STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

November 18, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ira M. Maurer, Esq.
Law Offices of Elkind, Flynn & Maurer, P.C.
11 Martine Avenue, Penthouse
White Plains, New York 10606

Perry Orens, M.D.
Redacted Address

Leslie Eisenberg, Esq.
Assistant Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Suite 601
New York, New York 10001

Perry Orens, M.D.
Redacted Address

RE: In the Matter of Perry Orens, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 99-285) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct

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

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above. As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

transcript(s) and all documents in evidence.

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

Sincerely,

Redacted Signature

Tyrone T. Butler, Director
Bureau of Adjudication

TTB: mla

Enclosure

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

COPY

IN THE MATTER
OF
PERRY ORENS, M.D.

DETERMINATION
AND
ORDER

BPMC 99- 285

FRANK E. IAQUINTA, M.D., (Chair), **NISHA K. SETHI, M.D.**, and **MICHAEL A. GONZALEZ, R.P.A.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE ("ALJ"), served as the Administrative Officer.

The Department of Health appeared by **HENRY M. GREENBERG, ESQ.**, General Counsel, by **LESLIE EISENBERG, ESQ.**, Assistant Counsel.

Respondent, **PERRY ORENS, M.D.**, appeared personally and was represented by **ELKIND, FLYNN & MAURER, P.C., IRA M. MAURER, ESQ.**, of counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceedings were made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

patient[6]; and professional misconduct by reason of failing to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient[7]. In order to expedite the proceeding, limit repetitious testimony and conserve resources, the ALJ reduced the number of patients for whom evidence would be received from ten (10) to six (6). The Hearing Committee was informed of the ALJ's ruling on June 22, 1999 [T-183-184][8].

The charges brought forward from the Department concern the medical care, treatment and services provided by Respondent to ten (10) patients (A through J)[9]. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

Respondent admits to being licensed to practice medicine in New York and admits that he treated all of the patients indicated in the Statement of Charges. Respondent denies the remainder of the Statement of Charges. Respondent denies each specification of misconduct (Respondent's Exhibit # A).

The Hearing consisted of seven (7) separate days. The Department called one (1) witness. The Respondent called four (4) witnesses, including himself.

---

[6] Education Law § 6530(35) and Twenty-Fourth through Thirty-Third Specifications of Department's Exhibit # 1.

[7] Education Law § 6530(32) and Thirty-Fourth Specification of Department's Exhibit # 1(10 patients).

[8] Numbers in brackets refer to Hearing transcript page numbers [T-]; to Pre-Hearing transcript page numbers [P.H.T-] or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee did not review the Pre-Hearing or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

[9] Patients are identified in an Appendix to the Statement of Charges, Department's Exhibit # 1.

PROCEDURAL HISTORY

Date of Notice of Hearing:	April 14, 1999
Date of Service of Notice of Hearing:	April 19, 1999
Date of Statement of Charges:	April 13, 1999
Date of Service of Statement of Charges:	April 19, 1999
Answer to Statement of Charges:	May 27, 1999
Pre-Hearing Conference Held:	June 7, 1999
Hearings Held: - (First Hearing day):	June 8, 1999
June 22, 1999; June 30, 1999; July 07, 1999; July 14, 1999; July 19, 1999; August 11, 1999	
Petitioner's Proposed Findings of Fact, Conclusions of Law and Sanction:	Received September 16, 1999
Respondent's Proposed Findings of Fact And Conclusions of Law:	Received September 23, 1999
Deliberations Held: - (Last Hearing day):	October 06, 1999

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. **Where there was conflicting evidence or testimony, the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence.** All Findings and Conclusions herein were unanimous. The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was licensed to practice medicine in New York State on June 23, 1959 by the issuance of license number 082198 by the New York State Education Department (Department's Exhibits # 1 and # 2); (Respondent's Exhibits # A and # K)[10].

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period of May 1, 1998 through April 30, 2000 (Department's Exhibits # 1 and # 2).

3. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent had no objection regarding personal service effected on him); (P.H.L. §230[10][d]); (Department's Exhibit # 1); [P.H.T-6-7].

PATIENT A

4. Respondent treated Patient A from January 13, 1994 through August 1996, at Respondent's office in Great Neck, NY (Department's Exhibits # 3-A, 3-B and 3-C).

5. At the initial consult on January 13, 1994, Respondent noted that Patient A complained of non-specific symptoms including confusion, fatigue and aches, and he noted that Patient A had a rash the previous year (Department's Exhibit # 3-A); [T-94-96].

6. Respondent failed to take and/or note an adequate history in that he failed to elicit and document details relevant to Patient A's complaint of confusion, fatigue and aches, including but not limited to, the time frame, duration, complicating features and presenting features of the complaints. Respondent failed to note pertinent positives and pertinent negatives. Respondent failed to perform and

---

[10] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit) or submitted by Dr. Perry Orens (Respondent's Exhibit).

document a directed review of systems associated with the patient's complaints and failed to develop a focused history to narrow down the possible causes of Patient A's fatigue, aches and confusion. Respondent failed to address each of Patient A's complaints [T-20-21, 44, 94-96, 98-107, 110-112, 122-128].

7. Respondent repeatedly failed to take and/or note adequate follow-up histories at Patient A's subsequent visits. For example, on March 4, 1994, Respondent failed to note any follow-up on Patient A's complaint of chest and knee pain. On March 14, 1994, Respondent failed to note any details regarding Patient A's complaint of dizziness and chest pain. On May 25, 1994, Respondent failed to note any details regarding Patient A's complaint of weak legs. On June 1, 1994, Respondent failed to note any details regarding the patient's complaint that she feels "awful" and, on August 1, 1994, Respondent failed to note any detail regarding Patient A's rash and fever. Respondent made no attempt to determine the etiology of these complaints, to determine if they were adverse reactions to the medications and, he failed to connect them in any meaningful way to any other complaint Patient A expressed (Department's Exhibit # 3-A); [T-110-112, 122-123, 235-248].

8. Respondent failed to perform and/or note an appropriate physical examination by failing to examine the organ systems related to Patient A's presenting complaint of fatigue, aches and confusion. Although Respondent noted some elements of an examination including blood pressure and no heart murmur, Respondent failed to perform and/or note a skin examination, a neurologic examination, a joint examination and an examination of the muscular system (Department's Exhibit # 3-A); [T-100-106, 111, 119, 129].

9. Respondent failed to evaluate Patient A appropriately for Lyme disease. The history and physical examination of Patient A, as documented by Respondent, is insufficient to support a clinical diagnosis for Patient A [T-105-108, 113, 118-121].

10. Respondent failed to diagnose Patient A appropriately. There is no clear diagnosis documented in the medical records of Patient A (Department's Exhibit # 3-A); [T-105-108, 113-118].

11. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease. Patient A's complaints of fatigue, aches and confusion could be associated with conditions, including but not limited to, thyroid disease, lupus, arthritis, allergies, mitral valve prolapse, subacute bacterial endocarditis, TB, AIDS, hepatitis, vascular disease, endocrinological abnormalities, diabetes and/or other infectious diseases [T-99, 103, 105, 108-110, 118, 119, 132].

12. There are no documented objective findings in Patient A's medical records to support a diagnosis of active Lyme disease. It was inappropriate for Respondent to treat Patient A for Lyme disease and it was inappropriate for Respondent to treat Patient A with parenteral therapy [T-251-253].

13. Respondent treated Patient A for Lyme disease when in fact he did not diagnose Patient A with Lyme disease or rule out other causes [T-117, 118, 120-121].

14. At the time Respondent began treating Patient A, there were no clear exigent circumstances to warrant his treating the patient before completing a diagnosis [T-112-115].

15. Respondent inappropriately treated Patient A with doxycycline, claforan, rocephin, bicillin, primaxin and suprax (Department's Exhibits # 3-A and 3-B); [T-117, 252-253].

16. Respondent inappropriately treated Patient A by prescribing and maintaining her on parenteral antibiotic therapy (Department's Exhibits # 3-A and 3-B); [T-117, 252-253, 274-275].

17. Respondent failed to monitor Patient A appropriately during the course of treating her [T-80, 83, 126-135].

18. Respondent failed to follow-up appropriately on abnormal laboratory results by failing to determine the cause of Patient A's continually abnormal liver function tests [T-132-135, 255].

19. Respondent failed to follow-up appropriately when Patient A developed adverse reactions to administered therapy. For example, on March 14, 1994, when Patient A complained of chest pain, which could have been a myocardial infarction but could also have been associated with her medication, Respondent failed to examine her, failed to characterize the pain and, failed to order appropriate tests to aid in determining the cause of the chest pain (Department's Exhibit # 3-A); [T-122-123, 128-129, 132, 134-135].

20. Respondent inappropriately ordered, without justification, 26 Lyme serologies for Patient A, from eight different laboratories. There was no justifiable reason to order this number of tests in a short period of time and there was no medical rationale to continue ordering serologies throughout the course of treatment [T-135-139, 256-261].

21. Respondent ordered thyroid tests in an untimely fashion for Patient A and then inappropriately repeated the tests when her results were normal [T-135, 137].

22. Respondent failed to perform or note a lumbar puncture to determine if Patient A had central nervous system involvement (Department's Exhibits # 3-A and 3-B); [T-105, 123, 132, 134, 137, 262].

23. Respondent provided treatment to Patient A and ordered testing for Patient A that he knew, or should have known, was not warranted by Patient A's condition (Department's Exhibits # 3-A, 3-B and 3-C); [T-119, 135-137].

24. Respondent failed to maintain records for Patient A that accurately reflect the treatment and care rendered to the patient. For example, Respondent failed to clearly document an evaluation and treatment plan for the patient. Additionally, it is not possible to determine from Respondent's records what medication he ordered for Patient A, when the medication was changed, the reason for changing

medications and, the duration of therapy (Department's Exhibits # 3-A, 3-B and 3-C); [T-20-21, 44, 94-107, 110-112, 122-128, 139, 140, 605-607, 609-614, 642-643, 912-915].

PATIENT B

25. Respondent treated Patient B from August 17, 1995 through July 1996, at Respondent's office (Department's Exhibits # 4-A and 4-B).

26. Respondent failed to take and/or note an adequate history in that he failed to clearly document a chief complaint, a focused history of the present illness, pertinent negatives and pertinent positives. Respondent failed to note any information regarding a tick bite and/or a rash, significant factors for Lyme disease. Respondent failed to follow-up on the patient's reported thyroid problem including failing to ask questions regarding the endocrine system such as sensitivity to heat and cold and changes in her menstrual cycle. Respondent failed to document any detail regarding Patient B's use of antidepressants. Respondent failed to note the reason for the prior treatment of amoxicillin for ten days (Department's Exhibits # 4-A and 4-B); [T-278-279, 281-282, 285-286, 300, 309].

27. Respondent failed to perform and/or note an appropriate physical examination. Respondent failed to examine Patient B's eyes and her neurologic system, to evaluate her complaints of headaches and double vision. Respondent failed to examine Patient B's chest or cardiac system, to evaluate her reported cardiac problems including tachycardia. Respondent failed to examine Patient B's musculoskeletal system and nervous system, to evaluate Patient B's complaints of knee pain and weakness (Department's Exhibits # 4-A and 4-B); [T-279-282, 285-286, 310].

28. Respondent repeatedly failed to take and/or note adequate follow-up histories and failed to perform and/or note appropriate follow-up physical examinations on Patient B's subsequent visits (Department's Exhibit # 4-A); [T-278-280].

29. Respondent failed to evaluate Patient B appropriately and he diagnosed Lyme disease inappropriately by failing to complete an appropriate history and physical examination in a systematic way. There is no evidence in the record to support a clear diagnosis of Lyme disease [T-281-282, 297, 750].

30. Respondent failed to appropriately rule out differential diagnoses for Patient B. Depression and thyroid disease could be associated with some of Patient B's complaints, including fatigue and joint pain. Diabetes is another alternative diagnosis that could cause Patient B's elevated blood glucose. Respondent failed to evaluate Patient B for any conditions other than Lyme disease [T-281-282, 293, 304].

31. Respondent inappropriately prescribed parenteral therapy for Patient B without documented evidence of central nervous system infection [T-282-283, 300-301].

32. Respondent inappropriately treated Patient B with rocephin, doxycycline, biaxin, bicillin and suprax (Department's Exhibits # 4-A and 4-B); [T-303].

33. Respondent inappropriately treated Patient B, a young female with elevated liver function, with doxycycline. Doxycycline, a tetracycline, is contraindicated in people with liver conditions and should not be used if a woman is pregnant or planning to become pregnant [T-286-289, 719, 768].

34. Respondent ordered excessive courses of antibiotic therapy (Department's Exhibits # 4-A and 4-B); [T-303].

35. Respondent inappropriately ordered multiple Lyme serologies without medical indication (Department's Exhibits # 4-A and 4-B); [T-289, 297-298].

36. Respondent failed to perform or note the necessary diagnostic test of a lumbar puncture to rule out evidence of central nervous system involvement (Department's Exhibits # 4-A and 4-B).

37. Diplopia, especially as associated with Lyme disease, can be a significant problem and requires evaluation. Patient B complained of double vision at her initial consult, and throughout treatment. Respondent failed to examine Patient B and document findings regarding her vision problem. Respondent did refer Patient B to an ophthalmologist, but Respondent failed to appropriately follow-up to obtain the results of the ophthalmology consult (Department's Exhibit # 4-A); [T-290-292].

38. Respondent failed to perform and document a neurologic examination of Patient B and he failed to refer Patient B for an appropriate neurologic evaluation [T-279-280, 290-292].

39. Although Respondent noted that Patient B was taking prescription antidepressants, Respondent failed to follow-up with Patient B's psychiatrist and failed to evaluate or monitor Patient B's use of antidepressant medications (Department's Exhibit # 4-A); [T-281, 292-293].

40. Respondent provided treatment to Patient B and ordered testing for Patient B that he knew, or should have known, was not warranted by Patient B's condition (Department's Exhibits # 4-A and 4-B).

41. Respondent failed to maintain records that accurately reflect the care and treatment rendered to Patient B. Respondent repeatedly failed to document what medications he ordered, when and why they were stopped and, when and why they were restarted (Department's Exhibits # 4-A and 4-B); [T-293].

PATIENT C

42. Respondent treated Patient C from August 16, 1995 through October 1995, at Respondent's office (Department's Exhibits # 5-A and 5-B).

43. At the consult visit on August 16, 1995, Respondent noted a prior history of Lyme disease and a "typical rash again" in May. Respondent also listed symptoms reported by Patient C including upper respiratory infection all the time, pain in knees with slight swelling, fatigue, headaches and memory problems (Department's Exhibit # 5-A).

44. Respondent failed to take an adequate history by failing to indicate a chief complaint, failing to document a detailed history of Patient C's presenting illness, failing to develop the complaints, and failing to determine any relationship between the complaints (Department's Exhibit # 5-A); [T-308-309].

45. Respondent failed to perform and/or note an appropriate physical examination. Even though Patient C complained of neurologic related problems including headaches and memory impairment, Respondent failed to perform a neurologic examination. Even though Patient C complained of joint pain, specifically a swollen knee, Respondent failed to examine her musculoskeletal system, particularly her knee (Department's Exhibit # 5-A); [T-310-311].

46. Respondent repeatedly failed to take and/or note adequate follow-up histories and failed to perform and/or note appropriate follow-up physical examinations for Patient C (Department's Exhibits # 5-A and 5-B).

47. Respondent failed to appropriately evaluate Patient C for active/ongoing Lyme disease. Based on Patient C's history of Lyme disease and complaints of neurologic related problems, Respondent should have performed an appropriate neurologic evaluation. Respondent failed to conduct a neurologic evaluation of Patient C and Respondent failed to refer her for a neurologic evaluation. Patient C's complaints could be associated with rheumatologic conditions such as rheumatoid arthritis or lupus, and

Respondent should have performed a rheumatologic evaluation of Patient C. Respondent failed to perform a rheumatologic evaluation and he failed to refer Patient C for a rheumatologic evaluation (Department's Exhibits # 5-A and 5-B); [T-309-313, 318].

48. Respondent failed to appropriately rule out differential diagnoses for Patient C, whose complaints of fatigue, headaches and joint pains could be associated with a broad array of possible diagnoses including lupus, rheumatoid arthritis, other rheumatoid conditions, osteoarthritis, and depression [T-311-312, 323-324].

49. Respondent inappropriately treated Patient C without clearly documented objective findings to support a diagnosis of Lyme disease [T-313-314, 321-325].

50. Respondent inappropriately prescribed parenteral antibiotics therapy, without evidence of active infection. There is too little data in the medical records of Patient C to support any diagnosis (Department's Exhibits # 5-A and 5-B); [T-313-314, 321-325].

51. Respondent inappropriately treated Patient C with rocephin and with oral antibiotics (Department's Exhibits # 5-A and 5-B); [T-313-314, 321].

52. Respondent inappropriately ordered multiple Lyme serologies and multiple blood chemistries without documenting a rational basis for doing so (Department's Exhibits # 5-A and 5-B); [T-317-318].

53. Respondent provided treatment to Patient C and ordered testing for Patient C that he knew, or should have known, was not warranted by Patient C's condition (Department's Exhibits # 5-A, and 5-B).

54. Respondent failed to maintain a record for Patient C that accurately reflects the care and treatment he rendered to the patient. For instance, Respondent's record for Patient C contains too little information to support a diagnosis (Department's Exhibits # 5-A and 5-B); [T-325].

PATIENT H

55. Respondent treated Patient H from August 2, 1994 through October 1995, at Respondent's office (Department's Exhibits # 10-A and 10-B).

56. At the initial consult on August 2, 1994, Respondent noted that Patient H had a flu-like illness the previous March and that she reported non-specific symptoms that included joint pain and palpitations. Respondent noted that Patient H had been previously treated with rocephin, apparently based on one positive serology, even though he noted that she had several negative Lyme serologies, a negative lumbar puncture and a negative MRI. Respondent also noted that Patient H developed sludge in her gallbladder (Department's Exhibit # 10-A).

57. Although Respondent noted aspects of the patient's overall history in his consult note, Respondent failed to take and/or note an adequate history by failing to note a chief complaint and by failing to adequately develop Patient H's non-specific symptoms by thoroughly reviewing the systems related to her complaints (Department's Exhibits # 10-A and 10-B); [T-335-337].

58. Respondent failed to perform and/or note an appropriate physical examination by failing to examine the patient's organ systems related to her complaints including the patient's cardiac, neurologic and musculoskeletal systems (Department's Exhibits # 10-A and 10-B); [T-336-337].

59. Respondent repeatedly failed to take and/or note follow-up histories and failed to perform and/or note appropriate physical examinations at Patient H's subsequent visits (Department's Exhibits # 10-A and 10-B); [T-337].

60. There is insufficient data in Respondent's medical records of Patient H to determine what conditions this patient had, and there is little evidence to support a diagnosis of Lyme disease (Department's Exhibits # 10-A and 10-B); [T-338-339, 356-359, 368].

61. Respondent failed to appropriately rule out differential diagnoses. Patient H's complaints of fatigue and a flu-like illness could be associated with a viral infection (Department's Exhibits # 10-A and 10-B); [T-339, 367].

62. Respondent inappropriately treated Patient H since he treated her for Lyme disease without a firm diagnosis (Department's Exhibits # 10-A and 10-B); [T-339, 359].

63. Respondent inappropriately treated Patient H with parenteral therapy since Respondent failed to document objective abnormalities to indicate central nervous system infection (Department's Exhibits # 10-A and 10-B); [T-339, 359].

64. Respondent inappropriately treated Patient H with rocephin, claforan, suprax, primaxin and biaxin (Department's Exhibits # 10-A and 10-B).

65. Respondent inappropriately treated Patient H with repeat courses of antibiotic therapy over the course of four months. Respondent inappropriately maintained Patient H on oral antibiotics after completing parenteral therapy (Department's Exhibits # 10-A and 10-B); [T-368-369, 372].

66. Respondent failed to appropriately monitor Patient H during the course of therapy [T-337-338, 341-348, 350-354, 360-361, 363-364].

67. Respondent failed to appropriately follow-up on abnormal laboratory results. Respondent failed to determine the cause of Patient H's elevated liver function tests and hematologic abnormalities, including low platelet and white blood counts, which are potential adverse drug reactions. Instead of assessing Patient H when her laboratory results were abnormal, Respondent stopped and started her medication [T-337-338, 340-344, 370].

68. Respondent failed to appropriately followed-up when Patient H experienced adverse drug reactions to administered therapy. When Patient H experienced gallbladder problems, which could be an adverse drug reaction, Respondent switched her medication to another medication of a similar class, without attempting to determine the cause of the problem. Similarly, when Patient H experienced low

white blood counts, a rash and a fever, symptoms that indicate a potential adverse drug event, an infection or a problem with an IV line, Respondent failed to immediately evaluate Patient H and determine the cause of the event [T-342-345, 350-351, 360-364, 370].

69. Respondent inappropriately ordered multiple Lyme serologies without documented rationale [T-344-345].

70. There is no record to show that Respondent followed-up on the gastroenterology evaluation of Patient H (Department's Exhibits # 10-A and 10-B); [T-345-348].

71. Respondent failed to timely refer Patient H for a cardiac evaluation when she complained of palpitations (Department's Exhibit # 10-A); [T-346-348, 352-353].

72. Respondent provided treatment to Patient H and ordered testing for Patient H that he knew, or should have known, was not warranted by Patient H's condition (Department's Exhibits # 10-A and 10-B).

73. Respondent failed to maintain a record that accurately reflects the care and treatment he rendered to Patient H. For example, there is no evidence in the record indicating who the referring physician was, what the prior treatment consisted of, what medications were ordered and when and, when and why the medications were stopped and started (Department's Exhibits # 10-A and 10-B); [T-346-348, 370-371].

PATIENT I

74. Respondent treated Patient I from August 26, 1994 through April 1996, at Respondent's office (Department's Exhibits # 11-A and 11-B).

75. At the initial consult on August 26, 1994, Respondent noted that Patient I reported feeling tired, loss of balance, tingling in her head and blurred vision. Respondent noted that Patient I had no history of a rash (Department's Exhibit # 11-A).

76. Respondent failed to take and/or note an adequate history by failing to do a focused review of systems and failing to thoroughly evaluate Patient I's complaints (Department's Exhibits # 10-A and 10-B); [T-373-375, 413-416].

77. Respondent failed to perform and/or note an appropriate physical examination. Respondent failed to examine Patient I's ears and failed to perform a neurological examination based on her complaint of loss of balance. Respondent failed to examine Patient I's musculoskeletal system when she complained about painful joints (Department's Exhibits # 10-A and 10-B); [T-373-374, 376-377]

78. Respondent repeatedly failed to take and/or note follow-up histories and repeatedly failed to perform and/or note follow-up physical examinations at Patient I's subsequent visits (Department's Exhibits # 10-A and 10-B); [T-375].

79. Respondent failed to appropriately evaluate Patient I by failing to take an adequate history, failing to perform an appropriate physical examination and failing to reasonably consider alternative diagnoses (Department's Exhibits # 10-A and 10-B); [T-376-377, 408-409, 413-416].

80. Respondent failed to appropriately rule out differential diagnoses for Patient I (Department's Exhibits # 10-A and 10-B); [T-376-377, 408-409].

81. Respondent treated Patient I inappropriately by treating her for Lyme disease when there is no clear evidence to support a diagnosis of Lyme disease. In fact, the record does not include sufficient information to determine what condition Patient I had. Respondent inappropriately treated Patient I with parenteral therapy since there is no evidence of central nervous system involvement (Department's Exhibit # 11-A); [T-376-377, 385-391, 404-407].

82. Respondent inappropriately treated Patient I with rocephin, claforan, doxycycline, biaxin, suprax, primaxin and, bicillin. Respondent inappropriately treated Patient I with parenteral antibiotics. Respondent inappropriately treated Patient I with oral antibiotics (Department's Exhibits # 11-A and # 11-B); [T-398].

83. Respondent inappropriately treated Patient I with cephalosporins when he believed her to be allergic to penicillin. Penicillin and cephalosporins cross react and could lead to anaphylaxis [T-379-380].

84. Respondent failed to appropriately monitor Patient I when she developed abnormal laboratory results. For example, Respondent failed to follow-up on Patient I's abnormal liver function tests, elevated cholesterol and electrolyte abnormalities (Department's Exhibit # 11-A); [T-378-381].

85. Respondent inappropriately ordered multiple Lyme serologies and multiple blood tests without a reasonable documented basis [T-381].

86. Respondent failed to perform and/or note an appropriate neurologic examination based on Patient I's complaints of loss of balance, head tingling and double vision and, Respondent failed to refer Patient I for a neurologic examination [T-373-374, 377, 381].

87. Respondent noted in his consult notes that Patient I was to see an eye, nose, and throat specialist. Respondent failed to follow-up appropriately on this evaluation or referral [T-382-383].

88. Respondent provided treatment to Patient I and ordered testing for Patient I that he knew, or should have known, was not warranted by Patient I's condition (Department's Exhibits # 11-A and # 11-B).

89. Respondent failed to maintain records that accurately reflect the care and treatment rendered to Patient I. For example, Respondent failed to document the medications used to treat the patient and the reasons for switching her medications (Department's Exhibits # 11-A and # 11-B); [T-378, 388].

PATIENT J

90. Respondent treated Patient J from April 14, 1994 through May 1995, at Respondent's office (Department's Exhibit # 12).

91. At the consult visit on April 14, 1994, Respondent noted that Patient J reported being bitten in July and that she developed joint pains, fatigue and cognitive dysfunction. Respondent also noted that Patient J had been told by a rheumatologist that she had spondylolisthesis (Department's Exhibit # 12).

92. Respondent failed to take and/or note an adequate history, in that he failed to review the systems related to Patient J's complaints, failed to detail or characterize the bite and rash which could be a bug bite or erythema migrans, failed to develop any of the patient's complaints that could be related to spondylolisthesis, including knee and hip pain and paresthesias and, failed to note any drug allergies (Department's Exhibit # 12); [T-420-425, 438].

93. Respondent failed to perform and/or note an appropriate physical examination in that he failed to perform a focused examination of the patient including examining her joints and spine, especially since Respondent knew of her possible spondyloarthropathy. Respondent failed to perform a neurologic examination to address the patient's complaints of paresthesia and cognitive problems [T-421-425, 427, 438].

94. Respondent repeatedly failed to take and/or note follow-up histories and failed to perform and/or note follow-up physical examinations at Patient J's subsequent visits. For example, Respondent did not address the patient's complaints of face twitching, tingling and throat swelling (Department's Exhibit # 12); [T-422-425].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions as to the allegations contained in the Statement of Charges were by unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the April 13, 1999, Statement of Charges, are **SUSTAINED:**[11]

First Paragraph [preamble - not numbered] : [1 - 2]

Paragraphs: A., A.1., A.2., A.3., A.4., A.5.a. (sustained in part), A.5.b., A.5.c., A.5.d., A.6., A.7. (sustained in part), A.8., and A.9. (Patient A) : [4 - 24]

Paragraphs: B., B.1., B.2., B.3., B.4., B.5.b., B.6., B.7. (sustained in part), B.8., B.9., B.10., B.11., and B.12. (Patient B) : [25 - 41]

Paragraphs: C., C.1., C.2., C.3., C.4., C.5., C.6.a., C.6.b., C.7., C.9., and C.10.

(Patient C) : [42 - 54]

Paragraphs: H., H.1., H.2., H.3., H.4., H.5.a., H.5.b., H.5.c., H.5.d., H.6., H.7., H.8., H.9., and H.10.

(Patient H) : [55 - 73]

Paragraphs: I., I.1., I.2., I.3., I.4., I.5.a., I.5.b., I.5.c., I.6., I.7., I.8., I.9. and I.10.

(Patient I) : [74 - 89]

Paragraphs: J., J.1., J.2., J.3., J.4., J.5.a., J.5.b., J.5.d., J.6., J.7., J.8., and J.9.

(Patient J) : [90 - 107]

---

[11] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee.

DISCUSSION

Respondent is charged with thirty-four (34) specifications[12] alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a variety of forms or types of conduct which constitute professional misconduct.

The ALJ discussed with the Hearing Committee the types of medical misconduct alleged in this proceeding. These definitions were obtained from a memorandum, prepared by Henry M. Greenberg, General Counsel for the New York State Department of Health, dated January 9, 1996[13]. This document, entitled Definitions of Professional Misconduct under the New York Education Law, ("**Misconduct Memo**"), sets forth some suggested definitions of practicing the profession: (1) fraudulently; (2) with negligence on more than one occasion; (3) with gross negligence; (4) with incompetence on more than one occasion; and (5) with gross incompetence.

During the course of its deliberations on these charges, the Hearing Committee consulted the relevant definitions contained in the Misconduct Memo, which are as follows:

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

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

---

[12] Reduced by ALJ to twenty-two (22) specifications for the purposes of this proceeding.

[13] A copy was provided to Respondent.

Acceptable medical standards are based on what a reasonably prudent physician, possessed of the required skill, training, education, knowledge or experience to act as a physician, would do under similar circumstances (and having the same information, i.e.: without the benefit of hindsight). Proof that a physician failed to exercise the care that a reasonably prudent physician would exercise under the circumstances is sufficient to sustain a finding of negligence in a medical misconduct proceeding; Matter of Bogdan v. NYS-BPMC, 195 A.D.2d 86 appeal dismissed and leave to appeal denied, 83 N.Y.2d 901 (1994); Matter of Enu v. Sobol, 171 A.D.2d 302 (3rd. Dep't., 1991) and 208 A.D.2d 1123 (3rd. Dep't., 1994) (expert witness qualifications).

A physician can make a mistake or an error in medical judgment without being negligent. However, a physician's decision or act which is without proper medical foundation or not the product of careful examination or deviates from acceptable medical standards or knowledge is more than a mere error in medical judgment; Krapvika v. Maimonides Medical Center, 119 A.D.2d 801, 805 (2d Dep't., 1986) (dissent- citing Bell v. New York City Health & Hosps. Corp. and Huntley v. State of New York [citations omitted]).

The ALJ informed the Hearing Committee that he believed that the presentation of evidence on 10 patients would be unduly repetitious because the factual allegations on all 10 patients were almost exactly alike. The ALJ ruled that the Department could attempt to show a pattern of conduct with 6 patients as opposed to 10 patients. The Hearing Committee agrees with the ALJ's ruling and believes that to have received evidence on the 10 patients would have been unduly burdensome for both parties. The Hearing Committee is convinced that no different result would have occurred, for either party, had evidence on all 10 patients been received.

The Hearing Committee used ordinary English usage and understanding for all other terms, allegations and charges. Other issues raised are addressed where appropriate.

With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility.

Dr. Raymond Dattwyler testified as the State's expert. The standards of care relevant to the six patients and their presentation were articulated by Dr. Dattwyler. Dr. Dattwyler is an authority in the field of evaluating and treating Lyme disease. He is Professor of Medicine, Chief of the Division of Allergy, Clinical Immunology and Chief of the Lyme Disease Center at SUNY Stony Brook. Dr. Dattwyler teaches medical students and residents. Dr. Dattwyler was clear that although his personal standards may be higher than the minimum standard of care, his opinion regarding Respondent's medical care was based on the minimally accepted standard of care. Dr. Dattwyler testified specifically about the patients in this case and rendered an opinion based on Respondent's records for these patients. The Hearing Committee did not find that Dr. Dattwyler was biased against Respondent nor that he had any animus towards Respondent.

Dr. Sam Donta testified on behalf of Respondent. The Hearing Committee found Dr. Donta to be generally honest in his answers. Unfortunately, Dr. Donta did not testify directly about the patients in this case nor did he render an opinion about Respondent's medical conduct based on the specific records or patients in this case. Dr. Donta testified that although he previously reviewed the records in this case, it was a long time ago, he did not write a report regarding his review and he did not remember much about the records. Dr. Donta testified that in many respects his own practice differs from Respondent's medical practice. For instance, Dr. Donta treats patients with oral medications, not parenteral therapy. Moreover, Dr. Donta repeatedly stated that he could not render an opinion about Respondent's records because he is not an expert on medical records. Dr. Donta's testimony was of little value to the Hearing Committee.

Dr. Richard Tilton (Ph.D.) testified on behalf of Respondent. The Hearing Committee found Dr. Tilton to be a generally credible witness. The Hearing Committee finds that this case is not about Lyme disease but about medical treatment and quality of care, therefore, Dr. Tilton's testimony had little relevance to the 6 patients at issue. Even if this case was about Lyme disease, Dr. Tilton was not in a position to render an opinion about the appropriateness of Respondent's medical conduct since he is not a medical expert.

Obviously Respondent had the greatest amount of interest in the results of these proceedings. Respondent is articulate and is able to rationalize his actions and inactions based on his views of Lyme disease. Many of Respondent's rationalizations and justifications for his questionable actions are inconsistent. The Hearing Committee observed a physician who refused to even acknowledge the simple fact that his record keeping was extremely poor even for a "consultant".

Respondent's testimony about being a consulting physician is incredible and not supported by his records. Respondent failed to document, and could not state, who the referring physicians were, what other evaluations or treatments the patients had and, even though he testified that he communicated with other physicians, there is no such evidence in his records. Respondent's testimony about his reliance on laboratory results is inconsistent. Respondent ordered multiple tests looking for a positive result to support his preconceived conclusion that his patients had Lyme disease.

Using the above definitions and understanding, including the relevant portions of the remainder of the Misconduct Memo and the legal understanding set forth above, the Hearing Committee concludes by a unanimous vote that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State.

There are accepted standards of medical care that every physician must adhere to. When evaluating any patient, a reasonably prudent physician must thoroughly and appropriately assess the patient by taking an adequate history, performing an appropriate physical examination, ordering appropriate laboratory tests and, by considering and ruling out alternative diagnoses. Once the patient has been appropriately evaluated, a reasonably prudent physician makes a diagnosis and treats the patient accordingly. The entire evaluation process must be documented. Respondent failed to comply with these basic principles in caring for each of the patients in this case.

Respondent failed to find and document objective abnormalities to support a diagnosis of Lyme or any other disease and, he failed to document evidence of central nervous system infection, which would require treating a patient with intravenous (parenteral) therapy. Instead, Respondent ordered multiple Lyme serologies searching for a positive result as support for his conclusion that his patients had Lyme disease and he immediately began treating his patients with parenteral therapy, rather than oral medications. During extended courses of therapy, Respondent failed to appropriately monitor his patients by ignoring potentially serious adverse drug events and by failing to do anything regarding his patients abnormal laboratory results.

As a result, Respondent placed his very sick patients at substantial risk. By failing to appropriately evaluate and diagnose his patients, Respondent failed to determine what conditions they had so he could appropriately treat them. By treating them inappropriately, with long-term parenteral therapy, Respondent subjected them to unnecessary, lengthy, expensive and risky treatment. Respondent testified that his patients were desperate; they went from physician to physician looking for someone who would listen to them. In fact, Respondent victimized a vulnerable patient population by treating them for long periods of time for something they did not or may not have had.

A reasonably prudent physician must maintain records that accurately reflect the care and treatment rendered to a patient. The main purpose of medical records is to clearly document the clinical findings of the patient and the specific care and treatment rendered by the physician. Records need to reflect this treatment to refresh the memory of the treating physician and so a subsequently treating physician knows the medical history of the patient.

Respondent failed to maintain records that accurately reflect the care and treatment rendered to his patients. No subsequently treating physician would be able to treat Respondent's patients by using his records; they would have to start over again. Respondent's records are substandard and evidence substandard medical care. Respondent failed to document a diagnostic and management plan for his patients. Respondent failed to document what medications he ordered and when and why he changed the medications. In fact, Respondent had difficulty reading his own records and answering questions based on his records.

Respondent's defense that the standard of care as presented by the Department does not apply to him and that his conduct is acceptable since he practices as other physicians "in the community" practice is invalid. As previously discussed, the appropriate standard to be applied in professional misconduct proceedings is the "reasonably prudent physician" standard Chime v. DeBuono, 687 N.Y.S.2d 814 (3rd Dept. 1999). The Hearing Committee looked at whether a reasonably prudent physician under similar circumstances to the facts in the instant case, acts as Respondent did. The preponderance of the evidence in this case supports an answer that a reasonably prudent physician, under similar circumstances, would not act as Respondent did in dealing with each of the patients in this case.

The facts presented evidenced an overall pattern of sub-standard medical care, regardless of the type of condition the patients presented. The fact that the disease involved may have been Lyme

was of little significance. Respondent did not adequately work-up the patients, recorded very little information about them and failed to do independent evaluations on them. Respondent treated and tested his patients excessively without adequate medical justification. If you cannot diagnose the patient's condition, it is gross negligence to treat that patient for a year with antibiotics. Respondent's treatment of the six patients herein was inappropriate, regardless of whether they had Lyme disease or not. On a number of occasions, the Hearing Committee found that Respondent was cavalier about the treatment to his patients.

The Hearing Committee did not sustain the Charges of Gross Incompetence or Incompetence on more than one occasion because we believe that there was insufficient evidence to prove that Respondent is incompetent. Rather, we believe that Respondent knows what to do but is careless in his record keeping and so biased in his crusade against Lyme disease that he intentionally disregards other diagnoses.. In addition, the Hearing Committee believes Respondent to be manipulative (of insurance companies) for his own self-interest. Respondent's greed manifests itself in excessive testing and referrals to a home health care company to which he has some financial interests or connections.

The fact that Respondent provided treatment to six patients and ordered tests for six patients when he knew, or should have known, that the treatment and the testing was not warranted by the patients' conditions is sufficient to sustain Charges of fraudulent practice of the profession of medicine.

The Department of Health has met its burden of proof as to: six (6) acts of gross negligence; six (6) acts of negligence; six (6) acts of fraudulent practice of medicine; six (6) acts of excessive testing; and six (6) acts of failing to maintain accurate records as charged in the April 13, 1999 Statement of Charges. The Department of Health has proved a pattern and practice of sub-standard patient care.

The Hearing Committee does not find that Respondent lacks the skill or knowledge of proper medical care as to Patients A, B, C, H, I, and J or that Respondent lacks the skill or knowledge to practice the profession and we do not sustain the charges of gross incompetence or the charge of incompetence on more than one occasion.

DETERMINATION AS TO PENALTY

The Hearing Committee pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, by a vote of 2 to 1, determines that Respondent's license to practice medicine in the State of New York should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

The Hearing Committee believes that Respondent ordered tests for his own financial gain, through patient payments and/or insurance coverage/reimbursements. The number and duplication of tests ordered was clearly excessive, repetitive and on numerous occasions not warranted. Incomprehensibly on a number of occasions, tests which should have been ordered for the patient's benefit were not done. Respondent provided no reasonable explanation for these deviations from standard of care.

The Hearing Committee concludes and determines that Respondent's fraudulent acts standing alone provide sufficient grounds to revoke Respondent's license.

To practice medicine, a physician must possess integrity as much as he must possess knowledge or skill. A physician must deal honestly with his patients, with other physicians, with third party payers and with regulators.

The extensive and excessive testing leads the Hearing Committee to conclude that Respondent used his medical license to commit fraud for his own enrichment.

The fraud committed by Respondent was clearly by design and not a mistake. The Hearing Committee also believes that the pattern of fraud presented is inconsistent with the practice of medicine. The Hearing Committee determines that Respondent has violated the public trust which is bestowed by virtue of his licensure as a physician. Physicians have privileges that are available solely due to the fact that one is a physician. The public places great trust in physicians solely based on the fact that they are physicians. Hence, it is expected that a physician will not violate the trust the public has bestowed on him by virtue of his professional status.

Respondent's excessive submissions to the laboratories and then for payment could only occur because of his role as a physician. Respondent has violated the public trust granted to him by virtue of his license.

The Hearing Committee was also very concerned about Respondent's apparent belief that medical records are unimportant. The Hearing Committee recognizes that the lack of documentation does not necessarily result in inadequate medical care or negligence. However, in the cases presented in this proceeding, the lack of documentation was so pervasive that it showed a pattern of not thinking thoroughly through the patient's medical problems and being careless, inattentive and inaccurate. All of these factors result in poor, inadequate and dangerous patient care.

Aside from the fraudulent activities discussed above, Respondent's records deviated significantly from accepted medical standards both because of their deficiencies and their lack of accurate information. The negligence and inaccurate records taken together, but without the fraud, would similarly result in a finding by the Hearing Committee that the appropriate sanction is revocation.

Overall, Respondent has been careless in his medical record keeping, intentionally careless in his diagnoses, gave medications without medical justifications or rationale, treated patients with medications that have substantial risks without adequate monitoring and subjected his patients to unnecessary risks.

The Hearing Committee has determined that Respondent was grossly negligent in the treatment of Patients A, B, C, H, I, and J. As to Patient A, it is mere luck that she did not die. These six cases of gross negligence had very little to do with Lyme disease. The absence of a clear diagnosis; the parenteral antibiotics therapy for extensive periods of time; followed, on occasion, by the oral antibiotics also given for substantial periods of time; the stopping and starting of medications without rationale; the switching of medications without rationale; the lack of monitoring; and the extremely vague incomplete medical records when taken together constitute egregious conduct in the practice of medicine. All of these factors taken together produced a clear pattern of abysmal patient care provided by Respondent to the six patients discussed above.

Respondent has presented no mitigation. Respondent has not learned from his errors, has no insight and finds no defect in his conduct. Respondent fails to even recognize that the medical records that he maintained are grossly defective.

As discussed above, the majority of the Hearing Committee believed that the six acts of gross negligence alone were sufficient to revoke Respondent's license. The majority of the

Hearing Committee also believed that the acts of excessive testing and fraud were sufficient to revoke Respondent's license. The majority of the Hearing Committee further believed that the six acts of negligence when combined with the extensive medical records deficiencies were also sufficient to revoke Respondent's license.

One member of the Hearing Committee voted against revocation but was in favor of an extensive actual suspension (2 to 3 years) of Respondent's license and thereafter a practice monitor during a lengthy probationary period.

The Hearing Committee, unanimously, did not impose a civil penalty on Respondent because we believe that there was insufficient evidence of the amount of financial gain the Respondent obtained. Since the Hearing Committee found that Respondent is a potential danger to the public, the imposition of public service would be contraindicated.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, a majority of the Hearing Committee determines and concludes that the sanction of revocation strikes the appropriate balance between the need to protect the public, deter future misconduct, and punish Respondent.

The Hearing Committee, unanimously, considers Respondent's misconduct to be very serious. The majority of the Hearing Committee believes that no other available sanction is sufficient to address Respondent's numerous acts of gross negligence, negligence on at least six (6) occasions, fraud, excessive and unwarranted testing and bad record keeping.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is **REVOKED**, and;

2. The First Specification of professional misconduct from the Statement of Charges (Department's Exhibit # 1 - Negligence on more than one occasion) is **SUSTAINED,** and;

3. The Third through Fifth and Tenth through Twelfth Specifications of professional misconduct from the Statement of Charges (Department's Exhibit # 1 - Gross Negligence) are **SUSTAINED,** and;

4. The Fourteenth through Sixteenth and Twenty-First through Twenty-Third Specifications of professional misconduct from the Statement of Charges (Department's Exhibit # 1 - Fraudulent Practice) are **SUSTAINED,** and;

5. The Twenty-Fourth through Twenty-Sixth and Thirty-First through Thirty-Third Specifications of professional misconduct from the Statement of Charges (Department's Exhibit # 1 - Excessive Tests) are **SUSTAINED,** and;

6. The Thirty-Fourth Specification of professional misconduct from the Statement of Charges (Department's Exhibit # 1 - Inaccurate Records) is **SUSTAINED,** and;

7. Other Specifications of professional misconduct from the Statement of Charges (Department's Exhibit # 1), consistent with the discussions contained in the determination are **NOT SUSTAINED,** and;

8. This Determination and Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **Albany, New York**
November, 17 1999

Redacted Signature

FRANK E. IAQUINTA, M.D., (Chair)
NISHA K. SETHI, M.D.,
MICHAEL A. GONZALEZ, R.P.A.

To:

Perry Orens, M.D.
Redacted Address

Perry Orens, M.D.
Redacted Address

Ira M. Maurer, Esq.
Law Offices of Elkind, Flynn & Maurer, P.C.
11 Martine Avenue, Penthouse
White Plains, NY 10606

Leslie Eisenberg, Esq.
Assistant Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001

APPENDIX I

Ps Ex. #1

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

IN THE MATTER

OF

PERRY ORENS, M.D.

STATEMENT

OF

CHARGES

PERRY ORENS, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 23, 1959, by the issuance of license number 082198 by the New York State Education Department. Respondent is currently registered with New York State Department of Education to practice medicine for the period of May 1, 1998 through April 30, 2000.

FACTUAL ALLEGATIONS

A. Respondent provided care and treatment to Patient A from on or about January 13, 1994 through in or about August 1996.

1. Respondent repeatedly failed to take and/or note an adequate history.
2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.
3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient A appropriately for Lyme disease.
4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease in a timely fashion.
5. Respondent treated Patient A inappropriately:
   a. Respondent treated Patient A for Lyme disease when, in fact, Patient A did not have Lyme disease.

PLAINTIFF'S / DEFENDANT'S EXHIBIT 1

b. Respondent inappropriately prescribed parenteral antibiotics to Patient A.

c. Respondent failed to monitor Patient A appropriately.

d. Respondent failed to follow-up appropriately on abnormal laboratory results and/or when Patient A developed adverse reactions to administered therapy.

6. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology, rheumatologic test, thyroid function tests and/or Vitamin B12 levels.

7. Respondent failed to perform and/or note necessary diagnostic laboratory testing including but not limited to lumbar puncture and/or EKG, in a timely fashion.

8. Respondent provided treatment and/or ordered testing for Patient A that he knew was not warranted.

9. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient A.

B. Respondent provided care and treatment to Patient B from on or about August 17, 1995 through in or about July 1996.

1. Respondent repeatedly failed to take and/or note an adequate history.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient B appropriately for Lyme disease.

4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease.

5. Respondent treated Patient B inappropriately:

   a. Respondent treated Patient B for Lyme disease when, in fact, Patient B did not have Lyme disease.

   b. Respondent inappropriately prescribed parenteral antibiotics to Patient B.

   c. Respondent failed to monitor Patient B appropriately.

   d. Respondent failed to follow-up appropriately on abnormal laboratory results and/or when Patient B developed adverse reactions to administered therapy.

6. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology and/or immunology profile.

7. Respondent failed to perform and/or note necessary diagnostic laboratory testing including but not limited to lumbar puncture and/or echocardiogram.

8. Respondent failed to follow-up appropriately to obtain results of the ophthalmology consult that he referred Patient B for in or about January 1996, after Patient B complained of diplopia.

9. Respondent failed to perform an appropriate neurological examination and/or failed to refer Patient B for neurological evaluation.

10. Respondent failed to consult with Patient B's treating psychiatrist and/or failed to evaluate or monitor Patient B's use of antidepressant medications.

11. Respondent provided treatment and/or ordered testing for Patient B that he knew was not warranted.

12. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient B.

C. Respondent provided care and treatment to Patient C from on or about Augus 16, 1995 through in or about October 1995.

1. Respondent repeatedly failed to take and/or note an adequate history.
2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.
3. Respondent failed to evaluate Patient C appropriately for active/ongoing Lyme disease by failing to perform a neurological examination and/or by failing to refer Patient C for neurological evaluation.
4. Respondent failed to refer Patient C for rheumatologic evaluation.
5. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease in a timely fashion.
6. Respondent treated Patient C inappropriately:
   a. Respondent treated Patient C inappropriately for Lyme disease.
   b. Respondent inappropriately prescribed parenteral antibiotics to Patient C.
   c. Respondent failed to monitor Patient C appropriately.
   d. Respondent failed to follow-up appropriately on abnormal laboratory results.
7. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology.
8. Respondent failed to perform and/or note necessary diagnostic laboratory testing including but not limited to PCR and/or urinalysis.
9. Respondent provided treatment and/or ordered testing for Patient C that he knew was not warranted.
10. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient C.

D. Respondent provided care and treatment to Patient D from on or about May 3 1993 through in or about December 1993.

1. Respondent repeatedly failed to take and/or note an adequate history.
2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.
3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient D appropriately for Lyme disease.
4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease.
5. Respondent treated Patient D inappropriately:
   a. Respondent treated Patient D for Lyme disease when, in fact, Patient D did not have Lyme disease.
   b. Respondent inappropriately prescribed parenteral antibiotics to Patient D.
   c. Respondent failed to monitor Patient D appropriately.
   d. Respondent failed to follow-up appropriately on abnormal laboratory results and/or when Patient D developed adverse reactions to administered therapy.
6. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology and/or PSA.
7. Respondent provided treatment and/or ordered testing for Patient D that he knew was not warranted.
8. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient D.

E. Respondent provided care and treatment to Patient E from on or about August 30, 1995 through in or about May 1996.

1. Respondent repeatedly failed to take and/or note an adequate history.
2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.
3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient E appropriately for Lyme disease.
4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease.
5. Respondent failed to perform an appropriate neurological examination and/or failed to refer Patient E for neurological evaluation.
6. Respondent failed to refer Patient E for psychological evaluation.
7. Respondent treated Patient E inappropriately:
   a. Respondent treated Patient E for Lyme disease when, in fact, Patient E did not have Lyme disease.
   b. Respondent inappropriately prescribed parenteral antibiotics to Patient E.
   c. Respondent failed to monitor Patient E appropriately.
   d. Respondent failed to follow-up appropriately on abnormal laboratory results and/or when Patient E developed adverse reactions to administered therapy.
8. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology, serum PCR, MRI and/or hepatitis screening.
9. Respondent failed to perform and/or note necessary diagnostic laboratory testing including but not limited to ANA and/or rheumatoid

factor.

10. Respondent provided treatment and/or ordered testing for Patient E that he knew was not warranted.

11. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient E.

F. Respondent provided care and treatment to Patient F from on or about December 5, 1994 through in or about May 1995.

1. Respondent repeatedly failed to take and/or note an adequate history.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient F appropriately for Lyme disease.

4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease.

5. Respondent treated Patient F inappropriately:

   a. Respondent treated Patient F for Lyme disease when, in fact, Patient F did not have Lyme disease.

   b. Respondent inappropriately prescribed parenteral antibiotics to Patient F.

   c. Respondent failed to monitor Patient F appropriately.

6. Respondent failed to follow-up, in a timely manner, on the neurology consultation that Respondent referred Patient F for in or about December 1994.

7. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology.

8. Respondent failed to obtain a psychological evaluation for Patient F, as recommended by the neurology consult.

9. Respondent provided treatment and/or ordered testing for Patient F that he knew was not warranted.

10. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient F.

G. Respondent provided care and treatment to Patient G from on or about July 8, 1994 through in or about December 1995.

1. Respondent repeatedly failed to take and/or note an adequate history.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient G appropriately for Lyme disease.

4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease.

5. Respondent treated Patient G inappropriately:

   a. Respondent treated Patient G for Lyme disease when, in fact, patient G did not have Lyme disease.

   b. Respondent inappropriately prescribed parenteral antibiotics to Patient G.

   c. Respondent failed to monitor Patient G appropriately.

   d. Respondent failed to follow-up appropriately on abnormal laboratory results and/or when Patient G developed adverse reactions to administered therapy.

6. Respondent inappropriately ordered and/or performed laboratory

testing including but not limited to multiple Lyme serology, urine antigen test and/or IGG subclasses immuno globulin.

7. Respondent failed to perform and/or note necessary diagnostic laboratory testing including but not limited to EKG, appropriate cardiac evaluation and/or lumbar puncture.
8. Respondent provided treatment and/or ordered testing for Patient G that he knew was not warranted.
9. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient G.

H. Respondent provided care and treatment to Patient H from on or about August 2, 1994 through in or about October 1995.

1. Respondent repeatedly failed to take and/or note an adequate history.
2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.
3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient H appropriately for Lyme disease.
4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease.
5. Respondent treated Patient H inappropriately:
   a. Respondent treated Patient H for Lyme disease when, in fact, Patient H did not have Lyme disease.
   b. Respondent inappropriately prescribed parenteral antibiotics to Patient H.
   c. Respondent failed to monitor Patient H appropriately.
   d. Respondent failed to follow-up appropriately on abnormal

laboratory results and/or when Patient H developed adverse reactions to administered therapy.

6. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology, multiple PT and/or PPT.
7. Respondent failed to follow-up appropriately on the gastroenterology evaluation of Patient H.
8. Respondent failed to timely refer Patient H for a cardiology consult.
9. Respondent provided treatment and/or ordered testing for Patient H that he knew was not warranted.
10. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient H.

I. Respondent provided care and treatment to Patient I from on or about August 26, 1994 through in or about April 1996.

1. Respondent repeatedly failed to take and/or note an adequate history.
2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.
3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient I appropriately for Lyme disease.
4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease.
5. Respondent treated Patient I inappropriately:
   a. Respondent treated Patient I for Lyme disease when, in fact, Patient I did not have Lyme disease.
   b. Respondent inappropriately prescribed parenteral antibiotics to

Patient I.

c. Respondent failed to monitor Patient I appropriately.

6. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology.

7. Respondent failed to perform an appropriate neurological examination and/or failed to refer Patient I for neurological evaluation.

8. Respondent failed to follow-up appropriately on internist and eye nose and throat evaluations of Patient I.

9. Respondent provided treatment and/or ordered testing for Patient I that he knew was not warranted.

10. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient I.

J. Respondent provided care and treatment to Patient J from on or about April 14, 1994 through in or about May 1995.

1. Respondent repeatedly failed to take and/or note an adequate history.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent diagnosed Lyme disease inappropriately and/or failed to evaluate Patient J appropriately for Lyme disease.

4. Respondent failed to appropriately rule out differential diagnoses other than Lyme disease.

5. Respondent treated Patient J inappropriately:

a. Respondent treated Patient J for Lyme disease when, in fact, Patient J did not have Lyme disease.

b. Respondent inappropriately prescribed parenteral antibiotics to

Patient J.

c. Respondent failed to monitor Patient J appropriately.

d. Respondent failed to follow-up appropriately on abnormal laboratory results and/or when Patient J developed adverse reactions to administered therapy.

6. Respondent inappropriately ordered and/or performed laboratory testing including but not limited to multiple Lyme serology.

7. Respondent failed to follow-up appropriately on rheumatologic and neurologic evaluations of Patient J.

8. Respondent provided treatment and/or ordered testing for Patient J that he knew was not warranted.

9. Respondent failed to maintain records that accurately reflect the evaluation and treatment of Patient J.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraph A and each of its subparagraphs, and/or B and each of its subparagraphs, and/or C and each of its subparagraphs, and/or D and each of its subparagraphs, and/or E and each of its subparagraphs,

and/or F and each of its subparagraphs, and/or G and each of its subparagraphs, and/or H and each of its subparagraphs, and/or I and each of its subparagraphs, and/or J and each of its subparagraphs.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1999) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraph A and each of its subparagraphs, and/or B and each of its subparagraphs, and/or C and each of its subparagraphs, and/or D and each of its subparagraphs, and/or E and each of its subparagraphs, and/or F and each of its subparagraphs, and/or G and each of its subparagraphs, and/or H and each of its subparagraphs, and/or I and each of its subparagraphs, and/or J and each of its subparagraphs.

THIRD THROUGH TWELFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. Paragraph A and each of its subparagraphs.
4. Paragraph B and each of its subparagraphs.

5. Paragraph C and each of its subparagraphs.
6. Paragraph D and each of its subparagraphs.
7. Paragraph E and each of its subparagraphs.
8. Paragraph F and each of its subparagraphs.
9. Paragraph G and each of its subparagraphs.
10. Paragraph H and each of its subparagraphs.
11. Paragraph I and each of its subparagraphs.
12. Paragraph J and each of its subparagraphs.

THIRTEENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

13. Paragraph A and each of its subparagraphs, and/or B and each of its subparagraphs, and/or C and each of its subparagraphs, and/or D and each of its subparagraphs, and/or E and each of its subparagraphs, and/or F and each of its subparagraphs, and/or G and each of its subparagraphs, and/or H and each of its subparagraphs, and/or I and each of its subparagraphs, and/or J and each of its subparagraphs.

FOURTEENTH THROUGH TWENTYTHIRD SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

14. Paragraph A and A8.

15. Paragraph B and B11.

16. Paragraph C and C9.

17. Paragraph D and D7.

18. Paragraph E and E10.

19. Paragraph F and F9.

20. Paragraph G and G8.

21. Paragraph H and H9.

22. Paragraph I and I9.

23. Paragraph J and J8.

TWENTYFOURTH THROUGH THIRTYTHIRD SPECIFICATIONS

EXCESSIVE TESTS AND TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1999) by ordering excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

24. Paragraph A and A6.

25. Paragraph B and B6.

26. Paragraph C and C7.

27. Paragraph D and D6.

28. Paragraph E and E8.

29. Paragraph F and F7.

30. Paragraph G and G6.

31. Paragraph H and H6.

32. Paragraph I and I6.

33. Paragraph J and J6.

THIRTYFOURTH SPECIFICATION

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

34. Paragraphs A and A9 and/or, B and B12 and/or, C and C10 and/or, D and D8 and/or, E and E11 and/or, F and F10 and/or, G and G9 and/or, H and H10 and/or, I and I10 and/or, J and J9.

DATED: April 13, 1999
New York, New York

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct