STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

March 12, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Amy Merklen, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237-0032

Paul Maglione, M.D.
200 Melrose Avenue
Syracuse, New York 13212

Douglas M. Nadjari, Esq.
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420 Lakeville Road
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Tabak & Stimpfl
190 EAB Plaza
East Tower – 15th Floor
Uniondale, New York 11556-0190

RE: In the Matter of Paul Maglione, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-334) of the Professional Medical Conduct Administrative Review Board 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

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

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

In the Matter of

Paul Maglione, M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 02-334

Before ARB Members Grossman, Lynch, Pellman, Price and Briber
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): **Amy B. Merklen, Esq.**
For the Respondent: **T. Lawrence Tabak, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent practiced medicine with negligence on more than one occasion and failed to maintain accurate records. The Committee voted to place the Respondent's New York Medical License (License) on probation for five years. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney 2003), both parties ask the ARB to modify that Determination. After considering the records and the parties' review submissions, we affirm the Committee's Determination in full.

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(3-6) & 6530(32) (McKinney Supp. 2003) by committing professional misconduct under the following specifications:

- practicing with negligence on more than one occasion,
- practicing with gross negligence,

- practicing with incompetence on more than one occasion,
- practicing with gross incompetence, and,
- failing to maintain accurate records.

The charges before the Committee concerned the treatment that the Respondent rendered to eight persons, Patients A-H. The record refers to the Patients by initials to protect privacy. Following a hearing, the Committee rendered the Determination now on review.

The Committee dismissed the charges alleging gross negligence, gross incompetence and incompetence on more than one occasion. The Committee sustained the charges that the Respondent practiced with negligence on more than one occasion upon finding that the Respondent:

- failed to send Patient A to the hospital after the Patient suffered a stroke,
- failed to monitor Patient B's thyroid function,
- performed an incomplete neurological examination on Patient C,
- exceeded the appropriate time limit for treating Patient E with testosterone,
- used the drug methotrexate on a trial basis with Patient F, and,
- failed to contact Patient G periodically to monitor the Patient's diabetes and blood pressure.

The Committee also found the Respondent failed to maintain accurate records for Patients A, B, C, D, E, F and H by failing to document an adequate history and/or physical for the Patients.

In making their findings, the Committee found credible the testimony by the Petitioner's expert, Harry Metcalf, M.D. The Committee found the Respondent's expert, Carl Marlow, M.D., hedged on inconsistencies and exhibited a bias toward the Respondent. The Committee also found the Respondent credible, but often arrogant and unwilling to admit his shortcomings.

The Committee voted to suspend the Respondent's practice for five years, to stay the suspension and to place the Respondent on probation for five years under the terms that appear as Appendix II to the Committee's Determination. The probation terms include a monitor on the Respondent's practice. The Committee found the penalty appropriate to assure that he Respondent will establish a better office system to follow up with patients and to document non-responsive patients. The Committee found the Respondent errors mostly minor, but found troubling the Respondent's failure to recognize the seriousness of Patient A's condition.

Review History and Issues

The Committee rendered their Determination on October 25, 2002. This proceeding commenced on November 6, 2002, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and response brief and the Respondent's brief and response brief. The record closed when the ARB received the Petitioner's response brief on December 16, 2002.

The Petitioner's brief argues that the Committee made inconsistent findings. The Respondent asks the ARB to revisit the Committee's findings on credibility, to overturn the Committee and find the Respondent practiced with gross negligence and to overturn the Committee and revoke the Respondent's License.

In his response to the Petitioner's brief, the Respondent argued that the Committee stood in the best position to judge credibility. The Respondent also argued that, even if the ARB upholds the Committee's findings on negligence, the Committee found the Respondent's conduct minor.

The Respondent's brief concedes that the Respondent's records lacked certain information, but argues that the Respondent has corrected the record-keeping problems and asks the ARB to dismiss the record-keeping charges in the interests of justice. The Respondent contends that he failed to receive due process due to vague charges that covered many years in patients' treatment. The Respondent also argues that the record fails to support the charges that the Respondent practiced with negligence on more than one occasion.

The Petitioner's response, to the Respondent's brief, argues that the charges provided the Respondent specific enough information to inform the Respondent concerning the nature of the charges and to allow the Respondent to raise a defense. In the response brief, the Petitioner also raised for the first time an alleged error by the Committee's Administrative Officer. The Petitioner argued that the Administrative Officer limited the Petitioner in the number of patient cases the Petitioner could present to the Committee.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination on the charges and on the penalty.

We hold that the Committee acted appropriately in finding that the Respondent failed to maintain accurate records. The Respondent conceded that his records lack certain information, but asked that we dismiss the record-keeping charges because the Respondent changed his record keeping problems voluntarily. We reject the request. The Respondent can choose to abandon any voluntarily changes he made. We agree with the Committee that the probation terms should include provisions that will assure that the Respondent has adjusted his office system and documentation.

We hold further that the evidence before the Committee, including the testimony by the Petitioner's expert, Dr. Metcalf, proved that the Respondent practiced with negligence on more than one occasion. Both parties have asked the ARB to revisit the Committee's Determination on witness credibility, and either dismiss the charges or reject the Respondent's explanations that the Committee accepted. The ARB defers to the Committee as the fact finder in their determination to accept Dr. Metcalf's testimony about the proper standard of care. We also agree with the Committee that the Respondent's conduct amounted to minor mistakes and we reject the Petitioner's request that we hold the Respondent practiced with gross negligence.

We hold that the Respondent received proper notice about the charges against him. The Respondent called the charges vague. We note that the Committee dismissed some charges (A.3 and A.4) as too general. We also note that certain charges contained specific references to dates (A.7- A.8, B.8, G.5). We also conclude from the record that the Respondent raised a defense specific to all the charges that the Committee sustained.

The Petitioner, in the Petitioner's response brief, asked that the ARB state that the Committee's Administrative Officer acted without authority in limiting the number of patient cases that the Petitioner could argue before the Committee at hearing. The ARB has ruled previously that we will consider an issue that a party raises only if that party raises the issue in the party's review brief, so that the adverse party will receive an opportunity to respond, Matter of Jacob Neuman, M.D., ARB 97-34, 1997 WL 1053262 (N.Y.D.O.H. Admin. Rev. Bd.). By failing to raise the case limitation issue in the Petitioner's main brief, the Petitioner waived the issue and we refuse to consider the issue from the Petitioner's response brief.

We affirm the Committee's Determination to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation for five years. We agree with the

Committee's Determination that found the Respondent's conduct to warrant a penalty less severe than revocation or actual suspension. We also agree with the Committee that the cases at issue do prove, however, the need to impose safeguards to assure that the Respondent improves his office system to follow up with patients. We also find troubling the Respondent's failure to insist on hospitalization for Patient A. We agree with the Committee that the practice monitor and the other probation terms will provide the safeguards necessary in this case.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB affirms the Committee's Determination on the charges.
2. The ARB affirms the Committee's Determination to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation for five years under the terms at Appendix II to the Committee's Determination.

Robert M. Briber
Thea Graves Pellman
Winston S. Price, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Paul Mangione, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Mangione.

Dated: 3/5/2003

Robert M. Briber

In the Matter of Paul Maglione, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Maglione.

Dated: Nov 4, **2003**

Thea Graves Pellman

In the Matter of Paul Maglione, M.D.

Winston S. Price, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Maglione.

Dated: Mar 04, 2003

Winston S. Price, M.D.

In the Matter of Paul Maglione, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Maglione.

Dated: March 7, 2003

Stanley L Grossman MD.

Stanley L Grossman, M.D.

In the Matter of Paul Mangione, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Mangione.

Dated: March 4, **2003**

Therese G Lynch M.D

Therese G. Lynch, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

October 25, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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Tabak & Stimpfl
190 EAB Plaza
East Tower – 15th Floor
Uniondale, New York 11556-0190

RE: In the Matter of Paul Maglione, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-334) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER

OF

PAUL MAGLIONE, M.D.

DETERMINATION

AND

ORDER

BPMC #02-334

ANDREW J. MERRIT, M.D., Chairperson, **WALTER T. GILSDORF, M.D.** and **WILLIAM W. WALENCE Ph.D,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.,** served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **DONALD P. BERENS, Jr.,** General Counsel, **AMY B. MERKLEN, ESQ.,** Assistant Counsel, of Counsel. The Respondent appeared by **KERN, AUGUSTINE, CONROY & SCHOPPMANN, P.C., T. LAWRENCE TABAK, ESQ.,** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged forty-nine (49) specifications of professional misconduct, including allegations of negligence, incompetence, gross negligence, gross incompetence and failure to maintain accurate medical records. The charges are more specifically set forth in the Statement of Charges dated April 2, 2002, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	April 2, 2002
Pre-Hearing Conference	May 1, 2002
Hearing Dates:	May 22, 2002
	June 12 , 2002
	June 19, 2002
	July 10, 2001
	July 24, 2002
	July 31, 2002
	August 7, 2002

WITNESSES

For the Petitioner:	Harry L. Metcalf, M.D. Daughter of Patient A Pauline Frazier, RN David Brittain, M.D.
For the Respondent:	Margaret Kelly-Hurley Paul Maglione, M.D. Carl Marlow, M.D. Edwarda Kelly, RN

FINDINGS OF FACT

1. Respondent was licensed to practice medicine in New York State on or about August 29, 1958 by issuance of license number 081206 by the New York State Education Department. (Ex. 1)

2. Respondent was personally served with a copy of the notice of hearing, statement of charges, and summary of Department of Health hearing rules on April 4, 2002.

3. Respondent's Answer denied any and all wrongdoing as alleged in Petitioner's Statement of Charges. (Ex. A)

4. Harry L. Metcalf, M.D. testified as an expert for Petitioner. Dr. Metcalf was licensed to practice medicine in the State of New York in 1962 by license number 087718.(Ex.3)

5. Dr. Metcalf was trained in Family Practice and received his degree from the University of Buffalo School of Medicine. (Ex. 3) He is currently boarded by the American Academy of Physicians and has been since its inception in 1972. Dr. Metcalf is still actively seeing

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T. ____ and Ex. _____ indicate a reference to the transcript of the hearing or to an exhibit in evidence.

patients as a member of the Highgate Medical Group, P.C. (Ex. 3) Dr. Metcalf sees approximately 2500 patients.(T. 26) Besides seeing patients everyday, Dr. Metcalf teaches family practice a the State University at Buffalo Medical School in a clinical setting.(T. 27)

Patient A

6. Respondent provided medical care for Patient A, an 80 year old male from on or about 1965 to approximately August 1999 at 200 Melrose Avenue, N. Syracuse, New York (hereinafter "Respondent's office"). (T. 722-727)

7. On August 18, 1999, Patient A presented in Respondent's office. (T. 54)

8. Patient A, on August 18, 1999 or shortly thereafter, told his daughter (Witness 1), what took place during his appointment with Respondent on August 18, 1999. (T. 392) Patient A told his daughter that during his appointment on August 18, 1999, he had trouble communicating and Respondent indicated to Patient A that he was having a stroke. (T. 398) Patient A called his niece and told her he was having a stroke. (T. 414) Patient A told his daughter that Respondent told Patient A to go home and that he would have someone drive him home. (T. 399)

9. Patient A told Pauline Frazier, Professional Medical Conduct Program Manger, that Respondent never told him to go to the hospital. (T. 399, 433) Further, Patient A told her that he had a stroke in Respondent's office on August 18, 1999. (T. 427) Patient A did not remember getting an aspirin in Respondent's office. (T. 427) Respondent told Patient A, on August 18, 1999, to go home and call his family. (T. 427, 433) During Patient A's interview with Ms. Frazier, Patient A was awake, alert and oriented. He gave consistent and responsive answers to her questions. (T. 437).

10. During Respondent's February 7, 2000 interview with Dr. Brittain, Respondent told Dr. Brittain that on August 18, 1999 only he and Patient A were in the exam room. (T. 514, Ex. 7) Respondent told Dr. Brittain that there wasn't much the hospital would or could do for a stroke patient anyway.

11. During Dr. Brittain's interview, Respondent stated that he requested that Patient A go to the hospital, but also stated that the hospital would not have done anything for the patient and they would have sent the patient home. (T. 507-508)

12. Patient A would generally do what Respondent asked him to do. (T. 733)

13. Upon examination, Respondent noticed that Patient A started to mumble, lost his train of thought and had a vacant stare on his face. It lasted for 10 to 15 seconds. Respondent suspected that Patient A had just experienced a TIA. (T. 735)

14. Margaret Kelly-Hurley was not in the exam room with Patient A and Respondent. (T. 808)

15. Margaret Kelly-Hurley testified that she drove Patient A to his home on the afternoon of August 18, 1999. (T. 803) According to Ms. Kelly-Hurley, Patient A walked without assistance, got into the car by himself and gave directions to his home. (T. 804) Moreover, Ms. Kelly-Hurley remembered that Patient A asked her about her college as they were driving and they had a discussion about the safety of him leaving his car in the parking lot of the office. (T. 805) He got out of the car on his own and walked to his house without any trouble. (T. 806)

16. On August 18, 1999, Respondent failed to note in Patient A's medical record that Patient A refused to go to the hospital. On August 18, 1999, Respondent's notes in Patient A's medical record do not indicate Respondent told Patient A to go to the hospital. (T. 1077)

17. On August 18, 1999, if Patient A had recovered insomuch as Patient A was no longer slurring speech and was no longer incoherent, Respondent should have noted such in the medical record. (T. 1097)

18. Respondent told Dr. Brittain that he took Patient A's blood pressure but only recorded the systolic reading. (T. 512-513)

19. It is important to know what a patient's diastolic reading is as well as the systolic reading when taking a patient's blood pressure. (T. 512-513)

20. The Hearing Committee finds Respondent's charts illegible and they could not read the medical records.

Patient B

21. Respondent provided general medical care for Patient B, a 33 year old male, from on or about May 1969 until approximately November 2000. (Ex. 12 and 12A) Respondent was Patient B's physician for over 31 years. (T. 815)

22. Respondent on various occasions failed to document an adequate medical history of Patient B. (T. 121-122)

23. Respondent on various occasions failed to document performing adequate physical exams for Patient B. (T. 125)

24. At the March 1993 visit, Respondent suspected thyroid disease but could not confirm it with the lab screen. (T.819) The tests performed document this, and the prescription for Inderal is treatment for heart palpitations. (T. 818)

25. Patient B was at risk for running triple beats and ventricular tachycardia which had to be addressed. (T. 818-819)

26. In May 1996, Dr. Maglione noted his diagnosis of hyperthyroidism. (T. 820-821) He ordered a thyroid stimulating hormone (TSH) test, which came back very low and confirmed his diagnosis. (T. 821-822)

27. Dr. Maglione referred Patient B to St. Joseph's Hospital Nuclear Department for radioactive iodine treatment. (T. 823) The hospital report objectively and conclusively confirms Dr. Maglione's diagnosis of hyperthyroidism. (Ex. J) The radiologist at St. Joseph's independently came to a diagnosis of hyperthyroidism and acted as a secondary opinion in this case. (T. 867)

28. Respondent admitted that Patient B should have been monitored after the RAI treatment between July 1996 and July 2000 because Patient B would most likely become hypothyroid. (T. 844)

29. Respondent failed to adequately monitor Patient B. (T. 136-138)

Patient C

30. Respondent provided general medical care to Patient C, a 75 year old male, from on or about October 1997 through approximately February 2000 at Respondent's office. (Ex. 13, 13A)

31. Respondent on various occasions failed to document an adequate medical history for Patient C. (T. 206) Respondent on various occasions failed to document performing adequate physical exams for Patient C. (T. 206)

32. On October 15, 1997, Patient C fell off a truck and struck his head on a rock. He was taken by ambulance to North Medical Urgent Care. He went to Respondent's office on October 16, 1997. (Ex. 13, 13A)

33. Respondent failed to record the physical exam he allegedly performed on Patient C on October 16, 1997. (T. 886) Respondent failed to record what Patient C's

physical exam consisted of and what tests were positive or negative. (T. 1148)

34. Respondent assessed the patient's condition and planned to follow him. (T. 877-878)

35. Respondent, on or about October 1997, failed to perform and/or document performing an adequate neurological exam for Patient C despite the patient's history.

36. Patient C exhibited a normal blood pressure at the emergency room after his fall on October 15, 1997. Respondent monitored Patient C's blood pressure on subsequent visits and believed that it was not hypertension and did not warrant treatment. (Ex. 13, 13A, T. 882-883)

37. On February 7, 2000, Respondent prescribed Indocin, which is the appropriate treatment for gout and did in fact relieve Patient C's symptoms. (Ex. 13, p.2, T. 883-884, 1145)

38. Respondent failed to list Patient C's symptoms on October 16, 1997. Even if Respondent did do all of these things but failed to document them, it is still a deviation from accepted medical standards of care. (T. 207, 210, 262) Respondent failed to note what joint was involved when diagnosing Patient C with gout on February 7, 2002. (T. 899,902-903)

Patient D

39. Respondent provided general medical care to Patient D, a 35 year old female, from on or about December 1997 to approximately February 2001 at his office. (Ex. 14, 14A)

40. Respondent on various occasions failed to record an adequate medical history for Patient D. (T. 274)

41. Respondent on various occasions failed to document the performance of adequate physical exams for Patient D. (T. 273-274)

42. Respondent adequately assessed Patient D's drug dependence. He tried to taper her off the pain medications and tired to keep her maintained on the least harmful one. (T. 924)

43. Respondent's chart confirms that tests were performed at various times during her treatment, including x-rays and CAT scans. (Ex. 14, p. 24-28, 36)

44. After a negative EEG by the consulting neurologist, Respondent discontinued the patient's seizure medication. (Ex. 14, p. 12-13: T. 922) When she presented with slurred speech and trouble walking, he referred her for a CAT scan, which was read as normal. (Ex. 14, p. 26) Respondent also referred her for a chest x-ray to rule-out pneumonia. (Ex. 14, p.25)

45. Respondent made numerous referrals to specialists. He referred her to radiologists for testing, a neurologist, Dr. Marasigian, a pain specialist, Dr. Masten, to the Pain Clinic to Dr. Chertow and Dr. Tiso, as well speaking with Dr. Ron Dougherty, a drug habituation specialist. He also referred her for physical therapy. (Ex. 14, p.1, 5,6,15,16,53, Ex. 14A; T. 925)

46. Patient D did not have a seizure disorder prior to her admission to Community General Hospital in December of 1998. This was a new onset seizure with no prior seizure history. This diagnosis was made based on an EEG and the patient was put on Dilantin. Respondent discussed this onset with Dr. Lipsky and agreed to follow-up treatment with Dilantin and monitor the patient's blood levels. (T. 921-922)

47. The records for Patient D are poor with minimal notations on vital signs.

Patient E

48. Respondent provided general medical care for Patient E, a 37 year old male, from on or about April 1998 through approximately May 1999 at his office. (Ex. 15, 15A)

49. Respondent on various occasions failed to record an adequate medical history for Patient E. (T. 332-333)

50. Respondent on various occasions failed to document the performance of adequate physical exams for Patient E. (T. 332-333, 1187, 1190)

51. Respondent failed to elicit and/or document Patient E's chief complaint that was the basis for testosterone treatment. (T. 334-335); Ex. 15. p.12)

52. Respondent developed an adequate initial plan to treat Patient E, however he did not document it. (T. 955-957)

53. While sexual dysfunction could be a reason for testosterone injections in older men, Patient E was 34 years old without a history of sexual dysfunction according to the record kept by Respondent. (T. 337) Furthermore, Patient E received approximately 10-12 shots of testosterone in an 8 month period. (T. 964-965) While testosterone can be used as a short-term treatment for impotency, short-term is 3 to 6 months. (T. 1182-1183) Respondent's treatment of Patient E exceeded that limit.

54. Respondent did monitor the patient's cholesterol on three different occasions during a two-year period. (Ex. 15, p.9-11) Back in 1998, the cholesterol level of 175 was a normal reading. On April 30, 1998, Respondent calculated the LDL at 117, normal, at the time was 130. His cholesterol on that date was 222, also within the normal range. The fact that his triglycerides were elevated in the presence of normal cholesterol and normal LDL

did not indicate a requirement for medical intervention. (T. 958)

55. Respondent's medical record for Patient E failed to meet accepted medical standards of care. Respondent failed to document Patient E's chief complaint that was being treated by testosterone. Respondent failed to record a diagnosis for Patient E. Respondent failed to record Patient E's complaints and diagnosis.(T. 332-334, 336)

56. Respondent conceded that no chief complaints or physical examinations are recorded in Patient E's chart. There is no diagnosis made or recorded and no plan of treatment. There are deficiencies in Patient E's medical record. Respondent is not current with the current regulations. Patient E's medical record is written this way for reasons of confidentiality. Other than just leaving information out of a chart, there are other ways to keep information confidential. It can be written on straight sheet stamped confidential and filed and stored separately. (T. 1190,1193-1194)

Patient F

57. Respondent provided general medical care for Patient F, a 51 year old female, in his office from on or about July 1991 through approximately January 2001. (Ex. 16, 16A)

58. Respondent on various occasions failed to record an adequate medical history for Patient F. Respondent failed to document a medical history for Patient F

according to accepted medical standards of care. (T. 362)

59. Respondent on various occasions failed to document the performance of adequate physical exams for Patient F.

60. In January of 1995, Patient F presented to Respondent with 4+ ankle edema and left flank pain. Respondent failed to adequately evaluate and monitor Patient F's condition. In January of 1995, Respondent failed to take Patient F's blood pressure, temperature, weight, perform a physical examination, check for evidence of tenderness and take a urine culture because of a concern for pyle nephritis. Respondent failed to discover an adequate answer to Patient F's 4+ ankle edema. Respondent failed to follow up on 4+ ankle edema. (T. 366-368, 382) Respondent thought Patient F possibly had rheumatoid arthritis. (T. 982) Patient F came to Respondent's office in January 1995 with 4+ ankle edema (T. 989); Ex. 16, p. 28) Respondent failed to sufficiently address and/or work up Patient F's ankle edema. (T. 366-368) Respondent acknowledged that 4+ ankle edema is significant. (T. 992)

61. Patient F presented with a rash as well on December 4, 1995. Lupus can present similar symptoms as "diffuse arthritis." (T 370-371) [Respondent never considered Lupus as a differential diagnosis for Patient F].

62. In order to diagnose a patient with rheumatoid arthritis, a reasonable prudent physician would use the patient's history, do a complete physical examination, evaluate all of the patient's joints, take a sedimentation rate and test the patient for the rheumatoid factor. Respondent failed to perform any of these tests and examinations, Respondent failed to adequately evaluate and monitor Patient F's condition. (T. 364, 366)

63. On June 29, 1995, Respondent prescribed Methotrexate for Patient F. (T. 986) Methotrexate is a very potent anti-folic acid/anti-inflammatory drug that used to be used to treat cancer. Methotrexate is now used to treat arthritis, predominately rheumatoid arthritis. (T. 363) Methotrexate is not a medication that should be used on a trial basis. (T. 364, 382)

64. Respondent failed to keep a medical record for Patient F according to accepted medical standards of card. (T. 362) Respondent failed to document Patient F's refusal to see a Rheumatologist. (T. 995)

Patient G

65. Respondent provided general medical care for Patient G, a 65 year old male, in his office from on or about March 2000 through approximately August 2000.

66. Respondent first treated Patient G on March 6, 2000. (Ex. 17, p.3) A history and physical are documented, as well as an assessment, plan and initial diagnosis of diabetes, hypertension and hypercholesterolemic.

67. Patient G was started on Glucotrol for his diabetes and Lotrel to address his hypertension. (T. 615)

68. Respondent adequately developed an accurate initial working diagnosis for Patient G. (Ex. 17, p. 2,3); T. 619)

69. Respondent ordered all medically indicated tests in March of 2000, including an EKG, lab panel, albumen, BUN, calcium, cholesterol, creatine, glucose, hemoglobin, SGOT, protein uric acid, HDL, SGPT, triglyceride and calculated LDL. (Ex. 17, p. 4,6)

70. However, despite the fact that Patient G's March 6, 2000 EKG summary read borderline abnormal, Respondent failed to repeat Patient G's EKG. (T. 1248, 1252)

71. Patient G should have been monitored every 2 weeks after Patient G's initial appointment on March 6, 2000.(T. 566) Waiting 5 months after the initial diagnosis of hypertension to see the patient again is a deviation form accepted medical standards of care. (T. 567-569)

72. Respondent failed to place Patient G on glucose monitoring on a March 6, 2000 visit. Respondent failed to document instructing Patient G regarding a diabetic diet. (T. 564, 566)

73. Respondent failed to maintain an accurate medical record for Patient G in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient G. (T. 563, 570-571)

Patient H

74. Respondent provided general medical care to Patient H, a 30 year old male, from on or about May 1986 through approximately January 2000 in Respondent's office. (Ex. 18, 18A)

75. Respondent on various occasions failed to document an adequate medical history for Patient H.

76. Respondent on various occasions failed to document the performance of an adequate physical exam for Patient H.

77. On August 19, 1986, Patient H presented with an elevated blood sugar of 154. (Ex. 18, p.10) Taking into consideration that the patient's blood sugar nine days prior was 87 (within normal range), Respondent felt this reading was an aberration and did not feel it needed to be treated.(Ex. 18, p. 10; T. 693-694) Respondent repeated the blood sugar on September 5, 1989, which came back normal at 89. (Ex. 18, p. 7) The patient never developed diabetes. (T. 697)

78. Respondent did an adequate assessment and plan for this patient and also monitored him. This however, was not documented in the medical record.

79. Respondent did not attribute any symptoms to Patient G's weight gain. In Respondent's opinion, the patient was over-eating. (T. 695-696)

80. When Patient H told Respondent that he wanted to join the police academy, Respondent told him that he would have to lose weight. Subsequent to that instruction, Patient G lost 30 lbs. on his own. (T. 696)

81. Respondent failed to maintain accurate medical records fo Patient H in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient H. (T. 717-718)

CONCLUSIONS OF LAW

Respondent is charged with forty-nine (49) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of

Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

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

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

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

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that fourteen (14) of the forty-nine (49) specifications of professional misconduct should be sustained. It should be noted that three patient cases were redacted from the Statement of Charges by the Administrative Law Judge in the interests of time and efficiency of the hearing process. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties. Harry Metcalf, M.D. testified for the Department. His credentials are outlined in Finding of Fact #5. The Hearing Committee found Dr. Metcalf to be a credible witness. They note that although he took the Department's view, on cross examination he admitted where there were problems with the charges. David Brittain, M.D., Medical Coordinator for the Department's Syracuse Regional office also testified. The Hearing Committee found Dr. Brittain to be a credible witness although they are troubled that he destroyed his personal notes of his interview with Respondent. Patient A's daughter also testified for the Department. The Hearing Committee found her to be an understandably biased witness and notes that her testimony was not corroborated by other witnesses. Thus, her testimony was given little weight.

The Respondent called Carl Marlow, M.D. as his expert witness. Dr. Marlow specialized in family practice in North Syracuse from 1954 to 1994. He was board certified during that entire time period. (T. 1008-1009) At present, he is a compliance officer doing quality assurance work for a group of approximately 50 physicians. (T. 1000) The Hearing Committee found Dr. Marlow to be credible but biased towards Respondent and that he sometimes hedged on inconsistencies. They note that he appeared to utilize outside information as he knew more about the cases than what was in the record. Respondent also took the stand on his own behalf. The Hearing Committee found Respondent credible but he was often arrogant and clearly angry at

the process. They further found that Respondent was non-apologetic and he did not admit his shortcomings with respect to record charting. Overall, the Hearing Committee found his testimony credible with respect to Patients B through H, but less credible with respect to Patient A.

Respondent also called his long time office nurse, Edwarda Kelly. The Hearing Committee found her to be an honest, but intimidated and anxious witness. They note that she didn't answer questions where she didn't have the knowledge. Respondent also called Ms. Kelly's daughter, Margaret Kelly-Hurley to testify. The Hearing Committee found her testimony to be credible, particularly regarding her observations of Patient A on the drive home from Respondent's office.

PATIENT A

Factual Allegations A, A.1, A.2, A.7 and A.8: SUSTAINED

Factual Allegations A. .3, A.4, A.5 and A.6 : NOT SUSTAINED

The Hearing Committee finds that Respondent failed to document adequate medical histories and physical exams for Patient A. They note that even the transcribed record for the 1999 visits lack detail. (Ex. 10) The Hearing Committee finds that Charges A.3 and A.4 are too general and were not supported by the evidence as Department's expert admitted to not reviewing Patient A's records prior to 1999. (T. 70) The Hearing Committee believes that Respondent did recognize the urgent nature of Patient A's condition on August 18, 1999. After Respondent believed that he had

witnessed a TIA, he did additional testing, i.e. cardiogram, lab screen, as well as further physical examination. (T. 735-738) He also did not allow the patient to drive home and told Patient A that he would call him at home after he got the lab reports back. (T. 739) The Hearing Committee finds that there is insufficient proof in the record to support the Department's position that Patient A should have been given aspirin after this event. The Hearing Committee believes that Respondent should not have allowed Patient A to go home. They are uncertain regarding the communication between Patient A and Respondent regarding the possibility of a stroke and Patient A's understanding of the need for hospitalization. However, the Hearing Committee believes that Respondent probably mentioned going to the hospital, but did not insist upon it, particularly if Patient A resisted. The Hearing Committee believes that Patient A would have benefitted from going to the hospital sooner, despite Respondent's opinion that if he had a TIA, the hospital would probably not have done anymore for him. The Hearing Committee concludes that at minimum Patient A should have remained in Respondent's office under observation until his family was contacted.

The Hearing Committee finds Respondent to be negligent for not sending Patient A to the hospital. They further find that his judgement here does not rise to the level of gross negligence, gross incompetence or basic incompetence. The Hearing Committee also finds that Respondent's medical records were illegible and lacked detail and thus fell below accepted standards of record keeping. As a result, the Hearing Committee sustains the 17th and 39th Specifications.

PATIENT B

Factual Allegations B, B.1, B.2, B.8 and B.9: SUSTAINED

Factual Allegations B.3 through B.7: NOT SUSTAINED

The Hearing Committee finds that medical history and physical exams were not adequately documented. They further find that Respondent's assessments for palpitations and suspected hyperthyroidism were adequate but sloppy. The use of Inderal was also medically justified. Both experts agreed that Inderal can be used to treat hyperthyroidism if there was a symptom of tachycardia. (T. 191, 1105, 1127) The Hearing Committee also finds that Respondent appropriately referred Patient B to the hospital for radioactive Iodine treatment. (T. 823)

The Hearing Committee, however, finds that Respondent failed to adequately monitor Patient B's thyroid function after he received the RAI treatment. (T. 844, 1121-1122) They conclude that Respondent's failure to monitor this is an act of negligence. They further find inadequate record documentation. As a result, the 18th and 40th Specifications are sustained.

PATIENT C

Factual Allegations C .5 and C.6: WITHDRAWN by Department

Factual Allegations C, C.1, C.2, C.4, C.7 and C.9: SUSTAINED

Factual Allegations C.3 and C.8: NOT SUSTAINED

The Hearing Committee finds that the medical history and physical exams were not adequately documented, but that Respondent properly assessed Patient C as an urgent care patient. The Hearing Committee finds the evidence conflicted whether Patient C was unconscious for 45 minutes or 45 seconds after his fall, thus that part of Charge C.4 is not sustained. The Committee, however, finds that an incomplete neurological examination was performed as per the chart. (T. 255-256) The Hearing Committee believes that Respondent adequately monitored Patient C's blood pressure although he did not always document it. (T.882-883) The diagnosis and treatment of Patient C's gout was also appropriate except Respondent did not chart which joint was involved. The Hearing Committee concludes that there was one act of negeligence and substandard record keeping. As a result, the Hearing Committee sustains the 19th and 41st Specifications.

PATIENT D

Factual Allegations D, D.1, D.2 and D.7 : SUSTAINED

Factual Allegations D.3 through D.6: NOT SUSTAINED

Once again the documentation of patient history and physical is inadequate. However, the Hearing Committee finds that this drug dependent patient was adequately diagnosed and treated by Respondent. He tried to taper off her use of narcotics and came up with a plan that was documented in the record.

Respondent also discussed the matter with the pharmacist and made the appropriate referrals for this difficult patient. As a result, only the 42nd Specification for inadequate records is sustained.

PATIENT E

Factual Allegations E, E.1 through E. 5 and E.7: SUSTAINED

Factual Allegations E.6: NOT SUSTAINED

Respondent failed to record an adequate medical history and document physical exams for Patient E. While he assessed the problem and developed an adequate initial plan, Respondent did not document it. Respondent elected to keep Patient E's complaints of impotence and sexual difficulties confidential and not record them. (T. 948-949) Although the initial injections of testosterone were appropriate, the Hearing Committee finds that Respondent exceeded the time limit for appropriate treatment without any medical justification. There is also no documentation that he intended to stretch out the time between injections. The Hearing Committee finds however, that Respondent did appropriately monitor Patient E's cholesterol during a 2 year period. The Hearing Committee finds neglect and poor record keeping in the treatment of this patient. As a result, the 21st and the 43rd Specifications are sustained.

PATIENT F

Factual Allegations F, F.1 through F.7: SUSTAINED

The Hearing Committee finds that the documentation of the history and physical exams are inadequate for the problems of Patient F. Respondent made no real evaluation of this patient and the treatment and laboratory testing were inadequate. (T. 366-372) The Hearing Committee agrees with Dr. Metcalf that Methotrexate should not be used on a trial basis. (T. 364, 382) They disagree with Dr. Marlow that it was acceptable to try Methotrexate for a difficult diagnosis, and then discontinue it if it is not working. (T. 1210) The Hearing Committee concludes that Respondent acted negligently in his treatment of Patient F. Also again the records are poor. If Patient F had refused to see a rheumatologist, it should have been documented. As a result, the Hearing Committee sustains the 22nd and 44th Specifications.

PATIENT G

Factual Allegations G, G.5 through G.8: SUSTAINED

Factual Allegations G.1 through G.4: NOT SUSTAINED

In this instance, the Hearing Committee finds that Respondent adequately documented Patient G's history and physical exams. He also developed an adequate plan to address the patient's initial diagnosis of diabetes, hypertension and hypercholesterolemic. Although Respondent ordered considerable tests, he failed to repeat the EKG when the prior test read borderline abnormal. While the Hearing Committee believes that Respondent instructed the patient to monitor his blood

pressure and diabetes, Respondent is not excused for his failure to contact Patient G for periodic monitoring. Although the Hearing Committee does not deem this to be a serious violation, it does fall below the standard of care and constitutes neglect. Overall record keeping is also inadequate. As a result, the Committee sustains the 23rd and 45th Specifications.

PATIENT H

Factual Allegations H, H.1, H.2 and H.7: SUSTAINED

Factual Allegations H. 3 through H.6: NOT SUSTAINED

Medical history and physical exams for Patient H are not adequately documented. However, Respondent did follow up with blood sugar testing and determined that the patient did not develop diabetes. (T. 696-697) Respondent concluded that the patient had been overeating. Patient H subsequently lost 30 lbs on his own to qualify for the police department. (T. 695-696) The Hearing Committee finds no negligence in this case, only poor record keeping. As a result, the 46th Specification is sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to

practice medicine in New York State should be suspended for a period of five (5) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent will be placed on probation with a practice monitor. The complete terms of probation are attached to this Determination and Order as Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for a five year stayed suspension with probation and a practice monitor because they do not believe that revocation is commensurate with the level of professional misconduct in this instance. The Hearing Committee believes that while there are clearly instances of negligence, most are minor and none rise to the level of gross negligence. They also found no evidence of incompetence to any degree in the record. The Hearing Committee further believes that 5 years is a considerable period to keep Respondent on probation and note that at least 60 records will be monitored per month.

The Hearing Committee finds the case of Patient A more troubling, but notes that Respondent did recognize the seriousness of Patient A's condition. Even if the patient had acted coherently after the suspected TIA, Respondent should have insisted that the patient be hospitalized where he would have received additional testing and evaluation. With respect to Patients B through H, the Committee finds that despite his poor record

keeping, Respondent made too many right decisions and too few wrong ones. This is evidenced by the overall outcomes of these seven patients. The Hearing Committee believes that Respondent truly needs a better office system to follow up with patients. He also needs to document when patients are not responsive. In conclusion, the Hearing Committee believes that a five year stayed probation with a practice monitor effectively safeguards the public health in this instance. Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

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

1. The Seventeenth through Nineteenth, the Twenty-First through Twenty-Third and the Thirty-Ninth through Forty-Sixth of the Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The First through Sixteenth, Twentieth, Twenty-Fourth through Thirty-Eighth and Forty-Seventh through Forty-Ninth of the Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;**

3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **FIVE (5) YEARS,** said suspension to be **STAYED;** and

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and

5. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Syracuse, New York

10/24/ **2002**

Andrew J Merrit MD

ANDREW J. MERRIT, M.D.

(Chairperson)

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APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
PAUL MAGLIONE, M.D.

STATEMENT
OF
CHARGES

Paul Maglione, M.D., Respondent, was authorized to practice medicine in New York State on or about August 29, 1958 by the issuance of license number 081206 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care for Patient A, an 80 year old male, from on or about 1965 to approximately August 1999 at 200 Melrose Avenue, N. Syracuse, New York (hereinafter "Respondent's office"). Respondent's care and treatment of Patient A failed to meet accepted standards of medical care, in that:

1. Respondent on various occasions failed to obtain and/or document an adequate medical history for Patient A.
2. Respondent on various occasions failed to perform and/or document the performance of an adequate physical exam for Patient A.
3. Respondent failed to develop an adequate assessment and plan for Patient A and/or failed to document an adequate assessment and plan.
4. Respondent failed to develop and/or document the development of an accurate initial and/or working diagnostic impression for Patient A.
5. Respondent failed to recognize the urgent nature of Patient A's condition.
6. On August 18, 1999, Respondent failed to administer the appropriate medication despite medical indication.

7. On August 18, 1999, Respondent sent Patient A home when such action was not medically indicated.

8. Respondent failed to maintain a record for Patient A in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient A.

B. Respondent provided general medical care for Patient B, a 33 year old male, from on or about May 1969 until approximately November 2000. Patient B presented with symptoms of hyperthyroidism and hypothyroidism. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care, in that:

1. Respondent on various occasions failed to obtain and/or document an adequate medical history of Patient B.

2. Respondent on various occasions failed to perform and/or document performing adequate physical exams for Patient B.

3. Respondent failed to adequately assess and plan and/or document such assessment and plan for Patient B.

4. Respondent, after seeing Patient B on or about March 1993, when Patient B presented with heart palpitations, failed to formulate and/or document an accurate initial and/or working diagnosis for Patient B.

5. Respondent treated Patient B with Inderal without adequate medical indication and/or documenting such medical indication.

6. Respondent on or about 1993 and/or 1994 failed to order and/or perform medically indicated diagnostic tests relating to Patient B's possible hyperthyroidism.

7. Respondent treated Patient B with Radioactive Iodine I-131 without adequate medical indication and/or documenting such medical indication.

8. Respondent, from on or about 1996 until approximately July 2000, failed to adequately monitor Patient B's thyroid function and/or document such monitoring for Patient B.

9. Respondent failed to maintain an accurate medical record for Patient B in accordance with accepted medical standards of care and/or in a manner that accurately reflects his care and treatment of Patient B.

C. Respondent provided general medical care to Patient C, a 75 year old male, from on or about October 1997 through approximately February 2000 at Respondent's office. During this time, Patient C's office records indicated that Patient C possibly suffered

from diabetes, hypertension and gout. In addition, Patient C had been unconscious on one occasion for 45 minutes. Respondent's care and treatment of Patient C failed to meet accepted medical standards of care in that:

1. Respondent on various occasions failed to obtain and/or document an adequate medical history for Patient C.
2. Respondent on various occasions failed to perform and/or document performing adequate physical exams for Patient C.
3. Respondent failed to adequately assess and plan and/or document such assessment and plan for Patient C.
4. Respondent, on or about October 1997, failed to perform and/or document performing an adequate neurological exam for Patient C despite the patient's history of a 45 minute unconscious episode.
5. Respondent, on or about October 1997, failed to refer and/or document referring Patient C to an appropriate specialist.
6. Respondent failed to adequately monitor and/or document monitoring Patient C's blood sugar, after measuring a blood sugar of 153 on October 24, 1997.
7. Respondent failed to adequately monitor and/or document monitoring Patient C's blood pressure after measuring a blood pressure of 180/84 in October 1997.
8. Respondent, on or about February of 2000, diagnosed Patient C with gout without adequate medical indication and/or failed to document such medical indication.
9. Respondent failed to maintain accurate medical records for Patient C in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient C.

D. Respondent provided general medical care to Patient D, a 35 year old female, from on or about December 1997 to approximately February 2001 at his office. Patient D's medical records indicate Respondent treated her for migraine headaches. Respondent's treatment of Patient D failed to meet acceptable medical standards of care, in that:

1. Respondent on various occasions failed to obtain and/or record an adequate medical history for Patient D.

2. Respondent on various occasions failed to perform and/or document the performance of adequate physical exams for Patient D.

3. Respondent failed to adequately assess and plan and/or document an adequate assessment and plan for Patient D.

4. Respondent failed to adequately treat and/or document treating Patient D regarding the results of diagnostic tests.

5. Respondent failed to refer and/or document such referral of Patient D to an appropriate specialist.

6. Respondent failed to timely diagnose and/or document a timely diagnosis for seizures which Patient D developed while under Respondent's care.

7. Respondent failed to maintain accurate medical records for Patient D in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient D.

E. Respondent provided general medical care for Patient E, a 37 year old male, from on or about April 1998 through approximately May 1999 at his office. Respondent's treatment of Patient E failed to meet acceptable medical standards of care, in that:

1. Respondent on various occasions failed to obtain and/or record an adequate medical history for Patient E.

2. Respondent on various occasions failed to perform and/or document the performance of adequate physical exams for Patient E.

3. Respondent failed to adequately assess and plan and/or document an assessment and plan for Patient E.

4. Respondent failed to develop and/or document an accurate initial and/or working diagnosis for Patient E.

5. Respondent injected and/or prescribed testosterone for Patient E without adequate medical indication and/or failed to document such indication.

6. Respondent failed to adequately monitor and/or document monitoring Patient E's cholesterol after measuring Patient E's cholesterol at 175 and triglyceride levels at 259 in May 1999.

7. Respondent failed to maintain an accurate medical record for Patient E in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient E.

F. Respondent provided general medical care for Patient F, a 51 year old female, in his office from on or about ~~July 2000~~ October 1991 through approximately January 2001. According to Patient F's medical record maintained by Respondent, Patient F suffered from an undefined, undiagnosed and undocumented type of arthritis. Respondent's treatment of Patient F failed to meet accepted medical standards of care in that:

1. Respondent on various occasions failed to obtain and/or record an adequate medical history for Patient F.
2. Respondent on various occasions failed to perform and/or document the performance of adequate physical exams for Patient F.
3. Respondent failed to adequately assess and plan and/or document such assessment and plan for Patient F.
4. Respondent failed to develop and/or document the development of an accurate initial diagnosis and/or working diagnosis.
5. Respondent failed to order and/or document ordering medically indicated laboratory tests for Patient F.
6. Respondent prescribed Methotrexate for Patient F without adequate medical indication and monitoring and/or without documenting such medical indication and monitoring.
7. Respondent failed to maintain an accurate medical record for Patient F in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient F.

G. Respondent provided general medical care for Patient G, a 65 year old male, in his office from on or about March 2000 through approximately August 2000. According to Patient G's medical records maintained by Respondent, Patient G possibly suffered from diabetes and high blood pressure. Respondent's care and treatment of Patient G failed to meet acceptable medical standards of care, in that:

1. Respondent on various occasions failed to obtain and/or record an adequate medical history for Patient G.
2. Respondent on various occasions failed to perform and/or document the performance of adequate physical exams for Patient G.
3. Respondent failed to adequately assess and plan and/or document such assessment and plan for Patient G.

4. Respondent failed to develop and/or document an accurate initial and/or working diagnosis for Patient G.

5. Respondent, on or about March 2000, failed to order and/or document ordering medically indicated laboratory tests.

6. Respondent failed to adequately monitor and/or document monitoring Patient G's hypertension and/or diabetes.

7. Respondent failed to document instructing Patient G on how to monitor Patient G's blood pressure and/or diabetes.

8. Respondent failed to maintain an accurate medical record for Patient G in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient G.

H. Respondent provided general medical care to Patient H, a 30 year old male, from on or about May 1986 through approximately January 2000 in Respondent's office. Patient H's office record indicated an elevated blood sugar and weight gain. Respondent's care of Patient H failed to meet accepted medical standards of care, in that:

1. Respondent on various occasions failed to obtain and/or document an adequate medical history for Patient H.

2. Respondent on various occasions failed to perform and/or document the performance of an adequate physical exam for Patient H.

3. Respondent on various occasions failed to adequately assess and plan and/or document such an assessment and plan for Patient H.

4. Respondent failed to adequately monitor and/or document monitoring Patient H's blood sugar after it was measured at 154 in 1986.

5. Respondent failed to formulate an adequate initial and/or working diagnosis for Patient H, and/or document such diagnosis.

6. Respondent failed to monitor and/or document monitoring Patient H's weight gain of fifty-nine pounds (59 lbs) between 1989 and ~~1993~~. 1996.

7. Respondent failed to maintain accurate medical records for Patient H in accordance with accepted medical standards of care and/or in a manner that accurately reflected his care and treatment of Patient H.

Pages 7 through 9 have been omitted

SPECIFICATIONS

SPECIFICATIONS ONE THROUGH SEVEN

GROSS NEGLIGENCE

Respondent is charged with practicing medicine with gross negligence on a particular occasion in violation of New York Education Law § 6530(4), in that Petitioner charges:

1. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6, A7 and/or A8.
2. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8, and/or B9.
3. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8, and/or C9.
4. The allegations in paragraphs D, D1, D2, D3, D4, D5, D6, and/or D7.
5. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, and/or E7.
6. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6, and/or F7.
7. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6, G7, and/or G8.

SPECIFICATIONS EIGHT THROUGH SIXTEEN

GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence within the meaning of New York State Education Law § 6530(6) in that petitioner charges:

8. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6, A7 and/or A8.
9. The allegations in paragraphs H, H1, H2, H3, H4, H5, H6, and/or H7.
10. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8, and/or B9.
11. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8, and/or C9.
12. [redacted]
13. The allegations in paragraphs D, D1, D2, D3, D4, D5, D6, and/or D7.
14. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6, and/or F7.
15. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6, G7, and/or G8.
16. [redacted]

SPECIFICATIONS SEVENTEEN THROUGH TWENTY-SEVEN

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of NYS Education Law § 6530(3) in that Petitioner charges that Respondent committed two or more of the following:

17. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6, A7, and/or A8.
18. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8 and/or B9.
19. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8 and/or C9.
20. The allegations in paragraphs D, D1, D2, D3, D4, D5, D6, and/or D7.
21. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, and/or E7.
22. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6, and/or F7.
23. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6, G7 and/or G8.
24. The allegations in paragraphs H, H1, H2, H3, H4, H5, H6, and/or H7.
25. [redacted]
26. [redacted]
27. [redacted]

SPECIFICATIONS TWENTY-EIGHT THROUGH THIRTY-EIGHT

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing with incompetence on more than one occasion within the meaning of NYS Education Law § 6530(5) in that the Petitioner charges that the Respondent committed 2 or more of the following:

28. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6, A7 and/or A8.
29. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8 and/or B9.
30. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8 and/or C9.
31. The allegations in paragraphs D, D1, D2, D3, D4, D5, D6 and/or D7.

32. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, and/or E7.
33. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6, and/or F7.
34. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6, G7, and/or G8.
35. The allegations in paragraphs H, G1, H2, H3, H4, H5, H6, and/or H7.
36. [redacted]
37. [redacted]
38. [redacted]

SPECIFICATIONS THIRTY-NINE THROUGH FORTY-NINE

FAILURE TO MAINTAIN ACCURATE MEDICAL RECORDS

Respondent is charged with professional misconduct under NYS Education Law § 6530(32) by reason of his failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the of the patient in that, petitioner charges:

39. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6, A7 and/or A8.
40. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8 and/or B9.
41. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8, and/or C9.
42. The allegations in paragraphs D, D1, D2, D3, D4, D5, D6, and/or D7.
43. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, and/or E7.
44. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6, and/or F7.
45. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6, G7, and/or G8.
46. The allegations in paragraphs H, G1, H2, H3, H4, H5, H6, and/or H7.
47. [redacted]
48. [redacted]
49. [redacted]

DATED: April 2 ,2002
Albany, New York

Peter D. Van Buren

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

APPENDIX II

APPENDIX II

TERMS OF PROBATION

1. Respondent shall conduct him/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19),

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Suite 303, Troy, New York12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law Section 171(27); State Finance Law Secton 18; CPLR Section 5001; Executive Law Section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. An approved practice monitor shall be in place within thirty (30) days of the effective date of this Order.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unaccounted basis at least monthly and shall examine a selection (no less than **sixty (60) charts** per month) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

9. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and all assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding any/or any such other proceeding against Respondent as may be authorized pursuant to the law.