STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Lorna McBarnette
Executive Deputy Commissioner

June 29, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jose B. Llorens, M.D.
4 Cabriolet Lane
Melville, New York 11747

Charles B. Rosenblum, Esq.
Krohn, Rosenblum & Scharoff, Esqs.
25 Merrick Avenue
Merrick, New York 11566

Daniel Guenzburger, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

RE: In the Matter of Jose B. Llorens, M.D.

Dear Dr. Llorens, Mr. Rosenblum and Mr. Guenzburger:

Enclosed please find the Determination and Order (No. BPMC-92-52) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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 than 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
Corning Tower - Room 2503
Empire State Plaza
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.

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

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

IN THE MATTER	:	DETERMINATION AND ORDER
OF	:	OF THE HEARING COMMITTEE
JOSE B. LLORENS, M.D.	:	Order No. BPMC-92-52

The undersigned Hearing Committee consisted of **Kenneth Kowald**, Chairperson, **Daniel A. Sherber, M.D.** and **Benjamin Wainfeld, M.D.** The Committee was duly designated, constituted and appointed by the State Board for Professional Medical Conduct (Board). **Harry Shechtman, Esq.**, Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of New York Public Health Law §230 and New York State Administrative Procedure Act §§301-307 to receive evidence concerning the charges that the Respondent has violated provisions of New York Education Law §6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made.

The Committee has considered the entire record and makes this Determination and Order based upon its Findings of Fact and Conclusions.

The Statement of Charges alleges 13 Specifications based upon factual allegations covering the treatment of five patients (A through E) by the Respondent as set forth in the Factual Allegations of the Statement of Charges.

The **First Specification** alleges professional misconduct consisting of negligence on more than one occasion as defined in New York Education Law §6530(3).

The **Second Specification** alleges professional misconduct consisting of incompetence on more than one occasion as defined in New York Education §Law 6530(5).

The **Third through Eighth Specifications** allege professional misconduct by ordering excessive tests not warranted by the patient's condition within the purview of New York Education §Law 6530(35).

The **Ninth through Thirteenth Specifications** allege a failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the purview of New York Education Law §6530(2).

SUMMARY OF PROCEEDINGS

Notice of Hearing dated:	December 12, 1991
Statement of Charges dated:	December 12, 1991
Notice of Hearing and Statement of charges served upon Respondent:	December 13, 1991
Notice of Hearing returnable:	January 8, 1991
Place of Hearing:	5 Penn Plaza New York, New York
Answer:	None
Bureau of Professional Medical Conduct appeared by:	Daniel Guenzburger Assistant Counsel
Respondent appeared by:	Krohn, Rosenblum & Scharoff, Esqs. By: Charles B. Rosenblum, Esq. of Counsel

Pre-Hearing Conference held:	January 8, 1992
Hearings were held on:	January 8, 1992 January 27, 1992 February 12, 1992 April 10, 1992
Hearing closed:	April 10, 1992
Proposed Findings of Fact	
By Department:	May 7, 1992
By Respondent:	May 11, 1992
Deliberations held on:	May 15, 1992

There was an intra-hearing conference out of the presence of the Committee on February 12, 1992 wherein a motion by the Department to have a representative of the Department of Social Services testify was denied.

Various minor amendments and deletions were made in the Statement of Charges during the pre-hearing conference and course of the hearings. Exhibit 1 contains the Statement of Charges in its final form.

WITNESSES

The sole witness for the Department (Petitioner) was Marshal Anton Mundheim, M.D., who testified as an expert.

The sole witness for the Respondent was the Respondent himself, Jose B. Llorens, M.D.

GENERAL FINDINGS OF FACT

1. Jose B. Llorens, M.D., the Respondent, was authorized to practice medicine in New York State on September 16,

1974 by the issuance of license number 121628 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at 4 Cabriolet Lane, Melville, New York.

