaluation of near exhaustion, generalized fatigue, marked excessive dryness to the skin, eyes and mouth, a previous diagnosis of possible Fibromyalgia, and Sjogren's Syndrome. Patient C had documented complaints of generalized nonspecific musculoskeletal pain but a previous workup was negative for definite autoimmune disease. (Ex. 6A, p. 19.)

177. On November 25, 2014, Patient C denied having problems in her breasts. (Ex. 6A, p. 20, T. 384.)

178. Huyck's assessment on November 25, 2014 included Keratoconjunctivitis Sicca, Arthralgias, back pain, hip/thigh pain and fatigue, and Dr. Huyck was suspicious of underlying connective tissue disease. (Ex. 6A, p. 22.)

179. On January 13, 2015, Dr. Huyck considered the diagnoses of Lupus or Overlap Syndrome based on Patient C's symptoms, physical findings, and borderline positive Antinuclear Antibody level. (Ex. 6A, pp. 24-32).

180. Between November 2014 and November 2017, Patient C had approximately 35 office visits at Arthritis Care, 15 of which were the Respondent. (Ex. 6A; T. 388-389.)

181. Patient C saw the Respondent for the first time on April 17, 2015. (Ex. 6A; pp. 40-48.)

182. The Respondent routinely performed physical exams of Patient C, with some degree of a physical exam performed at every appointment. (T. 389.)

183. On May 19, 2015, the Respondent documented that Patient C had nonspecific autoimmune disorder with arthralgias and fatigue with complaints of pain all over but especially in the back and hips. The Respondent's physical exam documented bilateral lower lumbar tenderness to palpation and bilateral greater trochanteric bursa tenderness to palpation. (Ex. 6A, p. 49-50.)

184. On May 19, 2015, the Respondent performed an injection in Patient C's right trochanteric bursa to reduce inflammation and pain. (Ex. 6A, p. 51; T. 910.)

185. On June 23, 2015, the Respondent's differential diagnosis for Patient C was Lupus versus Spondyloarthropathy. (Ex. 6A, p. 60.)

186. On August 27, 2015, the Respondent documented that Patient C was tender to palpation over her sacroiliac joints bilaterally which the Respondent treated with a bilateral sacroiliac joint injection. (Ex. 6A, pp. 67-68.)

187. Patient C regularly experienced sharp pain in her chest concentrated near the bottom of her ribs toward the sternum which caused her pain when breathing and moving, and on multiple occasions the Respondent evaluated Patient C for pain in her chest. (T. 405-407.)

188. On September 9, 2015, Patient C had a documented complaint of increasing left flank pain which felt like swelling or a lump, and the Respondent's physical exam documented left flank and left middle abdominal tenderness to palpation (Ex. 6A, pp. 70-71.)

189. On June 1, 2016, Dr. Huyck's assessment of Patient C included Relapsing Polychondritis. (Ex. 6A, pp. 99-101.)

190. On July 21, 2016, the Respondent documented an evaluation of Patient C's costal cage and noted findings of tenderness in the anterior chest costochondral margins bilaterally. (Ex. 6A, pp. 110-111; T. 407.)

191. On August 1, 2016, Dr. Huyck documented possible diagnoses of Polychondritis, Lupus, Sjogren's, or other autoimmune inflammatory diseases. (Ex. 6A, p. 117.)

192. On October 17, 2016, Dr. Huyck documented that Patient C was evaluated for costochondritis. (Ex. 6A, p. 133, T. 406.)

193. On January 16, 2017, the Respondent documented Patient C's complaint as pain occurring around her sternum and documented findings of tenderness to palpation over Patient C's sternal cartilage junction bilaterally as well as the costal cartilage junction. (Ex. 6A, p. 157-158.)

194. On May 15, 2017, the Respondent documented that Patient C was experiencing a flareup of symptoms with left flank pain and swelling, and he documented findings of mild swelling of the paraspinal muscles bilaterally with some tenderness, bilateral costochondral tenderness to palpation, and tenderness to palpation along the left chest wall lateral to the left breast in the anterior axillary line. (Ex. 6A, p. 176-177.)

195. Patient C was always alone with the Respondent during the physical exams. (T. 389.)

196. Patient C never complained to the Respondent that she had any issue with her breasts. (T. 397.)

197. At Patient C's first encounter with the Respondent on April 17, 2015, the Respondent touched Patient C's breasts by placing his hands under her clothing and squeezing, fondling and/or groping them. (T. 391-392, 396-397.)

198. The Respondent touched Patient C's breasts in a similar manner on at least four or five other occasions. (T. 394, 396.)

199. The Respondent also exposed Patient C's breasts by holding her clothing back or pulling her clothing away. (T. 399-401.)

200. The Respondent did not offer Patient C any covering to minimize her exposure (T. 401.)

201. The Respondent did not explain to Patient C why he was touching her breasts. (T. 391-392, 397.)

202. Patient C felt violated, uncomfortable, confused, and embarrassed during the examinations where the Respondent touched her breasts. (T. 402.)

203. The standard of care requires a physician's assistant to document the performance of a breast exam if one was performed. The Respondent never documented the need for touching Patient C's breasts or that he performed a breast exam. (Ex. 6A, T. 931.)

204. There was no legitimate medical purpose for Respondent to touch the Patient C's breasts in the manner he did, and he failed to protect Patient C's privacy. (T. 931-933).

205. The Respondent severely deviated from the standard of care on every occasion that he squeezed, groped, and/or fondled Patient C's breasts. (T. 933-934.)

206. The Respondent created a risk of harm to Patient C of damaging the trust relationship between patient and provider causing the patient to become reluctant to seek medical care, and a risk of emotional harm and post-traumatic stress disorder. (T. 934, 766.)

207. On May 19, 2015, the Respondent performed an injection procedure in Patient C's right trochanteric bursa. (Ex. 6A, pp. 49-51.)

208. During the trochanter injection procedure on May 19, 2015, the Respondent instructed Patient C to expose her buttocks while lying on the exam table. Patient C complied by lowering her garments approximately one quarter of the way down her backside. She remained exposed for approximately ten minutes. (T. 412, 417-418.)

209. The Respondent did not offer Patient C any covering to minimize her exposure during the May 19, 2015 injection procedure. (T. 417.)

210. On May 19, 2015, the Respondent touched Patient C's lower back and exposed buttocks in a massaging, fondling, caressing and groping way, and did not explain the purpose for touching her in that manner. (T. 418.)

211. The Respondent left Patient C exposed more than necessary to effectuate the procedure and failed to protect her privacy. (T. 943-944.)

212. The standard of care required that Patient C be covered after the injection on May 19, 2015 and uncovered again only to the extent necessary if re-examination was needed. (T. 943-944.)

213. The Respondent's conduct during the May 19, 2015 procedure deviated from accepted standards of care to a moderate to severe degree causing a risk of harm to Patient C, including damage to the trust relationship and a risk of emotional harm to Patient C. (T. 766, 945.)

214. On August 19, 2015, the Respondent performed an injection procedure in Patient C's bilateral sacroiliac joint. (Ex. 6A, pp. 66-69.)

215. The Respondent did not provide Patient C a gown for either injection procedure. (T. 412.)

216. During the procedure on August 27, 2015, the Respondent instructed Patient C to lower her pants and pull up her shirt while Patient C was lying on the exam table. Patient C complied. The Respondent instructed Patient C to lower her pants further and the Respondent again complied. The Respondent then abruptly and roughly pulled Patient C's pants and underwear down such that half of Patient C's buttocks were exposed. (T. 413-417.)

217. The Respondent did not offer Patient C any covering to minimize her exposure. (T. 415.)

218. The Respondent used his bare hand to touch Patient C's lower back and exposed buttocks in a massaging, fondling, caressing, and grabbing way during the procedure on August 27, 2015. (T. 415-416).

219. An appropriate evaluation of the sacroiliac joints does not necessitate massaging the patient. (T. 942-943).

220. The Respondent did not explain to Patient C the purpose of touching her in that manner. (T. 416.)

221. The Respondent injected Patient C about six to eight inches above where her pants and underwear had been pulled down. (T. 416.)

222. Patient C remained lying on the table with half of her buttocks exposed for approximately fifteen minutes. (T. 415-416.)

223. The Respondent leaving Patient C exposed for approximately fifteen minutes after the injection did not serve any legitimate medical purpose. (T. 941-942.)

224. The Respondent exposed Patient C to a greater extent than necessary without any medical benefit and failed to protect Patient C's privacy. (T. 939-940.)

225. The manner in which the Respondent exposed Patient C on August 27, 2015 was contrary to accepted standards of care and constituted a moderate to severe deviation. (T. 940.)

226. The deviation from the standard of care created a risk of harm to Patient C including a risk to her ability to trust treatment providers, and a risk of emotional harm. (T. 766, 940-941.)

227. The manner in which the Respondent touched Patient C's buttocks on August 27, 2015 was not medically justifiable, was contrary to accepted standards of care and constituted a moderate to severe deviation. (T. 941-942.)

228. At each of Patient C's appointments with the Respondent, the Respondent instructed Patient C to lower her undergarments and pull up her shirt to expose herself and walk back and forth in front of the Respondent. Then the Respondent would bring Patient C between his legs and touch Patient C's exposed buttocks using a fondling, grabbing, and squeezing manner. (T. 419-421.)

229. There is no recognized or documented medical benefit or therapeutic objective for exposing and touching Patient C's exposed buttocks in the manner she described. (T. 945-948.).

230. The Respondent's repeated exposure of Patient C's buttocks was not done in a discreet way as required by accepted standards of care. (T. 946-947.)

231. The Respondent's repeated exposure and touching of Patient C's buttocks on each occasion constituted a severe deviation from the standard of care. (T. 946-947.)

232. The Respondent hugged Patient C in the exam room while the two were alone at every appointment she had with him, usually at the beginning and end of the appointment. The hugging made Patient C uncomfortable. (T. 423-425.)

233. The Respondent asked Patient C questions related to intimacy. The questions made Patient C uncomfortable. (T. 430-432.)

234. Patient C informed Dr. Huyck about her concerns with the Respondent around the time of her last appointment at Arthritis Care, and she later received a letter dismissing her from the practice. (T. 440-444.)

Patient D

235. Patient D was first treated at Arthritis Care on April 1, 2015 at the age of 28, and continued treatment until at least on or about April 8, 2018. (Ex. 7).

236. Patient D's chief complaint at the time of her first appointment was Rheumatoid Arthritis with consistent pain, and lupus diagnosed by another provider. Her documented symptoms including weight gain, fatigue, sleep trouble, headaches, joint pain, joint swelling, urinary infections, painful intercourse, easy bruising or bleeding, and shortness of breath. (Ex. 7, pp. 1036-1038; T. 1000.)

237. Patient D reported having a history of depression, asthma, Rheumatoid Arthritis, stomach ulcers and Still's Disease. (Ex. 7, p. 1036.)

238. Patient D described that her adolescent Still's Disease developed into inflammatory arthritis and rheumatoid disease, and after a period of about 3 years where she was in remission, Patient D started having increasing pain in her knees, wrists, and other areas, including the back, elbows, fingers, feet, and ankles. (Ex. 7, p. 1041; T. 1013.)

239. Patient D denied having any chest pain. (Ex. 7, p. 1042.)

240. Patient D never presented to Arthritis Care with complaints or symptoms in her breasts (Ex. 7, T. 1028).

241. Between April 2015 and April 2018, Patient D had approximately 55 appointments at Arthritis Care – 7 with Dr. Huyck, 7 with the Respondent, and 41 with a nurse practitioner. (Ex. 7; T. 1022-1023.)

242. Patient D's seven appointments with the Respondent occurred between September 2015 and March 2016. (Ex. 7; T. 1023.)

243. At each appointment with the Respondent, Patient D was alone in the exam room with the Respondent. (T. 1037, 1041.)

244. At Patient D's first appointment with the Respondent on September 15, 2015, Respondent documented that Patient D's nerve conduction studies showed peripheral neuropathy and possible lumbar radiculopathy. (Ex. 7, p. 993; T. 1148.)

245. The Respondent also documented on September 15, 2015 that Patient D denied chest pain or shortness of breath, but that Patient D had intermittent cough present for one or two months, and intermittent swelling of her joints, particularly her knees, and pins and needles in her feet, among other symptoms. (Ex. 7, p. 993.)

246. On September 15, 2015 the Respondent performed a physical exam with negative findings except for small punctate bumps. (Ex. 7, p. 994; T. 1149-1150.)

247. At an encounter on October 15, 2015, the Respondent documented symptoms of wide somatic complaints, acute bronchitis with significant cough, moderate to severe fatigue, chest pain and shortness of breath intermittently. There was no compelling evidence that

Patient D's asthma or acute bronchitis were related to any rheumatological disease. (T. 1152-1153.)

248. On October 15, 2015, the Respondent performed a physical exam and documented bilateral tenderness upon palpation of Patient D's lower lumbar spine. (Ex. 7, p. 964.)

249. At an encounter on January 19, 2016, the Respondent documented that Patient D was followed for inflammatory arthritis, positive ANA, peripheral neuropathy, celiac disease, and sacroiliac pain, and she was noted to be experiencing pain in her back, knees, and ankle. (Ex. 7, p. 931.)

250. On January 19, 2016, the Respondent performed a physical exam of Patient D and documented that Patient D was tender to palpation in the gluteal muscles with trigger points. (Ex. 7, p. 932; T. 1035.)

251. On January 19, 2016, the Respondent assessed Patient D as having myalgia and inflammatory polyarthropathy, among other conditions. (Ex. 7, p. 933.)

252. On January 19, 2016, the Respondent recommended trigger point injections for treatment. (Ex. 7, p. 933.)

253. The Respondent treated Patient D's back pain and muscle knots by kneading the area and by injection procedures. (T. 1030.)

254. On February 19, 2016, the Respondent performed a left lateral gluteal trigger point injection. (Ex. 7, p. 929.)

255. The standard of care requires that a physician's assistant ensure that a patient has maximum privacy when performing a physical examination, including the identification of trigger points. If the examination necessitates contact with the patient's sensitive areas, the physician's assistant must ensure the patient is appropriately gowned and any exposure is limited to the area being examined. (T. 1169-1170.)

256. When performing a gluteal trigger point injection procedure, the standard of care requires that the procedure is performed in a way that protects the patient's privacy, including ensuring the patient is covered except for the area being injected which would permit exposing about two square centimeters. Limiting exposure protects the patient's privacy and enhances the sterility of the procedure. (T. 1168-1169.)

257. On February 19, 2016, the Respondent instructed Patient D, who was wearing her street clothes, to lie on the exam table on her stomach (T. 1057-1058.)

258. On February 19, 2016, the Respondent pulled Patient D's pants halfway down over her buttocks and kneaded her buttocks on the left side for about two to three minutes. (T. 1030, 1037, 1055-1058.)

259. On February 19, 2016, the Respondent told Patient D he was looking for knots as he was kneading her buttocks. (T. 1058.)

260. On February 19, 2016, Patient D's pants were pulled down lower than needed to expose the injection site. (T. 1058-1059.)

261. Patient D felt exposed and uncomfortable at the injection procedure on February 19, 2016. (T. 1058-1059.)

262. On two occasions, the Respondent kneaded Patient D near her pant/waistline, making her feel uncomfortable. (T. 1030, 1056, 1060.)

263. On March 10, 2016, the Respondent documented that Patient D had a flareup of back pain but she had some relief from a prior left lateral gluteal trigger point injection. The Respondent documented that Patient D's pain was primarily now on her right side and that she was not getting relief from muscle relaxers or massage. (Ex. 7, p. 919.)

264. On March 10, 2016, the Respondent examined Patient D and documented tenderness to palpation over the sacroiliac joints bilaterally and marked tenderness to palpation over the lateral gluteal muscles with trigger points. (Ex. 7, p. 920).

265. On March 10, 2016, the Respondent documented performing an Arthrocentesis of Patient D's bilateral sacroiliac joint. (Ex. 7, p. 921.)

266. Patient D felt her appointments with the Respondent were inappropriate on multiple occasions. (T. 1037-1038.)

267. On three occasions the Respondent slid his hand across Patient D's breasts and let his hands linger on her breasts while listening to her chest with a stethoscope. (T. 1040-1043.)

268. On one occasion, the Respondent instructed Patient D to bend over while she was wearing a gown. While Patient D was bending over, the Respondent touched own Patient D's spine and kneaded her lower back and upper buttocks in a manner that felt sensual to Patient D. Also while bending over, the Respondent reached below Patient D's gown and grabbed her exposed breasts. (T. 1043-1051.)

269. The Respondent did not inform Patient D that he was going to touch her breasts or the purpose thereof. (T. 1052.)

270. There were no symptoms documented in Patient D's medical record specific to her breasts and the Respondent did not document that he performed a breast exam on Patient D or touched her breasts. (Ex. 7; T. 1179-1180.)

271. Patient D requested not to see the Respondent for future appointments after her visit with the Respondent where he grabbed Patient D's breasts. (T. 1051.)

272. There was no medical justification or benefit for the Respondent to grab Patient D's breasts in the manner she described. (T. 1180-1181.)

273. The Respondent's conduct when he touched Patient D's breasts while the patient was bent over in a gown constituted a moderate to severe deviation from the standard of care. (T. 1181.)

274. The Respondent's conduct when he touched Patient D's breasts while the patient was bent over in a gown was a violation of Patient D's privacy. (T. 1181.)

275. The Respondent's conduct when he touched Patient D's breasts while the patient was bent over in a gown created a risk of harm to Patient D of harm to trust and emotional harm including post-traumatic stress. (T. 766, 1181-1182.)

276. The standard of care requires that when performing an examination of the back of a patient where the patient is bending, a physician's assistant must promote patient privacy by covering any area of the body that is not being examined. (T. 1183.)

277. On the occasion where Patient D was instructed to bend over while wearing a medical gown, Patient D's breasts and buttocks were exposed unnecessarily and without legitimate medical purpose. (T. 1045, 1183.)

278. The Respondent failed to protect Patient D's privacy when he examined her while she was bending over and her breasts and buttocks were exposed. (T. 1183-1184.)

279. The Respondent's failure to protect Patient D's privacy during examination constituted a deviation from the standard of care and created a risk of harm to the patient, including a potential impact on the trust relationship between the patient and provider. (T. 766, 766.)

280. At the end of every appointment with the Respondent, the Respondent touched Patient D's upper and inner thigh over her clothing while he discussed the treatment plan, making Patient D very uncomfortable. (T. 1038, 1040, 1062-1063.)

281. The Respondent's contact with Patient D's upper and inner thighs at the end of Patient D's appointments had no legitimate medical purpose or diagnostic benefit and constituted a severe deviation from the standard of care. (T. 1184-1185.)

282. The Respondent did not document any legitimate medical rationale for touching Patient D's upper and inner thigh in the manner and frequency she described. (T. 1185.)

283. The Respondent's repeated touching of Patient D's upper and inner thigh created a risk of harm to Patient D, including a risk of damaging the trust Patient D places in her healthcare providers and a risk of emotional harm. (T. 766, 1185.)

284. On March 21, 2016, the Respondent instructed Patient D to follow up with him in one month. Patient D did not return to see the Respondent for any of her other appointments at Arthritis Care. (Ex. 7, p. 914-916; Ex. 7; T. 1053.)

285. Patient D now only wears a gown at medical appointments if she is having a surgical procedure because of her experiences with the Respondent. (T. 1066.)

Patient E

286. Patient E was first treated at Arthritis Care on October 3, 2013, at the age of 55, and continued treatment there until about May 29, 2015. (Ex. 8A, pp. 10, 53, T. 612-613.)

287. Patient E had previously been diagnosed with rheumatoid arthritis around the year 2000. (Ex. 8A, p. 7; T. 613-614.)

288. On her intake paperwork at Arthritis Care, Patient E noted symptoms including fatigue, headaches, numbness and tingling, muscle weakness, morning stiffness, joint pain, joint swelling, neck pain, back pain, depression, sleep trouble, and memory problems. (Ex. 8A, p. 9.)

289. Patient E's symptoms interrupted her normal daily activities and caused her difficulty performing normal tasks. (T. 616.)

290. Patient E described some mild short-term memory lapses but denied hallucinations or delusions. (Ex. 8A, p. 9; T. 614, 617-618).

291. Patient E described her pain symptoms as occurring in her hands, knees, feet, lower and upper back, and neck. (Ex. 8A, p. 9; T. 619.)

292. Between October 2013 and May 2015, Patient E had 13 appointments at Arthritis Care, six of those appointments were with Dr. Huyck and seven of those appointments were with the Respondent. (Ex. 8A; T. 623.)

293. Patient E's first appointment with the Respondent was on November 20, 2013. (Ex. 8A, p. 18.)

294. On November 20, 2013, the Respondent assessed Patient E as having rheumatoid arthritis. (Ex. 8A, p. 21.)

295. On February 11, 2014, the Respondent documented that Patient E continued to complain of pain in her knees, and pain in her hands and feet. (Ex. 8A, pp. 23-24.)

296. On February 11, 2014, the Respondent documented having performed an injection procedure of Arthrocentesis in Patient E's left knee. (Ex. 8A, p. 23-24.)

297. On March 11, 2014, the Respondent documented that the injection procedure provided some improvement for a period of two to three days, after which the pain returned to its previous level. (Ex. 8A, p. 26.)

298. On October 8, 2014, the Respondent documented that Patient E complained of low back pain and that x-rays of Patient E's sacroiliac showed evidence of sacroiliitis. The Respondent also documented a physical exam with right sacroiliac tenderness to palpation. (Ex. 8A, p. 39-40.)

299. On October 8, 2014, the Respondent documented having performed another Arthrocentesis in Patient E's right sacroiliac joint. (Ex. 8A, p. 39, 40; T. 626.)

300. The injection on October 8, 2014 was the first time Patient E had Arthrocentesis of her sacroiliac joint. (T. 627.)

301. During the procedure on October 8, 2014, the Respondent was alone with Patient E in the exam room and instructed Patient E to lie on her stomach on the exam table. (T. 627-630.)

302. Patient E was wearing leggings and she was not offered or instructed to put on a gown. (T. 627, 630.)

303. While Patient E was on her stomach on the exam table, the Respondent forcefully pulled down Patient E's leggings and underwear, exposing half of her buttocks, without warning or consent from Patient E. (T. 627-631.)

304. After lying partially exposed for 10 to 30 seconds, the Respondent then forcefully pulled Patient E's pants and underwear down below her buttocks to her thighs. (T. 627-632.)

305. The Respondent did not offer any warning or obtain any consent prior to exposing Patient E's buttocks and part of her upper thighs. (T. 628, 632.)

306. The Respondent did not provide or offer Patient E any covering. (T. 632.)

307. Patient E began to move around because she felt uncomfortable, at which point the Respondent yelled at her to remain still. (T. 628.)

308. The Respondent placed a flat hand on Patient E's right buttock for a couple of seconds, removed it, and then placed a flat hand on Patient E's left buttock, both touches occurring without the Respondent explaining the purpose thereof. (T. 628, 633.)

309. The location where the Respondent touched Patient E's buttocks was not near the location of the injection, and the Respondent did not ask Patient E if he was eliciting pain while touching her. (T. 629, 634.)

310. Patient E felt a single injection in her left upper buttocks beneath her waist, the location of which was much higher than the place to where her pants were pulled down. (T. 628, 634-635.)[4]

311. The injection site for an Arthrocentesis of the sacroiliac joint is three to five inches lateral to the midline and the sacroiliac joint is palpated in the area of the upper buttocks. (T. 1208-1209.)

312. Following the procedure, Patient E felt humiliated, exposed, and like her privacy was not protected. (T. 628-629, 636-637.)

313. The Respondent exposed Patient E beyond what was required to perform the injection procedure and failed to protect her privacy. (T. 1211-1213.)

314. A reasonably prudent physician's assistant would have appropriately gowned the patient and exposed only the area where the injection would occur. (T. 1210.)

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[4] The Respondent documented the injection as occurring on Patient E's right side and Patient E testified as to the injection occurring on her left side. (Ex. 8A, p. 40; T. 685.) The side of the injection has no bearing on the substance of the facts or conclusions herein as determined by the Hearing Committee.

315. The manner in which the Respondent pulled down Patient E's garments constituted inappropriate physical contact a severe deviation from the standard of care. There was no medical reason for Patient E to be exposed and uncovered as described. (T. 1210-1211.)

316. The injection procedure performed by the Respondent on October 8, 2014 was not performed in accordance with accepted standards of care. (T. 1210-1211).

317. The Respondent caused a risk of harm to Patient E including damage to the trust relationship between Patient E and her medical providers and the risk of emotional harm. (T. 766, 1211.)

318. Patient E did not report the incident to anyone at Arthritis Care because she was shaken, confused, and humiliated. (T. 638.)

319. Patient E experienced some short-term relief of her symptoms from the October 8, 2014 injection procedure. (Ex. 8A, p. 42; T. 639.)

320. On April 15, 2015, Dr. Huyck performed an Arthrocentesis of Patient E's right sacroiliac joint. (Ex. 8A, p. 51; T. 626.)

321. Patient E specifically requested to have Dr. Huyck, rather than the Respondent, perform the injection procedure. (T. 639-640.)

322. The April 15, 2015 injection was the second time that Patient E had that type of procedure in her sacroiliac joint. (T. 640-641.)

323. The manner in which Dr. Huyck performed the injection in Patient E's sacroiliac joint was unlike the way the Respondent performed the procedure in that Dr. Huyck lowered Patient E's pants a few inches, provided a cover for exposed areas, and communicated to Patient E the steps of the procedure including when he needed her to lower her pants and the purpose of touch during the procedure. (T. 640-642.)

324. The difference in the way Dr. Huyck performed the injection procedure on April 15, 2015 as compared to the way the Respondent performed the procedure on October 8, 2014 caused Patient E to become emotional. (T. 642-643.)

325. Patient E encountered the Respondent in the hallway at Arthritis Care after her April 15, 2015 injection procedure with Dr. Huyck and she felt bothered and anxious. (T. 642-643.)

326. Patient E's last appointment at Arthritis Care was on May 29, 2015 with Dr. Huyck. She stopped going to Arthritis Care for treatment because of her experience with the Respondent and her desire to never see him again. (Ex. 8A, pp. 53-56; T. 650.)

327. Patient E's experiences with the Respondent changed the way she interacts with healthcare providers in that she gets very anxious around the time of her appointment and is uncomfortable in an exam room with the door closed. (T. 651.)

328. As of the date of her testimony, Patient E was not engaged with a Rheumatology practice for treatment although she still experiences similar symptoms. (T. 619, 651-652.)

Patient F

329. Patient F was first treated at Arthritis Care on April 24, 2013 at the age of 44. (Ex. 9A, p. 137, T. 541-542.)

330. Patient F was referred to Arthritis Care by her primary care physician for chronic pain, arthritis pain, joint pain, and to reduce some of the medications she was taking. (Ex. 9A, p. 8, 137; T. 543-544.)

331. Patient F's intake paperwork listed her reasons for going to Arthritis Care as osteoarthritis and osteoporosis. (Ex. 9A, p. 17.)

332. Patient F experienced pain in her upper and lower back, hips, and neck, as well as morning stiffness, joint pain, and joint swelling. (Ex. 9A, p. 18; T. 544-545.)

333. Patient F reported having short term memory problems but denied problems with delusions or hallucinations. (Ex. 9A, p. 16; T. 546.)

334. On April 24, 2013, Patient F saw Dr. Huyck who documented her chief complaint as needing further evaluation and treatment of her diffuse pain syndrome and noted possible diagnoses of chronic pain syndrome or Fibromyalgia because Patient F's symptoms were not indicative of autoimmune disease, lupus, or inflammatory arthritis. (Ex. 9A, pp. 137, 140; T. 547-548.)

335. On May 15, 2013, Dr. Huyck documented that x-rays revealed that Patient F had some moderate osteoarthritis of the hips for which he recommended injections. (Ex. 9A, pp. 19-22; T. 549.)

336. On September 6, 2013, Patient F first saw the Respondent for an appointment. (Ex. 9A, pp. 152-154; T. 549-550.)

337. Patient F had approximately 15 appointments with the Respondent while she was a patient at Arthritis Care. (Ex. 9A; T. 550.)

338. Patient F had approximately 9 injection procedures performed by providers at Arthritis Care – 1 performed by Dr. Huyck, 1 by a nurse practitioner, and 7 by the Respondent. (Ex. 9A; T. 551-552.)

339. Patient F found the injections beneficial in the treatment of her pain. (T. 552.)

340. On April 18, 2016, Patient F saw the Respondent at Arthritis Care, and the Respondent documented a history of chronic pain associated with sacroiliac pain and findings of a physical exam including tenderness over the bilateral sacroiliac joints, upper paraspinal muscles, and right greater trochanteric. (Ex. 9A; pp. 52-54.)

341. On April 18, 2016, the Respondent documented an Arthrocentesis injection procedure of the bilateral sacroiliac joint. (Ex. 9A, p. 55-56; T. 552-553, 973.)

342. Patient F was alone in the exam room with the Respondent during the procedure. (T. 555.)

343. Patient F was wearing leggings and a long sweater at the time of the procedure and was positioned face down on the exam table. (T. 554-556.)

344. The Respondent pulled down Patient F's pants and underwear to the bottom of her buttocks while she was on the table. (T. 553-557.)

345. The Respondent did not ask Patient F to expose the injection site and Patient F did not ask the Respondent for assistance to expose the injection site. (T. 556.)

346. After exposing Patient F's buttocks, the Respondent did not provide Patient F with a covering. (T. 556-557.)

347. The Respondent pressed on Patient F's exposed body and marked areas with a marker. (T. 557.)

348. Patient F remained lying on the exam table in an exposed state prior to getting the injection for approximately 10 minutes. (T. 557.)

349. Patient F felt the injection occur in her right upper hip area or the top of her buttocks. (T. 553, 557.)

350. The Respondent instructed Patient F to remain in that position to give the medicine time to work, and Patient F was left in that state without a covering for approximately 10 to 15 minutes. (T. 553-558.)

351. The standard of care when performing a sacroiliac injection requires a physician's assistant to protect the patient's privacy and limit the exposure to the specific area of the body that needs to be injected. (T. 978.)

352. The performance of a bilateral sacroiliac injection as documented on April 18, 2016, does not require the patient to be exposed to the extent that was described by Patient F. (T. 975-977.)

353. If the patient's clothing inhibited the procedure, the patient should be provided a gown so that other areas of the body were appropriately covered. (T. 977.)

354. Requiring a patient to remain in an exposed state for ten minutes before or after the injection does not serve a legitimate medical purpose. (T. 978.)

355. 581. The Respondent's conduct on April 18, 2016 did not protect Patient F's privacy. (T. 979-980.)

356. The Respondent inappropriately contacted Patient F when he pulled down her pants and underwear. (T. 980.)

357. The Respondent deviated from the standard of care on April 18, 2016 to a moderate or severe degree when he inappropriately contacted Patient F by pulling down her pants and underwear. (T. 980.)

358. The Respondent created a risk of harm to the patient, including damaging the trust relationship and causing emotional distress. (T. 766, 980.)

359. Following the period of exposure after the injection, Patient F pulled her own clothing back up and got off the exam table. (T. 554, 559.)

360. After Patient F got off the exam table, the Respondent instructed her to walk toward him and away from him while he sat in a chair. (T. 554, 559.)

361. The Respondent then pressed on Patient F's hips as she stood before him and he was in a seated position. (T. 554, 559.)

362. The Respondent pulled Patient F's leggings down almost to her knee without warning or explanation, exposing her right hip and buttocks. He then looked over her body and touched her by pressing and grabbing her hips while she stood in front of him. (T. 554, 559-560.)

363. The Respondent did not provide any explanation for touching Patient F's exposed body. (T. 560.)

364. Patient F felt horrified and like her privacy had been violated. She pulled her pants up and ran out of the exam room. (T. 554, 560-561.)

365. The Respondent failed to act in accordance with patient privacy standards when he pulled Patient F's pants down as she was standing after the injection procedure. (T. 981.)

366. The Respondent did not protect Patient F's privacy when he pulled her pants down the second time and his action was a deviation from the standard of care. (T. 981-982.)

367. The Respondent's contact with Patient F's exposed body described by the patient as grabbing was a severe deviation from the standard of care and created a risk of harm to the patient including emotional distress and damage to the trust relationship between patient and provider. (T. 766, 981-982.)

368. On April 18, 2016, Patient F left Arthritis Care without checking out at the front desk because she was upset. (T. 561.)

369. Patient F's experience with the Respondent has impacted her ability to place trust in treatment providers. She has difficulty trusting male providers and is apprehensive to go to appointments with male providers because of her experiences with the Respondent. (T. 571-572.)

370. Patient F reported the incident with the Respondent to the office manager at Arthritis Care shortly after leaving her appointment on April 18, 2016. She then met with Dr. Huyck the following day to discuss the incident. (T. 561-563.)

371. Dr. Huyck told Patient F that she would only see him or the nurse practitioner for treatment going forward. (T. 564.)

372. Dr. Huyck documented an April 19, 2016 conversation with Patient F in her medical record during which they discussed the prior day's appointment, among other things. (Ex. 9A, p. 142.)

373. The Respondent documented on April 18, 2016 that he wanted to see Patient F for a follow-up appointment in two weeks, but Patient F did not return to the practice until June 20, 2016 and she saw a different provider. (Ex. 9A, p. 56-57.)

374. Patient F did not see the Respondent for another appointment after April 18, 2016. (Ex. 9A; T. 554.)

CONCLUSIONS OF LAW

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department. (See Prince, Richardson on Evidence § 3-206.) Having considered the complete record in this matter, the Hearing Committee concludes that the Department has established each of the nineteen specifications contained in the Statement of Charges. The sustained specifications include professional misconduct by practicing the profession with negligence on more than one occasion [NY Educ. Law § 6530(3)], practicing the profession with gross negligence [NY Educ. Law § 6530(4)], practicing the profession with incompetence on more than one occasion [NY Educ. Law § 6530(5)], conduct in the practice of medicine which evidences moral unfitness to practice medicine [NY Educ. Law § 6530(20)], willfully harassing, abusing, or intimidating a patient either physically or verbally [NY Educ. Law § 6530(31)], and failing to maintain a record which accurately reflects the evaluation and treatment of the patient [NY Educ. Law § 6530(32)]. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee.

DEPARTMENT'S EXPERT

The Department's expert witness was Robert Lesser, M.D., FACP, FACR. Dr. Lesser is licensed to practice medicine in New York. Dr. Lesser is board certified in Internal Medicine and Rheumatology. At the time of the hearing, he was working with New York University Langone Health's faculty group practice. Dr. Lesser has worked in several hospital settings and he owned and operated his own private rheumatology practice from 1988 to 2014. He has experience in teaching, supervising, and mentoring medical students, residents, and fellows during various appointments at hospitals and while in private practice. Dr. Lesser has familiarity with the

standards of care relating to the practice of medicine generally and in the specific area of rheumatology. (Ex. 10; T. 721-987, 1126-1374.)

Dr. Lesser reviewed the medical records from Arthritis Care for all six patients involved in this case. He also reviewed the transcripts from each day that the six patients testified. Dr. Lesser's testimony was informed, thoughtful, clear and comprehensive. He demonstrated knowledge of the patients' clinical presentations and their specific experiences with the Respondent. The Hearing Committee finds Dr. Lesser to be well-credentialed, his testimony to be very credible, and his opinions on deviations in standard of care to be appropriately rendered.

RESPONDENT'S EXPERT

The Respondent's expert witness was Hal Blatman, M.D. Dr. Blatman is licensed to practice medicine in Ohio, New York and Washington. Dr. Blatman is board certified in Occupational Medicine and Integrative Medicine. At the time of the hearing, he was practicing in the areas of regenerative medicine and orthopedic rehabilitation, and held an affiliate faculty position at Bastyr University in Seattle, Washington. Dr. Blatman testified that his approach to pain treatment is unconventional and has been developed over decades of research, experience and mentorship, and his specialized training as a healing touch practitioner and craniosacral therapist. He further testified as to diagnosing myofascial pain by touching and feeling nuances and textures in the body. Dr. Blatman presented a one-hour workshop between 1990 and 2005 at which the Respondent was present.

(Exhibit F, T. 1765-1860.)

Dr. Blatman did not review the medical records from Arthritis Care for any of the patients in this case. He did not review the transcripts containing the testimony of any of the patients. Dr. Blatman's testimony, while quite interesting, lacked knowledge of the specific patients and allegations relative to them in this matter. Dr. Blatman did not dispute the specific testimony provided by Dr. Lesser regarding deviations by the Respondent in standards of care. The Hearing

Committee finds Dr. Blatman's testimony to be largely irrelevant to the specifications of professional misconduct in the Statement of Charges.

PATIENTS A - F TESTIMONY

Patients A, B, C, D, E and F each testified at the hearing as to their specific experience with the Respondent. The Hearing Committee found the testimony of each patient to be credible. The Hearing Committee further found that the credibility of each was bolstered when taking into account commonalities of experiences recounted independently by the patients. For example, four of the patients (A, B, C and D) testified about the Respondent inappropriately touching their breasts, three of the patients (C, E and F) testified about the Respondent inappropriately removing their clothing, and two of the patients (B and C) testified as to the Respondent inappropriately hugging them. Several of the patients also testified about an inappropriate feel to the way in which the Respondent touched them on examination and about being exposed unnecessarily during their visits with the Respondent. Moreover, the testimony of two patients (B and F) were substantiated by documented complaints within their medical records from Arthritis Care. The Hearing Committee found all the patients to be forthright, candid and genuine.

RESPONDENT'S TESTIMONY

The Respondent was present on each hearing date and provided testimony. The Hearing Committee found the Respondent to be knowledgeable and experienced in his practice as a physician's assistant, and found no significant concerns with his provision of rheumatological clinical care contained in the medical records of the six patients. As to the specific allegations made by the patients, the Respondent's testimony fell largely into two categories – outright denials of allegations made by the patients and explanations in which he placed blame on the patients for misinterpreting his actions or in which he unconvincingly attempted to justify his actions. The Hearing Committee found the explanations advanced by the Respondent to be self-serving and, in some instances, simply implausible. The Hearing Committee also found the Respondent's testimony regarding Dr. Huyck's opinion of the Respondent and the circumstances surrounding

the Respondent's departure from Arthritis Care to be less than forthright and lacking in truthfulness. Overall, the Hearing Committee found the Respondent to be lacking in credibility.

FIRST SPECIFICATION

The Department's First Specification charges the Respondent with professional misconduct for practicing medicine with negligence on more than one occasion in his care of Patients A through F, in violation of New York Education Law § 6530(3). Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients. Bogdan v. State Board for Professional Medical Conduct, 195 A.D.2d 86 (3d Dept. 1993). The Respondent's inappropriate touching of patients, manner of pulling away patients' clothing, unnecessary exposure of areas of patients' bodies and failure to protect their privacy, and failure to obtain consent for each of the above, as detailed within the Findings of Fact, support a finding of negligence on more than one occasion as those actions and/or omissions by the Respondent are deviations from acceptable medical standards in the treatment of patients. Accordingly, this specification is sustained.[5]

SECOND – FIFTH SPECIFICATIONS

The Department's Second through Fifth Specifications charge the Respondent with professional misconduct for practicing medicine with gross negligence in his care of Patients A through D, respectively, in violation of New York Education Law § 6530(4). Gross negligence is defined as negligence which involves a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences. Post v. State of New York Department of Health, 245 A.D.2d 985 (3d Dept. 1997). There is no need to prove that the

[5] Although the Respondent's performance of sacroiliac injections on Patients B and F is not directly specified within the Statement of Charges as a basis for the alleged negligence, the Hearing Committee notes that it has serious concerns regarding the manner in which the Respondent performed the procedures, i.e., the lack of a sterile environment and the failure to appropriately visualize the joint being injected. These concerns are noteworthy but do not form a basis for the Hearing Committee's sustaining this specification.

medical provider was conscious of the impending dangerous consequences of his conduct. Minielly v. Commissioner of Health, 222 A.D.2d 750 (3d Dept. 1995). The Respondent's inappropriate physical contact with Patients A as described in the Findings of Fact, including the contact with her breasts, is a serious deviation from acceptable medical standards which presented a risk of potentially grave consequences to Patient A. The Respondent's inappropriate physical contact with Patient B as described in the Findings of Fact, including the contact with her breasts and her perianal area, and the Respondent's repeated exposure of her body, is a serious deviation from acceptable medical standards which presented a risk of potentially grave consequences to Patient B. The Respondent's inappropriate physical contact with Patient C as described in the Findings of Fact, including the contact with her breasts and buttocks, and the Respondent's repeated exposure of her body, is a serious deviation from acceptable medical standards which presented a risk of potentially grave consequences to Patient C. The Respondent's inappropriate physical contact with Patient D as described in the Findings of Fact, including the contact with her breasts and thighs, is a serious deviation from acceptable medical standards which presented a risk of potentially grave consequences to Patient D. In addition to these acts and omissions by the Respondent constituting negligence, they rise to the level of gross negligence. Accordingly, Specifications Two through Five are sustained.[6]

SIXTH SPECIFICATION

The Department's Sixth Specification charges the Respondent with professional misconduct for practicing medicine with incompetence on more than one occasion in his care of Patients A through F, in violation of New York Education Law § 6530(5). Incompetence is defined

[6] Although the Respondent's performance of sacroiliac injections on Patient B is not directly specified within the Statement of Charges as a basis for the alleged gross negligence, the Hearing Committee notes that it has serious concerns regarding the manner in which the Respondent performed the procedures, i.e., the lack of a sterile environment and the failure to appropriately visualize the joint being injected. These concerns are noteworthy but do not form a basis for the Hearing Committee's sustaining Specification Three.

as the lack of the requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 609 (3d Dept. 1996). The Respondent's manner of examining the patients and his failure to provide information to and obtain consent from the patients prior to coming into contact with private areas of their bodies, as well as his failure to protect their privacy, as detailed in the Findings of Fact, support a finding of incompetence on more than one occasion as those same actions and/or omissions by the Respondent demonstrate the Respondent's lack of the requisite skill or knowledge to practice medicine safely. Accordingly, this specification is sustained.[7] The Hearing Committee specifically notes that, except for as noted in Footnote 6 below, it finds no evidence of acts or omissions demonstrating incompetence by the Respondent in his clinical care contained in the medical records of the six patients.

SEVENTH – TWELFTH SPECIFICATIONS

The Department's Seventh through Twelfth Specifications charge the Respondent with professional misconduct for engaging in conduct in the practice of medicine which evidences moral unfitness to practice medicine based on his treatment of Patients A through F, respectively, in violation of New York Education Law § 6530(20). Conduct in the practice of medicine which evidences moral unfitness to practice medicine is established if a physician "violat[es] the trust the public bestows on the medical profession and/or violat[es] the medical profession's moral standards." Prado v. Novello, 301 A.D.2d 692 (3d Dept. 2003) (citing Matter of Pearl, Administrative Review Board Determination and Order No. 01-93 [2001]). The Respondent's inappropriate touching of patients, manner of pulling away patients' clothing, unnecessary exposure of areas of patients' bodies and failure to protect their privacy, and failure to obtain consent for each of the above, as detailed within the Findings of Fact, support a

[7] Although the Respondent's performance of sacroiliac injections on Patients B and F is not directly specified within the Statement of Charges as a basis for the alleged incompetence, the Hearing Committee notes that it has serious concerns regarding the manner in which the Respondent performed the procedures, i.e., the lack of a sterile environment and the failure to appropriately visualize the joint being injected. These concerns are noteworthy but do not form a basis for the Hearing Committee's sustaining this specification.

finding of conduct evidencing moral unfitness. Accordingly, Specifications Seventh through Twelfth are sustained.

THIRTEENTH – EIGHTEENTH SPECIFICATIONS

The Department's Thirteenth through Eighteenth Specifications charge the Respondent with committing professional misconduct for willfully harassing, abusing or intimidating a patient either physically or verbally in his treatment of Patients A through F, respectively, in violation of New York Education Law § 6530(31). Willfully harassing, abusing, or intimidating a patient either physically or verbally has a plain meaning. New York Courts have upheld Board for Professional Medical Conduct determinations to sustain charges of willful harassment, abuse or intimidating in cases where the licensee engaged in inappropriate sexual conduct directed toward patients. Coderre v. DeBuono, 247 A.D.2d 793 (3d Dept. 1998); Gross v. DeBuono, 223 A.D.2d 789 (3d Dept. 1996); Murray v. Chassin, 213 A.D.2d 858 (3d Dept. 1995). The Respondent's inappropriate touching of patients, manner of pulling away patients' clothing, unnecessary exposure of areas of patients' bodies and failure to protect their privacy, and failure to obtain consent for each of the above, as detailed within the Findings of Fact, support a finding of willfully harassing, abusing or intimidating the patients. Accordingly, Specifications Thirteenth through Eighteenth are sustained.

NINETEENTH SPECIFICATION

The Department's Nineteenth Specification charges the Respondent with professional misconduct for failing to maintain a record for Patients A through D which accurately reflects the evaluation and treatment of the patients, in violation of Education Law § 6530(32). A medical record needs to convey objectively meaningful medical information concerning a patient treated to other physicians. Maglione v. New York State Dept. of Health, 9 A.D.2d 522 (3d Dept. 2004). Documentation by the Respondent in the physical examination sections of the medical records of Patients A through D are largely boilerplate. The majority are lacking in detailed findings upon examination. The records also omit any record of Respondent's contact with the breasts of

Patients A through D and the perianal area of Patient B, and any medical justification for such contact. These omissions render the medical records for these four patients inadequate. Accordingly, this specification is sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to statute, including revocation, suspension, probation, censure, and the imposition of civil penalties.

The Hearing Committee heard testimony it deemed credible from the Department's expert, Dr. Lesser, as to the Respondent's deviations from the appropriate standard of care. Conversely, the Hearing Committee heard the testimony from the Respondent's expert, Dr. Blatman, which it deemed largely uninformed and irrelevant.

The Hearing Committee appreciates Patients A, B, C, D, E, and F testifying, particularly given the sensitive nature of this matter. It found them to be credible despite the Respondent's attempt to raise doubt as to their reliability by questioning them about prescribed medications, memory, and mental health, as well as the Respondent's suggestions that the complaints of patients were encouraged and/or fostered by a staff member at Arthritis Care. All six patients were sincere and believable, and the patients independently testified as to acts and omissions by the Respondent that illustrate a pattern of deviations from the standard of care that jeopardized their well-being.

The Hearing Committee found the Respondent's testimony to be disingenuous and his denials and justifications to be largely implausible. The Respondent expressed remorse for the patients' feelings without expressing true remorse for his actions and his role in what the patients experienced and felt.

The Hearing Committee finds appropriate revocation of the Respondent's license to practice as a physician's assistant. Despite the Respondent's request for a lesser penalty at this proceeding, the Respondent previously refused to avail himself of similar measures requested by

Dr. Huyck. It therefore finds no penalty other than revocation sufficient to appropriately address the Respondent's deliberate, habitual and pervasive behaviors that put the public at risk.

ORDER

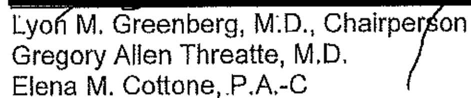
Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The First through Nineteenth Specifications of professional misconduct, as set forth in the Statement of Charges, are sustained; and

2. The Respondent's license to practice as a physician's assistant in the State of New York is revoked; and

3. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon the Respondent at his last known address and such service shall be effective upon receipt or seven days after mailing, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Albany, New York
9-8-22 2022



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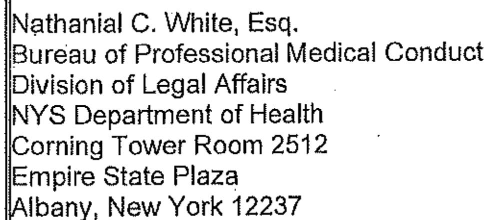
Gregory Allen Threatte, M.D.
Elena M. Cottone, P.A.-C



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

IN THE MATTER OF RONALD MONSON, P.A.	STATEMENT OF CHARGES

RONALD MONSON, P.A., the Respondent, was authorized to practice as a physician assistant in New York State on or about September 1, 1987, by the issuance of license number 003350 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. The Respondent worked as a physician assistant at Arthritis Care, P.C. in Troy, New York until about December 2017. Patient A (all patients are identified in Appendix "A") was a patient at Arthritis Care, P.C. in February 2017. Patient A, a then-42-year-old female when she started at the practice, presented for a rheumatology consultation due to a positive antinuclear antibody level, hives and wrist pain, among other things. Respondent provided medical care to Patient A on two occasions in February 2017. Respondent's care of Patient A violated accepted standards of practice and/or violated professional boundaries, in that:

1. Respondent, on or about February 1, 2017, performed an evaluation and/or examination of Patient A that failed to adequately protect the patient's privacy.
2. Respondent engaged in inappropriate physical contact with Patient A when, on or about February 1, 2017, he touched Patient A's thighs, and/or breasts, and/or other areas of her body, in a manner that served no legitimate medical purpose, and/or in a manner contrary to accepted standards of practice.

3. Respondent, on or about February 1, 2017, performed an inappropriate and/or inadequate physical examination of Patient A.
4. Respondent failed to maintain an adequate medical record for Patient A.

B. Patient B was a patient at Arthritis Care, P.C. between about April 2013 and May 2018. Patient B, a then-29-year-old female when she started at the practice, presented with complaints of pain in her neck, low back, knees, feet and ankles, among other things. Respondent provided medical care to Patient B on multiple occasions between 2013 and 2017. Respondent's care of Patient B violated accepted standards of practice and/or violated professional boundaries, in that:

1. Respondent, on one or more occasions, performed an evaluation and/or examination of Patient B that failed to adequately protect the patient's privacy.
2. Respondent, on one or more occasions, engaged in inappropriate physical contact with Patient B, including touching the patient's buttocks, and/or her perianal area, and/or breasts, and/or other areas of the body, in a manner that served no legitimate medical purpose, and/or in a manner contrary to accepted standards of practice.
3. Respondent, on one or more occasions, performed an inappropriate and/or inadequate physical examination of Patient B.
4. Respondent failed to maintain an adequate medical record for Patient B.

C. Patient C was a patient at Arthritis Care, P.C. between about November 2014 and January 2018. Patient C, a then-27-year-old female when she started at the practice, presented with complaints of exhaustion, fatigue, excessive dryness to the skin, eyes and mouth, a possible diagnosis of fibromyalgia and Sjogren's syndrome, among other things. Respondent provided medical care to Patient C on multiple occasions between 2014 and 2017. Respondent's care of Patient C violated accepted standards of practice and/or violated professional boundaries, in that:

1. Respondent, on one or more occasions, performed an evaluation and/or examination of Patient C that failed to adequately protect the patient's privacy.
2. Respondent, on one or more occasions, engaged in inappropriate physical contact with Patient C, including touching the patient's buttocks, and/or breasts, and/or other areas of the body, in a manner that served no legitimate medical purpose, and/or in a manner contrary to accepted standards of practice.
3. Respondent, on one or more occasions, performed an inappropriate and/or inadequate physical examination of Patient C.
4. Respondent failed to maintain an adequate medical record for Patient C.

D. Patient D was a patient at Arthritis Care, P.C. from about April 2015 until at least April 2018. Patient D, a then-28-year-old female when she started at the practice, presented for a rheumatology consultation, among other things. Respondent provided medical care to Patient D on multiple occasions between 2015 and 2016. Respondent's care of Patient D violated accepted standards of practice and/or violated professional boundaries, in that:

1. Respondent, on one or more occasions, performed an evaluation and/or examination of Patient D that failed to adequately protect the patient's privacy.
2. Respondent, on one or more occasions, engaged in inappropriate physical contact with Patient D, including touching the patient's buttocks, and/or breasts, and/or other areas of the body, in a manner that served no legitimate medical purpose, and/or in a manner contrary to accepted standards of practice.
3. Respondent, on one or more occasions, performed an inappropriate and/or inadequate physical examination of Patient D.
4. Respondent failed to maintain an adequate medical record for Patient D.

E. Patient E was a patient at Arthritis Care, P.C. from about October 2013 until about May 2015. Patient E, a then-55-year-old female when she started with the practice, presented for a rheumatology consultation because of significant joint pain, among other things. Respondent provided medical care to Patient E on multiple occasions

between 2013 and 2015. Respondent's care of Patient E violated accepted standards of practice and/or violated professional boundaries, in that:

1. Respondent, on one or more occasions, inappropriately pulled away Patient E's clothing and left the patient exposed.
2. Respondent, on one or more occasions, engaged in inappropriate physical contact with Patient E, including the pulling away of clothing and/or touching Patient E's buttocks in a manner that served no legitimate medical purpose and/or in a manner contrary to accepted standards of practice.

F. Patient F was a patient at Arthritis Care, P.C. from about April 2013 until at least June 2018. Patient F, a then-44-year-old female when she started at the practice, presented for a rheumatology consultation for further evaluation and treatment of diffuse pain syndrome, among other things. Respondent provided medical care to Patient F on multiple occasions between 2013 and 2016. Respondent's care of Patient F violated accepted standards of practice and/or violated professional boundaries, in that:

1. Respondent, while performing a procedure on or around March or April of 2016, inappropriately pulled away Patient F's clothing and left the patient exposed.
2. Respondent, while performing a procedure on or around March or April of 2016, engaged in inappropriate physical contact with Patient F, including pulling away Patient F's clothing.

SPECIFICATION OF CHARGES

FIRST 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:

1. Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, F and F.1 and/or F and F.2.

SECOND THROUGH FIFTH 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:

2. Paragraphs A and A.1, and/or A and A.2, and/or A and A.3; and/or
3. Paragraphs B and B.1, and/or B and B.2, and/or B and B.3; and/or
4. Paragraphs C and C.1, and/or C and C.2, and/or C and C.3; and/or
5. Paragraphs D and D.1, and/or D and D.2, and/or D and D.3.

SIXTH 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:

6. Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, F and F.1 and/or F and F.2.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

7. Paragraphs A and A.1, A and A.2, and/or A and A.3; and/or
8. Paragraphs B and B.1, B and B.2, and/or B and B.3; and/or
9. Paragraphs C and C.1, C and C.2, and/or C and C.3; and/or
10. Paragraphs D and D.1, D and D.2, and/or D and D.3; and/or
11. Paragraphs E and E.1, E and/or E and E.2; and/or
12. Paragraphs F and F.1 and/or F and F.2.

THIRTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

WILLFULLY HARASSING, ABUSING, OR INTIMIDATING A PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(31) by willfully harassing, abusing, or intimidating a patient either physically or verbally, as alleged in the facts of:

13. Paragraphs A and A.1, A and A.2, and/or A and A.3; and/or
14. Paragraphs B and B.1, B and B.2, and/or B and B.3; and/or
15. Paragraphs C and C.1, C and C.2, and/or C and C.3; and/or
16. Paragraphs D and D.1, D and D.2, and/or D and D.3; and/or
17. Paragraphs E and E.1, and/or E and E.2; and/or
18. Paragraphs F and F.1, and/or F and F.2.

NINETEENTH 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:

19. Paragraphs A and A.4, B and B.4, C and C.4, and/or D and D.4.

DATE: August 28, 2020
Albany, New York

TIMOTHY J. MAHAR
Deputy Counsel
Bureau of Professional Medical Conduct