STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Dennis P. Whalen
Executive Deputy Commissioner

February 10, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Leslie Eisenberg, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

Bruce V. Hillowe, JD, Ph.D.
The Chancery
190 Willis Avenue-Suite 100
Mineola, New York 11501

Monroe Harris, D.O.
165-15 71st Avenue
Flushing, New York 11365

Monroe Harris, D.O.
262-04 Hungry Harbor Road
Rosedale, New York 11432

RE: In the Matter of Monroe Harris, D.O.

Dear Parties:

Enclosed please find the Determination and Order (No.99-31) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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 penalties **other than suspension or revocation** 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

MONROE HARRIS, D.O.

DETERMINATION

AND

ORDER

OPMC-99-31

MICHAEL R. GOLDING, M.D., Chairperson, **JOHN T. PRIOR, M.D.** and **MR. ALAN KOPMAN,** 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 Section 230(10)(e) of the Public Health Law. **MICHAEL P. MCDERMOTT, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	October 14, 1998
Pre-Hearing Conference:	October 21, 1998
Hearing Dates:	November 5, 1998 December 15, 1998 December 16, 1998 December 17, 1998

Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Date of Deliberations:	January 20, 1999
Petitioner appeared by:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health by: Leslie Eisenberg, Esq. Asst. Counsel, of Counsel
Respondent appeared by:	Bruce V. Hillowe, JD., Ph.D. The Chancery 190 Willis Ave, Suité 100 Mineola, New York 11501

WITNESSES

For the Petitioner	(1) Steven Heymsfield, M.D.
For the Respondent	1) Monroe Harris, D.O. the Respondent 2) Patient A 3) Patient B 4) Patient C 5) Stephen D. Migden, Ph.D. 6) Louis Reznick, D.O. 7) David M. Benjamin, Ph.D.

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with Fraudulent Practice, Moral Unfitness, Making or Filing a False Report, Negligence on More Than One Occasion, Incompetence on More Than One Occasion and Failure to Maintain Records.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made part hereof.

FINDINGS OF FACT

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 findings. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

FINDINGS AS TO THE RESPONDENT

1. Monroe Harris, D.O., the Respondent, was authorized to practice medicine in New York State on February 15, 1964, by the issuance of license number 091907 by the New York State Education Department. (Pet's. Ex. 2a)

2. The Respondent received his D.O. degree from the College of Osteopathic Medicine and Surgery in 1963. He performed his internship at Saginaw Osteopathic Hospital and his residency at Allentown Osteopathic Hospital. He is board certified in both family practice and geriatrics. (Resp's. Ex. G; Tr. 199-201).

3. From 1965 to the present, the Respondent has maintained a family practice. From 1989 to the present, he has maintained offices at 165-15 71st Avenue, Flushing, New York 11365 and at 262-04 Hungry Habor Road, Rosedale, New York 11432. About 25% of his current patient caseload are weight management patients. (Resp. Ex. G; Tr. 199-201).

FINDINGS AS TO THE ISSUE OF FRAUD

4. The Respondent had hospital privileges at several hospitals including the Catholic Medical Center of Brooklyn and Queens, Inc., Deepdale General Hospital and Little Neck Community Hospital (Pet's. Exs. 6,7,8,9 and 10; Resp's. Ex. G)

5. On November 16, 1992, the Respondent entered into a Stipulation and Order with the New York State Department of Health, Bureau of Controlled Substances, in which the Respondent, admitted to failures regarding the dispensing of controlled substances in violation of Article 33 of the Public Health law.(Pet's. Ex.14).

6. On December 2, 1992, said Stipulation and Order was so ordered by the Commissioner of Health, by which Stipulation and Order the Respondent was sanctioned for violations of Article 33 of the New York Public Health Law and 10 NYCRR 80. 72, with a penalty of $4,000 fine, $2,000 of which was suspended (Pet's. Ex. 14; Tr. 209).

7. Prior to the imposition of the aforesaid sanction, and while under investigation by the New York State Department of Health, Bureau of Controlled Substances, the Respondent failed to disclose on three reappointment applications, i.e., two applications to the Catholic Medical Center of Brooklyn and Queens, Inc. dated September 23, 1990 and September 4, 1992 respectively, and one application to Deepdale General Hospital dated December 6, 1991, that he was under investigation by the State Department of Health. (Pet's. Ex. 6, 7 and 8).

8. On May 5, 1994, following the imposition of Commissioner's Order of December 2, 1992, the Respondent failed to disclose on a reappointment application to Little Neck Community Hospital that he had been professionally disciplined. (Pet's. Ex. 9; Tr. 217-219)

9. On September 1, 1994, the Respondent signed an Application for Consent Order with the New York State Department of Health, Board for Professional Medical Conduct, in which he admitted prior violations of Article 33 of the New York Public Health Law (the same violations that had led to the prior sanction by the Department of Health, Bureau of Controlled Substances) (Pet's. Exs. 14 and 15).

10. On September 3, 1994, the Respondent failed to disclose on an application for reappointment to the Catholic Medical Center of Brooklyn and Queens, Inc. that he had been previously sanctioned by the Department of Health, Bureau of Controlled Substances, and further, he also failed to disclose on said application that he was under current investigation by the Board for Professional Medical Conduct.

    The Respondent testified that with hindsight he would have answered differently in this particular application. (Pet's. Ex.10; Tr. 219-223).

11. On September 26, 1994, the Respondent was notified by the Board for Professional Medical Conduct that the Application for Consent Order had been granted; that the effective date of the Order would be October 3, 1994, and that the imposed penalty would be a two years stayed suspension and a $2000 fine (Pet's. Ex. 15)

12. On August 23, 1995, the Governing Board of the Catholic Medical Center voted not to reappoint the Respondent to the hospital staff based on his failure to disclose the suspension of his medical license on his reappointment application.

    Pursuant to the Catholic Medical Center staff by-laws, the Respondent requested a hearing. (Pet's. Exs. 12 and 16, pp.5-6).

13. On September 25, 1995, the Respondent participated in a hearing regarding his staff reappointment before the Catholic Medical Center Board of Trustees Ad Hoc Committee (Pet's. Ex.16).

14. On October 19,1995, the Catholic Medical Center notified the Respondent that the Ad Hoc Committee had upheld the vote denying him reappointment to the hospital staff. The Respondent appealed. (Pet's. Ex. 13)

15. On December 11, 1995, the Respondent participated in another hearing regarding his staff reappointment before the Catholic Medical Center Board of Trustees. (Pet's. Ex.17)

16. On March 11, 1996, the Catholic Medical Center advised the Respondent that the Board of Trustees had voted to deny his reappointment to the hospital staff, and that effective immediately, all rights and privileges afforded to the Respondent were no longer in effect. (Pet's. Ex. 11).

17. On November 4, 1996, the Respondent submitted a completed license registration renewal form to the New York State Department of Education on which he represented that no

hospital had restricted or terminated his employment or privileges when, in fact, he knew by March 11, 1996, that the Catholic Medical Center had not reappointed him to the hospital staff and had effectively revoked any rights and privileges he previously had at the hospital. (Pet's. Ex. 2b and Ex.11).

18. Dr. Stephen D. Migden, a clinical psychologist and expert witness for the Respondent, testified that the Respondent suffers from learning disabilities: attention deficit hyperactivity disorder, disorder of written expression and dyslexia.

Dr. Migden further opined that such disabilities might have caused the Respondent to misunderstand or be confused about the questions on the applications which he is accused of falsifying (Resp's. Ex. C; Tr. 423-493).

HEARING COMMITTEE CONCLUSIONS AS TO THE ISSUE OF FRAUD

The Hearing Committee rejects Dr. Migden's opinion that the Respondent's learning disabilities "might" have caused the Respondent to misunderstand or be confused about the questions on the applications which he is accused of falsifying.

The Respondent is a graduate of the College of Osteopathic Medicine and Surgery and is board certified in both family practice and geriatrics. He has practiced medicine for 33 years. Given this background, the Hearing Committee believes that the contention that the Respondent misunderstood or was confused about questions on the applications in question is just not plausible.

The Respondent's own testimony demonstrates the implausibility of this claim since he testified that he has known that he has learning disabilities and yet, has managed to complete his education and training and maintains an active, successful practice. (Tr. 232,269-273).

In addition, at the Catholic Medical Center hearings regarding his reappointment, the Respondent provided several reasons why he completed his application in the manner that he did. His reasons included that he was in a hurry, his secretary read it to him, he was in denial, and that since his sanction was not in effect at the time he signed the application, he had a "ratification period" in which he was not obligated to disclose the suspension of his medical license (Pet's Ex. 16, pp 9-10, 12, 14; Tr. 221, 571)

At no time did he claim that he was confused due to a learning disability.

Based on a preponderance of the credible evidence, the Hearing Committee concludes that the Respondent falsely represented his professional status and prior disciplinary history on hospital staff reappointment applications and on the license registration renewal form which he submitted to the State Department of Education. In each instance, the Respondent knew that the information he was providing was false, and he intended to mislead the recipients with his false representations.

GENERAL FINDINGS RE: PRESCRIBING APPETITE SUPPRESSANT MEDICATIONS

19. In his bariatrics practice, the Respondent treats patients for weight loss with appetite suppressant medications, primarily Didrex.

Didrex is a schedule III controlled substance. Adipex, Pondimin, Tenuate and Redux, the other medications prescribed by the Respondent in treating patients for weight reduction, are schedule IV controlled substances. (Tr. 33-34, 85, 203-204, 742-748).

20. The appetite suppressant medications prescribed by the Respondent are anorexiants which suppress the appetite by acting on the sympathetic nervous system.

These medications can elevate blood pressure, cause palpitations, tachycardia, insomnia and dry mouth. They are contraindicated in patients with hypertension, cardiovascular disease, a history of drug abuse and for women who are or may become pregnant.(Resp's Ex. B; Tr. 37-38,758).

21. Before prescribing appetite suppressant medications, a reasonably prudent physician takes a complete history, including a medical, nutritional and social history.

As part of a complete history, the physician looks for:

- obesity related illnesses such as diabetes, gallstones, heart disease, osteoarthritis and thyroid disease
- what other medications the patient is taking
- the patients' prior diet attempts
- what types of food the patients eats
- the patient's exercise habits
- if the patient's parent's, children and/or siblings are or were obese
- what the patient's weight record has been throughout life.

Where a checklist-type form is used and completed by the patient, the physician should personally evaluate the information and note additional information obtained after talking to the patient. (Tr. 27-29, 605, 759-761)

22. Before prescribing appetite suppressant medications, a reasonably prudent physician performs a baseline physical examination. For weight control, a focused physical examination, including the patient's vital signs, head, eyes, ears, neck, thyroid gland, heart, lungs and abdomen, is sufficient.

23. Before prescribing appetite suppressant medications, a reasonably prudent physician orders laboratory tests, including blood tests, as a baseline. Specifically, lab tests for abnormal lipid levels, abnormal blood sugar and abnormal uric acid levels should be performed. Lab tests are important to look for comorbidity, to help determine what further evaluations are needed, and to assist in evaluating possible toxicity. (Tr. 28, 47-50,605, 759-761).

24. During the course of long term treatment with appetite suppressant medications, a reasonably prudent physician monitors the patient.

Monitoring includes:

- follow-up visits, at least monthly:
- physical examination of vital signs including blood pressure and weight
- history, focusing on diet, exercise and side effects, and
- repeat lab tests every three to six months, to check if comorbidities are improving and if the patient is experiencing side effects or toxicity. (Tr. 40-41, 50, 759-761)

25. Physicians must keep accurate medical records that reflect the care and treatment provided to a patient

- to assist the physician while treating the patient and
- to aid any subsequent treating physician to understand what was done and why. (Tr.29)

FINDINGS AS TO PATIENT A

26. During the period, May 16,1987 through May 1, 1996, the Respondent treated Patient A at his offices in Flushing, N.Y. and Rosedale, N.Y.

At the time of his initial visit, Patient A was 32 years old; 5 feet 8½ inches tall and weighed 145 pounds. He was not over weight (Pet's. Exs. 3a and 3b; Tr. 27, 608).

27. The Respondent failed to take and/or note an adequate history for Patient A in that:

- he failed to note a chief complaint or problem for which the patient sought treatment
- he failed to make a diagnosis of the patients condition
- he failed to record any information regarding Patient A's attempts to lose (or maintain) weight or about his diet and exercise habits
- he failed to note any information about Patient A's medical, nutritional or social history. (Tr. 27-30, 620, 622, 646).

28. There is nothing in the patient's medical record to indicate that the Respondent performed an adequate initial physical examination of Patient A (Pet's. Exs. 3a and 3b).

29. The Respondent prescribed Didrex, an appetite suppressant medication, for Patient A. This was inappropriate because Patient A was not overweight (Tr. 27, 620).

30. The Respondent continued to prescribe Didrex for Patient A for approximately nine years, with the patient returning for follow-up visits on an almost monthly basis.

    Patient A gained weight during this nine year period. (Pet's. Ex. 4b pp. 8-19 Tr. 39,44, 623-624)

31. Prior to initiating treatment with appetite suppressant medications, the Respondent failed to determine if Patient A had any comorbidities and/or any contraindicated conditions. (Tr.51).

32. Throughout the nine year period of treatment, the Respondent failed to order and/or perform any laboratory tests whatsoever.

    The Respondent explained that he does not perform lab tests because they are expensive and because they are for research; he just treats patients (Tr. 47-49, 307-308, 635).

33. The Respondent failed to perform adequate periodic physical examinations of Patient A. In fact, for three years, the Patient A's medical record only indicates dates, patient's weight and occasional blood pressure readings (Pet's. Ex. 3b, pp. 8-14; Tr.32).

34. The Respondent failed to appropriately monitor Patient A during the nine year period of treatment. The medical record does not reflect adequate follow-up histories, physical examinations, counseling, or laboratory tests (Tr. 42-51, 635)

35. The Respondent provided two sets of patient records for Patient A, certifying that each was a complete and true copy. The two records contain different information.

(Pet's. Ex. 3a and 3b).

The Respondent's contents that his secretary copied the records incorrectly (Tr. 293, 312, 323, 326, 330)

36. The Respondent's records for Patient A included typed versions of his handwritten notes. (Pet's. Ex. 3b. pp 22-27).

The transcripts, which were prepared by the Respondent at the request of the OPMC Physician Monitoring Unit for the purpose of evaluating the Respondent while he was on probation, contain additional information that does not appear in his handwritten records. (Tr. 81, 310, 312, 522-523, 672-675).

37. The Respondent's typed records include a note that "[t]he above patient advised us that he had blood work recently from Dr. Calebretta, and had normal results". (Pet's. Ex. 3b, p.27) This notation is useless since it details nothing about what tests were performed, when they were performed and what were the results (Tr. 320, 645-646).

38. The Respondent failed to maintain medical records that accurately reflect the care and treatment of Patient A. In fact, the Respondent's own medical expert testified that if he were to take over the treatment of this patient with this record, he would have to start from scratch. (Pet's. Exs. 3a and 3 b;Tr. 30,75,88,617,620,622, 634-646).

CONCLUSIONS OF THE HEARING COMMITTEE

AS TO PATIENT A

Based in the foregoing findings of fact, the Hearing Committee concludes as follows:

- the Respondent failed to take and /or note an adequate history for Patient A.
- the Respondent failed to perform and/or note an adequate physical examination for Patient A.
- the Respondent failed to appropriately treat Patient A for weight loss, including but not limited to, inappropriately prescribing Didrex, an appetite suppressant medication.
- the Respondent failed to appropriately monitor Patient A.
- the Respondent failed to maintain a medical record which accurately reflects the care and treatment of Patient A.

FINDINGS AS TO PATIENT B

39. During the period of January 4, 1994 through June 5,1998, the Respondent treated Patient B at his office in Flushing, N.Y.

    At the time of her initial visit, Patient B was eighteen years old; 5 feet 5 inches tall and weighed 229 pounds. All medical witnesses agree that Patient B was obese (Pet's Exs. 4a and 4b; Tr. 12, 499, 648).

40. The Respondent had Patient B complete a patient history form and took an oral history of her presenting problem (Pet's. Ex. 4b; Tr. 388, 498-499).

41. The Respondent performed an adequate initial physical examination of Patient B (Pet's. Ex. 4b; Tr. 390, 504-505).

42. The Respondent prescribed several appetite suppressant medications for Patient B based on her current history of obesity, her inability to control her weight with diet and exercise alone, and her response to medications. He counseled Patient B about the continuing importance of diet and exercise in controlling her weight; he gave her a written diet program, and counseled her about the risks and the benefits associated with the long-term off-label use of appetite suppressant medications. He specifically counseled Patient B about the potential dangers posed by the medication to an unborn child. (Pet's. Ex. 4a; Tr. 387-392, 498-518).

43. The Respondent monitored Patient B during treatment through regular physical examinations and by asking the patient about any side-effects. (Pet's. Ex. 4b; Tr. 389-392, 506-508).

44. The Respondent's medical records are barely adequate with regard to his treatment and care of Patient B. (Pet's. Ex. 4a and 4b).

45. The Respondent provided two sets of patient records for Patient B, certifying that each was a complete and true copy. The first set of records did not included Patient B's first five visits (Pet's. Ex. 4a, pg 4); the second set includes information relating to another patient (Pet's. Ex. 4b, pg. 7) and, both sets included transcribed portions with additional information not found in the Respondent's handwritten notes. (Pet's. Ex. 4b, pg. 8-11, Tr. 81, 113, 521-523, 672-675).

CONCLUSION OF THE HEARING COMMITTEE AS TO PATIENT B

The Hearing Committee determines that Patient B was a very credible witness. Given the compelling nature of her testimony and the marginal adequacy the patient's medical record, the Hearing Committee concludes that there is not a preponderance of evidence to support the charges against the Respondent relating to his treatment of Patient B.

FINDINGS AS TO PATIENT C

46. During the period, June 1981 through July 1998, the Respondent treated Patient C at his office in Flushing, N.Y. Patient C is Patient B's mother.

    At the time of her initial visit, Patient C was approximately 45 years old, 5 feet tall and weighed 145 pounds. All medical witnesses agree that she was overweight. (Pet's. Ex. 5b; Tr. 124, 550,682).

47. The Respondent failed to take and/or note an adequate history for Patient C in that:

    - he failed to note a chief complaint or problem;
    - he failed to make a diagnosis;
    - he failed to note any information regarding Patient C's prior weight loss efforts, diet and exercise habits
    - he failed to take any medical, nutritional and/or social history

In addition, although the record includes a history form on which the patient indicated that she had high blood pressure and open heart surgery, the Respondent failed to note these facts, or any history, in the patient's medical record.

Further, the only reference to a date on the history form is the patient's last physical which she indicated was on performed by the Respondent. on May 1, 1994. However, there is no corresponding note for a physical, or an office visit, in the patient's medical record. (Tr. 126-127, 582).

48. The Respondent inappropriately treated Patient C for weight loss with appetite suppressant medications since she had contraindicated conditions, i.e., hypertension and heart diease. The Respondent testified, that he knew that Patient C had these conditions. (Tr. 125, 132, 136, 550, 582-583, 694, 705).

49. Although Patient C was being treated during the same period by other physicians, the Respondent never obtained medical records regarding Patient C from any of the other treating physicians (Tr.694).

50. The Respondent failed to order and/or perform any laboratory tests for Patient C. Prior to initiating treatment, the Respondent failed to determine if Patient C had any comorbidities and/or contraindicated conditions. Over the course of at least 17 years of treatment, the Respondent never ordered or performed any lab tests for Patient C. (Tr. 128, 693, 695).

51. The Respondent failed to perform adequate periodic physical examinations on Patient C. For several years of treatment, the Respondents records only reflect dates and Patient C's weight. (Pet's. Ex. 5b, p.4, 17-19; 22-23; Tr. 128, 135).

52. The Respondent primarily prescribed Didrex for Patient C. However, at times he changed her medication to Adipex and Pondimin (fen-fen), but failed to record any explanation for changing the medications. (Pet's. Ex. 5b, pp.6-7; Tr. 133)

53. The Respondent first prescribed fen-fen for Patient C on March 3, 1995 but failed to advise her about the risk of primary pulmonary hypertension associated with taking fen-fen. Although the record indicates "PPH", there is no evidence that the Respondent actually advised Patient C regarding the risks involved. (Pet's. Ex. 5b, p.7).

54. The Respondent failed to appropriately monitor Patient C during treatment. Although the Respondent and Patient C both testified that at follow-up visits the Respondent checked Patient C's blood pressure, heart and lungs, and counseled her about diet and exercise, the medical records do not reflect adequate follow-up histories, physical examinations, counseling, inquires about side effects and/or repeat lab tests. (Tr. 134-135, 142, 693, 695, 699-701).

55. Over the 17 years that the Respondent treated Patient C with appetite suppressants, she gained weight. The Respondent failed to discontinue her medication; try other modalities of treatment, or refer her to a specialist.

56. Patient C testified that she wanted the pills because she liked the way she felt; the pills gave her energy. (Tr. 407, 419).

57. The Respondent provided two set of patient records for Patient C, certifying that each is a complete and true copy.

The records are so out of order that even the Respondent couldn't figure out the date of Patient C's first visit. (Tr. 558, 563-565).

Patient C's visits are missing from the first set of records, and the typed portions have additional information that is not in the Respondent's handwritten notes. (Pet's. Ex. 5b, pp 9-13; Tr.81)

58. The Respondent failed to record Patient C's heart condition, her two angioplasties and the identity of her cardiologist in her medical record (Pet's. Ex. 5a and 5b)

59. The Respondent failed to maintain records that accurately reflect the care and treatment of Patient C. (Pet's. Exs. 5a and 5b).

CONCLUSIONS OF THE HEARING COMMITTEE AS TO PATIENT C

Based on the foregoing Findings of Fact, the Hearing Committee concludes as follows:

- the Respondent failed to take and/or note an adequate history of Patient C.
- the Respondent failed to perform and/or note adequate physical examination.
- the Respondent inappropriately prescribing Didrex and other appetite suppressant medications for a patient suffering with coronary arterial disease with significant symptoms which required two angioplasties.

- the Respondent failed to appropriately monitor Patient C during treatment.
- the Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient C.
- The Respondent's treatment of Patient C fell so far below the minimum standards of acceptable medical practice that it constituted gross negligence.

VOTE OF THE HEARING COMMITTEE

(ALL VOTES WERE UNANIMOUS UNLESS OTHERWISE SPECIFIED)

FIRST THROUGH SIXTH SPECIFICATION: FRAUDULENT PRACTICE

SUSTAINED As to all the changes specified in the Statement of Charges.

SEVENTH SPECIFICATION: MORAL UNFITNESS

NOT SUSTAINED As to any of the charges specified in the Statement of Charges.

NOTE: Although the Hearing Committee voted to sustain the fraudulent practice charges against the Respondent, the Hearing Committee has determined the Respondent's actions in this regard do not rise to the level of Moral Unfitness.

EIGHT THROUGH THIRTEENTH SPECIFICATION:

MAKING OR FILING A FALSE STATEMENT

SUSTAINED As to all the charges specified in the Statement of Charges.

FOURTEENTH SPECIFICATION:

NEGLIGENCE ON MORE THAN ONE OCCASION

SUSTAINED As to those charges specified in paragraphs G (1), G (2), G (3), G (4), G (5), I(1), I (2), I (3), I (4) and I (5) of the Statement of Charges.

NOT SUSTAINED As to those charges specified in paragraphs H (1), H (2), H (3), H (4), and H (5) of the Statement of Charges.

NOTE: The Hearing Committee concluded that the Respondent's medical records for Patient B were only marginally acceptable but the inadequacies do not constitute negligence.

FIFTEENTH SPECIFICATION: INCOMPETENCE ON MORE THAN ONE OCCASION

SUSTAINED As to those charges specified in paragraphs G (1), G (2), G (3), G (4), G (5), I (1), I(2), I (3), I (4) and I (5) of the Statement of Charges.

NOT SUSTAINED As to those charges specified in paragraphs H (1), H (2), H (3), H (4) and H (5) of the Statement of Charges.

SIXTEENTH THROUGH EIGHTEENTH SPECIFICATIONS:

FAILURE TO MAINTAIN RECORDS

SUSTAINED As to those charges specified in paragraphs G (5) and I (5) of the Statement of Charges.

NOT SUSTAINED As to those charges specified in paragraphs H (5) of the Statement of Charges.

DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee has concluded that the Respondent's treatment of Patient A was negligent; his treatment of Patient B just barely met the minimum standards of acceptable medical care and his treatment of Patient C was grossly negligent.

Although this case was limited to the consideration of the Respondent's treatment of three patients, the Hearing Committee is convinced that they are representative of the Respondent's medical practice.

The Respondent has submitted two sets of medical records for each of three patients considered in this case. The Hearing Committee has noted that the second sets are much more

detailed than the first sets and were obviously not prepared contemporaneously with the events. but were prepared later in anticipation of review.

The Hearing Committee is convinced that the Respondent does not recognize his shortcomings, and given his age and his attitude, he is not a candidate for training.

Based on the fact that the Hearing Committee has voted to sustain six charges of fraudulent practice; six charges of making a false report; ten charges of negligence; ten charges of incompetence and two charges of failure to maintain records, and also considering the Respondents previous violations of the Public Health Law, the Hearing Committee determines by a vote of 2-1 that the Respondent's license to practice medicine in the State Of New York should be **REVOKED.**

ORDER

IT IS HEREBY ORDERED THAT

1. The Respondent's license to practice medicine in the State of New York is hereby **REVOKED**
2. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: New York, New York
4 Feb 1999

Michael R. Golding, M.D.
Chairman

John T. Prior, M.D.
Mr. Alan Kopman.

APPENDIX ONE

Petitioner's Ex Exhibit
DATE 10/21/98

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

IN THE MATTER
OF
MONROE HARRIS, D.O.

STATEMENT

OF

CHARGES

MONROE HARRIS, D.O., the Respondent, was authorized to practice medicine in New York State on or about February 15, 1964, by the issuance of license number 091907 by the New York State Education Department. On or about October 3, 1994, Respondent became subject to an Order issued by the State Board of Professional Medical Conduct which imposed a disciplinary sanction of a two years stayed suspension of his medical license, two years probation and a $2,000 fine. Respondent is currently registered with the New York State Department of Education to practice medicine for the period March 1, 1997 through February 28, 1999. From at least 1989 to the present, Respondent has maintained offices at 165-15 71st Avenue, Flushing, New York 11365 and 262-04 Hungry Harbor Road, Rosedale, New York 11432 (hereinafter Respondent's "offices").

FACTUAL ALLEGATIONS

A. On or about September 23, 1990, Respondent submitted an application for staff reappointment to Catholic Medical Center of Brooklyn and Queens,

Inc., 88-25 153rd Street, Jamaica, New York 11432 (hereinafter "Catholic Medical Center"), on which Respondent knowingly and falsely represented that since his last reappointment, his medical license, registration and/or professional conduct had never been and/or was not currently in the process of being investigated when, in fact, Respondent knew since in or about September 1989, that he was the subject of an investigation being conducted by the Department of Health, Bureau of Controlled Substances (hereinafter "BCS"). Specifically, BCS was investigating Respondent's unlawful prescribing, dispensing and record keeping of controlled substances including, but not limited to, Didrex, an appetite suppressant.

B. On or about December 6, 1991, Respondent submitted an application for staff reappointment to Deepdale General Hospital, 55-15 Little Neck Parkway, Little Neck, New York 11362, on which he knowingly and falsely represented that he was not the subject of an investigation by any State licensing board or other governmental agency when, in fact, he knew that he was the subject of an investigation being conducted by BCS.

C. On or about September 4, 1992, Respondent submitted an application for staff reappointment to Catholic Medical Center on which he knowingly and falsely represented that since his last reappointment, his medical license,

registration and/or professional conduct had never been and/or was not currently in the process of being investigated when, in fact, he knew that he was the subject of an investigation being conducted by BCS.

D. On or about May 25, 1994, Respondent submitted an application for staff reappointment to Little Neck Community Hospital, 55-15 Little Neck Parkway, Little Neck, New York 11362, on which he knowingly and falsely represented that he had never been professionally sanctioned when, in fact, Respondent knew that on or about November 16, 1992, he signed a Stipulation and Order admitting to failures regarding his dispensing of controlled substances in violation of Article 33 of the Public Health Law and consenting to a $4,000 civil penalty.

E. On or about September 3, 1994, Respondent submitted an application for staff reappointment to Catholic Medical Center, on which he knowingly and falsely represented that since his last reappointment, he had never been professionally sanctioned and/or that he had never been and/or was not currently the subject of a disciplinary proceeding or inquiry when, in fact, Respondent knew that in 1992 he had entered into a Stipulation and Order with BCS, and further, that he was the subject of an investigation conducted by the Department of Health, Office of Professional Medical

Conduct and that on or about September 1, 1994, Respondent signed an Application for Consent Order, to resolve the then pending disciplinary action, in which he agreed to a disciplinary sanction of a two years stayed suspension of his medical license, two years probation and a $2,000 fine.

F. On or about November 4, 1996, Respondent submitted an application to the New York State Education Department for license registration renewal on which he knowingly and falsely represented that he had never been terminated from any hospital when, in fact, Respondent knew on or about March 11, 1996 that Catholic Medical Center had terminated his privileges for failing to disclose on his reappointment application that his medical license was currently in the process of being investigated and/or suspended.

G. Respondent treated Patient A for weight reduction from on or about May 16, 1987 through on or about May 1, 1996, at his offices.

1. Respondent failed to take and/or note an adequate history.
2. Respondent failed to perform and/or note an adequate physical examination.
3. Respondent failed to appropriately treat Patient A for weight loss

including but not limited to inappropriately prescribing Didrex, an appetite suppressant medication.

4. Respondent failed to appropriately monitor Patient A for Patient A's condition during treatment with appetite suppressant medication.

5. Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient A.

H. Respondent treated Patient B for weight reduction from on or about January 4, 1994 through on or about June 5, 1998, at his offices.

1. Respondent failed to take and/or note an adequate history.

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

3. Respondent failed to appropriately treat Patient B for weight loss including but not limited to inappropriately prescribing Didrex and other appetite suppressant medications.

4. Respondent failed to appropriately monitor Patient B for Patient B's condition during treatment with appetite suppressant medication.

5. Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient B.

I. Respondent treated Patient C for weight reduction from on or about June 8, 1981 through on or about July 1, 1998, at his offices.

1. Respondent failed to take and/or note an adequate history.
2. Respondent failed to perform and/or note an adequate physical examination.
3. Respondent failed to appropriately treat Patient C for weight loss including but not limited to inappropriately prescribing Didrex and other appetite suppressant medications.
4. Respondent failed to appropriately monitor Patient C for Patient C's condition during treatment with appetite suppressant medication.
5. Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient C.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1998) formerly N.Y. Educ. Law §6509(2) (as amended effective September 1, 1975), during the period post September 1, 1975, by practicing the profession of medicine fraudulently as

alleged in the facts of the following:

1. Paragraph A.

2. Paragraph B.

3. Paragraph C.

4. Paragraph D.

5. Paragraph E.

6. Paragraph F.

SEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1998) formerly N.Y. Educ. Law §6509(2) (as amended effective September 1, 1975), during the period post September 1, 1975, by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

7. Paragraphs A, B, C, D, E and/or F.

EIGHTH THROUGH THIRTEENTH SPECIFICATIONS

MAKING OR FILING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined

in N.Y. Educ. Law §6530(21)(McKinney Supp. 1998) formerly N.Y. Educ. Law §6509(9) and N.Y.C.R.R. §29.1(b)(6) (effective October 1, 1977), during the period post October 1, 1977, by wilfully making or filing a false report as alleged in the facts of:

8. Paragraph A.

9. Paragraph B.

10. Paragraph C.

11. Paragraph D.

12. Paragraph E.

13. Paragraph F.

FOURTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) formerly N.Y. Educ. Law §6509(2) (as amended effective September 1, 1975), during the period post September 1, 1975, by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

14. Paragraphs G, G.1, G.2, G.3, G.4, G.5, H, H.1, H.2, H.3, H.4, H.5, I, I.1, I.2, I.3, I.4 and/or I.5.

FIFTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) formerly N.Y. Educ. Law §6509(2) (as amended effective September 1, 1975), during the period post September 1, 1975, by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

15. Paragraphs G, G.1, G.2, G.3, G.4, G.5, H, H.1, H.2, H.3, H.4, H.5, I, I.1, I.2, I.3, I.4 and/or I.5.

SIXTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 1998) formerly N.Y. Educ. Law §6509(9) and N.Y.C.R.R. §29.2(a)(3) (effective October 1, 1977), during the period post October 1, 1977, by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

16. Paragraph G and G.5.

17. Paragraph H and H.5.

18. Paragraph I and I.5.

DATED: October 14, 1998
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct