STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

January 4, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
Offices of NYS Dept. of Health
Metropolitan Regional Office
5 Penn Plaza- Sixth Floor
New York, New York 10001

Nathan L. Dembin, Esq.
225 Broadway, Suite 1905
New York, New York 10007

Carl Balmir, M.D.
1984 Byron Avenue
Elmont, New York 11003

RE: In the Matter of Carl Balmir, M.D.

Dear Mr. Sheehan, Mr. Balmir and Mr. Dembin:

Enclosed please find the Determination and Order (No. 94-281) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the

requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

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IN THE MATTER	:	**DETERMINATION**
OF	:	**AND**
CARL BALMIR, M.D.	:	**ORDER**
		94-281

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Robert J. O'Connor, M.D., Chairperson, Hilda Ratner, M.D. and **Ms. Eugenia Herbst** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Marilyn S. Reader, Esq.,** duly under contract with the New York State Department of Health as an Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	April 18, 1994
Statement of Charges dated:	April 18, 1994
Pre-hearing conference:	April 25, 1994
Hearing dates:	June 30, 1994 July 27, 1994 August 30, 1994 September 20, 1994 October 3, 1994

Intra-hearing conferences:	September 20, 1994 August 30, 1994 October 3, 1994
Proposed findings of facts received:	October 26, 1994
Deliberation date:	November 7, 1994 November 15, 1994
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York 10001
Petitioner appeared by:	Peter Millock, Esq. General Counsel NYS Department of Health Office of Professional Medical Conduct 5 Penn Plaza New York, New York 10001 By: Terrence Sheehan, Esq. Associate Counsel
Respondent appeared in person and was represented by:	Nathan L. Dembin, Esq. 225 Broadway, Suite 1905 New York, New York 10007

Motions:

5/6/94 -- Conference call. The Committee granted Respondent's application to adjourn the first day of the hearing from May 11, 1994 to June 3, 1994 because Respondent's counsel, Nathan Dembin, Esq., is actually engaged in trial before the New York County Supreme Court, in the case of Fried v. YM&WHA, Index No. 16474/92.

6/1/94 -- Conference call. The Committee granted Respondent's application again to adjourn first day of hearing from June 3, 1994 to June 30, 1994 because Respondent's counsel is actually engaged in trial before Kings County Supreme Court Justice John DeLury in criminal trial People of the State of New York v. Fenci Ekenzi, Indictment No. 5005/93. Respondent waived the statutory time periods of PHL §230(f)10 (Committee Ex. 1).

WITNESSES

For the Petitioner:

1) Eric J. Vanderbush, M.D.

For the Respondent:

1) Perry Berg, M.D.
2) Carl Balmir, M.D., the Respondent

STATEMENT OF CHARGES

Essentially the Respondent is charged with professional misconduct by reason of:

a. Practicing medicine with negligence on more than one occasion;

b. Ordering excessive tests and treatment not clinically indicated; and

c. Failing to maintain adequate and accurate records of patients.

The Statement of Charges is annexed hereto as Appendix A.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. Carl Balmir, M.D., the Respondent, was duly licensed to practice medicine in New York State by the issuance on March 25, 1983 of license number 153637 by the New York State Education Department (Pet's Ex. 11) .

2. The Respondent currently is registered with the New York State Education Department to practice medicine through December 31, 1996 (T. 596).

3. This proceeding was commenced by the service of the Notice of Hearing and Statement of Charges upon the Respondent on April 19, 1994.

4. In or about June, 1988 through November 1988, Respondent practiced medicine at a medical practice called Doctors Office located near 116th and Second Avenue New York, New York (T. 615-616 and 696).

5. Respondent's handwriting is illegible and many of the notes he recorded on the patients' medical records cannot be deciphered (Pet's Exs. 2-10).

6. Respondent did not review any medical records for Patients A through I reporting their previous treatment, if any, by another physician at the medical office facility called Doctors Office (T. 776).

7. Respondent's assertions that he performed genitalia examinations on Patients A, C, D, E, F, G and I is not credible (Pet's Ex. 2, 4, 5, 6, 7, 8, 9 and 10 and T. 723-740).

8. Respondent's assertions that he performed the various physical examinations noted in the medical records of Patient A through I is not credible. The uniformity of the complaints, the uniformity of physical findings such as tenderness at L4, L5 and S1 for Patients A through I (Pet's Ex. 2 through 10 and T. 522), the fact that gastric ulcer, an uncommon disorder in young people, is reported in the history of all these patients (T. 100, 476 and 520), the simultaneous and contradictory notation of "clear" and "sore" ENT for Patients F and I (Pet's Ex. 7 and 10 and T. 330), inconsistencies between purported physical findings and diagnoses made by Respondent such as upper respiratory infection in Patients A and B when the physical findings noted for ENT is "clear" or "neg", sinuses are "normal" or "neg" and head is "neg" (Pet's Ex. 2 and 3 and T. 29-30, 468 and 108), the notation of a physical finding of "normal" genitalia when it is incredible from Respondent's testimony that he performed a physical exam of the genitalia on these patients, and inconsistencies between physical findings and prescriptions ordered for the patients cause the Committee to have

grave doubts whether the purported physical examinations were actually performed (Pet's Ex. 2 through 10).

9. Respondent would fill empty bottles brought by patients he had never before treated or seen and Respondent prescribed medications despite the lack of symptoms or findings based on the patients' statement that another physician had given them the prescription (T. 769-772).

10. Nor did Respondent obtain patients' prior medical records even if the patient had been treated in the same Doctors Office by another physician (T 775-776).

FINDINGS OF FACT AS TO PATIENT A

1. Respondent treated Patient A , a thirty-five year old male, in Doctors Office on two occasions, October 11, 1988 and October 26, 1988.

2. The history obtained and recorded for the October 11, 1988 visit is too cursory and mostly illegible, and there is no history recorded for the October 26, 1988 examination (Pet's Ex. 2).

3. Although the October 11, 1988 visit is noted to be a follow-up, Respondent failed to clearly state for what conditions Respondent is following up (Pet's Ex. 2).

4. On both occasions, Respondent failed to clearly distinguish between the chief complaints and the present history to enable another physician to determine what was Patient A's chief complaint, his recent history or even the conditions for which Patient A returned for follow-up treatment (Pet's Ex. 2 and T. 25-26).

5. The history obtained and recorded by Respondent failed to provide sufficient information as to the course of current complaints or past medical history, or to include the course, duration, severity, frequency of events or progress of the complaints (Pet's Ex. 2 and T. 25-26), and Respondent failed to clarify whether he is recording information relating to the course of a current complaint or Patient A's past medical history (Pet's Ex. 2 and T. 25-27, 27-29, 38 and 40).

6. Although the history notes Patient A is asthmatic, Respondent failed to

obtain from the patient and record information whether this is a childhood asthma, whether there have been recent attacks, and if so, the frequency or severity of recent attacks. Nor are any medications the patient may be currently taking recorded (Pet's Ex. 2 and T. 26-27 and 445).

7. The history includes the notation of lower back pain without reporting whether this is a new condition or a continuing complaint. If a new complaint, Respondent failed to obtain and report when the pain began, how severe, for what duration and the cause of the injury if known to Patient A. If a continuing complaint, Respondent failed to report what treatment, if any, was given for the condition and whether the treatment was effective (Pet's Ex. 2 and T. 27-29, 37-39 and 465).

8. The history reports a history of gastric ulcer but failed to note if the diagnosis of gastric ulcer was made recently or months ago (Pet's Ex. 2 and T. 37). The record failed to report the frequency or severity of the pain(T. 460). Nor is it possible to determine from Respondent's notations whether Patient A's purported gastric ulcer was or was not an active ulcer (T. 462).

9. The physical findings of "clear" ENT and "normal" sinuses noted by Respondent are inconsistent with and contradict Respondent's diagnoses of pharyngitis and upper respiratory infection (Pet's Ex. 2 and T. 29-30 and 468).

10. The physical finding of "normal" skin together with the absence of any complaint about itching, soreness or any skin disorder is inconsistent with the prescription of Valisone cream (Pet's Ex. 2 and T. 30-31).

11. Zantac was prescribed on both occasions (Pet's Ex. 2). The medical justification for this medication is not apparent in the record (T. 31) The existence of epigastric tenderness does not indicate active ulcer disease (T. 472-475). Many people, who have no ulcer disease or, in fact, no disease at all, express tenderness when their epigastrium is palpated (T. 460 and 474-475) .

12. The antibiotic Keflex was prescribed on October 11, 1988 (Pet's Ex. 2) and

its prescription was not warranted by either Respondent's physical findings or the presenting complaints Respondent noted in Patient A's medical record (T. 31 and 469). While Keflex may be warranted for a reported asthmatic who has recurrences of asthma with symptoms of production of yellow sputum and increased difficulties, Respondent failed to report any of these events in Patient A's history or such physical findings to medically justify the prescription of Keflex (T. 396 and 469).

13. Respondent prescribed Dolobid to Patient A on both visits (Pet's Ex. 2). While Dolobid, a non-steroidal anti-inflammatory drug (hereafter called "NSAID"), may be warranted to treat backache pain, the medication is contraindicated in the presence of known ulcer disease. Respondent failed to obtain and record information relating to the severity or duration of Patient A's back pain (Pet's Ex. 2 and T. 465-466) and prescribing Dolobid was medically inappropriate for Patient A, whom Respondent has diagnosed as having a gastric ulcer (Pet's Ex. 2 and T. 32-33 and 466-468).

14. Respondent performed a spirometry test on Patient A on October 11, 1988. Although Respondent failed to record the assessment of the spirometry test or to indicate whether Patient A had recently taken Proventil before administering the test (T. 449-452), it is a simple, reproducible test which can differentiate patterns of lung disease, determine the severity of disease for disability assessment and define changes due to response to therapy or progression of the disease (Rspt's Ex. A-3).

15. Although Respondent made a current diagnosis of asthma and prescribed Proventil on both office visits, Respondent failed to adequately evaluate Patient A's asthma condition. Respondent recorded no information about the severity of this patient's condition, the frequency of episodes, whether Patient A has ever been hospitalized for his asthma or intubated and the degree he is incapacitated by it (T. 35). There is no follow-up for Patient A's reported asthma. On October 26, 1988, Respondent has again prescribed Proventil but fails to indicate anything about the status of Patient A's asthma, although it is unusual to exhaust the Proventil inhaler within two weeks unless the patient has very severe asthma

(Pet's Ex. 2 and T. 35-37).

16. Nor did Respondent follow-up on the gastric ulcer Respondent diagnosed on October 11, 1988. Gastric ulcers generally heal with therapy. Although the medical record fails to indicate the duration of the gastric ulcer, the record reports some history of a gastric ulcer and reflects continuing epigastric tenderness (Pet's Ex. 2 and T. 37). A gastric ulcer that has not healed requires more investigation than was done by Respondent (T. 37).

17. Respondent also failed to adequately investigate Patient A's backache. The history failed to indicate the severity or duration of the pain. Respondent prescribed Dolobid on both visits and, on October 26, 1988, except for noting "backache follow-up" , Respondent failed to indicate any information about whether Patient A's pain was less, the same or greater, which activities trigger pain, the effectiveness of the medication or even the location of the pain. Respondent failed to investigate the cause of the backache (T. 38-39).

18. Although Respondent diagnosed Patient A as having a gastric ulcer and reported a history of gastric ulcer, Respondent prescribed an NSAID which increases the risk of bleeding without obtaining baseline hemoglobin and hematocrit tests (T. 38-39).

19. Respondent failed to perform baseline BUN and creatinine tests on Patient A (T. 40).

CONCLUSIONS AS TO PATIENT A

In Allegations A.1, Respondent is charged with a failure to obtain and note an adequate history (A.1(a)) and a failure to perform and note an adequate physical examination on two occasions (A.1(b)). The Committee sustains both of these charges.

In reviewing Respondent's medical records it is impossible to determine whether he is recording history or chief complaints. Whether for a first examination or a follow-up visit, the information Respondent obtained and recorded is grossly insufficient and meaningless to enable a successor physician to determine Patient A's past medical history, Patient A's current physical complaints and the course of events relating to whatever may be Patient A's

chief complaints. One is required to speculate as to the reason for Patient A's visits to Respondent's office. In addition to the inadequate information and the lack of clarity between what constitutes history or chief complaint, Respondent's writing is illegible and it is nearly impossible for a successor physician to read the chart without guessing as to what Respondent has written.

Respondent failed to obtain and note an adequate history from Patient A for the back pain, gastric ulcer or asthma. In particular, as to the back pain, Respondent failed to obtain information as to when the back pain began, its severity, its location, the activity which triggers the pain or aggravates the pain and what may have caused the pain. Also, Respondent failed to obtain and record the history relevant to the reported gastric ulcer such as when was it first diagnosed, at what hospital did Patient A have the upper GI series, when was the diagnostic procedure performed, what course of treatment or medications given to Patient A and is Patient A currently taking medication for the gastric ulcer. Respondent further failed to obtain and record an adequate history for the asthma, such as whether the asthma is childhood asthma, whether there have been recent episodes, and if so, the duration and frequency of the attacks.

Respondent failed to perform and note an adequate physical exam. The findings of clear ENT and normal sinuses are inconsistent with and contradict Respondent's diagnosis of upper respiratory infection and pharyngitis. The notation at extremities of "pain on SLR" fails to indicate the duration or severity of pain, whether the pain radiates, whether there is weakness or numbness, and if so, where. The physical finding of normal skin, as well as, the absence of any complaint or history of itching, soreness or skin disorder is inconsistent and conflicts with the prescription of Valisone cream. Further, the information recorded in Patient A's record is insufficient to support Respondent's diagnosis of an active gastric ulcer. Although Respondent has noted "neg" next to genitalia, the Committee finds Respondent's testimony demonstrates Respondent did not conduct a examination of Patient A's genitalia. As noted above, based upon the uniformity of findings for Patients A through I, the number

of purported physical findings which contradict diagnoses rendered and prescriptions ordered, causes the Committee to disbelieve that the purported physical examination was actually performed.

Therefore, Allegations A.l (a) and A.1(b) are sustained.

In Allegation A.2, Respondent is charged with inappropriately prescribing Zantac on two occasions (A.2(a)), Proventil inhaler on one occasion (A.2(b)), Dolobid on two occasions (A.2(c)), Keflex on one occasion (A.2(d)) and Valisone cream on one occasion (A.2(e)). Generally, the medical reason for prescribing medication should be clearly presented in the medical record. As the medical records for Patient A fail to present evidence of an active gastric ulcer, of an upper respiratory infection and pharyngitis, and the existence of a rash for which steroid cream is indicated, the basis for the prescriptions of Zantac, Keflex, and Valisone cream are not medically justified by the medical record. Furthermore, since Respondent prescribed Zantac and treated the gastric ulcer as if it were an active ulcer, the use of Dolobid was contraindicated. Dolobid, an NSAID, exacerbates an ulcer and generally is contraindicated for a patient with a gastric ulcer. Significantly, Respondent's medical expert concluded that based on the information in Patient A's medical record it is inappropriate to prescribe Dolobid.

On October 26, 1988, Respondent does not discuss Patient A's asthma, the occurrence of attacks, their frequency or intensity and the reason for the second prescription of Proventil inhaler is not medically justified.

Therefore, Allegations A.2(a) through (e) are sustained.

In Allegations A.3, Respondent is charged with inappropriately ordering a pulmonary function test. Despite the sparsity of Respondent's notations relating to asthma and the fact that it is impossible to determine whether Patient A was complaining of current difficulties caused by recent episodes of asthma, administering a pulmonary function test to Patient A is appropriate. While the chart is unquestionably inadequate, Respondent's decision to administer a pulmonary function test is a clinical judgment based on information that Patient

A is reportedly an asthmatic and Respondent noted wheezing. A spirometry is a simple, non-invasive test with some diagnostic benefits for the physician and no risk to the patient. Respondent used his own equipment and did not charge Patient A for this procedure. **Therefore, Allegation A.3 is not sustained.**

In Allegations A.4 and A.5, Respondent is charged with failure to adequately follow-up on and evaluate Patient A's noted complaints and/or diagnoses or to obtain appropriate laboratory tests. Although Respondent makes the diagnoses of asthma, gastric ulcer and backache for Patient A, Respondent failed to perform any tests to evaluate these conditions. On the October 26, 1988 visit, Respondent failed to obtain and record follow-up information about the duration, intensity, frequency or improvement of these conditions, and Respondent failed to assess the effectiveness of the medications previously prescribed for these conditions. Although Respondent on October 26, 1988 continues to treat Patient A for an active gastric ulcer, Respondent failed to refer Patient A to a gastroenterologist.

Moreover, while Respondent prescribed Dolobid to Patient A, who Respondent diagnosed as having a gastric ulcer, Respondent failed to obtain a baseline hemoglobin or hematocrit. As the medical records do not indicate the previous performance of BUN or creatine tests, Respondent should also have performed these tests.
Therefore, Allegations A.4(a) through (c) and A.5 are sustained.

FINDINGS OF FACT AS TO PATIENT B

1. Respondent treated Patient B, a 37 year old male, at his medical office called Doctors Office on September 12, 1988 and October 11, 1988 (Pet's Ex. 3).

2. Respondent failed to clearly denote whether the reported information is history or chief complaints (Pet's Ex. 3). Regardless of whether history or chief complaint, Respondent failed to obtain an adequate history of these disorders as to when they each first occurred, where they were diagnosed, how they were diagnosed, whether there have been recent episodes of ulcer pain or asthma attacks, the duration and severity of any attacks,

when the motor vehicle accident occurred, the trauma Patient B suffered, the site of the injury, the course of pain, its duration, its severity, its frequency and what, if any, incapacity it causes (T. 106-107).

3. In the physical examination Respondent notes "rash" on the skin, but failed to describe where the rash is, how it appears, whether it is generalized or localized, and the type of rash (Pet's Ex. 3 and T. 111). Further, findings on the physical examination are inconsistent with Respondent's diagnosis of upper respiratory infection. Respondent noted "neg" for ENT, head and sinuses, glands "normal," lungs "clear to A & P," and Respondent did not indicate Patient B complained of a respiratory problem (Pet's Ex. 3). Despite these negative physical findings and the absence of any complaint by Patient B, Respondent made an unsubstantiated diagnosis of URI (Pet's Ex. 3 and T. 107-108).

4. On September 12, 1988, Respondent prescribed Zantac, Proventil inhaler, Dolobid, Valisone cream and Ceclor. On October 11, 1988, Respondent prescribed for a second time Zantac, Proventil inhaler and also prescribed Naprosyn, Lotrimin and rubbing alcohol. Although Respondent has diagnosed Patient B as having an active gastric ulcer, Respondent has prescribed the NSAID's Dolobid and Naprosyn to Patient B (Pet's Ex. 3 and T. 111-112). Ceclor is an antibiotic (T. 111) and there is no bacterial infection noted on the medical record for which Ceclor would be medically warranted (T. 111).

5. Zantac was prescribed on both occasions (Pet's Ex. 3). The medical justification for this medication is not apparent in the record. As discussed in ¶11 above, the existence of epigastric tenderness does not indicate active ulcer disease (T. 472-475). Many people, who have no ulcer disease or, in fact, no disease at all, express tenderness when their epigastrium is palpated (T. 460 and 474-475) .

6. On September 12, 1988, Respondent ordered a spirometry test. Although Respondent appended the spirometry reading, Respondent failed to include an assessment of the spirometry test in Patient B's medical record.

7. Respondent failed to adequately follow-up Patient B's reported gastric ulcer.

When Patient B visited Respondent a second time one month after the first visit, the gastric ulcer is again reported and Respondent again prescribes Zantac. Although from the record it is impossible to determine whether Patient B in fact has a gastric ulcer, and if so, whether it is active and what is its severity, Respondent is treating Patient B as if he has an active gastric ulcer. Accordingly, Respondent failed to order an endoscopy or to refer Patient B to a specialist (Pet's Ex. 3 and T. 113-114).

8. Although Respondent diagnosed Patient B as having a gastric ulcer and reported a history of gastric ulcer, Respondent prescribed an NSAID which increases the risk of bleeding without obtaining baseline hemoglobin and hematocrit tests (Pet's Ex. 3). Because of Patient B's history of gastric ulcer, a hematocrit and hemoglobin tests were medically indicated (T. 114-115).

CONCLUSIONS AS TO PATIENT B

In Allegation B.1 respondent is charged with failing to obtain and note an adequate history (B.1(a)) and failing to perform and note an adequate physical examination (B.2(b)). It is impossible to determine from Patient B's medical records what is reported as history and what are Patient B's chief complaints. Whether history or chief complaints, the information obtained and noted is too bare to be meaningful to Respondent or a successor physician. There is a complete absence of data as to when, where, by whom and by what methods the asthma and gastric ulcer were diagnosed, what treatment Patient B has received for these disorders, has Patient B had recent episodes of either disorder, when, the duration and severity of attacks and what triggered the attacks of either asthma or gastric ulcer. Nor does the history indicate when the motor vehicle accident occurred, how it occurred, the manner in which Patient B was injured during the accident, the site of Patient B's back pain, the duration or severity of the pain and what, if any, deficit Patient B has suffered as a result of the injury.

Respondent failed to perform and note an adequate physical examination. While

Respondent notes a rash on the skin, he fails to note where it is, how it appears, whether localized or generalized, or the type of rash. Although Respondent makes a diagnosis of upper respiratory infection there is nothing in the history, chief complaints or findings of the physical examination to support this diagnosis. As noted above in ¶8 of the general findings, the Committee finds Respondent's assertions that he performed the physical examination and made the findings as presented in Patient B's medical record to be incredible.

Therefore, Allegations B.1(a) and B.1(b) are sustained.

In Allegations B.2, Respondent is charged with inappropriately prescribing Zantac on two occasions (B.2(a)), Proventil inhaler on one occasion (B.2(b)), Dolobid on one occasion (B.2(c)), Valisone Cream on one occasion (B.2(d), Ceclor on one occasion (B.2(e)), Naprosyn on one occasion (B.2(f)) and Lotrimin cream on one occasion (B.2(g)). Generally, the medical reason for prescribing medication should be clearly presented in the medical record. As the medical records for Patient B fail to present evidence of an active gastric ulcer or of an upper respiratory infection, the basis for the prescriptions of Zantac and Ceclor are not medically justified by the medical record. Furthermore, since Respondent prescribed Zantac and treated the gastric ulcer as if it were an active ulcer, the use of Dolobid and Naprosyn was contraindicated. Nor does the medical record demonstrate a pain killer such as Tylenol had been tried and did not work for Patient B's back pain. Dolobid and Naprosyn are NSAIDs which are known to exacerbate an ulcer.

Although the rash is inadequately described, the basis of the charge in B.2((d) and (g) is not one of record keeping. Respondent had an opportunity to observe the rash and is presumed to have exercised his clinical judgment in determining the prescription of Valisone cream and Lotrimin cream. The medical record on October 11, 1988 noted "rash improving." Although the medical record fails to note the occurrence of recent asthma attacks and the severity or frequency of attacks, this is not a charge of record keeping. It is medically appropriate for a clinician to prescribe a Proventil inhaler to a person with a history of

asthma with current symptoms of wheezing and a second prescription after one month's use is not improper.

Therefore, Allegations B.2(a), (c), (e) and (f) are sustained.
Allegations B.2 (b), (d) and (g) are not sustained

In Allegation B.3, Respondent is charged with inappropriately ordering a pulmonary function test. Spirometry is a non-invasive, simple test which can give baseline information on the status of a patient with a history of asthma. Respondent testified he used his own equipment and did not charge the patients a fee for this procedure.

Therefore, Allegation B.3 is not sustained.

In Allegations B.4(a) and (b), Respondent is charged with failing to adequately follow-up on and evaluate Patient B's gastric ulcer and asthma. Although Respondent makes the diagnoses of asthma and gastric ulcer for Patient B, Respondent failed to perform any tests to evaluate these conditions. On the October 11, 1988 visit, Respondent failed to obtain and record follow-up information about the duration, intensity, frequency or improvement of these conditions, and Respondent failed to assess the effectiveness of the medications previously prescribed for these conditions. Although Respondent on October 11, 1988 continues to treat Patient A for an active gastric ulcer, Respondent failed to refer Patient A to a gastroenterologist.

Moreover, while Respondent prescribed Dolobid and Naprosyn to Patient B, who Respondent diagnosed as having a gastric ulcer, Respondent failed to obtain a baseline hemoglobin or hematocrit which are necessary in order to adequately monitor whether the NSAIDs are causing bleeding in Patient B.

Therefore Allegations B.4(a), B.4(b) and B.5 are sustained.

FINDINGS OF FACT AS TO PATIENT C

1. Respondent treated Patient C at his Doctors Office on or about June 16, 1988 and also ordered prescriptions on October 11, 1988 (Pets. Ex. 4).

2. Respondent failed to distinguish between history and chief complaint (Pet's Ex. 4 and T. 146-147). Respondent failed to obtain and note an adequate history of the gastric ulcer, asthma or back pain. As to the gastric ulcer, Respondent failed to obtain and note information as to when it was diagnosed, by whom and where, whether Patient C has had symptoms, the duration, severity and frequency of any recent episodes, and a history of treatment and medications Patient C has received for the gastric ulcer. Similarly, while Respondent notes "asthma from childhood," Respondent failed to obtain and note information as to the severity of the asthma, whether Patient C has ever been hospitalized, what are the medications given to Patient C for the asthma, what treatment he has received, has Patient C recently suffered asthma attacks, and if so, the frequency and severity of the attacks. Nor has Respondent obtained and noted details relating to either a history or chief complaint of pain on walking. Where is the pain? What organ system is involved? When did pain begin? What is its severity, intensity and duration? Does Patient C know what caused the injury? Respondent further failed to obtain and note details about the rash in the groin area--when did Patient C first observe it, has it changed in appearance, has it remained the same size since first observed (Pet's Ex. 4).

3. Respondent failed to perform and note an adequate physical exam. Although Respondent notes a rash in the groin area, Respondent fails to describe the type of rash such as a fungus, venereal or contact dermatitis rash, how it appears, and is it localized or generalized. Although Respondent makes diagnoses of asthma and gastric ulcer, there is nothing in the physical examination or the complaints reported by Patient C to support such diagnoses (T. 150). Respondent makes a diagnosis of arthritis and, except for the non-specific finding of pain in the L4, L5, S1 area which itself is not evidence of arthritis, there is no physical finding or information to warrant the diagnosis of arthritis (T. 150-151 and 174).

4. The medical record for June 16, 1988 appears to be a primary visit. However, Respondent has failed to obtain and note Patient C's height, weight, temperature

or respiration (Pet's Ex. 4).

5. On June 16, 1988, Respondent prescribed a Proventil inhaler, Zantac, Feldene, Lotrimin and Valium. On October 11, 1988, Respondent prescribed to Patient C another Proventil inhaler, Zantac, Ceclor and Robitussin. On June 16, 1988 there is no medical justification for prescribing the Proventil inhaler since there is no indication that Patient C is complaining of current symptoms of asthma or experienced recent attacks, and the physical examination does not note any wheezing or other asthmatic symptoms. As the medical record for Patient C fails to present evidence of an active gastric ulcer, the basis for the prescriptions of Zantac are not medically justified by the medical record. Furthermore, since Respondent prescribed Zantac and treated Patient C as if he had an active gastric ulcer, the use of Feldene was contraindicated. No physical findings nor the complaints medically reported warrant prescriptions for valium or feldene (T. 153-154).

6. There is no medical record for October 11. 1988 making it impossible for the Committee to determine the basis or lack of basis for prescribing medications to Patient C on that day.

7. On June 16, 1988, Respondent performed a pulmonary function on Patient C. The medical record only indicates Patient C has asthma from childhood. Patient C is 36 years old and the medical record does not indicate Patient C is complaining of recent episodes of asthma or suffering from any recent respiratory problems (T. 150-151 and 398).

8. Respondent diagnosed Patient C as having asthma, gastric ulcer and arthritis. There is no future management plan noted that shows how Respondent intended to follow-up on these disorders or any evidence Respondent referred Patient C to specialists for appropriate treatment for these disorders. Nor is there an plan for following the reported rash (Pet's Ex. 4).

9. Although Respondent diagnosed Patient C as having a gastric ulcer and reported a history of gastric ulcer, Respondent prescribed an NSAID which increases the risk of bleeding without obtaining baseline hemoglobin and hematocrit tests (Pet's Ex. 4).

Because of Patient C's history of gastric ulcer, a hematocrit, hemoglobin, tests were medically indicated (T. 191-192).

CONCLUSIONS AS TO PATIENT C

In Allegation C.1, Respondent is charged with a failure to obtain and note an adequate history (C.1(a)) and a failure to perform and note an adequate physical examination (C.1(b)). The history and chief complaints are blurred together. The information relating to childhood asthma or a positive upper GI series for gastric ulcer is sparse and insufficient. Respondent failed to obtain and note when these conditions were diagnosed, where, by whom, what treatment Patient C has received since the diagnoses were made, whether Patient C has had recent episodes of either the asthma or gastric ulcer, and if so, the frequency or severity of the events. In addition, Respondent has failed to obtain sufficient information about the rash and back pain.

Respondent has stated diagnoses such as arthritis, gastric ulcer and asthma for which there are no supporting physical findings. Respondent ordered a pulmonary function test despite the notation in the physical examination that the lungs are clear. As noted above in ¶8 above in general findings, the Committee finds Respondent's assertions that he performed the physical examination and made the findings as presented in Patient B's medical record to be incredible.

Therefore, Allegations C.1(a) and (b) are sustained.

In Allegation C.2, Respondent is charged with inappropriately prescribing Valium on one occasion (C.2(a)), Proventil inhaler on one occasion (C.2(b)), Zantac on two occasions (C.2(c)), Feldene on one occasion (C.2(d)), Lotrimin cream on one occasion (C.2(e)), and Ceclor on one occasion (C.2(f)). As state above, generally, the medical reason for prescribing medication should be clearly presented in the medical record. As the medical record for June 16, 1988 fails to indicate Patient C has reported recent episodes of asthma and the physical examination shows the lungs are clear with no evidence of wheezing, the

prescription of Proventil inhaler is not medically warranted. The medical records for Patient C fail to present evidence of an active gastric ulcer or arthritis and the basis for the prescriptions of Zantac and Feldene are not medically justified by the medical record. Furthermore, since Respondent prescribed Zantac and treated the gastric ulcer as if it were an active ulcer, the use of Feldene was contraindicated. Nor does the medical record demonstrate a pain killer such as Tylenol had been tried and did not work for Patient C's pain on walking and long standing.

Although the rash is inadequately described, the basis of the charge in C.2(e) is not one of record keeping. Respondent had an opportunity to observe the rash and is presumed to have exercised his clinical judgment in determining the prescription of Lotrimin cream.

There is no medical record for Patient C in evidence for October 11, 1988. The Committee believes that absent a patient record the State fails to prove by a preponderance of the evidence that Respondent's prescriptions on October 11, 1988 were inappropriate. Applying the presumption of regularity, it is presumed the prescription for Ceclor and Zantac on October 11, 1988 for Patient C was justified and appropriate.

Therefore, Allegations C.2(a) through (d) are sustained.
Allegations C.2(e) and (f) are not sustained.

In Allegation C.3, Respondent is charged with inappropriately performing a pulmonary function test. Although Patient C is reported to have had asthma since childhood, the medical record on June 16, 1988 does not show Patient C to be symptomatic or to have complained of recent episodes of asthma. Therefore, there is no medical justification for performing the spirometry test on Patient C.

Therefore, Allegation C.3 is sustained.

In Allegations C.4 and C.5, Respondent is charged with failing to adequately follow-up on and evaluating Patient C's complaints and/or diagnoses (C.4) and failing to obtain appropriate laboratory tests (C.5). Respondent diagnosed Patient C as having asthma, gastric ulcer and arthritis. Respondent failed to formulate a future management plan for treatment

of and follow-up on these disorders; nor did Respondent refer Patient C to specialists for appropriate treatment for these disorders. In addition, there is no plan for following up on the reported rash (Pet's Ex. 4).

Although Respondent diagnosed Patient C as having a gastric ulcer and reported a history of gastric ulcer, Respondent prescribed an NSAID which increases the risk of bleeding without obtaining baseline hemoglobin and hematocrit tests (Pet's Ex. 4). Because of Patient C's history of gastric ulcer, a hematocrit, hemoglobin, tests were medically indicated (T. 191-192).

Therefore, Allegations C.4 and C.5 are sustained.

FINDINGS OF FACT AS TO PATIENT D

1. Respondent treated Patient D at his medical office called Doctors Office on approximately three occasions on September 15, 1988, October 11, 1988 and October 31, 1988 (Pet's Ex. 5).

2. September 15, 1988 is an initial visit. The history obtained and noted lacks significant information. There is no information as to when the gastric ulcer was diagnosed, where and by whom, what treatment and medications, if any, Patient D has had for it, whether Patient D is currently experiencing problems (Pet's Ex. 5 and T. 200). If so, when did the difficulties begin, what are the symptoms, what is the frequency, duration and severity of the attacks. Nor is there sufficient data relating to the trauma (T.225) - when did it occur, how, what is the trauma, what is the injury, where is the pain, for how long has Patient D experienced pain, under what circumstances does Patient D experience pain, how often and how severe. Similarly, the information obtained and noted by Respondent for the cough, sore throat and leg ulcer is deficient as to when they were first noted by Patient D, have the conditions changed since first observed by Patient D, is there any discharge from the cough, where precisely is the leg ulcer and does Patient D know what caused it (Pet's Ex. 5 and T. 202). The history reported on October 11, 1988 with respect to asthma and gastric

ulcer is spare even for a focused examination. This is the first time asthma is reported in the history and the history fails to include when the asthma was first diagnosed, has Patient D had asthma attacks recently, and if so, the frequency, severity and duration of the attacks, did Patient D use medication and go to the hospital (T. 207-208).

3. Respondent failed to perform and note an adequate physical examination. The rash or leg ulcer is not described as to its appearance, the type of rash, whether local or generalized, where is the leg ulcer located, what size, on which leg and in what location, where is the rash (T. 217, 234, 246 and 251). It is impossible to discern whether the rash and the leg ulcer are the same or two different problems (T. 202 and 234). The physical examination reports pain in the extremities, however fails to describe the most basic information as to where the pain is experienced by Patient D. The diagnoses of asthma and upper respiratory infection are contradicted by the findings of clear lungs noted in the physical examination (Pet's Ex. 5 and T. 201). Nor are the diagnoses of arthritis and gastric ulcer supported by either the findings noted in the physical examination or the complaints of Patient D (Pet's Ex. 5).

4. On September 15, 1988, Respondent prescribed a Proventil inhaler, Lotrisone cream, Zantac, Dolobid and Keflex. On October 11, 1988, Respondent prescribed to Patient D another Proventil inhaler, Dolobid, Zantac and Valisone cream. On October 31, 1988, Respondent prescribed to Patient D a Proventil inhaler, Dolobid and Lotrisone cream. Except for the three prescriptions for a Proventil inhaler over a six week period there is no indication in the medical records of Patient D experiencing asthma attacks. Nothing is stated in the history or chief complaints of any of the visits that Patient D has experienced an asthma attack, the frequency, severity or duration of the attacks and how recently (T. 202-204 and 207-208). On September 15, 1988, lungs are reported clear. Keflex, an antibiotic, is prescribed without evidence that Patient D has a bacterial infection (T. 204-205). Lotrisone cream and Valisone cream are topical steroid creams prescribed to Patient D without medical indication. As the existence of an active gastric ulcer is not demonstrated,

Zantac was not medically indicated. However, as Respondent was treating Patient D with Zantac despite the lack of current complaint or consistent physical findings and noted a diagnosis of gastric ulcer, Dolobid was contraindicated as a medication for Patient D without first using other pain killers (T. 204 and 236-237).

5. Respondent performed a pulmonary function test although Patient D had clear lungs and no complaint of current asthma difficulties (T. 213-214).

6. Respondent diagnosed Patient D as having asthma, gastric ulcer and arthritis. There is no future management plan noted that shows how Respondent intended to follow-up on these disorders or any evidence Respondent referred Patient D to specialists for appropriate treatment for these disorders. Nor is there an plan for following the reported rash (Pet's Ex. 5).

7. Although September 15, 1988 appears to be an initial visit and although Respondent prescribed Dolobid to Patient D who Respondent states has a gastric ulcer, Respondent did not order hemoglobin, hematocrit, urine analysis, BUN and creatinine tests for Patient D.

CONCLUSIONS AS TO PATIENT D

In Allegation D.1, Respondent is charged with failing to obtain and note an adequate history (D.1(a)) and failing to perform and note an adequate physical examination. The Committee finds Respondent obtained and noted an inadequate history. The history of gastric ulcer, back pain, trauma, coughing and leg ulcer are too spare and fail to report significant information such as when the diagnosis or event occurred, the duration, severity, recent problems Patient D has experienced from these disorders, the site of the leg ulcer, which leg, has it gotten worse since first observed, the details of the trauma and injury suffered, how long ago, where is the pain, and what triggers the pain.

The physical examination fails to expand on positive findings or to adequately describe significant findings. Respondent notes a leg ulcer and rash, but fails to describe

whether they are one or two different disorders, on which leg is the ulcer and where on the leg, what is its size and appearance, is the rash on some other part of the body, and if so, where is the rash, what type of rash, what size, is it generalized or localized? Respondent notes pain on walking, but fails to indicate where the pain is experienced, whether it is localized or radiating and whether there is any weakness. The notation of clear lungs contradicts the diagnosis of upper respiratory infection. Diagnoses such as asthma, gastric ulcer, upper respiratory infection lack reported positive physical findings.

Therefore, Allegations D.1(a) and (b) are sustained.

In Allegation D.2(a) through (f), Respondent is charged with inappropriately prescribing Proventil inhaler on two occasions, Lotrisone cream on two occasions, Zantac on two occasions, Dolobid on two occasions, Keflex on one occasion, and Valisone cream on one occasion. According to the medical records, there is no indication Patient D complained of recent asthma problems and his lungs were clear. Prescriptions for Proventil inhalers are not medically justified by the medical record. Keflex, an antibiotic, was prescribed even though there is no evidence Patient D had a bacterial infection. As the existence of an active gastric ulcer is not demonstrated, Zantac was not medically indicated. However, as Respondent was treating Patient D with Zantac and noted a diagnosis of gastric ulcer, Dolobid was contraindicated as a medication for Patient D without first using other pain killers. The prescriptions for the steroid creams were also not medically supported by the medical record.

Therefore, Allegations D.2(a) through (f) are sustained.

In Allegation D.3, Respondent is charged with inappropriately ordering a pulmonary function test. Patient D is reported to have clear lungs and there is no reported complaint of recent problems with asthma. A spirometry was not medically warranted.

Therefore, Allegation D.3 is sustained.

In Allegations D.4 and D.5, Respondent is charged with failing to adequately follow-up on and evaluate Patient D's noted complaints and/or diagnoses of asthma, gastric ulcer and arthritis (D.4) and failing to obtain appropriate laboratory tests (D.5). While the medical record does not support the diagnoses for asthma, active gastric ulcer or arthritis, Respondent prescribed medication over a six week period for these disorders. Presumably, Respondent determined these were significant conditions requiring immediate treatment. Respondent failed to formulate a treatment plan or to refer Patient D to specialists for further treatment. Nor did Respondent order hematocrit, hemoglobin, BUN or creatinine tests for Patient D. **Therefore, Allegations D.4 and D.5 are sustained.**

FINDINGS OF FACT AS TO PATIENT E

1. On October 26, 1988, Respondent treated Patient E at his medical office called Doctors Office for an initial visit (Pet's Ex. 6).

2. Respondent's notations blur history and Patient E's complaints (Pet's Ex. 6 and T. 268). A successor physician is unable to determine Patient E's complaints. The history obtained and noted is scant. It merely lists "g ulcer, had UGI positive, abd pain, backache, asthmatic" and fails to include any information as to onset, duration, treatment or any history of these conditions. (Pet's Ex. 6 and T. 259). As to the notations of abdominal pain and back ache, there is no indication where in the abdomen or back Patient E experiences pain, when Patient E first observed pain, what triggers the pain, and has the pain increased or abated over time. Nor did Respondent obtain and note whether Patient E has been treated for these conditions by another physician, what medication, if any, he has taken and what treatment was provided (Pet's Ex. 6)

3. In the physical examination, Respondent noted a rash and failed to describe its type, size, whether localized or generalized. Respondent notes contradictory findings for the lungs noting "clear few wheezing" (Pet's Ex. 6 and T. 262). The Committee finds Respondent's assertion that he performed the physical examination of the lungs to be

incredible. There are no physical findings to support Respondent's diagnoses for asthma and gastric ulcer. Nor are there physical findings suggesting a bacterial infection to justify the prescription of Keflex (T. 262).

4. During this visit, Respondent prescribed Zantac, Dolobid, Lotrisone cream and Keflex. Neither patient complaints or physical findings noted by Respondent warrant a prescription of Keflex, an antibiotic for bacterial infections (T. 262 and 798-799). Dolobid was also prescribed and Dolobid, an NSAID, is contraindicated for a patient with a gastric ulcer (T. 263 and 265). Respondent diagnosed Patient E as having a gastric ulcer and prescribed Zantac T. 263 and 265).

5. During this visit, Respondent ordered an audioscope and pulmonary function test. As there is no complaint of hearing loss and Respondent noted that ENT is clear, there is no indication of the need for an audioscope (T. 261). Similarly, the pulmonary function test is not medically justified based on the information Respondent noted on Patient E's medical record (T. 263). The lack of a patient complaint about asthma and the self-contradictory notation that the lungs are "clear-few wheezings" contraindicate the necessity for such a test.

6. Respondent failed to formulate a future management plan for Patient E and failed to follow-up on confirming the effectiveness of the medications prescribed. Also, Respondent failed to evaluate the current status of the gastric ulcer and asthma conditions which he treated by medication as active conditions (Pet's Ex. 6).

7. Respondent failed to order hemoglobin, hematocrit, BUN and creatinine tests (Pet's Ex. 6 and T. 263).

CONCLUSIONS AS TO PATIENT E

In Allegation E.1, Respondent is charged with failing to obtain and note an adequate history (E.1(a)) and failing to perform and note an adequate physical examination (E.1(b)). Respondent failed to distinguish between history and Patient E's chief complaints.

Respondent failed to obtain and note salient details regarding Patient E's history of gastric ulcer, asthma, back pain and abdominal pain relating to onset, duration, severity, prior diagnosis and treatment, any hospitalization and whether Patient E is currently experiencing problems from any of these disorders.

Respondent failed to perform and note an adequate physical examination. Respondent's notation of rash in perineal area is grossly insufficient. Respondent's notation of lungs as "clear" and also "few wheezing" is contradictory and meaningless to another physician reviewing the record. There is no indication of a bacterial infection although Respondent prescribed Keflex for Patient E. As noted above in ¶8 above in general findings, the Committee finds Respondent's assertions that he performed the physical examination and made the findings as presented in Patient E's medical record to be incredible.

Therefore, Allegations E.1(a) and (b) are sustained.

In Allegations E.2, Respondent is charged with inappropriately prescribing Zantac, Dolobid, Lotrisome cream and Keflex. As state above, generally, the medical reason for prescribing medication should be clearly presented in the medical record. There is no evidence Patient E had a bacterial infection and the prescription for Keflex is medically unwarranted. Since Respondent treated Patient E as a patient with an active gastric ulcer, the prescription for Zantac may have been medically justified. However, at the same time, the Dolobid was contraindicated for a patient with a gastric ulcer. The medical record notes a rash. Although the rash is not adequately described this charge is not one of record keeping and it is presumed Respondent appropriately prescribed Lotrimin for the rash.

Therefore, Allegations E.2(b) and (d) are sustained.
Allegations E.2(a) and (c) are not sustained.

In E.3, Respondent is charged with inappropriately ordering a pulmonary function test and an audioscope. There is no medically warranted justification for either test. Patient E did not complain of hearing loss and the ENT are reported "clear." Nor is there evidence

of current asthma from the record. Again, there is no complaint noted and the contradictory notations of "clear" and "few wheezing" for lungs does not medically justify the spirometry test.

Therefore, Allegations E.3(a) and (b) are sustained.

In Allegation E.4, Respondent is charged with inadequately following-up on and evaluating Patient E's noted complaints and/or diagnoses of asthma, gastric ulcer, rash and backache. Respondent failed to formulate a future management plan for treating the asthma and gastric ulcer or to monitor the effectiveness of the medications prescribed to Patient E.

Therefore, Allegations E.4(a) through (d) are sustained.

In Allegation E.5, Respondent is charged with a failure to obtain appropriate laboratory tests. Respondent did not order hemoglobin, hematocrit, urine analysis, BUN and creatinine tests as baseline tests.

Therefore, Allegation E.5 is sustained.

FINDINGS OF FACT AS TO PATIENT F

1. On October 11, 1988, at his medical offices called Doctors Office, Respondent treated Patient F for a follow-up visit. (Pet's Ex. 7).

2. Respondent noted the complaints of Patient E as back pain, asthma, gastric ulcer and rash without any further detail about when Patient E first observed the back pain or rash, what may have caused either the back pain or rash, if known to Patient E, has either the back pain or rash changed since first observed by Patient E (Pet's Ex. 7 and T. 271).

3. Respondent in the physical examination notes a rash on the skin. Respondent fails to describe where on the body the rash is, what type of rash, its size, its appearance (T. 271-274 and 283-284 and 293). Respondent notes ENT "clear" and "sore throat." Sore throat is not a physical finding, but a complaint (T. 272-273 and 293). The physical findings noted of "clear" ENT, "clear" lungs, "clear" sinuses contradicts

Respondent's diagnosis of pharyngitis (Pet's Ex. 7 and T. 273 and 293). The diagnoses of gastric ulcer and asthma also are not supported by the physical findings noted in the physical examination (T. 274 and 276).

4. On October 11, 1988, Respondent prescribed Zantac, Dolobid, Valisone cream and Ceclor. The prescription for Ceclor is not medically justified since the medical record does not indicate Patient E had a bacterial infection (T. 276-277 , 287 and 798-799). Patient F did not demonstrate symptomatology for which Zantac is appropriate (T. 275). Dolobid is contraindicated for a patient Respondent believes has a gastric ulcer (T. 288-289). Valisone cream is an appropriate prescription for contact dermatitis (T. 288).

5. Respondent failed to formulate a future management plan for evaluating the effectiveness of the medications prescribed (Pet's Ex. 7).

6. Although Respondent prescribed an NSAID to Patient F, a patient Respondent was treating for a gastric ulcer, Respondent failed to order a hemoglobin, hematocrit, BUN or creatinine tests for baselines (Pet's Ex. 7 and T. 277).

CONCLUSIONS AS TO PATIENT F

In Allegations F.1, Respondent is charged with failing to obtain and note an adequate history (F.2(a)) and failing to perform and note an adequate physical examination (F.1(b)). The Committee notes the medical record for October 11, 1988 is presented as a follow-up visit. Although this is a focused examination, Respondent's notations as to Patient F's complaints are too scant and provide insufficient information relating to the complaints of back pain, rash, gastric ulcer and asthma. It is unclear whether Patient F is reporting current difficulties with either asthma or the gastric ulcer. There is no description as to when the back pain began, where it is, whether focused or radiating, what movements trigger it and whether it has increased or abated with time. Respondent failed to inquire and note significant history about the rash as to the site of the rash, when Patient F first observed it, does it itch or hurt, does Patient F know what caused the rash, has its appearance changed

since first observed by Patient F.

The physical examination contains insufficient description and includes findings which conflict with the diagnosis of pharyngitis and the prescription of Ceclor. The finding of "clear" and "sore throat" for ENT is contradictory and the notation of " rash" for skin without further description is grossly inadequate. As noted above in ¶8 above, in general findings, the Committee finds Respondent's assertions that he performed the physical examination and made the findings as presented in Patient F's medical record to be incredible.

Therefore, Allegations F.1(a) and (b) are sustained.

In Allegations F.2(a) through (d), Respondent is charged with inappropriately prescribing Zantac, Dolobid, Valisone cream and Ceclor. As there is no evidence of a bacterial infection, the prescription of Ceclor to Patient F was not medically justified. Patient F lacked symptoms to medically warrant Zantac. However, as Respondent treated Patient F as if Patient F had an active gastric ulcer, the prescription of Dolobid was contraindicated. Valisone cream is appropriate to treat contact dermatitis.

Therefore, Allegations F.2(a), (b) and (d) are sustained.
Allegation F.2(c) is not sustained.

In Allegations F.3(a) through (d), Respondent is charged with failing to follow-up on and evaluating Patient F's noted complaints and/or diagnoses of asthma, gastric ulcer, rash and back ache. Respondent did not formulate a future plan to monitor the effectiveness of the medications he prescribed or to monitor the use of Dolobid by Patient F, a patient Respondent treated as if he had an active gastric ulcer.

Therefore, Allegations F.3(a) through (d) are sustained.

In Allegation F.4, Respondent is charged with failing to obtain appropriate laboratory tests for Patient F. Respondent treated Patient F for a gastric ulcer. When Respondent prescribed Dolobid, an NSAID, for Patient F, Respondent failed to obtain hematocrit,

hemoglobin, BUN and creatinine tests as baselines.

Therefore, Allegation F.4 is sustained.

FINDINGS OF FACT AS TO PATIENT G

1. Respondent treated Patient G at his medical office called Doctors Office on approximately three occasions, September 13, 1988, October 11 and 26, 1988(Pet's Ex. 8).

2. Respondent noted complaints of back pain - MA, asthma, gastric ulcer, a positive UGI Bellevue Hospital, Rx Zantac, and ETOH. There is a dearth of historical data relating to these illnesses. Respondent failed to obtain and note details about the motor vehicle accident, such as when did it occur, how was Patient G injured, what is the site of Patient G's injury and has it worsened or improved since the accident. There also is insufficient information about the asthma, gastric ulcer and alcohol use. Respondent failed to obtain and note previous treatments for asthma or alcohol use or information as to when asthma was diagnosed, has Patient G had any recent episodes, and has Patient B been hospitalized for asthma or alcohol use (Pet's Ex. 8 and T. 295-596).

3. On September 13, 1988, under the physical examination part of the medical record, Respondent notes "rash on groin" without any description of the type of rash, its size, or its appearance. Respondent's notations for lungs as "clear" and "few wheezing" is contradictory and fails to make medical sense (Pet's Ex. 8 and T. 297). On October 11 and 26, 1988, Respondent failed to perform and note adequate physical examinations even if only focused examinations. Respondent's notations are cryptic and illegible. On September 13 and October 11, 1988, Respondent prescribed the antibiotics Ceclor and Keflex although neither the physical examinations or presenting complaints indicate Patient G had a bacterial infection on those dates (Pet's Ex. 8 and T. 305 and 316). On October 25, 1988, Respondent failed to perform or note Patient G's blood pressure. Nor is there any indication in the physical examination of hypertension. However, despite the lack of evidence indicating Patient G is hypertensive, Respondent prescribed Catapress (Pet's Ex. 8 and T. 305-306 and

323-324).

4. On each visit, Respondent also prescribed Zantac and Naprosyn to Patient G. Except for the notation on October 25, 1988 "gastric ulcer improving," the existence of an active gastric ulcer is not demonstrated in the medical records and Zantac was not medically indicated. However, as Respondent was treating Patient G with Zantac despite the lack of current complaint or consistent physical findings and Respondent diagnosed Patient G as having a gastric ulcer, Naprosyn, an NSAID, was contraindicated as a medication for Patient G without first using other pain killers (T. 304-305). Respondent appropriately prescribed Lotrisone cream for the rash.

5. Respondent saw Patient G over approximately a six week period. Although Respondent noted continued back pain, Respondent failed to formulate a plan to evaluate the back pain and did not refer Patient G to a specialist. Although Respondent treated Patient G as a patient with an active gastric ulcer, Respondent did not formulate a treatment plan or refer Patient G to a gastroenterologist. Respondent prescribed a Proventil inhaler on each visit. While there is nothing in Patient G's medical record to indicate he suffered sever asthma, three prescriptions for Proventil inhaler within six weeks should suggest to the practitioner that the patient's asthma is severe (T. 303-304). Despite prescribing three Proventil inhalers in approximately six weeks to Patient G, Respondent did not evaluate Patient G's asthma or refer Patient G to a specialist. Respondent appropriately followed the rash.

6. Respondent did not order hemoglobin, hematocrit, urine analysis, BUN and creatinine tests.

CONCLUSIONS AS TO PATIENT G

In Allegations G.1(a) and (b), Respondent is charged with failing to obtain and note an adequate history and failing to perform and note an adequate examination. Respondent's history lacks salient and significant data relating to medical history and presenting

complaints. Although a follow-up visit may not require the detail of an initial visit, details relating to onset of condition, precise description of the location of pain or injury, and the severity and duration of the symptoms during the intervening period should be included. Respondent notes "back pain - MVA" and fails to obtain and note when the accident occurred, what trauma if any Patient G suffered, where specifically Patient G was injured. In the record of an initial visit, as well as follow-up examinations, Respondent fails to distinguish between medical history and chief complaints.

Respondent's physical examination lacks adequate detail. Merely noting "rash on groin" is insufficient and fails to describe the type of rash, its size, and its appearance. Respondent notes contradictory findings such as "clear" and "few wheezing." On September 13 and October 11, 1988, Respondent prescribed the antibiotics Ceclor and Keflex, however the medical record fails to show Patient G had a raised temperature or any symptoms of a bacterial infection. On October 25, 1988, Respondent prescribed Catapress, however the medical record is devoid of any evidence that Patient G is hypertensive. As noted above in ¶8 above, in general findings, the Committee finds Respondent's assertions that he performed the physical examination and made the findings as presented in Patient G's medical record to be incredible.

Therefore, Allegations G.1(a) and (b) are sustained.

In Allegations G.2(a) through (h), Respondent is charged with inappropriately prescribing Zantac on three occasions, Naprosyn on three occasions, Lotrisone cream on two occasions, Theodore on one occasion, Ceclor on one occasion, Proventil inhaler on two occasions, Keflex on one occasion and Catapress on one occasion. Although the medical records on September 13 and October 11, 1988 fail to indicate Patient G had a bacterial infection, Respondent inappropriately prescribed Ceclor and Keflex. On September 13 and October 11, 1988, Respondent prescribed Zantac even though neither the history, presenting complaints of Patient G or the physical exam indicated an active gastric ulcer. While treating Patient G as if he had an active ulcer Respondent inappropriately prescribed

Naprosyn, an NSAID, which is contraindicated in patients with a gastric ulcer. On October 25, 1988, Respondent prescribed Catapress without medical justification that Patient G was hypertensive. The State failed to introduce evidence relating to Theodore and therefore, failed to meet its burden of proof. Patient G had a rash and although the rash is inadequately described in the medical records, it is presumed Respondent appropriately prescribed Lotrisone cream. The Committee also finds the prescriptions for the Proventil inhaler to be appropriate.

Therefore, Allegations G.2(a), (b), (e), (g) and (h) are sustained.
Allegations G.2 (c), (d) and (f) are not sustained.

In Allegation G.3, Respondent is charged with failing to adequately follow-up and evaluate Patient G's noted complaints and/or diagnoses of asthma, gastric ulcer, rash and back ache. Respondent treated Patient G for back ache, gastric ulcer and asthma for six weeks during which Respondent prescribed Zantac, NSAIDs and three Proventil inhalers and Respondent failed to order diagnostic tests to evaluate the conditions, failed to evaluate the effectiveness of the medication regimen, and did not refer Patient G to appropriate specialists. Respondent appropriately followed the rash and the effectiveness of the medication.

Therefore, Allegations G.3(a), (b) and (d) are sustained.
Allegation G.3(c) is not sustained.

In Allegation G.4, Respondent is charged with failing to obtain appropriate laboratory tests. Respondent did not order hemoglobin, hematocrit, urine analysis, BUN or creatinine tests for Patient G as baselines.

Therefore, Allegation G.4 is sustained.

FINDINGS OF FACT AS TO PATIENT H

1. Respondent treated Patient H at his medical office called Doctors Office on two occasions, September 16, 1988 and October 11, 1988. (Pet's Ex. 9).

2. The history and presenting complaints are merged. The information elicited and noted by Respondent is scant and inadequate (Pet's Ex. 9 and T. 328 and 340). Although Patient H indicated back pain from trauma, Respondent failed to ascertain or note such information as when the trauma occurred, what was the trauma, where was Patient H injured during the trauma, where has Patient H experienced the back pain, how frequent, how severe, is the pain localized or radiating, is there any weakness (Pet's Ex. 9). Although asthma is noted on each visit, Respondent has failed to obtain and learn whether Patient H is currently having attacks, how often, the duration and what is the patient doing for them (T. 340).

3. On September 16, 1988, Respondent in the physical examination notes "rash in groin" but fails to describe the type of rash, its size or appearance. Respondent diagnoses asthma, gastric ulcer and arthritis, however there are no physical findings to support such diagnoses. On October 11, 1988, Respondent fails to perform or note any physical examination as to body temperature, head, lungs, ENT, mouth, even though Respondent diagnoses an upper respiratory infection and pharyngitis and prescribes Keflex, an antibiotic (Pet's Ex. 9 and T. 330).

4. On September 16, 1988, Respondent prescribed Zantac, Proventil inhaler, Naprosyn and Lotrisone cream to Patient H. On October 11, 1988, Respondent again prescribed Zantac and a Proventil inhaler, and also prescribed Dolobid an Keflex. As the existence of an active gastric ulcer is not demonstrated, Zantac was not medically indicated. However, as Respondent was treating Patient H with Zantac and noted a diagnosis of gastric ulcer, Naprosyn and Dolobid were contraindicated as a medication for Patient H without first using other pain killers (T.328-329). On October 11, 1988, Respondent fails to note that Patient H complained of a sore throat or any other symptoms relating to an upper respiratory infection and the physical examination is devoid of any evidence of an upper respiratory infection or pharyngitis. Respondent prescribed Keflex, an antibiotic, without any medical justification (T. 330-331). As the existence of an active gastric ulcer is not demonstrated, Zantac was not medically indicated. However, as Respondent was treating Patient H with

Zantac and noted a diagnosis of gastric ulcer, Dolobid was contraindicated as a medication for Patient H without first using other pain killers. Respondent wrote prescriptions to fill empty bottles of patients who told him another physician prescribed the medication for a particular condition (T.769-770).

5. On September 16, 1988, Respondent ordered a spirometry and audioscope test for Patient H. Patient H had not complained of hearing loss and Respondent noted in ENT "normal." There is no medical justification for the audio test (T. 339). However, the spirometry is appropriate for an asthmatic who evidences wheezing.

6. Respondent failed to adequately follow-up on the diagnoses of asthma, gastric ulcer and arthritis. Gastric ulcers tend to heal when treated properly. The gastric ulcer persisted for nearly three weeks and Respondent failed to investigate this condition with an endoscopy or to refer Patient H to a specialist (T. 340-341 and 343). Similarly with the asthma, although Respondent kept prescribing Proventil inhalers, Respondent failed to evaluate how often the asthma attacks have occurred, how bad they are, what is the patient doing for them or to formulate a plan to evaluate the effectiveness of the medication regimen (T. 340). Nor did Respondent refer Patient H to a specialist to evaluate his asthma and treatment regimen (T. 340). Although respondent notes arthritis as a diagnosis, there is nothing in the medical record to support the diagnosis (T.340).

7. Respondent did not order hemoglobin, hematocrit, BUN or creatinine tests to establish baselines for Patient H. These tests were particularly required since Respondent diagnosed Patient H as having a gastric ulcer and also prescribed Dolobid and Naprosyn, drugs known to cause bleeding in patients with a gastric ulcer.

CONCLUSIONS AS TO PATIENT H

In Allegations H.1(a) and (b), Respondent is charged with failure to obtain and note an adequate history (H.1(a)) and failure to perform and note an adequate physical exam. The pattern described for Patients A through G applies to Respondent's history and physical

examination for this patient. The history was cursory, the physical examination recorded in part conflicted with or failed to substantiate the diagnoses or prescriptions. Even taking into consideration that October 11, 1988 was a focused examination, the history and physical examination are grossly inadequate.

Therefore, Allegations H.1(a) and (b) are sustained.

In Allegations H.2(a) through (f), Respondent is charged with inappropriately prescribing Zantac on two occasions, Proventil inhaler on one occasion, Naprosyn on one occasion, Dolobid on one occasion, Lotrisone cream on one occasion and Keflex on one occasion. Without making an independent determination that the patient medically required the medication, Respondent wrote prescriptions when patients gave him empty bottles and report another physician prescribed the medication for a particular condition. Keflex and Ceclor were prescribed even though Patient H did not evidence signs of a bacterial infection. NSAIDs were prescribed in disregard to Respondent's diagnosis that Patient H had an active gastric ulcer. Zantac was prescribed even though Patient H had no current symptoms of gastric ulcer.

Therefore, Allegation H.2(a), (c), (d) and (f) are sustained.
Allegations H.2 (d) and (e) are not sustained.

In Allegations H.3(a) and (b), Respondent is charged with inappropriately ordering a spirometry and an audioscope. Although Patient H did not complain of hearing loss and there was no evidence of an auditory deficit, Respondent performed an audioscope without medical justification. Since Patient H had a history of asthma and wheezing is reported, Respondent appropriately ordered the spirometry.

Therefore, Allegation H.3(b) is sustained.
Allegation H.3(a) is not sustained.

In Allegation H.4, Respondent is charged with failing to adequately follow-up on and evaluate Patient H's noted complaints and/or diagnoses of asthma, gastric ulcer and arthritis. Respondent failed to formulate management plans for his treatment of Patient H's. gastric

ulcer and asthma. Nor did Respondent formulate a plan for the treatment of arthritis, which he lists as a diagnosis but for which there is no presenting complaint by the patient or support for in the medical records.

Therefore, Allegations H.4(a) through (c) are sustained.

In Allegation H.5, Respondent is charged with failing to obtain appropriate laboratory tests for patient H. As with the previous patients, Respondent failed to order hemoglobin, hematocrit, urine analysis, BUN and creatinine tests as baselines for Patient H.

Therefore, Allegation H.5 is sustained.

FINDINGS OF FACT AS TO PATIENT I

1. Respondent treated Patient I at his medical office called Doctors Office on approximately two occasions, October 11 and 25, 1988 (Pet's Ex. 10).

2. Respondent failed to distinguish information relating to history and Patient I's presenting complaints. Respondent reports the information in a confusing manner and his illegible writing adds to the inability of another physician to understand the medical record. The information Respondent obtained and noted is cursory; it fails to explain either long term history or the short term course of Patient H's presenting complaints. Respondent failed to obtain and note information as to Patient H's "known asthma," such as have there been recent attacks, and if so, their frequency and severity. (Pet's Ex. 10 and T. 345-355)

3. Respondent wrote contradictory findings in the physical examination such as ENT "clear" and "sore" (Pet's Ex. 10 and T. 354). The entry "sore" under ENT is not a physical finding that is a medically meaningful term to another physician reviewing the chart (T. 354). Respondent diagnosed pharyngitis, yet notes the ENT "clear." Respondent prescribed Tinactin, a medication for athlete's foot, however Respondent notes skin "normal" (Pet's Ex. 10 and T. 356). Respondent prescribed penicillin, however there is no record of an infection. ENT is "clear," sinuses "clear," mouth "normal," lungs "clear to A & P" and

Respondent failed to obtain and note Patient I's temperature.

4. Respondent prescribed Zantac, Naprosyn, Proventil inhaler and Lotrisone cream on both occasions and also Penicillin on October 11, 1988 (Pet's Ex. 10). Patient I did not have an infection and the prescription of Penicillin was not medically justified (T. 355 and 356). Patient I's skin is noted as normal and no presenting complaint of a skin disorder; there is no medically justification for the prescription of Lotrisone cream (Pet's Ex. 10). Nor do the medical records justify the prescriptions for Zantac since there is no indication Patient I 's gastric ulcer is active or has troubled Patient I since 1964. However, as Respondent treated Patient I as if Patient I had a gastric ulcer, the prescriptions for Naprosyn were contraindicated (Pet's Ex. 10 and T. 355-356 and 385). Patient I is asthmatic and the Committee finds it was appropriate for Respondent to prescribe the Proventil inhaler.

5. Respondent failed to adequately follow-up on and evaluate Patient I's back pain and asthma. Although Respondent prescribed Proventil inhaler on two occasions in a short period of time, Respondent failed to inquire and note whether Patient I had recent asthma attacks, and if so, their frequency and severity to evaluate the effectiveness of the medication and did not refer Patient I to a specialist. Although Patient I's back pain persisted and Patient I had indicated to Respondent that Patient I had received a direct trauma to his back, Respondent did not order any X-rays or other diagnostic tests to evaluate the back pain and did not refer Patient I to a specialist.

6. Respondent did not order any blood or laboratory tests for Patient I.

CONCLUSIONS AS TO PATIENT I

In Allegations I.1, Respondent is charged with failing to obtain and note an adequate history and failing to perform and note an adequate physical examination. Again, as with Respondent's medical records for the other patients, the history and presenting complaints are not distinguished, the notes are cryptic and cursory, and fail to inform an successor physician of either Patient I's medical history or his chief complaints.

Respondent's physical examination also fails to adequately inform another physician of his findings and the bases for his diagnoses or prescriptions. As noted above in ¶8 above, in general findings, the Committee finds Respondent's assertions that he performed the physical examination and made the findings as presented in Patient I's medical record to be incredible.

Therefore, Allegations I.1(a) and (b) are sustained.

In Allegations I.2(a) through (e), Respondent is charged with inappropriately prescribing Zantac on two occasions, Naprosyn on two occasions, Proventil inhaler on one occasion, Lotrisone cream on one occasion and Penicillin on one occasion. Except for the prescription for Proventil inhaler, there is no medical justification for the remaining prescriptions. There is no evidence of a disorder medically justifying the prescriptions for Zantac, Penicillin or Lotrisone cream and since Respondent treated Patient I as if Patient I had an active gastric ulcer, the prescriptions for Naprosyn were contraindicated.

Therefore, Allegations I.2(a), (b), (d) and (e) are sustained.
Allegation I.2 (c) is not sustained.

In Allegations I.3(a) and (b), Respondent is charged with failing to adequately follow-up on and evaluate Patient I's noted complaints and/or diagnoses of back pain and asthma. Respondent failed to adequately inquire about the recent events of asthma in order to determine whether to refer Patient I to a specialist. Although advised of a direct trauma to Patient I's back, Respondent failed to inquire as to when the trauma occurred, how did the trauma happen, or specifically where in his back was Patient I injured. Respondent further failed to order an X-ray or other diagnostic tests to evaluate Patient I's back pain possibly resulting from the reported trauma.

Therefore, Allegations I.3(a) and (b) are sustained.

In Allegation I.4, Respondent is charged with failing to obtain laboratory tests including hemoglobin, hematocrit, urine analysis, BUN and creatinine. Respondent did not order any of theses tests for Patient I as a baseline and to monitor the Naprosyn, which has

known dangers for patients with gastric ulcer.

Therefore, Allegations I.4 is sustained.

VOTE OF THE HEARING COMMITTEE

THE HEARING COMMITTEE VOTES UNANIMOUSLY (3-0) AS FOLLOWS:

FIRST SPECIFICATION:
(Negligence On More Than One Occasion)

SUSTAINED AS TO PARAGRAPHS: A.1(a), A.1(b), A.2(a) through A.2(e), A.4(a) through A.4(c), A.5; B.1(a), B.1(b), B.2(a), B.2(c), B.2(e), B.2(f), B.4(a), B.4(b), B.5; C.1(a), C.1(b), C.2(a) through C.2(d), C.3, C.4(a) through C.4(c), C.5; D.1(a), D.1(b), D.2(a) through D.2(f), D.3, D.4(a) through D.4(c), D.5; E.1(a), E.1(b), E.2(b), E.2(d), E.3(a), E.3(b), E.4(a) through E.4(d), E.5; F.1(a), F.1(b), F.2 (a), F.2(b), F.2(d), F.3(a) through (d), F.4; G.1(a), G.1(b), G.2(a), G.2(b), G.2(e), G.2(g), G.2(h), G.3(a), G.3(b), G.3(d), G.4; H.1(a), H.1(b), H.2(a), H.2(c), H.2(d), H.2(f), H.3(b), H.4(a) through H.4(c), H.5; I.1(a), I.1(b), I.2(a), I.2(b), I.2(d), I.2(e), I.3(a), I.3(b) and I.4.

NOT SUSTAINED AS TO PARAGRAPHS: A.3; B.2(b), B.2(d), B.3; C.2(e), C.2(f); E.2(a), E.2(c); F.2(c); G.2(c), G.2(d), G.2(f), G.3(c); H.2(b), H.2(e), H.3(a); and I.2(c).

SECOND THROUGH TENTH SPECIFICATIONS:
(Unnecessary tests and treatment)

SUSTAINED AS TO PARAGRAPHS: A.2(a) through A.2(e); B.2(a), B.2(c), B.2(e), B.2(f); C.2(a) through C.2(d), C.3; D.2(a) through D.2(f), D.3; E.2(b), E.2(d), E.3(a), E.3(b); F.2(a), F.2(b), F.2(d); G.2(a), G.2(b), G.2(e), G.2(h); H.2(a), H.2(c), H.2(d), H.2(f), H.3(b); I.2(a), I.2(b), I.2(d) and I.2(e).

NOT SUSTAINED AS TO PARAGRAPHS: A.3; B.2(b), B.2(d), B.2(g), B.3, C.2(e), C.2(f); F.2(c); G.2(c), G.2(d), G.2(f); and I.2(c).

ELEVENTH THROUGH NINETEENTH SPECIFICATIONS:
(Failure to Maintain Adequate Records)

SUSTAINED AS TO PARAGRAPHS: A.1(a), A.1(b); B.1(a), B.1(b); C.1(a), C.1(b); D.1(a), D.1(b); E.1(a), E.1(b); F.1(a), F.1(b); G.1(a), G.1(b); H.1(a), H.1(b); I.1(a) and I.1(b).

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Committee found Respondent's method of taking and recording a history, and performing and noting a physical examination, fell below acceptable standards for record keeping. Moreover, it evidenced treatment which falls below that level of care and diligence expected of a prudent physician in this state. Repeatedly, Respondent formulated diagnoses that were either not supported by the patients' medical records or conflicted with information in the medical records. Respondent demonstrated an attitude that he believed once he completed his treatment of a patient on a particular day at the Doctors Office he had no responsibility to follow-up by either providing on-going care himself or referring the patient to another physician. Respondent only performed those tests for which he himself had equipment, regardless of whether those diagnostic tests were warranted. Respondent would not perform or order any diagnostic procedures or tests which needed to be sent out to a lab or performed off premises despite their need for baseline or diagnostic purposes. The Committee was greatly disturbed by Respondent's practice of dispensing medication merely on the basis of either a patient's request or the presentation of previously used prescription containers because of the potential deleterious effects and dangers posed to patients. Respondent showed a notable inability to correlate the need for medication with the patient's existing condition, as well as deficient skills for management of chronic conditions such as asthma, gastric ulcer and arthritis.

