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

November 6, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Timothy John Hamilton, II, RPA
2451 Webb Avenue #15G
Bronx, New York 10468

RE: In the Matter of Timothy John Hamilton, II, RPA

Effective Date: 11/13/95

Dear Ms. Abeloff and Mr. Hamilton:

Enclosed please find the Determination and Order (No. 95-261) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm

Enclosure

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

IN THE MATTER

OF

TIMOTHY JOHN HAMILTON II, R.P.A.

DETERMINATION

AND

ORDER

BPMC-95-261

ROBIN N. BUSKEY, R.P.A., Chairperson, **THAKOR C. RANA, M.D.**, and **RALPH LEVY, D.O.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(1)(e) and 230(12) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **JERRY JASINSKI,** Acting General Counsel, **DIANNE ABELOFF, ESQ.,** Associate Counsel, of Counsel. The Respondent did not appear and was not represented by counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged eighteen specifications of professional misconduct, including allegations of negligence on more than one occasion, incompetence on more than one occasion, ordering excessive tests or treatment, and failure to maintain records.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached as Appendix I hereto and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	July 26, 1995
Amendment to Statement of Charges Dated:	October 19, 1995
Pre-Hearing Conference:	None
Hearing Date:	September 8, 1995
Received Petitioner's Proposed Findings of Fact, Conclusions of Law:	None submitted
Received Respondent's Proposed Findings of Fact, Conclusions of Law:	None submitted
Deliberation Date:	September 8, 1995
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York

WITNESSES

For the Petitioner:	Thomas Roselle, R.P.A.
For the Respondent:	None

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

GENERAL FINDINGS

1. Respondent was authorized to practice as a physician assistant in the State of New York on or about March 6, 1981, by the issuance of license number 001589 by the New York State Education Department. He is not registered in New York at the present time. (Pet. Ex. 5,)

PATIENT A:

2. On February 21, 1990, Respondent saw Patient A for epigastric pain and burning on urination. He performed a history and physical examination, ordered lab tests and prescribed medications. Respondent diagnosed peptic ulcer disease, urinary tract infection, low back pain and depression. He prescribed Duricef, Prozac, Pepcid, Maalox, and Naprosyn. (Pet. Ex. 7)

3. Thomas Roselle, a physician assistant with 10 years of experience in primary care practice, testified as an expert witness for the Petitioner. Mr. Roselle testified that the history, physical, diagnosis, tests and treatment for Patient A were all inadequate. (T. 10, 12-15, 17, -19, Pet. Ex. 7)

4. Mr. Roselle further testified that the medical records maintained by Respondent for Patient A were inadequate. (T. 12,16, Pet. Ex. 7)

5. On April 13, 1990, Respondent saw Patient A again. Respondent did not perform a physical exam, but he prescribed Augmentin, Calan, Voltaren, Seldane and Ventolin. (Pet. Ex. 7)

6. Mr. Roselle testified that on April 13, 1990, Respondent performed an inadequate follow-up, history and physical upon Patient A and that the medications he prescribed were inappropriate. (T. 16-19; Pet. Ex.7)

PATIENT B:

7. On March 14, 1990, Respondent saw Patient B and performed a history and physical exam, ordered lab tests and prescribed Ceclor, Zantac, Calan, Proventil and Seldene. (Pet. Ex.. 8)

8. Mr. Roselle testified that Respondent performed an inadequate history and physical exam upon Patient B, and that Respondent also ordered inappropriate tests and prescriptions. (T. 26-30, Pet. Ex. 8)

PATIENT C:

9. On April 3, 1990, Respondent undertook the care and treatment of Patient C. At that time, Patient C complained of burning on urination, low back pain, rash on her chest, shortness of breath and stomach pain. (Pet. Ex. 9)

10. Respondent performed a history and physical exam, ordered lab tests and prescribed Ceclor, Axid, Maalox, Naprosyn and Ventolin. (Pet. Ex. 9)

11. Mr. Roselle testified that Respondent performed an inadequate history and physical upon Patient C and that he ordered inappropriate lab tests and prescriptions. Mr. Roselle further testified that Respondent made no attempt to follow-up or contact Patient C regarding her abnormal lab results involving high serum gastric level and positive RA latex. (T. 33-37, Pet. Ex. 9)

PATIENT D:

12. On February 19, 1990, Respondent saw Patient D for complaints of stomach pain, burning on urination, shortness of breath, knee pain, decreased hearing and abdominal pain. Respondent performed a history and physical exam and ordered lab tests and medications. Respondent's diagnosis for Patient D was peptic ulcer, urinary tract infection, arthritis and asthma. Respondent prescribed Zantac, Maalox, Ventolin Inhaler, Augmentin and Naprosyn. (Pet. Ex. 10)

13. On April 23, 1990, Respondent saw Patient D for increased blood pressure. Respondent took Patient D's blood pressure and then prescribed Caraphate, Ventolin, Ceclor, Naprosyn and Maalox. (Pet. Ex.10)

14. Mr. Roselle testified that on both visits, Respondent performed an inadequate history and physical examination of Patient D as well as ordered inappropriate lab tests and prescriptions. (T. 39-48)

PATIENT E:

15. On March 22. 1990, Respondent saw Patient E for asthma, stomach pain, rash, cold, nervousness, ear pain, headache and cough. Respondent performed a history and physical examination, ordered lab tests and prescribed medications. (Pet. Ex. 11)

16. Respondent diagnosed Patient E with peptic ulcer disease, asthma/COPD, otitis media and upper respiratory infection. Respondent prescribed Augmentin, Zantac, Proventil, Theodur and Robitussin. (Pet. Ex. 11)

17. Mr. Roselle testified that Respondent performed an inadequate history and physical examination of Patient E, as well as ordered inappropriate lab tests and prescriptions. In addition, Respondent completely failed to address the treatment of the patient's skin rash problem. (T. 51-54)

PATIENT F:

18. On May 2, 1990, Respondent saw Patient F for complaints of cough, yellow phlegm, rash, back pain and peptic ulcer disease. Respondent performed a history and physical examination and he ordered lab tests and prescribed medications. (Pet. Ex. 12)

19. Respondent diagnosed Patient F with peptic ulcer, low back pain and an upper respiratory infection. Respondent prescribed Zantac, Lotrisone Cream, Ceclor, Naprosyn and Maalox. (Pet. Ex. 12)

20. Mr. Roselle testified that Respondent performed an inadequate history and physical examination of Patient F as well as ordered inappropriate lab tests and prescriptions. (T. 55-57)

PATIENT G:

21. On February 19, 1990, Respondent saw patient G for complaints of abdominal pain, shortness of breath, chronic hearing loss, urinary tract infection, cough and low back pain. Respondent performed a history and physical examination and he ordered lab tests and prescribed medications. (Pet. Ex. 13)

22. Respondent diagnosed Patient G with peptic ulcer disease, urinary tract infection, low back pain and asthma. Respondent prescribed Proventil Inhaler, Pepcid, Maalox, Naprosyn and Ceclor. (Pet. Ex. 13)

23. Mr. Roselle testified that on February 19, 1990, Respondent performed an inadequate history and physical upon Patient G and ordered inappropriate lab tests and medications. (T. 59-63)

24. On April 27, 1990, Respondent saw Patient G for complaints of low back pain, burning on urination and asthma. (Pet. Ex. 13)

25. Mr. Roselle testified that on the April 27, 1990 visit, Respondent failed to meet accepted medical standards because he did not address Patient G's chief complaint of back pain. There is no documentation of any physical exam and there is no follow-up of the patient's elevated blood pressure. (T. 60-61)

PATIENT H:

26. On March 12, 1990, Respondent saw Patient H for complaints of abdominal pain, asthma, burning on urination, low back pain and chest congestion. Respondent performed a history and physical examination and he ordered lab tests and prescribed medications. (Pet. Ex. 14)

27. Respondent diagnosed Patient H with peptic ulcer disease, urinary tract infection, low back pain, asthma and rash in the groin. Respondent prescribed Pepcid, Ceclor, Naprosyn, Ventolin Inhaler and Lotrisone Cream. (Pet. Ex. 14)

28. Mr. Roselle testified that Respondent performed an inadequate history and physical exam upon Patient H and he ordered inappropriate lab tests and medications. (T. 66-68)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(2)
Paragraph A.1(a):	(3)
Paragraph A.1(b):	(3)
Paragraph A.2(a-j):	(2, 5, 6)
Paragraph A.3:	(3)
Paragraph A.4:	(3)
Paragraph A.5:	(3)

Paragraph A.6: (2)

Paragraph A.7: (2, 6)

Paragraph A.8: (4)

Paragraph B: (7)

Paragraph B.1(a): (8)

Paragraph B.1(b): (8)

Paragraph B.2(a-d): (7, 8)

Paragraph B.3: (8)

Paragraph B.4: (8)

Paragraph B.5: (8)

Paragraph C: (9)

Paragraph C.1(a): (11)

Paragraph C.1(b): (11)

Paragraph C.2(a-d): (10, 11)

Paragraph C.3: (11)

Paragraph C.4: (11)

Paragraph C.5: (11)

Paragraph D: (12, 13)

Paragraph D.1(a): (14)

Paragraph D.1(b): (14)

Paragraph D.2(a-d): (13, 14)

Paragraph D.3: (14)

Paragraph D.4: (14)

Paragraph D.5: (14)

Paragraph E: (15)

Paragraph E.1(a): (17)

Paragraph E.1(b): (17)

Paragraph E.2(a-d): (16, 17)

Paragraph E.3: (17)

Paragraph E.4: (17)

Paragraph E.5: (17)

Paragraph F: (18)

Paragraph F.1(a): (20)

Paragraph F.1(b): (20)

Paragraph F.2(a-e): (19, 20)

Paragraph F.3: (20)

Paragraph F.4: (20)

Paragraph G: (21)

Paragraph G.1(a): (23, 25)

Paragraph G.1(b): (23, 25)

Paragraph G.2(a-e): (22, 23)

Paragraph G.3: (25)

Paragraph G.4: (23, 25)

Paragraph G.5: (23, 25)

Paragraph H: (26)

Paragraph H.1(a): (28)

Paragraph H.1(b): (28)

Paragraph H.2(a-e): (27, 28)

Paragraph H.3: (28)

Paragraph H.4: (28)

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parenthesis refer to the Factual Allegations which support each specification:

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

First Specification: (Paragraph A and all the subparagraphs thereunder)
(Paragraph B and all the subparagraphs thereunder)
(Paragraph C and all the subparagraphs thereunder)
(Paragraph D and all the subparagraphs thereunder)
(Paragraph E and all the subparagraphs thereunder)
(Paragraph F and all the subparagraphs thereunder)
(Paragraph G and all the subparagraphs thereunder)
(Paragraph H and all the subparagraphs thereunder)

INCOMPETENCE ON MORE THAN ONE OCCASION

Second Specification: (Paragraph A and all the subparagraphs thereunder)
(Paragraph B and all the subparagraphs thereunder)
(Paragraph C and all the subparagraphs thereunder)
(Paragraph D and all the subparagraphs thereunder)
(Paragraph E and all the subparagraphs thereunder)
(Paragraph F and all the subparagraphs thereunder)
(Paragraph G and all the subparagraphs thereunder)
(Paragraph H and all the subparagraphs thereunder)

ORDERING EXCESSIVE TESTS OR TREATMENT

ORDERING EXCESSIVE TESTS OR TREATMENT

Third Specification:	Paragraphs A(2) and A(2)(a) through A(2)(i), A(3) and A(5).
Fourth Specification:	Paragraphs B(2) and B(2)(a) through B(2)(b), and B(4).
Fifth Specification:	Paragraphs C(2) and C(2)(a) through C(2)(d), and C(3).
Sixth Specification:	Paragraphs D(2) and D(2)(a) through D(2)(d), and D(3).
Seventh Specification:	Paragraphs E(2) and E(2)(a) through E(2)(d), and E(4).
Eighth Specification:	Paragraphs F(2) and F(2)(a) through F(2)(e), and F(2).
Ninth Specification:	Paragraphs G(2) and G(2)(a) through G(2)(e), and G(4).
Tenth Specification:	Paragraphs H(2) and H(2)(a) through H(2)(e), and H(3).

FAILURE TO MAINTAIN RECORDS

Eleventh Specification:	(Paragraphs A and A(8)).
Twelfth Specification:	(Paragraphs B and B(5)).
Thirteenth Specification:	(Paragraphs C and C(5)).
Fourteenth Specification:	(Paragraphs D and D(5)).
Fifteenth Specification:	(Paragraphs E and E(5)).
Sixteenth Specification:	(Paragraphs F and F(3)).
Seventeenth Specification:	(Paragraphs G and G(5)).
Eighteenth Specification:	(Paragraphs H and H(4)).

DISCUSSION

Respondent is charged with eighteen specifications alleging professional misconduct within the meaning of Education Law Section 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the 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 and the fraudulent 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.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that all eighteen specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset, the Hearing Committee made a determination as to the credibility of the Department's expert witness, Thomas Roselle, R.P.A. Mr. Roselle appeared to be a very knowledgeable physician assistant, who was wholly familiar with the types of patients seen by Respondent and the type of services rendered. The Hearing Committee deemed Mr. Roselle to be the appropriate peer to review Respondent's records and practice in this instance. The Hearing Committee fully accepts Mr. Roselle's assessment for Patients A through H that indicates a pattern that Respondent's practice was wrought with negligence, incompetence, excessive tests and treatments and inadequate record keeping. The Hearing Committee, however, has reviewed each patient record and has commented upon the most obvious instances of Respondent's professional

misconduct as set forth below.

PATIENT A:

Patient A saw Respondent twice, on February 21, 1990 and April 13, 1990. There however, is no evidence in Respondent's records that he relayed the results of the abnormal lab tests prior to Patient A's April 13th appointment. Respondent also failed to document any comments about the abnormal labs in the patient's records. Furthermore, Respondent never advised Patient A to stop drinking and smoking despite his hepatitis and peptic ulcer. Therefore, the Hearing Committee sustains all charges with respect to Patient A.

PATIENT B:

Patient B was a 270 pound male who drank 2 pints of alcohol per day and smoked one pack of cigarettes per day. He saw Respondent for complaints of arrhythmia. Respondent failed to address the significant history of Patient B which included diabetes, kidney disease and drug abuse. Respondent also failed to provide adequate hospitalization information for this patient . Therefore, the Hearing Committee sustains all charges with respect to Patient B.

PATIENT C:

Respondent diagnosed Patient C with a urinary tract infection without even taking a urine culture. Respondent failed to request a follow-up visit , despite Patient C's positive RA latex lab results and her complaints of rash on her chest and low back pain. Therefore, the Hearing Committee sustains all charges with respect to Patient C.

PATIENT D:

Respondent saw Patient D for complaints of stomach pain, burning on urination, shortness of breath, knee pain, decreased hearing and abdominal pain. Respondent failed to perform an adequate work-up and evaluation of Patient D's complaints and diagnoses of peptic ulcer disease, asthma, burning on urination, and knee pain. Therefore, the Hearing Committee sustains all charges with respect to Patient D.

PATIENT E:

Patient E, a 37 year old female, saw Respondent for complaints of asthma, stomach pain, rash, cold, nervousness, ear pain, headache and cough. Despite a normal HEENT exam, Respondent inappropriately diagnosed otitis media (inflammation of the middle ear), yet failed to treat Patient E for the rash that she complained about. Therefore, the Hearing Committee sustains all charges with respect to Patient E.

PATIENT F:

Respondent saw Patient F for complaints of cough, yellow phlegm, rash, back pain and peptic ulcer disease. Despite the patient's smoking history and the fact that he was coughing up yellow phlegm, no sputum was obtained. In addition, Respondent failed to screen for tuberculosis or chest X-ray and he provided no patient education on quitting smoking. Therefore, the Hearing Committee sustains all charges with respect to Patient F.

PATIENT G:

Respondent saw Patient G on more than one occasion for complaints that included abdominal pain, shortness of breath, chronic hearing loss, urinary tract infection, low back pain and asthma. Patient G was an alcoholic who exhibited positive abnormal tests for hepatitis. Respondent failed to adequately follow-up and address this patient's particular problems. Therefore, the Hearing Committee sustains all charges with respect to Patient G.

PATIENT H:

Respondent saw Patient H for complaints of abdominal pain, asthma, burning on urination, low back pain and chest congestion. In this instance, Respondent prescribed Ceclor, which is an inappropriate drug for a urinary tract infection. The medical record provides no evidence that Patient H's urine was ever tested.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice as a physician assistant in New York State should be revoked and that he should be fined a penalty of $10,000. 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.

This matter involved a repeated pattern of professional misconduct by Respondent in a an approximately four month period for each of the eight patients involved. Respondent

deviated from the accepted standard of practice for a physician assistant in every area of his practice. For each patient, the medical history, evaluation, diagnosis, treatment and follow-up were totally inadequate. When follow-up visits were scheduled, they failed to address the patient's real medical problems.

The Hearing Committee further notes that Respondent always utilized the most expensive treatment and prescriptions. DAW prescriptions were always prescribed and generic prescriptions were never used to keep down the costs to the Medicaid program. Respondent was clearly motivated by greed, at the expense of the needs of his patients. In many instances, Respondent prescribed drugs that jeopardized the well-being of his patients.

The Hearing Committee believes that revoking Respondent's license is appropriate based on Respondent's substandard practice of medicine, his use of excessive tests and treatments and his poor record keeping The additional penalty of a $10,000 fine is invoked to send a message to Respondent and others like him, that abuse of the Medicaid system will not be tolerated. Under the totality of the circumstances, revocation of Respondent's license and a $10,000 fine are the only appropriate sanctions in this instance.

ORDER

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

1. The First through Eighteenth Specifications of Professional Misconduct, as set forth in the Amended Statement of Charges (Petitioner's Exhibit #1A) are **SUSTAINED**; and

2. Respondent's license to practice as a physician assistant in New York State be and is hereby **REVOKED**.

3. A fine in the amount of **TEN THOUSAND DOLLARS ($10,000)** be and hereby is imposed against Respondent. Payment of the aforesaid sum shall be made to the Bureau of Accounts Management, New York State Department of Health, Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York 12237 within thirty (30) days of the effective date of this Order;

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses (Tax Law Section 171(27); State Finance Law Section 18; CPLR Section 5001; Executive Law Section 32.

DATED: Albany, New York

11/1, **1995**

ROBIN N. BUSKEY, R. P.A., Chairperson

THAKOR C. RANA, M.D.
RALPH LEVY, D.O.

TO: Dianne Abeloff, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Timothy John Hamilton, II, R.P.A.
2451 Webb Avenue, #15G
Bronx, New York 10468

APPENDIX I

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

IN THE MATTER
OF
TIMOTHY JOHN HAMILTON II, R.P.A.

STATEMENT
OF
CHARGES

TIMOTHY JOHN HAMILTON II, R.P.A, the Respondent, was authorized to practice as a physician's assistant in New York State on or about March 6, 1981 , by the issuance of license number 001589 by the New York State Education Department.

FACTUAL ALLEGATIONS

A On or about February 21, 1990 and on or about April 13, 1990, Respondent undertook the care and treatment of Patient A at a medical office located at 1814 Third Avenue, New York, N.Y. 10035 (hereinafter referred to as "the Third Avenue office").

1. On each visit by Patient A, Respondent failed to:

   a. Obtain and note an adequate history.

   b Perform and note an adequate physical examination.

2. At either the February 21st or the April 13th visit, Respondent inappropriately prescribed:

treatment rendered.

B. On or about March 14, 1990. Respondent undertook the care and treatment of Patient B at his Third Avenue Office.

1. Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

   a. Ceclor

   b. Zantac

   c. Calan

   d. Proventil

3. Respondent failed to appropriately address medical problems that were checked off on the history intake, i.e. diabetes, kidney disease and drug abuse.

4. Respondent performed an audiogram without medical indication.

5. Respondent failed to maintain a record for Patient B which accurately reflects the patient's history, examination, diagnosis, tests, and

treatment rendered.

C. On or about April 3, 1990, Respondent undertook the care and treatment of Patient C at his Third Avenue Office.

1. Respondent failed to.

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed.

   a. Ceclor
   b. Axid
   c. Maalox
   d. Naprosyn

3. Respondent inappropriately ordered the following chemistries, protein, lipoprotein and hemoglobin electrophoreses, LDH and CPK isoenzymes, hepatitis serologies.

4 Respondent failed to follow-up or attempt to follow up with Patient C on her abnormal laboratory tests results.

5. Respondent failed to maintain a record for Patient C which accurately reflects the patient's history, examination, diagnosis, tests, and

treatment rendered.

D On or about February 19, 1990 and April 23, 1990, Respondent undertook the care and treatment of Patient D at his Third Avenue office.

1. On each visit by Patient D, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed.

   a. Zantac

   b Maalox

   c Ventolin Inhaler

   d. Augmentin on February 19, 1990 and Ceclor on April 23, 1990.

3. Respondent inappropriately ordered and/or performed the following: hepatitis serologies, thyroid antibody titers and a hemoglobin electrophoresis, spirometry and an audiogram .

4. Respondent failed to perform an adequate work-up and evaluation of Patient D's complaints and/or diagnoses of peptic ulcer disease, asthma, burning on urination, and knee pain

5. Respondent failed to maintain a record for Patient D which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

E On or about March 22, 1990, Respondent undertook the care and treatment of Patient E at his Third Avenue office.

1 On each visit by Patient E, Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2 Respondent inappropriately prescribed:

a. Augmentin
b. Zantac
c. Proventil
d. Theodur

3. Respondent failed to appropriately address the patient's complaint of periumbilical rash.

4. Respondent performed and / or ordered the following tests without medical indication: audiogram, serology and immunology, thyroid, hepatitis, protein electrophoresis, alk. phos. isoenzymes, LDH isoenzymes.

5 Respondent failed to maintain a record for Patient E which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

F. On or about May 2, 1990, Respondent undertook the care and treatment of Patient F at his Third Avenue office.

1. Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination

2. Respondent inappropriately prescribed:

   a. Zantac

   b. Lotrisone Cream

   c. Ceclor

   d. Naprosyn

   e. Maalox

3. Respondent performed and/or ordered the following tests without

medical

indication: audiogram and a battery of blood tests

4. Respondent failed to maintain a record for Patient F which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

G. On or about February 19, 1990 ,and April 27, 1990 , Respondent undertook the care and treatment of Patient G at his Third Avenue Office.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed on February 19,1990:

a. Proventil Inhaler
b. Pepcid
c. Maalox
d. Naprosyn
e. Ceclor

3. Respondent failed to follow - up on an elevated blood pressure.

4 Respondent inappropriately ordered and/or performed the following

tests: audiogram, routine chemistries and electrophoreses, isoenzymes and serologies.

5. Respondent failed to maintain a record for Patient G which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

H. On or about March 12, 1990, Respondent undertook the care and treatment of Patient H at his Third Avenue office.

1. On each visit by Patient H, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

   a. Pepcid
   b. Ceclor
   c Naprosyn
   d. Ventolin Inhaler
   e. Lotrisone Cream

3. Respondent inappropriately ordered and/or performed the following tests, audiogram, serology and electrophoresis battery in addition to routine chemistries and a CBC.

4. Respondent failed to maintain a record for Patient H which accurately

reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1995) by practicing the profession with negligence on more than one occasion in that Petitioner charges two or more of the following:

1. The facts in paragraphs A and all the subparagraphs thereunder, B and all the subparagraphs thereunder, C and all the subparagraphs thereunder, D and all the subparagraphs thereunder, E and all the subparagraphs thereunder, F and all the subparagpahs thereunder, G and all the subparagraphs thereunder, and/or H and all the subparagraphs thereunder.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530 (5) (McKinney Supp. 1995) by practicing the profession with negligence on more than one occasion in that Petitioner charges two or more of the

following:

2. The facts in paragraphs A and all the subparagraphs thereunder, B and all the subparagraphs thereunder, C and all the subparagraphs thereunder, D and all the subparagraphs thereunder, E and all the subparagraphs thereunder, F and all the subparagpahs thereunder, G and all the subparagraphs thereunder, and/or H and all the subparagraphs thereunder.

THIRD THROUGH TENTH SPECIFICATIONS

UNNECESSARY TESTS AND/OR TREATMENT

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1995) by ordering excessive tests and/or treatments not warranted by the condition of the patient, in that Petitioner charges:

3. The facts in paragraphs A(2) and A(2)(a) through A(2)(i), A(3) and A(5).

4. The facts in paragraphs B(2) and B (2)(a) through B(2)(d), and B(4).

5. The facts in paragraphs C(2) and C(2)(a) through C(2)(d), and C(3).

6. The facts in paragraphs D(2) and D(2)(a) through D(2)(d), and D(3).

7. The facts in paragraphs E(2) and E(2)(a) through E(2)(d), and E(4).

8. The facts in paragraphs F (2) and F(2)(a) through F(2)(e), and F(3).

9. The facts in paragraphs G(2) and G(2)(a) through G(2)(e), G (4).

10. The facts in paragraphs H (2) and H(2)(a) through H(2)(e), and H(3).

ELEVENTH THROUGH EIGHTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

The Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1995) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

11 The facts in paragraphs A and A(8).

12. The facts in paragraphs B and B(5).

13. The facts in paragraphs C and C(5).

14. The facts in paragraphs D and D(5).

15. The facts in paragraphs E and E(5).

16. The facts in paragraphs F and F(3).

17. The facts in paragraphs G and G(5).

18. The facts in paragraphs H and H (4).

DATED: October , 1995
New York, New York

ROY NEMERSON
Deputy Counsel, Bureau of
Professional Medical Conduct