New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

Dennis P. Whalen
Executive Deputy Commissioner of Health
Anne F. Saile, Director
Office of Professional Medical Conduct
William J. Comiskey, Chief Counsel
Bureau of Professional Medical Conduct

William P. Dillon, M.D.
Chair
Denise M. Bolan, R.P.A.
Vice Chair
Ansel R. Marks, M.D., J.D.
Executive Secretary

July 7, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Prem Nath, M.D.
Federal Plaza
Rte. 17 M
Monroe, NY 10950

RE: License No. 133218

Dear Dr. Nath:

Enclosed please find Order #BPMC 99-150 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **July 7, 1999.**

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Hedley Park Place, Suite 303
433 River Street
Troy, New York 12180

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management
New York State Department of Health
Corning Tower, Room 1315
Empire State Plaza
Albany, New York 12237

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Anthony Z. Scher, Esq.
c/o Wood & Scher
14 Harwood Court
Scarsdale, NY 10583

Michael Hiser, Esq.

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

IN THE MATTER

OF

PREM NATH, M.D.

CONSENT
AGREEMENT
AND
ORDER
BPMC #99-150

PREM NATH, M.D., (Respondent) deposes and says:

That on or about December 16, 1977, I was licensed to practice as a physician in the State of New York, having been issued License No. 133218 by the New York State Education Department.

My current address is Federal Plaza, Rte. 17M, Monroe, New York 10950 and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with 36 specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I admit guilt to the Twenty fourth through the Thirtieth Specifications, and I do not contest the Eleventh and Twelfth Specifications, in full satisfaction of the charges against me. I hereby agree to the following penalty:

> My medical license will be suspended for a period of thirty six months, with nine months actual suspension and the last twenty seven months stayed. The suspension shall commence upon the effective date of the Order herein. The terms of the suspension are more fully

set forth in Exhibit "C", annexed hereto, which terms are made a part of this Order and which terms shall begin on the effective date of the Order herein. Following the nine month period of suspension and before I resume the private practice of medicine, I will complete an initial 500 hours of community service in a medical setting and as further provided in the terms and conditions as set forth in the Terms of Probation, annexed hereto as Exhibit "B", which terms are made a part of this Agreement and which terms shall begin on the effective date of the Order. Additionally, from the effective date of the Order herein, my practice of medicine in New York State shall be limited to exclude the practice of pain management, that is, a prohibition from treating patients with chronic pain. Following the 9 month period of suspension and for a period of five (5) years thereafter, I shall be placed on probation and my practice of medicine in New York State shall be monitored upon such terms and conditions as set forth in Exhibit B. I will also complete Continuing Medical Education courses as set forth in Exhibit B. Finally, I shall pay a $25,000 fine as set forth below:

FINE PAYMENTS

Unless otherwise specified herein, the fine is payable according to the following schedule:

a. $6,250.00 to be paid within thirty (30) days of the effective date of this Order;
b. $6,250.00 to be paid by November 15, 1999;
c. $6,250.00 to be paid by March 15, 2000; and
d. $6,250.00 to be paid by July 15, 2000.

Payments must be submitted to:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1245
Albany, New York 12237

I further agree that the Consent Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, Respondent shall maintain current registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses his/her license; and

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning

upon the effective date of the Consent Order and will continue while the licensee possesses his/her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29)(McKinney Supp. 1999).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this

matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

AFFIRMED:

DATED June 16, 1999

Prem Nath

PREM NATH, M.D.
RESPONDENT

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 6/17/99

ANTHONY Z. SCHER, Esq.
Attorney for Respondent

DATE: 6/21/99

MICHAEL HISER, Esq.
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: 6/28/99

ANNE F. SAILE
Director
Office of Professional
Medical Conduct

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

IN THE MATTER

OF

PREM NATH, M.D.

CONSENT

ORDER

Upon the proposed agreement of PREM NATH, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 1/1/99

WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
PREM NATH, M.D.	:	CHARGES

----------X

PREM NATH, M.D., the Respondent, was authorized to practice medicine in New York State on December 16, 1977 by the issuance of license number 133218 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department for the period April 1, 1998, through March 31, 2000.

FACTUAL ALLEGATIONS

A. At various times from on or about September 11, 1992 to on or about September 1997, Respondent provided medical care to Patient A (Patients are identified in the Appendix) at Respondent's office(s) at Route 32 and Shuit Valley, Central Valley, New York ("the Central Valley office"). Respondent's care and treatment failed to meet acceptable standards of medical care in that:

1. Respondent failed to prescribe and/or adequately document the prescription of non-narcotic analgesics for Patient A prior to prescribing narcotic analgesics.

2. Respondent failed to adequately explore or document alternative treatment modalities other than the use of controlled substances and/or failed to adequately consult with appropriate specialists.
3. Respondent failed to maintain an accurate record of medications prescribed for Patient A, including but not limited to, prescriptions for Lorcet, Percocet and Phenergan with Codeine.
4. Respondent prescribed controlled substances for Patient A, including but not limited to Lorcet, Percocet and Valium, in inappropriate dosages and for an excessive period of time.
5. Respondent, on numerous occasions, prescribed controlled substances to Patient A without adequate medical justification and/or failed to document such.
6. Respondent failed to manage, or treat Patient A's psychiatric problems or make a referral for such management or treatment and/or failed to adequately document such.
7. Respondent failed to follow up and/or document any follow up on an April 1994 thoracic surgeon recommendation and/or on tests recommended for anemia in March 1994 and/or failed to monitor the anemia and/or failed to adequately document such.
8. Respondent ordered excessive treatment of Patient A which was not warranted by her condition.

9. Respondent failed to provide and/or adequately document adequate and/or appropriate preventive health measures for Patient A.

10. Respondent, at various times from October 1993 through December 1996 intentionally misrepresented in writing the evaluation or treatment of Patient A as having occurred on a specific date or time when, in fact, the evaluation or treatment never occurred or occurred on a different date or time.

11. Respondent failed to maintain records for Patient A which adequately reflect the evaluation and treatment for Patient A.

12. Respondent, on numerous occasions, failed to document in Patient A's medical record his prescription(s) of controlled substances to Patient A.

B. At various times from on or about November 28, 1994 to on or about May 1996, Respondent provided medical care to Patient B at the Central Valley office. Respondent's care and treatment of Patient B. failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document a adequate medical history of Patient B.

2. Respondent, prescribed controlled substances to Patient B without adequate medical justification and/or failed to adequately document such.

3. Respondent failed to adequately explore or document alternative treatment modalities other than the use of controlled substances and/or failed to adequately consult with appropriate specialists.

4. Respondent failed to appropriately monitor and/or document the monitoring of Patient B's ischemic heart disease and palpitations.

5. Respondent failed to provide and/or document adequate and/or appropriate preventive health measures for Patient B.

6. Respondent failed to provide and/or document adequate instructions to Patient B regarding pain management of herniated disc.

7. Respondent failed to maintain adequate records for Patient B which adequately reflect the evaluation and/or treatment for Patient B.

8. Respondent, on numerous occasions, failed to document in Patient B's medical record his prescription(s) of controlled substances to Patient B.

C. Respondent provided care to Patient C, date of birth, June 21, 1983, on or about October 6, 1993 to on or about February 8, 1996, at the Central Valley office. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate

medical history of Patient C.

2. Respondent, at various times during the course of treatment, failed to perform and/or document the performance of an adequate physical examination of Patient C.
3. Respondent ordered excessive treatment of Patient C which was not warranted by his condition.
4. Respondent failed to follow up and/or appropriately treat recurrent Upper Respiratory Infections, failed to make an adequate referral for such and/or failed to adequately document such.
5. Respondent failed to adequately explore or document alternative treatment modalities other than the use of controlled substances and/or failed to adequately consult with appropriate specialists.
6. Respondent prescribed Phenergan with Codeine and Vicodin in inappropriate dosages for Patient C, for an excessive period, and /or without adequate justification and/or failed to document such.
7. Respondent failed to provide and/or document appropriate and adequate preventive health measures to Patient C.
8. Respondent failed to maintain adequate records for Patient C which adequately reflect the evaluation and/or treatment for Patient C.
9. Respondent, on numerous occasions, failed to record his prescriptions of controlled substance(s) to Patient C in Patient C's medical record.

D. Respondent provided care to Patient D, date of birth November 13, 1981, from on or about November 8, 1993 to on or about February 8, 1996 at the Central Valley office. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history of Patint D, including failure to obtain a complete immunization record for Patient D.
2. Respondent, at various times during the course of treatment, failed to conduct and/or document an adequate physical examination of Patient D.
3. During the course of treatment, Respondent ordered excessive treatment for Patient D.
4. Respondent failed to follow up and/or evaluate the diagnosis of infectious mononucleosis, failed to treat recurrent Upper Respiratory Infections, failed to make an adequate referral for such and/or failed to adequately document such.
5. Respondent diagnosed Patient D with a migraine headache, with weight loss and with chronic fatigue syndrome without adequate justification and/or failed to adequately document such.
6. Respondent failed to provide and/or document adequate and/or appropriate preventive health measures to Patient D.
7. Respondent failed to adequately explore or document alternative treatment modalities other than the use of

controlled substances and/or failed to adequately consult with appropriate specialists.

8. Respondent prescribed Phenergan with Codeine and Vicodin in inappropriate dosages for Patient D, for an excessive period, without adequate justification and/or failed to adequately document such.

9. Respondent inappropriately prescribed Ciprofloxacin to Patient D, given that Patient D was a child under the age of eighteen.

10. Respondent failed to maintain adequate records for Patient D which adequately reflect the evaluation and/or treatment for Patient D.

11. Respondent, on numerous occasions, failed to record his prescription(s) of controlled substances to Patient D in Patient D's medical record.

E. Respondent provided care to Patient E from on or about July 22, 1991 through on or about April 14, 1998, at the Central Valley office. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate medical history of Patient E.

2. Respondent prescribed controlled substances, including Fiorinal and Vicodin, to Patient E without adequate medical justification, for an excessive period of time and/or failed to adequately document such.

3. Respondent inappropriately prescribed Vicodin, Fiorinal and/or Phenergan with Codeine for Patient E contemporaneously and/or within the same or overlapping periods.

4. Respondent prescribed Zoloft for Patient E in inappropriate dosages.

5. Respondent prescribed controlled substances including Fiorinal, Vicodin and/or Phenergan with Codeine to Patient E without attempting other treatment modalities and/or failed to adequately document such.

6. Respondent diagnosed Patient E with Pyelonephritis and disc herniation without adequate medical justification and/or failed to adequately document such.

7. Respondent failed to timely refer Patient E to an expert in pain management and/or other modality to address pain management.

8. Respondent failed to follow up on the request(s) for chemical screens and/or failed to document such.

9. Respondent failed to provide and/or document appropriate preventive health measures to Patient E.

10. During the course of treatment, Respondent ordered excessive treatment for Patient E.

11. Respondent, at various times from August 1991 through on or about July 1997 intentionally misrepresented in writing the evaluation or treatment of Patient E as having occurred on a specific date or time when, in fact, the evaluation or treatment either never occurred or occurred at a different date and time.

12. Respondent failed to maintain records for Patient E which adequately reflect the evaluation and/or treatment of Patient E.

13. Respondent, on numerous occasions, failed to record his prescription(s) of controlled substances to Patient E in Patient E's medical record.

F. Respondent provided care to Patient F from on or about September 3, 1991 to on or about April 14, 1998, at the Central Valley office. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate medical history of Patient F.
2. Respondent failed to adequately explore or document alternative treatment modalities other than the use of controlled substances and/or failed to adequately consult with appropriate specialists.
3. Respondent prescribed controlled substances including Vicodin, Fiorinal and/or Fioricet for Patient F without adequate medical justification, for an excessive period of time and/or failed to adequately document such.
4. Respondent failed to provide and/or document adequate or appropriate preventive health measures to Patient F.
5. Respondent prescribed Prozac without adequate medical justification and/or without appropriate discussion, and/or failed to document such.
6. Respondent failed to appropriately treat Patient F's

hypertension and depression and/or failed to adequately document such.

7. Respondent failed to order a radiograph to view the ribs of Patient F on August 9, 1994 and/or failed to adequately document such.
8. Respondent prescribed antibiotics to treat upper respiratory infections without adequate medical justification and/or failed to adequately document such.
9. Respondent failed to appropriately treat Patient F's epididymitis and headache complaints, failed to order appropriate tests and/or failed to document such.
10. Respondent failed to timely refer Patient F to an expert in pain management and/or other modality to address pain management.
11. During the course of treatment, Respondent ordered excessive treatment for Patient F.
12. Respondent, at various time from October 1991 through on or about September 1997 intentionally misrepresented in writing the evaluation or treatment of Patient F as having occurred on a specific date or time when, in fact, the evaluation or treatment never occurred or occurred at a different date or time.
13. Respondent failed to maintain records for Patient F which adequately reflect the evaluation and treatment of Patient F.
14. Respondent, on numerous occasions, failed to record his prescription(s) of controlled substances to Patient F

in Patient F's medical record.

G. At various times, from on or about January 1998 to on or about May 22, 1998, Respondent provided medical care to Patient G at Respondent's Central Valley office. Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care, in that:

1. Respondent, on or about January 16, January 22, March 13 and/or April 24, 1998, intentionally misrepresented in writing the evaluation or treatment of Patient G as having occurred on a specific date or time when, in fact, the evaluation or treatment never occurred or occurred at a different date or time.
2. Respondent failed to perform an initial physical examination of Patient G.
3. Respondent failed to obtain an adequate medical history from Patient G.
4. Respondent provided and/or prescribed controlled substances to Patient G without adequate medical justification.
5. Respondent failed to provide appropriate health maintenance to Patient G and/or failed to adequately document such.

SPECIFICATIONS

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(4) by reason of his having practiced the profession with gross negligence on a particular occasion, in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.4, A and A.5, A and A.6, A and A.7, A and A.10, A and A.11, and/or A and A.12.

2. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.7, and/or B and B.8.

3. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.5, C and C.6, and/or C and C.9.

4. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.6, D and D.7, D and D.8, D and D.10, and/or D and D.11.

5. The facts in Paragraphs E and E.1, E and E.2, E and E.5, E and E.6, E and E.7, E and E.9, E and E.11, E and E.12, and/or E and E.13.

6. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.10, F and F.12, F and F.13, and/or F and F.14.

7. The facts in Paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

EIGHTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(3) by reason of having practiced the profession with negligence on more than one occasion, in that Petitioner charges that Respondent committed at

least two of the following:

8. The facts in Paragraphs A and A.1, A and A.2, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, and/or A and A.12, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, F and F.13, F and F.14, G and G.1, G and G.2, G and G.3, G and G.4, and/or G and G.5.

NINTH THROUGH FIFTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(6) by reason of his having practiced the profession with gross incompetence in that Petitioner charges:

9. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.10, A and A.11, and/or A and A.12

10. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.7, and/or B and B.8.

11. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.5, C and C.6, and/or C and C.9.

12. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.6, D and D.7, D and D.8, D and D.10, and/or D and D.11.

13. The facts in Paragraphs E and E.1, E and E.2, E and E.5, E and E.6, E and E.7, E and E.9, E and E.11, E and E.12, and/or E and E.13.

14. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.10, F and F.12, F and F.13, and/or F and F.14.

15. The facts in Paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

SIXTEENTH SPECIFICATION

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(5) by reason of having practiced the profession with incompetence on more than one occasion, in that Petitioner charges that Respondent committed at least two of the following:

16. The facts in Paragraphs A and A.1, A and A.2, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, and/or A and A.12, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, F and F.13, F and F.14, G and G.1, G and G.2, G and G.3, G and G.4, and/or G and G.5.

SEVENTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(2) by reason of having

practiced the profession fraudulently or beyond its authorized scope, in that Petitioner charges:

17. The facts in Paragraphs A and A.3, A and A.5, A and A.8, A and A.10, A and A.11 and/or A and A.12.

18. The facts in Paragraphs B and B.2, B and B.7 and/or B and B.8.

19. The facts in Paragraphs C and C.3, C and C.8 and/or C.9.

20. The facts in Paragraphs D and D.3, D and D.5, D and D.10 and/or D and D.11.

21. The facts in Paragraphs E and E.2, E and E.3, E and E.10, E and E.11, E and E.12, and/or E and E.13.

22. The facts in Paragraphs F and F.3, F and F.5, F and F.8, F and F.11, F and F.12, F and F.13, and/or F and F.14.

23. The facts in Paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

TWENTY FOURTH THROUGH THIRTIETH SPECIFICATIONS

FAILING TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(32) by reason of having failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, in that Petitioner charges:

24. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.5, A and A.6, A and A.7, A and A.9, A and A.10, A and A.11, and/or A and A.12.

25. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, and/or B and B.8.

26. The facts in Paragraphs C and C.1, C and C.2, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8 and/or C and C.9.

27. The facts in Paragraphs D and D.1, D and D.2, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.10, and/or D and D.11.

28. The facts in Paragraphs E and E.1, E and E.2, E and E.5, E and E.6, E and E.8, E and E.9, E and E.10., E and E.11 and/or E and E.12.

29. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.11, F and F.12, and/or F and F.13.

30. The facts in Paragraphs G and G.1, G and G.2, G and G.4, and/or G and G.5.

THIRTY-FIRST THROUGH THIRTY-SIXTH SPECIFICATIONS

ORDERING OF EXCESSIVE TREATMENT

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(35) by reason of his having ordered excessive treatment not warranted by the condition of the patient, in that Petitioner charges:

31. The facts in Paragraphs A and A.4 and/or A and A.8.

32. The facts in Paragraphs C and C.3, and/or C and C.6.

33. The facts in Paragraphs D and D.3, D and D.5, and/or D and D.8.

34. The facts in Paragraphs E and E.2, E and E.3, E and E.4, and/or E and E.10.

35. The facts in Paragraphs F and F.3, F and F.5, and/or F. and F.11.

36. The facts in Paragraphs G and G.4.

DATED: April 7, 1999
Albany, New York

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

EXHIBIT "B"

TERMS OF PROBATION

1. Respondent shall conduct himself/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.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director of the Office of Professional Medical Conduct, New York State Department of Health, 433 River Street, Suite 303, Troy, NY 12180-2299; 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. 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 section 18; CPLR section 5001; Executive Law section 32].

4. 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.

5. 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.

6. 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.

CONTINUING MEDICAL EDUCATION

7. Respondent shall enroll in and complete a continuing medical education program in the areas of (1) medical record documentation and (2) the principles of family practice, equivalent to at least 30 credit hours each year over a three year

period. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the first three years of probation.

COMMUNITY/PUBLIC SERVICE

8. Respondent shall perform 1000 hours of community service. The service must be medical in nature, and delivered in a facility or with an organization equipped to provide medical services and serving a needy or medically underserved population. A written proposal for community service must be submitted to, and is subject to the written approval of the Director of OPMC. Community service performed prior to written approval shall not be credited toward compliance with this Order. The initial five hundred (500) hours of this requirement must be performed immediately following the nine month suspension period. Respondent may not resume the private practice of medicine or the practice of medicine for compensation until the initial 500 hour requirement is satisfied. Thereafter, Respondent shall complete the balance of 500 hours of community service over the next two years, as measured from the time that Respondent again begins the private practice of medicine or the practice of medicine for compensation.

PRACTICE MONITOR

9. 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.

   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 unannounced basis at least monthly and shall examine a selection (no less than 20) 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.

At the conclusion of Respondent's third year of monitoring, Respondent may petition the Director to evaluate his medical practice and the need for continuation of a practice monitor and may request that such monitoring be terminated. Any determination by the Director to discontinue monitoring at that time is subject to the full discretion of the Director.

10. 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.

EXHIBIT C

TERMS OF SUSPENSION

1. Respondent shall immediately cease and desist from engaging in the practice of medicine in accordance with the terms of the Order. In addition, Respondent shall refrain from providing an opinion as to professional practice or its application and from representing himself as being eligible to practice medicine during the period of actual suspension.

2. Respondent shall have delivered to OPMC at Hedley Park Place, 433 River Street 4th Floor, Troy, NY 12180-2299 his original license to practice medicine in New York State and current biennial registration within thirty (30) days of the effective date of the Order.

3. Respondent shall within fifteen (15) days of the Order notify his patients of the suspension of his medical practice and will refer all patients to another licensed practicing physician for their continued care, as appropriate.

4. Respondent shall make arrangements for the transfer or maintenance of the medical records of his patients (including maintenance of the medical records by Respondent). Within thirty days of the effective date of the Order, Respondent shall notify OPMC of these arrangements including the appropriate and acceptable contact person's name, address, and telephone number who shall have access to these records. Original records shall be retained for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after the patient reaches the age of majority whichever time period is longer. Records shall be maintained in a safe and secure place which is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information on the record is kept confidential and made available only to authorized persons. When a patient or and/or his or her representative requests a copy of the patient's medical record or requests that the original medical record be forwarded to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient (not to exceed seventy-five cents per page.) Radiographic, sonographic and like materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of their inability to pay.

5. Respondent shall not charge, receive or share any fee or distribution of dividends for professional services rendered by himself or others while barred from engaging in the practice of medicine. Respondent may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of this Order.

6. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine and if his license is revoked, surrendered or suspended for a term of six months or more under the terms of this Order, Respondent shall divest himself of all financial interest in the professional services corporation in accordance with New York Business Corporation Law. Such divesture shall occur within 90 days. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within ninety (90) days of the effective date of this Order.

7. Failure to comply with the above directives may result in a civil penalty or further criminal penalties as may be authorized pursuant to the law. Under Section 6512 of the Education Law it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when such professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in section 230-a of the Public Health Law, which includes fines of up to $10,000 for each specification of charges of which the Respondent is found guilty and may include revocation of a suspended license.