STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

February 13, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jacob Neuman, M.D.
144-27 78th Avenue
Flushing, New York 11367

Anthony Z. Scher, Esq.
Wood and Scher
The Harwood Bldg.
Scarsdale, New York 10583

Daniel Guenzburger, Esq.
New York State Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: In the Matter of Jacob Neuman, M.D.

Dear Dr. Neuman, Mr. Scher and Mr. Guenzburger:

Enclosed please find the Determination and Order (No. 97-34) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

COPY

IN THE MATTER

OF

JACOB NEUMAN, M.D.

DETERMINATION

AND

ORDER

BPMC-97-34

DAVID T. LYON, M.D., Chairperson, **ROBERT J. O'CONNOR, M.D.**, and **MS. CAROLYN C. SNIPE**, 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 Sections 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **NANCY M. LEDERMAN**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	November 7, 1995
Hearing dates:	February 29, 1996 March 21, 1996 April 26, 1996 May 15, 1996 May 30, 1996 June 20, 1996 August 28, 1996 October 9, 1996 October 30, 1996

The hearing date scheduled for December 12, 1996 was adjourned upon request of both parties and without objection. The hearing date scheduled for January 11, 1996 was adjourned when Respondent's attorney was unable to appear because of blizzard conditions. The 120-day hearing period set forth in Public Health Law Section 230(10)(f) was waived upon request of the Respondent. (T. 7-8)

Committee member Robert J. O'Connor, M.D., absent on May 30, 1996, affirms that he has read and considered evidence introduced at and the transcript of the hearing of that date. (T. 1010) David T. Lyon, M.D., Chairperson of the Committee, absent for the first few minutes of the hearing on August 28, 1996, affirms that he has read and considered evidence introduced at and the transcript of the hearing of that date. (T. 1370)

Pre-hearing Conference:	December 4, 1995
Deliberation date(s):	December 11, 1996
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner appeared by:	NYS Department of Health By: Daniel Guenzburger Assistant Counsel

Respondent appeared by:

Anthony Z. Scher, Esq.
Wood and Scher
The Harwood Building
Scarsdale, New York 10583

WITNESSES

For the Petitioner:

(1) Charles Maltz, M.D.

For the Respondent:

(1) Jacob Neuman, M.D.
(2) Saul Agus, M.D.
(3) Mikhail Kantius, M.D.
(4) Margaret Brandwein, M.D.
(5) Patient D
(6) Patient E's mother
(7) Judith Eisen
(8) Pedro Santiago

STATEMENT OF CHARGES

Respondent was authorized to practice medicine in New York State on June 11, 1982 by the issuance of license number 150244 and is currently licensed to practice medicine with the New York State Department of Education. On November 7, 1995, Respondent was served with a Notice of Hearing and Statement of Charges. Respondent was charged with misconduct under New York Education Law Section 6530.

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion, practicing with incompetence on more than one occasion, practicing fraudulently, filing a false report, ordering excessive tests not warranted by the condition of the patient, failing to maintain records which accurately reflect evaluation and treatment, and engaging in conduct which evidences moral unfitness to practice medicine.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT - GENERAL

Having heard testimony and considered evidence presented by the Department of Health and the Respondent, respectively, the Hearing Committee hereby makes the following findings.

Citations refer to evidence found persuasive by the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

1. Respondent Jacob Neuman, M.D., was authorized to practice medicine in New York State on or about June 11, 1982, by the issuance of license number 150244, by the New York State Education Department. (Ex. 2)

2. Respondent graduated from the University of Guerro Medical School, Mexico in 1978. He performed an internship at Maimonides Medical Center in 1979, a residency in internal medicine at Booth Memorial Hospital from 1980-1982, and a gastroenterology residency at Winthrop University Hospital from 1982 to 1984. (T. 218-229)

3. Respondent opened a private practice towards the end of his gastroenterology residency.

4. Respondent's practice is approximately 50 percent internal medicine and 50 percent gastroenterology. (T. 234) He performs about six or seven endoscopic procedures a day. (T. 235) Respondent lacks board certification in either gastroenterology or internal medicine, and has failed the internal medicine board examination. (T. 319)

5. From the onset of his private practice, many of Respondent's patients had Group Health Insurance ("GHI"). The five patients that are the subject of this proceeding were first discovered through a GHI audit for alleged over-utilization of endoscopic procedures. (T. 230-231)

6. Respondent first learned that he was the subject of an Office of professional Medical Conduct ("OPMC") investigation in either 1994 or 1995, when OPMC requested copies of office charts for various patients. At that time, Respondent submitted records to OPMC that included progress notes with references to pathology reports referred to in the progress notes. (T. 365)

7. Respondent had three interviews with representatives of OPMC concerning the issues under investigation. At the second interview, an OPMC physician asked Respondent why there were no reports of the pathological evaluations. The interview was cancelled, according to Respondent, because everyone in attendance agreed that it would be a waste of time to proceed without the pathology reports. (T, 255-256)

8. Shortly after the interview was cancelled, Respondent submitted to OPMC, through his attorney Garfunkel, Wild & Travis, P.C., office charts which contained numerous pathology reports on Parkway Hospital stationary.

9. The pathology reports for Patients A through E, on Parkway Hospital stationary, were neither issued by Parkway Hospital nor based on an official evaluation performed by a Parkway Hospital pathologist. (Petitioner and Respondent's Joint Exhibit 1, Exs. 4-8)

10. Respondent testified that he and Dr. Kantius, a pathologist employed at Physician's Hospital, would jointly evaluate histology slides.

11. Respondent testified that after he reviewed a slide with Dr. Kantius, Respondent would record the results of the evaluation on a Parkway Hospital pathology form.

12. The forms Respondent employed had the name of a Parkway Hospital pathologist and for each report Respondent assigned a pathology accession number. In spite of the fact that

Respondent testified that he only performed a small number of his own pathological evaluations each year, the pathological accession number he recorded on the reports went into the thousands. Where Respondent represented that he performed two pathological evaluations in one year, the accession numbers for the report performed later in the calendar year was always higher than on a report for evaluations purportedly performed earlier in the year. (Exs. 4 through 9)

13. Dr. Segan replaced Dr. Pachter as the pathologist at Parkway Hospital on September 24, 1990. (Ex. 13) However, the date of the pathology report in Patient D's chart that bears Dr. Segan's name is June 7, 1990. (Ex. 7, p. 17) Respondent testified that he switched to forms bearing Dr. Segan's signature because these forms were available at the Parkway Hospital pathology laboratory at the time he purportedly performed the evaluation, a date more than three months before Dr. Segan actually commenced employment at Parkway Hospital. (T. 1511)

14. Respondent conceded that anyone who looked at the pathology reports he submitted would assume the report was, in fact, generated by Parkway Hospital. (T. 10, 320)

15. Initially, Respondent testified that the histology slides that he and Dr. Kantius reviewed together had been prepared at Parkway Hospital. Respondent claimed that he removed the slides from Parkway Hospital because the Parkway Hospital pathologist, Dr. Pachter, was extremely busy and would not sit down with Respondent to review the slides. (T. 274-276) Respondent testified that he would remove histology slides from the Parkway Hospital pathology laboratory without obtaining permission from either Dr. Pachter, the pathologist, or any other hospital personnel. Respondent stated that he did not compensate Parkway Hospital for slides he removed from the pathology laboratory. (T. 326)

16. The slides introduced in evidence as biopsies of Patients A through E were not produced at Parkway Hospital. After Respondent testified that the histology slides for Patients A

through E had been prepared at Parkway Hospital, the Petitioner called Patricia Waters, a histologist at Parkway Hospital since 1965. Ms. Waters, who is the only person who prepares histology slides at Parkway Hospital, disputed Respondent's claim that the slides for Patients A through E had been prepared at Parkway. (T. 1269, 1303, 1307-1309; Exs. C-1 through C-19)

17. Ms. Waters testified that Parkway Hospital has always used slides manufactured by Baxter, and that the slides Respondent claims were the biopsies of Patients A through E were not Baxter slides. Baxter slides have a clear coarse frosting at one end of the slides, and the purported biopsy slides for Patients A through E have either white frosting, smooth frosting, or frosting that is not as coarse as on a Baxter slide. (T. 1307-1322) Other distinguishing features mentioned by Ms. Waters included differences in the manner specimens were placed on histology slides, differences in the way identifying information was recorded on a slide, and the fact that two of the slides were immuno-histo chemistry slides. (T. 1322-1324; Ex. 11)

18. Following Ms. Waters's testimony, Respondent claimed that he came to the realization that most of the slides for Patients A through E had been prepared at Advanced Diagnostic Laboratories, a commercial laboratory located in Maspeth, Queens that closed in 1991. Respondent conceded that he could not be certain where the slides had been prepared. (T. 1380-1381)

CONCLUSIONS - GENERAL

Respondent's subsequent testimony offered no credible explanation for where slides were prepared for purported pathological evaluations in 1992 and 1993, after the closing of Advanced Diagnostics in 1991. Respondent testified that the slides might have been made at either Flushing Hospital, St. Joseph's Hospital, or Physician's Hospital. (T. 1430)

The Hearing Committee does not find credible Respondent's belated testimony that the

slides for Patients A to E were processed at advanced Diagnostics Laboratory or other laboratories.

Respondent failed to have pathological evaluations performed on tissue samples biopsied. Respondent's testimony that he evaluated the tissue samples on those slides with the assistance of Dr. Kantius is not credible.

There is no credible evidence that these slides are in fact of tissue samples taken from Patients A through E.

Respondent intended to deceive OPMC that Patients A through E had pathological evaluations performed on or about the dates of the purported pathology reports on Parkway Hospital stationary. The pathology evaluation forms in the records of Patients A through E are wholly fraudulent. Not only are they not valid Parkway Hospital reports, they do not represent pathology evaluations of those patients performed by Respondent or anyone else.

Respondent knowingly and falsely represented that Parkway Hospital had issued pathology reports for Patients A through E when in fact, the Respondent knew that the purported Parkway Hospital pathological evaluation reports in the patient charts were fabrications. (T. 10, 320; Exs. 4-8; Joint Ex. I).

FINDINGS OF FACT - PATIENT A

1. On or about and between November 15, 1983 and January 21, 1991, the Respondent treated Patient A, a 53-year-old male. (Ex. 4)

2. On or about January 15, 1985, based on the purported pathological evaluation reported on a Parkway Hospital form, Respondent diagnosed adenomatous polyp. (Ex. 4, pp. 5 and 6) An adenomatous polyp is a pre-malignant type lesion. Such a diagnosis would justify sequential follow-up colonoscopies to screen for a malignant condition. (T. 33) The diagnosis of adenomatous polyp cannot be made without a pathological evaluation of a biopsy. (T. 35)

Respondent failed to have a pathological evaluation performed and had no legitimate medical basis for diagnosing an adenomatous polyp. (Ex. 4)

3. On or about January 20, 1986, almost exactly a year after Respondent's medical records indicate that Patient A had an adenomatous polyp, the Patient presented to Respondent for a follow-up colonoscopy and biopsy. Respondent sent a specimen to a private commercial laboratory, National Health Labs. Findings from that specimen indicated normal tissue and no pathology present. (Ex. 4, p. 8)

4. In a progress note dated January 23, 1986 Respondent wrote: "Path report done at Parkway Hospital shows Tubulovillous Adenoma with no dysplasia change, Patient advise to have yearly colonoscopies for follow-up." (Ex. 4, p. 2) Based on the hearing Committee's findings concerning pathology reports by Respondent, there was no indication for a colonoscopy at this time.

5. Respondent lacked adequate medical indication for follow-up colonoscopies. Patient A's chart contains reports of five pathological evaluations, three pathology reports from private commercial laboratories, one pathological evaluation reported on Parkway Hospital stationary and 1 pathological evaluation reported by Respondent in a progress note. Significantly, all three of the reports from the commercial laboratories report findings of no medical significance. The reports of the commercial laboratories dated January 23, 1986, January 20, 1988, and January 23, 1991 do not provide justification for sequential follow-up coloonoscopies. (Ex. 4, pps. 8, 12 and 15)

6. Respondent failed to have pathological evaluation performed on biopsies taken on three separate occasions:

a. On or about January 6, 1985, during the course of a sigmoidoscopy, Respondent

took a biopsy of a small polyp. Although Respondent's progress note indicates "Biopsies taken and sent to pathology", the chart does not contain any follow-up information pertaining to the biopsy. (Ex. 4, back of page 1) Although Respondent testified that the laboratory called to say there was nothing to evaluate, it is not credible that no report was generated on a specimen. (T. 262)

b. On or about January 13, 1985, during the course of a colonoscopic examination, Respondent took a biopsy. The patient chart includes a fabricated evaluation report. No credible evidence supports the performance of a pathological evaluation. (Ex. 4)

c. On or about February 12, 1990, Respondent notes taking a biopsy during the course of a colonoscopic examination, but failed to record the results of a pathological evaluation or any other follow-up information about the biopsy. (Ex. 4, p. 13)

7. Respondent did not fail to perform a pathological evaluation on February 24, 1987 and January 16, 1989. No biopsies were taken on those dates and thus a pathological evaluation could not be performed. (Ex. 4)

CONCLUSIONS - PATIENT A

Respondent knowingly and falsely represented in a progress note January 23, 1986 and to Patient A that the patient should have an annual colonoscopic examination because a colonic biopsy indicated tubulovillous adenoma. (Ex. 4, p. 2) The determination that Patient A had a pre-malignant condition that warrants follow-up colonoscopic examination requires pathological evaluation of a biopsy. Since the only credible pathological finding, set forth in a report from the National Health Laboratories dated January 21, 1986, indicated the medically insignificant finding of "Edematous Colonic Mucosa," Respondent knew that evaluation neither supported a finding of tubulovillous adenoma nor the treatment recommendation of annual colonoscopic examination. (T. 35, 37; Ex. 4, pps. 2 and 8)

Respondent knowingly and falsely represented that Parkway Hospital had issued a pathology report for Patient A on or about January 15, 1985.

Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient A, including but not limited to knowingly including fabricated pathology reports in the patient's chart. With respect to the reports of stool cultures, the Hearing Committee finds that Respondent performed stool cultures in his office by using the Bacti Bio General Plate, although the Committee finds that Respondent performed stool cultures in his office by using the Bacti Bio General Plate, although the Committee makes no finding as to the validity of the cultures performed. (Ex. A; T. 470, 1172)

DETERMINATIONS - PATIENT A

1. **Allegations A-1.a, A-1.b, and A-1.d are SUSTAINED.**

Respondent performed colonoscopies without adequate indication on or about January 20, 1986, February 24, 1987, and January 18, 1989. (T. 33-35; Ex. 4) **Allegations A-1.c, A-1.e, and A-1.f are NOT sustained.**

2. **Allegation A-2 is NOT SUSTAINED.** Evidence does not support a finding that the colonoscopy performed on or about January 21, 1991, was inappropriate.

3. Allegations A-3.a, A-3.b, and A-3.e are **SUSTAINED.**

Respondent failed to have pathological evaluations performed on or about January 6, 1985, January 13, 1985, and February 12, 1990. (T. 262; Ex. 4) **Allegations A-3.c ad A-3.d are NOT SUSTAINED.**

4. **Allegation A-4 is SUSTAINED.** Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to

failing to maintain reports of biopsies and having fabricated pathology reports included in the record. (Ex. 4)

5. **Allegation A-5 is SUSTAINED.** Respondent knowingly and falsely represented in a progress note and to Patient A that the patient should have annual colonoscopic examinations because a biopsy indicated tubulovillous adenoma, when respondent knew that his evaluation supported neither the finding nor the treatment recommendation. (T. 35, 37; Ex. 4)

6. **Allegation A-6 is SUSTAINED.** Respondent knowingly and falsely represented that Parkway Hospital had issued a pathology report for Patient A on or about January 15, 1985, when Respondent knew that the report in the patient chart of a purported Parkway Hospital pathological evaluation was a fabrication. (T. 10, 320; Ex. 4; Joint Ex. I)

FINDINGS OF FACT AS TO PATIENT B

1. On or about between January 23, 1985 and February 7, 1991, the Respondent treated Patient B, a 39-year-old female. (Ex. 5)

2. Between January 30, 1987 and February 7, 1991, Respondent performed 10 esoophagogastroduoendoscopies ("EGD"). An EGD is a endoscopic procedure that permits the physician to directly visualize the upper gastrointestinal tract. (Ex. 5; T. 654) Respondent performed the EGDs to evaluate Patient B's condition of reflux esophagitis, a condition in which reflux acid from the stomach backs up into the esophagus. (T. 133)

3. Patient B had chronic osteoarthritis which was treated with various types of non-steroidal anti-inflammatory medications (NSAIDS). Such medications irritate the stomach and could contribute to Patient B's reflux esophagitis. (T. 129) Respondent admitted that Patient B

refused to comply with his recommendation to refrain from taking NSAIDs, and also would decide on her own to stop taking the anti-acid medication that he had prescribed. Such patient non-compliance contributes to reflux esophagitis. (T. 723)

4. The EGDs ordered by Respondent were warranted by the condition of the patient, which included persistent vomiting, nausea, abdominal pain, and melena. (T. 1108-1109, 111-1112; Exs. 5, E)

5. Respondent performed colonoscopies on three separate occasions without adequate indication:

a. Respondent performed a colonoscopy on or about June 12, 1988, after having previously performed a colonoscopy on March 17, 1988, to determine whether Patient B had a recurrence of ulcerative colitis or whether she now had infectious colitis. (Ex. 5, p. 21) Since a stool culture is the appropriate method to make such a determination, the ordering of a colonoscopy was unnecessary. (T. 136)

b. Respondent ordered a colonoscopy on June 8, 1989, which was not indicated. Rather than performing a colonoscopy, Respondent should have taken a stool sample to test for clostridium difficile, a bacteria that frequently causes diarrhea following a course of treatment with antibiotics, or possibly performed a sigmoidoscopy. (T. 139)

c. Respondent ordered a colonoscopy on May 25, 1990 to determine if Patient B had ulcerative colitis or pseudomembranous colitis. Pseudomembranous colitis is often caused by an overgrowth of bacteria after treatment with antibiotics. The appropriate way to distinguish between the two conditions is to perform a stool test, not through a colonoscopic examination. (T. 142)

CONCLUSIONS - PATIENT B

Respondent knowingly and falsely represented that Parkway Hospital had issued pathology reports for Patient B on or about June 10, 1987, November 9, 1987, March 18, 1988, June 14, 1988 and June 9, 1989, when in fact, the Respondent knew that the reports in the patient chart of purported Parkway Hospital pathological evaluations were fabrications. (T. 10, 320; Ex. 5; Joint Ex. I)

Respondent failed to have pathological evaluations performed on tissue samples biopsied on or about June 7, 1987, November 7, 1987, March 17, 1988, June 12, 1988, and June 8, 1989, Respondent's testimony that he evaluated the aforementioned tissue samples with the assistance of Dr. Kantius is not credible. (Ex. 5)

Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to having fabricated pathology reports in the patient chart. (Ex. 5)

DETERMINATIONS - PATIENT B

1. **Allegation B-1 is NOT SUSTAINED.** Evidence did not support that Respondent ordered an excessive number of EGDs not warranted by the condition of the patient. (T. 1108-1112; Ex. 5)

2. **Allegation B-2 is SUSTAINED.** Respondent performed colonoscopies without adequate indication on or about June 12, 1988, June 8, 1989, and May 25, 1990. (T. 136, 139, 142; Ex. 5)

3. **Allegations B-3.a, b, c, d, e, f, g, h, and j are SUSTAINED.** Respondent failed to have pathological evaluations performed on or about June 7, 1987, June 22, 1987, November 7, 1987, March 17, 1988, April 21, 1988, June 12, 1988, January 5, 1989, June 8, 1989, and February 7, 1991. (Ex. 5) **Allegation B-3.i is NOT SUSTAINED.**

4. **Allegation B-4 is SUSTAINED.** Respondent knowingly and falsely represented that Parkway Hospital had issued a pathology report for Patient B on or about June 10, 1987, November 9, 1987, March 18, 1988, June 14, 1988, and June 9, 1989, when Respondent knew that the report in the patient chart of a purported Parkway Hospital pathological evaluation was a fabrication. (T. 10, 320; Ex. 5; Joint Ex. I)

5. **Allegation B-5 is SUSTAINED**. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to knowingly including fabricated pathology reports in the patient record. (Ex. 5)

FINDINGS OF FACT - PATIENT C

1. On or about and between August 4, 1989 and June 12, 1993, the Respondent treated Patient C, a 12-year-old female. (Ex. 6)

2. Respondent inappropriately performed a colonoscopy on or about August 25, 1989. Patient C presented to Respondent a day after she had been discharged from Parkway Hospital for an umbilical hernia repair. While in the hospital, Patient C had been treated with intravenous antibiotics. She complained to Respondent of left lower quadrant abdominal pain with cramps and rectal bleeding. Rather than performing a colonoscopy, Respondent should have taken a stool sample to test for clostridium difficile, a bacteria that frequently causes diarrhea following a course of treatment with antibiotics. The performance of a colonoscopy was especially inappropriate in light of the psychologically traumatic affect of invasive rectal procedures on patients of young age. Finally, the minimal risk that this young patient had cancer further undermines any reason for performing a colonoscopy. (T. 507)

3. Respondent performed EGDs on September 11, 1989 and May 8, 1990, upon

presentation of upper GI distress, abdominal pain, nausea, vomiting, and the presence of melena. (T 1158-1160).

4. Respondent performed a colonoscopy on or about June 21, 1990. Patient C reported complaints of constipation and rectal bleeding.

5. Respondent performed EGDs on September 11, 1989 and May 8, 1990, upon presentation of upper GI distress, abdominal pain, nausea, vomiting, and the presence of melena. (T. 1158-1160).

6. On or about February 8, 1990, Respondent treated a retropharyngeal abscess. A retropharyngeal abscess is an abscess in the back of the throat or pharynx. Gastroenterologists lack the specialized training necessary to treat such a condition. (T. 462) Respondent employed a flexible laryngoscope to visualize the abscess, and in the course of the procedure incised and drained the abscess. Although the flexible laryngoscope is usually passed through the nose, Respondent passed the laryngoscope through Patient C's mouth. (T. 461, 892) There is no evidence that a culture was obtained.

CONCLUSIONS - PATIENT C

The Hearing Committee does not find credible Respondent's testimony that he performed the colonoscopy on August 25, 1989, out of a concern that Patient C had a colonic obstruction secondary to her surgery. Although Respondent testified that the surgeon who performed Patient C's umbilical hernia repair raised this issue in a telephone conversation, there is no documentation in Patient C's chart to support that such conversation ever took place. (T. 865; Ex. 6, p. 2)

Respondent inappropriately performed a colonoscopy on or about June 21, 1990, when

Patient C reported complaints of constipation and rectal bleeding. Rather than performing a colonoscopy, Respondent should have either awaited the results of the stool culture or performed a sigmoidoscopy to determine if Patient C had a reoccurrence of her previously diagnosed proctosigmoiditis. (T. 465)

Respondent performed EGDs on September 11, 1989 and May 8, 1990, which were appropriate upon presentation of upper GI distress, abdominal pain, nausea, vomiting, and the presence of melena. (T. 1158-1160).

On or about February 8, 1990, the Respondent inappropriately treated a retropharyngeal abscess, by failing to refer Patient C to a specialist. Gastroenterologists lack the specialized training necessary to treat such a condition. (T. 462)

DETERMINATIONS - PATIENT C

1. **Allegation C-1 is SUSTAINED.** Respondent performed colonoscopies without adequate indication on or about August 25, 1989 and June 21,1990. (T. 465, 507; Ex. 6)

2. **Allegation C-2 is NOT SUSTAINED.** Evidence did not support that Respondent performed EGDs without adequate indication on September 11, 1989 or May 8, 1990. (T. 1158-1160)

3. **Allegation C-3 is SUSTAINED.** Respondent failed to refer Patient C to a specialist for retropharyngeal abscess on or about February 8, 1990. (T. 461-462; Ex. 6)

4. **Allegation C-4 is SUSTAINED.** Respondent failed to culture a retropharyngeal abscess that he drained on or about February 8, 1990. (T. 461-462, 892; Ex. 6)

5. **Allegations C-5 is SUSTAINED.** Respondent failed to have pathological evaluations

performed on or about August 25, 1989, September 11, 1989, and May 8, 1990. (Ex. 6)

6. **Allegation C-6 is SUSTAINED**. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to failing to maintain reports of biopsies and having fabricated pathology reports included in the record. (T. 10, 320; Ex. 6; Joint Ex. I)

FINDINGS OF FACT AS TO PATIENT D

1. On or about and between June 14, 1987 and November 18, 1993, the Respondent treated Patient D, a 41 year old female. Although Respondent's progress notes indicate that Patient D had a chronic complaint of rectal bleeding, the fact that during her treatment Patient D had 11 CBCs with normal hemoglobin and hematocrits suggests that she did not experience significant blood loss. (Ex. 7; T. 561)

2. Respondent performed EGDs on July 14, 1987, November 8, 1987, and September 9, 1988, which were indicated for upper GI symptoms, abdominal pain, acute bleeding, and to document healing of ulcer. (T. 1176-1179, 1182)

3. On or about September 27, 1987, Respondent performed a second colonoscopy in response to complaints of rectal bleeding, and because he had failed to visualize the right side of the colon when he performed a colonoscopy in 1987. (Ex. 7) A colonscopy was performed on February 13, 1990 in response to the same complaint of rectal bleeding. These procedures were indicated by the rectal bleeding. (T. 1189; Ex. E)

4. Respondent performed colonoscopies on two separate occasions: on June 4, 1990, and on July 6, 1990, the Respondent performed a colonoscopy to decompress the patient

for fecal impaction. (T. 532-533)

5. Respondent aspirated bile from the common bile duct and represented that he performed an endoscopic retrograde cholangiopancreatogram ("ERCP") on May 17, 1990. (T. 1412)

6. Respondent billed GHI for an ERCP, and noted in Patient D's chart that he performed an ERCP. (T. 1412-1414)

7. Respondent represented that Parkway Hospital had issued pathology reports for Patient D on or about September 28, 1987, February 16, 1990, and June 7, 1990. (T. 10, 320; Ex. 7; Joint Ex. I)

CONCLUSIONS - PATIENT D

Respondent performed colonoscopies not warranted by the patient's condition on two separate occasions:

a. On June 4, 1990, as Respondent had already diagnosed a condition, proctosigmoiditis, that would explain Patient D's symptoms, the performance of the colonoscopy was inappropriate. (T. 532-533)

b. On July 6, 1990, Respondent performed a colonoscopy to decompress the patient for fecal impaction, an inappropriate procedure. (T. 533)

Although Respondent billed GHI for an ERCP, and noted in Patient D's chart that he performed an ERCP, he testified that he did not perform an ERCP under fluoroscopy, and explained that he intended to bill as an ERCP, not supported by any other evidence. (T. 1412-1414)

Respondent knowingly and falsely represented that Parkway Hospital had issued

pathology reports for Patient D on or about September 28, 1987, February 16, 1990, and June 7, 1990, when in fact, the Respondent knew that the reports in the patient charts of purported Parkway Hospital pathological evaluations were fabrications. (T. 10, 320; Ex. 7; Joint Ex. I)

Respondent failed to have pathological evaluations performed on tissue samples biopsied on September 28, 1987, February 16, 1990, and June 7, 1990. (Ex. 7)

Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to maintaining fabricated pathology reports in Patient D's chart. (Ex. 7)

DETERMINATIONS - PATIENT D

1. **Allegation D-1 is NOT SUSTAINED.** Evidence did not support that Respondent ordered an excessive number of EGDs not warranted by the condition of the patient. (T. 1176, 1178-1179, 1182; Exs. 7, E)

2. **Allegation D-2.c and D-2.d are SUSTAINED.** Respondent performed colonoscopies without adequate indication on or about June 4, 1990 and July 6, 1990. (T. 532-533) **Allegations D-2.a, and D-2.b are NOT sustained.**

3. **Allegation D-3 is SUSTAINED.** Respondent inappropriately performed a procedure on or about May 17, 1990 termed by him to be an ERCP. (T. 1185, 1412-1414)

4. **Allegations D-4.a, D-4.b, D-4.e, and D-4.f are SUSTAINED.** Respondent failed to have pathological evaluations performed on tissue samples biopsied on or about July 14, 1987, September 27, 1987, February 13, 1990, and April 13, 1990. (Ex. 7) **Allegations D-4.c., d, g, h, and i are NOT SUSTAINED.**

5. **Allegation D-5 is SUSTAINED**. Respondent knowingly and falsely represented that Parkway Hospital had issued a pathology report for Patient D on or about September 28, 1987, February 16, 1990, and June 7, 1990, when Respondent knew that the report in the patient chart of a purported Parkway Hospital pathological evaluation was a fabrication. (T. 10, 320; Ex. 7; Joint Ex. I)

6. **Allegation D-6 is SUSTAINED.** Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to knowingly including fabricated pathology reports in the patient record. (Ex. 7)

FINDINGS OF FACT - PATIENT E

1. On or about and between June 1, 1983 and July 11, 1993, the Respondent treated Patient E, a 23-year-old female. Respondent performed 15 EGDs and eight colonoscopies during the course of treatment of Patient E.

2. Respondent performed seven EGDs indicated by nausea, epigastric pain, vomiting, and melena. (T. 1226, 1235; Ex. 8, E)

3. Respondent performed colonoscopies on ten separate occasions:

a. On March 4, 1984, after having previously performed a colonoscopy on June 13, 1983, Respondent performed a colonoscopy with the only indications being abdominal pain and guaiac positive stools. (T. 567)

b. On December 6, 1984, a colonoscopy was performed in response to complaint of rectal bleeding. (T. 571)

c. On June 9, 1985, a colonscopy was performed. (T. 572)

d. Colonoscopies were performed on August 15, 1985, September 23, 1985, and

November 14, 1985. Patient E. had already been diagnosed as having colitis. (T 572, 576, 577)

e. On January 30, 1986, Patient E had an extremely high fever, 103 degrees Fahrenheit. Respondent treated her in an office setting, (T. 578)

f. On September 26, 1989, March 5, 1991, and April 3, 1992, Respondent performed a colonoscopy to determine if Patient E had an exacerbation of her colitis. (T. 585-587)

4. During colonoscopies performed on or about June 9, 1985 and January 30, 1986, Respondent electrocoagulated active bleed sites, a procedure to stop bleeding at specifically defined sites. (T. 1253-1255)

5. Respondent represented that Parkway Hospital had issued pathology reports for Patient E on or about March 6,1 984, December 7, 1984, June 10, 1993. (T. 10, 320; Ex. 8)

6. Respondent failed to have pathological evaluations performed on tissue samples biopsied on or about March 6, 1984, December 7, 1984, June 10, 1985, November 15, 1986, September 29, 1989, July 9, 1992, and June 10, 1993.

7. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient.

CONCLUSIONS - PATIENT E

Respondent appropriately performed seven EGDs indicated by nausea, epigastric pain, vomiting, and melena. (T. 1226, 1235; Ex. 8, E)

Respondent inappropriately performed colonoscopies on ten separate occasions:

a. On March 4, 1984, after having previously performed a colonoscopy on June 13, 1983, Respondent performed a colonoscopy with the only indications being abdominal pain and guaiac positive stools. These indications do not justify performance of the procedure. (T. 567)

b. On December 6, 1984, a colonoscopy was performed in response to complaint of rectal bleeding. Respondent should have limited his examination to a sigmoidoscopy to determine if the patient had colitis or bleeding from her hemorrhoids. (T. 571)

c. On June 9, 1985, a colonscopy was performed that was inappropriate because there was no change in the patient's clinical situation. (T. 572)

d. Colonoscopies performed on August 15, 1985, September 23, 1985, and November 14, 1985, were inappropriate because there was no further reason to colonoscope Patient E, since she had already been diagnosed as having colitis. (T. 572, 576, 577)

e. On January 30, 1986, Patient E had an extremely high fever, 103 degrees Fahrenheit. Respondent should not have treated her in an office setting, (T. 578)

f. On September 26, 1989, March 5, 1991, and April 3, 1992, Respondent performed a colonoscopy when a sigmoidoscopy was indicated to determine if Patient E had an exacerbation of her colitis. (T. 585-587)

During colonoscopies performed on or about June 9, 1985 and January 30, 1986, Respondent electrocoagulated active bleed sites, an appropriate procedure to stop bleeding at specifically defined sites. (T. 1253-1255)

Respondent knowingly and falsely represented that Parkway Hospital had issued pathology reports for Patient E on or about March 6,1 984, December 7, 1984, June 10, 1993, when in fact, the Respondent knew that the reports in the patient chart of purported pathological evaluations performed at Parkway Hospital were fabrications. (T. 10, 320; Ex. 8)

Respondent failed to have pathological evaluations performed on tissue samples biopsied

on or about March 6, 1984, December 7, 1984, June 10, 1985, November 15, 1986, September 29, 1989, July 9, 1992, and June 10, 1993.

Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to knowingly placing fabricated pathology reports in the patient's chart.

DETERMINATIONS - PATIENT E

1. **Allegation E-1 is NOT SUSTAINED.** Evidence did not support that Respondent ordered an excessive number of EGDs not warranted by the condition of the patient. (Exs., 8, E)

2. **Allegation E-2 is SUSTAINED**. Respondent performed colonoscopies without adequate indication on or about March 4, 1984, December 6, 1984, June 9, 1985, January 30, 1986, September 26, 1989, March 5, 1991, and April 3, 1992. (T. 567, 571-572, 576-578, 585-587)

3. **Allegation E-3 is NOT SUSTAINED.** Evidence did not support that Respondent inappropriately performed electrocoagulation on active bleeding sites on June 9, 1985 and January 30, 1986. (T, 1253-1255)

4. **Allegation E-4 is SUSTAINED**. Respondent failed to have pathological evaluations performed on or about March 4, 1984, December 6, 1984, June 9, 1985, January 30, 1986, November 13, 1986, August 4, 1988, May 2, 1989, September 26, 1989, March 5, 1991, July 7, 1992, and June 8, 1993. (Ex., 8)

5. **Allegation E-5 is SUSTAINED**. Respondent knowingly and falsely represented that Parkway Hospital had issued a pathology report for Patient E on or about March 6, 1984, December 7, 1984, June 10, 1985, November 15, 1986, September 29, 1989, July 9, 1992, and

June 10, 1993, when Respondent knew that the report in the patient chart of a purported Parkway Hospital pathological evaluation was a fabrication. (T. 10, 320; Ex. 8; Joint Ex. I)

6. **Allegation E-6 is SUSTAINED.** Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to knowingly placing fabricated pathology reports in the patient record.

VOTE OF THE HEARING COMMITTEE

Allegations A-1.a-b, A-1.d, A-3.a-b, A-3.e, A-4 through A-6, B-2, B-3.a through B-3.h, B-3.j, B-4 through B-5, C-1, C-3 through C-6, D-2.c-d, D-3, D-4.a-b, D-4.3-f, D-5, D-6, E-2, and E-4 through E-6 are **SUSTAINED.**

Allegations A-1.c, A-1.e-f, A-2, A-3.c-d, B-1, B-3.i, C-2, D-1, D-2.a-b and D-4.c-d, d-4.g through D-4.i, E-1 and E-3 are **NOT SUSTAINED.**

FINAL CONCLUSIONS

Respondent ordered excessive and unwarranted endoscopic procedures and fraudulently attempted to justify them by submitting fabricated pathology reports to OPMC. The Hearing Committee sustained allegations that Respondent ordered excessive tests not warranted by the condition of the patient, failed to have pathology evaluations performed, knowingly and falsely represented that Parkway Hospital had issued pathology reports on Patients A through E, and failed to maintain an accurate record of patient evaluation and treatment. On one occasion, Respondent fraudulently advised a patient of pathological diagnosis to induce further testing.

In reaching its factual conclusions about Respondent's actions and his treatment of Patients A through E, the Hearing Committee notes that it found the testimony of Respondent to

be totally unbelievable and wholly lacking in credibility. Although the Department and Respondent produced essentially credible witnesses, the testimony of Respondent's witnesses for the most part was not probative because in each case their testimony was not relevant or premised on tainted and non-credible evidence linked to Respondent.

The testimony of Respondent's expert, Dr. Agus, for example, was based in whole on the assumption that Respondent's records were genuine and thus had little or no value. Similarly, Dr. Brandwein's testimony concerning the consistency between diagnoses on the pathology reports in Respondent's charts and the slides that she evaluated assumed incorrectly that the slides Respondent gave her to evaluate were biopsy slides of Patients A through E.

Respondent's testimony as to pathological evaluation of biopsies performed on Patients A through E showed an arrogant disregard and disdain for the truth that was particularly troubling to the Hearing Committee. Respondent testified that he maintained slides of biopsies for Patients A through E in his office. Originally, he testified that the slides were made at Parkway Hospital, and that he had admittedly improperly removed the slides from the hospital pathology laboratory. Respondent testified at great length about production of the slides and the process by which he took them from the Parkway Hospital laboratory. After the testimony of the Parkway Hospital histologist, Patricia Waters, irrefutably demonstrated that the slides could not possibly have been made at Parkway Hospital, Respondent changed his testimony. he suddenly "recalled" that the slides had been prepared at Advanced Diagnostics Laboratory ("ADL"), which closed in 1991. While such a major departure from Respondent's original defense would be suspect under any circumstance, the fact that ADL was out of operation and that the Department would therefore be precluded from obtaining documentation from the laboratory to disprove Respondent's second concocted story, makes Respondent's testimony even more suspect.

Respondent never offered a credible explanation why a busy gastroenterologist would take time to perform his own pathological evaluations, even with the assistance of Dr. Kantius, or why such a procedure would be preferable to having pathological evaluations performed at a laboratory. Neither Dr. Kantius nor Pedro Santiago, the driver from ADL, provided persuasive

evidence linking the slides that Respondent offered into evidence with Patients A through E. Respondent failed to produce any documentation of insurance reimbursement to corroborate his testimony, although Respondent's attorney asserted that he had subpoenaed such information from GHI. (T. 1384)

Contrary to Respondent's testimony that he reviewed histology slides for Patients A through E with Dr. Kantius and that based on their joint review he wrote pathology reports on Parkway Hospital stationary, the only credible interpretation of the evidence is that Respondent never had pathological evaluations performed and that he fabricated pathology reports with the specific intent to deceive the OPMC evaluators.

Respondent's actions concerning the pathological reports contained in his charts deserve special mention. The Hearing Committee noted that Respondent took great pains to make the reports appear like genuine reports from the Parkway Hospital pathology laboratory. Not only are all the purported reports on Parkway Hospital stationary and bearing the name of Parkway Hospital pathologists, the findings are reported in the jargon of a pathologist rather than in terminology that one would expect from a gastroenterologist. Even more telling, the reports bear pathological accession numbers in number and order to make them appear as if they are genuine hospital pathology laboratory reports. (Ex. 5, pps. 6 and 7, 19 and 22; Ex. 7, pps. 13 and 17; and Ex. 8, pps. 44 and 48) In at least one instance, Respondent backdated a purported evaluation using a form that was not in existence on the date of the purported evaluation using a form that was not in existence on the date of the purported evaluation. (T. 1511; Ex. 7, p. 17; Ex. 13) The Committee finds this to be clear evidence of Respondent's fraudulent intent as well as additional persuasive proof that Respondent never performed pathological evaluations.

Respondent performed a number of endoscopic procedures which the Hearing Committee found were not warranted by the patient's condition. In regard to those other procedures for which the Committee found insufficient evidence to support a charge that they were inappropriately performed, the Committee notes that Respondent's willingness to place fabricated reports in patient charts made the Committee skeptical of the truth of all progress notes in

Respondent's patient charts. However, the Hearing Committee was forced to rely on those records where no other evidence was offered.

Respondent's motive was clear, to justify the performance of unwarranted procedures. Respondent's fraud was matched by his disregard for his patients' welfare. Respondent exhibited no hesitation at subjection of Patient C, a 12 year-old girl, to repeated unnecessary colonoscopies. The Hearing Committee notes with particular outrage Respondent's treatment of Patient A, a man with a family history of colon cancer. Respondent ordered annual colonoscopies for this patient based on purported pathological evaluations indicating a diagnosis of a premalignant condition. The first purported pathological evaluation indicating a pre-malignant condition is reported on a Parkway Hospital stationary form dated January 15, 1985. (Ex. 4, p. 6) The second purported pathological evaluation indicating a premalignant condition, tubulovillous adenoma, is reported in Respondent's progress note dated January 23, 1986. (Ex. 4, p. 2) During the six-year period that Respondent performed annual colonoscopic examinations for Patient A, the Respondent had three biopsies evaluated at commercial laboratories, which all reported normal colonic mucosa, a finding that would not justify sequential follow-up colonoscopies. In the face of these three pathology evaluations and without obtaining proper confirmation that Patient A actually had a pre-malignant condition, Respondent subjected Patient A to numerous invasive endoscopic procedures and to the psychological stress of living with a diagnosis that he had a pre-malignant condition.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Hearing Committee makes the following Conclusions of Law with regard to the Specifications.

All votes of the Hearing Committee were unanimous.

1. The First Specification charges Respondent with practicing with negligence on more

than one occasion, based upon factual allegations A through E of the Statement of Charges. The Hearing Committee sustains this specification and finds that Respondent's treatment of Patient A through E was negligent within the meaning of New York State Education Law Section 6530(3)) in that it did not conform to the standard of care of a reasonably prudent physician under the same circumstances. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The First Specification is SUSTAINED.

2. The Second Specification charges Respondent with practicing with incompetence on more than one occasion, based upon factual allegations A through E of the Statement of Charges. The Hearing Committee does not sustain this allegation and finds that Respondent was not incompetent within the meaning of New York State Education Law Section 5630(5) in that Respondent did not demonstrate a lack of requisite skill and knowledge.

The Second Specification is NOT SUSTAINED.

3. The Third through Nineteenth Specifications charge Respondent with practicing the profession of medicine fraudulently, based upon factual allegations A, B, D, and E of the Statement of Charges. The Hearing Committee sustains this specification and finds that the Respondent practiced the profession of medicine fraudulently within the meaning of New York State Education Law Section 6530(2) in that he intentionally and falsely represented to OPMC that he had performed pathology evaluations that were not performed and produced fabricated pathology evaluation reports on Parkway Hospital stationery to support his deception. Further, Respondent falsely advised Patient A of a purported pathological diagnosis to justify annual colonoscopic examinations. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Third through Nineteenth Specifications are SUSTAINED.

4. The Twentieth through Thirty-sixth Specifications charge Respondent with filing a false report, as set forth in factual allegations A, B, D, and E of the Statement of Charges. The Hearing Committee sustains these allegations and finds that Respondent wilfully filed a false report within the meaning of New York State Education Law Section 6530921) in that Respondent intentionally and falsely represented to OPMC that he had performed pathology evaluations that were not performed and produced fabricated pathology evaluation reports on Parkway Hospital stationery to support his deception. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Twentieth through Thirty-sixth Specifications are SUSTAINED.

5. The Twenty-seventh through Forty-first Specification charges Respondent with ordering excessive tests not warranted by the condition of the patient, as set forth in factual allegations A through E of the Statement of Charges. The Hearing Committee sustains these allegations and finds that Respondent ordered excessive tests within the meaning of New York State Education Law Section 6530935). in so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Twenty-seventh through Forty-first Specifications are SUSTAINED.

6. The Forty-second through Forty-sixth Specification charge Respondent with failing to maintain records which accurately reflected the evaluation and treatment of a patient, as set forth in factual allegations A through E of the Statement of Charges. The Hearing Committee sustains these allegations and finds the Respondent failed to maintain adequate records within the meaning of New York State Education Law Section 5630(32), including but not limited to knowingly placing in patient records fabricated pathology reports. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Forty-second through Forty-sixth Specification are SUSTAINED.

7. The Forty-seventh Specification charges Respondent with being morally unfit to practice the profession of medicine, as set forth in factual allegations A and A-5 of the Statement of Charges. The Hearing Committee sustains the allegation and finds that Respondent evidenced moral unfitness to practice the profession within the meaning of New York State Education law Section 6530(20) in that Respondent fraudulently advised Patient A of a purported pathological diagnosis to induce the patient to undergo annual colonoscopic examinations.

The Forty-seventh Specification is SUSTAINED.

ORDER AND PENALTY

In determining a penalty, the Hearing Committee was motivated by its belief that Respondent's extreme fraudulent actions displayed unmitigated greed and active exploitation of his patients. At all times, Respondent's treatment of his patients took a back seat to his fraudulent deception, all to justify the performance of procedures and to confirm his questionable diagnoses without performing biopsies or pathology evaluations.

Particularly troubling to the Committee was Respondent's blatant disregard for the truth in pursuit of his fraud and without regard for the condition of his patients. His testimony showed an arrogant disregard and disdain for the truth that was cavalier and inexcusable. His moral unfitness to practice medicine was evidenced by his intentional misrepresentation to Patient A that he had a pathological condition warranting annual colonoscopies.

In determining a penalty, the Hearing Committee was motivated by its belief that the serious nature of the findings warrants nothing less than the maximum sanction available to this committee. The Hearing Committee notes that its determination that Respondent's license to practice medicine in the State of New York be revoked is based independently upon each of the specifications of misconduct sustained.

The Committee further was motivated by its belief that the egregious nature of

Respondent's fraudulent actions, including his untruthful testimony before the Committee, warranted a financial penalty. The total fine imposed represents the Committee's determination that Respondent be fined $10,000 for each patient exploited for Respondent's financial gain.

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

1. The license to practice medicine of Respondent **JACOB NEUMAN** is hereby **REVOKED**, and that

2. Respondent will pay a fine in the amount of fifty thousand ($50,000) dollars.

This Order shall take effect **IMMEDIATELY.**

DATED: 3/11/97

BY: REDACTED

DAVID T. LYON, M.D.
Chairperson

ROBERT J. O'CONNOR, M.D.
CAROLYN C. SNIPE

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

IN THE MATTER

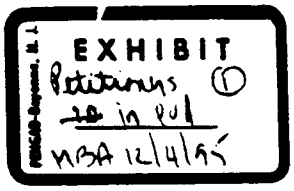
OF

JACOB NEUMAN, M.D.

NOTICE

OF

HEARING



TO: Jacob Neuman, M.D.
144-27 78th Avenue
Flushing, New York 11367

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on December 12 1995, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, 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 issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the

Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995), 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, §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 §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO

REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
Nov 7, 1995

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: DANIEL GUENZBURGER
Assistant Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2617

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

IN THE MATTER OF JACOB NEUMAN, M.D.	STATEMENT OF CHARGES

JACOB NEUMAN, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 11, 1982, by the issuance of license number 150244 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about and between January 6, 1985 and January 21, 1991 the Respondent treated Patient A, a 53 year old male, at his office located at 144-27 78th Avenue, Flushing, New York. (Patient A and the other patients in the Statement of Charges are identified in the Appendix). During the period of treatment regarding Patient A, Respondent:

1. Performed colonoscopies on or about the following dates without adequate indication:

   a. January 20, 1986.
   b. February 24, 1987.
   c. January 16, 1988.
   d. January 18, 1989.
   e. February 12, 1990.
   f. January 21, 1991.

2. Inappropriately performed a colonoscopy on or about January 21, 1991, which was contraindicated by Respondent's preliminary diagnosis of acute diverticulitis.

3. Failed to have pathological evaluations performed on biopsies taken on or about the following dates:

   a. January 6, 1985.
   b. January 13, 1985.
   c. February 24, 1987.
   d. January 16, 1989.
   e. February 12, 1990.

4. Failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to failing to maintain reports of biopsies, stool and urine tests, and having fabricated pathology reports included in the record.

5. Respondent knowingly and falsely represented in a progress note dated January 23, 1986 and to Patient A that the Patient should have an annual colonoscopic examination because a colonic polyp biopsy indicated tubulovillous adenoma, when in fact, the Respondent knew that his evaluation neither supported the finding nor the treatment recommendation.

6. Respondent knowingly and falsely represented that Parkway Hospital had issued a pathology report for Patient A on or about

January 15, 1985, when in fact, Respondent knew that the report in the patient chart of a purported Parkway Hospital pathological evaluation was a fabrication.

B. On or about and between June 23, 1985 and February 7, 1991 the Respondent treated Patient B, a 39 year old female at the onset of treatment, at his office. During the period of treatment regarding Patient B, which included the performance of ten esophagogastroduoendoscopies and four colonoscopies, Respondent:

1. Ordered an excessive number of esophagogastroduoendoscopies not warranted by the condition of the patient.

2. Performed colonoscopies on or about the following dates without adequate indication:

   a. June 12, 1988.
   b. June 8, 1989.
   c. May 25, 1990.

3. Failed to have pathological evaluations performed on tissue samples biopsied on or about the following dates:

   a. June 7,1987.
   b. June 22, 1987.
   c. November 7,1987.

d. March 17, 1988.

e. April 21, 1988.

f. June 12, 1988.

g. January 5, 1989.

h. June 8, 1989.

i. June 15, 1990.

j. February 7, 1991.

4. Respondent knowingly and falsely represented that Parkway Hospital had issued pathology reports for Patient B on or about the dates set forth below, when in fact, the Respondent knew that the reports in the patient chart of purported Parkway Hospital pathological evaluations were fabrications.

a. June 10, 1987.

b. November 9, 1987.

c. March 18, 1988.

d. June 14, 1988.

e. June 9, 1989.

5. Failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to failing to maintain reports of biopsies, stool and urine tests, and having fabricated pathology reports included in the record.

C. On or about and between August 4, 1989 and June 12, 1993 the Respondent treated Patient C, a 12 year old female at the onset of treatment, at his office.

During the period of treatment regarding Patient C, Respondent:

1. Performed colonoscopies on or about the following dates without adequate indication.

   a. August 25, 1989.
   b. June 21, 1990.

2. Performed esophagogastroduodenoscopiees on or about the following dates without adequate indication:

   a. September 11, 1989.
   b. May 8, 1990.

3. Failed to refer to refer Patient C to a specialist for treatment of a retropharyngeal abscess on or about February 8, 1990.

4. Failed to culture a retropharyngeal abscess that he drained on or about February 8, 1990.

5. Failed to have pathological evaluations performed on tissue samples biopsied on or about the following dates:

   a. August 25, 1989.
   b. September 11, 1989.
   c. May 8, 1990.

6. Failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to failing to maintain reports of biopsies, stool and urine tests.

D. On or about and between June 14, 1987 and November 18, 1993 the Respondent treated Patient D, a 41 year old female at the onset of treatment, at his office. During the period of treatment regarding Patient D, which included the performance of five esophagogastroduoendoscopies and five colonoscopies, Respondent:

1. Ordered an excessive number of esophagogastroduoendoscopies not warranted by the condition of the patient.

2. Performed colonoscopies on or about the following dates without adequate indication:

   a. March 26, 1989.
   b. February 13, 1990.
   c. June 4, 1990.
   d. July 6, 1990.

3. Inappropriately performed an endoscopic retrograde cholangiopancreatogram on or about May 17, 1990.

4. Failed to have pathological evaluations performed on tissue

samples biopsied on or about the following dates:

a. July 14, 1987.
b. September 27, 1987.
c. November 8, 1987.
d. September 27, 1988.
e. February 13, 1990.
f. April 13, 1990.
g. June 4, 1990.
h. July 6, 1990.
i. August 23, 1990.

5. Respondent knowingly and falsely represented that Parkway Hospital had issued pathology reports for Patient D on or about the dates set forth below, when in fact, the Respondent knew that the reports in the patient charts of purported Parkway Hospital pathological evaluations were fabrications.

a. September 28, 1987.
b. February 16, 1990.
c. June 7, 1990.

6. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to failing to maintain reports of biopsies, stool and urine tests, and having fabricated pathology reports included in the record.

E. On or about and between June 1, 1983 and June 11, 1993 the Respondent treated Patient E, a 23 year old female at the onset of treatment, at his office. During the period of treatment regarding Patient E, which included the performance of fifteen esophagogastroduoendoscopies and eight colonoscopies, Respondent:

1. Ordered an excessive number of esophagogastroduoendoscopies not warranted by the condition of the patient.

2. Performed colonoscopies on the following dates without adequate indication:

   a. March 4, 1984.
   b. December 6, 1984.
   c. June 9, 1985.
   d. January 30, 1986.
   e. September 26, 1989.
   f. March 5, 1991.
   g. April 3, 1992.

3. Inappropriately performed electrocoagulation on active bleeding sites on various dates, including but not limited to June 9, 1985 and January 30, 1986.

4. Failed to have pathological evaluations performed on tissue samples biopsied on or about the following dates:

   a. March 4, 1984
   b. December 6, 1984.
   c. June 9, 1985.
   d. January 30, 1986.
   e. November 13, 1986.
   f. August 4, 1988.
   g. May 2, 1989.
   h. September 26, 1989.
   i. March 5, 1991.
   j. July 7, 1992.
   k. June 8, 1993.

5. Respondent knowingly and falsely represented that Parkway Hospital had issued pathology reports for Patient E on or about the dates set forth below, when in fact, the Respondent knew that the reports in the patient chart of purported pathological evaluations performed at Parkway Hospital were fabrications.

   a. March 6, 1984.
   b. December 7, 1984.
   c. June 10, 1985.
   d. November 15, 1986.
   e. September 29, 1989.
   f. July 9, 1992.

g. June 10, 1993.

6. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of the patient, including but not limited to failing to maintain reports of biopsies, stool and urine tests, and having fabricated pathology reports included in the record.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1995) by practicing the profession of medicine with negligemce on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in paragraphs A, A1, A1(a), A1(b), A1(c), A1(d), A1(e), A1(f), A2, A3, A3(a), A3(b), A3(c), A3(d), A3(e), A4, A5, A6, B, B1, B2, B2(a), B2(b), B2(c), B, B3, B3(a), B3(b), B3(c), B3(d), B3(e), B3(f), B3(g), B3(h), B3(i), B3(j), B4, B4(a), B4(b), B4(c), B4(d), B4(d), B4(e), B5, C, C1, C1(a), C1(b); C2, C2(a), C2(b), C3, C4, C5, C5(a), C5(b), C5(c), C6, D, D1, D2, D2(a), D2(b), D2(c), D2(d), D3, D4; D4(a),

D4(b), D4(c), D4(d) D4(e), D4(f), D4(g), D4(h), D4(i), D5, D5(a), D5(b), D5(c), D6, E, E1, E2, E2(a), E2(b), E2(c), E2(d), E2(e), E2(f), E2(g), E3, E4, E4(a), E4(b), E4(c), E4(d), E4(e), E4(f), E4(g), E4(h), E4(i), E4(j), E4(k); E5, E5(a), E5(b), E5(c), E5(d), E5(e), E5(f), E5(g), and/or E6.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(5)(McKinney Supp. 1995) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. The facts in paragraphs A, A1, A1(a), A1(b), A1(c), A1(d), A1(e), A1(f), A2, A3, A3(a), A3(b), A3(c), A3(d), A3(e), A4, A5, A6, B, B1, B2, B2(a), B2(b), B2(c), B, B3, B3(a), B3(b), B3(c), B3(d), B3(e), B3(f), B3(g), B3(h), B3(i), B3(j), B4, B4(a), B4(b), B4(c), B4(d), B4(d), B4(e), B5, C, C1, C1(a), C1(b), C2, C2(a), C2(b), C3, C4, C5, C5(a), C5(b), C5(c), C6, D, D1, D2, D2(a), D2(b), D2(c), D2(d), D3, D4; D4(a), D4(b), D4(c), D4(d), D4(e), D4(f), D4(g), D4(h), D4(i), D5, D5(a), D5(b), D5(c), D6, E, E1, E2, E2(a), E2(b), E2(c), E2(d), E2(e), E2(f), E2(g), E3, E4, E4(a), E4(b), E4(c), E4(d), E4(e), E4(f), E4(g), E4(h), E4(i), E4(j), E4(k); E5,

E5(a), E5(b), E5(c), E5(d), E5(e), E5(f), E5(g), and/or E6.

THIRD THROUGH NINETEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(2)(McKinney Supp. 1995) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. The facts in Paragraphs A and A5.
4. The facts in Paragraphs A and A6.
5. The facts in Paragraphs B, B4 and B4(a).
6. The facts in Paragraphs B, B4 and B4(b).
7. The facts in Paragraphs B, B4 and B4(c).
8. The facts in Paragraphs B, B4 and B4(d).
9. The facts in Paragraphs B, B4 and B4(e).
10. The facts in Paragraphs D, D5 and D5(a).
11. The facts in Paragraphs D, D5 and D5(b).
12. The facts in Paragrqphs D, D5 and D5(c).
13. The facts in Paragraphs E, E5 and E5(a).
14. The facts in Paragraphs E, E5 and E5(b).
15. The facts in Paragraphs E, E5 and E5(c).
16. The facts in Paragraphs E, E5 and E5(d).
17. The facts in Paragraphs E, E5 and E5(e).
18. The facts in Paragraphs E, E5 and E5(f).
19. The facts in Paragraphs E, E5 and E5(g).

TWENTIETH THROUGH THIRTY-SIXTH SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 1995) by willfully making or filing a false report, as alleged in the facts of:

20. The facts in Paragraphs A and A5.
21. The facts in Paragraphs A and A6.
22. The facts in Paragraphs B, B4 and B4(a).
23. The facts in Paragraphs B, B4 and B4(b).
24. The facts in Paragraphs B, B4 and B4(c).
25. The facts in Paragraphs B, B4 and B4(d).
26. The facts in Paragraphs B, B4 and B4(e).
27. The facts in Paragraphs D, D5 and D5(a).
28. The facts in Paragraphs D, D5 and D5(b).
29. The facts in Paragrqphs D, D5 and D5(c).
30. The facts in Paragraphs E, E5 and E5(a).
31. The facts in Paragraphs E, E5 and E5(b).
32. The facts in Paragraphs E, E5 and E5(c).
33. The facts in Paragraphs E, E5 and E5(d).
34. The facts in Paragraphs E, E5 and E5(e).
35. The facts in Paragraphs E, E5 and E5(f).
36. The facts in Paragraphs E, E5 and E5(g).

TWENTY-SEVENTH THROUGH FORTY-FIRST SPECIFICATION

EXCESSIVE TESTING

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1995) by ordering excessive tests not warranted by the condition of the patient, as alleged in the facts of:

37. The facts in Paragraphs A, A1, A1(a), A1(b), A1(c), A1(d), A1(e), and A1(f).

38. The facts in Paragraphs B, B1, B2, B2(a), B2(b), and B2(c).

39. The facts in Paragraphs C, C1, C1(a), C1(b), and C1(c), C2, C2(a), and C2(b).

40. The facts in Paragraphs D, D1, D2, D2(a), D2(b), and D2(c), D2(d).

41. The facts in Paragraphs E, E1, E2, E2(a), E2(b), E2(c), E2(d) ,E2(e), E2(f) and E2(g).

FORTY-SECOND THROUGH FORTY-SIXTH SPECIFICATIONS

FAILING TO MAINTAIN AN ADEQUATE RECORD

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1995) by failing to maintain a record for

each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

42. The facts in Paragraphs A and A4.

43. The facts in Paragraphs B and B5.

44. The facts in Paragraphs C and C6.

45. The facts in Paragraphs D and D6.

46. The facts in Paragraphs E and E6.

FORTY-SEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1995) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

47. The facts in Paragraphs A and A5.

DATED: November 7, 1995
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct