STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

September 21, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Robert S. Asher, Esq.
295 Madison Avenue
New York, New York 10017

Alexander Oliver, M.D.
1954 Union Port Road Apt. 6J
Bronx, New York 10462

RE: In the Matter of Alexander Oliver, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-212) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

ALEXANDER OLIVER, M.D.

DETERMINATION

AND

ORDER

BPMC-98-212

The undersigned Hearing Committee consisting of **NORTON SPRITZ, M.D., Chairperson, RUFUS NICHOLS M.D.** and **EUGENIA HERBST**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE, ESQ.** (Administrative Law Judge) served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **ALEXANDER OLIVER M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	
Pre-Hearing Conferences:	April 23, 1998
Hearing dates:	May 4, 1998 May 14, 1998 May 15, 1998 June 25, 1998
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Date of Deliberation:	July 14, 1998
Petitioner appeared by:	Terrance Sheehan, Esq. Associate Counsel NYS Department of Health
Respondent appeared by:	Robert S. Asher 295 Madison Avenue New York, N.Y. 10017

WITNESSES

For the Petitioner:	Elliot J. Howard, M.D.
For the Respondent:	Alexander Oliver, M.D. Donald A. Feinfeld, M.D.

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with acceptable standards of medical practice in this State. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious means a conspicuously bad act or severe deviation from standards.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

Inaccurate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

Please note that the transcript was incorrectly typed in that from pages 757 forward the testimony refers to Patient C but should actually be Patient D.

FINDINGS OF FACT WITH REGARD TO PATIENT "A"

The following findings of fact were made after review of the entire record. Numbers in parenthesis (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant.

The Petitioner was required to meet the burden of proof 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. All findings and conclusions herein were unanimous unless otherwise noted.

1. Alexander Oliver, M.D., Respondent, was authorized to engage in the practice of medicine in the State of New York, on or about December 3, 1985, by the issuance of license number 164828 by the New York State Education Department (Pet. Exh. 3)

2. Between October 12, 1988, through on or about May 19, 1990, Patient A was a patient of Dr. Oliver at the Delancey Health Clinic, 154 Allen Street, New York, N.Y. (Pet. Exh. 4; T. 27)

3. Respondent testified that he failed to obtain and note an adequate patient history (T. 655)

4. Dr. Howard testified that the Respondent failed to perform and note adequate physical examination of Patient A. (Pet. Exh 4; T. 191)

5. Dr. Howard testified that Respondent inappropriately and without legitimate medical purpose repeatedly prescribed several medications. (T. 25)

6. Respondent prescribed Bentyl for Patient A for the claimed treatment of chronic pain in the lower right quadrant. (T. 372) Respondent found epigastric tenderness and suprapubic tenderness, but admitted that this tenderness is not in the same area as the right lower quadrant. (T. 415) The Respondent failed to determine whether a mass was present. (T. 417)

7. The Respondent continued to prescribe Bentyl without further indications of pain. (Pet. Exh. 4; T. 386 -387, 417)

8. On October 12, 1988, Respondent prescribed a headache-sedative type medication, Fioinal, two antihistamines, Benadryl and Vistaril and an antispasmodic, Bentyl. Respondent testified that he prescribed the medications on the first three visits based solely upon the patient's claim of sinusitis, even though Patient A was not displaying the symptoms at those times (T. 385) nor did Respondent perform a simple test for sinusitis for this patient. (T. 415)

9. On February 11, 1989, April 25, 1990, and May 19, 1990, Respondent prescribed Tagament for Patient A even though there was no complaint or finding relating to a problem with stomach acid. (Pet. Exh. 4; T. 36, 40 - 41)

10. Dr. Howard testified that the Respondent's medical prescriptions for Patient A without a medical history, physical examination and any present symptoms is not within the minimally accepted standards of medical care. (T. 29 - 30)

11. Dr. Howard testified that Patient A's electrocardiogram results suggested abnormality and the Respondent failed to properly interpret the test results. (T. 28) Respondent testified that he did not follow up on the results of this test. (T. 373)

12. Respondent's diagnosis that Patient A suffered from arthralgia is unsupported by the Patient's medical record (Pet. Exhs. 4; T. 25)

13. Respondent's diagnosis of sinusitis is unsupported by the Patient's medical record and/or the ENT examination which as reported to be normal. (Pet. Exh. 4, T. 25) Respondent testified that there was nothing in the Patient's chart for the first three visits justifying the diagnosis of sinusitis, except the Patient's prior history. (Pet. Exh. 4; T. 384 - 385, 386, 382; 668, 797)

14. Respondent testified that he failed to maintain a medical record for Patient A which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan, and analysis of laboratory test results. (Pet. Exh. 4; T. 655, 798)

PATIENT B

15. Patient B was a patient of the Respondent on or about October 5, 1989, through March 8, 1990.

16. Respondent testified that he failed to obtain and note adequate medical history. (T. 708)

17. Respondent failed to perform and note adequate physical examination.

18. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed medications. (Pet. Exh 9; T 51, 54, 58, 60 - 62, 104, 110, 111, 121)

19. Respondent prescribed Lasix for Patient B on the first visit dated October 8, 1989 and several times thereafter. (Pet. Exh 5) Dr. Howard testified that the prescription of Lasix was not indicated for this Patient. (T. 51, 52, 57, 58, 60) Additionally, the prescription of Slow-K is used to counter the effects of Lasix. If Lasix was not indicated, neither would Slow-K. (T. 51)

20. The Respondent inappropriately prescribed Diprosone Cream for Patient B for dermatitis related to lupus without any laboratory tests for a proper diagnosis of lupus. (T. 243, 254)

21. Dr. Howard testified that Patient B was prescribed Brethine without any indications. (T. 54)

22. Respondent prescribed medications to Patient B without any attempt to coordinate his treatment with other providers of medical care for the same patient. (T. 106, 107, 110, 111, 121, 286, 287, 303)

23. Respondent testified that he failed to maintain a record for Patient B which accurately reflected the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan and analysis of lab test results. (T 47, 48, 49, 52 - 61, 106, 107, 110)

24. Dr. Howard testified that Respondent inappropriately made a diagnosis that Patient B suffered from diabetes melitis (T. 54 - 56, 107, 338, 339)

25. Respondent failed to explore and follow-up the reason for and continued need for antituberculosis medication. (T 104, 105)

26. Respondent testified that he was not aware of the treatment plan for tuberculosis, he just advised the patient to continue the medication (T. 271, 272)

27. Respondent failed to contact the physician who had been treating Patient B with anti-tuberculosis medication to coordinate the care for this patient or request the patient's records when Respondent began caring for the patient. (T. 251, 286, 287)

28. Respondent failed to explore and follow-up the reason for and continued need for anti-anginal medication. (T. 49)

29. Respondent created a record for Patient B which is false and does no reflect legitimate patient care. (T. 62)

PATIENT C

30. On or about August 1988 and on or about May 1990, Respondent treated Patient C, a 51 year old man, at the Clinic. (Pet. Exh. 6)

31. Respondent testified that he failed to obtain and note adequate medical histories. (Pet. Exh. 6)

32. Dr. Howard testified Respondent failed to indicate the basis of a diagnoses of anxiety and hypertension in a physical examination. (T. 125 - 127, 141, 468, 499, 471, 472, 489, 490; Pet. Exh. 9)

33. Respondent prescribed Ativan for Patient C based on the patient's request. (T. 125, 127, 128; Pet. Exh. 6)

34. Dr. Howard testified that the Respondent prescribed Ativan without consulting with the patient's psychiatrist. (T 129, 130)

35. The Respondent testified that although he noticed that the patient displayed behaviorial characteristics of an addicted person and there was no reliable evidence that the patient wasn't getting the medication from the psychiatric clinic. (481, 482)

36. Respondent testified he had over-prescribed Ativan for the patient on August 30, 1988. (T. 483)

37. Respondent prescribed Minipress for Patient C on several visits, including the initial visit (Pet. Exh. 6) based on the patient's history of hypertension. (T. 125)

38. The Respondent failed to take the patient's blood pressure regularly and when he did take it, it was within normal limits. (Pet. Exh 6)

39. Respondent prescribed Minipress after not giving it for about one year without taking a blood pressure on the patient.

40. Dr. Howard testified that the prescription of Minipress for this patient was not justified (T. 125)

41. Respondent failed to determine whether Patient C was getting Minipress during time periods when she was not seeing the Respondent. (Pet. Exh 6; 138, 139, 485, 486)

42. Respondent failed to document in the patient's medical chart any reason for having prescribed Motrin. (Pet. Exh 6, T. 473, 474)

43. Respondent failed to note or interpret or follow-up the abnormal electrocardiogram for Patient C. (Pet. Exh.6; T. 130)

44. Respondent testified that he failed to maintain a record for Patient C which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan, and analysis of laboratory test results. (Pet. Exh 6; T. 131, 138 - 143)

PATIENT D

45. Patient D, a 47 year old woman, was a patient of the Respondent between on or about October 1988 and on or about April 1990. (Pet. Exh. 7)

46. Respondent failed to obtain and note an adequate medical history. (Pet. Exhs. 7 & 9)

47. The Respondent testified that he failed to perform and note an adequate physical examination of Patient D. (T. 775 - 776)

48. Dr. Howard testified that Respondent inappropriately and without legitimate medical purpose repeatedly prescribed medication such as Alupent, Ativan, Antivert and Naprosyn. (Pet. Exh. 9; T. 147 - 150, 760 - 762)

49. Dr. Howard testified that Patient D requested specific prescription medications that are common to drug abusers. (T. 148)

50. Respondent testified that he failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan, and analysis of laboratory results. (T. 11, 547 - 548, 798)

PATIENT E

51. Patient E, a 57 year old woman was a patient of the Respondent on or about November 1988 and April 1990. (Pet. Exh. 8)

52. Respondent failed to obtain and note adequate medical histories. (Pet. Exh 8 & 9).

53. Dr. Howard testified that Respondent failed to perform and note adequate physical examination. (T. 179, 180)

54. Although Respondent noted Patient E had a physician at Gouverneur Hospital, he did not contact Patient E's treating physician, Dr. Pace to get a history or summary of the previous and current care for this patient. (T. 613, 179)

55. Patient E was seen by Respondent for management of her diabetes melitis and Respondent failed to appropriately manage Patient E's diabetes. (Pet. Exhs. 8 & (T. 181- 185)

56. Dr. Feinfeld, Respondent's expert agreed that Respondent's management of Patient E's diabetes did not comport with the minimally acceptable standards of medical care. (T. 786)

57. Respondent expert testified that Respondent failed to note or follow up the abnormal lab test results showing high cholesterol, and positive RPR and MHA -TP (Pet. Exh. 9) Nor did the patient's chart reflect that Respondent had properly followed up on the positive syphilis test. (Pet. Exhs. 8 & 9)

58. The Respondent testified that he failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan, and analysis of laboratory results. (T. 11, 640, 798)

PANEL'S DETERMINATION ON CHARGES

Paragraphs A, A(1) - A(4), A(6) is **SUSTAINED**

Charge A.1. - A.6. is **SUSTAINED**

Charge B.1. - B.6. is **SUSTAINED**

Charge C.1. - C.6. is **SUSTAINED**

Charge D.1. - D.5. is **SUSTAINED**

Charge E.1 - E.5. is **SUSTAINED**

PANEL'S DETERMINATION ON SPECIFICATIONS

First Specification is **GUILTY**

Second Specification is **GUILTY**

Third through Seventh Specification is **GUILTY**

Eighth through Twelfth Specification is **GUILTY**

Thirteenth through Sixteenth Specification is **GUILTY**

Seventeenth through Twenty-first Specification is **GUILTY**

Twenty-second Specification is **GUILTY**

DISCUSSION

After hearing the testimony of the experts for both the Department of Health and the Respondent and the testimony of the Respondent, it was clear that the Respondent had used poor judgment in treating his patients and was irresponsible in medicating patients while he was aware they were being seen by other physicians at other clinics. He repeatedly failed to contact the patient's physicians in order to coordinate the care for the patient or request patient's records. (T. 251, 286 - 287) This practice placed the patients in serious danger.

The Respondent inappropriately reported a diagnosis or medication without performing his own physical or necessary testing to substantiate the diagnosis. He repeatedly relied on the patient's own report of a diagnosis, yet raised the question of the veracity of the patients he was relying on to report.

The Respondent's reasoning that performing a test was unnecessary because the results of the tests may not be positive (T.414) is not consistent with acceptable medical practice. The Respondent testified that when he ordered a test if the patient was unable to utilize his clinic at the clinic hours he never referred them to other clinics and therefore they would not be tested.

The Panel found the Respondent's testimony to be contradictory and not credible. (T. 232 - 233, 322 - 323) The Respondent first testified that on the Goldwater application he failed to indicate that he had been suspended from the medicaid program.(T 291 - 293) Then the Respondent later testified that he misunderstood the question to refer to the New York City medicaid program. (T 448 - 450) Additionally, the patient's medical charts were certified by the Respondent as the true and complete records of the patients. However, during the course of the hearing, the Respondent referred to a different set of medical charts which he claimed were the true medical records. The Respondent's expert, Dr. Feinfeld testified that there was no evidence of other records.

The Panel found that the Respondent's testimony as to whether he was the patient's primary care physician or adjunct physician was unnacceptable. Although the Respondent saw one patient twenty-three times in eighteen months he testified he was only the "adjunct" physician, failed to coordinate care with another physician, failed to set up a treatment program and yet treated the patient's diabetes (T. 612 - 628).

The Panel found that, in addition to the evidence of incompetence and negligence, Dr. Oliver's actions were, in many instances, fraudulent, his records were knowingly false and the overall charge of his being morally unfit to practice was sustained. These conclusions were strengthened by the concerns about Dr. Oliver's credibility indicated above and arose from several observations. There was a general pattern, evident in all five patients, of prescriptions, office visits, and tests (notably EKG's) whose purpose was neither documented nor evident from the testimony of the experts and of Dr. Oliver himself. The effectiveness or complications o f the medications were almost never described nor was the effect of the medication on the putative clinical condition defined. Information necessary to monitor the effects of medication was undocumented, as for example in the prescription of insulin over a prolonged period, to Patient E without documentation of plasma glucose. The EKG's taken in Dr. Oliver's office were generally not interpreted, and in no instance was their indication or their effect on clinical management documented. Finally, there was continuous ambiguity in Dr. Oliver's records and testimony concerning the nature of his role in the care of these patients. There were repeated and often frequent office visits that were apparently duplicative of those of other physicians. The actions of these other physicians and health care facilities, with rare exceptions, were not documented in his records nor was there any attempt to coordinate his care with that of the other caregivers. Taken together, these findings support the charges that Dr. Oliver was prescribing medication, arranging office visits, and carrying out tests for his enrichment rather than the clinical care of his patients.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee, after giving due consideration to all the penalties available have unanimously determines that the Respondent's license to practice medicine in the state of New York should be **REVOKED**.

ORDER

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

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

DATED: New York, New York
9/15/98 **1998**

NORTON SPRITZ, M.D., J.D.

RUFUS NICHOLS, M.D.
EUGENIA HERBST

APPENDIX I

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

IN THE MATTER

OF

ALEXANDER OLIVER, M.D.

NOTICE
OF
HEARING

TO: ALEXANDER OLIVER, M.D.
1954 Union Port Road, Apt. 6J
Bronx, NY 10462

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1997) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1997). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on ~~NOV. 6, 1997~~ MAY 4, 1998, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF

ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 1997) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

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

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. October 9, 1997). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
October 9 ,1997

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Terrence Sheehan
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

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

IN THE MATTER
OF
ALEXANDER OLIVER, M.D.

STATEMENT
OF
CHARGES

ALEXANDER OLIVER, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 3, 1985, by the issuance of license number 164828 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between in or about October, 1988 and in or about March, 1990, Respondent treated Patient A, a 43 year old woman, at the Delancey Health Clinic, 154 Allen Street, New York, N.Y. (the Clinic). (The names of patients are contained in the attached Appendix.)

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed:
   a. Fioricet
   b. Florinal
   c. Tagamet
   d. Ampicillin

e. Benadryl

f. Bentyl

g. Corticosporin

3. Respondent failed to note or follow-up the following abnormalities:

a. persistent lab results showing low Hgb., Hct and Plt. counts.

b. an abnormal electrocardiogram.

4. The following diagnoses made by Respondent are inappropriate, undocumented and without legitimate medical purpose:

a. sinusitis

b. arthralgia

c. anxiety

5. Respondent, with intent to deceive, created a record for Patient A which is knowingly false and does not reflect legitimate patient care.

6. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan, and analysis of lab test results.

B. Between on or about October, 1989 and on or about March, 1990, Respondent treated Patient B, a 52 year old woman, at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed:
   a. Diprosone cream
   b. Lasix
   c. Brethene
   d. Slow K

3. Respondent failed to explore or follow-up why Patient B was taking anti-tuberculosis and anti-anginal medication.

4. The following diagnoses made by Respondent are inappropriate, undocumented and without legitimate medical purpose:
   a. peripheral vascular disease
   b. lupus
   c. diabetes melitis

5. Respondent, with intent to deceive, created a record for Patient B which is knowingly false and does not reflect legitimate patient care.

6. Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination,

diagnoses, treatment plan, and analysis of lab test results.

C. Between on or about August, 1988 and on or about May, 1990, Respondent treated Patient C, a 51 year old man, at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed:
   a. Vistaryl
   b. Buspar
   c. Ativan
   d. Minipres
   e. Motrin

3. Respondent failed to note or follow-up the following abnormality:
   a. An abnormal electrocardiogram

4. The following diagnoses made by Respondent are inappropriate, undocumented and without legitimate medical purpose:
   a. hypertension
   b. anxiety

5. Respondent, with intent to deceive, created a record for Patient C which is knowingly false and does not reflect legitimate patient care.

6. Respondent failed to maintain a record for Patient C which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan, and analysis of lab test results.

D. Between on or about October, 1988 and on or about April, 1990, Respondent treated Patient D, a 47 year old woman, at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed:
   a. Valium
   b. Vistaril
   c. Catapres
   d. Lasix
   e. Dyazide
   f. Antivert
   g. penicillin
   h. Naprosyn

3. The following diagnoses made by Respondent are inappropriate, undocumented and without legitimate medical purpose:
   a. asthma
   b. gastritis

4. Respondent, with intent to deceive, created a record for Patient D which is knowingly false and does not reflect legitimate patient care.

5. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan, and analysis of lab test results.

E. Between on or about November, 1988 and on or about April, 1990, Respondent treated Patient E, a 57 year old woman, at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Patient E was seen by Respondent for management of her diabetes melitis, which she had for 12 years. Respondent failed to appropriately manage Patient E's diabetes.

3. Respondent failed to note or follow-up the following abnormalities:
   a. lab tests showing high cholesterol, and positive RPR and MHA-TP.
   b. positive syphilis test

4. Respondent, with intent to deceive, created a record for Patient E

which is knowingly false and does not reflect legitimate patient care.

5. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examination, diagnoses, treatment plan, and analysis of lab test results.

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. 1997) 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. Paragraphs A and A(1)-A(4) and A(6), B and B(1) - B(4) and B(6), C and C(1) - C(4) and C(6), D and D(1) - D(3) and D(5), E and E(1) - E(3) and E(5).

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. 1997) 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. Paragraphs A and A(1)-A(4) and A(6), B and B(1) - B(4) and B(6),

C and C(1) - C(4) and C(6), D and D(1) - D(3) and D(5), E and E(1) - E(3) and E(5).

THIRD THROUGH SEVENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1997) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A and A(2), A(4) and A(5).
4. Paragraphs B and B(2), B(4) and B(5).
5. Paragraphs C and C(2), C(4) and C(5).
6. Paragraphs D and D(2) - D(4).
7. Paragraphs E and E(4).

EIGHTH THROUGH TWELFTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 1997) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

8. Paragraphs A and A(2), A(4) and A(5).
9. Paragraphs B and B(2), B(4) and B(5).
10. Paragraphs C and C(2), C(4) and C(5).
11. Paragraphs D and D(2) - D(4).
12. Paragraphs E and E(4).

THIRTEENTH THROUGH SIXTEENTH SPECIFICATIONS

UNNECESSARY TESTS OR TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1997) by ordering excessive tests or treatment as alleged in the facts of:

13. Paragraphs A and A(2)
14. Paragraphs B and B(2).
15. Paragraphs C and C(2).
16. Paragraphs D and D(2).

SEVENTEENTH THROUGH TWENTY-FIRST SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 1997) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

17. Paragraphs A and A(6).
18. Paragraphs B and B(6).
19. Paragraphs C and C(6).
20. Paragraphs D and D(5).
21. Paragraphs E and E(5).

TWENTY-SECOND SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1997) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

22. Paragraphs A and A(2), A(4), A(5), B and B(2), B(4), B(5), C and C(2), C(4), C(5), D and D(2) - D(4), and E and E(4).

DATED: October 9, 1997
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct