STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

January 12, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael Hiser, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2429
Albany, New York 12237

Walter Nieves, M.D.
Tallman Medical Center
11 North Airmont Road
Suffern, NY 10901-5103

Barry Gold, Esq.
Thuillez, Ford, Gold & Connolly
90 State Street
Albany, NY 12207

EFFECTIVE DATE JULY 23, 1995

RE: In the Matter of Walter Nieves, M.D.

Dear Mr. Hiser, Dr. Nieves and Mr. Gold:

Enclosed please find the Determination and Order (No. 93-167) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Very truly yours,

Tyrone T. Butler/crc

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	ADMINISTRATIVE REVIEW BOARD
OF	:	DETERMINATION AND ORDER
WALTER L. NIEVES, M.D.	:	ARB NO.93-167

The Administrative Review Board for Professional Medical Conduct (Review Board), consisting of ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D. and EDWARD C. SINNOTT, M.D. [1] held deliberations on December 10, 1993 to review the Professional Medical Conduct Hearing Committee's (Committee) October 21, 1993 Determination finding Dr. Walter Nieves guilty of professional misconduct. The Respondent requested the review through a Notice which the Review Board received on October 26, 1993. James F. Horan served as Administrative Officer to the Review Board. Michael A. Hiser, Esq. submitted a brief for the Office of Professional Medical Conduct (Petitioner) on November 29, 1993 and a reply to the Respondent's brief on December 6, 1993. Barry A. Gold, Esq. submitted a brief for Dr. Nieves on November 29, 1993.

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[1] Dr. William Stewart did not participate in deliberations in this case due to illness.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Office of Professional Medical Conduct charged the Respondent with practicing the profession fraudulently, practicing with negligence on more than one occasion, practicing with incompetence on more than one occasion and failing to maintain adequate records. The charges against the Respondent involve the care the Respondent provided to seven persons, Patients A through G.

The Hearing Committee sustained the charges that the Respondent practiced the profession fraudulently, practiced with negligence on more than one occasion and failed to maintain adequate records. The Committee did not sustain the charge that the Respondent was guilty of incompetence on more than one

occasion. In the cases of all seven patients, the Committee found that the Respondent failed to perform an adequate neurologic examination and that he knowingly misrepresented that he had performed adequate examinations. The Committee also found that the Respondent's consultation reports did not accurately reflect the information gathered during examinations which the patients described or gathered during examinations of the duration which the patients described. The Committee also found that the Respondent had failed to properly monitor Patient F's serum level for Dilantin toxicity and had failed to appropriately treat Patient F when the patient experienced symptoms of Dilantin toxicity.

The Committee based their conclusions upon the testimony of Patients A through G, whom the Committee found to be credible witnesses. The Committee found the Respondent's testimony to be evasive and self serving. The Committee also found that there were recurring similarities in the testimony of the witnesses as to the type of the examination which the Respondent conducted, the duration of the examination and the identical wording of the neurological reports for Patients A, B, D, E and F.

The Hearing Committee suspended the Respondent's license to practice for a period of two years, but stayed all but three months of the suspension. The Committee fined the Respondent Five Thousand ($5000.00) Dollars on each of the seven specifications of fraud which the Committee sustained, One Thousand ($1000.00) Dollars on each sustained specification of failing to maintain

adequate records and Three Thousand ($3000.00) Dollars for practicing with negligence on more than one occasion, for a total fine of Forty-Five Thousand ($45,000.00) Dollars.

REQUEST FOR REVIEW

The Respondent argues that the proof at the hearing, basically the testimony by Patients A through G, was not adequate to support the Committee's findings that Dr, Nieves was guilty of negligence on more than one occasion, fraud and failing to maintain adequate records. The Respondent argues that the Respondent performed proper examinations and the Respondent's records constitute proof of that. The Respondent argues further that there are no grounds for the finding concerning the treatment for Patient F with Dilantin. The Respondent contends that Hearing Officer erred in not allowing the Respondent access to letters written by Patients F and G concerning Dr. Nieves. The Respondent argues that the penalty is unwarranted, especially the Thirty-Five Thousand ($35,000.00) Dollar fine for fraud.

The Petitioner asks that the Review Board sustain the Hearing Committee's Determination, except that the Petitioner asks the Board to modify the Hearing Committee's penalty to place the Respondent on probation during the twenty-one months of the stayed license suspension. The Petitioner argues that a period of oversight over the Respondent is necessary, since with the stay of twenty-one months of the suspension, the penalty against the Respondent amounts to only three months.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board finds that the question of whether the Hearing Committee's Administrative Officer should have permitted the Respondent access to letters written supposedly by Patients F and G is a procedural issue which is beyond our scope of review.

The Review Board votes to sustain the Hearing Committee's determination that the Respondent was guilty of fraud, negligence on more than one occasion and failure to maintain adequate records. The determination is consistent with the Committee's finding that Patients A through G were credible witnesses, that the Respondent had failed to perform adequate neurologic examinations and that the Respondent had knowingly misrepresented that he had performed adequate examinations. The Committee's determination on negligence is also consistent with the Committee's finding that Respondent failed to monitor Patient F properly and treat Patient F appropriately for Dilantin toxicity.

The Review Board votes to sustain in part and modify in part the Hearing Committee's Determination to suspend the Respondent's medical license for twenty-four months, with all but three months of the suspension stayed, and to fine the Respondent Forty-Five Thousand ($45,000.00) Dollars. The Review Board sustains the three month actual suspension and the total amount of

the fine. We modify the Determination to provide that the Respondent shall be on probation for the twenty-one month period of the stayed suspension. The Determination to suspend the Respondent's license for three months and fine the Respondent Forty-Five Thousand ($45,000.00) Dollars is consistent with the Committee's Finding that the Respondent was guilty of repeated acts of fraud, repeated acts of negligence and failure to maintain adequate records. The Review Board finds that the suspension and fine is an appropriate penalty for the Respondent's repeated and intentional acts of fraud and his repeated negligent care.

Due to the Respondent's repeatedly negligent care and repeatedly fraudulent acts in the care for Patients A through G, the Review Board finds that the Respondent's practice should be monitored for some time following the period of suspension to assure the Respondent has corrected the deficiencies in his practice. The Review Board votes to place the Respondent on probation for twenty-one months following the Respondent's actual period of suspension, on terms of probation to be set by the Director of the Office of Professional Medical Conduct. Those terms shall include a practice monitor.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board sustains the Hearing Committee's October 21, 1993 Determination finding Dr. Walter Nieves guilty of professional misconduct.

2. The Review Board sustains the Hearing Committee's Determination to suspend Dr. Nieves' license for three months and to fine him Forty-Five Thousand Dollars.

3. In addition, the Review Board places the Respondent on probation for twenty-one months following the period of suspension.

ROBERT M. BRIBER

MARYCLAIRE B. SHERWIN

WINSTON S. PRICE

EDWARD C. SINNOTT

IN THE MATTER OF WALTER NIEVES, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Nieves.

DATED: January 11, 1994
Albany, New York

ROBERT M. BRIBER

IN THE MATTER OF WALTER NIEVES, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Nieves.

DATED: Albany, New York

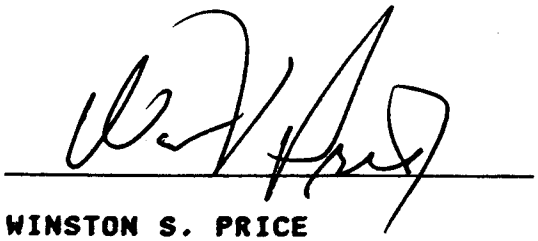
Maryclaire B. Sherwin

MARYCLAIRE B. SHERWIN

IN THE MATTER OF WALTER NIEVES, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Nieves.

DATED: Brooklyn, New York



WINSTON S. PRICE

IN THE MATTER OF WALTER NIEVES, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Nieves.

DATED: Albany, New York
January 7, 1994

EDWARD C. SINNOTT, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

October 21, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Walter Nieves, M.D.
Tallman Medical Center
11 North Airmont Road
Suffern, New York 10901-5103

Barry Gold, Esq.
Thuillez, Ford, Gold
& Connolly
90 State Street
Albany, New York 12207

Michael Hiser, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2438
Albany, New York 12237

RE: In the Matter of Walter Nieves, M.D.

Dear Dr. Nieves, Mr. Gold and Mr. Hiser:

Enclosed please find the Determination and Order (No. BPMC-93-167) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

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

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

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

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

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	DETERMINATION
OF	:	AND
WALTER L. NIEVES, M.D.	:	ORDER
		NO. BPMC-93-167

DAVID T. LYON, Chairman, BENJAMIN WAINFELD, M.D. and ROBIN N. BUSKEY, R.P.A. duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. MICHAEL P. MCDERMOTT, ESQ., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

At the first hearing date, November 19, 1992, Linda D. Lewis, M.D., an original panel member, recused herself. The hearing proceeded on that date with two panel members, David T. Lyon, M.D. and Robin N. Buskey, R.P.A.

Benjamin Wainfeld, M.D. was substituted for Dr. Lewis and participated in all subsequent hearing dates.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	August 25, 1992
Pre-Hearing Conference:	November 9, 1992
Hearing Dates:	November 19, 1992 January 27, 1993 March 23, 1993 March 29, 1993 April 16, 1993 May 4, 1993 June 22, 1993
Place of Hearing:	Newburgh, New York (First two hearing Dates) New York, New York (All other hearing dates)
Date of Deliberations:	July 30, 1993
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Michael Hiser, Esq. Associate Counsel
Respondent appeared by:	Thuillez, Ford, Gold & Connolly 90 State Street Albany, New York 12207 By: Barry Gold, Esq. of Counsel

WITNESSES

For the Petitioner:

1. Patient B
2. Patient A
3. Patient E
4. Patient D
5. Patient C
6. Patient F
7. Lawrence P. Corbett, M.D.
8. Patient G

For the Respondent:

1. Walter L. Nieves, M.D.
2. Evelyn Prat-Vincent (Model for Demonstration)
3. Susan P. Predmore

STATEMENT OF CHARGES:

Essentially, the Statement of Charges charges the Respondent with practicing the profession fraudulently; practicing with negligence on more than one occasion; and with failing to maintain accurate records.

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

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

GENERAL FINDINGS

1. The Respondent is a physician duly licensed to practice medicine in the State of New York under license number 132973 issued by the State Education Department. The Respondent was registered to practice medicine for the period January 1,

1991 through December 31, 1992, from Tallman Medical Center, 11 North Airmont Road, Suffern, New York 10901-5103.

FINDINGS AS TO PATIENT A

2. Patient A, a 38 year old female, received medical care from the Respondent in the form of a neurologic consultation at the Respondent's office at Tallman Medical Center, 11 North Airmont Road, Suffern, New York on September 15, 1987. Patient A's chief complaint was of a headache (Pet.'s Ex. 2, pp. 3-4; Pet. Ex. 3)

3. Patient A went into the Respondent's office and spoke with the Respondent for a few minutes after which they spent approximately five minutes in the examination room (Tr. 110-111).

4. After an examination that took no more than five minutes the Respondent prepared to leave the room. Patient A stopped him and asked him questions about headaches and he responded to her questions for approximately ten to fifteen minutes (Tr. 115-116; 146-147).

5. Patient A recalled that the examination consisted of her moving her arms and that a pin wheel type object was used (Tr. 111-113).

6. Patient A did not recall if a stethoscope was used; whether her height and weight were taken; whether her blood pressure was taken; whether her pulse or temperature were taken; whether a tuning fork was used; whether her abdomen was palpated;

whether she was asked to move her arms against pressure; whether a light was used; whether she was asked to read or smell anything; whether her face was touched; or whether there was any discussion of chemicals in her workplace. She nonetheless testified that the exam was over in approximately five minutes (Tr. 113, 154-155, 158).

7. The Respondent had no recollection of Patient A's examination or how long he spent with Patient A (Tr. 842, 858).

8. The Respondent prepared a report of consultation based on the September 15, 1987 examination. The report purports to reflect a complete consultation, including history, physical examination, neurological examination, and impression, but the Babinski reflex is not mentioned (Pet's. Ex. 2; pp. 3-4).

9. The Respondent's handwritten notes of his examination of Patient A contains none of the findings of physical examination or neurological examination as set out in the consultation report (Pet's. Ex. 2, p. 2).

10. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient A (Tr. 639-640).

11. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient A (Tr. 639-640).

CONCLUSIONS AS TO PATIENT A

The Hearing Committee accepts Patient A's description of the examination performed by the Respondent on September 15, 1987. Despite the fact that she could not remember specific portions of the examination, she was a credible witness. Her description of the examination, particularly the length of time involved, was consistent during direct and cross examination.

An adequate neurological examination could not have been performed in the length of time as testified to by the patient.

The Hearing Committee concludes:

a) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient A.

b) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient A.

c) The Respondent failed to perform an adequate neurologic examination of Patient A.

d) The Respondent knowingly misrepresented, in his report of the neurologic examination of Patient A, that he had performed an adequate neurologic examination.

FINDINGS AS TO PATIENT B

12. Patient B, a 41 year old male, received medical care from the Respondent in the form of a neurologic consultation at the Respondent's office on February 2, 1990 at the request of Progressive Evaluation Services as part of a worker's compensation claim.

The Respondent's responsibility was to comment on the continued need for treatment, the degree of causally related disability, the continued need for physical therapy, the causal relationship between any disability found and the injuries reported, and any other matters deemed relevant. Patient B's chief complaint was of cervical pain following a work related accident (Pet's. Ex. 4, p. 11; Pet's. Ex. 6).

13. During the examination, Patient B took off his shirt and undershirt. The respondent tapped down Patient B's back, using his fingers. Patient B experienced severe pain on two occasions during the examination of his back. The Respondent also used a pinwheel up and down the patient's back, neck and arms. He asked Patient B to describe his symptoms, then took his height and weight. It was not established whether Patient B's blood pressure and temperature were taken (Tr. 45, 47-49, 74).

14. Patient B's time in the examination room was approximately 15-20 minutes (Tr. 49).

15. The Respondent had no independent recollection of Patient B's examination (Tr. 858, 1045, 1067).

16. The Respondent prepared a report of consultation based on the February 2, 1990 examination. The report of consultation purports to reflect a complete consultation, including history, physical examination, neurologic examination and impression, but the Babinski reflex is not mentioned (Pet's. Ex. 4, pp. 2-5; Tr. 452).

17. The neurological consultation report contains numerous findings on physical and neurologic exams not reflected in the Respondent's handwritten notes (Pet's. Ex. 4, pp. 205, 36-37).

18. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient B (Tr. 365-367).

19. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient B (Tr. 365-367).

CONCLUSIONS AS TO PATIENT B

The Hearing Committee accepts Patient B's description of the examination performed by the Respondent on February 2, 1990. Patient B was clear and consistent and he was a credible witness.

An adequate neurological examination could not have been performed in the length of time as testified to by the

patient.

The Hearing Committee concludes:

a) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient B.

b) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient B.

c) The Respondent failed to perform an adequate neurologic examination of Patient B.

d) The Respondent knowingly misrepresented, in his report of the neurologic examination of Patient B, that he had performed an adequate neurologic examination.

FINDINGS AS TO PATIENT C

20. Patient C, a 41 year old female, received medical care from the Respondent in the form of a neurologic consultation at the Respondent's office on March 27, 1990. Patient C's chief complaint was of a headache (Pet's. Ex. 11, pp. 2-3; Pet's. Ex. 12).

21. An examination was performed by the Respondent and he prepared a report of neurological consultation based on the examination (Pet's. Ex. 11, pp. 2-3; Tr. 273, 284).

22. Patient C was fully clothed throughout the

examination, and all aspects of the examination were completed in under fifteen minutes (Tr. 276, 283).

23. The examination consisted essentially of the measurement of her blood pressure and the taking of blood. The Respondent did not use a hammer; have Patient C touch her fingers to her nose; touch her eyes with his fingers; ask her to respond to rapidly alternating movements with his fingers; ask her to stand up; ask her to walk; ask her to walk heel to toe; use a pin device; use a wheel; take her temperature; ask her to move her arms; use a tuning fork; ask her to smell anything; ask her to look at an eye chart; test her vision; test her peripheral vision; use a light in her eyes; darken the room; ask her to focus on anything near or far; touch cotton anywhere on her body; touch her eyelashes; ask her to clamp her jaws; ask her to make any facial expressions; ask her to move her eyelids; ask her to stand on one leg; test her hearing; use a tongue depressor; ask her to taste anything; touch her on her shoulders; touch her on her neck; ask her to stick out her tongue; ask her to move her arms against pressure; ask her to move her legs against pressure; nor feel her abdomen (Tr. 276-284).

24. The Respondent had no independent recollection of Patient C's examination (Tr. 258; 1206).

25. The Respondent prepared a report of neurological consultation based on the March 27, 1990 examination. The report purports to reflect a complete neurologic consultation, including history, physical examination, neurologic examination, and

diagnostic impression but the Babinski reflex is omitted. The Respondent's handwritten notes of the examination contain little of the information reflected in the consultation report (Ex. 11, pp. 2-3).

26. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient C (Tr. 457-458).

27. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient C (Tr. 457).

CONCLUSIONS AS TO PATIENT C

The Hearing Committee accepts Patient C's description of the examination performed by the Respondent on March 27, 1990. Her testimony was definite and consistent.

The Hearing Committee concludes:

a) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient C.

b) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient C.

c) The Respondent failed to perform an adequate neurologic examination of Patient C.

d) The Respondent knowingly misrepresented, in his report of the neurologic examination of Patient C, that he had performed an adequate neurologic examination.

FINDINGS AS TO PATIENT D

28. Patient D, a 34 year old male, received medical care from Respondent in the form of a neurologic consultation at Respondent's office on June 1, 1990. Patient D's chief complaint was of a headache (Pet's. Ex. 9, pp. 10-11; Pet's. Ex. 10).

29. After five or six minutes in the Respondent's office, Patient D and his wife went to the Respondent's examination room where an examination was conducted. The examination was completed in approximately ten minutes (Tr. 231).

30. During the examination the Respondent took Patient D's blood pressure; had Patient D take his shirt and sneakers off; used a hammer on the patient's knees and elbows; had the patient stand up and walk forward with his eyes open. The Respondent also used a pinwheel-type object on the patient's arms and legs. He palpated the patient's shoulders and neck, and asked him to move his hands and legs against resistance. Finally the Respondent palpated the patient's abdomen.

The patient was unsure whether he was asked to walk heel to toe; whether a light was used in his eyes; whether a tongue depressor was used; and whether his temperature or pulse were

taken (Tr. 221-230).

31. During the course of the examination, the Respondent did not ask Patient D to walk erect with eyes closed; to place his arms or legs in a particular position; to smell anything; to focus on any object far or near; to move his eyes to follow a moving object; to stand on one foot; to make any particular facial expression; to taste anything or to stick out his tongue.

A tuning fork was not used; no charts were used to test vision; peripheral vision was not tested; lights in the examination room were not dimmed; no fabrics or materials were used on the skin or eyes; nothing was used to touch the eyes; the eyelids were not touched and hearing was not tested (Tr. 221-230).

32. The Respondent had no independent recollection of Patient D's examination (Tr. 858, 1291).

33. The Respondent prepared a report of neurological consultation based on the June 1, 1990 examination. The report purports to reflect a complete consultation, including history, physical examination, neurological examination, and impression, but the Babinski reflex is omitted (Pet's. Ex. 9, pp. 10-11).

34. Pages eight and thirteen of Patient D's medical record are the handwritten notes made by the Respondent during the examination of June 1, 1990. The report of neurological consultation contains numerous findings on physical and neurological examination not reflected in the Respondent's handwritten notes (Pet's. Ex. 9, pp. 8, 10, 11, 13,).

35. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient D (Tr. 503-504).

36. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient D (Tr. 502-503).

CONCLUSIONS AS TO PATIENT D

The Hearing Committee accepts Patient D's description of the examination performed by the Respondent on June 1, 1990.

Patient D was a credible witness, he was very forthcoming, and he readily admitted when his recollection was unclear.

The Hearing Committee concludes:

a) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient D.

b) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient D.

c) The Respondent failed to perform an adequate neurologic examination of Patient D.

d) The Respondent knowingly misrepresented, in his report of the neurologic examination of Patient D, that he had performed an adequate neurologic examination.

FINDINGS AS TO PATIENT E

37. Patient E, a 26 year old female, received medical care from the Respondent in the form of an initial neurologic consultation at the Respondent's office on June 21, 1990. Patient E's chief complaint was of a headache, dizziness, nausea, and double vision following head trauma (Pet's. Ex. 7, pp. 7, 9).

38. Patient E went into the Respondent's examination room for an examination that lasted approximately ten minutes. She sat on the examination table for most of the ten minutes that she was in the room. She briefly walked heel to toe across the room; she touched her nose with her finger; she was pricked by a pin; and the Respondent shone a light in her eyes (Tr. 173, 175).

39. The Respondent did not ask Patient E to remove any clothing; to read anything; to smell anything or to move her limbs in any position. He did not take her blood pressure or examine her abdomen and she did not lie down at any time during the examination (Tr. 175-176, 188-189; 192).

40. The Respondent had no independent recollection of Patient E's examination (Tr. 858, 1328-1329).

41. The Respondent prepared a report of his initial neurologic consultation with Patient E, based on the June 21,

1990 examination (Pet's. Ex. 7, pp. 10-11).

42. The report for Patient E purports to reflect a complete consultation, including history, physical examination, neurologic examination and impression, but the Babinski reflex was omitted (Tr. 454).

43. Pages four and five of Patient E's medical record are the handwritten notes made by the Respondent of the June 21, 1990 examination. The report of consultation contains much information not reflected in the handwritten notes (Pet's. Ex. 7, pp. 4-5, 10-11).

44. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient E (Tr. 536-541).

45. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient E (Tr. 534-536, 1338).

CONCLUSIONS AS TO PATIENT E

The Hearing Committee accepts Patient E's description of the examination performed by the Respondent on June 21, 1990.

Patient E was a very credible witness and had a specific recollection of most of the details of what was and what was not done during the course of the examination. She also had a

specific recollection of the time it took for the Respondent to conduct the examination.

The Hearing Committee concludes:

a) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient E.

b) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient E.

c) The Respondent failed to perform an adequate neurologic examination of Patient E.

d) The Respondent knowingly misrepresented, in his report of the neurologic examination of Patient E, that he had performed an adequate neurologic examination.

FINDINGS AS TO PATIENT F
(Neurological Examination)

46. Patient F, a 56 year old female, received medical care from the Respondent in the form of an initial neurologic consultation at the Respondent's office on June 20, 1989. Patient F's chief complaint was of pain over the right lower rib region (Pet's. Ex. 13, pp. 1-2; Tr. 311).

47. During the course of the examination, the Respondent palpated Patient F's abdomen; he looked into her eyes

with a light and had her move her legs. He also drew blood and at some point during the examination he dimmed the room lights (Tr. 323-326).

48. The Respondent did not take the patient's blood pressure; use a stethoscope; check her heartbeat; tap with his fingers on her chest; have her disrobe; take her pulse; take her temperature; use a hammer to test reflexes; ask her to touch her fingers to her nose; ask her to tough her fingers to Respondent's fingers; have her stand; have her walk heel to toe; use a pin; ask her to position her limbs in any particular position; use a tuning fork; ask her to smell anything; ask her to taste anything; use a chart to test her vision; test her peripheral vision; ask her to focus on anything near or far; use fabric or cotton to touch her skin or eyes; ask her to make facial expressions; ask her to move her eyelids; test her hearing; use a tongue depressor; touch her neck or shoulders; have her stick her tongue out; or have her move her arms against pressure (Tr. 318-326; 408-413).

49. Patient F was in the examination room for fifteen to twenty minutes, including the time it took to draw blood (Tr. 327).

50. The Respondent had no independent recollection of Patient F's examination but he did recall two phone calls with the patient (Tr. 401, 858).

51. The Respondent prepared a report of consultation based on the June 20, 1989 examination (Pet's. Ex. 13, pp. 102).

52. The Respondent's handwritten notes of the

examination contain little or the information that is reflected in the report of consultation (Pet's. Ex. 13; pp, 1-2, 3).

53. The report for Patient F purports to reflect a complete neurologic consultation, including history, physical examination, neurological examination, and impression, but the Babinski reflex was omitted (Tr. 454).

54. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient F (Tr. 566-570).

55. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient F (Tr. 567-568).

FINDINGS AS TO PATIENT F
(Dilantin Issue)

56. Dilantin is an anti-convulsant medication used in attempts at pain control in neuritic situations where there may be inflammatory nerve pain. The usual adult initial dosage is 200 or 300 milligrams a day (Resp's. Ex. F; Tr 573).

57. Side effects of Dilantin are dose related and consist of symptoms of toxicity, usually beginning with some unsteadiness or blurring of the vision, balance difficulty and progressing more severely to coordination problems, gait difficulties, and nystagmus, with accompanying problems with eyesight (Resp's. Ex. F; Tr. 573-574).

58. On June 20, 1989 the Respondent prescribed Dilantin 100 mg., to be taken three times a day, for Patient F. The patient took the medication as prescribed on June 20, June 21 and the morning of June 22 (Pet's. Ex. 13, p. 2; Tr 337-338).

59. On the morning of June 22, 1989, Patient F spoke to Respondent by telephone. The Respondent doubled the dose of Dilantin to 600 mg. a day, to be taken 200 mg., three times a day (Tr. 337-338, 1385).

60. Patient F took the Dilantin as prescribed, 200 mg. three times a day, from the middle of June 22 through June 27 (Tr. 338).

61. Dilantin 600 mg./day, is a loading dose, and any patient receiving such a dose should take that amount for only two to three days. After that time the patient may experience symptoms of toxicity (Tr. 575-576).

62. A serum level should be taken at the first sign of toxicity (Tr. 578).

63. At her visit on June 27, 1989, Patient F complained of a burning sensation and feeling light-headed and tired (Pet's. Ex. 13, p. 4).

64. The Respondent's records indicate that on June 27, 1989, he decreased Patient F's dosage of Dilantin from 600 mg./day to 400 mg./day and prescribed Lioresal. After her office visit on June 27, 1989, Patient F remained on at least 400 mg. of Dilantin.

On July 1, 1989, Patient F was seen at the Emergency Room at

Good Samaritan Hospital, Suffern, New York. She complained of palpitations and light headedness and disclosed hives on the face and arms. The final diagnosis was drug reaction (Pet's. Ex. 13, p. 4; Pet's. Ex. 14, p. 2; Tr. 339).

CONCLUSIONS AS TO PATIENT F

The Hearing Committee accepts Patient F's description of the examination performed by the Respondent on June 20, 1989.

Patient F was a credible witness who had a specific recollection of the details of the examination and the amount of time it took to conduct it.

The Hearing Committee concludes:

a) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient F.

b) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient F.

c) The Respondent failed to perform an adequate neurologic examination of Patient F.

d) The Respondent knowingly misrepresented, in his report of the neurologic examination of Patient F, that he had performed an adequate neurologic examination.

e) The Respondent, after prescribing Dilantin for

Patient F, failed to monitor Patient F's serum level for Dilantin toxicity.

f) The Respondent, after having been informed that Patient F was experiencing symptoms of Dilantin toxicity, failed to appropriately treat Patient F.

FINDINGS AS TO PATIENT G

66. Patient G, a 59 year old male, was admitted to the Good Samaritan Hospital in Suffern, New York, on April 17, 1989 due to complaints of dizziness. Patient G received medical care from Respondent in the form of neurologic consultation and follow-up on April 17, 18 and 19, 1988 (Pet's. Ex. 20, pp. 1, 7).

67. The Respondent's examination of Patient G took approximately five to seven minutes, during which the Respondent asked Patient G to follow the Respondent's moving finger. He also tapped Patient G's knees with his finger (Tr. 904-905).

68. The Respondent had no independent recollection of the examination he performed on Patient G on April 17, 1988 (Tr. 1484, 1488).

69. The Respondent prepared a handwritten consultation note regarding Patient G which purports to reflect a complete consultation, including history, physical examination, and impression. The handwritten consultation contains no reference to muscle wasting or fasiculations, testing of smell or testing of hearing. It does contain a reference to the patient's Babinski response (Pet's. Ex. 20, p. 24).

70. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient G.

71. The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient G.

72. The Respondent visited Patient G again on April 18 and 19, 1988. The Respondent's notes of these visits are documented in the Good Samaritan Hospital record (Pet's. Ex. 20, pp. 17-18).

73. The Respondent spent only a minute or two with Patient G on these follow-up visits (Tr. 912, 947).

74. The Respondent had no independent recollection of the length of time he spent with Patient G on the follow-up visits (Tr. 1493).

CONCLUSIONS AS TO PATIENT G

The Hearing Committee accepts Patient G's description of the examination performed by the Respondent on April 17, 1988. The Hearing Committee also accepts his description of the Respondent's follow-up visits on April 18 and 19, 1988.

Patient G was a credible witness. He was observant, articulate and obviously paid attention to details.

The Hearing Committee concludes:

a) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered in a neurologic consultation such as described by Patient G.

b) The report of consultation, including neurologic examination section, could not have accurately reflected information gathered during an examination of the duration described by Patient G.

c) The Respondent failed to perform adequate neurologic examination of Patient G on April 17, April 18 and/or April 19, 1988.

d) The Respondent knowingly misrepresented, in his notes of the neurologic examinations of April 17, April 18 and/or April 19, 1988, that he had performed adequate neurologic examinations.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous (3-0) unless otherwise specified)

FIRST THROUGH SEVENTH SPECIFICATIONS (Practicing the profession fraudulently)

SUSTAINED as to those charges specified in paragraphs A-A2, B-B2, C-C2, D-D2, E-E2, F-F2 and G-G2 of the Statement of Charges.

NOT SUSTAINED as to those charges specified in paragrpahs A-A1, B-B1, C-C1, D-D1, E-E1, F-F1 and G-G1 of the

Statement of Charges.

EIGHTH SPECIFICATION (Negligence on more than one occasion)

SUSTAINED as to all of the charges specified in the Statement of Charges.

NINTH SPECIFICATION (Incompetence on more than one occasion)

NOT SUSTAINED as to any of the charges specified in the Statement of Charges.

TENTH THROUGH SIXTEENTH SPECIFICATION (Failing to maintain an accurate record)

SUSTAINED as to all of the charges specified in the Statement of Charges.

HEARING COMMITTEE DETERMINATION

The Hearing Committee found Patients A, B, C, D, E, F and G to be credible witnesses. None of the patients knew each other; they testified about independent incidents and they had no apparent reason to conspire against the Respondent. There is no indication that the patients' testimony was tainted in any way or that it was the result of improper motive. Their testimony was consistent and remained so during extensive direct and cross examination.

On the other hand, the Hearing Committee found the Respondent's testimony to be evasive and self serving. His

appointments schedule, which records appointments at fifteen minute intervals contradicts his testimony that he allocated forty-five minutes to one hour to new patients.

The Hearing Committee has considered the recurring similarity of the testimony of all of the patients who appeared before the Committee as to the type of examination conducted by the Respondent, the duration of the examinations and the identical wording of the neurological reports for Patients A, B, C, D, E and F.

In deliberating on this case, the Hearing Committee has taken into consideration the amount of time which has elapsed since the reported incidents occurred and has determined that the time lapse has not affected the patients' memories so as to undermine their essential credibility.

The Hearing Committee is also aware of the testimony concerning billing and declassification of disability issues and has discounted such testimony as irrelevant to the charges.

The Hearing Committee has determined that the appropriate penalty in this case should be a suspension of licensure and a fine as follows:

The Respondent's license to practice medicine in the State of New York should be suspended for two years. The last twenty-one months of said suspension is stayed, three months actual suspension.

A fine is assessed against the Respondent as follows:

1. $5,000.00 for each of seven specifications of

practicing the profession fraudulently, $5,000.00 x 7 = $35,000.00.

2. $3,000.00 for one specification of negligence on more than one occasion.

3. $1,000.00 for each of seven specifications of failing to maintain an accurate record, $1,000.00 x 7 = $7,000.00.

Total fine - $45,000.00.

ORDER

It is hereby ORDERED that

1. The Respondent's license to practice medicine in the State of New York is **SUSPENDED** for a period of two years, the last twenty-one months of said suspension is **STAYED**, three month actual suspension.

2. A fine in the amount of forty-five thousand ($45.000.00) dollars is imposed upon the Respondent. Payment of the fine shall be made within thirty (30) days of the effective date of this ORDER to the New York State Department of Health, Bureau of Accounts Management, Corning Tower Building, Room 1344, Empire State Plaza, Albany, New York, 12237.

3. This ORDER shall be effective upon service on the Respondent or the Respondent's attorney by personal services or by certified or registered mail.

DATED: Schenectady, New York
SEPTEMBER 30, 1993

DAVID T. LYON, M.D.
CHAIRMAN

BENJAMIN WAINFELD, M.D.
ROBIN N. BUSKEY, R.P.A.

ANY CIVIL PENALTY NOT PAID BY THE DATE PRESCRIBED HEREIN SHALL BE SUBJECT TO ALL PROVISIONS OF LAW RELATING TO DEBT COLLECTION BY THE STATE OF NEW YORK. 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 §171(27); STATE FINANCE LAW §18; CPLR §5001; EXECUTIVE LAW §32).

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

----------X

	:	AMENDED
IN THE MATTER	:	STATEMENT
OF	:	OF
WALTER L. NIEVES, M.D.	:	CHARGES

----------X

WALTER L. NIEVES, M.D., the Respondent, was authorized to practice medicine in New York State on October 28, 1977, by the issuance of license number 132973 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from Tallman Medical Center, 11 North Airmont Road, Suffern, New York 10901-5103.

FACTUAL ALLEGATIONS

A. Patient A (patients are identified in the Appendix), a 38 year old female, received medical care from Respondent in the form of a neurologic consultation at the Respondent's office at Tallman Medical Center, 11 North Airmont Road, Suffern, New York 10901 (hereafter "Respondent's office") on or about

September 15, 1987. Patient A's chief complaint was of a headache.

1. Respondent failed to perform an adequate neurologic examination of Patient A.
2. Respondent knowingly misrepresented, in his report of the neurologic examination of Patient A, that he had performed an adequate neurologic examination.

B. Patient B, a 41 year old male, received medical care from Respondent in the form of a neurologic consultation at Respondent's office on or about February 2, 1990. Patient B's chief complaint was of cervical pain following a work related accident.

1. Respondent failed to perform an adequate neurologic examination of Patient B.
2. Respondent knowingly misrepresented, in his report of the neurologic examination of Patient B, that he had performed an adequate neurologic examination.

C. Patient C, a 41 year old female, received medical care from Respondent in the form of a neurologic consultation at the Respondent's office on or about March 27, 1990. Patient C's chief complaint was of a headache.

1. Respondent failed to perform an adequate neurologic examination of Patient C.

2. Respondent knowingly misrepresented, in his report of the neurologic examination of Patient C, that he had performed an adequate neurologic examination.

D. Patient D, a 34 year old male, received medical care from Respondent, in the form of a neurologic consultation at Respondent's office, on or about June 1, 1990. Patient D's chief complaint was of a headache.

1. Respondent failed to perform an adequate neurologic examination of Patient D.

2. Respondent knowingly misrepresented, in his report of the neurologic examination of Patient D, that he had performed an adequate neurologic examination.

E. Patient E, a 26 year old female, received medical care from Respondent in the form of a neurologic consultation at Respondent's office on or about June 21, 1990. Patient E's chief complaint was of a headache.

1. Respondent failed to perform an adequate neurologic examination of Patient E.

2. Respondent knowingly misrepresented, in his report of the neurologic examination of Patient E, that he had performed an adequate neurologic examination.

F. Patient F, a 56 year old female, received medical care from Respondent in the form of a neurologic consultation at Respondent's office on or about June 20, 1989. Patient F's chief complaint was of pain over the right lower rib region.

1. Respondent failed to perform an adequate neurologic examination of Patient F.

2. Respondent knowingly misrepresented, in his report of the neurologic examination of Patient F, that he had performed an adequate neurologic examination.

3. Respondent, after prescribing Dilantin for Patient F, failed to monitor Patient F's serum level for Dilantin toxicity.

4. Respondent, after being informed that Patient F was experiencing side effects identical to those of Dilantin toxicity, failed to appropriately treat Patient F.

G. Patient G, a 59 year old male, was admitted to the Good Samaritan Hospital, Suffern, New York, (hereafter, "the Hospital") on April 17, 1988 due to complaints of dizziness. Patient G received medical care from Respondent in the form of neurologic consultations at the Hospital on April 17, 18 and 19, 1988.

1. Respondent failed to perform adequate neurologic examinations of Patient G on April 17, April 18 and/or April 19, 1988.

2. Respondent knowingly misrepresented, in his notes of the neurologic examinations of April 17, April 18 and/or April 19, 1988, that he had performed adequate neurologic examinations.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with professional misconduct by reason of practicing the profession of medicine fraudulently, within the meaning of N.Y. Educ. Law §6530(2) (McKinney Supp, 1992), in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and A and A.2.
2. The facts in Paragraphs B and B.1 and B and B.2.
3. The facts in Paragraphs C and C.1 and C and C.2.
4. The facts in Paragraphs D and D.1 and D and D.2.
5. The facts in Paragraphs E and E.1 and E and E.2.
6. The facts in Paragraphs F and F.1 and F and F.2.
7. The facts in Paragraphs G and G.1 and G and G.2.

EIGHTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law §6530(3) (McKinney Supp. 1992), in that Petitioner charges that Respondent committed two or more of the following:

8. The facts in Paragraphs A and A.1, B and B.1, C and C.1, D and D.1, E and E.1, F and F.1, F and F.3, F and F.4, and/or G and G.1.

NINTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law §6530(5) (McKinney Supp. 1992), in that Petitioner charges that Respondent committed two or more of the following:

9. The facts in Paragraphs A and A.1, B and B.1, C and C.1, D and D.1, E and E.1, F and F.1, F and F.3, F and F.4, and/or G and G.1.

TENTH THROUGH SIXTEENTH SPECIFICATIONS

FAILING TO MAINTAIN AN ACCURATE RECORD

Respondent is charged with professional misconduct by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Educ. Law §6530(32) (McKinney Supp. 1992), in that Petitioner charges:

10. The facts in Paragraphs A and A.2.

11. The facts in Paragraphs B and B.2.

12. The facts in Paragraphs C and C.2.

13. The facts in Paragraphs D and D.2.

14. The facts in Paragraphs E and E.2.

15. The facts in Paragraphs F and F.2.

16. The facts in Paragraphs G and G.2.

DATED: Albany, New York
February 22, 1993

Peter D. Van Buren

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

PROBATION TERMS SET BY THE

DIRECTOR OF THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT

FOR

WALTER NIEVES, M.D.

NEW YORK MEDICAL LICENSE # 132973

PURSUANT TO ORDER # 93-167 of the

ADMINISTRATIVE REVIEW BOARD

1. ♦ Respondent will meet with a member of the Office of Professional Medical Conduct staff on a schedule determined by the Director or designee.

2. ♦ Respondent will conform fully (A) to the professional standards of conduct imposed by law and by his profession (B) with all civil and criminal laws, rules and regulations.

3. ♦ Respondent will notify the Office of Professional Medical Conduct of:

   (A) any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within thirty days of each action;

   (B) any and all changes in personal and professional addresses and telephone numbers and facility affiliations, within thirty days of each action; this will include any change in practice location, within or outside of the State of New York. The date of departures and the date of return, if any, must be reported in writing.

4. ♦ A violation of any aspect of the terms of probation shall be considered professional misconduct, pursuant to Section 230 of the Public Health Law and Section 6530 of the Education Law.

5. ♦ Respondent's practice of medicine shall be monitored as described in Attachment A.

PRACTICE MONITOR

- Respondent's practice of medicine shall be monitored by a physician monitor, board certified in neurology ("practice monitor") approved in advance, in writing, by the Director of the Office of Professional Medical Conduct. Respondent may not practice medicine until an approved practice monitor and monitoring program is in place. Any practice of medicine prior to the submission and approval of a proposed practice monitor will be determined to be a violation of probation.

  a. The practice monitor shall report in writing to the Director of the Office of Professional Medical Conduct or her designee, on a schedule to be determined by the Office. The practice monitor shall visit Respondent's medical practice at each and every location, on a random basis and shall examine a random selection of records maintained by Respondent, including patient histories, prescribing information and billing records. Respondent will make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. 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 immediately be reported to the Office of Professional Medical Conduct by the monitor.

  b. Any change in practice monitor must be approved in writing, in advance, by the Office of Professional Medical Conduct.

  c. All expenses associated with monitoring, including fees to the monitoring physician, shall be the sole responsibility of the Respondent.

  d. It is the responsibility of the Respondent to ensure that the reports of the practice monitor are submitted in a timely manner. A failure of the practice monitor to submit required reports on a timely basis will be considered a possible violation of the terms of probation.

  e. Respondent must maintain medical malpractice insurance coverage with limits no less than $2 million dollars per occurrence and $6 million dollars per policy year, in accordance with Section 230 (18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director or her designee prior to the placement of a practice monitor.

  f. Medical record reviews and/or random office audits at any or all of the Respondent's practice locations, may be conducted by the Office of Professional Medical Conduct, at the Director's discretion.