STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

November 30, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Guenzburger, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

John N. Tasolides, Esq.
350 Jericho Turnpike
Jericho, New York 11753-1317

Michael Martin Katz, M.D.
246 Hedge Lane
Hewlett Harbour, New York 11557

Michael Martin Katz, M.D.
968 Grand Street
Brooklyn, New York 11211

RE: In the Matter of Michael Martin Katz, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-334) 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 together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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

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

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER
OF
MICHAEL MARTIN KATZ, M.D.

DETERMINATION
AND
ORDER

William A. Stewart, M.D., Calvin Simons, M.D., and **Ruth Horowitz, Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230 (1) of the Public Health Law, served as the Hearing Committee for this matter pursuant to Sections 230(10) (e) and 230 (12) of the Public Health Law. **Jane B. Levin, Esq.**, Administrative Law Judge, served as the Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Commissioner's Order and Notice of Hearing dated:	July 7, 2000
Statement of Charges dated:	June 30, 2000
Answer dated:	August 21, 2000
Hearing Dates:	July 17, 2000 September 12, 2000 September 13, 2000 September 18, 2000

	September 19, 2000 October 2, 2000 October 3, 2000
Deliberation Date:	October 30, 2000
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Petitioner appeared by:	Donald P. Berens, Jr. General Counsel NYS Department of Health By: Daniel Guenzburger, Esq. Associate Counsel
Respondent appeared by:	John N. Tasolides, Esq. 350 Jericho Turnpike Jericho, N.Y. 11753

WITNESSSES

For the Petitioner:

1) Peter Kalina, M.D.
2) Kim Nolan

For the Respondent:

1) Robert L. Bard, M.D.
2) Joseph Mormino, M.D.
3) Joseph Thomas Mecca, M.D.
4) Michael Martin Katz, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct in that he practiced with negligence and gross negligence, incompetence and gross incompetence, failed to maintain records, practiced fraudulently, and that he made or

filed a false report. The charges are more specifically set forth in the Statement Of Charges, a copy of which is attached hereto and made a part hereof. [1]

FINDINGS OF FACT

Numbers in parentheses refer to transcript pages or numbers of 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.

GENERAL FINDINGS

1. Michael Martin Katz, the Respondent, was authorized to practice medicine in the State of New York on or about October 30, 1985 by the issuance of license number 164591 by the New York State Education Department (Pet. Ex. 2).

2. The Respondent graduated from the University of Pennsylvania Medical School in 1973. He did a rotating internship at Bryn Mawr Hospital, Pennsylvania and thereafter a radiology residency at the University of Wisconsin and a one year fellowship in ultrasound and CT scanning at the Alton Ochsner Foundation (T. 941-2). He became board certified in 1978 (T. 944-45).

3. The Respondent has practiced radiology in many types of settings, including serving as the Director of Radiology at Caledonian/Brooklyn Hospital, Brooklyn, New York T. 966-67).

[1] The Statement of Charges was amended as follows: Allegations G, K, L M (in part) and N.6 were withdrawn, and Allegation B. 4 was added.

4. For the last ten years, the Respondent has been a half time salaried employee at Kingsborough Medical Group in Brooklyn, New York, a professional corporation that he owned which handled the mammography program for HIP (T. 971). Additionally, he has interpreted MRIs and other radiological studies performed at other diagnostic facilities he owns, including Metro Medical Diagnostics, P.C.; Ocean Diagnostics, P.C.; Junction Diagnostic Imaging, P.C. and Ultra-Diagnostics, P.C. (T. 896-897; Resp. Ex. V). The MRI cases involving Patients B, D, E, F and H were based on studies performed at these facilities (Pet. Exs. 7, 11, 13, 15 and 17). No allegations were made concerning the technical quality of the MRI films made at any of these facilities.

5. Respondent employed four other radiologists at his facilities, including Dr. Joseph Mecca, who testified as an expert witness for the Respondent (T. 1034). Respondent also interpreted diagnostic studies as an independent contractor for diagnostic facilities in which he had no ownership interest, including the Neuro Diagnostic and Treatment Facility of Staten Island. This facility is owned by Dr. Joseph Mormino, a neurosurgeon who testified on behalf of Respondent. For the past five years, the Respondent has interpreted approximately 15 MRIs a week from this facility (T. 722, 732). The MRI studies of Patients A, C, I and J were based on studies performed at this center.

6. Respondent also interpreted approximately 20 ultrasounds of the spine per week for Island Wide P.C. located in Long Island (T. 1034).

7. The Respondent testified that when he interprets a MRI, he dictates his findings over the telephone while looking at the film. He does not keep contemporaneous notes of his dictation. The Respondent further testified that the transcriptionist uses a pre-formatted report for each type of study, which uses a normal study as a default setting. The

report is prepared on the letterhead of the entity which will bill for it. When a report indicates findings other than normal, the typist is responsible to delete the language pertaining to normal findings and replace it with language dictated by Respondent which indicates the abnormal findings or pathology. After the report is typed and delivered to the Respondent, he reviews it briefly and signs his name. He does not make any attempt to insure the report being signed is appropriate to the dictated findings on a particular patient's MRI. The report is then delivered to the entity which will bill for it. The Respondent does not keep records of his reports himself. All reports and films are stored by whichever facility is billing for that patient (T. 1019; 1069; 1101).

FINDINGS OF FACT AS TO PATIENT A

1. On or about May 28, 1997, Respondent interpreted a non-contrast MRI of the brain of Patient A, which had been performed at Neuro Diagnostic & Treatment Center, Staten Island, New York (Pet. Ex. 5).

2. Patient A presented to this center with a prescription for a non-contrast brain MRI signed by Victor Ho, M.D., a neurosurgeon. A clinical diagnosis of pituitary adenoma was noted on the prescription (Pet. Ex. 5).

3. The pituitary is a gland located at the base of the center of the brain. Its size varies with the patient's age, and in the case of Patient A, a 34 year old male, would normally measure between 7 and 9 millimeters (T. 60). An adenoma is a type of tumor (T. 56, 58).

4. Both the Respondent and Dr. Mormino testified that the Respondent was aware that a pituitary adenoma had been previously diagnosed in this patient, and that when the

Respondent called the referring physician to request permission to perform a contrast study, the referring physician refused his request (T. 721; 1062; 1067-1070).

5. The Petitioner's expert, Dr. Peter Kalina, testified that a contrast study is only necessary to diagnose a microadenoma, which is less than 10 millimeters in size.

6. Dr. Kalina testified that Patient A's MRI demonstrated with "100 percent cent certainty" that Patient A had a pituitary adenoma three times normal size, measuring 25 millimeters (Pet. Exs. 4, 5; T. 61;71; 73; 113; 192).

7. In addition, the coronal image of the MRI demonstrated that the abnormally enlarged pituitary pressed on the optic chiasm. Normally there should be a plane of cerebral spinal fluid between the pituitary gland and the optic chiasm (T. 73).

8. Respondent's interpretation of Patient A's MRI stated that the area of the brain in which the pituitary is located, the sella and parasellar region, were unremarkable, and that the study was a normal non-contrast MRI . He also indicated that additional views should be taken to "totally exclude the possibility of a pituitary adenoma" (Ex. 5).

9. The pulse sequences and other settings used on the equipment taking a particular MRI are always recorded on the films themselves (T. 383-385). The Respondent's report failed to note that the MRI study included coronal T1 and T2 weighted images, as well as axial T1 weighted images. Respondent's report noted only that T1 weighted sagittal and T2 weighted axial views were included (Pet. Exs. 4b, 5; T. 75-76).

10. The Respondent testified that when he reviewed and signed the report he did not pick up what he termed word processing errors (T. 1069-70).

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient A because his report failed to accurately document a diagnosis of the patient's pituitary adenoma and contained multiple inaccuracies.

2. Factual allegations A., A.1, A.2, A.3, and A.4 are sustained with respect to gross negligence, negligence, and failure to maintain records. The allegations of gross incompetence and incompetence are not sustained.

FINDINGS OF FACT AS TO PATIENT B

1. In or about February 1998, Metro Medical Diagnostics, a company owned by Respondent, submitted to New York Central Mutual Insurance Company (NYCM) a claim for no-fault automobile insurance reimbursement for a brain MRI study and interpretation regarding Patient B, who had been in an automobile accident. The interpretive report signed by Respondent and dated December 10, 1997 was annexed to the insurance claim (Pet. Ex. 7, pg. 1 and 2).

2. The report for Patient B that Respondent submitted to NYCM described the "brain parenchyma as normal in size, contour and intensity" and concluded that the study was a normal non-contrast MRI of the brain (Pet. Ex. 6).

3. In or about October 1999, in response to a records request from OPMC, the Respondent submitted to OPMC a report of the same MRI study, also signed and dated December 10, 1997. However, on the report which Respondent provided to OPMC, he noted an impression of "multiple small areas of increased signal intensity predominantly in the

periventricular area" that could be seen as "a variant of normal" or as "compatible with a diagnosis of multiple sclerosis" (Pet. Ex. 7, pg. 2).

4. An identical report to the one received by OPMC was also sent to the referring physician, Dr. Zina Turovsky (Pet. Ex. 7, pg. 2; Resp. Ex. T).

5. Dr. Kalina testified that the MRI films of Patient B demonstrated abnormal foci of increased signal intensity in the periventricular area. On the axial T2 weighted images the abnormal lesions appear white in areas of the brain that should normally appear dark. The abnormal lesions were even more apparent on the proton density images. He further testified that the axial proton density sequences demonstrate that the paranasal sinuses were white, indicating that Patient B likely had sinusitis. Normally, the sinuses would appear to be black, indicating that they are filled with air (T. 220). Dr. Kalina concluded that with such pathology present, the study could not be considered a variant of normal (T. 212-219).

6. The Respondent testified that he was not aware of the existence of two reports for the same patient until OPMC brought it to his attention. Respondent testified that he could only speculate as to why two different reports existed for Patient B, and concluded that two reports had been generated for this patient by his clerical staff, one utilizing the default normal brain MRI format, and one incorporating his dictated findings (T. 1001-02; 1015). He further testified that he reviewed and signed both reports, and since the patient had an unfamiliar Russian name, he did not recognize that he had signed two different reports for the same patient (T. 1015).

7. Respondent knew that Patient B had multiple sclerosis, since on the version of the report submitted to both the referring physician and OPMC, he noted that, based on a

previous report that he had reviewed on this patient, there had been no change in the patient's multiple sclerosis in the interval between studies (Pet. Ex. 7, pg. 2).

8. Kim Nolan, an employee of NYCM for more than 10 years, testified that on February 10, 1998, she reviewed the claim filed by Metro Medical Diagnostics for Patient B. As a medical examiner, her job was to determine if the claim was related to a motor vehicle accident, and would therefore be paid by NYCM (T. 757; 767-770).

9. At the time Ms. Nolan reviewed the Metro Medical Diagnostics claim and report indicating a normal brain, the NYCM file for Patient B contained reports from two other physicians indicating that Patient B had a history of multiple sclerosis. Because of this discrepancy, she referred this insurance claim regarding Patient B to the Special Investigations Unit of her company (T. 792).

10. Dr. Katz and Dr. Mormino testified that they are not involved in billing or payment matters with insurance companies, and instead rely on billing or management companies to perform these functions (T. 842-844; 1015-1019).

11. Petitioner did not present any evidence that Respondent directed the submission of the erroneous report to NYCM, or that he willfully and knowingly intended to deceive NYCM.

CONCLUSIONS AS TO PATIENT B

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient B because he issued duplicate reports for the same patient, neither of which was labelled as an "amended" report. Additionally, the first report

contained numerous errors, and the second described the study as a variant of normal and failed to describe abnormal paranasal sinuses.

2. Petitioner failed to prove by a preponderance of the evidence that Respondent intended to deceive either OPMC or NYCM. The existence of two different reports appears to be another example of Respondent's poor pattern of practice, especially with regard to generation of his reports, rather than an intention to deceive.

3. Factual allegations B, B.1(a), B.1(b), B.2(b) and B.3, and B.2(a) only as to that part of the allegation that describes the study as a variant of normal, are sustained with respect to gross negligence and negligence. The allegations of gross incompetence and incompetence are not sustained.

4. Factual allegations B., B.2, B.2 (c) and B.4 are not sustained with respect to fraudulent practice or the making of a false report.

FINDINGS OF FACT AS TO PATIENT C

1. The MRI studies of patients C, D, E, F, H, I, and J all involve questions of disc bulging or herniation. Dr. Kalina testified as follows: a disc bulge is a circumferential outpouching of the outer part of the disc, typically in a symmetric manner, usually attributed to a longstanding degenerative process (T. 276); herniations are a more focal outpouching of the disc, specifically in the midline or to the immediate left or right of midline; when the herniation is larger and more focal, the usual etiology is related to trauma; smaller herniations may be caused by degeneration (T. 277).

2. There is some difference of terminology among radiologists. Dr. Mecca testified that a disc bulge may also be described as a disc herniation or protrusion (T. 650;

838). There is also a lack of consistency among radiologists in the use of terminology to describe indentation or compression of the spinal cord (T. 287; 298; 650; 838).

3. On or about May 22, 1997 the Respondent interpreted an MRI of the lumbosacral spine of Patient C. The study was performed at the Neuro Diagnostic Center owned by Joseph Mormino, M.D. (Pet. Ex. 9).

4. Respondent diagnosed generalized bulging of the disc from L2 to L5 and a left sided focal herniation at L5-S1.

5. Dr. Kalina testified that the MRI demonstrated a left sided disc herniation at L4/5 with thecal sac indentation. The left sided disc herniation appeared in the sagittal T2 weighted sequence and on axial T1 weighted sequences (Pet. Ex. 8; T. 278-282).

6. Dr. Kalina testified that the sagittal views demonstrated that a portion of the disc had migrated superiorly to lie behind the L4 vertebral body, and that this could only be characterized as a herniation (T. 298).

7. The Respondent and Dr. Mecca testified that this was not an extruded disc fragment but a chemical shift artifact (T. 274-284).

8. Respondent did not note in his report that the MRI study included sagittal T1 weighted images (Pet. Exs. 8, 9; T. 323).

CONCLUSIONS AS TO PATIENT C

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient C because his report failed to accurately document a diagnosis of the patient's left sided disc herniation at L4/5 and contained an inaccuracy regarding the pulse sequences.

2. Factual allegations C., C.1, C.2, and C.3, are sustained with respect to gross negligence, negligence, and failure to maintain records. The allegations of gross incompetence and incompetence are not sustained.

FINDINGS OF FACT AS TO PATIENT D

1. On or about May 22, 1997 the Respondent interpreted an MRI study of the lumbosacral spine of Patient D, noting a diagnosis of a central focal herniation at L3/4, causing anterior compression of the thecal sac in the midline (Pet. Exs. 10, 11).

2. Dr. Kalina testified that the MRI study demonstrated a healthy spine (T. 338), and that the L3/4 disc did not extend beyond its normal expected confine (T.336-338).

3. Dr. Kalina further testified that the pulse sequences used in the study regarding time to echo and time to repetition were incorrectly stated on both the sagittal gradient echo, sagittal T1 and axial images (T. 369).

CONCLUSIONS AS TO PATIENT D

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient D because his report contained an inaccurate diagnosis, when in fact it was a normal spinal study, and incorrectly stated pulse sequences.

2. Factual allegations D., D.1, D.2, D.3, and are sustained with respect to gross negligence, negligence, and failure to maintain records. The allegations of gross incompetence and incompetence are not sustained.

FINDINGS OF FACT AS TO PATIENT E

1. On or about October 2, 1997, the Respondent interpreted a MRI study of the cervical spine of Patient E, noting a diagnosis of central focal herniation at C4/5 causing anterior compression of the cervical cord in the midline and a disc bulge at C5/6 (Pet. Exs. 13, 14).

2. Dr. Kalina testified that spinal cord compression is a serious pathologic condition caused when a herniated disc actually compresses or indents the spinal cord. Because cord compression involves direct pressure on a neural structure, the condition is often associated with clinical signs and symptoms (T. 400).

3. Dr. Kalina testified that Patient E had a normal study, with no disc herniation or cord compression (T. 400-408).

CONCLUSIONS AS TO PATIENT E

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient E because his report contained an inaccurate diagnosis, when in fact it was a normal spinal study.

2. Factual allegations E., E.1, E.2, and E.3 are sustained with respect to gross negligence, negligence, and failure to maintain records. The allegations of gross incompetence and incompetence are not sustained.

FINDINGS OF FACT AS TO PATIENT F

1. On or about November 22, 1997 the Respondent interpreted an MRI study of the cervical spine of Patient F, noting a diagnosis of central focal herniation at C5/6 causing

anterior compression of the cervical cord in the midline and a disc bulge at C4/5 (Pet. Ex. 15).

2. Dr. Kalina testified that there was no disc pathology at the C5/6 level, as demonstrated by the sagittal T1 weighted sequences as well as the axial gradient echo images (T. 410-414).

3. Dr. Kalina also testified that the pulse sequences were inaccurately noted on the Respondent's report (T. 414).

CONCLUSIONS AS TO PATIENT F

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient F because his report contained an inaccurate diagnosis, when it fact it was a normal spinal study, and because it contained inaccurate documentation of pulse sequences.

2. Factual allegations F. F.1, F.2, and F.3 are sustained with respect to gross negligence, negligence, and failure to maintain records. The allegations of gross incompetence and incompetence are not sustained.

FINDINGS OF FACT AS TO PATIENT H

1. On or about April 14, 1997, Respondent interpreted an MRI of the cervical spine of Patient H, noting a diagnosis of central focal herniation at C4/5, causing anterior compression of the cervical cord in the midline (Pet. Ex. 17. 18).

2. Dr. Kalina testified that Patient H did not have a disc herniation, but rather a disc bulge at C4/5, with no cord compression, as demonstrated on the sagittal T1 sequence and the axial gradient image (Pet. Exs. 17, 18; T. 436-439).

3. Dr. Kalina also testified that the Respondent's description of normal cervical lordosis was inaccurate, since Patient H had a reversal of the normal curve (Pet. Exs. 17, 18; T. 435).

4. Dr. Kalina stated that the Respondent's report failed to note the sagittal T1 weighted image and that the sagittal gradient echo was described as a sagittal T2 weighted image (T. 438).

CONCLUSIONS AS TO PATIENT H

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient H because his report inaccurately described a disc herniation and cord compression, rather than a disc bulge without compression, inaccurately documented normal cervical lordosis, and inaccurately described the MRI settings.

2. Factual allegations H., H.1, H.2, H.3, and H.4 are sustained with respect to gross negligence, negligence, and failure to maintain records. The allegations of gross incompetence and incompetence are not sustained.

FINDINGS OF FACT AS TO PATIENT I

1. On or about February 3, 1998 the Respondent interpreted an MRI of the cervical spine of Patient I, noting a diagnosis of central focal herniation at C6/7 causing

anterior compression of the cervical cord in the midline, with normal cervical lordosis (Pet. Ex. 19).

2. Dr. Kalina testified that there was no disc pathology at C6/7. As demonstrated by the sagittal T1 weighted image, there was no thecal sac indentation, no cord compression and no herniation (T. 460-463).

3. Dr. Kalina testified that there was a right sided disc herniation at C5/6, which the Respondent did not report, as well as abnormal cervical lordosis. He also stated that the Respondent inaccurately described the pulse sequences in that the sagittal T1 weighted sequence was performed but not noted, and the sagittal gradient echo sequence was described as a sagittal T2weighted sequence (T. 460-464).

CONCLUSIONS AS TO PATIENT I

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient I because his report failed to accurately document a diagnosis of C5/6 disc herniation, and abnormal cervical lordosis, and inaccurately documented the pulse sequences.

2. Factual allegations I., I.1, I.2, I.3, I.4, and I.5 are sustained with respect to gross negligence, negligence, and failure to maintain records. The allegations of gross incompetence and incompetence are not sustained.

FINDINGS OF FACT AS TO PATIENT J

1. On or about April 21, 1998, the Respondent interpreted an MRI of the cervical spine of Patient J, noting a diagnosis of left sided focal herniation at C5/6 causing anterior compression of the cervical cord to the left of midline (Pet. Ex. 21).

2. Dr. Kalina testified that there was a right sided C5/6 disc herniation without cord compression, and that the Respondent inaccurately described the pulse sequences because he failed to note that T1 weighted sagittal images were performed and that he described the sagittal gradient echo sequence as a sagittal T2 weighted sequence (T. 492).

CONCLUSIONS AS TO PATIENT J

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient J because his report failed to accurately document a diagnosis of right sided C5/6 disc herniation without cord compression, and inaccurately described the MRI pulse sequences.

2. Factual allegations J., J.1, J.2, J.3 are sustained with respect to gross negligence, negligence, and failure to maintain records. The allegations of gross incompetence and incompetence are not sustained.

FINDINGS OF FACT AS TO PATIENT M THROUGH U

1. Between on or about June 27, 1996 and May 20, 1998, the Respondent interpreted spinal ultrasound studies of the cervical, thoracic and lumbar spines of Patients M through U to evaluate the paravertebral soft tissues surrounding the spine (Pet. Ex. 23; T.498-499).

2. Respondent's expert testified that the use of ultrasound to study muscles, including those in the back and those surrounding the spine, is well established (Resp. Exs. H, J, K, L, M, N, P, Q; T. 554-567).

3. The Respondent's ultrasound reports also referred to the posterior longitudinal ligament, which is not a paravertebral tissue, but actually part of the spine. Therefore, it should not be part of an ultrasound interpretation (T. 618-620).

4. The petitioner's expert had no experience with ultrasound of this area, and testified that both CT and MRI would demonstrate excellent "detail as far as the characteristics of tissues" (T. 508-510).

5. There is much debate in the literature and among the leading professional radiological organizations, the American College of Radiology and the American Institute of Ultrasound, concerning the value of spinal ultrasound because its efficacy has not been established by adequate research studies (Pet. Exs. 24, 25, 30, 31; Resp. Exs. H, J, K, L, M, N, P, Q).

6. Petitioner does not allege poor interpretation of the ultrasound studies, but rather alleges that even though Respondent's role was limited to interpretation of studies ordered and performed by others, he had an obligation not to perform any interpretation at all because the efficacy of these studies is still under investigation (T. 518).

7. Respondent did not maintain any copies of the reports he generated for the ultrasound studies, but sent them to the billing entity for each patient. Although the ultrasound reports indicate the referring physician, the reports do not indicate who was the radiologist or radiological professional corporation responsible for the ultrasound study (Pet. Ex. 23, reports for patients O, P, R, S, T).

CONCLUSIONS AS TO PATIENT M THROUGH U

1. The Petitioner did not prove by a preponderance of the evidence that Respondent failed to meet minimally acceptable standards of medical practice in his care of Patients M through U by rendering interpretations of ultrasound reports ordered and performed by others. Factual allegations M., M.1, M.2, M.3, M.4, M.5, M.6, M.7, M.8 with respect to negligence and incompetence are not sustained.

2. Factual allegations N., N.1, N.2, N.3, N.4, N.5 are sustained with respect to failure to maintain records.

FINDINGS OF FACT AS TO FRAUD

1. On MRI and ultrasound reports for Patients A through H and Patients M through U, Respondent represented that he was a Fellow of the American College of Radiology ("F.A.C.R.") (Pet. Exs. 5, 7, 9, 11, 13, 15, 17, 19, 21, 23, 29).

2. Board certification in some specialty areas of medicine entitles the physician to use the initials "F.A." followed by the initials of the speciality society, after the title M.D., to indicate that the physician is a fellow of that particular society. The American College of Radiology, however, uses the designation "Member" to indicate board certification. In a letter to the Respondent, William F. Shields, the General Counsel of the American College of Radiology indicated that "this occasionally results in some confusion because several other medical specialty organizations such as the American College of Surgeons, the American College of Obstetricians and Gynecologists, the American Academy of Orthopedic Surgeons, and the American Academy of Dermatology utilize the term Fellow to denote their basic

membership status. As a result, we regularly write to clarify this matter for members who use the F.A.C.R. designation but are not in fact fellows" (Resp. Ex. S).

3. The Respondent testified that he first learned that he had been using the wrong designation when he received a letter from the General Counsel (Pet. Ex. 29) in late October, 1999, prior to the filing of the charges herein (T. 947-950).

4. The Respondent supplied a copy of that letter to OPMC (T. 950-51).

5. The Respondent testified that the day after receiving the letter, he telephoned Mr. Shields, apologized and stated he would immediately use the correct designation (Resp. Ex. S; T. 952-955).

6. There was no evidence presented by the Petitioner that indicated the Respondent knowingly and falsely intended to deceive either other physicians or the public by his use of the designation "F.A.C.R." or that he has continued to use it.

7. The Statement of Charges also alleges fraudulent practice with respect to Patient B. As stated above, the Petitioner did not submit evidence that Respondent knowingly and falsely intended to deceive either OPMC or NYCM by filing a false report.

CONCLUSIONS AS TO FRAUD

1. The Petitioner failed to prove by a preponderance of the evidence that the allegations with respect to fraud and the making of a false report are sustained, because there was no evidence that the Respondent acted knowingly, falsely, and with the intent to deceive.

2. Factual allegations B., B.2, B.2.(c), B.4 and O are not sustained with respect to fraudulent practice or the making of a false report.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous, unless specified.)

FIRST THROUGH TWELFTH SPECIFICATIONS:
(Gross negligence)

All allegations are sustained, with the exception of factual allegation B.2(a) which is sustained only as to that part of the allegation which included an inappropriate description of the study as a variant of normal, but not sustained as to that part of the allegation which described the study as compatible with the diagnosis of multiple sclerosis.

THIRTEENTH THROUGH TWENTY FOURTH SPECIFICATIONS:
(Gross incompetence)

No allegations were sustained.

TWENTY-FIFTH SPECIFICATION:
(Negligence)

All allegations are sustained, with the exception of factual allegation B.2(a) which is sustained in part only as to that part of the allegation which included an inappropriate description of the study as a variant of normal, but not sustained as to that part of the allegation which described the study as compatible with the diagnosis of multiple sclerosis.

TWENTY-SIXTH SPECIFICATION:
(Incompetence)

No allegations were sustained.

TWENTY-SEVENTH THROUGH FORTY-THIRD SPECIFICATIONS:
(Failure to maintain records)

All allegations were sustained.

FORTY-FOURTH THROUGH FORTY-SIXTH SPECIFICATIONS:
(Fraudulent practice)

No allegations were sustained.

FORTY-SIXTH THROUGH FORTY-SEVENTH SPECIFICATIONS:
(False report)

No allegations were sustained.

CREDITABILITY OF WITNESSES

Dr. Katz was not always a credible witness. Much of his testimony was self-serving and characterized by an inability to accept responsibility for his actions and to excuse them on the basis that "everyone does them that way." We were, however, persuaded by specific portions of his testimony. We accept his account of the errors on his reports concerning settings of the MRI scanner, although this does not excuse his carelessness. We also accept as credible his testimony regarding the fraud issues of the duplicate reports on Patient B and the use of the designation "F.A.C.R."

We accept Dr. Kalina's interpretations of the MRI scans as accurate. Specifically, we do not accept Drs. Katz and Mecca's claims of "chemical shift artifact" to explain findings on certain of the films. It should be noted that Dr. Mormino is a neurosurgeon, not a radiologist.

The Committee also notes that Respondent's witnesses, Drs. Bard, Mormino and Mecca, all had professional and business relationships with him and that we therefore found their testimony somewhat biased. We accepted Dr. Kalina's opinion on MRI issues where it differed with the opinion of these witnesses.

The insurance company representative, Ms. Nolan, was highly credible.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee votes to suspend the Respondent's license for a period of one year, dating from the time of the summary order, July 7, 2000. When the Respondent returns to practice, he is to be permanently restricted to practicing radiology only in a hospital setting which has a department of radiology, certified by the American College of Radiology, and is to be supervised by the Chair of that department. The Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct, a full description of his employment and each time he changes employment he shall update OPMC to insure that he complies with this restriction.

In reaching this conclusion, the Committee considered the full range of penalties available, including revocation. Specifically, we do not find any evidence of fraud or incompetence and we therefore feel that the public can be adequately protected by these limitations on Respondent's practice.

The allegations sustained confirm that Respondent conducted his practice in a careless and substandard way. His testimony during the course of the hearing revealed that he is a bright, experienced and competent radiologist, but one with distorted priorities, who has cut all corners to maximize income, including quality control. His testimony revealed a lack of insight into the problems with his practice, blaming most errors on either the

technician performing the MRI or his typist, rather than taking responsibility himself. He displayed a cavalier attitude toward the accuracy of his MRI reports by not reviewing them in conjunction with contemporaneous notes, and his explanation that every radiologist does it that way does not excuse his errors.

We believe, for example, that Respondent knew Patient A had a pituitary adenoma, but even for this patient, which he claimed stood out in his mind, he allowed an erroneous report to be generated which he then signed without correcting. By interpreting far too many patient studies a day he ignored the protocols and safeguards needed to insure that the type of errors he made do not occur. Rather, he depended on his referring physicians to catch his mistakes, which he claimed minimized the possibility of patient harm.

With respect to whether the Respondent should have interpreted ultrasound studies, the Committee found the ACR statements regarding ultrasound more persuasive than the views of Respondent's experts, but the allegations were not proven by a preponderance of the evidence. The allegations about ultrasound studies were poorly drawn and confusing, and the department should have presented a credible witness on this issue. Although Dr. Kalina provided highly credible testimony on the MRI cases, he simply was not familiar enough with the ultrasound issue, nor did he know of any colleagues who used it for these types of cases.

With regard to fraud, the Committee accepts the Respondent's explanation of why the duplicate reports were issued for Patient B. The Petitioner failed to prove an intentional deception and in light of Respondent's carelessness in regard to issuing patient reports, it is surprising that there were not more of these errors. With regard to the second issue concerning fraud, Respondent's use of the F.A.C.R. designation, we simply do not believe it

was done with any intent to deceive, since we do not think he aspired to academic glory or an enhanced professional reputation for the purpose of gaining more referrals, since he was already too busy.

Patient harm was not an issue in this case. However, given the Respondent's practice pattern, no physician receiving one of the Respondent's MRI reports could count on its accuracy before making clinical decisions. Further, while the presence of patient harm may be an aggravating factor in cases of physician misconduct, its lack is never a mitigating factor. We therefore feel that the severity of the penalty is appropriate to the level of misconduct.

ORDER

Based upon the foregoing IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice medicine in the State of New York is hereby suspended for a period of one year dating from the time of the summary order of July 7, 2000.

2. Respondent is permanently restricted to the practice of radiology in a hospital department of radiology which has been certified by the American College of Radiology and is to be supervised by the Chair of that department.

3. Respondent shall submit annual written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299, said notice to include a full description of any employment and practice, professional and

residential addresses and telephone numbers. The Director of OPMC must be notified of all changes in employment during the entire period of Respondent's licensure in the State of New York.

Dated: Syracuse, New York
29 **November 2000**

William A. Stewart

WILLLIAM A. STEWART, M.D.
Chairperson

CALVIN SIMONS, M.D.
RUTH HOROWITZ, PH.D.

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

IN THE MATTER

OF

MICHAEL MARTIN KATZ, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: MICHAEL MARTIN KATZ, M.D.

246 Hedge Lane
Hewlett Harbour, New York 11557

968 Grand Street
Brooklyn, New York 11211

The undersigned, Dennis P. Whalen, Executive Deputy Commissioner of Health after an investigation, upon the recommendation of a Committee on Professional Medi Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continuec practice of medicine in the State of New York by Michael Martin Katz, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 2000) that effective immediately Michael Martin Katz, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified o vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 2000).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 2000), and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 2000). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on July 17, 2000 at 10:00 a.m., at the offices of the New

PETITIONERS EX. 1 for ID & in evidence 7/17/00 mm

7/17/00.

York State Health Department, 5 Penn Plaza, Sixth Floor, New York, NY 10001, and a such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents a to cross-examine witnesses and examine evidence produced against him. A summary the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, a by telephone (518-402-0748), 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. Claims of court engagement will require detailed affidavits of actual engagement. Clair of illness will require medical documentation.

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 th charges are sustained, a determination of the penalty or sanction 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 OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a (McKinney Supp. 2000). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
July 7 ,2000

DENNIS P. WHALEN
Executive Deputy Commissioner
New York State Health Department

Inquiries should be directed to:

Daniel Guenzburger
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
5 Penn Plaza
Suite 601
New York, New York 10001
(212) - 613-2608

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

IN THE MATTER

OF

MICHAEL MARTIN KATZ, M.D.

STATEMENT

OF

CHARGES

MICHAEL MARTIN KATZ, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 30, 1985, by the issuance of license number 164591 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On all dates relevant to the Statement of Charges the Respondent, a board certified radiologist, maintained offices at 4060 Hylan Boulevard, Staten Island, New York and at 2615 East 16th Street and 2818 Ocean Avenue, Brooklyn, New York, and at 225A East 149th Street, Bronx, New York. On or about May, 28, 1997, Respondent performed and interpreted an MRI of the brain of Patient A. The referring physician noted on the request for the MRI that he suspected a pituitary adenoma. (Patient A and the other patients in the Statement of Charges are identified in the attached Appendix.) Respondent:

1. Failed to diagnose a pituitary adenoma.
2. Inappropriately described the sella and parasellar region as unremarkable.
3. Inappropriately concluded that the MRI was a normal non-contrast MRI of the brain.

4. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the intervals, views, and/or pulse sequences used for Patient A's study.

B. In or about February, 1998, the Respondent submitted a claim for insurance reimbursement to New York Central Mutual Insurance Company ("New York Central Mutual") for services rendered interpreting an MRI of the brain of Patient B. On the MRI report that Respondent submitted with the New York Central insurance claim he noted a diagnostic impression of normal non-contrast MRI of the brain. Subsequently, in or about October, 1999, Respondent submitted a report of the same MRI study to the Office of Professional Medical Conduct ("OPMC"). Both MRI reports were identically dated December 10, 1997. However, on the report which Respondent provided OPMC he noted an impression of "multiple small areas of of increased signal intensity predominantly in periventricular area" that could be seen "as a variant of normal" or as "compatible with the diagnosis of multiple sclerosis".

1. With respect to the report that Respondent submitted to New York Central Mutual, Respondent:

   a. Inappropriately concluded that the study was a normal non-contrast MRI of the brain.
   b. Inappropriately described the "brain parenchyma as normal in size, contour and signal intensity."

2. With respect to the report Respondent submitted to OPMC,

Respondent:

a. Inappropriately described the study "as a variant of normal" or as "compatible with the diagnosis of multiple sclerosis".

b. Failed to appropriately document that he had issued an amended report.

c. Knowingly concealed that he had issued a report with a diagnosis of normal non–contrast MRI of the brain. Respondent intended to deceive.

3. With respect to both reports, Respondent inappropriately described normal paranasal sinuses.

YBL Added 10/2/00 4. Knowingly concealed from New York Central Mutual ("NYCM") that he had issued a report with a diagnostic impression of multiple*

C. On or about May, 22, 1997, the Respondent interpreted an MRI study of the lumbosacral spine of Patient C. Respondent:

1. Failed to describe a left sided disc herniation at L4/5.
2. Failed to describe thecal sac indentation on the left at L4/5.
3. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the pulse sequences used for Patient C's study.

D. On or about October 9, 1997, the Respondent interpreted an MRI study of the lumbosacral spine of Patient D. Respondent:

1. Inappropriately described a central focal herniation at L3/4.
2. Inappropriately described anterior compression of the thecal sac in the midline at L3/4.

* small areas of increased signal intensity predominantly in the periventricular area that could be seen as compatible with the diagnosis of multiple sclerosis.

3. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the pulse sequences used for Patient D's study.

E. On or about October 2, 1997, the Respondent interpreted an MRI study of the cervical spine of Patient E. Respondent:

1. Inappropriately described central focal herniation at C4/5.
2. Inappropriately described cord compression at C4/5.
3. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the pulse sequences used in Patient E's study.

F. On or about November 22, 1997, the Respondent interpreted an MRI of the cervical spine of Patient F. Respondent:

1. Inappropriately described central focal herniation at C5/6.
2. Inappropriately described cord compression at C5/6.
3. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the pulse sequences used for patient F's study.

G. On or about September 13, 1997, the Respondent interpreted an MRI of the Lumbar Spine performed on Patient G. Respondent:

Withdrawn 9/13/00

1. Inappropriately described central focal herniation at L5/S1.
2. Inappropriately described cord compression at L5/S1.

3. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing pulse sequences used for Patient G's study.

H. On or about April 14, 1997, the Respondent interpreted an MRI of the cervical spine performed on Patient H. Respondent:

1. Inappropriately described central focal herniation at C4/5.
2. Inappropriately described cord compression at C4/5.
3. Inappropriately described a normal cervical lordosis.
4. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the pulse sequences used for Patient H's study.

I. On or about February 3, 1998, the Respondent interpreted an MRI of the cervical spine of Patient I. Respondent:

1. Inappropriately described central focal herniation at C6/7.
2. Inappropriately described cord compression at C6/7.
3. Failed to describe a disc herniation at C5/6.
4. Inappropriately described normal cervical lordosis.
5. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the pulse sequences for Patient I's study.

J. On or about April 21, 1998, the Respondent interpreted an MRI of the cervical spine of Patient J. Respondent:

1. Inappropriately described a left sided focal herniation at C5/6.
2. Inappropriately described cord compression at C5/6.
3. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the pulse sequences for Patient J's study.

K. On or about July 9, 1997, the Respondent interpreted an MRI of the Lumbar Spine of Patient K. Respondent:

withdrawn 9/13/00

1. Failed to diagnose scoliosis.
2. Inappropriately described normal lumbar lordosis.
3. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing pulse sequences used in Patient K's study.

L. On or about February 26, 1998, Respondent interpreted an MRI of the lumbosacral spine of Patient L. Respondent:

withdrawn 9/13/00

1. Inappropriately described a central focal herniation at L4/5.
2. Incorrectly described nerve compression at L4/5.
3. Failed to maintain a record that accurately reflects his evaluation, including inaccurately describing the pulse sequences used in Patient L's study.

withdrawn in part 9/13/0

M. Respondent deviated from medically accepted standards by ~~by ordering and/or~~ interpreting ultrasound studies of the spine, with regard respectively to:

1. Ultrasound examinations of the cervical, thoracic, and lumbar

spine dated March 3,1997 of Patient M.

2. Ultrasound examinations of the cervical spine, thoracic spine, lumbar spine dated March 18, 1997 and May 19, 1997 of Patient N.
3. Ultrasound examinations of the cervical spine, thoracic spine, and lumbar spine dated August 4, 1997 of Patient O.
4. Ultrasound examinations of the cervical spine, thoracic spine, and lumbar spine dated August 18, 1997 and January 9, 1998 of Patient P.
5. Ultrasound examinations of the cervical spine, thoracic spine, and lumbar spine dated May 20, 1998 of Patient Q.
6. Ultrasound examinations of the cervical spine, thoracic spine, and lumbar spine dated November 3, 1997 of Patient R.
7. Ultrasound examinations of the cervical spine and lumbar spine dated June 27, 1996 of Patient S.
8. Ultrasound examinations of the cervical spine and thoracic spine dated December 18, 1997 of Patient T.
9. Ultrasound examinations of the lumbar and cervical spine dated November 18, 1996 of Patient U.

N. With respect to the ultrasound examinations for the patients listed below, Respondent failed to maintain a record of his evaluation.

1. Patient O.
2. Patient P.
3. Patient R.
4. Patient S.

5. Patient T.

~~6. Patient U.~~ withdrawn 10/27/00

O. On MRI and ultra-sound reports for Patients A through H and Patients K through U, Respondent knowingly and falsely represented that he was a Fellow of the American College of Radiology ("F.A.C.R"), when, in fact, he knew that he did not hold such a title. Respondent intended to deceive.

SPECIFICATION OF CHARGES

FIRST THROUGH TWELFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2000) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A1, A2 and/or A3.
2. Paragraphs B, B1, B1(a), B1(b), B2, B2(a) and/or B3.
3. Paragraphs C, C1 and/or C2.
4. Paragraphs D, D1 and /or D2.
5. Paragraphs E, E1 and/or E2.
6. Paragraphs F, F1 and/or F2.
7. Paragraphs G, G1 and/or G2.

8. Paragraphs H, H1 and/or H2.

9. Paragraphs I, I(1), I(2) and/or I(3).

10. Paragraphs J, J1 and or J2.

11. Paragraphs K, K1 and/or K2.

12. Paragraphs L, L1 and/or L2.

THIRTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2000) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

13. Paragraphs A1, A2 and/or A3.

14. Paragraphs B, B1, B1(a), B1(b), B2, B2(a) and/or B3.

15. Paragraphs C, C1 and/or C2.

16. Paragraphs D, D1 and /or D2.

17. Paragraphs E, E1 and/or E2.

18. Paragraphs F, F1 and/or F2.

19. Paragraphs G,G1 and/or G2.

20. Paragraphs H, H1 and/or H2.

21. Paragraphs I, I(1) I(2), and/or I(3).

22. Paragraphs J, J1 and or J2.

23. Paragraphs K, K1 and/or K2.

24. Paragraphs L, L1 and/or L2.

TWENTY-FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2000) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

25. Paragraphs A, A1, A2, A3, A4, B, B1,B1(a), B1(b), B2, B2(a), B2(b), B3, C, C1, C2, C3, D, D1, D2, D3, E, E1, E2, E3, F, F1,F2, F3, G, G1, G2, G3, H, H1, H2, H3, H4, I, I(1), I(2), I(3), I(4), I(5), J, J1, J2, J3, K, K1, K2, K3, L, L1, L2, L3, M, M1, M2, M3, M4, M5, M6, M7, M8, M9, N, N1, N2,N3, N4, N5, and/or N6.

TWENTY-SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2000) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

26. Paragraphs A, A1, A2, A3, A4, B, B1,B1(a), B1(b), B2, B2(a), B2(b), B3, C, C1, C2, C3, D, D1, D2, D3, E, E1, E2, E3, F, F1,F2, F3, G, G1, G2, G3, H, H1, H2, H3, H4, I, I(1), I(2), I(3), I(4), I(5), J, J1, J2, J3, K, K1, K2, K3, L, L1, L2, L3, M, M1, M2, M3, M4, M5, M6, M7, M8, M9, N, N1, N2,N3, N4, N5, and/or N6.

TWENTY-SEVENTH THROUGH FORTY-THIRD SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2000) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of paragraphs:

27. A and A4.
28. C and C3.
29. D and D3.
30. E and E3.
31. F and F3.
32. G and G3.
33. H and H4.
34. I and I(5).
35. J and J3.
36. K and K3.
37. L and L3.
38. N and N1.
39. N and N2.
40. N and N3.
41. N and N4.
42. N and N5.
43. N and N6.

FORTY-FOURTH THROUGH FORTY-SIXTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 2000) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

44. Paragraphs B, B2 and B2(c), B4. 10/2/00 JBL

45. Paragraph O.

FORTY-SIXTH THROUGH FORTY-SEVENTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 2000) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

46. Paragraphs B, B2 and B2(c), B4 10/2/00 JBL

47. Paragraph O.

FORTY-EIGHTH SPECIFICATION

EXCESSIVE TESTING

Withdrawn 10/3/00

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 2000) by ordering excessive tests not warranted by the condition of the patient, as alleged in the facts of:

48. Paragraphs M, M1, M2, M3, M4 M5, M6, M7, M8, and/or M9.

DATED: June 30, 2000
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct