New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

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Ansel R. Marks, M.D., J.D.
Executive Secretary

October 7, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Carl Fromer, M.D.
1534 Victory Boulevard
Staten Island, NY 10314

RE: License No. 142664

Dear Dr. Fromer:

Enclosed please find Order #BPMC 99-255 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **October 7, 1999.**

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

Board for Professional Medical Conduct
New York State Department of Health
Hedley Park Place, Suite 303
433 River Street
Troy, New York 12180

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management
New York State Department of Health
Corning Tower, Room 1315
Empire State Plaza
Albany, New York 12237

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Ted Taback, Esq.
Kern, Augustine, Conroy &
Schoppman, P.C.
420 Lakeville Road
Lake Success, NY 11042

Dianne Abeloff, Esq.

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

IN THE MATTER

OF

CARL FROMER, M.D.

SURRENDER

OF

LICENSE

BPMC #99-255

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

CARL FROMER, M.D., (Respondent) being duly sworn, deposes and says:

That on or about September 30, 1980, I was licensed to practice as a physician in the State of New York, having been issued License No. 142664 by the New York State Education Department.

My current address is 1534 Victory Boulevard, Staten Island, N.Y. 10314 and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with 31 specifications of professional misconduct.

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

I agree not to contest any of the allegations, in full satisfaction of the charges pending against me. I hereby agree to surrender my license as a physician in the State of New York and to pay a one hundred thirty thousand dollar fine ($130,0000) payable within 30 days from the effective date of the Order accepting the surrender of my medical license. The fine shall be paid by check made payable to the NYS Department of Health and mailed to Bureau of Accounts Management, NYS Department of Health, Corning Tower Building, Empire State Plaza, Albany, N.Y. 12237-0030 with a copy to Dianne Abeloff, NYS Department of Health, 5 Penn Plaza, 6th Floor, NY, NY 10001.

Any fine not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; [Tax Law section 171 (27); State Finance Law section 18; CPLR section 5001; Executive Law section 32].

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

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

I agree that, in the event the State Board for Professional Medical Conduct grants my application, an order shall be issued striking my name from the roster of physicians in the State of New York without further notice to me. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Surrender Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Surrender Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted

Carl Fromer M.D.

CARL FROMER, M.D.
RESPONDENT

DATED 9/21/99

Sworn to before me
on this 21st day of
September 1999

NOTARY

MARION HORN
Notary Public, State of New York
No. 43-4904002
Qualified in Richmond County
Commission Expires August 31, 01

The undersigned agree to the attached application of the Respondent to surrender his license.

Date: Sept. 21, 1999

T. LAWRENCE TABAK, Esq.
Attorney for Respondent

Date: 9/30/99

DIANNE ABELOFF
Associate Counsel
Bureau of Professional
Medical Conduct

Date: 10/5/99

ANNE F. SAILE
Director
Office of Professional Medical Conduc

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

IN THE MATTER

OF

CARL FROMER, M.D.

SURRENDER ORDER

Upon the proposed agreement of CARL FROMER, M.D. (Respondent) to Surrender his license as a physician in the State of New York, which proposed agreement is made a part hereof, it is agreed to and

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

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Surrender Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 10/5/99

WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

CARL FROMER, M.D.

STATEMENT

OF

CHARGES

CARL FROMER, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 30, 1980, by the issuance of license number 142664 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about October 12, 1994 through on or about Mary 6, 1996, Respondent treated Patient A (the identity of the patients is contained in the attached Appendix) at his office, 1534 Victory Blvd., Staten Island, N.Y. Respondent's care deviated from accepted medical standards in that:

1. Respondent diagnosed Patient A with glaucoma.

   a. Respondent incorrectly diagnosed Patient A with narrow angle glaucoma when she did not suffer from narrow angle glaucoma.

   b. Respondent knowingly and intentionally misdiagnosed Patient A with narrow angle glaucoma when she did not suffer from glaucoma.

EXHIBIT "A"

2. From on or about October 12, 1994 through on or about March 5, 1995, Respondent performed and/ or billed for seven laser iridotomies without medical indication.

a. Respondent knowingly and intentionally performed the laser iridotomies without medical indication.

b. Respondent failed to observe and/or document in his record any changes in her eyes as a result of the iridotomies.

3. Respondent maintained records which failed to accurately reflect his care and treatment of Patient A.

a. Respondent knowingly and intentionally maintained records which he knew failed to accurately reflect his care and treatment of Patient A.

B. From on or about February 18, 1992 through on or about August 24,1992 , Respondent treated Patient B in his office. Respondent's care of Patient B deviated from accepted medical standards, in that:

1. Respondent diagnosed Patient B with glaucoma.

a. Respondent failed to document sufficient clinical findings to support a diagnosis of glaucoma and/or treatment for glaucoma;

b. Respondent incorrectly diagnosed Patient B with glaucoma when she did not suffer from glaucoma;

c. Respondent knowingly and intentionally misdiagnosed Patient B with glaucoma when she did not suffer from glaucoma.

2. From on or about February 27, 1992 through July 13, 1992, Respondent performed and/or billed for six laser iridectomies on Patient B without medical indication.

a. Respondent knowingly and intentionally performed six laser iridectomies without medical indication.

b. Respondent failed to observe and/or document in his record any changes in her eyes as a result of the iridectomies.

3. From on or about February 18, 1992 through on or about August 5, 1992, Respondent performed and/or billed for seven B-scans on Patient B without medical indication.

a. Respondent knowingly and intentionally performed these B-scans when there were no medical indications.

b. Respondent failed to document in his record any interpretations of these B-scans.

4. From on or about February 25, 1992 through on or about August 5, 1992, Respondent performed and/or billed four fluorescein angiograms on Patient B without medical indication.

a. Respondent knowingly and intentionally performed these fluorescein angiograms when there were no medical indications.

b. Respondent failed to document in his record any interpretations of these fluorescein angiograms.

5. From on or about February 18, 1992 through on August 5, 1992, Respondent took and/or billed for four endothelium photographs with cell count on Patient B without medical indication.

a. Respondent knowingly and intentionally took four endothelium photographs with cell count without medical indication.

b. Respondent failed to document in the record his interpretation of these endothelium photographs with cell count.

6. From on or about February 18, 1992 through on or about August

24, 1992, Respondent performed and/or billed for nine visual field tests (tangent screen or static/kinetic perimetry), on Patient B without medical indication.

a. Respondent knowingly and intentionally performed these visual field tests without medical indication.

b. Respondent failed to document in the record his interpretation of these visual field tests.

7. Respondent maintained a record which failed to accurately reflect his care and treatment of Patient B.

a. Respondent knowingly and intentionally maintained a record which he knew failed to accurately reflect his care and treatment of Patient B.

C. From on or about May 4, 1992 through January 19, 1995, Respondent treated Patient C in his office. His care deviated from accepted medical standards, in that:

1. Respondent failed to document sufficient clinical findings to support a diagnosis of glaucoma and/or treatment for glaucoma;

a. Respondent incorrectly diagnosed Patient C with glaucoma when she did not suffer from glaucoma;

b. Respondent knowingly and intentionally misdiagnosed Patient C with glaucoma when she did not suffer from glaucoma.

2. From on or about May 4, 1992 through January 19, 1995, Respondent closed the lacrimal punctum on Patient C six times and/or billed for these procedures.

a. Respondent failed to document in the record his rationale for these closures and/or the method employed to close the lacrimal punctum.

b. Respondent knowingly and intentionally closed the lacrimal punctum when there were no medical indications for these procedures.

c. Respondent repeatedly closed the inferior punctum despite the fact that he had the patient on medications whose effects were opposite, namely to dry out the cornea.

3. From on or about July 28, 1992 through on or about December 8, 1992, Respondent performed and/or billed for seven iridectomies in Patient C's eyes without any medical indication.

a. Respondent knowingly and intentionally performed these iridectomies when there were no medical

indications.

b. Respondent failed to document in the record any change in Patient C's eye as a result of these iridectomies.

4. From on or about December 15, 1992 through on or about January 15, 1995, Respondent performed and/or billed for eleven B-scans on Patient C's eyes without medical indication.

a. Respondent knowingly and intentionally performed these B-scans when there were no medical indications.

b. Respondent failed to document in his record any interpretation of these B-scans.

5. From on or about May 4, 1992, through on or about November 18, 1994, Respondent performed six A-scans on Patient C without medical indication.

a. Respondent knowingly and intentionally performed these A-scans when there were no medical indications.

b. Respondent failed to document in his record any interpretation of these A-scans.

6. From on or about August 6, 1992 through on or about November 18, 1992, Respondent performed and/or billed for 11 fluorescein angiograms on Patient C's eyes without medical indication.

   a. Respondent knowingly and intentionally performed these fluorescein angiograms when there were no medical indications.

   b. Respondent failed to document in his record any interpretation of these fluorescein angiograms.

7. From on or about May 4, 1992 through on or about November 18, 1994, Respondent took and/or billed for nine endothelium photographs with cell counts of Patient C's eyes without medical indication.

   a. Respondent knowingly and intentionally took these endothelium photographs when there were no medical indications.

   b. Respondent failed to document in his record any interpretations of these endothelium photographs.

8. From on or about May 4, 1992 through on or about November 18, 1994, Respondent performed and/or billed for 17 visual field tests (tangent screen or static/ kinetic perimetry)on Patient C without medical indication.

a. Respondent knowingly and intentionally performed these visual field tests without medical indication.

b. Respondent failed to document record his interpretation of these visual field tests.

9. From on or about April 13, 1993 through on or about September 29, 1994, Respondent performed and/or billed for eight capsulectomies and severing of membranes on Patient C's eyes without medical indication.

a. Respondent knowingly and intentionally performed these capsulectomies and severing of membranes when there were no medical indications.

b. Respondent failed to document in his record any responses in the patient's eyes as a result of the capsulectomies and severing of membranes.

10. From on or about Respondent December 15, 1992 through on or about November 18, 1994, Respondent performed and/or billed for six fluorescein angiograms on Patient C without medical indication

a. Respondent knowingly and intentionally performed these fluorescein angiograms when there were no

medical indications.

b. Respondent failed to document in his record any interpretation of these fluorescein angiograms.

11. Respondent maintained records which failed to accurately reflect his care and treatment of Patient C.

a. Respondent knowingly and intentionally maintained a record which he knew failed to accurately reflect his care and treatment of Patient C.

D. From on or about December 15, 1987 to on or about January 18, 1994, Respondent treated Patient D at his office. Respondent's care deviated from accepted medical standards, in that:

1. From on or about June 13, 1988, through on or about January 18, 1994, Respondent performed and/or billed 21 trabeculoplasties on Patient D without medical indication.

a. Respondent knowingly and intentionally performed these trabeculoplasties without medical indication.

b. Respondent failed to document the location of the numerous trabeculoplasties in the patient's eyes.

c. Respondent failed to document any change in Patient D's eyes as a result of the trabeculoplasties.

d. The trabeculoplasties failed to correct Patient D's glaucoma and Respondent failed to change the treatment.

2. From on or about April 22,1991 through on or about October 29, 1993, Respondent performed and/or billed for 5 fluorescein angiograms on Patient D without medical indication.

a. Respondent knowingly and intentionally performed these fluorescein angiograms when there were no medical indications.

b. Respondent failed to document in his record any interpretations of these fluorescein angiograms.

3. From on or about January 7, 1991 through on or about February 18, 1994, Respondent dilated or closed Patient D's lacrimal punctum 13 times and/or billed for these procedures without documenting his rationale for these procedures and/or the method employed to perform these procedures.

4. From on or about April 22, 1991 through on or about March 1, 1993, Respondent took and/or billed for 4 sets of endothelium photographs with cell count of Patient D's eyes without medical

indication.

a. Respondent knowingly and intentionally took these endothelium photographs when there were no medical indications.

b. Respondent failed to document in his record any interpretations of these endothelium photographs.

5. From on or about December 5, 1987 through on or about April 4, 1994, Respondent performed and/or billed for 33 visual field tests (tangent screen, or static/kinetic perimetry) on Patient D without medical indication.

a. Respondent knowingly and intentionally performed these visual field tests without medical indication.

b. Respondent failed to document in the record his interpretation of these visual field tests.

6. Respondent maintained records which failed to accurately reflect his care and treatment of Patient D.

a. Respondent knowingly and intentionally maintained a record which failed to accurately reflect his care and treatment of Patient D.

E. In each extracapsular cataract extraction for each of the eyes of Patients A-F Respondent performed and/ or billed for the following procedures which wer excessive:

1. Lateral canthotomy due to purported elevated retrobulbar pressure;

   a. Respondent failed to note the pressure reading and investigate the cause of the elevated pressure;

   b. Respondent intentionally and knowingly wrote that the retrobulbar pressure was elevated when he knew that it was not.

2. Sector iridectomy and subsequent extension of the sector iridectomy due to an extremely miotic pupil;

   a. Respondent performed an extension of the sector iridectomy without valid medical indication since the lens was already removed.

3. Vitrectomy due to vitreous which came forward during the cataract extraction procedure;

   a. Respondent failed to document in his operative report the type of vitrector used.

b. Respondent knowingly and intentionally documented that a vitrectomy was necessary when it was not.

4. Peripheral iridectomy due to narrowing of the angle with poor filtration;

a. Respondent failed to explain in the operative record the necessity for a further peripheral iridectomy after earlier sector iridectomies in the operating room and prior laser iridotomies in Respondent's office.

F. The operative reports for the cataract operations for Patients A-F fail to accurately reflect the care and treatment rendered.

1. Respondent knowingly and intentionally maintained operative reports of Patients A-F which failed to accurately reflect the care and treatment rendered by Respondent to these patients.

G. On thirteen ocassions from in or about August 22, 1994 through in or about March 26, 1996, Respondent prescribed Lorazepam .5 mg or Ativan .5 mg purportedly for his grandmother, Patient G, when Respondent was the individual actually taking the drugs.

FIRST THROUGH FIFTH SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A., A.1.(a), A.2., A.2.(b),A.3.

2. Paragraphs B., B.1.(a),(b),B.2., B.2(b),B. 3., B.3.(b),B.4., B.4 (b), B.5., B. 5(b), B.6., B.6.(b),B.7.

3. Paragraphs C., C.1.(a), C.2., C.2.(a)(b)(c), C.,C.3.(b), C.,C.4.(b), C.5., C.5.(b), C.6.,C.6.(b), C.7., C.7.(b), C.8. C.8.(b),C.9., C.9.(b), C.10., C.10.(b), C.11.

4. Paragraphs D., D.1, D.1.(b)(c)(d), D. 2., D.2.(b), D.3., D.4.,D.4.(b), D.5., D. 5.(b), D.6.

5. Paragraphs E., E.1.(a), E.2., E.2.(a),E.3., E.3. (a), E.4.(a).

SIXTH SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in

N.Y. Educ. Law §6530(3)(McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

6. Paragraphs A., A.1.(a), A.2., A.2.(b),A.3.; B., B.1.(a),(b),B.2., B2(b),B. 3., B.3.(b),B.4., B.4 (b),B.5., B. 5(b), B.6., B.6.(b),B.7; C., C.1.(a), C.2., C.2.(a)(b)(c), C.,C.3.(b), C.,C.4.(b), C.5., C.5.(b), C.6.,C.6.(b), C.7., C.7.(b), C.8. C.8.(b),C.9., C.9.(b), C.10., C.10.(b), C.11; D., D.1, D.1.(b)(c)(d), D. 2., D.2.(b), D.3., D.4.,D.4.(b), D.5., D. 5.(b), D.6; E., E.1.(a), E.2., E.2.(a),E.3., E.3. (a), E.4.(a), F.

SEVENTH THROUGH ELEVENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

7. Paragraphs A., A.1.(a), A.2., A.2.(b),A.3.

8. Paragraphs B., B.1.(a),(b),B.2., B2(b),B. 3., B.3.(b),B.4., B.4 (b), B.5., B. 5(b), B.6., B.6.(b),B.7.

9. Paragraphs C., C.1.(a), C.2., C.2.(a)(b)(c), C.,C.3.(b), C.,C.4.(b),

C.5., C.5.(b), C.6.,C.6.(b), C.7., C.7.(b), C.8. C.8.(b),C.9., C.9.(b), C.10., C.10.(b), C.11.

10. Paragraphs D., D.1, D.1.(b)(c)(d), D. 2., D.2.(b), D.3., D.4.,D.4.(b), D.5., D. 5.(b), D.6.

11. Paragraphs E., E.1.(a), E.2., E.2.(a),E.3., E.3. (a), E.4.(a).

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1999) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

12. Paragraphs A., A.1.(a), A.2., A.2.(b),A.3.; B., B.1.(a),(b),B.2., B2(b),B. 3., B.3.(b),B.4., B.4 (b),B.5., B. 5(b), B.6., B.6.(b),B.7; C., C.1.(a), C.2., C.2.(a)(b)(c), C.,C.3.(b), C.,C.4.(b), C.5., C.5.(b), C.6.,C.6.(b), C.7., C.7.(b), C.8. C.8.(b),C.9., C.9.(b), C.10., C.10.(b), C.11; D., D.1, D.1.(b)(c)(d), D. 2., D.2.(b), D.3., D.4.,D.4.(b), D.5., D. 5.(b), D.6; E., E.1.(a), E.2., E.2.(a),E.3., E.3. (a), E.4.(a), F.

THIRTEENTH THROUGH NINETEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined b N.Y. Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

13. Paragraphs A., A.1.(b),A.2.(a),A.3(a).

14. Paragraphs B., B.1.(c),B.2.(a),B. 3.(a),B.4.(a), B.5. (a), B.6.(a),B.7(a).

15. Paragraphs C., C.1.(b), C.2.(a)(b), C.3.(a)(b), C.4.(a), C.5.(a), C.6.(a), C.7.(a), C.8. (a),C.9. (a), C.10.(a),C.11(a) .

16. Paragraphs D., D.1(a), D. 2.(a), D.3., D.4.(a), D.5.(a), D.6(a).

17. Paragraphs E., E.1.(a)(b), E.2., E.3. (b), E.4.(a).

18. Paragraphs F., F(1).

19. Paragraph G.

TWENTIETH THROUGH TWENTY FOURTH SPECIFICATIONS
EXCESSIVE TESTS AND TREATMENT

Respondent is charged with committing professional misconduct as defined

N.Y. Educ. Law §6530(35)(McKinney Supp. 1999) by ordering of excessive tests, treatment, not warranted by the condition of the patient, as alleged in the facts of:

20. Paragraph A.2.
21. Paragraphs B.2, B.3, B.4, B.5, B.6.
22. Paragraphs C.2, C.3, C.4, C.5, C.6, C.7, C.8, C.9, C. 10.
23. Paragraphs D.1, D.2, D.3, D.4, D.5.
24. Paragraphs E.1, E. 2, E. 3, E.4.

TWENTY FIFTH THROUGH THIRTIETH SPECIFICATIONS
INACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) 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:

25. Paragraph A.3.
26. Paragraph B.7.
27. Paragraph C.11.
28. Paragraph D.6.
29. Paragraphs E. 1(a), E. 1(b); E. 3(a)(b); E. 4(a).
30. Paragraph F.

THIRTY FIRST SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined i N.Y. Educ. Law §6530(20)(McKinney Supp. 1999) 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:

31. Paragraphs A through G and the subparagraphs therein.

DATED: July 21, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct