STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 28, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Stephen L. Lockwood, Esq.
Lockwood & Golden
1412 Genesee Street
Utica, New York 13502

Barry C. Plunkett, Esq.
NYS Department of Health
ESP – Corning Tower – Room 2509
Albany, New York 12237

Charles E. Gant, M.D.
6696 Henderson Road
Jamesville, New York 13078

RE: In the Matter of Charles Edward Gant, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-189) 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.

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.

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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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:cah
Enclosure

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

IN THE MATTER

OF

CHARLES EDWARD GANT, M.D.,

DETERMINATION

COPY

AND

ORDER

BPMC #01-189

A Notice of Hearing and a Statement of Charges, dated May 24, 2000 and May 22, 2000 respectively, were served upon the Respondent, Charles Edward Gant, M.D. DENISE M. BOLAN, R.P.A. (Chair), DONALD F. BRAUTIGAM, M.D. and WOODSON MERRELL, M.D. duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the 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 Barry C. Plunkett, Esq., Associate Counsel. The Respondent appeared by Lockwood & Golden, Stephen L. Lockwood, 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 Committee issues this Determination and Order.

PROCEDURAL HISTORY

Dates of Hearing:	June 7, 2000 June 15, 2000 June 28, 2000 July 10, 2000 July 18, 2000 July 26, 2000 August 9, 2000 August 17, 2000 September 12, 2000 September 26, 2000 November 6, 2000 November 13, 2000 November 28, 2000 December 11, 2000 January 8, 2001 January 16, 2001 January 29, 2001 February 28, 2001
Dates of Deliberations:	April 23 & 24, 2001

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated ten categories of professional misconduct, including gross negligence,

negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, failure to maintain accurate records, fraud in the practice of the profession, willfully making or filing a false report, conduct evidencing moral unfitness, ordering of excessive tests and receiving consideration from a third party for patient referral.

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

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are the unanimous determination of the Committee unless noted by an asterisk. 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 Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence. All findings were unanimous unless noted by an asterisk. Having heard

testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact.

1. Charles Edward Gant, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on or about February 29, 1980 by the issuance of license number 141276 by the New York State Education Department. (Ex. 3)

PATIENT A

2. Respondent provided medical care and treatment to Patient A, a 50 year old female who presented with polycythemia vera and malignant melanoma, during the period including July 27, 1999 through August 13, 1999 at 5900 N. Burdick St., East Syracuse, New York (hereafter, "Respondent's office") (Ex. 4).

3. A physician should obtain a complete history from a new patient and document it. The Respondent did not do this for Patient A. (T. 28-35; Ex. 4)

4. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient by ordering laboratory tests and evaluating the results of these tests. (T. 2649-50, 2978; Exs. 4 & MM)

5. A physician should perform an adequate physical on a new patient and document it. An adequate physical includes obtaining a number of vital measurements of the patient and a hands-on examination of the patient's body. The Respondent did not do this for Patient A. (T. 40-45; Ex. 4)

6. A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent failed to document such a diagnosis for Patient A. (T. 67-68, 70; Ex. 4)

7. The Respondent ordered iron supplementation for Patient A on or about July 27, 1999 and on subsequent times. This was not contraindicated. (T. 2656-65, 2980-83; Ex. 4)

8. The Respondent did not have to confer with Patient A's ~~concurrently or previous treating~~ physician. (T. ~~2667, 2797,~~ 2984-85; Ex. 4)

9. An adequate medical indication for a physician's diagnosis of disseminated systemic candidiasis should be documented in the patient's

record. The Respondent did not adequately document an indication in Patient A's medical record. (T. 71-72; Ex. 4)

10. The Respondent ordered a number of laboratory tests for Patient A which were medically indicated. (T. 2987; Ex.4)

11. Respondent sent samples relating to Patient A, for testing to the Great Smokies Diagnostic Laboratories (hereinafter "GSDL") when he knew that GSDL was not certified by New York State to perform such tests. (T. 390-93, 542-46, 2244-45; Exs. 4 & 32)

12. A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient A. (T. 90-93; Ex. 4)

13. A physician should include in a patient's record only those diagnostic codes for conditions for which he has evaluated and treated the patient. The Respondent included in Patient A's medical record diagnostic codes for conditions which he did not evaluate and/or treat Patient A. (T. 69-73; Ex. 4)

14. A physician should not provide a patient with erroneous diagnostic codes on the patient's billing statement for the purpose of the patient submitting them to his third-party health insurer for reimbursement. The

Respondent provided such erroneous codes to Patient A. (T. 73-74, 463, 1266, 1804-05; Ex. 4)

PATIENT B

15. Respondent provided medical care and treatment to Patient B, at Respondent's office during the period of January 13, 1999 through February 29, 1999. Patient B was 5years old and presented with complaints of fever, constipation, diarrhea and gas. (Exs. 5 & L).

16.* A physician should obtain a complete history from a new patient and document it. The Respondent did not do this for Patient B. (T. 248-51; Exs. 5, 20 & L)

17. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient, by among other actions, ordering laboratory tests and evaluating the results of these tests. (T. 2138-39, 2293-98, 2348, 2649-50, 2978; Exs. 5 & MM)

18. A physician should perform an adequate physical on a new patient and document it. An adequate physical includes obtaining a number of vital measurements of the patient and a hands-on examination of the patient's body. The Respondent did not do this for Patient B. (T. 253-56; Ex. 5 & L)

19. An adequate medical indication for a physician's diagnosis of disseminated systemic candidiasis should be documented in the patient's record. The Respondent did not adequately document an indication in Patient B's medical record. (T. 259-60; Exs. 57 & L)

20. A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent failed to document such a diagnosis for Patient B. (T. 256-57; Exs. 5 & L)

21. The Respondent ordered a number of laboratory tests for Patient B which were medically indicated. (T. 2341-43, 2347-49, 3350-51; Ex.5)

22. The Respondent did not prescribe ciprofloxacin for Patient B. (T. 2357-58; Exs. 5 & 50)

23. A physician should have a medical indication before prescribing an antihelminthic. The Respondent prescribed a homeopathic substance for Patient B without an adequate medical indication. (T. 271-72; Ex. 5)

~~24. The Respondent had a duty to adequately evaluate and if needed treat~~ Patient B for elevated levels of blood lead and other toxic heavy metals. The Respondent did this. (T. 2368-71, 3355-56; Ex. 5)

25. A physician has a duty to report blood lead levels which are above normal. Patient B's whole blood lead level was within the normal range

therefore there was no obligation to report this to the Public Health authorities. (Ex. 5)

26. The Respondent did not have to confer with Patient B's concurrently or previous treating physician. (T. 2374-79, 2797-99, 3079-81, 3358-60; Ex. 5)

27. The Respondent did not have a duty to obtain the medical records from Patient B's previous treating physicians. (T. 2381-82, 3360-3363)

28. Respondent sent samples relating to Patient B, for testing to the GSDL when he knew that GSDL was not certified by New York State to perform such tests. (T. 389-93, 542-46, 2244-45, 2349; Exs. 5, 20 & 32)

29. A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient B. (T. 282-84; Ex. 5)

30. A physician should include in a patient's record only those diagnostic codes ~~for conditions for which he has evaluated and treated the~~ patient. The Respondent included in Patient B's medical record diagnostic codes for conditions which he evaluated and/or treated Patient B. (T. 2386-91, 3364-65; Ex. 5)

31. A physician should not provide a patient with erroneous diagnostic codes on the patient's billing statement for the purpose of the patient submitting them to his third-party health insurer for reimbursement. The Respondent provided such erroneous codes to Patient B. (T. 280-84, 463, 1266, 1804-05; Ex. 5)

PATIENT C

32. Respondent provided medical care and treatment to Patient C, at Respondent's office during the period of December 18, 1998 through February 10, 2000. Patient C was a 15 year old female and presented with life threatening weight loss. (Ex. 6)

33.* A physician should obtain a complete history from a new patient and document it. The Respondent did not do this for Patient C. (T. 899; Ex. 6)

34. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient, by among other actions, ordering laboratory tests and evaluating the results of these tests. (T. 2463-64, 3420-23; Ex. 6)

35. A physician should perform an adequate physical on a new patient and document it. An adequate physical includes obtaining a number of vital measurements of the patient and a hands-on examination of the patient's

body. The Respondent did not do this for Patient C. (T. 865, 868, 897, 900; Ex. 6)

36. An adequate medical indication for a physician's diagnosis of disseminated systemic candidiasis should be documented in the patient's record. The Respondent did not adequately document an indication in Patient C's medical record. (T. 904-05, 2469; Ex. 6)

37. A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent failed to document such a diagnosis for Patient C. (T. 906-07; Ex. 6)

38. The Respondent ordered a number of laboratory tests for Patient C which were medically indicated. (T. 2489-94, 3445-46; Ex. 6)

39. A physician should document the medical indications when prescribing or continuing a prescription for Lamisil, Cortef, Cortisol, Vermox, Nizoral, Flagyl, Biltricide, Nystatin and Triest-Progesterone Cream. The Respondent prescribed or continued such medications for Patient C without documenting an adequate medical indication. (T. 3446-58; Ex. 6)

40. A physician should include in a patient's record only those diagnostic codes for conditions for which he has evaluated and treated the patient. The

Respondent included in Patient C's medical record a diagnostic code for a condition for which he did not evaluate and/or treat Patient C. (T. 904; Ex. 6)

41. A physician should not provide a patient with erroneous diagnostic codes on the patient's billing statement for the purpose of the patient submitting them to his third-party health insurer for reimbursement. The Respondent provided such erroneous codes to Patient C. (T. 906; Ex. 6)

42. A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient C. (T. 906-07; Ex. 6)

43. Respondent sent samples relating to Patient C, for testing to the GSDL when he knew that GSDL was not certified by New York State to perform such tests. (T. 907; Exs. 6, 20 & 32)

PATIENT D

44. Respondent provided medical care and treatment to Patient D, at Respondent's office during the period of January 29, 1999 through February

13, 1999. Patient D was 8 years old and received medical care for Attention Deficit Hyperactivity Disorder among other conditions. (Ex. 9)

45. A physician should obtain a complete history from a new patient and document it. The Respondent did this for Patient D. (T. 3231-34; Ex. 9)

46. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient, by among other actions, ordering laboratory tests and evaluating the results of these tests. (T. 3237-38; Ex. 9)

47. A physician should perform an adequate physical on a new patient and document it. An adequate physical includes obtaining a number of vital measurements of the patient and a hands-on examination of the patient's body. The Respondent did not do this for Patient D. (T. 590-91, 603; Ex. 9)

48. A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent failed to document such a diagnosis for Patient D. (T. 593-94; Ex. 9)

49. An adequate medical indication for a physician's diagnosis of disseminated systemic candidiasis should be documented in the patient's record. The Respondent did not adequately document an indication in Patient D's medical record. (T. 596; Ex. 9)

50. The Respondent ordered a number of laboratory tests for Patient D which were medically indicated. (T. 3261-65; Ex. 9)

51. The Respondent had a duty to adequately evaluate and if needed treat Patient D for elevated levels of blood lead and other toxic heavy metals. The Respondent did this. (T. 2167-71, 3266-70; Ex. 9)

52. A physician has a duty to report blood lead levels which are above normal. Patient D's whole blood lead level was within the normal range therefore there was no obligation to report this to the Public Health authorities. (Ex. 9)

53. A physician should document the medical indications when prescribing Nizoral. The Respondent prescribed such medication for Patient D without documenting an adequate medical indication. (T. 600 ; Ex. 9)

54. The Respondent did not have to confer with Patient D's concurrently or previous treating physician. (T.3276-79; Ex. 9)

55.* A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient D. (T. 603; Ex. 9)

56. A physician should include in a patient's record only those diagnostic codes for conditions for which he has evaluated and treated the patient. The Respondent included in Patient D's medical record diagnostic codes for conditions for which he evaluated and/or treated Patient D. (T. 2192-97, 3279-82; Ex. 9)

57. A physician should not provide a patient with erroneous diagnostic codes on the patient's billing statement for the purpose of the patient submitting them to his third-party health insurer for reimbursement. The Respondent provided such erroneous codes to Patient D. (T. 596-97; Ex. 9)

58. Respondent sent samples relating to Patient D, for testing to the GSDL when he knew that GSDL was not certified by New York State to perform such tests. (T. 2242-45; Exs. 9 & 32)

PATIENT E

59. Respondent provided medical care and treatment to Patient E, at Respondent's office during the period of June 11, 1999 through September

13, 1999. Patient E was three and one half years old and received medical care for allergies and autism among other conditions. (Ex. 10)

60. A physician should obtain a complete history from a new patient and document it. The Respondent did not do this for Patient E. (T. 704-06; Ex. 10)

61. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient, by among other actions, ordering laboratory tests and evaluating the results of these tests. (T. 1841-47, 3047-48; Ex. 10)

62. A physician should perform an adequate physical on a new patient and document it. An adequate physical includes obtaining a number of vital measurements of the patient and a hands-on examination of the patient's body. The Respondent did not do this for Patient E. (T. 706-09; Ex. 10)

63. A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent failed to document such a diagnosis for Patient E. (T. 710-11; Ex. 10)

64. An adequate medical indication for a physician's diagnosis of disseminated systemic candidiasis should be documented in the patient's

record. The Respondent did not adequately document an indication in Patient E's medical record. (T. 713-14; Ex. 10)

65. The Respondent ordered a number of laboratory tests for Patient E which were medically indicated. (T. 3063-69, 3144-45; Ex. 10)

66. The Respondent had a duty to adequately evaluate and if needed treat Patient E for elevated levels of blood lead and other toxic heavy metals. The Respondent did this. (T. 1868-69, 3075; Exs. 10 & R)

67. A physician has a duty to report blood lead levels which are above normal. Patient E's whole blood lead level was within the normal range therefore there was no obligation to report this to the Public Health authorities. (Exs. 10 & R)

68. A physician should document the medical indications when prescribing Nizoral. The Respondent prescribed such medication for Patient E without documenting an adequate medical indication. (T. 720; Ex. 10)

69. The Respondent did not have to confer with Patient E's concurrently or previous treating physician. (T. 3077-81; Ex. 10)

70.* A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient E. (T. 730-31; Ex. 10)

71. A physician should include in a patient's record only those diagnostic codes for conditions for which he has evaluated and treated the patient. The Respondent included in Patient E's medical record diagnostic codes for conditions for which he evaluated and/or treated Patient E. (T. 1878-87, 3083-86; Ex. 10)

72. A physician should not provide a patient with erroneous diagnostic codes on the patient's billing statement for the purpose of the patient submitting them to his third-party health insurer for reimbursement. The Respondent provided such erroneous codes to Patient E. (T. 715-16; Ex. 10)

73. Respondent sent samples relating to Patient E, for testing to the ~~GSDL when he knew that GSDL was not certified by New York~~ State to perform such tests. (T. 1951-56, 2242-45; Exs. 10 & 32)

PATIENT F

74. Respondent provided medical care and treatment to Patient F, at Respondent's office during the period of January 27, 1999 through March 3, 1999. Patient F was five years old and presented with complaints of arthritis. (Ex. 11)

75. A physician should obtain a complete history from a new patient and document it. The Respondent did not do this for Patient F. (T. 773-74; Ex. 11)

76. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient, by among other actions, ordering laboratory tests and evaluating the results of these tests. (T. 2001-11, 3190-92, 3199-3200; Ex. 11)

77. A physician should perform an adequate physical on a new patient and document it. An adequate physical includes obtaining a number of vital measurements of the patient and a hands-on examination of the patient's body. The Respondent did not do this for Patient F. (T. 774; Ex. 11)

78. A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent formulated such a diagnosis for Patient F. (T. 3202-03; Ex. 11)

79. There should be adequate medical indication when a physician documents a plan for treating a patient for a parasitic infection. The Respondent documented such a plan for Patient F with an adequate medical indication. (T. 3204-08; Ex. 11)

80. The Respondent did not have to confer with Patient F's concurrently or previous treating physician. (T. 2027-28, 3208-09; Ex. 11)

81. A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient F. (T. 2028-30, 3210-11; Exs. 11, L & M)

PATIENT G

82. Respondent provided medical care and treatment to Patient G, at Respondent's office during the period of August 17, 1999 through September 7, 1999. Patient G was 41 years old and received medical care for injuries sustained in a motor vehicle accident. (Ex. 12)

83. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient, by among other actions, ordering laboratory tests and evaluating the results of these tests. (T. 3001-11, 3190-92, 3199-3200; Ex. 12)

84. A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent failed to document such a diagnosis for Patient G. (T. 993-95; Ex. 12)

85. An adequate medical indication for a physician's diagnosis of disseminated systemic candidiasis should be documented in the patient's record. The Respondent did not adequately document this diagnosis in Patient G's medical record. (Ex. 12)

86. A physician should document the medical indications when prescribing Nizoral and Nystatin. The Respondent prescribed such medications for Patient G without documenting an adequate medical indication. (T. 995-96; Ex. 12)

87. With Patient G's presentation the Respondent had a duty to adequately evaluate and/or act upon the patient's creatinine level and history of glomerulonephritis. The Respondent fulfilled this duty. (T. 1710-13, 2885-86; Ex. 12)

88. The Respondent conferred with Patient G's concurrently or previous treating physician. (T. 1714-17, 2886-87; Ex. 12)

89. A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient G. (T. 998-99; Ex. 12)

90. A physician should include in a patient's record only those diagnostic codes for conditions for which he has evaluated and treated the patient. The Respondent included in Patient G's medical record a diagnostic code for a condition which he did not evaluate and/or treat Patient G. (T. 999-1001; Ex. 12)

91. A physician should not provide a patient with erroneous diagnostic codes on the patient's billing statement for the purpose of the patient submitting them to his third-party health insurer for reimbursement. The Respondent provided such erroneous codes to Patient G. (T. 999-1001; Ex. 12)

PATIENT H

92. Respondent provided medical care and treatment to Patient H, at Respondent's office during the period of April 13, 1999 through August 16, 1999. Patient H was 60 years old and presented with prostatic carcinoma among other conditions. (Ex. 13)

93. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient, by among other actions, ordering laboratory tests and evaluating the results of these tests. (T. 2772-73; Ex. 13)

94. A physician should perform an adequate physical on a new patient and document it. An adequate physical for a patient with prostatic carcinoma would include a rectal exam. The Respondent did not do this for Patient H. (T. 1105-06; Ex. 13)

95.* A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent documented such a diagnosis for Patient H. (T. 1431-32, 2788-89; Ex. 13)

96. Respondent did not advise Patient H to defer treatment for prostate cancer by surgery and radiation therapy, claiming that the Respondent could provide better treatment options. (T. 1382-83, 3653)

97. The Respondent did not have to confer with Patient H's

concurrently or previous treating physician. (T. 3648)

98. A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient H. (T. 1115-16; Ex. 13)

99. A physician should include in a patient's record only those diagnostic codes for conditions for which he has evaluated and treated the patient. The Respondent included in Patient H's medical record a diagnostic code for a condition for which he did not evaluate and/or treat Patient H. (T. 1120-21, 2803-06; Ex. 13)

100. A physician should not provide a patient with erroneous diagnostic codes on the patient's billing statement for the purpose of the patient submitting them to his third-party health insurer for reimbursement. The Respondent provided such erroneous codes to Patient H. (T. 1120-21; Ex. 13)

PATIENT I

101. Respondent provided medical care and treatment to Patient I, at Respondent's office during the period of January 21, 1999 through May 12,

1999. Patient I was 14 years old and presented with complaints of chronic and recurring headaches. (Ex. 14)

102. A physician has a duty to adequately evaluate his patient. The Respondent adequately evaluated this patient, by among other actions, ordering laboratory tests and evaluating the results of these tests. (Ex. 14)

103. A physician should perform an adequate physical on a new patient and document it. An adequate physical includes obtaining a number of vital measurements of the patient and a hands-on examination of the patient's body. The Respondent did not do this for Patient I. (T. 641; Ex. 14)

104. A physician should formulate and document an accurate initial and working diagnosis for a patient. The Respondent did not document such a diagnosis for Patient I. (T. 644-45; 2076-77; Ex. 14)

105. Respondent sent samples relating to Patient I, for testing to the GSDL when he knew that GSDL was not certified by New York State to ~~perform such tests~~. (T. 1951-56; Exs. 14 & 32)

106. The Respondent ordered a number of laboratory tests for Patient I which were medically indicated. (T. 2916-17; Ex. 14)

107. A physician should document the medical indications when prescribing Nystatin. The Respondent prescribed such medication for

Patient I without documenting an adequate medical indication. (T. 2125-28, 2917-18; Ex. 14)

108. The Respondent did not have to confer with Patient I's concurrently or previous treating physician. (T. 2086-88, 2918-19)

109. A physician has a duty to maintain a medical record which accurately reflects his evaluation and treatment of his patient. The Respondent did not do this for Patient I. (Ex. 14)

ALLEGATION J.

110. The Respondent represented that he trained in family practice and psychiatry when he knew he had completed only one year of a three year family practice residency and only 6 months of a psychiatry residency for which he received no credit. (T. 1476-77, 1482-85, 1488-89; Exs. 20, 25, 36 & 60)

ALLEGATION K.

111. Respondent did not enter into a scheme with GSDL to permit diagnostic testing of Respondents patients for which GSDL was not certified in New York. (T. 3555-56, 3608-09)

ALLEGATION L.

112. Respondent did not receive consideration from GSDL in exchange for referral of laboratory samples to GSDL. (T. 3602-3608)

ALLEGATION M.

113. The Respondent received consideration from Natural Solutions Research , Inc. (hereinafter NSR) in the form of promoting his medical practice, sale of his therapeutic agents and the sale of his book. NSR was a company in which the Respondent had an ownership interest and which distributed supplements and nutrient formulas that the Respondent prescribed to his patients.

Conclusions

The following conelusions were made pursuant to the Findings of Fact listed above. The 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: (2);

Paragraph A.1.: (3);

Paragraph A.3: (5);

Paragraph A.4: (6);

Paragraph A.7: (9);

Paragraph A.9: (11);

Paragraph A.10: (12);

Paragraph A.11: (13);

Paragraph A.12: (14);

Paragraph B: (15)

Paragraph B.1: (16);

Paragraph B.3: (18);

Paragraph B.4: (19);

Paragraph B.5: (20);

Paragraph B.8: (23);

Paragraph B.13: (28);

Paragraph B.14: (29);

Paragraph B.16: (31);

Paragraph C: (32);

Paragraph C.1: (33);

Paragraph C.3: (35);

Paragraph C.4: (36);

Paragraph C.5: (37);

Paragraph C.7: (39);

Paragraph C.8: (39);

Paragraph C.9: (39);

Paragraph C.10: (39);

Paragraph C.11: (39);

Paragraph C.12: (39);

Paragraph C.13: (39);

Paragraph C.15: (40);

Paragraph C.16: (41);

Paragraph C.17: (42);

Paragraph C.18: (43);

Paragraph D: (44);

Paragraph D.3: (47);

Paragraph D.4: (48);

Paragraph D.5: (49);

Paragraph D.9: (53);

Paragraph D.11: (55);

Paragraph D.13: (57);

Paragraph D.14: (58);

Paragraph E: (59);

Paragraph E.1: (60);

Paragraph E.3: (62);

Paragraph E.4: (63);

Paragraph E.5: (64);

Paragraph E.9: (68);

Paragraph E.11: (70);

Paragraph E.13: (72);

Paragraph E.14: (73);

Paragraph F: (74);

Paragraph F.1: (75);

Paragraph F.3: (77);

Paragraph F.7: (81);

Paragraph G.: (82);

Paragraph G.2: (84);

Paragraph G.3: (85);

Paragraph G.4: (86);

Paragraph G.5: (86);

Paragraph G.8: (89);

Paragraph G.9: (90);

Paragraph G.10: (91);

Paragraph H.: (92);

Paragraph H.2: (94);

Paragraph H.6: (98);

Paragraph H.7: (99);

Paragraph H.8: (100);

Paragraph I.: (101);

Paragraph I.2: (103);

Paragraph I.3: (104);

Paragraph I.4: (105);

Paragraph I.6: (107);

Paragraph I.8: (109);

Paragraph J.: (110);

Paragraph M.: (113).

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. An asterisk indicates the conclusion was not unanimous:

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Nineteenth Specification: (Paragraphs A., A.1., A.3.- 4., A.7., A.11.-12., B., B.1., B.3.- 5, B.8., B.13.-14., B. 16., C., C.1., C.3.-5., C.7.-13., C.15.- 18., D., D.3.-5.,D.9., D.11., D.13.-14., E., E.1., E.3.-5., E.9., E.11., E.13.-14., F., F.1., F.3., F.7., G., G.2.-5, G.8-10., H., H.2., H.6.-8., I., I.2.-4., ~~I.6. and I.8.).~~

PRACTICING THE PROFESSION FRAUDULENTLY

***Twenty-first Specification:** (Paragraphs A., A. 11.-12.);

***Twenty-second Specification:** (Paragraphs B., B.15.-16.);

***Twenty-third Specification:** (Paragraphs C., C.15.);

*Twenty-fourth Specification: (Paragraphs D., D.13.);

*Twenty-fifth Specification: (Paragraphs E., E.13.);

*Twenty-sixth Specification: (Paragraphs G., G.9.-10.);

*Twenty-seventh Specification: (Paragraphs H., H.7.-8.).

CONDUCT WHICH EVIDENCES MORAL UNFITNESS

*Forty-first Specification: (Paragraph J.);

Forty-fourth Specification: (Paragraph M.).

FILING A FALSE REPORT

Fifty-first Specification: (Paragraphs A. and A.12.);

Fifty-second Specification: (Paragraphs B. and B.16.);

Fifty-third Specification: (Paragraphs C. and C.15.-16.);

Fifty-fourth Specification: (Paragraphs D. and D.13.);

Fifty-fifth Specification: (Paragraphs E. and E.13.);

~~Fifty-sixth~~ Specification: (Paragraphs G. and G.9.-10.);

Fifty-seventh Specification: (Paragraphs H., H.7. and H.8.).

RECEIVING CONSIDERATION FROM A THIRD PARTY FOR PATIENT REFERRAL

Sixty-fifth Specification: (Paragraph M.).

FAILURE TO MAINTAIN ACCURATE RECORDS

Sixty-sixth Specification: (Paragraphs A. and A.10.);

Sixty-seventh Specification: (Paragraphs B. and B.14.);

Sixty-eighth Specification: (Paragraphs C. and C.17.);

Sixty-ninth Specification: (Paragraphs D. and D.11.);

Seventieth Specification: (Paragraphs E.. and E.11.);

Seventy-first Specification: (Paragraphs F. and F.7.);

Seventy-second Specification: (Paragraphs G.. and G.8.);

Seventy-third Specification: (Paragraphs H. and H.6.);

Seventy-fourth Specification: (Paragraphs I. and I.8.).

The Committee concluded that the following specifications were not sustained. An asterisk denotes the conclusion was not unanimous:

Specifications numbers 1-18, 20, 28, 29*, 30-40, 42-43, 45-50, 58-64.

DISCUSSION

Respondent was charged with seventy-four specifications alleging professional misconduct within the meaning of 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 Committee consulted a memorandum prepared by General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence in the practice of medicine and fraud in the practice of medicine.

~~The following definitions~~ were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Fraud in the practice is defined as 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 definitions as a framework for its deliberations, the Committee concluded, by a preponderance of the evidence, that the above delineated specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented William Maliha, M.D. as its expert witness. Dr. Maliha is a physician who is board certified in emergency medicine and family medicine. There was no evidence of any bias on the part of Dr. Maliha. The Committee found him to be a credible witness. However, they found his medical experience to be limited in both the type of practice that the Respondent is engaged in, namely complementary alternative medicine, and in some cases the type of patient presented, and therefore his testimony with respect to certain areas of that practice and certain patients was discounted. The petitioner also presented Dr. David C. Brittain as a fact witness. Dr. Brittain had conducted an interview of the Respondent and testified about his report of that interview. He was found to be a credible witness.

The Respondent presented the testimony of three expert witnesses, Drs. Schachter, Bock and Baker. The Committee found Drs. Bock and Schachter to be credible in those areas involving the adjunct or complementary practice of medicine. In particular the committee found Dr. Bock to very credible. His testimony was not slanted to advocate the Respondent's position but was objective and he was found to be knowledgeable with respect to the Respondent's practice modality. Dr. Baker's credibility was

questionable as he was found to have a conflict of interest since he had previously treated the patient he testified about which affected his objectivity and in the course of that treatment provided what might be construed as an incorrect diagnosis so that Patient C would be admitted to the hospital.

The Respondent also testified on his own behalf. The Committee found him to be well versed in his type of medical practice. At times they felt his testimony was evasive or inconsistent in particular with respect to the charges relating to coding , the GSDL and NSR.

Recurring Patient Charges

Dr. Maliha repeatedly testified that the Respondent's patient histories, physical examinations, laboratory work-ups, documentation of initial and working diagnoses and the accuracy of the medical records for the patients presented did not meet acceptable standards of medical care. With the few exceptions noted, the Committee found itself in agreement with his testimony relating to the histories, physicals, documentation of initial and working diagnoses and accuracy of records and sustained those charges.

With respect to the repeated charge of not adequately evaluating the patients enumerated, the Committee agreed with the Respondent's experts

that the Respondent's paradigm of using laboratory tests as the method of evaluating each patient was an acceptable practice. As such, the Committee also did not sustain the repeated charge of ordering excessive and/or not medically indicated laboratory tests. The Committee did conclude that the Respondent needs to document his interpretation of the laboratory results.

The Committee also determined that the Respondent as an adjunct-care provider did not violate the standards of practice by not consulting with the various patients' concurrent or prior treating physicians. The majority of the Patients were self-referrals and/or did not present with any life threatening symptoms. Although the Committee did not sustain these charges it felt that the Respondent needs to develop a system which would prompt his conferring with a patient's previous and/or concurrent physician when there is an acute medical issue that the Respondent would not be addressing or if there ~~may be~~ conflicting treatment which may be detrimental to the patient's health unless the patient has specifically prohibited the Respondent from contacting the other physician.

The Committee did conclude that in all cases charged, the Respondent sent specimens to the GSDL, when he knew or should have known that it

was not certified by New York to do such tests. The Respondent's explanation regarding setting up mail drops for the delivery of the test results and yet not being aware of GSDL's lack of certification was not credible.

Furthermore, in all cases charged, the Committee concluded that the Respondent did provide erroneous codes to the patients for the purpose of obtaining third party reimbursement and this constituted professional misconduct.

The Committee did find all of the Respondent's patients' records to be deficient. Although the Committee believed he spent sufficient time with each patient his documentation was totally inadequate. As a result of that deficiency, in each instance where the Respondent made a diagnosis of disseminated systemic candidiasis he failed to document the basis for this diagnosis and therefore those charges were sustained.

With respect to the repeated charge that the Respondent documented diagnostic codes for conditions he did not evaluate or treat, the Committee concurred with the Respondent that with a few exceptions, for those conditions listed, he did an appropriate evaluation and where indicated did treat. Whether or not it was inappropriate to evaluate the patient for some or

all of these conditions was not charged. The Committee notes that the ICD-9 codes are not sufficient as working diagnoses in a medical chart and are meant to be used solely for billing purposes. Additionally, the Respondent continued to use some of these codes even after the test results found them inapplicable to the particular patient.

Patient A

The Committee found the Respondent's medical records for this patient to be deficient. Thus, although the respondent formulated a working and initial diagnosis he did not document it. It was not clear from the records that there was a diagnosis upon which the Respondent was basing his treatment. The Committee concurred with the Respondent that this patient's immunity was compromised and any elevation of her IgG candida antibodies could be interpreted as possible candidiasis.

The Respondent's ordering of iron supplement was not contraindicated. The Committee concurred with the Respondent and Dr. Schachter that the more threatening malady was the melanoma and the taking of the iron supplement might have a beneficial effect on that disease.

Patient B

The Committee concluded that the Respondent did not prescribe ciprofloxacin. This was based on the fact that there were no prescriptions produced and the corroboration by the patient's mother that the patient was not prescribed this medication. This was not the conclusion the Committee reached with respect to the Respondent prescribing an antihelminthic. The patient record contained no evidence of a parasitic infection to justify prescribing any such substance.

The charges relating to the elevated levels of lead were unfounded. The Respondent did evaluate and found the patient's RBC lead levels, which are the definitive measurement, to be normal. Therefore, there was no obligation to notify the Public Health authorities.

Patient C

The Committee disagreed with the Petitioner's expert and found that the Respondent did not prevent the patient from getting care but rather worked with the patient's other concurrent and prior physicians. He did not refute the other physicians' approach but adopted a different treatment approach without refuting or adopting their diagnosis. The Committee did

find that the Respondent failed to document the medical indication for a number of the medications he prescribed for this patient and therefore sustained those charges.

Additionally, with respect to Patient C and D the Committee notes there were clerical errors in the diagnostic codes in the patients' records which resulted in the record indicating that the Respondent evaluated these patients for certain conditions for which he did not.

Patient D

In this case the Committee found the Respondent had documented an adequate history. As with Patient B the Committee did not find that the Respondent violated the standard of care with respect to the patient's lead levels in his blood for the same reasons cited above. Additionally, in this case although the hair analysis results were elevated, there was a high level of probability of it being a false reading. The Respondent prescribed Nizoral for this patient. Although the Respondent testified as to his reasoning for doing this he failed to document his rationale in the patient's record and therefore the charge was sustained.

Patient E

The Respondent's care of this patient with respect to alleged elevated lead levels was charged as failing to meet the standard of care. As with Patients B and D the Committee concluded there was no breach of the standard of care for the same reasons noted above. Furthermore, as with Patient D, this was notwithstanding an elevated lead level in the patient's hair analysis, since such reading had the possibility of being falsely elevated.

The Committee found that the Respondent also failed to document his basis for prescribing Nizoral for this patient.

Patient F

The Committee determined that in this case the Respondent did document an initial and working diagnosis. The initial diagnosis was set out in the patient's health history. This remained the working diagnosis and was clear from the patient's record. The Committee also agreed with the Respondent's expert that there was sufficient medical justification to treat this patient for a parasitic infection. The patient had GI bleeding and negative tests for candida and bacteria, which justified an empirical treatment for parasites.

Patient G

As noted above for Patients D and E there was no medical indication for prescribing Nizoral documented in the patient's record. As such the charge was sustained.

A specific charge for this patient was that the Respondent failed to adequately evaluate the patient's creatinine level and past history of glomerulonephritis. This charge was not sustained. The Respondent did test the creatinine level and knew the patient was being monitored for glomerulonephritis by her primary care physician. The Committee concurs with the Respondent's expert that this patient was not in the early stages of renal failure and the steps the Respondent took were adequate.

Patient H

The Committee found that the Respondent had documented an accurate initial and working diagnosis for this patient. This conclusion was reached based on the history in the record which included prior medical reports on the patient and the testimony of the patient. The Committee also did not sustain the charge which alleged that the Respondent had advised the patient to defer conventional treatment for his prostate cancer. The patient came to the Respondent having received complete medical advice from conventional-practice physicians but chose not to follow their recommended

course of treatment. The Committee determined that the Respondent fully advised the patient of the risks of complementary-alternative medical treatment and also advised him to keep up contact with his conventional practice physician. The Petitioner submitted insufficient proof to meet its burden with respect to that charge.

Patient I

With respect to the charge of prescribing Nystatin without medical indication, the Committee found that although the Respondent explained his justification when on the witness stand, he failed to document it in the medical record.

Fraud Charges

The Respondent was charged with making inaccurate representations on his website. The Committee found that the Respondent did make inaccurate representations on his website. Although the website used the term "trained in family practice..... and in psychiatry," the Respondent knew he had completed only one year of a residency in family practice and had spent only six months in a psychiatry residency program for which he received no credit. The Committee believed it was reasonable to assume a member of

the public would interpret his statement as other than what was factually accurate.

The Respondent was also charged with entering into a scheme with GSDL to permit certain uncertified diagnostic laboratory testing. "Scheme" is defined as a plan of action. The Petitioner did not produce any evidence of any plan that the Respondent devised with GSDL to obtain such testing. Additionally, a representative of GSDL testified that when they were advised that some laboratory results generated from samples from New York were being delivered to addresses outside the state they instituted an audit and ceased delivery of test results to those non-New York addresses which were determined to not be actual clinical practices. This charge was not sustained.

In a related charge the Respondent was alleged to have received consideration from GSDL for referral of laboratory samples in the form of GSDL promoting the Respondent's medical practice and his book. The Petitioner did not produce any direct evidence to support this charge. The Respondent offered the testimony of a GSDL spokesperson who denied such an arrangement and explained GSDL's policy for physician referral and the highlighting of books on its website. There was no evidence of the

Respondent receiving any consideration for his referrals of samples to GSDL.

Finally, the Respondent was charged with prescribing supplements for his patients which were sold by Natural Solutions Research, Inc.(hereinafter NSR), a company he had a founding interest in, and from which he received consideration for this prescribing, by the promotion of his medical practice, the sale of these prescribed supplements and offering his book for sale. The Committee determined that the Respondent's conduct amounted to a conflict of interest which was contrary to accepted standards of practice. The prescribing of supplements sold exclusively by a company in which the practitioner has an interest is inherently forbidden. The claim by the Respondent that he never made any profit from this practice is irrelevant. The committee concluded the conflict was an obvious one that the Respondent should have avoided and sustained this allegation.

DETERMINATION AS TO PENALTY

The 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 suspended for a **period of five years with all but a minimum of 6 months of the suspension stayed and his license shall be placed on probation for a period of no less than 4 and one half years, both in accordance with the terms specifically set forth in Appendix II.** 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 Committee unanimously agreed that the Respondent's license should not be revoked. The record in this case established Respondent was not incompetent nor did his conduct amount to gross negligence. Nor did they find that his diagnostic or testing practices were an attempt to reap excessive financial gain. He was well-versed in his type of practice and was not trying to take advantage of his patients. In mitigation of the findings of fraud, the Committee notes that the use of erroneous codes was not done for the Respondent's financial benefit since his practice was one of fee-for-service. The Committee felt his coding habits exhibited a lack of effort to

perform that aspect of his practice correctly. Had the Respondent taken the time he could have used legitimate codes for these patients.

The Committee felt that the findings relating to the GSDL and NSR which led to sustaining specifications of fraud and moral unfitness convey an aspect of dishonesty in the Respondent. However, it was the adamant belief of the Committee that there are degrees of fraud and moral unfitness and in this instance the Respondent's conduct did not warrant revocation of his license.

ORDER

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

1. The Nineteenth, Twenty-first through Twenty-seventh, Forty-first, Forty-fourth, Fifty-first through Fifty-seventh, Sixty-fifth and Sixty-sixth through Seventy-fourth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) are **SUSTAINED**;

2. Respondent's license is **SUSPENDED FOR 5 YEARS** with all but a minimum of 6 months stayed, the terms of the suspension are contained in

Appendix II, attached hereto and made a part of this Determination and Order;

3. Respondent license is placed on **PROBATION FOR 4 AND A HALF YEARS**, the terms of the probation are contained in Appendix II, attached hereto and made a part of this Determination and Order.

DATED: Newcomb, New York

August 22 **, 2001**

Denise M. Bolan, RPA-C

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APPENDIX I

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

----------X

IN THE MATTER	STATEMENT
OF	OF
CHARLES EDWARD GANT, M. D.	CHARGES

----------X

CHARLES EDWARD GANT, M. D., Respondent, was authorized to practice medicine in New York State on February 29, 1980, by issuance of license number 141276, by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine, with registration addresses of 6996 Henderson Road, Jamesville, New York (residence) and 5900 No. Burdick Street, East Syracuse, New York (hereafter "office").

FACTUAL ALLEGATIONS

A. From on or about July 27, 1999 through August 13, 1999, Respondent provided medical care to Patient A at his office. Patient A presented to Respondent with polycythemia vera and malignant melanoma. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in the following respects:

1. On July 27, 1999, and/or on subsequent occasions, Respondent failed to take and/or document an adequate medical history of Patient A.

2. On July 27, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient A.

3. On July 27, 1999, and/or on subsequent occasions, Respondent failed to perform an adequate physical examination of Patient A and/or document such examination.

4. On July 27, 1999, and/or on subsequent occasions, Respondent failed to formulate and/or document an accurate initial and/or working diagnostic impression of Patient A.

5. On or about July 27, 1999, and/or on subsequent occasions (e.g., August 13, 1999), Respondent ordered iron supplementation for Patient A when such treatment was contraindicated due to the patient's polycythemia vera.

6. From on or about July 27, 1999 through August 13, 1999, Respondent failed to appropriately or timely seek consultation with Patient A's previous and/or concurrent treating physicians and/or advise such physicians of Respondent's treatment.

7. From on or about July 27, 1999, and/or on subsequent occasions, Respondent diagnosed Patient A with disseminated systemic candidiasis without an adequate medical indication, and/or failed to document such indication.

8. On or about July 27, 1999, and/or on subsequent occasions, Respondent ordered laboratory tests for Patient A which were not medically indicated and/or were excessive and/or were inapplicable, and/or were redundant of other testing.

9. During and/or subsequent to treatment, Respondent sent various laboratory work regarding Patient A to Great Smokies Diagnostic Laboratories, when he knew, or should have known, such laboratory was not certified in NYS to perform such tests.

10. From on or about July 27, 1999 through August 13, 1999, Respondent failed to maintain an adequate medical record, which accurately reflected his evaluation

and/or treatment of Patient A.

11. During and/or subsequent to treatment, Respondent documented diagnostic codes representing anemia, vitamin deficiency, backache, insomnia, disseminated systemic candidiasis, thyroid disorder, gastroenteritis and colitis on patient A's medical record, when in fact, Respondent knew or should have known, that he did not appropriately evaluate and/or treat these conditions.

12. Respondent also provided the erroneous diagnostic codes to a clinical laboratory and documented them on billing statements given to patient A when the Respondent knew or should have known that the erroneous diagnostic codes would be used to seek reimbursement under patient's third-party health coverage.

B. From on or about January 13, 1999 through February 29, 1999, Respondent provided medical care to Patient B, then five years old, for complaints of fever, constipation, diarrhea, and gas, among other conditions. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in the following respects:

1. On or about January 13, 1999, and/or on subsequent occasions, Respondent failed to take and/or document an adequate medical history of Patient B.

2. On January 13, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient B and/or document such evaluation.

3. On January 13, 1999, and/or on subsequent occasions, Respondent failed to perform an adequate physical examination of Patient B and/or document such evaluation.

4. From on or about January 13, 1999, and/or on subsequent occasions, Respondent

diagnosed Patient B with disseminated systemic candidiasis without an adequate medical indication, and/or failed to document such indication.

5. On January 13, 1999, and/or on subsequent occasions, Respondent failed to formulate and/or document an appropriate initial and/or working diagnostic impression of Patient B.

6. On or about January 13, 1999, and/or on subsequent occasions, Respondent ordered laboratory tests for Patient B, which were not medically indicated and/or were excessive and/or were inapplicable, and/or were redundant of other testing.

7. On or about February 3, 1999, and/or on subsequent occasions, Respondent prescribed ciprofloxacin for Patient B, a drug contraindicated in children and/or for which the manufacturer warning that safety was effectiveness has not been established for pediatric use, without adequate justification.

8. On or about February 3, 1999, and/or on subsequent occasions, Respondent prescribed "antihelminthic--antibiotic" medication for Patient B without adequate medical indication and/or failed to document such justification.

9. On or about January 13, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate and/or treat Patient B with respect to the patient's elevated levels of lead and/or other toxic heavy metals as reported in elemental hair analysis laboratory studies.

10. On or about January 13, 1999, and/or on subsequent occasions, Respondent failed to notify appropriate Public Health authorities and/or treating consultants of the patient's elevated levels of lead and/or other toxic heavy metals as reported in elemental hair analysis laboratory studies.

11. From on or about January 13, 1999 through February 29, 1999, Respondent failed to appropriately or timely seek consultation with Patient B's previous and/or concurrent treating physicians and/or advise such treating physicians of Respondent's treatment.

12. From on or about January 13, 1999 through February 29, 1999, Respondent failed to obtain Patient B's medical records from the previous treating pediatrician.

13. During and/or subsequent to treatment, Respondent sent various laboratory work regarding Patient B to Great Smokies Diagnostic Laboratories, when he knew, or should have known, such laboratory was not certified in NYS to perform such tests.

14. From on or about January 13, 1999 through February 29, 1999, Respondent failed to maintain a medical record, which accurately reflected his evaluation and treatment of Patient B.

15. During and/or subsequent to treatment, Respondent documented diagnostic codes representing allergy, autism, retardation, anemia, vitamin deficiency, disorder of magnesium metabolism, immune disorder, disseminated systemic candidiasis, thyroid disorder, and malnutrition on patient B's medical record, when in fact, Respondent knew or should have known, that he did not appropriately evaluate and/or treat these conditions.

16. During and/or subsequent to treatment, Respondent also provided the erroneous diagnostic codes to a clinical laboratory and documented them on billing statements given to patient B when the Respondent knew or should have known that the erroneous diagnostic codes would be used to seek reimbursement under patients'

third-party health coverage.

C. From on or about December 18, 1998 through February 10, 2000, Respondent provided medical care to Patient C at his office, then a fifteen year old female, for life-threatening weight loss, among other complaints. Respondent's care and treatment of Patient C failed to meet accepted standards of medical care in the following respects:

1. On or about December 18, 1998, and/or on subsequent occasions, Respondent failed to take and/or document an adequate medical history of Patient C.

2. On or about December 18, 1998, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient C.

3. On or about December 18, 1998, and/or on subsequent occasions, Respondent failed to perform an adequate physical examination of Patient C and/or failed to document such examination.

4. From on or about December 18, 1998, and/or on subsequent occasions, Respondent diagnosed Patient C with disseminated systemic candidiasis without an adequate medical indication, and/or failed to document such indication.

5. On December 18, 1998, and/or on subsequent occasions, Respondent failed to formulate and/or document an appropriate initial and/or working diagnostic impression of Patient C.

6. On or about December 18, 1998, and/or on subsequent occasions, Respondent ordered laboratory tests for Patient C which were not medically indicated and/or were excessive and/or were inapplicable, and/or were redundant of other testing.

7. From on or about December 18, 1999, and/or on subsequent occasions, Respondent prescribed and/or continued prescriptions of Lamisil, Cortef/Cortisol, and Armour Thyroid for Patient C without adequate medical indication, and/or failed to document such indication.

8. On or about August 30, 1999 and/or October 25, 1999, Respondent prescribed Vermox for Patient C without adequate medical indication, and/or failed to document such indication.

9. In April 1999 (specific date not recorded in Respondent's notes) Respondent prescribed Nizoral for Patient C without adequate medical indication, and/or failed to document such indication.

10. On or about October 19, 1999, Respondent prescribed Flagyl for Patient C without adequate medical indication, and/or failed to document such indication.

11. On or about October 25, 1999, Respondent prescribed Biltricide for Paitent C without adequate medical indication, and/or failed to document such indication.

12. On or about December 8, 1999, and/or on subsequent occasions, Respondent prescribed and/or continued prescriptions of Nystatin for Patient C without adequate medical indication, and/or failed to document such indication.

13. On or about December 28, 1999, Respondent inappropriately prescribed Triest-Progesterone Cream for Patient C without adequate medical indication, and/or failed to document such indication.

14. On or about January 19, 2000, Respondent prescribed Epipea for Patient C without

adequate medical indication, and/or failed to document such indication

15. During and/or subsequent to treatment, Respondent documented diagnostic codes representing vitamin deficiency, disorder of magnesium metabolism, systemic poisoning by heavy metal antagonist, hepatitis, rectal prolapse, and disseminated systemic candidiasis on patient C's medical record, when in fact, Respondent knew or should have known, that he did not evaluate and/or treat these conditions.

16. During and/or subsequent to treatment, Respondent also provided the erroneous diagnostic codes to a clinical laboratory and documented them on billing statements given to Patient C when the Respondent knew or should have known that the erroneous diagnostic codes would be used to seek reimbursement under patient's third-party health coverage.

17. From on or about December 18, 1998, and/or on subsequent occasions, Respondent failed to maintain a medical record, which accurately reflected his evaluation and treatment of Patient C.

18. During and/or subsequent to treatment, Respondent sent various laboratory work regarding Patient C to Great Smokies Diagnostic Laboratories, when he knew, or should have known, such laboratory was not certified in NYS to perform such tests.

D. From ~~on or about~~ January 29, 1999 through February 13, 1999, Respondent provided medical care to Patient D at his office, then eight years old, for hyperactivity or Attention Deficit Hyperactivity Disorder, among other conditions. Respondent's care and treatment of Patient D failed to meet accepted standards of medical care in the following respects:

29 30, 42, 29

1. On or about January 29, 1999, and/or on subsequent occasions, Respondent failed to take and/or document an adequate medical history of Patient D.

2. On or about January 29, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient D and/or document such evaluation.

3. On or about January 29, 1999, and/or on subsequent occasions, Respondent failed to perform an adequate physical examination of Patient D and/or failed to document such examination.

4. On or about January 29, 1999, and/or on subsequent occasions, Respondent failed to formulate and/or document an appropriate initial and/or working diagnostic impression of Patient D.

5. From on or about January 29, 1999, and/or on subsequent occasions, Respondent diagnosed Patient D with disseminated systemic candidiasis without an adequate medical indication, and/or failed to document such indication.

6. On or about January 29, 1999 and/or on subsequent occasions, Respondent ordered laboratory tests for Patient D, which were not medically indicated and/or were excessive and/or were inapplicable, and/or were redundant of other testing.

7. On or about January 29, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate and/or treat Patient D with respect to the patient's elevated ~~levels of lead and/or~~ other toxic heavy metals as reported in elemental hair analysis laboratory studies.

8. On or about January 29, 1999, and/or on subsequent occasions, Respondent failed to notify appropriate Public Health authorities and/or treating consultants of

patient's elevated levels of lead and/or other toxic heavy metals as reported in elemental hair analysis laboratory studies.

9. On or about February 13, 1999, Respondent prescribed Nizoral for Patient D without adequate medical indication, and/or failed to document such indication.

10. From on or about January 29, 1999, and/or on subsequent occasions, Respondent failed to appropriately or timely seek consultations with Patient D's previous and/or concurrent treating physicians and/or advise such physicians of Respondent's treatment.

11. From on or about January 29, 1999 through February 13, 1999, Respondent failed to maintain a medical record which accurately reflected the evaluation and treatment of Patient D.

12. During and/or subsequent to treatment, Respondent documented diagnostic codes representing anemia, poisonings by cathartics, vitamin deficiency, disorder of magnesium metabolism, and disseminated systemic candidiasis on patient D's medical record, when in fact, Respondent knew or should have known, that he did not appropriately evaluate and/or treat these conditions.

13. During and/or subsequent to treatment, Respondent also provided the erroneous diagnostic codes to a clinical laboratory and documented them on billing statements given to patient D when the Respondent knew or should have known that the erroneous diagnostic codes would be used to seek reimbursement under patient's third-party health coverage.

14. During and/or subsequent to treatment, Respondent sent various laboratory work regarding Patient D to Great Smokies Diagnostic Laboratories, when he knew, or

should have known, such laboratory was not certified in NYS to perform such tests.

E. From on or about June 11, 1999 through September 13, 1999, Respondent provided medical care at his office to Patient E, then three and one-half years old, for a previously diagnosed condition of autism and a chief complaint of allergies. Respondent's care and treatment of Patient E failed to meet accepted standards of medical care in the following respects:

1. On or about June 11, 1999, and/or on subsequent occasions, Respondent failed to take and/or document an adequate medical history of Patient E.

2. On or about June 11, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient E and/or document such evaluation.

3. On or about June 11, 1999, and/or on subsequent occasions, Respondent failed to perform an adequate physical examination of Patient E and/or failed to document such examination.

4. On June 11, 1999, and/or on subsequent occasions, Respondent failed to formulate and/or document an appropriate initial and/or working diagnostic impression of Patient E.

5. From on or about June 11, 1999 and/or on subsequent occasions, Respondent diagnosed Patient E with disseminated systemic candidiasis without an adequate medical indication, and/or failed to document such indication.

6. On or about June 11, 1999, and/or on subsequent occasions, Respondent ordered laboratory tests for Patient E which were not medically indicated and/or were excessive and/or were inapplicable, and/or were redundant of other testing.

7. On or about June 11, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate and/or treat Patient E with respect to the patient's elevated levels of lead and/or other toxic heavy metals as reported in elemental hair analysis laboratory studies.

8. On or about June 11, 1999, and/or on subsequent occasions, Respondent failed to notify appropriate Public Health authorities and/or treating consultants of the patient's elevated levels of lead and/or other toxic heavy metals as reported in elemental hair analysis laboratory studies.

9. On or about September 13, 1999, Respondent prescribed Nizoral for Patient E without an adequate medical indication, and/or failed to document such indication.

10. From on or about June 11, 1999, and/or on subsequent occasions, Respondent failed to appropriately or timely seek consultation with Patient E's previous and/or concurrent treating physicians and/or advise such treating physicians of Respondent's treatment.

11. From on or about June 11, 1999 through September 13, 1999, Respondent failed to maintain a medical record which accurately reflected the evaluation and treatment of Patient E.

12. ~~During and/or subsequent~~ to ~~treatment,~~ Respondent documented diagnostic codes representing amino acid metabolism disorder, anemia, vitamin deficiency, disorder of magnesium metabolism, disseminated systemic candidiasis, and thyroid disorder on patient E's medical record, when in fact, Respondent knew or should have known, that he did not appropriately evaluate and/or treat these conditions.

13. During and/or subsequent to treatment, Respondent also provided the erroneous diagnostic codes to a clinical laboratory and documented them on billing statements given to patient E when the Respondent knew or should have known that the erroneous diagnostic codes would be used to seek reimbursement under patient's third-party health coverage.

14. During and/or subsequent to treatment, Respondent sent various laboratory work regarding Patient E to Great Smokies Diagnostic Laboratories, when he knew, or should have known, such laboratory was not certified in NYS to perform such tests.

F. On or about January 27, 1999, and/or on subsequent occasions, Respondent provided medical care at his office to Patient F, then five years old, for complaints of arthritis. Respondent's care and treatment of Patient F failed to meet accepted standards of medical care in the following respects:

1. On or about January 11, 1999 and/or on subsequent occasions, Respondent failed to take and/or document an adequate medical history of Patient F.

2. On or about January 11, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient F and/or document such evaluation.

3. On or about January 11, 1999, and/or on subsequent occasions, Respondent failed ~~to perform an adequate~~ physical examination of Patient F and/or document such examination.

4. From on or about January 11, 1999, and/or on subsequent occasions, Respondent failed to formulate and/or document an appropriate initial and/or working

diagnostic impression of Patient F.

5. On or about March 3, 1999, and/or on subsequent occasions, Respondent documented a plan to treat Patient F for a parasitic infection without an adequate medical indication.

6. On or about January 27, 1999, and/or on subsequent occasions, Respondent failed to appropriately or timely seek consultation with Patient F's previous and/or concurrent treating physicians and/or advise such physicians of Respondent's treatment.

7. On or about January 27, 1999, and/or on subsequent occasions, Respondent failed to maintain a medical record which accurately reflected the evaluation and treatment of Patient F.

G. From on or about August 17, 1999 through September 7, 1999, Respondent provided medical care in his office to Patient G, then 41 years old, for injuries sustained in a motor vehicle accident. Respondent's care and treatment of Patient G failed to meet accepted standards of medical care in the following respects:

1. From on or about August 17, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient G and/or document such evaluation.

2. From on or about August 17, 1999, and/or on subsequent occasions, Respondent failed to formulate and/or document an appropriate initial and/or working diagnostic impression of Patient G.

3. From on or about August 17, 1999, and/or on subsequent occasions, Respondent diagnosed Patient G with disseminated systemic candidiasis without an adequate

medical indication, and/or failed to document such indication.

4. On or about September 7, 1999, Respondent prescribed Nizoral for Patient G without adequate medical indication and/or failed to document such indication.

5. On or about September 7, 1999, Respondent prescribed Nystatin for Patient G without adequate medical indication and/or failed to document such indication.

6. From on or about August 17, 1999 through September 7, 1999, Respondent failed to adequately evaluate and/or act upon Patient G's creatinine level and past history of glomerulonephritis.

7. From on or about August 17, 1999 and/or on subsequent occasions, Respondent failed to appropriately or timely seek consultations with Patient G's previous and/or concurrent treating physicians and/or advise such physicians of Respondent's treatment.

8. From on or about August 17, 1999 through September 7, 1999, Respondent failed to maintain a medical record which accurately reflected the evaluation and treatment of Patient G.

9. During and/or subsequent to treatment, Respondent documented diagnostic codes representing heavy metal antagonist systemic poisoning, anemia, disseminated systemic candidiasis, and immune disorder on Patient G's medical record, when in ~~fact, Respondent knew or should have known, that he did not~~ appropriately evaluate and/or treat these conditions.

10. During and/or subsequent to treatment, Respondent also provided the erroneous diagnostic codes to a clinical laboratory and documented them on billing

statements given to patient G when the Respondent knew or should have known that the erroneous diagnostic codes would be used to seek reimbursement under patient's third-party health coverage.

H. From on or about April 13, 1999 through August 16, 1999, Respondent provided medical care at his office to Patient H, then 60 years old, for prostatic carcinoma, among other conditions. Respondent's care and treatment of Patient H failed to meet accepted standards of medical care in the following respects:

1. From on or about April 13, 1999 through August 16, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient H and/or document such evaluation

2. From on or about April 13, 1999 through August 16, 1999, and/or on subsequent occasions, Respondent failed to perform an adequate physical examination of Patient H and/or document such examination.

3. From on or about April 13, 1999, and/or on subsequent occasions, Respondent failed to formulate and/or document an accurate initial and/or working diagnostic impression of Patient H.

4. On or about April 13, 1999, and/or on subsequent occasions, Respondent advised Patient H to defer treatment for prostate cancer by surgery and radiation therapy because Respondent claimed he could provide better treatment options than those offered by Patient H's treating urologist.

5. On or about April 13, 1999, and/or on subsequent occasions, Respondent failed to appropriately or timely seek consultation with Patient H's previous and/or

concurrent treating physicians and/or advise such physicians of Respondent's treatment.

6. From on or about April 13, 1999 through August 16, 1999, and/or on any subsequent occasions, Respondent failed to maintain a medical record which accurately reflected the evaluation and treatment of Patient H.

7. During and/or subsequent to treatment, Respondent documented diagnostic codes representing candidiasis, cardiovascular disease, vitamin deficiency, systemic heavy metal antagonist poisoning, disorder of magnesium metabolism, and immune disorder on patient H's medical record, when in fact, Respondent knew or should have known, that he did not evaluate and/or treat these conditions.

8. During and/or subsequent to treatment, Respondent also provided the erroneous diagnostic codes to a clinical laboratory and documented them on billing statements given to patient H when the Respondent knew or should have known that the erroneous diagnostic codes would be used to seek reimbursement under patient's third-party health coverage.

I. On or about January 21, 1999 through May 12, 1999, Respondent provided medical care in his office to Patient I, then 14 years old, for complaints of chronic and recurrent headache. Respondent's care and treatment of Patient I failed to meet accepted standards of medical care in the following respects:

1. On or about January 21, 1999, and/or on subsequent occasions, Respondent failed to adequately evaluate Patient I and/or document such evaluation.

2. On or about January 21, 1999, and/or on subsequent occasions, Respondent failed

to perform an adequate physical examination of Patient I and/or document such examination.

3. From on or about January 21, 1999, and/or on subsequent occasions, Respondent failed to formulate and/or document an appropriate initial and/or working diagnostic impression of Patient I.

4. During and/or subsequent to treatment, Respondent sent various laboratory work regarding Patient I to Great Smokies Diagnostic Laboratories, when he knew, or should have known, such laboratory was not certified in NYS to perform such tests.

5. On or about January 21, 1999, and/or on subsequent occasions, Respondent ordered laboratory tests for Patient I, which were not medically indicated and/or were excessive and/or were inapplicable, and/or were redundant of other testing.

6. On or about May 12, 1999, and/or on subsequent occasions, Respondent prescribed Nystatin to Patient I without adequate medical indication, and/or failed to document such indication.

7. On or about April 3, 1999, and/or on subsequent dates occasions, Respondent failed to appropriately or timely seek consultation with Patient I's previous and/or concurrent treating physicians and/or advise such physicians of Respondent's treatment.

8. From on or about January 21, 1999 through May 12, 1999, and/or on any subsequent occasions, Respondent failed to maintain a medical record which accurately reflected the evaluation and treatment of Patient I.

J. Respondent, at his worldwide website (www.gantmdphd.com), represents that he "trained in family practice at Somerset Community Hospital, Somerset, New Jersey, and in psychiatry at Upstate Medical Center, Syracuse, New York." Respondent, at the time the above representations were made, knew that he had completed only one year of a three year family practice residency program and only six months of a psychiatry residency program for which he received no credit.

K. Respondent entered into a scheme with the Great Smokies Diagnostic Laboratories, 63 Zillicia Street, Asheville, North Carolina 28801-1074 (hereafter GSDL), to permit certain diagnostic testing of Respondent's patients, which GSDL was not certified by the State of New York pursuant to the Public Health Law, and Respondent knew or should have known that GSDL was not certified to perform such diagnostic tests.

L. Beginning prior to December 18, 1998 and continuing through February 10, 2000, Respondent, in exchange for referral of laboratory samples to GSDL, received consideration from GSDL, whereby GSDL promoted Respondent's medical practice and the book he authored, entitled, "ADD and ADHD Complimentary Medicine Solutions" (MindMenders Publishers, 1999), including provision on GSDL's website of an electronic mail order format for the public to purchase Respondent's book.

M. Beginning prior to December 18, 1998 and continuing through February 10, 2000, Respondent promoted, ordered, and/or prescribed to his patients therapeutic agents (i.e., supplements and nutrient formulas) which Respondent had developed and which were manufactured and labeled to his specifications and which were solely distributed by a company Respondent had a founding interest in, Natural Solutions Research, Inc. (hereafter NSR). During this period of time, Respondent received consideration from NSR, by its promotion of his medical practice, the sale of his therapeutic agents, and the sale of the book he authored ("ADD and ADHD Complimentary Medicine Solutions," MindMenders Publishers, 1999), at and through the NSR

company office and sales show room located adjacent to the Respondent's office.

SPECIFICATIONS

FIRST THROUGH NINTH SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with professional misconduct under NY Educ. Law §6530 (4) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A and A.2 and/or A and A.3 and/or A and A.4 and/or A and A.5 and/or A and A.6 and/or A and A.7 and/or A and A.8 and/or A and A.9 and/or A and A10 and/or A.11 and/or A.12.

2. The facts in Paragraphs B and B.1 and/or B and B.2 and/or B and B.3 and/or B and B.4 and/or B and B.5 and/or B and B.6 and/or B and B.7 and/or B and B.8 and/or B and B.9 and/or B and B.10 and/or B and B.11 and/or B and B.12 and/or B and B.13 and/or B and B.14 and/or B and B.14 and/or B and B.16.

3. The facts in Paragraphs C and C.1 and/or C and C.2 and/or C and C.3 and/or C and C.4 and/or C and C.5 and/or C and C.6 and/or C and C.7 and/or C and C.8 and/or C and C.9 and/or C and C.10 and/or C and C.11 and/or C and C.12 and/or C and C.13 and/or C and C.14 and/or C and C.15 and/or C and C.16 and/or C and C.17 and/or C and C.18.

4. The facts in Paragraphs D and D.1 and/or D and D.2 and/or D and D.3 and/or D and D.4 and/or D and D.5 and/or D and D.6 and/or D and D.7 and/or D and D.8 and/or D and D.9 and/or D and D.10 and/or D and D.11 and/or D and D.12 and/or D and D.13 and/or D and D.14.

5. The facts in Paragraphs E and E.1 and/or E and E.2 and/or E and E.3 and/or E and E.4 and/or E and E.5 and/or E and E.6 and/or E and E.7 and/or E and E.8 and/or E and E.9 and/or E and E.10 and/or E and E.11 and/or E and E.12 and/or E and E.13 and/or E and E.14.

6. The facts in Paragraphs F and F.1 and/or F and F.2 and/or F and F.3 and/or F and F.4 and/or F and F.5 and/or F and F.6 and/or F and F.7.

7. The facts in Paragraphs G and G.1 and/or G and G.2 and/or G and G.3 and/or G and G.4 and/or G and G.5 and/or G and G.6 and/or G and G.7 and/or G and G.8 and/or G and G.9 and/or G and G.10.

8. The facts in Paragraphs H and H.1 and/or H and H.2 and/or H and H.3 and/or H and H.4 and/or H and H.5 and/or H and H.6 and/or H and H.7 and/or H and H.8.

9. The facts in Paragraphs I and I.1 and/or I and I.2 and/or I and I.3 and/or I and I.4 and/or I and I.5 and/or I and I.6 and/or I and I.7 and/or I and I.8.

TENTH THROUGH EIGHTEENTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with professional misconduct under NY Educ. Law §6530 (6) by reason of his practicing the profession of medicine with gross incompetence, in that Petitioner charges:

10. The facts in Paragraphs A and A.1 and/or A and A.2 and/or A and A.3 and/or A and A.4 and/or A and A.5 and/or A and A.6 and/or A and A.7 and/or A and A.8 and/or A and A.9 and/or A and A10 and/or A.11 and/or A.12.

11. The facts in Paragraphs B and B.1 and/or B and B.2 and/or B and B.3 and/or B and B.4 and/or B and B.5 and/or B and B.6 and/or B and B.7 and/or B and B.8 and/or B and B.9 and/or B and B.10 and/or B and B.11 and/or B and B.12 and/or B and B.13 and/or B and B.14 and/or B and B.15 and/or B and B.16 .

12. The facts in Paragraphs C and C.1 and/or C and C.2 and/or C and C.3 and/or C and C.4 and/or C and C.5 and/or C and C.6 and/or C and C.7 and/or C and C.8 and/or C and C.9 and/or C and C.10 and/or C and C.11 and/or C and C.12 and/or C and C.13 and/or C and C.14 and/or C and C.15 and/or C and C.16 and/or C and C.17 and/or C and C.18.

13. The facts in Paragraphs D and D.1 and/or D and D.2 and/or D and D.3 and/or D and D.4 and/or D and D.5 and/or D and D.6 and/or D and D.7 and/or D and D.8 and/or D and D.9 and/or D and D.10 and/or D and D.11 and/or D and D.12 and/or D and D.13 and/or D and D.14.

14. The facts in Paragraphs E and E.1 and/or E and E.2 and/or E and E.3 and/or E and E.4 and/or E and E.5 and/or E and E.6 and/or E and E.7 and/or E and E.8 and/or E and E.9 and/or E and E.10 and/or E and E.11 and/or E and E.12 and/or E and E.13 and/or E and E.14.

15. The facts in Paragraphs F and F.1 and/or F and F.2 and/or F and F.3 and/or F and F.4 and/or F and F.5 and/or F and F.6 and/or F and F.7.

16. The facts in Paragraphs G and G.1 and/or G and G.2 and/or G and G.3 and/or G and G.4 and/or G and G.5 and/or G and G.6 and/or G and G.7 and/or G and G.8 and/or G and G.9 and/or G and G.10.

17. The facts in Paragraphs H and H.1 and/or H and H.2 and/or H and H.3 and/or H and H.4 and/or H and H.5 and/or H and H.6 and/or H and H.7 and/or H and H.8.

18. The facts in Paragraphs I and I.1 and/or I and I.2 and/or I and I.3 and/or I and I.4 and/or I and I.5 and/or I and I.6 and/or I and I.7 and/or I and I.8.

NINETEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under NY Educ. Law §6530 (3) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

19. The facts in Paragraphs

A and A.1 and/or A and A.2 and/or A and A.3 and/or A and A.4 and/or A and A.5 and/or A and A.6 and/or A and A.7 and/or A and A.8 and/or A and A.9 and/or A and A10 and/or A.11 and/or A.12.

B and B.1 and/or B and B.2 and/or B and B.3 and/or B and B.4 and/or B and B.5 and/or B and B.6 and/or B and B.7 and/or B and B.8 and/or B and B.9 and/or B and B.10 and/or B and B.11 and/or B and B.12 and/or B and B.13 and/or B and B.14 and/or B.15 and/or B.16.

C and C.1 and/or C and C.2 and/or C and C.3 and/or C and C.4 and/or C and C.5 and/or C and C.6 and/or C and C.7 and/or C and C.8 and/or C and C.9 and/or C and C.10 and/or C and C.11 and/or C and C.12 and/or C and C.13 and/or C and C.14 and/or C and C.15 and/or C and C.16 and/or C and C.17 and/or C and C.18.

D and D.1 and/or D and D.2 and/or D and D.3 and/or D and D.4 and/or D and D.5 and/or D and D.6 and/or D and D.7 and/or D and D.8 and/or D and D.9 and/or D and D.10 and/or D and D.11 and/or D and D.12 and/or D and D.13 and/or D and D.14.

E and E.1 and/or E and E.2 and/or E and E.3 and/or E and E.4 and/or E and E.5 and/or E and E.6 and/or E and E.7 and/or E and E.8 and/or E and E.9 and/or E and E.10 and/or E and E.11 and/or E and E.12 and/or E and E.13 and/or E and E.14.

F and F.1 and/or F and F.2 and/or F and F.3 and/or F and F.4 and/or F and F.5 and/or F and F.6 and/or F and F.7. and/or

G and G.1 and/or G and G.2 and/or G and G.3 and/or G and G.4 and/or G and G.5 and/or G and G.6 and/or G and G.7 and/or G and G.8 and/or G and G.9 and/or G and G.10.

H and H.1 and/or H and H.2 and/or H and H.3 and/or H and H.4 and/or H and H.5 and/or H and H.6 and/or H and H.7 and/or H.8.

I and I.1 and/or I and I.2 and/or I and I.3 and/or I and I.4 and/or I and I.5 and/or I and I.6 and/or I and I.7 and/or I and I.8.

TWENTIETH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under NY Educ. Law §6530 (5) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

20. The facts in Paragraphs

A and A.1 and/or A and A.2 and/or A and A.3 and/or A and A.4 and/or A and A.5 and/or A and A.6 and/or A and A.7 and/or A and A.8 and/or A and A.9 and/or A and A10 and/or A and A.11 and/or A.12.

B and B.1 and/or B and B.2 and/or B and B.3 and/or B and B.4 and/or B and B.5 and/or B and B.6 and/or B and B.7 and/or B and B.8 and/or B and B.9 and/or B and B.10 and/or B and B.11 and/or B and B.12 and/or B and B.13 and/or B and B.14 and/or B and B.15 and/or B and B.16.

C and C.1 and/or C and C.2 and/or C and C.3 and/or C and C.4 and/or C and C.5 and/or C and C.6 and/or C and C.7 and/or C and C.8 and/or C and C.9 and/or C and C.10 and/or C and C.11 and/or C and C.12 and/or C and C.13 and/or C and C.14 and/or C and C.15 and/or C and C.16 and/or C and C.17 and/or C and C.18.

D and D.1 and/or D and D.2 and/or D and D.3 and/or D and D.4 and/or D and D.5 and/or D and D.6 and/or D and D.7 and/or D and D.8 and/or D and D.9 and/or D and D.10 and/or D and D.11 and/or D and D.12 and/or D and D.3 and/or D and D.4.

E and E.1 and/or E and E.2 and/or E and E.3 and/or E and E.4 and/or E and E.5 and/or E and E.6 and/or E and E.7 and/or E and E.8 and/or E and E.9 and/or E and E.10 and/or E and E.11 and/or E and E.12 and/or E and E.13 and/or E and E.14.

F and F.1 and/or F and F.2 and/or F and F.3 and/or F and F.4 and/or F and F.5 and/or F and F.6 and/or F and F.7. and/or

G and G.1 and/or G and G.2 and/or G and G.3 and/or G and G.4 and/or G and G.5 and/or G and G.6 and/or G and G.7 and/or G and G.8 and/or G and G.9 and/or G and G.10.

H and H.1 and/or H and H.2 and/or H and H.3 and/or H and H.4 and/or H and H.5 and/or H and H.6 and/or H and H.7 and/or H.8.

I and I.1 and/or I and I.2 and/or I and I.3 and/or I and I.4 and/or I and I.5 and/or I and I.6 and/or I and I.7 and/or I and I.8.

TWENTY-FIRST THROUGH THIRTY-SECOND SPECIFICATIONS

FRAUD

Respondent is charged with professional misconduct under NY Educ. Law §6530 (2) by reason of his practicing the profession of medicine fraudulently, in that Petitioner charges:

21.	The facts in Paragraphs	A and A.8 and/or A and A.11 and/or A and A.12.
22.	The facts in Paragraphs	B and B.6 and/or B and B.15 and/or B and B.16.
23.	The facts in Paragraphs	C and C.6 and/or C and C.14 and/or C and C.15.
24.	The facts in Paragraphs	D and D.6 and/or D and D.12 and/or D and D.13.
25.	The facts in Paragraphs	E and E.6 and/or E and E.12 and/or E and E.13.
26.	The facts in Paragraphs	G and G.9 and/or G and G.10.
27.	The facts in Paragraphs	H and H.4 and/or H and H.7 and/or H and H.8.
28.	The facts in Paragraphs	I and I.5.
29.	The facts in Paragraphs	J.
30.	The facts in Paragraphs	K.
31.	The facts in Paragraphs	L.
32.	The facts in Paragraphs	M.

THIRTY-THIRD THROUGH FORTY-FOURTH SPECIFICATIONS
MORAL UNFITNESS

Respondent is charged with professional misconduct under NY Educ. Law §6530 (20) by reason of his conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that petitioner charges:

33.	The facts in Paragraphs	A and A.8 and/or A and A.11 and/or A and A.12.
34.	The facts in Paragraphs	B and B.6 and/or B and B.15 and/or B and B.16.
35.	The facts in Paragraphs	C and C.6 and/or C and C.14 and/or C and C.15.
36.	The facts in Paragraphs	D and D.6 and/or D and D.12 and/or D and D.13.
37.	The facts in Paragraphs	E and E.6 and/or E and E.12 and/or E and E.13.
38.	The facts in Paragraphs	G and G.9 and/or G and G.10.
39.	The facts in Paragraphs	H and H.4 and/or H and H.7 and/or H and H.8.
40.	The facts in Paragraphs	I and I.5.
41.	The facts in Paragraphs	J.
42.	The facts in Paragraphs	K.
43.	The facts in Paragraphs	L.
44.	The facts in Paragraphs	M.

FORTY-FIFTH THROUGH FIFTIETH SPECIFICATIONS
EXCESSIVE TESTING

Respondent is charged with professional misconduct under NY Educ. Law §6530 (35) by reason of his practicing the profession of medicine by ordering excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient, in that Petitioner charges:

45.	The facts in Paragraphs	A and A.8.
46.	The facts in Paragraphs	B and B.6.
47.	The facts in Paragraphs	C and C.6.
48.	The facts in Paragraphs	D and D.6.
49.	The facts in Paragraphs	E and E.6.
50.	The facts in Paragraphs	I and I.5.

FIFTY-FIRST THROUGH FIFTY-SEVENTH SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with professional misconduct under NY Educ. Law §6530 (21) by reason of his willfully making or filing a false report, in that Petitioner charges:

51. The facts in Paragraphs A and A.10 and/or A and A.12.
52. The facts in Paragraphs B and B.15 and/or B and B.16.
53. The facts in Paragraphs C and C.15 and/or C and C.16.
54. The facts in Paragraphs D and D.12 and/or D and D.13.
55. The facts in Paragraphs E and E.12 and/or E and E.13.
56. The facts in Paragraphs G and G.9 and/or G and G.10.
57. The facts in Paragraphs H and H.7 and/or H and H.8.

FIFTY-EIGHTH THROUGH SIXTH-THIRD SPECIFICATIONS

RECEIVING CONSIDERATION FROM A THIRD PARTY FOR PATIENT REFERRAL

Respondent is charged with professional misconduct under NY Educ. Law §6530 (18) by reason of giving and/or receiving consideration to and/or from a third party for referral of patients or professional services, in that Petitioner charges:

58. The facts in Paragraphs A and A.8.
59. The facts in Paragraphs B and B.6.
60. The facts in Paragraphs C and C.6.
61. The facts in Paragraphs D and D.6.
62. The facts in Paragraphs E and E.6.
63. The facts in Paragraphs I and I.4.
64. The facts in Paragraphs L.
65. The facts in Paragraphs M.

SIXTE-FOURTH THROUGH SEVENTY-FOURTH SPECIFICATIONS
INADEQUATE RECORDS

Respondent is charged with professional misconduct under NY Educ. Law §6530 (32) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

66.	The facts in Paragraphs	A and A.10.
67.	The facts in Paragraphs	B and B.14.
68.	The facts in Paragraphs	C and C.17.
69.	The facts in Paragraphs	D and D.11.
70.	The facts in Paragraphs	E. and E.11.
71.	The facts in Paragraphs	F and F.7.
72.	The facts in Paragraphs	G and G.8.
73.	The facts in Paragraphs	H and H.6.
74.	The facts in Paragraphs	I and I.8.

DATED: May 22, 2000
Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

TERMS OF SUSPENSION

Dr. Gant's license to practice medicine in the State of New York shall be suspended for a period of 5 years with all but a minimum of 6 months of the suspension stayed. The suspension shall last a minimum of 6 months or until Dr. Gant has successfully completed to the satisfaction of the Director of the Office of Professional Medical Conduct (OPMC), courses in medical coding, physical diagnosis, conducting and recording physicals, obtaining and documenting medical histories and record keeping or an equivalent program or course proposed by the Respondent. Prior to enrolling in any course to satisfy this condition of his suspension, Dr. Gant must obtain written approval of the course from the OPMC Director. All costs affiliated with satisfying the provisions of his suspension shall be the sole responsibility of Dr. Gant.

TERMS OF PROBATION

Dr. Gant's license to practice medicine in the State of New York shall be on probation for a period of no less than four and one half (4 1/2) years. The probation period shall not commence until Dr. Gant's license suspension has ended.

TERMS AND CONDITIONS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit prompt (within 20 days) written notification to the Board, addressed to the Director, Office of Professional Medical Conduct (OPMC), 433 River St., 4th Floor, Troy, New York 12180, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Respondent leaves New York to reside or practice outside the State, Respondent shall notify the Director of the OPMC in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York State shall toll the probationary period, which shall be extended by the length of residency or practice outside New York State.

5. Respondent shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms and conditions of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the OPMC at the address indicated above.

6. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Respondent elects not to practice medicine as a physician in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

7. During the first 2 years of probation the Respondent shall practice medicine only when supervised in his medical practice. The practice supervisor shall be on-site at all locations, unless determined otherwise by the Director of OPMC. The practice supervisor shall be proposed by Respondent and subject to the written approval of the Director. The practice supervisor shall not be a family member or personal friend, or be in a professional relationship which could pose a conflict with supervision responsibilities. If the Respondent's supervising physician practices adjunct or complimentary medicine the practice must have a relationship with the patients' primary care physicians and active communication with these primary care physicians.

Respondent shall ensure that the practice supervisor is familiar with the Order and terms of probation, and willing to report to OPMC. Respondent shall ensure that the practice supervisor is in a position to regularly observe and assess Respondent's medical practice. Respondent shall cause the practice supervisor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

Respondent shall authorize the practice supervisor to have access to his patient records and to submit quarterly written reports, to the Director of OPMC, regarding Respondent's practice. These narrative reports shall address all aspects Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, general demeanor, time and attendance, the supervisor's assessment of patient records selected for review and other such on-duty conduct as the supervisor deems appropriate to report.

Prior to the Respondent's period of probation commencing the respondent shall submit to the OPMC for its prior approval a list of all hospitals wherein the Respondent has privileges and for each such hospital a written acknowledgement of the terms of probation. If the Respondent obtains privileges at any additional hospitals during the period of probation he shall be required to comply with the same terms noted above in this paragraph, prior to practicing in said hospital. Respondent's period of probation and his ability to resume the practice of medicine in this state shall not commence until he receives written approval from the Director of OPMC that he is in compliance with the terms of probation.

8. During the remaining 2 and one half (2 and 1/2) years of probation the Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection no less than 10 of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

9. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.