2. All five patients herein were treated by the Respondent at his office at 3021 Third Avenue, Bronx, New York.

3. The treatments of the five patients took place at various times between April 2, 1987 and December 2,1988.

FINDINGS OF FACT REGARDING PATIENT A

4. The Respondent treated Patient A on October 5, 1987, October 5, 1988, November 9, 1988, and December 16, 1988. Patient A was 28 years old at the onset of treatment. (Exh. 3)

5. Patient A complained of back pain, abdominal pain, nervousness, skin rash, cough and shortness of breath at all visits. He had a past medical history of drug and alcohol abuse, peptic ulcer, asthma, back pain, and hepatitis. (Exh. 3)

6. At all 4 visits Respondent did not elicit any information from the patient concerning the complaint, of back pain, the duration of the complaint, location of the pain, aggravating and amelioration factors. (T. 36; Exh. 3)

7. At all four visits the Respondent did not elicit any information from the patient for the complaint of abdominal pain, aggravation and amelioration factors, whether the patient had vomiting blood with his stool, and if the pain radiates to the

back or other parts of the body. (T. 37; Exh. 3)

8. The Respondent noted that the patient had a history of drug and alcohol abuse, but did not indicate which drugs the patient abused, the patient's current use of drugs and alcohol, if the patient had ever received drug or alcohol rehabilitation treatment, and any medical complications related to the patient's substance abuse. (T. 39)

9. The Respondent noted that the patient had asthma but did not indicate the severity of the asthma and whether the patient had ever been hospitalized for the condition. (T. 80)

10. The Respondent noted the patient had a history of peptic ulcer, but did not note how the diagnosis had been made and what treatment the patient had received. (T. 37)

11. Respondent did not perform abdominal examinations at all 4 visits in response to the patient's complaints of abdominal pain. (T. 40, 43) The Respondent did not identify whether the abdomen was tender, nor specify the location of the tenderness and did not indicate whether the tenderness was direct or rebound tenderness. The physical examination did not identify the presence or absence of masses. (T. 41) On the October 1987 visit, the Respondent noted that there were abnormal findings in the abdomen, but did not provide any elaboration in the patient's chart (Ex. 3, p.4). Respondent only noted that the patient had epigastric tenderness. (Ex. 3)

11. On the visits of November 9, and December 16, 1988, the Respondent did not record any findings pertaining to an

abdominal examination. (Ex. 3)

14. The Respondent did not make a diagnoses of the cause of Patient A's chief complaints, namely chest pain, abdominal pain, and back pain listed as diagnoses in the patient's chart. (T. 44)

15. Respondent ordered an audiometric hearing test, although the patient did not complain that he had a problem with hearing and Respondent's physical examination did not indicate abnormal findings in the ear. (T. 49, 113).

16. Respondent ordered an abdominal sonogram for Patient A at the October 5, 1987 and October 5, 1988 visits based upon the patient's complaints and the Respondent's physical examination. (T. 49, 102; Ex. 3)

17. Respondent ordered an EKG at the October 5, 1988 visit. Patient had a negative EKG one year prior to this visit. On both occasions patient presented identical complaints. (T. 119)

18. There was no indication in the chart for an RBC pratoporphyrin test which was ordered by the Respondent. (T. 54)

19. Although the blood tests ordered at the October 5, 1988 visit revealed abnormal hepatitis, SGOT, SGPT, WBC, RCB, hemoglobin and hematocrit results, Respondent did not follow-up on the results. Respondent took no follow-up action, even though Patient A returned to Dr. Llorens office one month after he ordered the tests. (T. 58; Exh. 3)

CONCLUSIONS REGARDING PATIENT A

20. Respondent failed to take an adequate general history and adequate histories related to Patient A's specific complaints and symptoms. (See 6, 7 and 8 above.)

21. Failed to perform adequate abdominal examinations at visits dated October 5, 1987, October 5, 1988, November 9, 1988, and December 16, 1988. (See 11 above.)

22. Failed to maintain an adequate record of Patient A's presenting complaints, symptoms, and the findings of his physical examinations. (See 6, 7, 8, 9, 10 and 11.)

23. Failed to diagnose the cause of Patient A's chest, abdominal, and back pain. (See 11, 12 and 13.)

24. Ordered audiometry on October 5, 1987 without adequate medical indication for the tests. There was insufficient evidence to sustain the allegations that the abdominal sonogram was not indicated.

25. Ordered an EKG, and an RBC protoporphyrin test on October 5, 1988 without adequate medical indication for the tests. There was insufficient evidence to sustain the allegation that the abdominal sonogram was not indicated. (See 7 and 16 above.)

26. Failed to follow-up on abnormal SGOT, SGPT, WBC, RBC, hemoglobin, hematocrit, and hepatitis laboratory test results. (See 19 above.)

FINDINGS OF FACT REGARDING PATIENT B

27. Respondent treated Patient B, a 38 year old female, on July 23, 1987. (Exh. 4)

28. The Respondent took and recorded histories for the patient's complaints of abdominal and back pain. (T. 148; Exh. 4). The Respondent did not elicit any historical information about the patient's complaints of back and abdominal pain. (Exh. 4)

29. The Respondent took and recorded a history of the patient's complaint of vaginal discharge. The Respondent did not elicit any information such as duration of the discharge, the color of the discharge, whether there are mechanical or sexual practices that contribute to the discharge and the presence or absence of lower pelvic pain. (T. 149; Exh. 4)

30. The Respondent diagnosed vaginitis without either performing a pelvic exam and cultures or by referral of the patient to a gynecologist. (T. 152; Exh. 4, p. 2)

31. The Respondent did perform an abdominal examination. (Exh. 4)

32. The Respondent did not diagnose the cause of this patient's chief complaints. He listed back and abdominal pain as diagnosed in the patient's chart. (T. 152)

33. The Respondent ordered audiometry although Patient B did not complain that she had a problem with hearing and did not have a lifestyle that involved occupational or other exposure to extremely loud noise over extended periods of time. (Pet. Exh. 4)

34. The Respondent ordered hemoglobin and protein electrophoresis tests without indication. (T. 158, 159)

CONCLUSIONS REGARDING PATIENT B

35. Respondent did take an adequate general history and adequate histories related to Patient B's specific complaints and symptoms. (See 28 above.)

36. Failed to diagnose the cause of Patient B's back and abdominal pain. (See 28 above.)

37. Did perform an adequate abdominal examination. (See 31 above.)

38. Diagnosed vaginitis without supporting the diagnosis with appropriate clinical observations and laboratory tests, or by referring the patient to a gynecologist. (See 29 and 30 above.)

39. Did maintain an adequate record of Patient B's past medical history, presenting complaints, findings of the physical examination, prescriptions and plans for further treatment. (See 28 above.)

40. Ordered audiometry, protein electrophoresis and Hbg electrophoresis tests without adequate medical indication for the tests. (See 33 and 34 above.)

FINDINGS OF FACT REGARDING PATIENT C

41. The Respondent treated Patient C, a 34 year old male, on April 2 and 15, 1987.

42. The Respondent did not maintain a record for:

(a) Patient C's complaint of multiple abscesses. The only history Respondent recorded was that the abscesses were related to intravenous drug use. (T. 200)
(b) The only physical examination finding was multiple small abscesses. (Exh. 5, p. 3; T. 201, 207).

43. The Respondent did not take a culture of the abscesses. (T. 205)

44. The Respondent treated the abscesses with broad spectrum anti-biotic Ampicillin. (T. 205)

45. Respondent ordered an abdominal sonogram without indication. Patient C did not complain of abdominal pain and Dr. Lloren's physical examination did not reveal abnormal findings of the abdomen. (Exh. 5)

46. The Respondent ordered audiometry without indication. Patient C had no evidence of a current hearing problem, and lifestyle did not involve occupational or other significant exposure to extremely loud noise over extended periods of time. (T. 203-204)

47. Respondent ordered spirometry without indication, Patient C's complaint of cough provided an insufficient basis for ordering the test. The cough was not associated with significant symptoms affecting breathing, and Patient C did not have a history of asthma or other condition that would affect a patient's ability to breathe. (T. 204, 224)

48. The Respondent ordered a TT3 by Radioimmunoassay and protein electrophoresis tests without indication therefore in

the chart. (T. 158, 210)

49. Respondent did not follow-up on abnormal HGB, HCT, MCV and ALK PHOS laboratory test results. (T. 212)

50. The Respondent did not order a follow-up visit, in spite of the fact that he ordered laboratory tests. In addition, he made no attempt to contact the patient by mail or at the telephone number indicated in the chart after receipt of the laboratory results. (Exh. 5)

51. The Respondent did not diagnose the cause of Patient C's chief complaints of back pain and foot rashes. (T 214-217)

CONCLUSIONS REGARDING PATIENT C

52. Failed to maintain an adequate record of Patient C's presenting complaints, symptoms, and the findings of physical examinations. (See 42 and 42(b) above.)

53. Failed to diagnose the cause of Patient C's back pain and foot rash. (See 51 above.)

54. Did not have to culture the abscesses on Patient C's left forearm to identify the specific pathogen causing the infection. (See 43 above.)

55. Prescribed Ampicillin for abscesses on Patient C's left arm. (See 44 above.)

56. Ordered spirometry, tymponography, TT3 by Radioimmunoassay tests, protein electrophoresis and an abdominal sonogram without adequate medical indication for the tests. (See

47 and 48 above.)

57. Failed to follow-up on the abnormal Alk Phos, HGB, HCT and MCV laboratory test results in the laboratory report dated April 20, 1987. (See 49 and 50 above.)

FINDING OF FACT REGARDING PATIENT D

58. Respondent treated Patient D, a 32 year old male, on September 21, 1988 and December 2, 1988. (Exh. 6)

59. The Respondent did not take and record any history in response to the patient's complaint of headache. (Exh. 6) Respondent did not elicit the duration of the headache, location of the pain, whether the onset of the headache was gradual or sudden, and if the patient had trauma, fever, or visual symptoms associated with the headache. (T. 270)

60. The Respondent did not perform a gross neurological examination in response to the complaint of headache. (T. 270)

61. The Respondent did perform an abdominal examination. (T. 270)

62. The Respondent noted a mild heart murmur at the September 21, 1988 visit, but did not elicit and record adequate information to determine if the murmur was abnormal or the timing of the murmur, whether the murmur was in a systolic or diastolic state, location of the murmur, radiation of the murmur, intensity of the murmur, and the heart sounds that accompany the murmur. (T. 274)

63. The Respondent ordered audiometry and tympanography

without indication. Patient D had no evidence of a current hearing problem and Patient D's lifestyle did not involve occupational or other significant exposure to extremely loud noise over extended periods of time. (T. 279)

64. The Respondent ordered an abdominal sonogram without indication. (T. 49, 102)

65. The Respondent ordered the T3 (Triiodothyronine) and T4, Free Thyroid tests without indication. (T. 285)

66. The Respondent ordered the RBC protoporphyrin test and hemoglobin electrophoresis test without indication. (T. 287-288)

67. Respondent prescribed Feldene for Patient D, which was indicated even though the patient had peptic ulcer disease. (T. 290)

68. Respondent did make diagnoses of the cause of Patient D's chief complaints. (T. 290)

CONCLUSIONS REGARDING PATIENT D

69. Respondent did take an adequate history of Patient D's complaints and symptoms. (See 59 above.)

70. Did perform an adequate abdominal examination. (See 58 above.)

71. Failed to perform a neurological examination in response to a complaint of headache. (See 60 above.)

72. Failed to adequately record a description of Patient D's heart murmur to determine if the heart murmur was

abnormal. (See 62 above.)

73. Did maintain an adequate record of Patient D's presenting complaints, symptoms, the findings of his physical examinations, and the treatment ordered. (See 59 above.)

74. Did diagnose the cause of Patient D's back pain and headache. (See 58 above.)

75. Ordered audiometry, tympanography, echocardiogram, abdominal sonogram, T3 (Triiodothyronine), Hbg electrophoresis and RBC protoporphyrin tests without adequate medical indication for the tests. (See 63, 64, 65, 66 above.)

76. Prescribed Feldene to a patient with a diagnosis of peptic ulcer disease which was indicated under the circumstances. (See 67 above.)

FINDINGS OF FACT REGARDING PATIENT E

77. Respondent treated Patient E, a 35 year old male, on June 26, 1987. (Exh. 7)

78. Respondent ordered spirometry without indication, Patient's cough was not associated with significant symptoms affecting breathing, and Patient E did not have history of asthma or other condition that would affect the ability to breathe. (T. 204, 224, 322)

79. The Respondent performed an EKG on Patient E without indication in response to a complaint of occasional chest pain. (Exh. 7).

80. The Respondent ordered audiometry without

indication. Patient E had no evidence of a current hearing problem and his lifestyle did not involve occupational or other extended periods of time. (T. 49, 113, 323)

81. The Respondent ordered a TT3 by Radioimmunoassay, Hbg electrophoresis, and glycohemoglobin tests without indication. (T. 210, 287, 738)

82. The Respondent, ordered a glycohemoglobin test without indication. (738)

83. The TT3 by radioimmunoassay ordered by Respondent, is an expensive test which should not be performed as a screening test. (T. 209) This test was ordered without indication, therefore. (T. 209)

84. Respondent prescribed Naprosyn for Patient E. (T. 324)

85. Respondent prescribed erythromycin, an antibiotic, for a patient with a diagnosis of upper respiratory infection/bronchitis. (T. 325)

86. The fact that the abnormal WBC, SGOT, SGPT laboratory test results reported for Patient E suggested that Patient E's treatment with Naprosyn may have caused liver toxicity and the depression of the hematopoietic system, the Respondent did not follow-up on the results of the tests. (T. 328; Exh. 7)

87. Respondent did not follow-up on an abdominal sonogram report. (T. 328; Exh.7)

88. The Respondent noted an inadequate history for the Patient's complaint of back pain. (Exh. 7)

CONCLUSIONS REGARDING PATIENT E

89. Respondent ordered an EKG, spirometry, audiometry, TT3 by radioimmunoassay electrophoresis, and glycohemoglobin tests without adequate medical indication for the tests. (See 78, 79, above.)

90. The Respondent maintained an adequate record of Patient E's presenting complaints, symptoms, physical examination of the patient and the results of laboratory tests and procedures. (See 85 above.)

91. Prescribed Naprosyn to a patient with a history of peptic ulcer disease and did document why a less ulcerogenic anti-pain medication was not selected. (See 84 above.)

92. Prescribed Erythromycin with adequate indication. (See 85 above.)

93. Failed to follow up on abnormal laboratory results in that: Respondent failed to note the abnormal WBC, SGOT, SGPT laboratory test results and document a follow-up plan. (See 87 above.)

94. Respondent did note the diagnosis of gallstones in the abdominal sonogram report, but the patient did not return after one visit. (See 87 above.)

The Committee by unanimous vote made the following Conclusions upon the Factual Allegations:

Regarding Patient A: Sustained allegations: A, A-1, A-2, A-3, A-4 and A-7. It did not sustain A-5 and A-7 because this was a "gray area" with regard to the ordering of an abdominal sonogram.

Regarding Patient B: Sustained allegations: B, B-2, B-4 and B-6. It did not sustain B-1, B-3 and B-5 based on the charts and testimony.

Regarding Patient C: Sustained allegations: C, C-1, C-2, C-5 and C-6. Charges C-3 and C-4 are not sustained all based on charts and testimony.

Regarding Patient D: Sustained allegations: D, D-3, D-4, D-7 and D-9. Charges D-1, D-2, D-5, D-6 and D-8 are not sustained based on the charts and testimony.

Regarding Patient E: Sustained allegations: E, E-3, E-4, E-7, E-9. Charges E-1, E-2, E-5 E-6 and E-8 are not sustained based on the charts and testimony.

Determinations as to the specifications, all of which are the result of unanimous votes, are:

FIRST SPECIFICATION

Negligence on more than one occasion. The Committee sustains this charge based upon the care and treatment of each of the five patients which are the subjects of this hearing.

SECOND SPECIFICATION

The Committee is not satisfied that the evidence supported a charge of incompetence and, therefore, does not sustain this charge.

THIRD THROUGH EIGHTH SPECIFICATIONS ORDERING EXCESSIVE TESTS AND TREATMENT

The Committee concludes, based upon all of the evidence that the Respondent did order excessive tests and treatments for all five patients. The Committee, therefore, sustains these specifications.

NINTH THROUGH THIRTEENTH SPECIFICATIONS FAILING TO MAINTAIN ADEQUATE RECORDS

Based upon the bulk of the Findings and Conclusions, except for three instances with regard to Patients B, D and E, the Committee determines that the Respondent failed to maintain adequate records and, therefore, sustains these specifications.

ORDER

The Committee is of the firm opinion that Dr. Llorens has the ability and knowledge to be a competent doctor. However, the Committee feels that he should be supervised.

THE COMMITTEE UNANIMOUSLY ORDERS that Dr. Llorens' license to practice medicine be suspended for a period of two years from the effective date of this Order.

IT IS FURTHER ORDERED that the last 18 months of the suspension be stayed during which time Dr. Llorens shall be on probation. During the probationary period, whether he be in private practice or affiliated with a hospital or other institutions, his records should be randomly and periodically reviewed. The Committee feels strongly that such scrutiny is essential if Dr. Llorens is to practice medicine in a manner which does not jeopardize his practice nor create problems for future patients.

DATED: New York, New York

June 25, 1992

BY: Kenneth Kowald
KENNETH KOWALD, CHAIRPERSON

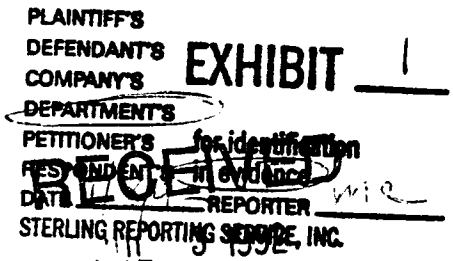
DANIEL A. SHERBER, M.D.
BENJAMIN WAINFELD, M.D.

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

IN THE MATTER : NOTICE

OF : OF

JOSE B. LLORENS, M.D. : HEARING



TO: JOSE B. LLORENS, M.D.
4 Cabriolet Lane
Melville, New York

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230, as amended by ch. 606, Laws of 1991 and N.Y. State Admin. Proc. Act Secs. 301-307 and 401 (McKinney 1984 and Supp. 1991). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the eighth day of January, 1992 at 10:00 in the forenoon of that day at 5 Penn Plaza, Hearing Room C, New York, New York and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by

counsel. You have the right to produce witnesses and evidence on your behalf, to 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, as amended by ch. 606, Laws of 1991, 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 or sanction to be imposed or appropriate action to be taken.

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, AS ADDED BY CH. 606, LAWS OF 1991. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York

December 12, 1991

Chris Stern Hyman /by RV

Chris Stern Hyman
Counsel

Inquiries should be directed to: Daniel Guenzburger
Assistant Counsel
5 Penn Plaza, 6th Floor
New York, New York, 10001

Telephone No.: 212-613-2617

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JOSE B. LLORENS, M.D.	:	CHARGES

----------X

JOSE B. LLORENS, M.D., the Respondent, was authorized to practice medicine in New York State on September 16, 1974 by the issuance of license number 121628 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1,1991 through December 31, 1992 at 4 Cabriolet Lane, Melville, New York.

FACTUAL ALLEGATIONS

A. On four occasions between October 5, 1987 and December 16, 1988 the Respondent treated Patient A, a 28 year old male, at his office at 3021 Third Avenue, Bronx, New York. (Patient A and all the other patients are identified in the attached Appendix). At each visit Respondent recorded the identical

complaints of back pain, abdominal pain, nervousness, skin rash, cough, and shortness of breath. He diagnosed asthma, upper respiratory infection, chest pain, abdominal pain, back pain, anxiety, and skin rash at each visit.

At the visits dated October 5, 1987 and October 5, 1988 the Respondent ordered an EKG, spirometry, audiometry, and abdominal sonogram. In addition, on October 5, 1988 he ordered hematology and chemistry screens, thyroid profile, syphilis serology, hepatitis, RBC protophyrin, Hbg electrophoresis and serum iron tests. In spite of the fact that the blood tests revealed abnormal hepatitis, SGOT, SGPT, WBC, RBC, hemoglobin and hematocrit results, there is no indication in the patient's record that the Respondent noted the abnormal test results or took any action in response to the results.

The Respondent's care and treatment deviated from acceptable standards in that Respondent:

1. Failed to take an adequate general history and adequate histories related to Patient A's specific complaints and symptoms.

2. Failed to perform adequate abdominal examinations at visits dated October 5, 1987, October 5, 1988, November 9, 1988, and December 16,1988.

3. Failed to maintain an adequate record of Patient A's presenting complaints, symptoms, and the findings of his physical examinations.

4. Failed to diagnose the cause of Patient A's chest, abdominal, and back pain.

5. Ordered audiometry and an abdominal sonogram on October 5, 1987 without adequate medical indication for the tests.

6. Ordered an EKG, abdominal sonogram, and an RBC protoporphyrin test on October 5, 1988 without adequate medical indication for the tests.

7. Failed to follow-up on abnormal SGOT, SGPT, WBC, RBC, hemoglobin, hematocrit, and hepatitis laboratory test results.

B. On July 23, 1987, the Respondent treated Patient B, a 38 year old woman, at his office. Patient B complained of abdominal pain, back pain, left leg pain, nervousness, shortness of breath, and vaginal discharge. Respondent noted epigastric and right upper quadrant tenderness. In spite of the fact that Respondent elected to defer performing a pelvic examination, he did not record an order for follow-up care.

Respondent ordered spirometry, audiometry, EKG, abdominal sonogram, hematology and chemistry screens, syphilis serology, protein electrophoresis, Hbg electrophoresis, radioimmunoassay and urine tests. He diagnosed asthma, anxiety, dyspnea, back pain, abdominal pain, and vaginitis. Respondent prescribed Zantac, Proventil Inhaler, Betadine Douche, Valium and Dolobid, 250 mg., once a day as needed.

The Respondent's care and treatment deviated from acceptable medical standards in that Respondent:

1. Failed to take an adequate general history and adequate histories related to Patient B's specific complaints and symptoms.

2. Failed to diagnose the cause of Patient B's back and abdominal pain.

3. Failed to perform an adequate abdominal examination.

4. Diagnosed vaginitis without supporting the diagnosis with appropriate clinical observations and laboratory tests, or by referring the patient to a gynecologist.

5. Failed to maintain an adequate record of Patient B's past medical history, presenting complaints, findings of the physical examination, prescriptions and plans for further treatment.

6. Ordered audiometry, protein electrophoresis and Hbg electrophoresis tests without adequate medical indication for the tests.

C. On or about April 2 and 15, 1987, the Respondent treated Patient C, a 34 year old male, at his office. Patient C complained of back pain, cough, and abscesses from needles on his left arm. He gave a history of drug and alcohol abuse. Respondent diagnosed multiple small abscesses on the left

forearm, bronchitis, back pain and foot rash. He prescribed Ampicillin for the abscesses on the arm, Valium, Lidex Cream, Clinoril, Benylin expectorant, and Phisohex.

On April 2, 1987, the Respondent ordered spirometry, audiometry, and an abdominal sonogram. At a follow-up visit on April 15, 1987, the Respondent ordered hematology and chemistry screens, serum protein electrophoresis, Hbg electrophoresis, syphilis serology, B12, folates, ferritin and urine and thyroid tests. In spite of the fact that the laboratory tests revealed abnormalities of the Alk Phos, Hbg, HCT and MCV, there is no indication in the patient's chart that Respondent noted the abnormal test results or took any action in response to the results.

The Respondent's care and treatment deviated from accepted standards in that Respondent:

1. Failed to maintain an adequate record of Patient C's presenting complaints, symptoms, and the findings of physical examinations.

2. Failed to diagnose the cause of Patient C's back pain and foot rash.

3. Failed to culture the abscesses on Patient C's left forearm to identify the specific pathogen causing the infection.

4. Prescribed Ampicillin for abscesses on Patient C's left arm rather than a a more potent anti-staphylococcal antibiotic.

5. Ordered spirometry, tymponography, ~~thyroid~~ T3 thyroid uptake Tests ~~tests~~, protein electrophoresis and an abdominal sonogram without adequate medical indication for the tests.

6. Failed to follow-up on the abnormal Alk Phos, HGB, HCT and MCV laboratory test results in the laboratory report dated April 20, 1987.

D. On September 21, 1988 and December 2, 1988, the Respondent treated Patient D, a 32 year old male, at his office. Patient D complained of headache, back pain, dyspnea, insomnia, nervousness, abdominal pain, and foot rash. Respondent noted a mild heart murmur. He diagnosed abdominal pain, peptic ulcer, back pain, insomnia, anxiety, and athletes foot. Respondent prescribed Feldene, 10 mg., once a day, diazepam, Zantac and Lotrisone cream.

At the initial visit the Respondent ordered an EKG, echocardiogram, spirometry, audiometry, tympanography, abdominal sonogram, chemistry and hematology screens, thyroid profile, syphilis serology, hepatitis antigen studies, GGTP, iron, triglycerides, Hbg electrophoresis and RBC protoporphyrin tests. The laboratory report indicates that the chemistry screen, GGTP, iron and trygliceride tests were not performed because the volume of blood in the sample was insufficient.

The Respondent's care and treatment deviated from accepted standards in that Respondent:

1. Failed to take an adequate history of Patient D's complaints and symptoms.

2. Failed to perform an adequate abdominal examination.

3. Failed to perform a neurological examination in response to a complaint of headache.

~~4. Failed to support the diagnosis of peptic ulcer with appropriate clinical observations and laboratory tests.~~

4 B. Failed to adequately record a description of Patient D's heart murmur, ~~to ascertain the cause of the murmur, and/or refer the patient to a specialist~~ to determine if the heart murmur was abnormal.

5 C. Failed to maintain an adequate record of Patient D's presenting complaints, symptoms, the findings of his physical examinations, and the treatment ordered.

6 D. Failed to diagnose the cause of Patient D's back pain and headache.

7 E. Ordered audiometry, tympanography, echocardiogram, abdominal sonogram, ~~thyroid~~ T3 - Free thyroxine and T4 free - ~~profile~~, Hbg electophoresis and RBC protoporphyrin tests without adequate medical indication for the tests.

8 F. Prescribed Feldene to a patient with a diagnosis of peptic ulcer disease without documenting why

a less ulcerogenic anti-pain medication was not selected.

9 ~~10~~. Failed to reorder laboratory tests which were not performed because the volume of the blood sample was insufficient.

E. On or about June 26, 1987 the Respondent treated Patient E, a 35 year old male, at his office. Patient E complained of back pain, chest pain, nervousness, cough, and abdominal pain. He gave a history of drug and alcohol abuse. Respondent diagnosed URI, back and chest pain, peptic ulcer, and R/O gallbladder disease. He prescribed Naprosyn, Valium, Zantac, Maalox, Robitussin expectorant, Sudafed, vitamins, and Erythromycin. No follow-up visit was ordered.

The Respondent ordered an EKG, spirometry, audiometry, and abdominal sonogram. The radiologist who interpreted the abdominal sonogram advised further diagnostic investigation to confirm a diagnosis of gallstones. Respondent also ordered hematology and chemistry screens, protein electrophoresis, syphilis, thyroid, Hbg electorphoresis, glycohemoglobin and urine tests. In spite of the fact that the blood tests indicated abnormalities of the WBC, [redacted], SGOT, SGPT and

hepatitis tests, there is no indication in the patient's chart that Respondent noted the abnormal test results or took any action in response to the results.

The Respondent's care and treatment deviated from accepted medical standards in that Respondent:

1. Ordered an EKG, spirometry, audiometry, ~~thyroid~~, Hbg electrophoresis, and glycohemoglobin tests without adequate medical indication for the tests.

2. The Respondent failed to maintain an adequate record of Patient E's presenting complaints, symptoms, physical examination of the patient and the results of laboratory tests and procedures.

3. Prescribed Naprosyn to a patient with a history of peptic ulcer disease without documenting why a less ulcerogenic anti-pain medication was not selected.

4. Prescribed Erythromycin without adequate indication.

5. Failed to follow up on abnormal laboratory results in that:

a. Respondent failed to note the abnormal WBC, [redacted], SGOT, SGPT laboratory test results and document a follow-up plan.

b. Respondent failed to note the diagnosis of gallstones in the abdominal sonogram report, inform the patient of the diagnosis and document a plan for treatment and/or further testing.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(3), as added by ch. 606, laws of 1991, in that the Petitioner charges that Respondent committed two or more of the following:

1. The facts in paragraphs A, A1, A2, A3, A4, A5, A6, A7, B, B1, B2, B3, B4, B5, B6, B7, C, C1, C2, C3, C4, C5, C6, D, D1, D2, D3, D4, D5, D6, D7, D8, D9, [redacted], E, E1, E2, E3, E4, E5, E5(a), and/or E5(b).

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(5), as added by ch. 606, laws of 1991, in that the

NINTH THROUGH THIRTEENTH SPECIFICATIONS

FAILING TO MAINTAIN ADEQUATE RECORDS

The Respondent is charged with professional misconduct pursuant to N.Y. Educ. Law Section 6530(32), as added by ch. 606, laws of 1991, by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

9. The facts in paragraphs A and A3.

10. The facts in paragraphs B and B5.

11. The facts in paragraphs C and C2.

12. The facts in paragraphs D and D6.

13. The facts in paragraphs E and E2.

DATED: New York, New York
12/12/91

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct