STATE OF NEW YORK
DEPARTMENT OF HEALTH

Office of Public Health Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Karen Schimke
Executive Deputy Commissioner

June 26, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Sylvia P. Finkelstein, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza-6th Floor
New York, New York 10001

Steven M. Rabinowitz, Esq.
Pryor, Cashman, Sherman & Flynn
410 Park Avenue
New York, New York 10022

Jose L. Garcia, M.D.
79-11 41st Avenue
Apt. A-710
Elmhurst, New York 11373

RE: In the Matter of Jose L. Garcia, M.D.

Effective Date: 07/03/95

Dear Ms. Finkelstein, Mr. Rabinowitz and Dr. Garcia:

Enclosed please find the Determination and Order (No. 95-132) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER OF JOSE L. GARCIA, M.D.	**DETERMINATION AND ORDER**

A Notice of Hearing and a Statement of Charges, dated March 13, 1995, were served upon the Respondent, Jose L. Garcia, M.D. **STEPHEN A. GETTINGER, M.D. (Chair), ELEANOR KANE, M.D. and BARRY N. KRIESBERG**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Sylvia P. Finkelstein, Esq., Associate Counsel. The Respondent appeared by Pryor, Cashman, Sherman & Flynn, Steven M. Rabinowitz Esq., of counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	March 18, 1995
Answer to Statement of Charges:	None
Dates of Hearing:	April 6, 1995 May 4, 1995 May 11, 1995

Witnesses for Department of Health:	Patient A Ellie Schoenbaum, M.D. Aracelis Negron-Sosa
Witness for Respondent:	None
Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendations	May 26, 1995
Received Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendations	May 25, 1995
Deliberations Held:	June 1, 1995

STATEMENT OF CASE

The Statement of Charges alleged three specifications of professional misconduct, including allegations of willfully abusing a patient, engaging in conduct which evidences moral unfitness to practice the profession and the fraudulent practice of medicine.

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

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all Findings and Conclusions herein are the unanimous determination of the Hearing Committee. Having heard testimony and considered evidence presented by the Department of Health and the

Respondent respectively, the Hearing Committee hereby makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. JOSE L. GARCIA, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on March 1, 1974, by the issuance of license number 119127 by the New York State Education Department. (Petitioner's Exhibit 3{hereinafter "Pet.Ex."})

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995, through September 30, 1996, with a registration address of Apt. A-710, 79-11 41 Avenue, Elmhurst , New York 11373. (Pet.Ex. 3)

3. At all times herein mentioned, Respondent was employed as a physician by the New York City Department of Health (NYCDOH), Corona Chest Clinic, located at 34-33 Junction Boulevard, Corona, New York. [{Transcript pp. 271-273, 284} (hereinafter "T.271-273, 284 " e.g.)].

4. In or about September, 1994, Patient A, a 22 year-old female, visited the NYCDOH Astoria Maternity and Infant Care Clinic located at 12-26 31st Avenue, Astoria, New York, where she was diagnosed as being 3 months pregnant. During that visit, a skin tuberculin test was administered which elicited a skin reaction. Patient A was referred to the NYCDOH Corona Chest Clinic for chest x-rays and follow-up to rule out tuberculosis. (T.37-38, 199-200, 203, 206-

POSITIVE

207).

5. When Patient A was informed that she might have tuberculosis and would have to go to the NYCDOH Corona Chest Clinic for treatment she cried and became emotionally upset. (T.40-41)

6. Patient A's first visit to the Corona Chest Clinic took place on or about October 4, 1994. At that time an x-ray was taken. The medical record contains a written report of that x-ray dated 10/4/94. (T.207-208; Pet.Ex. 4).

7. On or about October 7, 1994, Patient A went to the Corona chest clinic accompanied by a co-worker, to obtain the results of previously taken chest x-rays. On this date, Patient A came under the Care of Respondent for the first time. In the course of this visit, Respondent examined Patient A and gave her a piece of paper, on it were his home and work telephone numbers. (T.43-45,133)

8. Respondent told Patient A, among other things, that he was Hispanic and he was going to help her. Patient A found the Respondent to be very polite and patient and he made her feel very comfortable. Respondent instructed Patient A to come back to the clinic during the following week for sputum tests and to return the following Friday to see him. (T.44,46-50).

9. On or about October 14, 1994, Patient A returned to the clinic alone for the scheduled follow-up visit to find out the results of the previously taken x-rays. Respondent told Patient A that her x-rays were not available because they had been sent to a specialist. Respondent instructed Patient A to lower her pants and panties and she complied. As Patient A was standing, Respondent, while purportedly performing a physical examination, inserted his finger in Patient A's vagina and moved his finger in a circular motion. Respondent then instructed Patient A to return the following Friday to obtain the results of her x-rays. (T.50-61; Pet.Ex. 4, Respondent's Exhibits A,B {hereinafter "Res.Ex."}).

10. On or about October 21, 1994, Patient A returned to the Corona Chest

Clinic to obtain the results of her x-rays from Respondent. During this follow-up visit, Respondent told Patient A to stand behind the door and lower her pants and panties and she complied. Respondent, while purportedly performing a physical examination, inserted his finger into Patient A's vagina and moved his finger with a circular motion. Respondent then inserted his finger into her rectum until Patient A cried out in pain, at which time he removed his finger. (T.61-65; Res.Exs. A,B)

11. On at least two occasions following the October 21, 1994 visit, the Respondent telephoned Patient A at home. (T.70-72, 168).

12. On or about January 9, 1995, Patient A reported to the manager of the Corona Chest Clinic that Respondent had been calling her and that he had touched her vaginal area during prior visits. Up to this point, Respondent had not given Patient A a definitive diagnosis with respect to whether or not she had tuberculosis. On that same date, Patient A was seen by another physician who reviewed her x-rays and assessed that no treatment was presently needed. (T68,73-76,97-100,279-280; Pet.Ex. 4)

13. The manager of the Corona Chest Clinic, Aracelis Negron-Sosa, encouraged Patient A to write down a summary of what occurred during her clinical visits with Respondent. Patient A wrote a 6 page summary in Spanish and delivered it to Ms. Negron Sosa. (T.76-78, 280-282; Res.Ex. B).

14. There is no entry in the medical record to indicate that Respondent performed a proper pelvic examination, vaginal examination, or a rectal examination. There is no entry in the medical record to reflect that a pelvic, vaginal or rectal examination was warranted. (T.214, 266-268; Pet.Ex. 4)

15. Clinically, Respondent's touching of Patient A's vagina on October 14, 1994, and vagina and rectum on October 21, 1994 does not constitute a pelvic exam or a rectal exam. (T.215-218)

16. It is a deviation from acceptable standards of medical practice for a physician to touch a patient's vaginal and rectal area without a proper medical purpose. (T.222)

17. The Respondent did not deny any of the facts in evidence.

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact listed above. The Hearing Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A: (1,3,4,7);

Paragraph A.1: (9);

Paragraph A.2: (10) with the exception of that part of the paragraph which alleges that Respondent turned around to Patient A's back.

The Hearing Committee further concluded that the following Specifications should **be sustained**. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT EITHER PHYSICALLY OR VERBALLY

First Specification: (Paragraphs A.,A.1,A.2{with the exception noted above});

ENGAGING IN CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE MEDICINE

Second Specification: (Paragraphs A.,A.1,A.2.{with the exception noted above);

The Hearing Committee voted to **not sustain** the **third** specification.

DISCUSSION

The Hearing Committee was informed that they can draw a negative inference from the failure of the Respondent to testify and the Committee did draw such an inference. The Respondent never denied Patient A's allegations under oath. Her testimony was never refuted.

The Hearing Committee found the testimony of Patient A completely credible. Any discrepancy between her written statement and her testimony was reconciled by her explanation that she was reluctant to record the full extent she was violated in the event that her husband found out and her intent was to include

only pertinent information in the written statement. Her testimony was consistent and remained so during extensive direct and cross-examination. Patient A's recounting of events was credible and corroborated by other evidence. She was relatively calm with reactions that appeared to be appropriate to the situation.

Based on a preponderance of the evidence the Hearing Committee concludes that Respondent engaged in the conduct set forth in detail above with respect to Patient A. The Committee finds that Respondent, while purportedly rendering medical care, willfully abused Patient A by inappropriately touching her vaginal area on two separate occasions, and her rectal area on one occasion. Respondent has not denied that these acts occurred.

Actions which show a moral unfitness can arise from conduct which violates a trust related to the practice of the profession or from activity which violates the moral standards of the professional community to which the Respondent belongs.

The Committee found the Respondent's actions with respect to Patient A constituted a violation of professional trust. Patient A was referred to Respondent to rule out the possibility of a serious illness while she was in the early stages of her pregnancy. Respondent severely abused the trust that Patient A placed in him.

As noted above, Respondent has not denied any of the facts in evidence. No evidence was presented or adduced that would detract from the credibility or contradict the testimony of Patient A.

Therefore, The Committee found Respondent engaged in conduct which evidences moral unfitness to practice medicine in that the facts show Respondent to have violated his professional trust and the ethical standards of the medical community to which he belongs.

The Committee found that Respondent, while purportedly rendering medical care, willfully abused Patient A by engaging in inappropriate touching of

her vaginal area on one occasion, and of her vaginal and rectal area on another occasion.

Respondent was also charged with practicing the profession fraudulently under Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," included a suggested definition of the fraudulent practice of medicine.

The following definition from the memorandum was used by the Hearing Committee during its deliberations:

Fraudulent Practice of the Profession is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

Using the above-referenced definition as a framework for its deliberations with respect to the specification of practicing the profession fraudulently, , the Hearing Committee unanimously concluded that this specification was not supported by the evidence in the record. The Hearing Committee determined that the Respondent's conduct did not fit the definition as set out above and therefore the specification should not be sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and

Conclusions set forth above, unanimously determined that Respondent's license to practice medicine in New York State **should be revoked**. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The record in this case clearly established that Respondent willfully abused Patient A and exhibited conduct which indicates his moral unfitness to practice medicine.

Any individual who receives a license to practice medicine is placed into a position of public trust. Respondent essentially forfeited his right to that public trust by his actions with respect to Patient A.

The Hearing Committee unanimously determined that no sanction short of revocation would adequately protect the public.

ORDER

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

1. The First and Second Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I) are **SUSTAINED**;

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

DATED: New York, New York
June 24, 1995

STEPHEN A. GETTINGER, M.D. (CHAIR)

ELEANOR KANE, M.D.
BARRY N. KRIESBERG

TO: Sylvia P. Finkelstein, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Steven M. Rabinowitz, Esq.
Pryor, Cashman, Sherman & Flynn
410 Park Avenue
New York, New York 10022

Jose L. Garcia, M.D.
79-11 41st Avenue
Apt. A-710
Elmhurst, New York 11373

APPENDIX I

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

IN THE MATTER

OF

JOSE L. GARCIA, M.D.

STATEMENT
OF
CHARGES

JOSE L. GARCIA, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 1, 1974, by the issuance of license number 119127 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. At all times herein mentioned, Respondent was employed as a physician by the New York City Department of Health (NYCDOH), Corona Chest Clinic, located at 34-33 Junction Boulevard, Corona, New York. Respondent treated Patient A at said clinic on or about October 1994. (The identity of Patient A is disclosed in the annexed Appendix). In or about September 1994, Patient A visited the NYCDOH Astoria Maternity and Infant Care clinic located at 12-26 31st Avenue, Astoria, New York, where she was diagnosed as being 3 months pregnant. She was subsequently referred to the NYCDOH Corona clinic for chest x-rays.

1. In or about October, 1994, during a follow-up visit to the Corona clinic, Respondent instructed Patient A to remove her clothing. As Patient A was standing, Respondent, while purportedly performing a physical examination but not for a proper medical purpose, inserted his finger in Patient A's vagina and moved his finger in a circular motion.

2. In or about October, 1994, during another follow-up visit, Respondent told Patient A to stand behind the door and remove her clothing. Respondent, while purportedly performing a physical examination but not for a legitimate medical purpose, inserted his finger into Patient A's vagina and moved his finger with a circular motion. Respondent then turned around to Patient A's back, and inserted his finger into her rectum until Patient A cried out in pain.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT EITHER PHYSICALLY OR VERBALLY

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(31) (McKinney Supp. 1995), by willfully harassing, abusing or intimidating a patient either physically or verbally, in that Petitioner alleges the facts of the following:

1. Paragraphs A, A.1, and/or A.2.

SECOND SPECIFICATION

ENGAGING IN CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE THE PROFESSION

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(20) (McKinney Supp. 1995), by engaging in conduct in the practice of medicine which evidences moral unfitness to practice the profession, in that Petitioner alleges the facts of the following:

2. Paragraph A, A.1 and/or A.2.

THIRD SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1995) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraph A, A.1 and/or A.2.

DATED: March [illegible], 1995
New York, New York

CHRIS STERN HYMAN, Counsel
Bureau of Professional
Medical Conduct