STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

September 25, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Bradley C. Mohr, Esq.
NYS Department of Health
Corning Tower Room 2503
Empire State Plaza
Albany, New York 12237

Mamerto John Azurin, M.D.
343 Abbott Road
Buffalo, New York 14220

Terrence M. Connors, Esq.
Connors & Vilardo, LLP
1020 Liberty Building
420 Main Street
Buffalo, New York 14202

RE: In the Matter of Mamerto John Azurin, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 97-231) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

IN THE MATTER	DETERMINATION
OF	AND
MAMERTO JOHN AZURIN, M.D.	ORDER

BPMC-97-231

A Notice of Hearing and Statement of Charges, both dated DATE, were served upon the Respondent, Mamerto John Azurin, M.D. **PETER B. KANE, M.D. (Chair), ANN SHAMBERGER, and MOHAMMAD GHAZI-MOGHADAM, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Bradley C. Mohr, Esq., Assistant Counsel. The Respondent appeared by Connors & Vilardo, LLP, Terrence M. Connors, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	September 9, 1996
Answer to Statement of Charges filed:	
Pre-Hearing Conference:	October 4, 1996

Dates of Hearings:	March 12, 1997 April 10, 1997 May 1, 1997 June 17, 1997 June 18, 1997 June 19, 1997
Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendation:	July 17, 1997
Received Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendation:	July 17, 1997
Witnesses for Department of Health:	Grahame W. Fitz, M.D.
Witnesses for Respondent:	Julian Ambrus, M.D. Mamerto J. Azurin, M.D.
Deliberations Held:	July 31, 1997

STATEMENT OF CASE

The Petitioner initially brought charges against Respondent concerning the medical care and treatment of fourteen patients. He was charged with one specification of negligence on more than one occasion, one specification of incompetence on more than one occasion, six specifications of gross negligence (Patients A, E, G, L, M and N), and fourteen specifications of failure to maintain records which accurately reflect the care and treatment rendered to the patient. Lastly, Respondent was also charged with professional misconduct as a result of a prior criminal conviction for Medicaid fraud.

The specific circumstances of the treatment of each patient naturally varied. However, there was a striking similarity in the issues presented by the various cases. Virtually all of the cases present allegations that Respondent

failed to:

-- obtain/document adequate initial histories and physical examinations;

-- provide adequate primary care;

-- order/perform adequate laboratory and/or urine testing;

-- appropriately prescribe a variety of anorexiant drugs and other controlled substances;

-- maintain legible records which accurately reflect the evaluation and treatment of the patient.

The regulations governing the conduct of administrative hearings such as this one grant the administrative law judge (ALJ) certain authority to limit cumulative and repetitious testimony and to insure that hearings proceed in an efficient manner.[1]

At the Pre-hearing conference held on October 4, 1996, the Administrative Law Judge (following consultation with the Chair) moved to limit the presentation of cumulative testimony. The ALJ limited Petitioner to presentation of evidence regarding six of the fourteen patients. The six patients (A, E, G, L, M and N) present a broad cross-section of the issues raised by Petitioner and also represent those patients for which gross

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[1]10 NYCRR §51.9 sets forth the powers and responsibilities of administrative law judges (ALJs)in the conduct of administrative hearings.

10 NYCRR §51.9(c) grants the ALJ the power to:

(7) limit...repetitious examination or cross- examination, and the amount of corroborative or cumulative testimony....;

(11) do all acts and take all measures necessary, but not otherwise prohibited by this Part, for the maintenance of order and the efficient conduct of the hearing.

negligence was alleged. Testimony regarding the remaining eight patients was prohibited.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. 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.

1. Mamerto John Azurin, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State by the issuance of license number 100652 by the New York State Education Department on February 2, 1968. (Pet. Ex. #2).

2. Respondent was personally served with the Notice of Hearing, Statement of Charges and Summary of Department of Health Rules on September 9, 1996 (Pet. Ex. #1).

3. Grahame W. Fitz, M.D. testified as an expert witness on behalf of Petitioner. Dr. Fitz was board-certified in family medicine in 1984 and recertified in 1990 and 1996. He has been involved in the practice of family medicine since 1984. He has been a regional medical coordinator for an HMO and is an assistant clinical professor of family medicine at an area medical school as well as chief of the family medicine department

at a local hospital. (T. 34-40; Pet. Ex. #3).

4. Julian Ambrus, M.D. testified as an expert witness on behalf of Respondent. Dr. Ambrus is a Professor Emeritus of the Roswell Park Cancer Institute and Hospital. His expertise is primarily in the fields of oncology and hematology. He has maintained a private practice since 1992. (T. 630, 664; Resp. Ex. E).

5. Respondent also testified on his own behalf. He testified that he primarily maintains a general practice of medicine. (T. 922).

Patient A

6. Patient A was a 25 year-old male who presented to Respondent on February 11, 1985. The patient may or may not have been an amputee when he first presented - it was not noted in the chart, and Respondent does not remember. (T. 1109-1142; Pet. Ex. #4-A, p. 9; Pet. Ex. #4, p. 10).

7. The role of the medical history is that of a data base which gives the information upon which to make further decisions regarding the patient's medical treatment. It is one of the keys to proper diagnosis. (T. 50, 690).

8. The patient's medical history does not meet acceptable standards because it lacks information on such things as diabetes, hypertension, significant medical problems, significant injuries, accidents, whether the patient was sick as a child, and other significant medical problems. The medical history also failed to include a review of systems including

HEENT (head, eyes, ears, nose and throat), respiratory, cardiac, gastrointestinal and genitourinary systems. (T. 47-48, 50, 287).

9. The role of the physical examination, in a new patient, is to give a starting point regarding the patient's medical condition. When there is a focal complaint, the examination documents the care given, and whether there has been a change in the patient's condition when the physician next sees the patient. (T. 51).

10. A physical examination which meets minimally acceptable standards of care would include evaluation of the heart rate and sounds, lungs, temperature, HEENT, skin, neck, abdomen, lymph nodes, extremities, neurological status and general urinalysis. Respondent's initial physical examination of Patient A did not meet minimally acceptable standards of practice as no such findings were documented. (T. 48, 1087).

11. Respondent's medical examination and medical history failed to meet acceptable standards for either focused or general complaints. They are not acceptable because the same comprehensive history and physical examination are needed for both focused and general physical complaints. The difference is in the role which the physical examination and history may play with respect to a focused complaint as opposed to a general complaint. For a focused complaint, the goal is to deal with the particular problem and devise a treatment for the patient. For a general medical complaint, intervention may not be necessary because there may not be any particular problem to address. (T. 52).

12. Respondent's medical records regarding Patient A did not meet minimally acceptable standards. They can only be considered a partially accurate reflection of his evaluation and treatment. The records are illegible. (T. 42, 689).

13. On October 9, 1992, Patient A, a right leg amputee, was diagnosed with nodules of the right stump. There was no description of the patient's nodules or indication as to whether they were painful, inflamed or excoriated. Respondent prescribed Lortab for Patient A. (T. 81, 702-703; Pet. Ex. #4-A, p. 2).

14. Lortab is a pain reliever with hydrocodone. It can cause physical dependence after a few days and withdrawal after several weeks of continued use. Lortab can also cause constipation and fatigue. Lortab comes in three different dosages. Respondent's use of Lortab for the treatment of pain was acceptable. However, he failed to note in the record which dosage he was giving to the patient. This did not meet acceptable standards of practice. ((T. 81, 711-712; Ex. #44).

15. Respondent prescribed Lortab again on November 18, 1992. The patient's chief complaint on that visit was arthritic pain of the back and neck. There is no record of a physical examination of the patient's back or neck, only a diagnosis of cervical strain. The use of Lortab was minimally acceptable, based on this diagnosis. (T. 83, 256; Pet. Ex. #4-A, p. 2).

16. Respondent again prescribed Lortab to Patient A on January 6, 1993. The diagnoses noted on that occasion were arthritis, bursitis and obesity. The patient was also treated

with saline soaks and Naprosyn (a non-steroidal anti-inflammatory medication). (T. 84; Pet. Ex. #4-A, p. 1).

17. On March 15, 1993, the patient was diagnosed with arthritis and tendinitis of the wrist, and obesity. He was treated with Anaprox (a non-steroidal drug similar to Naprosyn) and Lortab. (T. 85; Pet. Ex. #4-A, p. 1).

18. On July 2, 1993, Respondent diagnosed arthritis of the spine, as well as obesity. He again prescribed Lortab for Patient A. (T. 86; Pet. Ex. #4-A, p. 1).

19. On August 13, 1993, Respondent noted in the chart "X-rays of spine prn" and substituted Darvocet for Lortab. (Pet. Ex. #4-A, p.1).

20. On January 8, 1992, Respondent prescribed Placidyl and Meprobamate for Patient A. Both of these drugs can cause sedation. Placidyl is a short term hypnotic indicated for periods of up to one week for the treatment of insomnia. Prolonged use of Placidyl may result in tolerance and psychological dependence. Prolonged use of this drug is not recommended. Placidyl should not be used by patients who have a psychological potential for drug dependence. (T. 87, 90; Pet. Ex. #4-A, p. 3; Pet. Ex. ## 23 and 24).

21. Respondent again prescribed Placidyl on March 30, 1992, April 27, 1992, June 6, 1992 and July 17, 1992. No diagnosis of insomnia was noted in the records. Respondent's use of Placidyl on these dates did not meet minimally acceptable standards of practice, as no diagnosis of insomnia was recorded. (T. 90-92, 737; Pet. Ex. #4-A, pp. 2-3; Pet. Ex. ##23 and 24).

22. Patient A had a history of drug dependence. This documented by the toxicology report, dated December 7, 1989, showing that this patient had a toxicology screening at Kenmore Mercy Hospital, along with a diagnosis of withdrawal symptoms. This report was part of Respondent's medical records for Patient A and should have alerted him that the patient had a potential for drug abuse and dependence. The toxicology report also showed that Patient had abused alcohol. It also showed that the patient was obtaining benzodiazepines from sources other than Respondent (either another physician or a street source). Respondent made no effort to contact the toxicology laboratory or the emergency room physician. He relied solely on the patient's explanations, although he was aware that addicted patients lie and obtain duplicate medications from other physicians. (T. 55-57, 241, 779, 1064-1066, 1135-1138; Pet. Ex. #4, p. 11).

23. During the period that Respondent treated Patient A, the patient underwent at least three hospitalizations for drug dependence (November 3, 1988, December 18, 1989, and April 17, 1990). Some of the drugs that the patient was treated for during those hospitalizations included drugs prescribed by Respondent (Noludar, Fiorinal and Valium). (T. 70-77; Pet. Ex. #4-B).

24. On April 8, 1989, Respondent prescribed Noludar to Patient A. Noludar is a short term hypnotic indicated for insomnia. It is also a central nervous system depressant with side effects of sedation and lack of alertness. The drug presents potential hazards in driving an automobile or other hazardous machinery. Noludar is only indicated for short term

use of up to seven nights. (T. 319-320; Pet. Ex. #4-A, p. 8; Pet. Ex. #38).

25. Respondent's prescription of Noludar on this occasion was below minimally acceptable standards because there were no documented indications for its use. (T. 319, 749-759).

26. Respondent again prescribed Noludar on May 31, 1989. Respondent's prescription of Noludar was below minimally acceptable standards because he failed to document any indication of insomnia on that occasion. (T. 320-321; Pet. Ex. #4-A, p. 7).

27. Respondent prescribed Noludar on July 19, 1989, August 21, 1989 and October 4, 1989. These prescriptions fell below minimally acceptable standards of practice because he failed to document any indications for the use of the drug on these occasions. (T. 322; Pet. Ex. #4-A, p. 7).

28. Respondent prescribed Adipex to Patient A during the period beginning May 12, 1986 through July 2, 1993 on 33 occasions. (T. 98-102; Pet. Ex. #4-A, pp. 1-9).

29. Adipex is a trade name for phentermine hydrochloride. It is an anorectic drug indicated in the management of exogenous obesity. It is intended as a short term adjunct (i.e., a few weeks) in a regimen of weight reduction based on caloric restriction. It is a stimulant and can cause headaches and insomnia. (T. 760, 772, 781; Pet. Ex. ## 19, 20 and 21).

30. Respondent's prescribing of Adipex was below minimally acceptable standards for the following reasons: it was given over a period of years; the patient didn't show improvement

with ongoing weight loss; it was maintained without any clear evaluation as to whether the patient should be involved in a different weight loss regimen, and Respondent failed to recognize the risks of the treatment versus the risks of mild obesity. Respondent also failed to document any recommendations for learned life style changes to enable the patient to maintain weight loss. Respondent also failed to document any consideration of alternative drugs such as Pondimin (fenfluramine) which are depressants, rather than stimulants. (T. 101-102, 804; Resp. Ex. C).

31. Adipex has numerous adverse reactions associated with its use, such as: palpitations, tachycardia, elevation of blood pressure, over-stimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache, dryness of the mouth, unpleasant taste, diarrhea, constipation and other gastrointestinal disturbances. (Pet. Ex. ## 19, 20 and 21).

32. Many of these adverse effects were reported in a long term study done by Michael Weintraub, M.D., and reported in a journal article that Respondent introduced into evidence. The adverse effects reported in that study included sleep disturbances, difficulty falling asleep, excessive sleepiness, disturbed sleep, vivid dreams, nervousness, tension, increased blood pressure, palpitations, irregular heart rhythm and dry mouth. Many of these adverse effects caused patients to drop out of the study, and many of these effects persisted throughout the entire four years that the study was in effect. (T. 581-646; Resp. Ex. C).

33. Respondent offered the Weintraub study into evidence to justify his long term prescribing of phentermine. However, the study was not on phentermine given alone, but in combination with fenfluramine. Respondent did not prescribe fenfluramine to the patient, either alone or in combination with phentermine. The Weintraub study also involved not only the use of diet, also involved a high intensity cardiac fitness program, behavior modification, regular group meetings, checklists, discussions of adverse effects and a newsletter. Respondent did not follow these protocols. He was not aware of the study until 1992 and it had no effect on his treatments. (T. 307-318, 1105-1106; Resp. Ex. C).

34. Respondent failed to order and/or perform any laboratory studies, such as thyroid studies, to attempt to ascertain any medical causes for the patient's obesity. In addition, Respondent failed to order serum electrolyte studies, despite the fact that he prescribed Lasix for this patient. (Pet. Ex. #4 and #4A).

Patient E

35. Patient E was a 30 year-old female who first presented to Respondent on November 3, 1986. (Pet. Ex. #8-A, p. 7; Pet. Ex. #8, p. 10).

36. The initial physical examination of Patient E recorded by Respondent did not meet minimally acceptable standards of practice. It lacked examination of the head, eyes, ears, nose, throat, lungs, abdomen, breasts, extremities, and skin, and a neurological evaluation. During the entire period of

treatment of this patient, from November 3, 1986 through August 16, 1993, Respondent never performed a physical examination meeting minimal standards for a patient who sought treatment for long term weight control. (T. 361-362, 384, 622-623; Pet. Ex. #8-A, pp. 1-9).

37. Respondent prescribed Adipex, a Schedule IV controlled substance, to Patient E on 34 occasions during the period from November 3, 1986 through July 16, 1993. (Pet. Ex. #8-A, pp. 1-9).

38. Respondent's prescribing of Adipex fell below minimally acceptable standards, for the same reasons cited with regard to Patient A. In addition, Respondent failed to note the dosage and duration of each prescription, or the number of pills prescribed, nor did he provide any indication as to whether this was intended as a short or long term therapy. (T. 363).

39. Respondent failed to determine if the Patient had diabetes by checking the blood sugar, or if she had a thyroid disease which could have caused her obesity. He also failed to inquire about possible drug dependence. (T. 364).

40. Respondent prescribed Adipex for an excessive period of time and contrary to the manufacturer's recommendation for the use of the drug. The patient had a substantial (20 pounds) weight gain during the approximately seven years of treatment with Adipex. However, there is no documented evidence that Respondent ever considered, discussed or recommended alternative therapies. (T. 366).

41. Respondent prescribed Lasix to Patient E on 19

occasions over a seven year period, beginning on November 3, 1986 and continuing through August 16,1993. Lasix is the trade name for furosemide, a powerful diuretic. Respondent's prescribing of Lasix for Patient E did not meet minimally acceptable standards of care. No physical findings were documented to indicate the need for a diuretic. (T. 367-370, 828; Pet. Ex. #8-A, pp. 2-9; Pet. Ex. ## 34, 36 and 37).

42. Lasix can deplete the patient's electrolytes, causing loss of potassium and sodium and increasing uric acid. It can cause dry mouth and weakness. It can also cause cardiac arrhythmia which may result in sudden cardiac death. When Lasix is prescribed serum electrolytes (particularly potassium), carbon dioxide, creatinine and BUN should be determined frequently during the first few months of therapy, and periodically thereafter. No such tests were ever ordered for Patient E, either prior to the initiation of therapy or thereafter. Respondent never inquired of the patient if she could have the laboratory tests performed through an HMO. There is no documented evidence that Respondent ever gave Patient E any instructions regarding the use of Lasix or warnings regarding its side effects, or dangers associated with the drug. (T. 368-370, 801, 1230; Pet. Ex. #8-A).

43. A physician prescribing Lasix on a regular basis should also assess the patient for dehydration, light-headedness and low blood pressure. (T. 370).

44. Lasix is not indicated as a component of a weight loss regimen. The type of edema for which Lasix is indicated is

limited to congestive heart failure, pulmonary edema, cirrhosis of the liver and renal disease. Lasix was not indicated for Patient E. An appropriate treatment for Patient E's edema would be to advise the patient to decrease salt intake, elevate the legs and wear compressive stockings. (T. 370, 389-390; Pet. Ex. ## 34, 36 and 37).

45. Respondent prescribed Placidyl for Patient E on 22 occasions over a period of four years, beginning on March 1, 1989. (T. 370-373; Pet. Ex. #8-A, pp. 1-9).

46. Respondent's prescribing of Placidyl for Patient E was below minimally acceptable standards of practice. Treatment was initiated without documenting an indication for the drug. Respondent then prescribed Placidyl for an excessive period of time. He repeatedly prescribed the drug when the patient had no complaint relating to insomnia. Prolonged use of Placidyl may result in tolerance and psychological and physical dependence. (T. 371-373, 832-841; Pet. Ex. # 23).

47. Respondent failed to note how the patient responded to Placidyl and whether there were any side effects. He also failed to consider whether Adipex, which Respondent also prescribed for Patient E, might have effected Patient E's sleep. (T.373, 843-845).

48. Respondent prescribed Klotrix, a potassium supplement, on May 29, 1987, August 21, 1987, October 19, 1987, June 27, 1988 and March 1, 1989. Respondent failed to order any laboratory tests to determine the patient's potassium levels. Laboratory testing is necessary because the physical and

symptomatic manifestations of changes in potassium level in a patient can be vague and unreliable. (T. 403-404, 412-413).

49. Respondent failed to order any laboratory tests to assess this patient for diabetes or thyroid disease. (T. 374).

50. Respondent failed to provide adequate primary care to Patient E during a February 26, 1990 encounter. The patient's medical record indicated that Respondent examined her for complaint of leg edema. However, a diagnosis of gastritis was recorded, although no complaint of stomach problems was noted. Respondent failed to note in the record the reasons for his diagnosis, nor did Respondent recall the reasons at the hearing. (T. 375-376, 1231; Pet. Ex. #8-A, p. 9).

51. Respondent's overall medical care and treatment of Patient E was substandard. In addition, his records for the patient were illegible and did not accurately reflect his evaluation and treatment of the patient. (T. 378; Pet. Ex. #10).

Patient G

52. Patient G was a 31 year-old female when she initially presented to Respondent. Respondent erroneously testified that the patient was in her late 40's. (T. 1245, 1275-1276; Pet. Ex. #10, p. 20).

53. Respondent's medical records are illegible. (T. 424; Pet. Ex. # 10).

54. Respondent's initial evaluation of Patient G met minimally acceptable standards of practice. It lacks part of the medical history, habits and life style, as well as a complete medical examination. The initial history did not document a

complete review of systems. (T. 450-453).

55. A physical examination conducted on February 6, 1984 met minimally acceptable standards for the examination of the patient's neck, although the documentation was inadequate. Respondent noted that the neck was supple, but not whether or not the nodes were palpated. (T.515; Pet. Ex. #10-A, p. 18).

56. Respondent first prescribed Placidyl to Patient G on January 6, 1989 and again on May 24, 1989, June 21, 1989 and September 18, 1989. Respondent's prescription of Placidyl on those occasions did not meet acceptable standards of care. The patient was asymptomatic and did not have any indications for the prescription of an hypnotic. There were no documented patient instructions for use or any indication that Respondent discussed the risks and benefits of the use of Placidyl with this patient. (T. 428-429; Pet. Ex. #10-A, pp. 8-9).

57. Respondent again prescribed Placidyl for Patient G on October 25, 1989, December 22, 1989, April 23, 1990, July 13, 1990, January 18, 1991, June 19, 1991 and May 18, 1992. Respondent's prescriptions for Placidyl on those dates fell below minimally acceptable standards because the patient had no documented indications for their use. There were no documented complaints regarding anxiety or insomnia on any of those dates. Respondent also failed to document any consideration as to whether the patient may have been experiencing any adverse effects from the use of phentermine, a central nervous system stimulant. Respondent also failed to document any instructions to the patient regarding the use of Placidyl. (T. 429-430, 843-

845, 1292; Pet. Ex. #10-A, pp. 6-7; Pet. Ex. ## 19, 20, 26, 29; Resp. Ex. C).

58. Respondent prescribed Tranxene for Patient G on 25 occasions during the period December 10, 1984 through March 27, 1987. Tranxene is a long-acting benzodiazepine with a half-life of approximately 24 - 48 hours. It is indicated for the management of anxiety disorders or for short term relief of symptoms of anxiety. Anxiety or tension associated with the stress of every day life usually does not require treatment with an anxiolytic medication. Tranxene can cause psychological and physical dependence. There are also risks in operating machinery, such as automobiles, because of sedative side effects. (T.431-432, 904, 1284; Pet. Ex. # 10-A, pp. 12-17; Pet. Ex. # 42).

59. Respondent's prescribing of Tranxene for Patient G was below minimally acceptable standards of practice. He prescribed the drug for this patient for a long period of time without clear indications. Respondent failed to document instructions for its use, and failed to record the dosages prescribed. There was no indication in the record that Respondent discussed the potential risks and side effects with the patient. (T. 433).

60. Respondent prescribed Librium for Patient G on June 2, 1987, July 20, 1987, August 19, 1987, October 12, 1987, November 9, 1987, December 14, 1987, and January 8, 1988. Librium is a benzodiazepine used as an anti-anxiety agent. It is similar to Tranxene, Restoril and Valium. (T. 436; Pet. Ex. #

10-A, pp. 11-12).

61. Respondent's prescription of Librium for Patient G was below minimally acceptable standards because it was given without documented indication and over an extended period of time. (T. 437).

62. Respondent prescribed Valium to Patient G on the following seven occasions during 1988: March 18, May 25, June 27, July 27, August 24, October 24 and November 30. Valium is diazepam, a moderately long-acting benzodiazepine. Its main side effect is sedation. It can also cause muscle relaxation and can be used occasionally for muscle spasm. It carries the same potential risks as other benzodiazepines. (T. 434-435; Pet. Ex. # 10-A, pp. 9-10; Pet. Ex. #43).

63. Respondent's prescribing of Valium over an extended period of time was below minimally acceptable standards of practice. He prescribed Valium for the patient even though there were no documented signs of anxiety on five of the seven dates in question (May 25, June 27, July 27, October 24 and November 30, 1988). There were no discussions in the record regarding a chronic anxiety disorder, nor any evidence that the patient indeed suffered such a condition. Respondent simply continued to maintain the patient on Valium. (T. $35, 479; Pet. Ex. #10-A, pp. 9-10).

64. Respondent prescribed Ionamin for Patient G on February 6, 1984, as well as on 16 other occasions during the period from March 4, 1984 through November 15, 1985. Ionamin is phentermine resin. It is indicated for short term weight loss in

programs generally of a few weeks in duration. (T. 437, 439; Pet. Ex. # 10-A, pp. 15-18; Pet. Ex. #29).

65. Respondent prescribed Fastin to Patient G on 11 occasions during the period from January 3, 1986 through May 13, 1987. Fastin is phentermine hydrochloride. It is similar to Ionamin and is also indicated for short term weight loss programs of a few weeks duration. (T. 437-439; Pet. Ex. #10-A, pp. 12-15; Pet. Ex. # 26).

66. Respondent prescribed Adipex (also phentermine hydrochloride) to Patient G on 58 occasions during the period from June 2, 1987 through August 25, 1993. (T. 438; Pet. Ex. #10-A, pp. 1-9).

67. Respondent's prescribing of Fastin, Ionamin and Adipex was below minimally acceptable standards of practice. He prescribed the drugs over a period of years, despite the fact that they are indicated only for short term weight loss. Moreover, they were not used in a well-designed weight loss program which would involve a nutritionist or multimodal methods of weight loss. (T. 439-440; Pet. Ex. ## 19, 26 and 29).

68. Respondent prescribed Lasix for Patient G on 52 occasions during the period from May 2, 1984 through April 2, 1993. (T. 440; Pet. Ex. # 10-A, pp. 2-18).

69. Respondent's prescription of Lasix for Patient G was below minimally acceptable standards of practice. None of the principal indications for Lasix, such as congestive heart failure, were documented as being present in this patient. Lasix should only be used to treat leg edema on a short-term trial

basis. If the leg edema were to persist, the appropriate response would have been to do further examination of the patient's condition. However, there was no indication of leg edema when Respondent first prescribed Lasix on May 2, 1984, or on most of the other occasions where it was prescribed. Respondent's prescribing of Lasix was also below acceptable standards because there was no follow-up laboratory testing to determine the patient's electrolyte levels. This put the patient at risk for the known complications associated with Lasix. (T. 441-443, 493, 503, 508-509; Pet. Ex. # 10-A, pp. 2-18).

70. Respondent failed to order appropriate laboratory testing to explore any of the possible conditions associated with obesity, such as diabetes or thyroid disorders. Respondent also failed to order serum electrolyte tests, either prior to beginning weight loss therapy, or at any time during the first eight and one-half years during which he provided medical care to this patient. (T. 443; Pet. Ex. #10-A, pp. 1-18).

Patient L

71. Patient L was a 29 year-old female who first presented to the Respondent on October 19, 1990. (Pet. Ex. # 15-A, p. 1; Pet. Ex. #15, p.1).

72. Respondent's medical records are illegible. Another practitioner would not be able to determine what Respondent's evaluation and treatment of the patient had been. (T. 517, 855; Pet. Ex. # 15).

73. Respondent's initial physical examination and history met minimally acceptable standards of practice. (T. 517,

523, 852-853).

74. Respondent prescribed Adipex for Patient L, beginning on October 19, 1990. He prescribed on 11 occasions during the period from October 19, 1990 through July 28, 1993. In fact, Adipex was prescribed on every visit record in the patient's chart. Respondent's use of Adipex for Patient L did not meet minimally acceptable standards of practice for the same reasons as expressed for Patients A, E and G in that the drug was prescribed far beyond the short-term use guidelines recommended by the manufacturer. (T. 518; Pet. Ex. # 15-A, pp. 1-4).

75. Respondent prescribed Lasix for Patient L on nine occasions during the period from October 19, 1990 through July 28, 1993. (T. 519-520; Pet. Ex. # 15-A, pp. 1-2).

76. Respondent's use of Lasix for Patient L was below minimally acceptable standards for the same reasons as expressed for Patients A, E and G. These reasons include: prescribing without indications and for a non-standard use, as well as the failure to monitor the patient's serum electrolytes through laboratory testing. (T. 520, 1323; Pet. Ex. # 15-A, p. 2; Pet. Ex. ## 34, 36, 37).

77. Respondent failed to conduct or order any laboratory tests for this patient. He should have ordered appropriate tests for diabetes and hypothyroidism before prescribing an anorectic. (T. 370, 521, 801).

Patient M

78. Patient M was a 33 year-old female when she first presented to Respondent on June 29, 1990. (Pet. Ex. # 16, p. 1).

79. Respondent's medical records for Patient M are illegible. A practitioner reading Respondent's medical records would not be able to determine what his evaluation and treatment of the patient had been. (T. 528-529; Pet. Ex. # 16).

80. On June 29, 1990, Respondent diagnosed Patient M as having a viral infection. He prescribed Duricef, an antibiotic. Respondent failed to record the patient's temperature and blood pressure. Respondent's use of Duricef for Patient M fell below minimally acceptable medical standards because antibiotics are not effective against viral infections. (T. 529, 534-535; Pet. Ex. #16-A, p. 1).

81. At the initial visit on June 29, 1990, Respondent also prescribed Ionamin for Patient M. (T. 530).

82. Respondent prescribed Adipex for Patient M on 23 occasions over the period from July 27, 1990 through August 25, 1993. Respondent's prescribing of Adipex for Patient M fell below minimally acceptable standards of practice for the same reasons as expressed for Patients A, E, G and L in that the drug was prescribed far beyond the short-term use guidelines recommended by the manufacturer. (T. 530; Pet. Ex. #16-A, pp. 1-7).

83. Respondent prescribed Lasix on 14 occasions during the period from July 27, 1990 through June 30, 1993. Respondent's prescribing of Lasix for Patient M fell below minimally acceptable standards of practice for the same reasons as expressed for Patients A, E, G and L. (T. 530; Pet. Ex. #16-A, pp. 1-9).

84. Respondent failed to order any laboratory tests to determine the patient's serum electrolytes, either prior to or during treatment with Lasix. This placed the patient at risk of developing a cardiac arrhythmia. There is no documentation in the record that Respondent ever advised Patient M of the risks associated with the use of Lasix. (T. 53-534).

85. On December 14, 1990, Respondent diagnosed Patient M with an upper respiratory viral infection. Respondent prescribed Biaxin, an antibiotic. This fell below minimally acceptable standards of practice because antibiotics are not effective against viral infection, and bacterial superinfections are not commonly associated with upper respiratory infections. (T. 536, 544-545, 876, 877; Pet. Ex. #16-A, p.6).

86. Failure to take the patient's temperature was also below acceptable standards for diagnosing whether a patient has a bacterial or viral infection. (T. 535, 545).

87. On October 4, 1991, Respondent diagnosed Patient M with a viral infection/rhinitis. He prescribed Ceclor, an antibiotic. The patient's symptoms - sore throat, body aches, headache and cough - are consistent with a viral infection. Antibiotics are not effective against viral infections. Prescribing an antibiotic under these circumstances is acceptable only where there is a high index of suspicion that the infection is bacterial. If he suspected a bacterial infection, Respondent should have ordered a throat culture. It would be acceptable to treat the patient with an antibiotic pending the results of the culture. This was not done by Respondent. (T. 536-537, 546-547,

879; Pet. Ex. #16-A, p. 4).

Patient N

88. Patient N was a 48 year-old female who first presented to Respondent on September 16, 1987. (Pet. Ex. # 17, 12; Pet. Ex. #17-A, p. 1).

89. The history taken by Respondent included a family history of a diabetic grandfather. Respondent failed to follow-up on this family history with appropriate blood and urine tests to determine the patient's glucose levels. It was especially important to rule out the presence of diabetes, which tends to run in families. He also failed to obtain laboratory values regarding the patient's kidney and thyroid functions.(T. 562-563; Pet. Ex. #17-A, p. 1).

90. Respondent's medical care and treatment of Patient N during the first visit on September 16, 1987 did not meet minimally acceptable standards of medical practice. The patient presented with complaints of nausea, fatty food intolerance and epigastric tenderness. Respondent diagnosed gastritis, r/o peptic ulcer and prescribed Donnatal Extentabs. He failed to take steps to determine which of a number of possible gastrointestinal complaints (including peptic ulcer) were the cause of the patient's symptoms. Respondent failed to perform a rectal examination to check for blood and did not order an upper GI series to seek radiological signs of an ulcer.(T. 570-571; Pet. Ex. #17-A, p.1).

91. Respondent's medical records for this patient are illegible. (T. 558).

92. Respondent prescribed Adipex on 52 occasions during the period from September 16, 1987 through August 2, 1992. (T. 558-560; Pet. Ex. #17-A, pp. 1-12).

93. Respondent prescribed Fastin on May 4, 1988. Fastin is another formulation of phentermine hydrochloride. (T. 558-560; Pet. Ex. #17-A, p. 2).

94. Respondent's prescribing of Adipex and Fastin for Patient N did not meet minimally acceptable standards of practice for the same reasons as expressed for Patients A, E, G, L and M in that the drug was prescribed far beyond the short-term use guidelines recommended by the manufacturer. (T. 559).

95. During the period of time during which Respondent prescribed Adipex and Fastin for Patient N, the patient gained weight. (T. 560; Pet. Ex. #17-A, pp. 1, 12).

96. Respondent prescribed Lasix for Patient N on 32 occasions during the period from September 16, 1987 through August 2, 1993. Respondent's prescribing of Lasix for Patient N fell below minimally acceptable standards of practice for the same reasons as expressed for Patients A, E, G, L and M. Lasix is indicated for the treatment of edema associated with congestive heart failure, cirrhosis of the liver and renal disease. It may also be used in adults for the treatment of hypertension. Respondent testified that he prescribed the drug because the patient had pitting edema of the legs from time to time. (T. 560-562, 1375-1376; Pet. Ex. #17-A, pp. 1-12; Pet. Ex. ## 34, 36 and 37).

97. Respondent's prescribing of Lasix also did not meet

acceptable standards because he failed to follow-up on the use of the drug with appropriate laboratory evaluations, including serum electrolytes, BUN, carbon dioxide and creatinine. (T. 369-370, 560-561, 801; Pet. Ex. #17-A; Pet. Ex. ##34, 36 and 37).

98. Respondent prescribed Duricef for Patient N on June 3, 1988 to treat a viral infection. The use of Duricef did not meet acceptable standards of practice because antibiotics are not effective against viral infections. If Respondent suspected a bacterial infection, he should have taken a throat culture. (T. 534, 564-565; Pet. Ex. #17-A, p. 3).

99. Respondent prescribed Duricef again on December 13, 1989 for a diagnosed viral infection. This was contrary to minimally acceptable standards of practice for the same reasons set forth in paragraph 96, *above*. (T. 566; Pet. Ex. # 17-A, p.3).

100. Respondent prescribed Ceclor for Patient N on August 5, 1988 for a diagnosis of viral infection. This was contrary to minimally acceptable standards of practice for the same reasons set forth in paragraph 96, *above*. (T. 565-566; Pet. Ex. #17-A, p. 3).

101. On December 9, 1987, Respondent administered Lincocin *via* intramuscular injection to Patient N, as well as prescribing Duricef, when the patient was diagnosed with acute pharyngitis. Lincocin (lincomycin hydrochloride) is indicated in the treatment of serious infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Its use should be reserved for penicillin-allergic patients or other patients for

whom penicillin is inappropriate. Because of the risk of colitis, before selecting lincomycin the physician should consider the nature of the infection and the suitability of less toxic alternatives such as erythromycin. (T. 567, 568; Pet. Ex. #17-A, p. 1; Pet. Ex. #41).

102. Respondent's use of Lincocin for Patient N did not meet minimally acceptable standards of practice. It is an inappropriate treatment for acute pharyngitis - a relatively minor ailment. Also, Respondent did not perform a throat culture to determine whether the patient was suffering from a bacterial infection susceptible to Lincomycin. (T. 568; Pet. Ex. #17-A, p. 1; Pet. Ex. #41).

103. On December 10, 1991, Patient N presented with complaints of sinus headache, cough, sore throat and earache. Respondent's diagnosis was rhinitis. He prescribed Seldane (a decongestant) and Ceclor (an antibiotic) but did not conduct a thorough physical examination. Respondent neglected to examine the patients ears, nasal membranes and throat. He also did not check the lymph nodes and the patient's eyes. The physical findings do not justify the prescription of antibiotics. (T. 570, 572-573; Pet. Ex. #17-A, p. 4).

104. On or about September 3, 1987, Respondent was indicted by the Erie County Grand Jury on one count of grand larceny in the second degree (a violation of N.Y. Penal Law §155:35), and thirteen counts of offering a false instrument for filing in the first degree (a violation of N.Y. Penal Law §175:35). On September 12, 1989, Respondent pled guilty to the

reduced charge of attempted grand larceny in the second degree (a violation of N.Y. Penal Law §110:00/155:35 - a Class E felony). Respondent was sentenced to an unconditional discharge and ordered to make restitution. (Pet. Ex. #18).

CONCLUSIONS OF LAW

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

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:[2]

Paragraph A: (6-33);

Paragraph A.1: (7-11);

Paragraph A.2: (7-33);

Paragraph A.4 (2-1 vote): (13, 15-16);

Paragraph A.5 with respect to those Placidyl prescription written on March 30, April 27, June 5 and July 17, 1992: (20-21);

Paragraph A.6: (24-27);

Paragraph A.7: (28-33);

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[2]The following Factual Allegations were not sustained:
Paragraph A.3;
Paragraph L.4;
Paragraph N.

Paragraph N.8 was withdrawn by Petitioner during the course of the hearing. In accordance with the ALJ ruling limiting the testimony to six patients, no findings of fact were made regarding Patients B, C, D, F, H, I, J and K.

Paragraph A.8: (12, 14);

Paragraph A.9: (34);

Paragraph A.10: (6-33);

Paragraph A.11: (12);

Paragraph A.12: (12);

Paragraph E: (35-51);

Paragraph E.1: (36);

Paragraph E.2: (29-33, 37-38);

Paragraph E.3: (41-44);

Paragraph E.4: (45-47);

Paragraph E.5: (38, 42);

Paragraph E.6: (39, 42, 48);

Paragraph E.7: (35-51);

Paragraph E.8: (51);

Paragraph E.9: (51);

Paragraph G: (52-70);

Paragraph G.1: (52-70);

Paragraph G.2: (56-57);

Paragraph G.3: (58-63);

Paragraph G.4: (58-63);

Paragraph G.5: (29-33, 64-67);

Paragraph G.6: (42-44, 68-69);

Paragraph G.7: (56-57);

Paragraph G.8: (69-70);

Paragraph G.9: (52-70);

Paragraph G.10: (53);

Paragraph G.11: (52-70);

Paragraph L: (71-77);

Paragraph L.1: (72, 76-77);

Paragraph L.2: (29-33, 74);

Paragraph L.3: (76-77);

Paragraph L.5: (42-44, 75-76);

Paragraph L.6: (72);

Paragraph L.7: (72);

Paragraph M: (78-87);

Paragraph M.2: (29-33, 81-82);

Paragraph M.3 with respect to laboratory and urine tests: (84, 87);

Paragraph M.4: (42-44, 83-84);

Paragraph M.5: (80, 85, 87);

Paragraph M.6: (78-87);

Paragraph M.7: (79);

Paragraph M.8: (79);

Paragraph N: (88-103);

Paragraph N.1: (29-33, 92-95);

Paragraph N.2: (89-90, 97-98, 102);

Paragraph N.3: (42-44, 96-97);

Paragraph N.4: (89);

Paragraph N.5: (98-103);

Paragraph N.6: (101-102);

Paragraph N.7: (101-102);

Paragraph N.9: (88-103);

Paragraph N.10: (91);

Paragraph N.11: (91);

Paragraph O: (104).

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

First Specification: (Paragraphs A, A.1, A.2, A.4, A.5, A.6, A.7, A.8, A.9, A.10, A.11, A.12, E, E.1, E.2, E.3, E.4, E.5, E.6, E.7,E.8,E.9, G, G.1, G.2, G.3, G.4, G.5, G.6, G.7, G.8, G.9, G.10, G.11, L, L.1, L.2, L.3, L.5, L.6, L.7, M, M.2, M.3, M.4, M.5,M.6, M.7, M.8, N, N.1, N.2, N.3, N.4, N.5, N.6, N.7, N.9, N.10, N.11);

Eighth Specification: (Paragraphs E.3, G.6, L.5, M.4, N.3);

Ninth Specification: (Paragraphs A.11 and A.12);

Thirteenth Specification: (Paragraphs E.8 and E.9);

Fifteenth Specification: (Paragraphs G.10 and G.11);

Twentieth Specification: (Paragraphs L.6 and L.7);

Twenty-First Specification: (Paragraphs M.7 and M.8);

Twenty-Second Specification: (Paragraphs N.10 and N.11);

Twenty-Third Specification: (Paragraph O).

The Hearing Committee further concluded that the following Specifications should not be sustained[3]:

Second Specification;

Third Specification;

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[3]As noted previously, by direction of the ALJ, Petitioner was precluded from presenting proof regarding eight of the fourteen patients contained in the Statement of Charges (Patients B, C, D, F, H, I, J and K). Accordingly, the Hearing Committee dismisses all specifications regarding those patients, without prejudice to the Petitioner.

Fourth Specification;

Fifth Specification;

Sixth Specification;

Seventh Specification;

Tenth Specification;

Eleventh Specification;

Twelfth Specification;

Fourteenth Specification;

Sixteenth Specification;

Seventeenth Specification;

Eighteenth Specification;

Nineteenth Specification.

DISCUSSION

Respondent is charged with twenty-three specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a January 9, 1996 memorandum prepared by Henry M. Greenberg, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing

Committee during its deliberations:

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

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

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

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that Respondent was guilty of negligence on more than one occasion with regard to the six patients at issue. However, the Committee also concluded that Respondent's misconduct did not rise to the level of gross negligence. The Committee further concluded that Respondent demonstrated incompetence on more than one occasion with regard to his use of Lasix. The Committee further concluded that Respondent's medical records for the six patients were woefully inadequate and sustained those specifications regarding these patients. Lastly, the Committee sustained the specification of professional misconduct pertaining to Respondent's criminal conviction for Medicaid fraud. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset, the Hearing Committee made a determination regarding the credibility of the witnesses put forth by the parties. Petitioner presented Grahame W. Fitz, M.D. Dr. Fitz is board certified in Family Medicine and has an extensive background in primary care. He is currently chief of the Department of Family Practice at St. Peter's Hospital, Albany, New York and is an Assistant Clinical Professor at Albany Medical Center. Although Dr. Fitz does have a strong primary care background, he was obviously uncomfortable testifying as an expert witness. Moreover, his experience in bariatrics (weight reduction) is rather limited, and he had little personal knowledge of the anorexiant medications prescribed by Respondent.

Respondent testified on his own behalf, and also presented the testimony of Julian L. Ambrus, M.D. Dr. Ambrus is a Professor Emeritus of the Roswell Park Cancer Institute and Hospital, and has had a distinguished career as a cancer researcher and physician. His curriculum vitae (Resp. Exhibit E) is an extensive recitation of his academic experience and publications. However, his expertise is in the field of oncology and hematology. (*See*, T. 630, 664). He is not a bariatrician and has only maintained a private practice since 1992. His practice consists of approximately one-half hematology and one-half internal medicine. The latter portion of his practice consists primarily of metabolic diseases for patients in the "second half of life". (T. 676-678). None of the patients at issue in this case involved any of these issues or were of this age group. None of Dr. Ambrus' many publications bore any

relationship to any of the issues presented in this case.

Much of Dr. Ambrus' testimony was based on assumptions without foundation in the records. His testimony consisted primarily of stating what acceptable standards would require and assumed that Respondent must have done those things. He admitted on more than one occasion that he was really only guessing. (*See*, T. 797, 839, 906, 909). Based on the foregoing, the Hearing Committee determined that Dr. Ambrus' testimony should not be given great weight.

Respondent also testified on his own behalf. His testimony was an obvious attempt to reconstruct what he might have done or should have done for his patients based on the therapy regimens which he prescribed. (*See*, T. 1364-1365). To accept his testimony as an actual recollection based on his sparse records would stretch the limits of imagination. During the period of time that the patients in question were treated, Respondent saw approximately 70 patients per day. (*See*, T. 1429). This would amount to thousands of patient visits over the years.

Respondent could not remember if Patient A presented on his first visit on one leg or two, or when the patient had his leg amputated. (*See*, T. 1109-1110, 1132, 1143). He described Patient G as a woman in her late 40's and then testified as to numerous details never charted to show his familiarity with the patient. Upon cross-examination, however, Respondent acknowledged that the patient was actually only 31 years old. (*See*, T.1245, 1274-1276). Respondent testified regarding the indications for initiating Lasix for Patient L. On cross-

examination, he admitted that he had no recollection of his reasoning, nor was any indication for the drug noted in the medical record. (*See*, T. 1323).

Respondent has an obvious stake in the outcome of this proceeding, and attempted to make the most of his testimony. However, the Hearing Committee found that they could not give weight to his testimony. Upon consideration of all of the testimony presented by the parties, the Hearing Committee determined, on balance, to place more weight on the testimony of Dr. Fitz, than on that of Respondent or Dr. Ambrus.

With respect to each of the patients at issue, the Statement of Charges alleges that Respondent failed to provide adequate primary care. Respondent argued that Petitioner has the burden of proving that, with respect to each patient, Respondent was in fact the primary care physician. Respondent argued that Dr. Fitz testified that he did not know whether the six patients at issue received primary care from other sources. Respondent further argued that five of the six patients had primary care physicians through their health maintenance organizations (HMOs), and were seen by Respondent as a consultant only for "focal medical complaints". (*See*, Respondent's Closing Memorandum, pp. 20-22).

The Hearing Committee rejects these arguments. Admittedly, these patients primarily came to Respondent for treatment for obesity. Nevertheless, he treated them for a variety of "focal medical complaints". He treated these patients for anxiety, insomnia, edema, as well as various gastrointestinal

complaints and upper respiratory infections. These conditions all fall within the spectrum of primary care. Even if Respondent was not the *primary care physician* for these patients, he did provide *primary care* to them. As a result, he is bound to meet the minimal standards of practice applicable to any physician who seeks to provide primary care. Moreover, it should be noted that Respondent admitted that he primarily maintained a general practice of medicine. He therefore cannot claim that he is not bound to follow minimally acceptable standards for the provision of primary care to his patients.

Respondent's hand-written records were virtually illegible. The only way that his records could be understood was through type-written transcripts prepared for this hearing by Respondent. The written transcripts revealed that Respondent's evaluation and treatment of the patients were woefully inadequate.

Respondent claimed that his records seemed sparse because he used "negative charting". Respondent would only record abnormal findings. Therefore, the absence of a particular notation would not mean that a certain evaluation or examination was not conducted, or that a certain element of a patient's history was not investigated. It would just mean that no abnormal or otherwise condition was found on evaluation or examination, or that no abnormal or otherwise significant information was elicited. (*See*, Respondent's Memorandum, p. 5; T. 925).

The Hearing Committee rejects this contention. A

fundamental element of medical record-keeping can be summarized as "If it's not written down, it wasn't done". Respondent frequently confused a review of systems with a physical examination, and failed to document any evaluation of heart rate and sounds, lungs, temperature, HEENT, skin, neck, abdomen, lymph nodes, extremities and neurological status. He frequently failed to note pertinent elements of family medical history. When significant medical history was obtained, such as a family history of diabetes, no attempt at follow-up was made. Despite his claim of only charting significant findings, Respondent frequently prescribed medications when no abnormal findings or appropriate diagnoses were documented. In addition, Respondent failed to record dosages and instructions for use for many of the drugs which he prescribed.

All of the patients at issue in this case were treated by Respondent for obesity. Respondent made no efforts to determine whether the patients' obesity might have been caused by other medical conditions, such as thyroid disorders. Respondent's main treatment for obesity consisted of the long-term use of anorexiant medications - primarily Adipex (phentermine hydrochloride). The manufacturers' recommendations for these anorexiant medications warn that they should be used as a short-term (i.e., a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. Despite these recommendations, Respondent prescribed anorexiant medications to his patients for periods of several years.

Respondent attempted to justify his long-term use of

these drugs by relying on the so-called Weintraub study (Respondent's Exhibit C). This study concerned the long-term use of phentermine in combination with fenfluramine (another anorexiant). This study, which was not conducted until well after Respondent began treating these patients, does not support his treatment regimen. Respondent never used the phentermine-fenfluramine combination, nor did he employ cardiac fitness programs, behavior modification, group meetings, or any of the other elements of the Weintraub protocols.

Although there were sketchy references to diet in the charts, Respondent's primary approach to weight control was the long-term prescription of anorexiant medications. The patient records reveal that this was an unsuccessful regimen. All of the patients either gained weight or lost only fractional amounts. Moreover, the long-term use of anorexiant medications placed Respondent's patients at risk of developing complications related to the prolonged use of anorexiant medications, such as palpitations, tachycardia, elevated blood pressure, headache, and various gastrointestinal disorders. The Hearing Committee unanimously concluded that Respondent's use of anorexiant medications for the management of obesity in the six named patients constituted negligence, as defined above. However, the Committee further concluded that Respondent's conduct was not so egregious as to constitute gross negligence.

Petitioner also charged Respondent with professional misconduct regarding his prescription of Lasix for five of the six patients (Respondent prescribed Lasix for Patient A, but was

not charged by Petitioner regarding its use). Respondent prescribed Lasix on numerous occasions over periods of years for Patients E, G, L, M and N. He testified that he prescribed the drug for treatment of pitting edema in the legs.

Lasix (furosemide) is a powerful diuretic. It is indicated for long-term treatment of edema related to congestive heart failure, pulmonary edema, cirrhosis of the liver and renal disease. It is not indicated for treating leg edema (except on a limited short-term trial basis), nor is it indicated as a component of a weight loss regimen. Prolonged use of Lasix can deplete the patient's electrolytes, which may result in cardiac arrhythmia and sudden cardiac death.

Despite the fact that Respondent claimed that he prescribed Lasix for leg edema, a review of the records does not support his claim. The records indicate that there was no discernible pattern to his prescriptions. He prescribed Lasix when edema was noted on some occasions, but did not prescribe on other occasions when edema was found. Further, he frequently prescribed Lasix when no findings of edema were noted. No efforts were made to treat any leg edema by less drastic methods such as decreased salt intake, elevation of the legs and use of compressive stockings.

The Hearing Committee concluded that, rather than prescribing Lasix to treat edema, it was far more likely that Respondent used the drug as an adjunct to his anorexiant-based weight loss regimen. This is an unacceptable use of such a potentially lethal medication.

Moreover, having determined to prescribe Lasix for his patients, Respondent failed to take appropriate steps to monitor their electrolyte levels. When Lasix is prescribed, laboratory studies such as serum electrolytes, creatinine and BUN should be performed frequently during the first few months of therapy, and periodically thereafter. No such studies were ordered, either prior to the initiation of therapy, or thereafter. Respondent also ordered potassium supplements for some patients, with no documented reason noted in the records. Respondent's claims that he monitored the patient's potassium levels purely through observation were not credible.

The Hearing Committee unanimously concluded that Respondent's use of Lasix for the named patients demonstrated both negligence and incompetence on more than one occasion, but did not rise to the level of gross negligence.

The previous discussion sets forth the Hearing Committee's conclusions regarding those issues which pertain to all six of the patients at issue. Next, we will address the Committee's findings specific to each patient.

Patient A

It was apparent from a review of the records that Patient A had a history of drug dependence, which Respondent knew or should have known. Certainly, Respondent was on notice of the patient's drug problems following his receipt of the December 7, 1989 toxicology report. This report documented a hospitalization for withdrawal symptoms. The report also indicated that the patient was obtaining benzodiazepines from sources other than Respondent. Nevertheless, Respondent made no effort to contact the toxicology laboratory or the hospital physician which treated the patient. Although Respondent stated that he discussed the situation with Patient A, no such discussion is noted in the record. Instead, Respondent prescribed hypnotic drugs, such as Noludar and Placidyl, on numerous occasions. No diagnosis of insomnia was recorded.

There is no evidence that Respondent ever considered the possibility that any anxiety or insomnia which the patient may have experienced was due to the effects of the anorexiant drugs which the patient was taking. These are some of the known side effects of Adipex, as reported in the PDR.

Respondent made little or no attempts to maintain any continuity of care for this patient. He made no effort to follow up on his referral of the patient to a surgeon for the nodules on the patient's stump, or for his August 13, 1993 order of "X-rays of spine prn". Even when Respondent knew of other practitioners treating the patient, he made no effort to contact them.

The Hearing Committee concluded that Respondent's

medical care and treatment of Patient A demonstrated negligence, but not gross negligence. The Committee further concluded that Respondent failed to maintain adequate records for the patient.

Patient E

Respondent treated Patient E for obesity over a period of nearly seven years. He began a long term weight loss regimen using anorexiant drugs with only a brief, substandard physical examination and medical history. Respondent failed to order any laboratory tests to assess the patient for diabetes, thyroid disease, or any other condition related to her obesity. He prescribed Lasix without documented indications. Respondent ordered postassium supplements from time to time. No indication for such supplements was noted in the record, because Respondent did not perform or order any laboratory tests to monitor the patient's serum electrolyte levels. Respondent prescribed Placidyl over a four year period, without medical indication.

The Hearing Committee concluded that Respondent's medical care and treatment of Patient E demonstrated negligence, as well as incompetence concerning his use of Lasix. The Committee did not sustain the allegation of gross negligence, and sustained the specification regarding inadequate records.

Patient G

Respondent prescribed Placidyl for this patient on eleven occasions during the period from January 6, 1989 through May 18, 1992. There were no documented complaints regarding insomnia on any of these dates. Respondent also prescribed various anti-anxiety medications (benzodiazepines) on dozens of

occasions during the period from December 10, 1984 through November 30, 1988. No documented complaints of anxiety were noted on nearly all of those visits.

Respondent attempted to justify the use of these drugs by claiming an elaborate medical history of anxiety and insomnia for this patient, whom Respondent described as a woman in her 40's. He claimed that the patient suffered from chronic anxiety due to the stress of her job as a licensed practical nurse, and because she had an elderly husband suffering from cancer. None of this information is noted anywhere in the patient's medical record. Moreover, the patient was, in fact, only 31 years-old when she began seeing Respondent. The Hearing Committee concluded that there was no medical justification for the long-term use of these drugs.

Respondent also treated the patient with anorexiant medications and Lasix. As noted previously, the Committee concluded that Respondent's use of these medications demonstrated negligence as well as incompetence with regard to the use of Lasix. The Hearing Committee determined that Respondent's overall treatment of this patient demonstrated negligence. The Committee further concluded that Respondent's misconduct did not rise to the level of gross negligence. In addition, the Committee concluded that Respondent's record did not accurately reflect the evaluation and treatment of the patient.

Patient L

The Hearing Committee's findings relative to Patient L primarily concern Respondent's long-term use of anorexiant drugs

and Lasix. These findings, as well as Respondent's failure to order appropriate laboratory tests for diabetes and hypothyroidism, led the Committee to conclude that Respondent's medical care and treatment of Patient L demonstrated negligence and that his use of Lasix demonstrated incompetence. The Hearing Committee did not find Respondent's conduct to be so egregious as to warrant a finding of gross negligence. The Hearing Committee further concluded that Respondent's medical record, which was virtually illegible, failed to accurately reflect the evaluation and treatment of the patient.

Patient M

Respondent's medical records for this patient are illegible. Only by reviewing the typed transcript was it possible to determine the nature of Respondent's medical treatment of the patient. Respondent's use of anorexiant drugs for this patient was substandard, for the same reasons expressed regarding the previous patients. In addition, Respondent again prescribed Lasix on multiple occasions, without valid medical indication. Again, Respondent failed to order any laboratory tests to determine the patient's serum electrolyte levels, either prior to or during treatment with the diuretic.

Of equal concern to the Hearing Committee was the fact that on three occasions Respondent prescribed antibiotics for conditions diagnosed as viral infections. The symptoms recorded by Respondent (when any were recorded) were more consistent with viral infections than bacterial infections. It is acceptable to prescribe antibiotics where there is a high index of suspicion

that an infection is bacterial. If Respondent suspected a bacterial infection, he should have ordered a throat culture. It would have been acceptable to treat the patient with an antibiotic pending the results of the culture. This was not done by Respondent.

The Hearing Committee unanimously concluded that Respondent's treatment of Patient M demonstrated negligence, but did not rise to the level of gross negligence. Moreover, his use of Lasix demonstrated incompetence, as discussed in connection with the previous patients. In addition, the Committee concluded that Respondent's medical record for this patient failed to accurately reflect his evaluation and treatment.

Patient N

The initial history taken by Respondent for this patient, who presented for treatment of obesity, revealed a diabetic grandfather. Respondent failed to follow-up on this history with appropriate blood and urine tests to determine the patient's glucose levels. He also failed to obtain laboratory values regarding her kidney and thyroid functions.

At the initial visit on September 16, 1987, the patient presented with various gastric complaints. Respondent diagnosed gastritis, rule out peptic ulcer. He prescribed Donnatal Extentabs. He failed to perform a rectal examination or to order any diagnostic studies to confirm his diagnosis, such as an upper GI series.

Respondent began the patient on a long-term regimen of anorexiant medications, including Adipex and Fastin, beginning

with the first office visit. His use of the drugs fell below minimally acceptable standards of practice for the same reasons discussed previously. Respondent also prescribed Lasix for Patient N on 32 occasions. His use of this diuretic fell below acceptable standards for the same reasons discussed regarding the previous five patients.

On five occasions, Respondent prescribed antibiotics for conditions described in the records as viral infections. The use of antibiotics to treat Patient N's viral infections was inappropriate for the same reasons discussed regarding Patient M. Of particular concern was the fact that on one occasion (December 9, 1987) administered Lincocin to Patient N, as well as prescribing Duricef, when the patient was diagnosed with acute pharyngitis. Lincocin is indicated in the treatment of serious infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Its use should be reserved for penicillin-allergic patients or other patients for whom penicillin is inappropriate. Respondent failed to ascertain whether the patient had an appropriate bacterial infection. In addition, there is no indication that the patient was allergic to penicillin. By using Lincocin unnecessarily, Respondent placed the patient at undue risk of developing colitis.

The Hearing Committee concluded that Respondent's treatment of Patient N demonstrated negligence, but did not rise to the level of gross negligence. In addition, the Committee concluded that Respondent's use of Lasix for Patient N demonstrated incompetence. Moreover, the medical record for

Patient N did not accurately reflect the evaluation and treatment of the patient.

Based upon the Hearing Committee's conclusions that Respondent's treatment of each of the six named patients demonstrated negligence but not gross negligence, the Committee sustained the First Specification and dismissed the Second through Seventh Specifications. Based upon the Committee's conclusions that Respondent's use of Lasix for Patients E, G, L, M and N also demonstrated incompetence, the Committee sustained the Eighth Specification. The Hearing Committee also sustained the Ninth, Thirteenth, Fifteenth, Twentieth, Twenty-First and Twenty-Second Specifications (failure to maintain records which accurately reflect the evaluation and treatment of the patient).

Criminal Conviction

On September 12, 1989, Respondent was convicted, by virtue of a guilty plea, of attempted grand larceny in the second degree. This offense constitutes a Class E felony under the New York Penal Law. Consequently, the Hearing Committee concluded that Respondent was guilty of professional misconduct in violation of Education Law §6530(9)(a)(i) [conviction of a crime under New York Law]. Accordingly, the Committee voted to sustain the Twenty-Third Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in

New York State should be suspended pending successful completion of a comprehensive course of re-training in the general practice of medicine. The re-training program (which shall be subject to the prior approval of the Director of the Office of Professional Medical Conduct) shall include, but not be limited to, the areas of pharmacology, physical diagnosis, record-keeping and clinical pathology. The suspension of Respondent's medical license shall be stayed only to the extent necessary to participate in the retraining program. Upon successful completion of the retraining program, Respondent shall be placed on probation for a period of three years. The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

Respondent has demonstrated shortcomings across the broad range of issues pertaining to the practice of medicine. He performed inadequate histories and physical examinations and failed to follow-up on those positive findings which he did record. His method of record-keeping is out of date and woefully inadequate. Respondent's approach to the treatment of obesity is ineffective and potentially dangerous for his patients. His indiscriminate use of antibiotics to treat viral infections is equally troubling. It became apparent to the members of this Committee that Respondent, although well-meaning, was lucky not to have harmed any of his patients.

The Hearing Committee gave strong consideration to the revocation of Respondent's medical license, but determined that this ultimate sanction was not appropriate.[4] The Committee unanimously concluded that Respondent is in need of a comprehensive program of retraining, in all facets of general medical practice, in order to practice with reasonable skill and safety. The Committee believes that Respondent has shown a willingness to improve his skills. Nevertheless, the Committee strongly believes that he should not practice unless he can successfully complete such a program. To that end, Respondent's license shall be suspended, except to the extent necessary to participate in, and successfully complete the retraining program.

In the event that he does complete his retraining, Respondent shall be placed on probation, with terms including practice monitoring, for a period of three years. The Hearing Committee believes that the sanction imposed strikes the appropriate balance between the need to protect the public and punish Respondent, while still providing the opportunity for Respondent to rehabilitate himself.

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[4]The Hearing Committee did consider the ramifications of Respondent's criminal conviction in making its determination regarding sanction. Normally, a conviction on Medicaid fraud would warrant revocation. Although it is not bound by the findings of the sentencing judge, the Committee did take guidance from the trial court. The court imposed an unconditional discharge, the lowest possible sanction, in addition to the restitution which was ordered and paid. The Committee considered these facts, as well as the nature of Respondent's offense and determined that no escalation of sanction was warranted in this instance.

ORDER

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

1. The First, Eighth, Ninth, Thirteenth, Fifteenth, Twentieth, Twenty-First, Twenty-Second and Twenty-Third Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;

2. The Second, Third, Fourth, Fifth, Sixth, and Seventh Specifications are **DISMISSED WITH PREJUDICE**;

3. The Tenth, Eleventh, Twelfth, Fourteenth, Sixteenth, Seventeenth, Eighteenth, and Nineteenth Specifications of professional misconduct are **DISMISSED WITHOUT PREJUDICE**;

4. Respondent's license to practice medicine as a physician in New York State be and hereby is **SUSPENDED** pending successful completion of a comprehensive course of retraining in general medical practice. Said course of retraining, which shall be subject to the prior approval of the Director of the Office of Professional Medical Conduct, shall include, but not be limited to, the areas of pharmacology, physical diagnosis, record-keeping, and clinical pathology. Respondent's suspension shall be stayed only to the extent necessary to participate in said course of retraining;

5. Upon successful completion of the course of retraining set forth in Paragraph 4, above, Respondent shall be placed on probation for a period of three (3) years. The complete terms of probation are attached to this Determination and Order in Appendix II, and are incorporated herein.

6. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: **Troy, New York**
9/22 , **1997**

PETER B. KANE, M.D. (CHAIR)

ANN SHAMBERGER
MOHAMMAD GHAZI-MOGHADAM, M.D.

TO: Bradley C. Mohr, Esq.
Assistant Counsel
New York State Department of Health
Corning Tower - Rm. 2503
Empire State Plaza
Albany, New York 12237

Mamerto John Azurin, M.D.
343 Abbott Road
Buffalo, New York 14220

Terrence M. Connors, Esq.
Connors & Vilardo, LLP
1020 Liberty Building
420 Main Street
Buffalo, New York 14202

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	NOTICE
OF	:	OF
MAMERTO JOHN AZURIN, M.D.	:	HEARING

----------X

TO: MAMERTO JOHN AZURIN, M.D.
343 Abbott Road
Buffalo, New York 14220

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1996). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 10th day of October, 1996, at 10:00 o'clock in the forenoon of that day at the Court Of Claims, Hearing Room Number One, The Justice Building--7th Floor, Empire State Plaza, Albany, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in

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order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1996), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1996). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
August 26, 1996

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

Joseph Huberty
Assistant Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
MAMERTO JOHN AZURIN, M.D.	:	CHARGES

----------X

MAMERTO JOHN AZURIN, M.D., the Respondent, was authorized to practice medicine in New York State on February 2, 1968 by the issuance of license number 100652 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through December 31, 1996. Respondent's address, as shown on Respondent's last registration with the New York State Education Department is 343 Abbott Road, Buffalo, New York 14220.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (all patients are identified in Appendix I, attached hereto) at Respondent's medical office at various times from on or about February 11, 1985 to on or about August 13, 1993.

1. Respondent failed to obtain and/or document an adequate initial history and/or physical examination of Patient A.

2. Respondent failed to evaluate and/or document such evaluation of Patient A during the course of Respondent's treatment.

3. Respondent prescribed Lortab, a Schedule III Controlled Substance, for Patient A without medical need therefor.

4. Respondent failed to record adequate and in some cases any notes justifying the medical need for the use of Lortab, a Schedule III Controlled Substance, in the treatment of Patient A.

5. Respondent prescribed Placidyl, a Schedule IV Controlled Substance for Patient A without medical need therefor.

6. On the following dates Respondent prescribed Noludar for patient A, a Schedule III Controlled Substance without medical need therefor: April 8, 1989, May 31, 1989, July 19, 1989, August 21, 1989, October 4, 1989, November 8, 1989, December 6, 1989, January 3, 1990 and/or February 9, 1990.

7. Respondent prescribed Adipex, a Schedule IV Controlled Substance, for Patient A in an excessive amount, for an excessive period of time and contrary to the manufacturers recommendations.

8. At various times Respondent failed to record adequate or in most cases any notes concerning the

drugs he prescribed for Patient A or the directions given for the taking or administration of such drugs.

9. Respondent failed to order and/or perform adequate and/or timely laboratory and/or urine tests on and for Patient A.

10. Respondent treated Patient A from on or about February 11, 1985 to on or about August 13, 1993 and during this period of time failed to provide Patient A ~~any~~ adequate primary care.

amended by Pet. 4/10/97 JYS

11. Respondent failed to maintain a legible patient record for Patient A.

12. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment rendered Patient A.

B. At various times between on or about May 20, 1985 to on or about February 25, 1991 Respondent treated Patient B at Respondent's medical office.

1. Respondent failed to obtain and/or document an adequate history and/or physical examination of Patient B.

2. Respondent failed to evaluate and/or document such evaluation during the course of his treatment of Patient B.

3. From on or about May 20, 1985 to on or about April 20, 1987 Respondent issued twenty (20) prescriptions for Tenuate Dospan (a Schedule IV Controlled Substance)

for Patient B without documenting medical justification and/or need therefor and contrary to the manufacturers recommendations.

4. From on or about May 18, 1987 to on or about February 25, 1991 Respondent issued about forty Three (43) prescriptions for Adipex, a Schedule IV Controlled substance for Patient B without medical justification therefor and contrary to the manufacturers recommendation.

5 Between on or about October 14, 1987 and February 25, 1991 Respondent issued about thirty four (34) prescriptions for Fiorinal with Codeine for Patient B without documented medical justification or need therefor.

6. Following an initial office visit on or about May 20, 1985, Respondent treated Patient B on or about sixty nine (69) additional office visits between on or about June 17, 1985 and on or about February 25, 1991. At no time during this stated period did Respondent conduct and/or record an adequate and in many cases any physical examination and/or make any findings for Patient B.

7. Respondent failed to order and/or perform adequate and/or timely laboratory and/or urine tests on and for Patient B.

8. Respondent treated Patient B from on or about May 20, 1985 to on or about February 25, 1991 and during that time failed to provide Patient B adequate primary care.

9. Respondent failed to maintain a legible medical record for Patient B.

10. Respondent failed to maintain a record for Patient B which accurately reflects Respondent's evaluation and treatment of Patient B.

C. At various times from on or about December 21, 1987 to on or about October 15, 1993 Respondent treated Patient C at his medical office.

1. Respondent failed to obtain and/or document an adequate initial medical history of Patient C.

2. Respondent failed to evaluate and/or document such evaluation of Patient C during his care and treatment of Patient C.

3. Respondent prescribed Adipex, a Schedule IV Controlled Substance for Patient C in excessive amounts, for an excessive period of time and contrary to the manufacturers recommendations.

4. Between on or about January 29, 1988 and December 14, 1988 Respondent prescribed Valium, a Schedule IV Controlled Substance for Patient C on ten (10)

occasions without medical justification and/or need therefor.

5. At no time during the course of care and treatment did Respondent perform and/or record an adequate physical examination of Patient C.

6. Respondent failed to maintain a legible medical record for Patient C.

7. Respondent failed to order and/or perform adequate and/or timely laboratory and/or urine tests on and for Patient C.

8. Respondent treated Patient "C" from on or about December 21, 1987 to on or about October 15, 1993 and during this period of time failed to provide Patient C with adequate primary care.

9. Respondent failed to maintain a medical record for Patient C which accurately reflects his evaluation and treatment of Patient C.

D. At various times between on or about May 17, 1971 and on or about August 11, 1993 Respondent treated Patient D at his medical offices.

1. Respondent failed to perform/conduct and/or record adequate on-going physical examinations of Patient D during the course of treatment.

2. Respondent prescribed Fastin, Adipex and/or Tenuate Dospan 75 (all Schedule IV Controlled substances) for

Patient D for an excessive periods of time and without medical justification and/or need therefor.

3. Respondent failed to order and/or perform adequate and or timely laboratory and/or urine tests on and for Patient D.

4. Respondent treated Patient D from on or about May 17, 1971 to on or about August 11, 1993 and during this period of time failed to provide Patient D with adequate primary care.

5. Respondent failed to maintain a legible medical record for Patient D.

6. Respondent failed to maintain a medical record for Patient D which accurately reflects Respondent's evaluation and treatment of Patient D.

E. At various times between on or about November 3, 1986 and August 16, 1993 Respondent treated Patient E at Respondent's medical offices.

1. Respondent failed to obtain and/or document an adequate medical history and physical examination of Patient E.

2. Respondent prescribed Adipex, a Schedule IV Controlled Substance for Patient E for an excessive period of time, without medical justification and/or need and contrary to the manufacturers recommendations.

3. Respondent prescribed Lasix, a diuretic, for Patient E without stated medical need, without instructions

for use and without any laboratory analysis follow-up to ascertain potassium levels and any other metabolic deficiencies that may result from the use of this drug.

4. Respondent prescribed Placidyl, a Schedule IV Controlled Substance, for Patient E without any stated medical justification and/or need therefor.

5. At various times Respondent failed to record adequate and in most cases any notes concerning the drugs he prescribed for Patient E, the quantities of such drugs and/or the instructions for their use.

6. Respondent failed to order and/or perform adequate laboratory and/or urine tests on and for Patient "E"

7. Respondent treated Patient E from on or about November 3, 1986 to on or about August 16, 1993 and during this period of time failed to provide adequate primary care.

8. Respondent failed to maintain a legible medical record for Patient E.

9. Respondent failed to maintain a record for Patient E which accurately reflects Respondent's evaluation and treatment of Patient E.

F. At various times between on or about March 12, 1985 and November 10, 1993 Respondent treated Patient F. at his medical offices.

1. Respondent failed to secure and record an adequate medical history from Patient F and/or perform and/or record an adequate initial medical examination of Patient F.

2. Respondent prescribed Adipex and Tenuate Dospan 75 (Both Schedule IV Controlled Substances) and Prelu-2 (a Schedule III Controlled Substance) for Patient F for excessive periods of time and contrary to the manufacturers recommendations for use of these drugs.

3. Respondent prescribed Meprobamate a Schedule III Controlled Substance; Valium and Tranxene, both Schedule IV Controlled Substances and Triavil, an anti-anxiety psychotic drug for Patient F without documented medical justification and/or need therefor.

4. Although Respondent examined and treated Patient F on about forty (40) different occasions between on or about April 12, 1985 and November 26, 1990, Respondent failed to perform a general physical examination of Patient F during that time and/or record his findings concerning such examination.

5. On or about February 19, 1993 Respondent diagnosed Patient F as suffering arthritis of the spine. Respondent failed to perform or secure any X-Ray or other diagnostic tests to confirm his diagnosis.

6. Respondent failed to maintain a legible medical record for Patient F.

7. Respondent failed to maintain a record for Patient F. which accurately reflects Respondent's evaluation and treatment of Patient F.

G. At various times between on or about February 6, 1984 and October 25, 1993 Respondent treated Patient G at his medical offices.

1. Respondent failed to adequately evaluate and/or document his evaluation of Patient G during the course of his treatment of Patient G.
2. Respondent prescribed Placidyl, a Schedule IV Controlled Substance for Patient G and failed to record adequate or in most cases any notes concerning the medical need for such drug or patient instructions for use of the drug.
3. Respondent prescribed Tranxene and/or Librium and/or Valium (all Schedule IV Controlled Substances) for Patient G and failed to record adequate and in most cases any notes concerning the indications for use of such drugs or any instructions for their use.
4. Respondent prescribed Tranxene and/or Librium and/or Valium for Patient G without medical need therefor.
5. Respondent prescribed Ionamin and/or Fastin and/or Adipex (all Schedule IV Controlled Substances) for Patient G for excessive periods of time and contrary

to the manufacturers recommendations for use of such drugs.

6. Respondent repeatedly prescribed Lasix, a diuretic, for Patient G over a period of nine (9) years and seven (7) months and at no time did Respondent direct or perform any laboratory analysis to ascertain potassium levels for Patient G or if Patient G was suffering any metabolic or other deficiencies or other side effects from the persistent use of Lasix.

7. On or about the following dates Respondent prescribed Placidyl, a Schedule IV Controlled Substance, for Patient G. although Patient G had "No Complaints" or was found by Respondent to be asymptomatic: ~~August 24, 1988~~, May 24, 1989, June 21, 1989, September 18, 1989, October 25, 1989, December 22, 1989, April 23, 1990, July 13, 1990, January 18, 1991, June 19, 1991 and/or May 18, 1992.

amended by 5.1.97 Pet. on 8 LS

8. Respondent failed to order and/or perform adequate and/or timely laboratory and/or urine tests on and for Patient G.

9. Respondent treated Patient G from on or about February 6, 1984 to on or about October 25, 1993 and during that time failed to provide adequate primary care.

10. Respondent failed to maintain a legible medical record for Patient G.

11. Respondent failed to maintain a medical record for Patient G which accurately reflects Respondent's evaluation and treatment of Patient G.

H. At various times between on or about December 10, 1984 and on or about August 25, 1993 Respondent treated Patient H at Respondent's medical offices.

1. Respondent failed to obtain and/or document an adequate initial history and or physical examination of Patient H.
2. Respondent failed to adequately evaluate and/or document his evaluation of Patient H during the course of treatment.
3. Respondent prescribed Lincocin, an antibiotic drug, for Patient H when Respondent diagnosed Patient H as suffering a "Viral Infection".
4. Respondent prescribed Lincocin for Patient H in excessive amounts and in disregard of the manufacturers warnings concerning use of this drug.
5. Respondent prescribed Prednisone for patient H on repeated occasions without documentation of the reasons for administration of this drug.
6. On occasions Respondent prescribed both Lincocin and/or Prednisone for Patient H without documented medical need therefor.

7. Respondent failed to maintain a legible medical record for Patient H.

8. Respondent failed to maintain a medical record for Patient H which accurately reflects Respondent's evaluation and treatment of Patient H.

I. On various occasions between on or about April 4, 1988 and September 6, 1993 Respondent treated patient I at his medical offices.

1. Respondent failed to make and/or record an adequate initial physical examination of Patient I.

2. Respondent failed to evaluate and/or document such evaluation of Patient I during the course of treatment.

3. At various times during the course of treatment Respondent failed to record adequate notes concerning the drugs he prescribed for Patient I, and/or the indications for use of said drugs and/or the quantity of such drugs prescribed and/or patient instructions for the use of such drugs as were prescribed.

4. Respondent prescribed Ionamin and/or Adipex, both Schedule IV Controlled Substances, for Patient I for an excessive length of time and contrary to the manufacturers recommendation.

5. Respondent prescribed Meprobamate, a Schedule III Controlled Substance, for Patient I for an excessive

period of time and without documented medical need therefor.

6. Respondent failed to maintain a legible medical record for Patient I.

7. Respondent failed to maintain a medical record for Patient I which accurately reflects Respondent's evaluation and treatment of Patient I.

J. At various times between on or about July 9, 1989 and December 3, 1993 Respondent treated Patient J at his medical offices.

1. Respondent failed to evaluate or adequately document his evaluation of Patient J during the course of treatment.

2. At various times during the course of treatment Respondent failed to record adequate notes concerning the drugs he prescribed for Patient J, and/or the indications for use of such drugs, and/or the quantity of the drugs so prescribed, and/or the instructions for the use of such drugs.

3. Respondent prescribed Adipex, a Schedule IV Controlled Substance, for Patient J for an excessive period of time, contrary to the manufacturers recommendations and without efficacious effect.

4. Respondent failed to order and/or perform adequate

and/or timely laboratory and/or urine tests on and for Patient J.

5. Respondent treated Patient J from on or about July 9, 1989 to on or about December 3, 1993 and during this period of time Respondent failed to provide Patient J with adequate primary care.

6. Respondent failed to maintain a legible medical record for Patient J.

7. Respondent failed to maintain a medical record for Patient J which accurately reflects Respondent's evaluation and treatment of Patient J.

K. At various times between on or about June 1, 1979 and July 14, 1993 Respondent treated Patient K at Respondent's medical offices.

1. Respondent failed to obtain and document a medical history and failed to perform and/or document an initial physical examination of Patient K.

2. Respondent failed to evaluate and/or record such evaluation of Patient K during the course of treatment of Patient K.

3. Respondent prescribed Adipex, Fastin and/or Ionamin, all Schedule IV Controlled Substances, for Patient K for an excessive period of time and contrary to the manufacturers recommendations.

4. Respondent continued to prescribe Adipex, Fastin and/or Ionamin for Patient K without medical need therefor.

5. Respondent failed to order and/or perform adequate and/or timely laboratory and/or urine tests on and for Patient "K".

6. Respondent treated Patient K from on or about June 1, 1979 to on or about July 14, 1993 and during this period of time Respondent failed to provide Patient K with adequate primary care.

7. Respondent failed to maintain a legible medical record for Patient K.

8. Respondent failed to maintain a medical record for Patient K which accurately reflects Respondent's evaluation and treatment of Patient K.

L. At various times between on or about October 19, 1990 and July 28, 1993 Respondent treated Patient L at Respondent's medical offices.

1. Respondent failed to adequately evaluate and/or document such evaluation of Patient L during the course of treatment of Patient L.

2. Respondent prescribed Adipex, a Schedule IV Controlled Substance for Patient L for an excessive period of time and contrary to the manufacturers recommendations.

3. Respondent failed to order and/or perform adequate

and/or timely laboratory and/or urine tests on and for Patient L

4. Respondent treated Patient L from on or about October 19, 1990 to on or about July 28, 1993. During this period of time Respondent failed to provide Patient L with adequate primary care.
5. Respondent prescribed Lasix, a diuretic, for Patient L for a prolonged period of time without ordering or securing any laboratory analysis on Patient L.
6. Respondent failed to maintain a legible medical record for Patient L.
7. Respondent failed to maintain a medical record for Patient L which accurately reflects Respondent's evaluation and treatment of Patient L.

M. At various times from on or about June 29, 1990 to August 25, 1993 Respondent treated Patient M at Respondent's medical offices.

1. Respondent failed to evaluate and/or document such evaluation of Patient M during his course of treatment.
2. Respondent prescribed Ionamin and/or Adipex, both Schedule IV Controlled Substances for Patient M for an excessive period of time and contrary to the manufacturers recommendations.

3. Respondent failed to order/perform adequate and/or timely laboratory, urine and/or diagnostic tests on and for Patient M.

4. In particular, Respondent prescribed Lasix, a diuretic, for Patient M over a long period of time without ordering/performing any laboratory analysis to ascertain potassium levels for Patient M or the presence of any undesirable side effects from the use of this drug.

5. On occasions Respondent prescribed antibiotic medications for Patient M when his diagnosis was "viral infection".

6. Respondent treated Patient M from on or about June 29, 1990 to on or about August 25, 1993. During this period of time Respondent failed to provide Patient M with adequate primary care.

7. Respondent failed to maintain a legible medical record for Patient M.

8. Respondent failed to maintain a medical record for Patient M which accurately reflects Respondent's evaluation and treatment of Patient M.

N. On various occasions between on or about September 16, 1987 and October 4, 1993 Respondent rendered care and treatment to Patient N at Respondent's medical offices.

1. Respondent prescribed Fastin and/or Adipex, both Schedule IV Controlled Substances, for Patient N for an excessive period of time and contrary to the manufacturers recommendation.
2. Respondent failed to order and/or perform adequate and or timely laboratory, urine and/or diagnostic tests on and for Patient N.
3. In particular, Respondent prescribed Lasix, a diuretic, for Patient N over a long period of time without ordering/performing any laboratory analysis to ascertain potassium levels for Patient N or the presence of any undesirable side effects of the administration of this drug.
4. Patient N presented with a family history of diabetes and Respondent failed to order laboratory tests to ascertain Patient N's glucose values.
5. At various times Respondent prescribed antibiotic medications for Patient N when Respondnt's stated diagnosis was "Viral Infection".
6. Respondent administered Lincocin IM to Patient N for pharyngitis without any documentation of objective findings indicating the medical need therefor.
7. Respondent administered Lincocin IM (an antibiotic) to Patient N and at the same time prescribed Duricef, another antibiotic medication.

withdrawn by Petitioner 5/1/97 JGB

8. ~~Respondent prescribed Tylenol #3 for Patient N without documenting any medical findings justifying the medical need therefor~~.

9. Respondent treated Patient N from on or about September 16, 1987 to on or about October 4, 1993. During this period of time Respondent failed to provide adequate primary care to Patient N.

10. Respondent failed to maintain a legible medical record for Patient N.

11. Respondent failed to maintain a medical record for Patient N which accurately reflects Respondent's evaluation and treatment of Patient N.

O On or about September 3, 1987 Respondent was indicted by the Erie County Grand Jury on the charge of Grand Larceny, Second Degree, a violation of Sec. 155:35 of the Penal Law, a Class D Felony, and thirteen counts of Offering a False Instrument for Filing, First Degree, a violation of Sec. 175:35 of the Penal Law. On or about September 12, 1989 Respondent appeared before the Erie County Supreme Court and by virtue of a plea of "Guilty" to the reduced charge of Attempted Grand Larceny, Second Degree, a violation of Sec. 110:00/ 155:35 of the Penal Law, Respondent was found "Guilty" of that reduced charge, a Class E Felony. Respondent was sentenced to an Unconditional Discharge.

P. Conviction of the commission an act constituting a crime under New York State Law, as set forth in paragraph "O" above, is defined as professional misconduct pursuant to the provisions of N.Y. Educ. Law Sec. 6530(9)(a)(i) (McKinney Supp. 1996).

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Petitioner charges Respondent with professional misconduct pursuant to N.Y. Educ. Law Sec. 6530(2) (formerly N.Y.Educ. Law Sec. 6509(2) in that Respondent has practiced his profession with negligence on more than one occasion in that Petitioner charges:

1. The facts in paragraphs A, A.1, A.2, A.3, A.5, A.6, A.7, A.8, B, B.1, B.2, B.3 B.4, B.5, B.6, B.7, B.8, C, C.1, C.2, C.3, C.4, C.5, C.7, C.8, D, D.1, D.2, D.3, D.4, E, E.1, E.2, E.3, E.4, E.6, E.7, F, F.1, F.2, F.4, F.5, G, G.1, G.2, G.3, G.4, G.5, G.6, G.7, G.8, G.9, H, H.1, H.2, H.6, I, I.1, I.2, I.4, I.5, J, J.1, J.3, J.4, J.5, K, K.1, K.2, K.3, K.4, K.5, K.6, L, L.1, L.4, L.5, M, M.1, M.2, M.3, M.4, M.5, M.6, N, N.1, N.2, N.3, N.4, N.5, N.7, and/or N.9.

SECOND THROUGH SEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Petitioner charges Respondent with professional misconduct pursuant to the provisions of N.Y. Educ. Law Sec. 6530(4) (formerly N.Y. Educ. Law 6509(2)) in that Respondent practiced the profession with gross negligence in that Petitioner charges:

2. The facts in paragraphs A and A.9.

3. The facts in paragraphs E and E.3.

4. The facts in paragraphs G and G.6.

5. The facts in paragraphs L and L.5.

6. The facts in paragraphs M and M.4.

7. The facts in paragraphs N, N.3 and/or N.4.

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Petitioner charges Respondent with professional misconduct pursuant to the provisions of N.Y. Educ. Law 6530(5) in that Respondent practiced the profession with incompetence on more than one occasion in that Petitioner charges:

8. The facts in paragraphs A, A.1, A.9, A.10, B, B.6, B.7, C, C.5, C.7, D, D.3, D.4, E, E.3, E.6, F, F.4, F.5, G, G.6, G.8, J, J.4, K, K.5, L, L.5, M, M.3, M.4, N, N.2, N.3 and/or N.4.

NINTH THROUGH TWENTY SECOND SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS WHICH ACCURATELY DESCRIBE THE EVALUATION AND TREATMENT OF THE PATIENT

Petitioner charges Respondent with professional misconduct pursuant to the provisions of N.Y. Educ. Law 6530(32) [formerly N.Y. Educ. Law 6509(9) (8 NYCRR 29.2(3))] in that Respondent failed to maintain a medical record which accurately reflects the evaluation and treatment of each patient in that Petitioner charges:

9. The facts in paragraphs A, A.1, A.2, A.4, A.8, A.11 and/or A.12.
10. The facts in paragraphs B, B.1, B.2, B.3, B.6, B.9 and/or B.10.
11. The facts in paragraphs C, C.1, C.2, C.5, C.6 and/or C.9.
12. The facts in paragraphs D, D.1, D.5 and/or D.6.
13. The facts in paragraphs E, E.1, E.4, E.5, E.8 and/or E.9.
14. The facts in paragraphs F, F.1, F.3, F.4, F.6 and/or F.7.
15. The facts in paragraphs G, G.1, G.2, G.3, G.10 and/or G.11.
16. The facts in paragraphs H, H.1, H.2, H.5, H.6, H.7 and/or H.8.
17. The facts in paragraphs I, I.1, I.2, I.3, I.5, I.6 and/or I.7.

18. The facts in paragraphs J, J.1, J.2, J.6 and/or J.7.

19. The facts in paragraphs K, K.1, K.2, K.7 and/or K.8.

20. The facts in paragraphs L, L.1, L.6 and/or L.7.

21. The facts in paragraphs M, M.1, M.7 and/or M.8.

22. The facts in paragraphs N, N.6, N.10 and/or N.11.

TWENTY THIRD SPECIFICATION

CONVICTED OF A CRIME UNDER NEW YORK STATE LAW

Petitioner charges Respondent with professional misconduct pursuant to the provisions of N.Y. Educ. Law Sec. 6530(9)(a)(i) in that Respondent was convicted of a crime under the laws of the State of New York in that Petitioner charges:

23. The facts in paragraphs O and P.

Dated: Albany, New York
August 26, 1996

Peter D. Van Buren

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

APPENDIX II

APPENDIX II
TERMS OF PROBATION

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

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

3. Dr. Azurin shall submit prompt written notification to the Board addressed to the Director, office of Professional Medical conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, residence or telephone number, within or without New York State.

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

5. Dr. Azurin shall have quarterly meetings with an employee or designee of the Office of Professional Medical Conduct during the period of probation. During these quarterly meetings Dr. Azurin's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed.

6. Dr. Azurin shall have quarterly meetings with a monitoring physician who shall review Dr. Azurin' practice. This monitoring physician shall review randomly selected medical records and evaluate whether Dr. Azurin's practice comports with generally accepted standards of medical practice. This monitoring physician shall be selected by Dr. Azurin and is subject to the approval of the Director of the Office of Professional Medical Conduct. Dr. Azurin shall not practice medicine until an acceptable monitoring physician is approved by the Director.

7. Dr. Azurin shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the Office of Professional Medical Conduct at the address indicated above.

8. Dr. Azurin shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If Dr. Azurin elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

9. If there is full compliance with every term set forth herein, Dr. Azurin may practice as a physician in New York State in accordance with the terms of probation; provided, however, that upon receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Dr. Azurin pursuant to New York Public Health Law §230(19) or any other applicable laws.