NEW YORK
THE STATE OF LEARNING

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

October 31, 1990

Herbert Halper, Physician
65 Oriental Boulevard
Broklyn, N.Y. 11235

Re: License No. 046748

Dear Dr. Halper:

Enclosed please find Commissioner's Order No. 11009. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:
Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er
Enclosures

CERTIFIED MAIL- RRR
cc: Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building - Suite 512
Scarsdale, N.Y. 10583

REPORT OF THE
REGENTS REVIEW COMMITTEE

HERBERT HALPER

CALENDAR NO. 11009

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

HERBERT HALPER **No. 11009**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

HERBERT HALPER, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on August 18, October 13, October 16, and October 23, 1989 hearings were held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of the first specification of the charges to the extent indicated in

its report, and the fourteenth through eighteenth specifications of the charges, made no conclusion as to the thirteenth specification of the charges, and concluded that respondent was not guilty of the remaining charges. The hearing committee recommended that respondent's license to practice as a physician in the State of New York be suspended for one year with eight months of the suspension period stayed pending respondent's compliance with an Office of Professional Medical Conduct inspection of his medical records, and that respondent be fined $10,000.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted, and that the recommendation of the hearing committee be accepted with a modification as indicated in his recommendation. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On July 10, 1990 respondent appeared before us in person, and was represented by an attorney, Anthony Z. Scher, Esq., who presented oral argument on respondent's behalf. Roy Nemerson, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State

of New York be suspended for two years, the last 20 months of such suspension stayed pending respondent's compliance with an Office of Professional Medical Conduct inspection of his medical records, and that respondent be fined $10,000.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was Censure and Reprimand.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's June 25, 1990 memorandum.

We note that we do not approve of the hearing committee, the Administrative Officer, and the Commissioner of Health abdicating responsibility for making any conclusion as to the thirteenth specification of the charges. It is not appropriate for those persons charged with conducting the hearing, making legal rulings at the hearing, and initially reviewing the hearing committee recommendations to simply throw up their hands and refuse to decide a charge on the grounds that it raises allegedly difficult legal issues. However, because we find the thirteenth specification to be relatively simple to address and therefore does not require input through a remand, we do not see any need for such further proceeding. It is our unanimous opinion that the thirteenth specification must be dismissed.

The thirteenth specification attempts to use a non-judicial

subpoena duces tecum as the foundation for a charge under 8 NYCRR §29.1(b)(13). 8 NYCRR §29.1(b)(13) defines unprofessional conduct to include the following:

> "failing to respond within 30 days to written communications from the Education Department or the Department of Health and to make available any relevant records with respect to an inquiry or complaint about the licensee's unprofessional conduct. The period of 30 days shall commence on the date when such communication was delivered personally to the licensee. If the communication is sent from either department by registered or certified mail, with return receipt requested, to the address appearing in the last registration, the period of 30 days shall commence on the date of delivery to the licensee, as indicated by the return receipt".

We reject petitioner's contention that a non-judicial subpoena duces tecum is a written communication as contemplated by 8 NYCRR §29.1(b)(13). The terms of 8 NYCRR §29.1(b)(13) are inconsistent and incompatible with the form and usage of subpoenas, and, consequently, are not meant to apply to subpoenas. For instance, the return date for subpoenas is not restricted to 30 days; it can be shorter or longer. The subpoena in this case was personally served on the respondent on September 20, 1988 and had a return date of October 28, 1988. This period allowed by the subpoena exceeds the 30 days allowed under 8 NYCRR §29.1(b)(13), and would make the application of 8 NYCRR §29.1(b)(13) unfair and nonsensical. Because return dates for subpoenas are not governed by 8 NYCRR §29.1(b)(13), it is clear, as a matter of practicality

and common sense, that subpoenas were not intended to fit under the category of written communications contemplated by 8 NYCRR §29.1(b)(13). Moreover, with respect to failing to respond, respondent did make a formal response to the subpoena on October 19, 1988 requesting that the subpoena be withdrawn. This response was within 30 days of the service of the subpoena.

We also note that 8 NYCRR §29.1(b)(13) requires that a professional respond and make records available. However, a subpoena duces tecum commands the actual production and delivery of specified documents to a specified individual. A respondent could comply with 8 NYCRR §29.1(b)(13) and yet run afoul of the terms of a particular subpoena. In addition, a subpoena, including a non-judicial subpoena if appropriately followed up, carries a separate set of contempt sanctions. Subpoenas are also subject to motions to quash. In our unanimous opinion, the unique attributes of subpoenas takes them out of the purview of 8 NYCRR §29.1 (b)(13).

With regard to the measure of discipline to be imposed herein, it is our unanimous opinion that the recommendations of the hearing committee and Commissioner of Health are too harsh. The fine recommended would make sense only if the thirteenth specification were to be sustained, and petitioner appears to have requested the fine based only upon the thirteenth specification. Since the thirteenth specification is being dismissed, a fine is not

appropriate under the circumstances of this case. We also note that five out of the six specifications of which we recommend respondent be found guilty concern record-keeping violations, which, under the circumstances of this case, we do not consider as supporting an actual suspension. Respondent has not been found guilty of gross negligence, gross incompetence, or incompetence. The only other specification sustained concerns negligence on more than one occasion. In this regard, most of the misconduct occurred from six to ten years ago. Only with regard to Patient C does the misconduct relate to a more recent period, and that is also at least three years ago. Respondent is 68 years old and has led a distinguished medical career that includes teaching at Rutgers University and Downstate Medical Center, service to his community, and playing a role in developing the field of angiography. Respondent earned much praise from the physician and various patients who testified on respondent's behalf. In view of the foregoing, including the age of the misconduct, the majority of which consists of record-keeping violations, and the weight of the testimony of respondent's character witnesses, we find a one year suspension, stayed, to be a sufficient and appropriate penalty in this case.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 49 findings of fact, and the

Commissioner of Health's recommendation as to those findings of fact, be accepted;

2. The hearing committee's conclusions as to the question of respondent's guilt be accepted, except that the hearing committee's failure to reach any conclusion as to the thirteenth specification not be accepted, and the Commissioner of Health's recommendation as to those conclusions be accepted, except that the Commissioner of Health's failure to reach any conclusion as to the thirteenth specification not be accepted;

3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;

4. Respondent be found guilty, by a preponderance of the evidence, of the first specification of the charges to the extent indicated in the hearing committee report, and the fourteenth through eighteenth specifications of the charges, and not guilty of the remaining charges, including the thirteenth specification;

5. That, based upon the reasons previously set forth in this report, respondent's license to practice as a physician in the State of New York be suspended for one year upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run

concurrently, and that execution of said suspensions be stayed.

Respectfully submitted,

J. EDWARD MEYER

MELINDA AIKINS BASS

SIMON J. LIEBOWITZ

J. Edward Meyer
Chairperson

Dated: August 31, 1990

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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IN THE MATTER	:	STATEMENT
OF	:	OF
HERBERT HALPER, M.D.	:	CHARGES

----------X

HERBERT HALPER, M.D., the Respondent, was authorized to practice medicine in New York State on October 9, 1947 by the issuance of license number 046748 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 January 1, 1989 through December 31, 1991.

FACTUAL ALLEGATIONS

A. On at least 11 dates during a period beginning on or about March 24, 1980 and ending on or about October 29, 1984, Patient A sought medical care from Respondent, at his medical office at 3079 Brighton 13th Street, Brooklyn, N.Y. 11235. (All patients are identified in Appendix A.) Patient A, a woman, was approximately 70 years old at the beginning of this period.

1. On or about March 24, 1980, Patient A consulted Respondent complaining of chest pain. Respondent's chart notes report a gallop rhythm, chest rhonchi, an STT wave abnormality with left anterior hemi-block, and a CBC shift to the left. A chest x-ray was done.

EXHIBIT "A"

a) Respondent failed to obtain and record an adequate history.

b) Respondent failed to perform and record an adequate physical examination.

c) Respondent failed to take appropriate action in light of a potentially dangerous cardiac problem.

d) Respondent incorrectly noted a CBC shift to the left when the CBC did not support such an interpretation.

e) Respondent incorrectly noted the presence of left anterior hemi-block when the EKG did not support such an interpretation.

2. On or about April 24, 1980 Patient A again consulted Respondent.

a) Respondent failed to obtain and record an adequate history.

b) Respondent failed to perform and record an adequate physical examination.

c) Respondent failed to take appropriate action in light of a potentially dangerous cardiac problem.

3. On or about March 3, 1981 Patient A again consulted Respondent, complaining of severe chest pains. Respondent noted a gallop rhythm, a blood pressure of 190/100, and an EKG evidencing incomplete right bundle branch block with left anterior hemi-block.

   a) Respondent failed to obtain and record an adequate history.

   b) Respondent failed to perform and record an adequate physical examination.

   c) Respondent failed to take appropriate action in light of a potentially dangerous cardiac problem.

   d) Respondent did not evaluate Patient A again until nine months later, at which time he made an appropriate but untimely referral to a specialist.

4. On or about October 29, 1984, Patient A consulted Respondent complaining of general weakness, shortness of breath, and palpitations. An EKG performed on that date evidenced a rhythm disturbance.

   a) Respondent inappropriately noted that the EKG indicated a regular sinus rhythm when it did not.

b) Respondent failed to obtain and record an adequate history.

c) Respondent failed to perform and record an adequate physical examination.

d) Respondent failed to take appropriate action in light of a potentially dangerous cardiac problem.

5. On or about March 11, 1982, April 15, 1982, April 22, 1983, March 7, 1984, May 1, 1984, and October 29, 1984, Respondent prescribed various medications for use by Patient A.

a) Respondent failed to adequately note the dosage and administration of the prescribed medication.

b) Respondent failed to obtain blood electrolyte and digitalis levels despite prescribing Digoxin, Lasix, and potassium supplements on and after April 15, 1982.

B. During the period beginning on or about October 12,1981 and ending on or about January 3, 1985, Patient B sought medical care from Respondent on approximately 51 occasions, at Respondent's medical office. Patient B, a man, was approximately 68 years old at the beginning of this period.

1. Despite Patient B's condition as described in Respondent's medical chart, including, but not limited to a history of peptic ulcer and diagnoses of anemia, hiatus hernia, and defect in the prepyloric region, ~~Respondent inappropriately prescribed:~~

   a) Motrin on 5/6/82, 8/27/82, 2/18/83, 4/19/83, 5/2/83, 5/16/83 and 12/20/83;

   b) Fiorinal on 10/21/82, 7/~~20/83~~ 9/20/83, 10/20/83, 12/20/83 and 1/26/84; and

   c) Clinoril on 2/7/84 and 2/21/84.

2. Respondent failed to ~~have~~ obtain a stool test for occult blood.

3. Respondent failed to perform appropriate tests to support his diagnosis of Patient B as suffering from iron deficiency anemia.

4. Respondent inappropriately treated Patient B with Imferon injections on 2/1/82, 2/8/82, 7/30/82, 8/6/82, 8/13/82, 8/20/82, 8/27/82, 11/30/82, 12/14/82, 12/23/82, 12/28/82, 8/5/83, 8/12/83, 8/20/83 and 8/26/83.

5. Respondent inappropriately prescribed daily salt tablets, beginning on or about 10/21/82, despite the patient's history of cardiac disease and edema.

6. Respondent failed to pursue appropriate diagnostic tests, referral, or treatment of Patient B in light of the patient's complaints of:

   a) severe chest pains, on 5/14/84;

   b) severe chest pains, on 11/26/84; and

   c) chest pain radiating to the left side, on 1/3/85.

C. During a period beginning on or about September 7, 1979 and ending on or about February 9, 1987, Patient C sought medical care from Respondent on approximately 53 occasions, at Respondent's medical office. Patient C, a man who was approximately 64 years old at the beginning of this period, had a history which included a coronary, angina, intermittent claudication and difficulty in breathing.

1. Despite the fact that significantly abnormal physical findings (including but not limited to rales, wheezes, and obesity, and laboratory results including abnormal EKG, chest x-ray, pulmonary function tests, and Doppler study), were made during Patient C's first two visits in September of 1979,

Respondent failed to perform an appropriate follow-up until five months had elapsed.

2. Respondent failed to obtain a serum electrolyte/chemistry prior to 10/21/86, despite the fact that on or about 4/10/80 and afterward, Respondent variously prescribed Lasix, Digoxin and other medication to Patient C who suffers significant cardiac, renal, and other diseases.

3. Respondent inappropriately prescribed Motrin, Feldene, Fiorinal, Fioricet, Meclomen, Naprosyn, and Synalgos DC to Patient C, despite the patient's condition which included, among other things, peptic ulcer disease and multiple gastrointestinal complaints.

4. Respondent failed to obtain a stool test for occult blood, despite Patient C's condition and Respondent's prescription of Motrin, Feldene, Fiorinal, Fioricet, Meclomen, Naprosyn, and Synalgos DC.

5. On or about 1/31/86, Patient C consulted Respondent complaining of severe chest pain, multiple vision, syncopal episode and difficulty in breathing.

Physical examination of Patient C demonstrated a severe systolic murmur, marked obesity, a blood pressure of 170/100, rales in both bases and marked pulmonary congestion. The patient's liver edge was palpable, his legs swollen, his left knee edematious. Respondent's notes indicated an "infectious problem," possible azotemia, and the presence of nephrosclerosis.

a) Despite the Patient C's condition on this date, Respondent failed to hospitalize or appropriately treat the patient, failed to obtain a consult, and failed to see the patient until 18 days later.

b) Respondent inappropriately prescribed Feldene in light of Patient C's condition on this date, including but not limited to the patient's renal disease.

6. On numerous dates during his treatment of Patient C, Respondent prescribed medication but failed to adequately note the dosage and administration of that medication.

D. During a period beginning on or about 6/14/79 and ending on or about 7/14/81, Patient D sought medical care from

Respondent on approximately 20 occasions, at Respondent's medical office. Patient D, a woman who was approximately 57 years old at the beginning of this period, had a history of myocardial infarction, pancreatitis and cholecystitis.

1. On or about 4/18/80, despite noting a diagnosis of unstable angina, Respondent failed to either adequately evaluate, treat or hospitalize Patient D.

2. On or about 6/20/80 Patient D consulted Respondent complaining of syncope and light-headedness. Under the circumstances, Respondent failed to adequately evaluate the patient's condition and failed to perform a neurological examination.

3. On or about 7/29/80, Patient D consulted Respondent complaining of shortness of breath. Despite diagnosing Patient D as suffering from congestive heart failure, Respondent failed to perform and note an appropriate history and physical examination.

4. On or about 12/2/80, despite Patient D's condition and Respondent's note of the need to "observe for possible Ca. metastacising from breast," Respondent failed to perform and note a breast examination, a bone examination, an appropriate SMA or mammography

and failed to adequately pursue and note additional, relevant history.

E. During a period beginning on or about 10/14/74 and ending on or about 12/2/80, Patient E consulted Respondent on approximately 70 occasions, at Respondent's medical office. Patient E, a man, was approximately 77 years old at the beginning of this period.

1. On or about and after 11/30/78, despite noting that Patient E might have a squamous cell cancer of the ear, and recommending a surgeon, Respondent failed to note any result of a work-up or whether surgery was performed.

2. On or about 5/4/79 Respondent noted that a chest x-ray showed a possible tumor in Patient E's right upper lobe. Despite this and despite Respondent's observations noted on 11/30/78, Respondent failed to pursue any follow-up diagnostic testing, consultation, or treatment other than to observe the growth of a right upper lobe pulmonary tumor with five subsequent chest x-rays over a 20-month period ending on 12/2/80, Patient E's final visit to Respondent's office, prior to the Patient's death.

F. On or about September 20, 1988 a written communication from the Department of Health was delivered personally to Respondent, requiring the production by the Respondent of various relevant records with respect to an inquiry or

complaint about the licensee's unprofessional conduct. By an October 21, 1988 oral agreement between counsel for the Department and counsel for Respondent, Respondent as given until October 28, 1988 to provide said documents, which included patient records for Patients A-E herein, and for five other patients.

Respondent has failed to produce these records.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING THE PROFESSION WITH NEGLIGENCE

The Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges that Respondent has committed two or more of the following:

1. The facts in Paragraphs A and A1-5, the facts in Paragraphs B and B1-6, the facts in Paragraphs C and C1-6, the facts in Paragraphs D and D1-4, and/or the facts in Paragraphs E and E1-2.

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH INCOMPETENCE

The Respondent is charged with practicing the profession with incompetence on more that one occasion within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges that Respondent committed two or more of the following:

2.The facts in Paragraphs A and A1-5, the facts in Paragraphs B and B1-6, the facts in Paragraphs C and C1-6, the facts in Paragraphs D and D1-4, and the facts in Paragraphs E and E1-2.

THIRD THROUGH SEVENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

The Respondent is charged with practicing the profession with gross negligence within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985) in that Petitioner charges:

3. The facts in Paragraphs A and A1-5.

4. The facts in Paragraphs B and B1-6.

5. The facts in Paragraphs C and C1-6.

6. The facts in Paragraphs D and D1-4.

7. The facts in Paragraphs E and E1-2.

EIGHTH THROUGH TWELTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985) in that Petitioner charges:

8. The facts in Paragraphs A and A1-5.

9. The facts in Paragraphs B and B1-6.

10. The facts in Paragraphs C and C1-6.

11. The facts in Paragraphs D and D1-4.

12. The facts in Paragraphs E and E1-2.

THIRTEENTH SPECIFICATION

UNPROFESSIONAL CONDUCT/FAILING TO MAKE RECORDS AVAILABLE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509(9)(McKinney 1985) by committing unprofessional conduct as defined by the Board of Regents in N.Y. Admin. Code tit. 8, Section 29.1(b)(13)(1987), by failing to respond within 30 days to a written communication from the Department of Health and to make available any relevant records with respect to an inquiry or complaint about the licensee's unprofessional conduct in that Petitioner charges:

13. The facts in Paragraph F.

FOURTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

UNPROFESSIONAL CONDUCT/FAILING TO MAINTAIN RECORDS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509(9)(McKinney 1985) by committing unprofessional conduct as defined by the Board of Regents in N.Y. Admin. Code tit. 8, Section 29.2(a)(3)(1987), by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that Petitioner charges:

14. The facts in Paragraphs A and A1-5.

15. The facts in Paragraphs B and B1-6.

16. The facts in Paragraphs C and C1-6.

17. The facts in Paragraphs D and D1-4.

18. The facts in Paragraphs E and E1-2.

DATED: New York, New York
July 26, 1989

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct

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

IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
HERBERT HALPER, M.D.	:	COMMITTEE

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

William W. Faloon, M.D., Chairperson, John T. Prior, M.D. and Ms. Jane McConnell 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 Section 230(10)(e) of the Public Health Law. Tyrone T. Butler, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this report.

SUMMARY OF PROCEEDINGS

Service of Notice of Hearing and Statement of Charges:	July 26, 1989
Prehearing conference:	August 17, 1989
Hearing Dates:	August 18, 1989
	October 13, 1989
	October 16, 1989
	October 23, 1989
Deliberations were held on:	December 8, 1989
	January 8, 1990

EXHIBIT "B"

Place of hearing:	8 East 40th Street New York, New York
Department of Health appeared by:	Peter J. Millock, Esq., General Counsel by Roy Nemerson, Esq. Office of Professional Medical Conduct 8 East 40th Street New York, New York
Respondent appeared by:	Wood & Scher, Esqs. by Anthony Z. Scher, Esq. The Harwood Building Scarsdale, New York 10583
Witnesses for Department of Health:	Dr. Eric J. Vanderbush, M.D.
Witnesses for Respondent:	Dr. Herbert Halper, M.D. (Respondent) Dennis Rucci Edward A. Lvovsky W[redacted] W[redacted] J[redacted] P[redacted]
Date Charges Amended:	October 23, 1989
Petitioner (Department) filed Proposed Findings of Fact, Conclusions of Law on:	December 1, 1989
Respondent filed Proposed Findings of Fact, Conclusions of Law on:	December 1, 1989

On July 26, 1989, the Respondent was served with the Notice of Hearing and Statement of Charges. The Department of Health and the Respondent presented their entire cases and the record was closed on October 23, 1989. On December 8, 1989 and January 8, 1990 the Hearing Committee held deliberations.

SUMMARY OF CHARGES

In the Statement of Charges (Dept's. Ex. 1 - copy attached), the Respondent, Herbert Halper, M.D., was charged with professional misconduct pursuant to Education Law §6509. The specific charges were: practicing the profession with negligence on more than one occasion [Education Law §6509(2)] (First specification), practicing the profession with incompetence on more than one occasion [Education Law §6509(2)] (Second specification), practicing the profession with gross negligence [Education Law §6509(2)] (Third through Seventh specifications), practicing the profession with gross incompetence [Education Law §6509(2)] (Eighth through Twelfth specifications).

The Respondent was further charged with unprofessional conduct [N.Y. Admin Code title 8, §29.1(b)(13)]. The specific charges were: failing to make records available (Thirteenth specification) and failing to maintain records (Fourteenth through Eighteenth specifications).

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. The Pre-hearing transcript was not made available to the Hearing Committee at the time of deliberations.

1. Herbert Halper, M.D. (hereinafter "the Respondent"), was authorized to practice medicine in New York State on October 9, 1947, by the issuance of license number 046748, 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 January 1, 1989, through December 31, 1991. (Ex. 1)

FINDINGS OF FACT PATIENT A

2. On at least 11 dates during a period beginning on or about March 24, 1980 and ending on or about October 29, 1984, Patient A sought medical care from the Respondent at his office, 3079 Brighton 13th Street, Brooklyn, N.Y. Patient A, female, was approximately 70 yrs. old in March of 1980. (Ex. 2, T. 435, 436, 527)

3. The Respondent was responsible for the care and treatment of Patient A, during the period March 24, 1980 through October 29, 1984, even though the patient was alleged to have been seen by other physicians and physician's assistants under the Respondent's direct supervision. Further, the Respondent billed Medicaid for treatment of Patient A during this period. (Ex. 2, 18, T. 435, 436)

4. The Respondent's medical records for Patient A, March 24, 1980 through October 29, 1984, are not signed or initialed, therefore the physician or PA who dictated the note cannot be identified. However, prescriptions and patient visit bills were submitted in the Respondent's name. (Ex. 18. T. 435, 436)

5. Dr. Bensianov was the physician who treated Patient A on April 22, 1983, May 1, 1984 and October 29, 1984, as indicated by the Medicaid printout. (Ex. 18, T. 431, 435)

6. The Respondent failed to record an adequate medical history for Patient A on March 24, 1980. (Ex. 2, T. 33-36, 128-129)

7. The record of the physical examination of Patient A, conducted on March 24, 1980, is incomplete in several pertinent areas, i.e: Blood pressure, pulse and respiration. (Ex. 2, T. 353-356)

8. Patient A did not have a proven dangerous cardiac problem when she was present at the Respondent's office on March 24, 1980. (Ex. 2)

9. Patient A was given a Complete Blood Count (CBC) on March 24, 1980. The laboratory results indicated a normal blood count. However, Respondent's records for Patient A indicate "...a shift to the left...". A "shift to the left" is a situation in which the younger white blood cells are present in the smear, this usually indicative of an infection. (Ex. 2, T. 45)

10. In the absence of a correcting note In Patient A's records for the March 24, 1980 CBC, it must be assumed that the Respondent accepted the "shift to the left" interpretation. (Ex. 2, T. 45)

11. Patient A agai consulted the Respondent on April 24, 1980. The Respondent failed to record an adequate medical history during this visit. The records of the physical examination conducted on this date are incomplete. However, Patient A did not have a proven dangerous cardiac problem when she was present on April 24, 1980. (Ex. 2, T. 48, 50, 52)

12. Patient A consulted the Respondent on March 3, 1981, after an absence of approximately one year without any other contact. Respondent failed to record an adequate medical history for Patient A during this visit and the record of the physical examination is incomplete. (Ex. 2, T. 55, 57.)

13. The medical note on March 3, 1981, for Patient A, indicates: high blood pressure, gallop rhythm, an EKG change from March 24, 1980, and severe chest pains. These findings indicate progressive cardiac disease. The Respondent did not prepare a treatment plan or make a referral in light of these new findings and changes in Patient A's condition. (Ex. 2, T. 57-60)

14. Patient A did not consult the Respondent again until December 3, 1981, when she was referred to a cardiovascular specialist. There is no written report in the patient's records from a cardiovascular specialist. The referral to a cardiovascular specialist should have been made on March 3, 1981. (Ex. 2)

15. Patient A consulted the Respondent on October 29, 1984 complaining of general weakness, shortness of breath and palpitations. She had a reasonably normal blood pressure and increased bronchial markings. An EKG performed on October 29, 1984 indicates a tachycardia. (Ex. 2, T. 66)

16. The Respondent failed to record an adequate medical history and physical examination for Patient A on October 29, 1984. (Ex. 2, T. 66)

17. The Respondent failed to take appropriate action and sent Patient A home without addressing the potentially cardiac problem, tachycardia. (Ex. 2, T. 66)

18. On or about March 11, 1982, April 15, 1982, April 22, 1983, March 7, 1984, May 1, 1984 and October 29, 1984, the Respondent prescribed various medication for Patient A. The medical records for Patient A do indicate the medications prescribed and, in general, the dosages. (Ex. 2, T. 68)

19. The use of a serum Digoxin or serum Potassium level is not ordinarily routine unless there is a reason to suspect an abnormality. (T. 139-142)

CONCLUSIONS - PATIENT A

The Committee finds unaminously that On March 24, 1980, the Respondent failed to record an adequate medical history, failed to record an adequate medical examination, incorrectly noted a CBC shift to the left and the presence of a left interior hemi-block not supported by the EKG. However, the committee does not find that the Respondent failed to take action regarding a potentially dangerous cardiac condition as the evidence does not indicate that such condition existed.

The Committee concludes that on April 24, 1980, when Patient A consulted the Respondent he failed to record an adequate history and record an adequate physical examination. The committee does not find evidence of a potentially dangerous cardiac condition on this date.

On March 3, 1981, the Committee finds that the Respondent failed to record an adequate history and physical examination. In addition, the respondent failed to make a timely referral to a cardiovascular specialist as was now indicated and take appropriate action in light of a potentially dangerous cardiac condition.

On October 29, 1984, the Respondent inappropriately noted that Patient A's EKG indicated a regular sinus rhythm when it did not. The Respondent failed to record an adequate medical history and physical examination. The Respondent also failed to take appropriate action in light of a potentially dangerous cardiac condition.

Although the medical records for Patient A indicate the medications and, in general, the prescribed dosages, the administration and dosage record is not adequate. The Committee agrees that serum Digoxin and serum Potassium levels are not mandated without a showing of some abnormality.

Therefore, the committee concludes that in his care and treatment of Patient A the Respondent was negligent and failed to maintain accurate records for this patient. However the committee does not find incompetence, gross negligence or gross incompetence as regards this patient.

FINDINGS OF FACT - PATIENT B

20. On approximately 51 occasions during the period October 12, 1981 through January 3, 1985, Patient B sought medical care from the Respondent at his medical office. Patient B was a male, approximately 68 years old in October of 1981. (Ex. 3)

21. The Respondent was responsible for the care and treatment of Patient B, during the period October 12, 1981 through January 3, 1985, even though the patient was alleged to have been seen by other physicians and physician's assistants under the direct supervision of the Respondent. Further, Respondent billed Medicaid for treatment of Patient B during this period. (Ex. 3, 18, T. 435-436)

22. Patient B was described as having a history of peptic ulcer and diagnoses of anemia, hiatus hernia, and defect in the prepyloric region. (Ex. 3)

23. Patient B received prescriptions for Motrin, Fiorinal and Clinoril at various times during the period, from May 6, 1982 through February 21, 1984. Drugs such as Motrin, Fiorinal and Clinoril are associated with gastrointestinal bleeding and present a risk to patients with pre-existing gastrointestinal disease. (Ex. 3,11,13,17, T. 184-186, 353-354)

24. When a patient is receiving medications such as Motrin, Fiorinal and Clinoril the reasonably prudent physician should obtain a stool test for occult blood. The Respondent did not obtain a stool test for Patient B during the time he was prescribed the aforementioned drugs. (Ex. 3, T. 183-187, 361)

25. On 11 occasions between February 8, 1982 and January 26, 1983, Patient B's medical records note a diagnosis of iron deficiency anemia. No laboratory tests including a serum iron and a ferritin level were performed and results obtained in order to support the diagnoses. (Ex. 3, T. 355-356)

CONCLUSIONS - PATIENT B

The Respondent prescribed drugs associated with gastrointestinal bleeding and Patient B had a history, known to the Respondent, of gastrointestinal disease, the Respondent did not obtain a stool test for occult blood.

Despite a noted diagnosis of iron deficiency anemia on at least 11 occasions the Respondent failed to order or perform the appropriate tests to support his diagnosis.

The committee finds that the Respondent was negligent in his care and treatment of Patient B and he failed to maintain the medical records of Patient B in a manner that accurately reflects the care and treatment of this patient. However, the committee does not find incompetence, gross negligence or gross incompetence in the Respondent's care and treatment of this patient.

FINDINGS OF FACT PATIENT C

26. During a period beginning on or about September 7, 1979 and ending on or about February 9, 1987, Patient C received medical care from the Respondent on approximately 53 occasions, at the Respondent's medical office. Patient C, male, approximately 64 years old in September of 1979. Patient C had a history which included a coronary, angina, intermittent claudication and difficulty in breathing. (Ex. 4, 18, T. 435-436)

27. The Respondent was responsible for the care and treatment of Patient C, on numerous occasions during the period noted above, even though the patient was alleged to have been seen by other physicians and physician's assistants under the direct supervision of the Respondent. Further, the Respondent billed Medicaid for treatment of Patient C during this period. (Ex. 4, 18, T. 435-436)

28. Patient C was examined by the Respondent on September 7, 1979 and September 11, 1979, and the physical examination revealed difficulty in breathing, wheezes and rales. (Ex. 4, T. 159-167)

29. Respondent failed to obtain serum electrolyte/chemistry prior to October 21, 1986, despite worsening signs of cardiac and possible renal disease. (Ex. 4, T. 193-196)

30. Respondent prescribed, the appropriate medications, a diuretic (Lasix) and a heart stimulant (Digoxin), to Patient C who was suffering from significant cardiac disease. (Ex. 4, T. 175-179)

31. Respondent prescribed Motrin, Feldene, Fiorinal, Meclomen, Naprosyn, and Synalgos DC to Patient C. The prescribing of these drugs to a patient with peptic ulcer disease and multiple gastrointestinal complaints is a calculated risk subject to the physician's judgement. (T. 184-186)

32. Respondent failed to obtain a stool test for occult blood, despite Patient C's condition and Respondent's prescription of Motrin, Feldene, Fiorinal, Meclomen, Naprosyn and Synalgos DC. (Ex. 4, T. 186-187)

33. On or about January 31, 1986, Patient C consulted the Respondent complaining of severe chest pain, multiple vision, syncopal episode and difficulty in breathing. A physical examination of Patient C revealed a severe systolic murmur, marked obesity, a blood pressure reading of 170/100, rales in both bases and marked pulmonary congestion. The patient's liver edge was palpable, his legs swollen and his left knee edematous. The medical notes indicated an "infectious problem," possible azotemia, and the presence of nephrosclerosis. (Ex. 4)

34. On January 31, 1986, Patient C's condition was such that he should have been hospitalized. The Respondent did not hospitalize Patient C, did not obtain a consult and did not see the patient again until after 18 days had elapsed. (Ex. 4, 18, T. 196-198)

35. The Respondent prescribed Feldene to Patient C on January 31, 1986. There is no laboratory evidence that Patient C had renal disease. Therefore the prescribing of Feldene did not constitute a departure from reasonable medical practice. (Ex. 4, 12, T. 201, 230-231)

36. A record of the dosages and the frequency of administration should be recorded in the patient's medical records. The medical records for Patient C do not reflect dosages or frequency of administration. (Ex. 4, T. 201-202)

CONCLUSIONS - PATIENT C

The Committee finds that there were significant abnormal findings made during Patient C's first two visits in September of 1979, and that the Respondent failed to do an appropriate follow-up until five months later.

The Respondent prescribed Lasix and Digoxin to Patient C, on or about April 10, 1980, who was suffering from cardiac disease. The Respondent failed to obtain a serum electrolyte/chemistry from Patient C until October 21, 1986.

The Respondent prescribed Motrin, Feldene, Fiorinal, Meclomen, Naprosyn and Synalgos DC to Patient C and failed to obtain a stool test for occult blood in order to monitor the patient's condition.

On January 31, 1986, despite the seriousness of Patient C's conditions and the diagnoses entered into the patient's medical records, the Respondent failed to hospitalize or take other necessary steps and did not see the patient again until 18 days later.

The Respondent failed to adequately note in the patient's records the dosages and administration schedule of prescribed medications.

The Committee finds that the prescribing of Lasix and Digoxin to a patient suffering from cardiac disease, peptic ulcer and multiple gastrointestinal complaints is not a departure from a reasonable standard of care.

Finally, the record does not offer any evidence that Patient C had renal disease, therefore, prescribing Feldene for this patient was not a departure from a reasonable standard of care.

Therefore, the committee concludes that the Respondent was negligent in his care and treatment of Patient C and failed to properly maintain records, for this patient, that accurately reflected the care and treatment of this patient. However, the committee does not find incompetence, gross negligence or gross incompetence in the care and treatment of this patient.

FINDINGS OF FACT - PATIENT D

37. During a period beginning on or about June 14, 1979 and ending on or about July 14, 1981, Patient D sought medical care from the Respondent on approximately 20 occasions, at Respondent's office. Patient D, female, was approximately 57 years old in June of 1979, had a history of myocardial infarction pancreatitis and cholecystitis. (Ex. 5 T. 283)

38. The Respondent was responsible for the care and treatment of Patient D, on numerous occasions during the above mentioned time period, not withstanding that the patient was alleged to have been seen by other physicians and physician's assistants in the employ of and under the direct supervision of the Respondent. Further, Respondent billed Medicaid for treatment of Patient D during this period. (Ex. 5, 18, T. 422, 435-436, 538-539)

39. On or about April 18, 1980, the Respondent noted a diagnosis for Patient D of unstable angina. A diagnosis of unstable angina would require the reasonably prudent physician to either hospitalize or treat the patient. The record indicates that the Respondent did not either hospitalize or treat Patient D for unstable angina. (Ex. 5, 283-286)

40 The diagnosis of unstable angina was not confirmed by either the Respondent, the Department's medical expert or laboratory tests. (Ex. 5, 283, 285-286)

41. On June 20, 1980, Patient D visited Respondent at his medical office and complained of syncope and light-headedness. A cursory neurological examination was performed. (Ex. 5, T. 286-289)

42. On July 29, 1980, Patient D visited the Respondent's offices complaining of shortness of breath. She was diagnosed as suffering from congestive heart failure. The Respondent did a urine test, CVC and a rudimentary physical examination. He did not perform an EKG or order a chest X-ray. (Ex.5, T. 290-293)

43. On December 2, 1980, Patient D was examined by the Respondent and a note was entered into the patient's medical record to the effect "...observe for possible Ca metastasizing from breast,...". The record does not indicate that a breast examination, bone examination, an appropriate SMA or mammography was performed. The Respondent failed to adequately pursue and note additional relevant medical history. (Ex.5, T. 293-296)

CONCLUSIONS - PATIENT D

The committee finds that on April 18, 1980, after recording a diagnosis of "unstable angina", the Respondent was negligent in his failure to properly treat or hospitalize Patient D.

On July 29, 1980, after diagnosing Patient D as suffering from congestive heart failure the Respondent was negligent in his failure to perform the appropriate examinations and note in the patients records an appropriate medical history.

Finally, on December 2, 1980, the Respondent was negligent in his failure to perform the proper examinations after noting in the patient's records "...observe for possible Ca...". In addition, a relevant medical history was not noted.

There was no credible evidence in the record that the diagnosis of June 20, 1980, unstable angina, was confirmed. In addition, the charge that the Respondent failed to perform a neurological examination at that time is unsupported, insofar as necessary appropriate neurological observations were carried out.

Therefore the committee concludes that the Respondent was negligent in his care and treatment of Patient D and failed to maintain records that accurately reflected the evaluation and treatment of this patient. The committee does not find that the Respondent was incompetent, grossly incompetent or grossly negligent in the care and treatment of this patient.

FINDINGS OF FACT - PATIENT E

44. During a period beginning on or about October 14, 1974, and ending on or about December 2 1980, Patient E, male, was treated by the Respondent on approximately 70 occasions. Patient E was approximately 77 years old in October of 1974. (Ex. 6, 18, T. 320)

45. Respondent was r ponsible for all of the evaluation, care and treatment of Patient E. (Ex. 6, 18, T. 428)

46. On November 30, 1978, Patient E visited the Respondent and his medical records indicate that he had a squamous sebaceous cell Ca. of the left ear. Patient E was recommended to a surgeon by the Respondent. The Respondent did not note in the patient's medical records the results of either a work-up or of the recommendation. (Ex. 6, T. 320)

47. On May 4, 1979, the Respondent noted that a chest X-ray indicated a possible tumor in Patient E's right upper lobe. The Respondent did not note any follow-up diagnostic testing. The Respondent did note in the patient's records his reasons for failure to elucidate the pulmonary diagnosis. (Ex. 6)

CONCLUSIONS PATIENT - E

The committee finds that although the Respondent did not note the results of a work-up or of the results of his recommendation that Patient E see a surgeon, regarding the squamous sebaceous cell Ca of the left ear, this failure is not indicative of negligence or incompetence in the Respondent's treatment of Patient E.

The committee believes the Respondent's testimony and is convinced that he did not pursue further diagnostic testing, regarding the patient's possible pulmonary tumor, as a result of the Patient and his family's request. Therefore, we do not find his actions in this instance negligent, incompetent, grossly negligent or grossly negligent. However, the committee does find that the Respondent failed to maintain records that accurately reflected the evaluation and treatment of this patient.

FINDINGS OF FACT ALLEGATION F

48. The Respondent was served with a non-judicial subpoena duces tecum, dated September 14, 1988, requesting the medical files of 10 of the Respondent's patients, including patients A - E above. (Ex. 7)

49. Respondent, through his attorney, requested withdrawal of the subpoena by letter dated October 19, 1988. The Department denied this request, in response, by letter, dated October 26, 1988. There is no evidence that the Department instituted any other action to enforce its subpoena. (Ex. 7)

CONCLUSIONS ALLEGATION E

The committee concludes that the issues alleged in Allegation E are not issues of fact but relevant matters of law.

The committee does not believe that it is qualified to find upon the obvious legal questions to wit: whether or not the Department exhausted all of its legal options in order to enforce the subpoena, whether the method used (subpoena duces tecum) was the proper one and, finally, was the authority of 8 NYCRR §29.1(b)(13)(1987), actually invoked as the basis of the records request.

GENERAL CONCLUSIONS

An overall review of the patient records for Patients A - E failed to reveal a signature or initial of the attending physician on any of the patient records. However, a review of the New York State Department of Social Service's Record of Billing (Ex. 18), indicates that the Respondent billed under his name for most of the patient visits that were cited in the Statement of Charges. In addition, the Respondent was responsible for the prescriptions given to patients A - E, which were listed under his name on the Medicaid printout (NYS Department of Social Service's Record of Billing, Ex. 18).

The Respondent stated, during his testimony, that he was the owner and operator of the medical facility located at 3079 Brighton 13th Street, Brooklyn, New York, known as "Halper Medical Services P.C.". Further, he stated that he was present during business hours and functioned as the supervisor of all medical activity. (T. 435)

Therefore, the committee rejects the Respondent's contention that he was not responsible, at any point, for the medical care, treatment and maintenance of medical records for Patients A - E.

The committee recognizes that there may have been communication difficulties, due to the language barrier, between the Respondent and many of his patients, including Patients A - D. However, the employment of Russian speaking physicians and physician's assistants did not absolve the Respondent of the ultimate responsibility for the care and treatment of the patients consulting his office.

The Department's expert witness, Dr. Vanderbush, testified that his practice and expertise was developed in the context of a teaching or academic milieu. However, in this area he has had a great deal of patient responsibility. Dr. Halper, although presently certified as a family practitioner and currently primarily engaged in clinical practice, has had substantial experience in academic medical centers not entirely unlike that of Dr. Vanderbush.

Therefore the committee finds that the argument proposing that Dr. Vanderbush is not qualified to comment on standards of practice, as they apply to Dr. Halper, is spurious and not applicable in this instance. The committee found Dr. Vanderbush to be a credible, consistent and competent witness. The Respondent did not offer any position other than his own in rebuttal to the Department's expert witness.

The committee would also like to note that it is very disturbed by Dr. Halper's testimony, during this proceeding, that he relies upon "total recall" instead of adequate written medical records.

The Hearing Committee unanimously reached each of the following conclusions:

The committee finds that as alleged the Respondent has practiced the profession with negligence on more than one occasion (First Specification) and failed to maintain adequate medical records (Fourteenth through Eighteenth Specification). However, the committee has not found evidence that the Respondent has practiced the profession with incompetence on more than one occasion (Second Specification), practiced the profession with gross negligence (Third through Seventh Specification) or gross incompetence (Eighth through Twelfth Specification). As noted above the committee does not make any conclusions as regards the allegation that the Respondent failed to make medical records available (Thirteenth Specification).

RECOMMENDATION

The Committee recommends unanimously that the Respondent be suspended from the practice of medicine for the period of one year with eight months of the suspension period stayed pending the Respondent's compliance with an OPMC inspection of his medical records. In addition, the Respondent should be assessed a fine of Ten Thousand Dollars ($10,000).

DATED: New York, N.Y.
March 2, 1990

Respectfully submitted

William W. Faloon, M.D.
Chairperson
John T. Prior, M.D.
Ms. Jane McConnell

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

IN THE MATTER :

OF :

HERBERT HALPER, M.D. :

COMMISSIONER'S RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on August 18, 1989, October 13, 1989, October 16, 1989 and October 23, 1989. Respondent, Herbert Halper, M.D., appeared by Anthony Z. Scher, Esq. The evidence in support of the charges against the Respondent was presented by Roy Nemerson, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be accepted with one modification. The total period of suspension should be two years. The last 20 months of such suspension should be stayed. This will allow some greater monitoring of Respondent's practice which I believe is essential to protect his patients.

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
May 21, 1990

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

HERBERT HALPER

CALENDAR NO. 11009

The University of the State of New York

IN THE MATTER

OF

HERBERT HALPER
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11009

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11009, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (October 19, 1990): That, in the matter of HERBERT HALPER, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 49 findings of fact, and the Commissioner of Health's recommendation as to those findings of fact, be accepted;
2. The hearing committee's conclusions as to the question of respondent's guilt be accepted, except that the hearing committee's failure to reach any conclusion as to the thirteenth specification not be accepted, and the Commissioner of Health's recommendation as to those conclusions be accepted, except that the Commissioner of Health's failure to reach any conclusion as to the thirteenth specification not be accepted;
3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified; and
4. Respondent is guilty, by a preponderance of the evidence,

of the first specification of the charges to the extent indicated in the hearing committee report, and the fourteenth through eighteenth specifications of the charges, and not guilty of the remaining charges, including the thirteenth specification;

that the penalty recommendation of the Regents Review Committee be modified and, based upon a more serious view of the misconduct committed, respondent's license to practice as a physician in the State of New York be suspended for two years upon each specification of the charges of which respondent was found guilty, said suspensions to run concurrently, and that execution of said suspensions be stayed; and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 26th day of October, 1990.

/Thomas Sobol

Commissioner of Education