STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

NEW YORK STATE DEPARTMENT OF HEALTH 19

September 7, 1995

RECEIVED
SEP 08 1995
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Catherine Cholakis, Esq.
NYS Dept. of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12203

David Steinberg, Esq.
27 Garden Street
Poughkeepsie, NY 12602

Mohammad Ghiasuddin, M.D.
93 East Main Street
Wappingers Falls, New York 12590

RE: In the Matter of Mohammad Ghiasuddin, M.D.
Effective Date: 09/14/95

Dear Ms. Cholakis, Mr. Steinberg and Dr. Ghiasuddin:

Enclosed please find the Determination and Order (No. 95-200) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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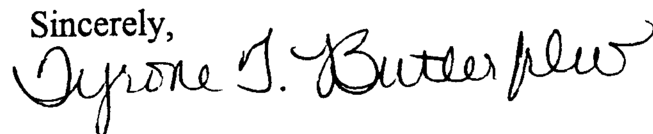
Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

NEW YORK STATE DEPARTMENT OF HEALTH 19

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

IN THE MATTER OF

MOHAMMAD GHIASUDDIN, M.D.

DETERMINATION

AND

ORDER

BPMC 95-200

The undersigned Hearing Committee consisting of **BENJAMIN WAINFELD, M.D.**, Chairperson, **ERWIN LEAR, M.D.**, and **EUGENIA HERBST**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE, Esq.** (Administrative Law Judge) served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by MOHAMMAD GHIASUDDIN, M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

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The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	
Pre-Hearing Conferences:	March 13, 1995
Hearing dates:	May 22, 1995 May 24, 1995 June 21, 1995
Deliberation date:	July 6, 1995
Place of Hearing:	NYS Department of Health New York, New York
Petitioner appeared by:	Jerome Jasinski, Esq. Acting General Counsel NYS Department of Health By: Katherine Cholakis, Esq. Assistant Counsel
Respondent appeared by:	3/13 - 5/24 David Steinberg 6/21 - pro se

WITNESSES

For the Petitioner:	Perry Harden Investigator for NYS Robert McFarlane Investigator for NYS

Respondent did not put on any witnesses

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SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with acceptable standards of medical practice in this State. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious means a conspicuously bad act or severe deviation from standards.

With regard to the witness testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

Inaccurate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

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FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on June 16, 1978, by issuance of license number 134610, and is currently registered with the New York State Education Department. (Stipulation between parties prehearing conference. T. 32-33).

2. On February 10, 1995, Respondent was served with a Notice of Hearing and Statement of Charges charging him with professional misconduct under various sections of NY Educ. Law. Sec. 6530 (Ex. 1, Ex. 2)

PATIENT "A"

3. Respondent provided medical care to Patient A from February, 1987 through October, 1993 following bilateral hip surgery for a congenital dislocation and "Nervous ++" (Ex. 4, T. 283)

4. Respondent treated Patient A on seventy-four occasions (Ex. 4, T. 284)

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5. Respondent's medical record for Patient A does not contain an adequate initial medical history, nor notation that an adequate history was taken at any point throughout the seventy-four patient encounters over six and a half years (Ex. 4, T. 288)

6. Respondent's medical record for Patient A does not contain notation of an adequate physical examination of Patient A (Ex. 4, T. 295)

7. Respondent prescribed Valium to Patient A at every office visit (74) over the six and a half years documented in the medical record (T. 299)

8. There was no adequate medical justification for Respondent to prescribe Valium to Patient A for six and a half years (T. 300)

13. Darvocet-N was prescribed for Patient A at every office visit (74) over the six and a half years (Ex. 4, T. 303)

14. There was no adequate medical justification for Respondent to prescribed Darvocet-N to Patient A for six and a half years (T. 304)

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15. There was no adequate medical justification for the prescription of Percodan to Patient A (Ex. 4, T. 308)

16. On no less than two office visits, Respondent prescribed Darvocet-N and Valium, along with Percodan without decreasing any of the dosages. On one occasion, Respondent prescribed Percodan and Valium, while increasing the dosage of Darvocet-N. This combination would expose Patient A to risk and was not medically justified (Ex. 4, T. 312-314)

17. Respondent prescribed Fiorinal to Patient A without medical justification. Respondent's prescribing of Fiorinal while the patient was taking Valium and Darvocet-N was inappropriate (Ex. 4, T. 318)

18. During the six and a half years Patient A was treated by the Respondent, on only one occasion did Respondent advise [patient] to see an orthopedic surgeon. (Ex. 4) Respondent never gave Patient A the name of a recommended surgeon, or followed up on this advice with the patient in any way.

19. Respondent failed to refer Patient A for counseling and/or to a pain specialist and/or to other appropriate specialists.

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PATIENT "B"

20. Respondent provided medical care to Patient B from December, 1987 through September, 1993 (Ex. 5)

21. Respondent's medical record for Patient B does not contain an adequate initial medical history, nor notation that an adequate medical history was taken throughout the years covered in the medical record (Ex. 5, T. 483)

22. Respondent's medical record for Patient B does not contain notation of an adequate physical examination of Patient B (Ex. 5, T. 483-484)

23. There was no adequate medical justification for Respondent to prescribe Valium to Patient B. (Ex. 5, T. 485)

24. Tylenol with Codeine was prescribed to Patient B by the Respondent without adequate medical justification (Ex. 5, T. 485)

25. Respondent prescribed Fiorinal with Codeine to Patient B without adequate medical justification (Ex. 5, T. 487)

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26. Respondent prescribed Inderal for Patient B without adequate medical justification (Ex. 5, T. 488-489)

27. Respondent prescribed Percodan on 4 occasions without adequate medical justification (Ex. 5, T. 486)

28. There was no adequate medical justification for Respondent to prescribe Stadol-NS to Patient B. (T. 490)

29. Respondent failed to perform appropriate diagnostic studies a complete physical, neurological and ophthalmologic examination of Patient B given Patient B's repeated complaints of headaches and anxiety (Ex. 5, T. 492)

30. Respondent's medical record for Patient B indicates that Patient B reporting having had a CAT scan previously, but Respondent failed to request and obtain the results of the CAT scan performed on Patient B (Ex. 5, T. 493)

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PATIENT "C"

31. Respondent provided medical care to Patient C from July, 1984 through September, 1993 (Ex. 6)

32. Respondent's medical record for Patient C does not contain an adequate initial medical history of Patient C, nor notation that an adequate medical history was taken at any point throughout the ten year period covered in the medical record (Ex. 6, T. 509-510)

33. Respondent's medical record does not contain notation of an adequate physical examination of Patient C. (Ex. 6, T. 510)

34. Respondent failed to perform follow-up and diagnostic tests for Patient C's anemia. (T. 510)

35. After Respondent prescribed Valium, Respondent failed to perform a re-test of blood count for Patient C, following a diagnosis of anemia (Ex. 6, T. 544)

36. There was no adequate medical justification for Respondent to prescribe Valium to Patient C. (Ex. 6, T. 516)

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37. There was adequate medical justification for Respondent's prescribing Darvocet-N to Patient C (Ex. 6, T. 517-518)

38. There was no adequate medical justification for Respondent's prescribing Percodan to Patient C (Ex. 6, T. 518)

39. During his course of treatment of Patient C, Respondent failed to evaluate Patient C for alternative therapy, such as physical therapy, or to an appropriate specialist (Ex. 6, T. 518) (see transcript)

PATIENT "D"

40. Respondent provided medical care to Patient D from September, 1988 through October, 1992. (Ex. 7)

41. Respondent's medical record for Patient D does not contain an adequate initial medical history of Patient D nor notation that an adequate history was ever taken (Ex. 7, T. 410)

42. Respondent's medical record for Patient D does not contain notation of an adequate physical examination of Patient D (Ex. 7, T. 410-411)

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43. There was no adequate medical justification for the prescription of Valium to Patient D. (Ex. 7, T. 412-413)

44. Respondent prescribed Tagamet to Patient D, without adequate medical justification (Ex. 7, T. 418-419)

45. Respondent failed to refer Patient D for a psychosocial evaluation, to a drug counselor, or other appropriate specialist (Ex. 7, T. 419-420)

PATIENT "E"

46. Respondent provided medical care to Patient E, a Bureau of Controlled Substances undercover officer, from July, 1992 through March, 1993 (Ex. 8)

47. Respondent's medical record for Patient E does not contain an adequate initial medical history nor any notation that an adequate history was ever taken on Patient E. (Ex. 8, T. 359)

48. Respondent's medical record for Patient E does not contain notation of an adequate physical examination of Patient E. (Ex. 8, T. 361-362)

49. There was no adequate medical justification for Respondent to prescribe Tylenol with Codeine to Patient E. (Ex. 8, T. 360)

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50. There was no adequate medical justification for Respondent to prescribed Fastin (Ex. 8, Ex. 11, Ex. 11a, Tx. 366-367)

51. Respondent prescribed Talwin to Patient E, despite Patient E telling Respondent that he had a history of using street drugs, particularly heroin, and that he had previously been through detoxification (Ex. 12, Ex. 13, Ex. 13a, T. 50-51, 56-57, 370)

52. In view of prior addiction, Respondent inappropriately prescribed Talwin to Patient E despite Patient E's telling Respondent that he was misusing the medication (Ex. 14, Ex. 14a, T. 62)

53. In view of prior addiction, there was no adequate medical justification for Respondent to prescribed Talwin to Patient E (Ex. 8, T. 61, Line 12)

54. Respondent did not refer Patient E for appropriate alternative treatment (T. 360-363)

PATIENT "F"

55. Respondent provided medical care to Patient F from September, 1985 through September, 1993 (Ex. 9)

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56. Respondent's medical record for Patient F does not contain an adequate initial medical history nor notation that an adequate history was ever taken of Patient F. (Ex. 9, T. 549)

57. Respondent's medical record for Patient F does not contain notations of an adequate physical examination of Patient F. (Ex. 9, T. 549)

58. There was no adequate medical justification for Respondent to repeatedly prescribe Valium to Patient F. (Ex. 9, T. 551)

59. There was no adequate medical justification for Respondent to prescribe Ativan to Patient F. (Ex. 9, T. 562)

60. There was no adequate justification for Respondent to prescribe Demerol to Patient F. (Ex. 9, T. 563)

61. There was no adequate justification for Respondent to repeatedly prescribe Percocet to Patient F. (Ex. 9, T. 554)

62. There was no adequate medical justification for Respondent to prescribe Dalmane to Patient F. (Ex. 9, T. 564)

63. There was no adequate medical justification for Respondent to prescribe Elavil to Patient F. (Ex. 9, T. 564-565)

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64. There was no adequate medical justification for Respondent to prescribe Dilaudid to Patient F. (Ex. 9, T. 565)

65. There was no adequate medical justification for Respondent to prescribe Dolophine to Patient F. (Ex. 9, T. 566)

66. Given Patient F's complaints, as documented in the medical record, Respondent failed to refer Patient F for an x-ray, physical therapy and a pain management clinic, and Respondent did not refer Patient F for an x-ray, physical therapy. (T. 555, 559, 572)

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DISCUSSION

The panel considered all the evidence and testimony from the prosecutor and listened to the responses of Dr. Ghiasuddin when questioned by the panel. The panel's decision is based on a finding that there is a potential harm to patients when treated by Dr. Ghiasuddin because of his failure to adjust drug dosages and the combination of controlled drugs prescribed.

During the panel's questioning of Dr. Ghiasuddin, they recognized that he had a serious lack of basic medical and pharmacological knowledge.

Dr. Ghiasuddin failure to obtain basic medical history or perform a physical examination on patients is detrimental for patients to continue treatment for years without any reference points.

In Dr. Ghiasuddin's treatment of patients for years on controlled substances, he failed to recognize that there was absolutely no improvement from his course of treatment. Dr. Ghiasuddin lacked any training in any specialty and there was evidence of absolutely no continuing medical evaluation. His knowledge of medical practice was grossly inadequate. He failed to pursue patients' medical problems with proper diagnostic studies or follow up treatments necessary.

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An adequate medical history contains information regarding the patient's chief complaint and its chronology, past medical history, and a social and family history, as well as a review of the systems. A complete history should be taken on the first visit and, depending on the patient's condition, repeated and updated throughout the years. Throughout a physician's treatment of a patient, every time a new symptom or medical problem arises, a patient history should be updated and documented. Patient histories taken at follow-up visits should include a patient's report of their symptoms and medical problems, any new medical problems that have come up as well as the evolution of the original complaint. (T. 285-287).

An initial physical examination consists of a brief description of the clinician's perception of the patient, taking vital signs including blood pressure, pulse, temperature and respiratory rate and an examination of the various regions and organs of the body. (T. 290)

A medical record should contain minimum information for each patient visit. This information should include what a clinician does and what his thought process is in any particular patient encounter. The absence of such information in the medical record leads to the conclusion that such activity did not take place. (T. 293, 442).

The risks of long term use of Valium include addiction, depression and fatigue (T. 297)

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Prior to prescribing Inderal, the Respondent did not know the patient's pulse and blood pressure, whether the patient was suffering from any depression, whether the patient had a history of asthma, bronchospasm or allergies (T. 488-489)

Prior to prescribing a narcotic drug, Patient E should have been referred to physical therapy, a period of bed rest, hot or cold compresses and medication such as aspirin, Tylenol, or non-steroidal anti-inflammatory drugs (T. 363, Line 9-17)

DECISION

The Hearing Committee SUSTAINED the following Factual Allegations:

Factual Allegation A: 1, 2 and 3

Factual Allegation B: 1 through 6

Factual Allegation C: 1 through 7

Factual Allegation D: 1 through 4

Factual Allegation E: 1 through 6

Factual Allegation F: 1 through 5

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The Hearing Committee agreed unanimously that the Respondent is guilty of:

Specifications 1 through 6: Gross Negligence

Specifications 7 through 12: Gross incompetence

Specification 13: Negligence on more than one occasion

Specification 14: Incompetence on more than one occasion

Specification 15: Failure to maintain records

Specification 16: Fraudulent practice

Specification 17: Moral Unfitness to Practice Medicine

Specification 18: Ordering Treatment not warranted

PENALTY

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

Respondent has demonstrated a serious lack of the basic skills necessary to practice medicine, as well as extremely poor judgment. These factors in combination render him unfit to practice medicine.

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The Respondent has already demonstrated that he does not attend continuing education programs nor is he knowledgeable in the current treatments for pain. The Respondent's continued practice of prescribing controlled substances to patients without knowledge of the patient's prior or current physical condition of health represents a failure to acknowledge basic medical practice.

The Hearing Committee unanimously determined that Respondent's continued practice of medicine would place the lives of his patients, as well as their unborn children, at grave risk. Consequently, the Committee determined that revocation was the only possible sanction in this case.

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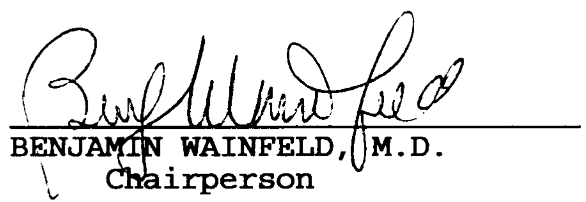
ORDER

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

Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order.

Dated: Albany, New York
1/30 , 1995



BENJAMIN WAINFELD, M.D.
Chairperson

ERWIN LEAR, M.D.
EUGENIA HERBST

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STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

---X

IN THE MATTER	: STATEMENT
OF	: OF
MOHAMMAD GHIASUDDIN, M.D.	: CHARGES

---X

MOHAMMAD GHIASUDDIN, M.D., the Respondent, was authorized to practice medicine in New York State on June 16, 1978, by the issuance of license number 134610 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period of January 1, 1993 through December 31, 1994, with a registration address of 93 East Main Street, Wappingers Falls, New York.

FACTUAL ALLEGATIONS

A. Respondent, during a period beginning on or about February 26, 1987 and continuing through to the present time, treated Patient A (all patients are identified in the Appendix) following bilateral hip surgery for congenital dislocation. Respondent's care and treatment of Patient A failed to meet acceptable standards of care, in that:

1. Respondent failed to elicit and/or record an adequate history.

2. Respondent failed to perform and/or record an adequate physical examination.

3. Respondent, repeatedly and/or inappropriately,

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prescribed controlled substances for Patient A including Valium, Darvocet-N, Percodan and Fiorinal, without any written evaluation of Patient A, and without referring Patient A for counselling and/or to a pain specialist and/or to other appropriate specialists.

B. Respondent, during a period beginning on or about December 7, 1987 and continuing through to the present time, treated Patient B on numerous occasions at Respondent's office. Respondent's care and treatment of Patient B failed to meet acceptable standards of care, in that:

1. Respondent failed to perform and/or record an adequate physical examination.

2. Respondent failed to elicit and/or record an adequate history.

3. Respondent, throughout his treatment of this patient, repeatedly and inappropriately prescribed controlled substances, including Valium, Tylenol with Codeine, Fiorinal, Inderal, Percodan and Stadol-NS without any written evaluation of this patient and/or without referring Patient B for counseling and/or to a pain specialist and/or to other appropriate specialist.

4. Respondent failed to order appropriate diagnostic studies for patient B.

5. Respondent's records indicate that this patient was seen be a neurologist and had a CAT scan of the head, yet there is nothing in the records to show that Respondent contacted this neurologist and/or request and received a copy of a report concerning this treatment and in spite of this, continued to prescribe to this patient.

6. Respondent failed to refer Patient B for appropriate alternative treatment and/or evaluations such as psychological evaluation or physical therapy.

C. Respondent, during a period beginning on or about July 17, 1984 and continuing through at least September, 1993, treated

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Patient C on numerous occasions at his office for complaints of back pain and anemia. Respondent's care and treatment of Patient C failed to meet acceptable standards of care, in that:

1. Respondent failed to elicit and/or record an adequate history.

2. Respondent failed to perform and/or record an adequate physical examination.

3. Respondent failed to perform and/or record the results of an anemia work-up or a re-test of the blood count for Patient C who was found to be borderline anemic.

4. Respondent failed to performed and/or record a stool guaiac test for blood loss in the bowel.

5. Respondent, repeatedly and/or inappropriately, prescribed controlled substances for Patient C including Valium, Darvocet-N and Percodan, without any written evaluation of Patient C, and/or without referring Patient C for counselling and/or to a pain specialist and/or to other appropriate specialists.

6. Throughout this period, Respondent failed to order and/or record appropriate diagnostic studies for this patient who complained of backaches.

7. Respondent continued Patient C a course of addicting pain medications without attempting other treatments such as psychological evaluation or physical therapy with pain management.

D. Respondent, during a period beginning on or about September 19, 1988 and continuing through at least October, 1992, treated Patient D on numerous occasions at his office for complaints of blisters and scales on his hands. Respondent's care and treatment of Patient D failed to meet acceptable standards of care, in that:

1. Respondent failed to elicit and/or record an adequate history.

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2. Respondent failed to perform and/or record an adequate physical examination.

3. Respondent, repeatedly and/or inappropriately, prescribed controlled substances for Patient D including Valium, Percocet, Tagamet and Tylenol, without any written evaluation of Patient D, and/or without referring Patient D for counselling and/or to a pain specialist and/or to other appropriate specialists.

4. Respondent continued Patient D on a course of addicting pain medications without attempting other treatments such as psychological evaluation or physical therapy with pain management.

E. Respondent, during a period beginning on or about July 23, 1992 and continuing through at least March 24, 1993, treated Patient E, an undercover agent with the Bureau of Contolled Substances, on numerous occasions at his office. Respondent's care and treatment of Patient E failed to meet acceptable standards of care, in that:

1. Respondent failed to elicit and/or record an adequate history.

2. Respondent failed to perform and/or record an adequate physical examination.

3. Respondent, repeatedly and/or inappropriately, prescribed controlled substances for Patient E including Tylenol with Codeine, Fastin and Talwin, without any written evaluation of Patient E, and/or without referring Patient E for counselling and/or to a pain specialist and/or to other appropriate specialists.

4. Respondent failed to order and/or record appropriate diagnostic studies for this patient.

5. Respondent continued Patient E a course of addicting pain medications without attempting other treatments such as psychological evaluation or physical therapy with pain management.

6. Respondent repeatedly and inappropriately prescribed controlled substances to Patient E despite Patient E's repeated admission he had no back problems, was "perfectly healthy" and used

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the drugs to "party on the weekends".

F. Respondent, during a period beginning on or about September 26, 1985 and continuing through to the present time, treated Patient F on numerous occasions at his office for complaints of back pain. Respondent's care and treatment of Patient F failed to meet acceptable standards of care, in that:

1. Respondent failed to elicit and/or record an adequate history.

2. Respondent failed to perform and/or record an adequate physical examination.

3. Respondent, repeatedly and/or inappropriately, prescribed controlled substances for Patient F including Valium, Darvocet-N, Tylenol with Codeine, Ativan, Demerol, Percocet, Dalmane, Elavil, Dilaudid and Dolophine, without any written evaluation of Patient F, and/or without referring Patient F for counselling and/or to a pain specialist and/or to other appropriate specialists.

4. Respondent failed to order and/or record appropriate diagnostic studies for this patient.

5. Respondent continued Patient F a course of addicting pain medications without attempting other treatments such as psychological evaluation or physical therapy with pain management.

SPECIFICATIONS OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of N.Y. Educ. Law §6530(4) (McKinney Supp. 1994) in that, Petitioner charges:

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1. The facts in Paragraphs A and A.1, A.2 and/or A.3.

2. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, and/or B.6.

3. The facts in paragraphs C and C.1, C.2, C.3, C.4, C.5, C.6, and/or C.7.

4. The facts in paragraphs D and D.1, D.2, D.3, and/or D.4.

5. The facts in paragraphs E and E.1, E.2, E.3, E.4, E.5 and/or E.6.

6. The facts in paragraphs F and F.1, F.2, F.3, F.4 and/or F.5.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged gross incompetence in violation of N.Y. Educ. Law §6530(6) (McKinney Supp. 1994) in that, Petitioner charges:

7. The facts in Paragraphs A and A.1, A.2 and/or A.3.

8. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, and/or B.6.

9. The facts in paragraphs C and C.1, C.2, C.3, C.4, C.5, C.6, and/or C.7.

10. The facts in paragraphs D and D.1, D.2, D.3, and/or D.4.

11. The facts in paragraphs E and E.1, E.2, E.3, E.4, E.5 and/or E.6.

12. The facts in paragraphs F and F.1, F.2, F.3, F.4 and/or F.5.

THIRTEENTH SPECIFICATION

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NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of N.Y. Educ. Law §6530(3) (McKinney Supp. 1994) in that, Petitioner charges two or more of the following:

13. The facts in paragraphs A and A.1, A.2, A.3; B.1, B.2, B.3, B.4, B.5, B.6; C and C.1, C.2, C.3, C.4, C.5, C.6, C.7; D and D.1, D.2, D.3, D.4; E and E.1, E.2, E.3, E.4, E.5, E.6; and/or F and F.1, F.2, F.3, F.4, F.5.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of N.Y. Educ. Law §6530(5) (McKinney Supp 1994) in that, Petitioner charges two or more of the following:

14. The facts in paragraphs A and A.1, A.2, A.3; B and B.1, B.2, B.3, B.4, B.5, B.6; C and C.1, C.2, C.3, C.4, C.5, C.6, C.7; D.1, D.2, D.3, D.4; E and E.1, E.2, E.3, E.4, E.5, E.6; and/or F and F.1, F.2, F.3, F.4, F.5.

FIFTEENTH SPECIFICATION

FAILING TO MAINTAIN RECORDS

Respondent is charged with failing to maintain records which accurately reflects the evaluation and treatment of the patient in violation of N.Y. Educ. Law §6530(32) (McKinney Supp 1994) in

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that Petitioner charges:

15. The facts in Paragraphs A and A.1, B and B.1, B.2, C.1, C.2, D and D.1, D.2, E and E.1, E.2, F and/or F.1, F.2.

SIXTEENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with practicing the profession fraudulently or beyond its authorized scope in violation of N.Y. Educ. Law §6530(2) (McKinney Supp. 1994) in that, Petitioner charges:

16. The facts in paragraphs D and D.3, D.4: E and E.3, E.5 and/ or E.6.

SEVENTEENTH SPECIFICATION

MORAL UNFITNESS TO PRACTICE MEDICINE

Respondent is charged with conduct which evidences moral unfitness to practice medicine in violation of N.Y. Educ. Law §6530(20) (McKinney Supp. 1994) in that, Petitioner charges:

17. The facts in paragraphs E and E.3, E.5 and/or E.6.

EIGHTEENTH SPECIFICATION

ORDERING TREATMENT NOT WARRANTED

Respondent is charged with ordering excessive treatment not warranted by the condition of the patient in violation of N.Y. Educ. Law §6530(35) (McKinney Supp. 1994) in that, petitioner

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charges:

18. The facts in paragraphs A and A.3; B and B.3; C and C.5; D and D.3; E and E.3, E.6; and/or F and F.3.

DATED: , 1994
Albany, New York

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

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