The Hearing Committee unanimously determines because of the serious nature of the charges and the cumulative occurrences of medical misconduct the Respondent's license to practice medicine in the State of New York should be **REVOKED**.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is **REVOKED**.

DATED: New York, New York
January 2, ,1995

ROBERT J. O'CONNOR, M.D.
Chairperson

Hilda Ratner, M.D.
Ms. Eugenia Herbst

Department Exhibit 1

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

IN THE MATTER OF CARL BALMIR, M.D.	NOTICE OF HEARING

TO: CARL BALMIR, M.D.
1984 Byron Avenue
Elmont, NY 11003

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 11th day of May, 1994, at 10:00 in the forenoon of that day at 5 Penn Plaza, Sixth Floor, New York, New York 10001 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 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. 1994), 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. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York

April 18, 1994

CHRIS STERN HYMAN,
Counsel

Inquiries should be directed to: Claudia Morales Bloch
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza- 6th floor
New York, New York 10001
Telephone No.: (212) 613-2615

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
CARL BALMIR, M.D.	:	CHARGES

----------X

CARL BALMIR, M.D., the Respondent, was authorized to practice medicine in New York State on March 25, 1983 by the issuance of license number 153637 by the New York State Education Department. The Respondent is not currently registered. His last known address is 1984 Byron Avenue, Elmont, NY 11003.

FACTUAL ALLEGATIONS

A. Between on or about October 11, 1988 and on or about October 26, 1988, Respondent treated Patient A at a medical practice in New York called, Doctor's Office, the exact location of which is unknown to Petitioner, (Respondent's office), on approximately 2 occasions. (Patient A and all other patients are identified in the attached Appendix.)

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Zantac on 2 occasions.

b. Proventil inhaler on 1 occasion.

c. Dolobid on 2 occasions.

d. Keflex on 1 occasion.

e. Valisone cream on 1 occasion.

3. Respondent inappropriately ordered a pulmonary function test.

4. Respondent failed to adequately follow-up on and evaluate Patient A's noted complaints and/or diagnoses of:

a. Asthma

b. Ulcers

c. Backache

5. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

B. Between on or about September 12, 1988 and on or about October 11, 1988, Respondent treated Patient B at Respondent's office on approximately 2 occasions.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Zantac on 2 occasions.

b. Proventil inhaler on 1 occasion.

c. Dolobid on 1 occasion.

d. Valisone cream on 1 occasion.

e. Ceclor on 1 occasion.

f. Naprosyn on 1 occasion.

g. Lotrimin cream on 1 occasion.

3. Respondent inappropriately ordered a pulmonary function test.

4. Respondent failed to adequately follow-up on and evaluate Patient B's noted complaints and/or diagnoses of:

a. Gastric Ulcer

b. Asthma

5. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

C. Between on or about June 16, 1988 and on or about October 11, 1988, Respondent treated Patient C at Respondent's office on approximately 2 occasions.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Valium on 1 occasion.

b. Proventil inhaler on 1 occasion.

c. Zantac on 2 occasions.

d. Feldene on 1 occasion.

e. Lotrimin cream on 1 occasion.

f. Ceclor on 1 occasion.

3. Respondent inappropriately ordered a pulmonary function test.

4. Respondent failed to adequately follow-up on and evaluate Patient C's noted complaints and/or diagnoses of:

a. Asthma

b. Gastric ulcer

c. Arthritis

5. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

D. Between on or about September 15, 1988 and on or about October 31, 1988, Respondent treated Patient D at Respondent's office on approximately 3 occasions.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Proventil inhaler on 2 occasions.

b. Lotrisone cream on 2 occasions.

c. Zantac on 2 occasions.

d. Dolobid on 2 occasions.

e. Keflex on 1 occasion.

f. Valisone cream on 1 occasion.

3. Respondent inappropriately ordered a pulmonary function test.

4. Respondent failed to adequately follow-up on and evaluate Patient D's noted complaints and/or diagnoses of:

a. Asthma

b. Gastric ulcer

c. Arthritis.

5. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

E. On or about October 26, 1988, Respondent treated Patient E at Respondent's office on approximately 1 occasion.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Zantac

b. Dolobid

c. Lotrisone cream

d. Keflex

3. Respondent inappropriately ordered:

a. Pulmonary function test

b. Audioscope

4. Respondent failed to adequately follow-up on and evaluate Patient E's noted complaints and/or diagnoses of:

a. Asthma

b. Gastric ulcer

c. Rash

d. Backache

5. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

F. On or about October 11, 1988, Respondent treated Patient F, at Respondent's office on approximately 1 occasion.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Zantac

b. Dolobid

c. Valisone cream

d. Ceclor

3. Respondent failed to adequately follow-up on and evaluate Patient F's noted complaints and/or diagnoses of:

   a. Asthma

   b. Gastric ulcer

   c. Rash

   d. Backache

4. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

G. Between on or about September 13, 1988 and on or about October 25, 1988, Respondent treated Patient G at Respondent's office on approximately 3 occasions.

1. Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Zantac on 3 occasions.

b. Naprosyn on 3 occasions.

c. Lotrisone cream on 2 occasions.

d. Theodore on 1 occasion.

e. Ceclor on 1 occasion.

f. Proventil inhaler on 2 occasions.

g. Kelfex on 1 occasion.

h. Catapress on 1 occasion.

3. Respondent failed to adequately follow-up on and evaluate Patient H's noted complaints and/or diagnoses of:

a. Asthma

b. Gastric ulcer

c. Rash

d. Backache

4. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

H. Between on or about September 16, 1988 and on or about October 11, 1988, Respondent treated Patient H at Respondent's office on approximately 2 occasions.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Zantac on 2 occasions.

b. Proventil inhaler on 1 occasion.

c. Naprosyn on 1 occasion.

d. Dolobid on 1 occasion.

e. Lotrisone cream on 1 occasion.

f. Keflex on 1 occasion.

3. Respondent inappropriately ordered:

a. Pulmonary function test

b. Audioscope

4. Respondent failed to adequately follow-up on and evaluate Patient H's noted complaints and/or diagnoses of:

a. Asthma

b. Gastric ulcer

c. Arthritis

5. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

I. Between on or about October 11, 1988 and on or about October 25, 1988, Respondent treated Patient I at Respondent's office on approximately 2 occasions.

1. Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

   a. Zantac on 2 occasions.

   b. Naprosyn on 2 occasions.

   c. Proventil inhaler on 1 occasion.

   d. Lotrisone cream on 1 occasion.

   e. Penicillin on 1 occasion.

3. Respondent failed to adequately follow-up on and evaluate Patient I's noted complaints and/or diagnoses of:

   a. Back pain

   b. Asthma

4. Respondent failed to obtain appropriate laboratory tests including hemoglobin/hematocrit, urine analysis, BUN and creatinine.

SPECIFICATIONS OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993) by practicing the profession with negligence on more than one occasion in that Petitioner charges two or more of the following:

1. A(1)(a), A(1)(b), A(2)(a) through A(2)(e), A(3), A(4)(a), A(4)(b), A(4)(c), A(5); B(1)(a), B(1)(b), B(2)(a) through B(2)(g), B(3), B(4)(a), B(4)(b), B(5); C(1)(a), C(1)(b), C(2)(a) through C(2)(f), C(3), C(4)(a), C(4)(b), C(4)(c), C(5); D(1)(a), D(1)(b), D(2)(a) through D(2)(f), D(3), D(4)(a), D(4)(b), D(4)(c), D(5); E(1)(a), E(1)(b), E(2)(a) through E(2)(d), E(3)(a), E(3)(b),

E(4)(a) through E(4)(d), E(5); F(1)(a), F(1)(b), F(2)(a) through F(2)(d), F(3)(a) through F(3)(d), F(4); G(1)(a), G(1)(b), G(2)(a) through G(2)(h), G(3)(a) through G(3)(d), G(4); H(1)(a), H(1)(b), H(2)(a) through H(2)(f), H(3)(a), H(3)(b), H(4)(a), H(4)(b), H(4)(c), H(5); I(1)(a), I(1)(b), I(2)(a) through I(2)(e), I(3)(a), I(3)(b), and/or I(4).

SECOND THROUGH TENTH SPECIFICATIONS

UNNECESSARY TESTS AND/OR TREATMENT

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1993) by ordering excessive tests and/or treatment not warranted by the condition of the patient in that Petitioner charges:

2. The facts in paragraphs A(2)(a) through A(2)(e) and A(3).

3. The facts in paragraphs B(2)(a) through B(2)(g) and B(3).

4. The facts in paragraphs C(2)(a) through C(2)(f) and C(3).

5. The facts in paragraphs D(2)(a) through D(2)(f) and D(3).

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

7. The facts in paragraphs F(2)(a) through F(2)(d).

8. The facts in paragraphs G(2)(a) through G(2)(h).

9. The facts in paragraphs H(2)(a) through H(2)(f), H(3)(a) and H(3)(b).

10. The facts in paragraphs I(2)(a) through I(2)(e).

ELEVENTH THROUGH NINETEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct within the meaning of NY Educ. Law Section 6530(32) (McKinney Supp. 1993) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that Petitioner charges:

11. The facts in paragraphs A(1)(a) and A(1)(b).

12. The facts in paragraphs B(1)(a) and B(1)(b).

13. The facts in paragraphs C(1)(a) and C(1)(b).

14. The facts in paragraphs D(1)(a) and D(1)(b).

15. The facts in paragraphs E(1)(a) and E(1)(b).

16. The facts in paragraphs F(1)(a) and F(1)(b)

17. The facts in paragraphs G(1)(a) and G(1)(b).

18. The facts in paragraphs H(1)(a) and H(1)(b).

19. The facts in paragraphs I(1)(a) and I(1)(b).

DATED: New York, New York
4/18/94

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct