STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

February 4, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Koshi Padnani, M.D.
47-00 99th Street
Corona, New York 11368

Jeffrey Rubin, Esq. and
David Cheung, Esq.
Rubin & Shang
515 Madison Avenue
New York, New York 10022

David W. Smith, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

RE: In the Matter of Koshi Padnani, M.D.

Dear Dr. Padnani, Mr. Rubin, Mr. Cheung and Mr. Smith:

Enclosed please find the Determination and Order (No. BPMC-93-14) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Very truly yours,

Tyrone T. Butler/nam

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

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

IN THE MATTER	:	HEARING COMMITTEE'S FINDINGS OF FACT,
OF	:	CONCLUSIONS, DETERMINATION
KOSHI PADNANI, M.D.	:	AND ORDER
		ORDER NO. BPMC-93-14

JERRY WAISMAN, M.D., Chairperson, **CYRIL J. JONES, M.D.**, and **SISTER MARY THERESA MURPHY**, duly designated members of the State Board for Professional Medical Conduct, appointed pursuant to Section 230(1) of the Public Health Law of the State of New York, served as the hearing committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **GERALD H. LIEPSHUTZ, ESQ.**, served as administrative officer for the hearing committee.

After consideration of the entire record, the hearing committee issues its Findings of Fact, Conclusions, Determination and Order.

SUMMARY OF CHARGES

Respondent was charged with the following acts of professional misconduct as more fully set forth in a copy of the STATEMENT OF CHARGES attached hereto:

1. Practicing the profession with negligence on more than one occasion under New York Education Law §6530(3) (**FIRST AND SECOND SPECIFICATIONS**)

2. Practicing the profession with incompetence on more than one occasion under New York Education Law §6530(5) (**THIRD SPECIFICATION**)

3. Unprofessional conduct under New York Education Law §6530(35) in that she ordered excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient (**FOURTH THROUGH SEVENTH SPECIFICATIONS**)

4. Unprofessional conduct under New York Education Law §6530(32) in that she failed to maintain a record for each patient which accurately reflects her evaluation and treatment of the patient (**EIGHTH THROUGH ELEVENTH SPECIFICATIONS**)

RECORD OF PROCEEDINGS

Service of NOTICE OF HEARING and STATEMENT OF CHARGES:	May 7, 1992
Department of Health (Petitioner) appeared by:	David W. Smith Assistant Counsel Bureau of Professional Medical Conduct
Respondent appeared by:	Rubin & Shang Attorneys at Law 515 Madison Avenue New York, New York 10022 BY: Jeffrey Rubin, Esq. and David Cheung, Esq., of Counsel
Hearing dates:	July 21, 1992 July 28, 1992 September 25, 1992
Adjournments:	June 16, 1992, due to the actual engagement of Respondent's counsel
Hearing Committee absences:	None
Witness for Petitioner:	Stephen E. Moshman, M.D.
Witness for Respondent:	Koshi Padnani, M.D., Respondent

Post-hearing written submissions received from:

Petitioner	November 10, 1992
Respondent	November 10, 1992

Hearing Committee's deliberations held: November 12, 1992

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record in this matter. Numbers in parentheses preceded by "T." refer to transcript pages, while those preceded by "Ex." refer to an exhibit in evidence. These citations represent evidence found persuasive by the hearing committee while arriving at a particular finding. Conflicting evidence was considered and rejected in favor of the cited evidence. All findings of fact were made by a unanimous vote of the hearing committee.

1. Koshi Padnani, M.D., Respondent, was authorized to practice medicine in New York State on July 30, 1984 by the issuance of license number 159535 by the New York State Education Department. She is registered with the Education Department to practice medicine for the period January 1, 1991 to December 31, 1992 (Ex. 2).

REGARDING PATIENT A - FIRST, THIRD, FOURTH AND EIGHTH SPECIFICATIONS

2. Between July, 1986 and May, 1987, Respondent treated Patient A for back pain and other medical conditions

at her office at 100 West 113th Street, New York City (Ex. 3).

3. It was not proved by a preponderance of the evidence that Respondent failed to obtain an adequate history and physical examination for Patient A. Such a history and examination are not noted in the medical record (Ex. 3), but lack of notation does not necessarily mean that they were not done. Additional proof, such as testimony by the patient, would be necessary to convince the hearing committee that an adequate history and examination were not done for this patient.

4. Respondent did not keep adequate records regarding Patient A. Respondent did not deny this failure (T. 235, 244-245; Ex. 3).

5. Respondent's notes indicate that Patient A was a substance abuser of alcohol (Ex. 3 at pp. 2, 4; T. 40). Respondent prescribed a controlled substance, valium, for Patient A on July 1, 1986, March 19, 1987, April 3, 1987 and May 4, 1987 (Ex. 3 at pp. 2-3). Prescribing valium to an alcchol abuser was inappropriate (T. 82-87).

6. In or about July, 1986, Respondent inappropriately caused an abdominal ultrasound to be performed on Patient A. She failed to note any condition which indicated the need for such test and, in fact, such test was not warranted by the condition of the patient (Ex. 3; T. 31, 327-335).

REGARDING PATIENT B - FIRST, THIRD, FIFTH AND NINTH SPECIFICATIONS

7. Between January, 1987 and August, 1987, Respondent treated Patient B for cough and other medical conditions at her office at 100 West 113th Street, New York City (Ex. 4).

8. It was not proved by a preponderance of the evidence that Respondent failed to obtain an adequate history and physical examination for Patient B. Such a history and examination are not noted in the medical record (Ex. 4), but lack of notation does not necessarily mean that they were not done. Additional proof, such as testimony by the patient, would be necessary to convince the hearing committee that an adequate history and examination were not done for this patient.

9. Respondent did not keep adequate records regarding Patient B. She did not deny this failure (T. 361-365; Ex. 4).

10. Patient B was a substance abuser as reflected in Respondent's notes. Therefore, the prescribing of a controlled substance, valium, by Respondent for the patient was inappropriate (Ex. 4 at pp. 2-8; T. 108-109, 111-112, 125-127, 432-434).

11. In January, 1987, Respondent inappropriately caused an abdominal ultrasound to be performed on Patient B. She failed to note any condition which indicated the need for

the ultrasound (Ex. 4; T. 106-107, 119).

12. The results of the ultrasound reflected liver and spleen enlargement, but Respondent failed to perform, order or note indicated laboratory and diagnostic tests. She failed to appropriately follow up the results of the ultrasound (Ex. 4; T. 118-120).

REGARDING PATIENT C - FIRST, THIRD, SIXTH AND TENTH SPECIFICATIONS

13. Between March, 1987 and September, 1987, Respondent treated Patient C for backache and other medical conditions at her office at 100 West 113th Street, New York City (Ex. 5).

14. It was not proved by a preponderance of the evidence that Respondent failed to obtain an adequate history and physical examination for Patient C. Such a history and examination are not noted in the medical record (Ex. 5), but lack of notation does not necessarily mean that they were not done. Additional proof, such as testimony by the patient, would be necessary to convince the hearing committee that an adequate history and examination were not done for this patient.

15. Respondent did not keep adequate records regarding Patient C. She did not deny this failure (T. 444-449, 472; Ex. 5).

16. Patient C was a substance abuser as reflected in Respondent's notes. Therefore, the prescribing of a controlled substance, valium, by Respondent for the patient

was inappropriate (Ex. 5 at pp. 6-9; T. 151-152).

17. In April, 1987, Respondent inappropriately caused to be performed an abdominal sonogram on Patient C. She failed to note any condition which indicated the need for such test (Ex. 5; T. 153, 172-173).

18. In March, 1987, a laboratory test ordered by Respondent indicated that Patient C had a substantially elevated T4 level (Ex. 5 at p. 4). Respondent failed to order, perform or note indicated laboratory and diagnostic tests. She failed to treat the condition (T. 155, 159-160; Ex. 5).

19. Beginning in March, 1987, Patient C had elevated blood pressure readings as reflected in Respondent's records (Ex. 5 at pp. 6-7). Respondent failed to order, perform or note indicated laboratory and diagnostic tests (Ex. 5; T. 155-157, 161-163), but she did not fail to treat Patient C's hypertension entirely (T. 461-462, 470-471).

REGARDING PATIENT D - FIRST, THIRD, SEVENTH AND ELEVENTH SPECIFICATIONS

20. Between April, 1987 and May, 1987, Respondent treated Patient D for backache and other medical conditions at her office at 100 West 113th Street, New York City (Ex. 6).

21. It was not proved by a preponderance of the evidence that Respondent failed to obtain an adequate history and physical examination for Patient D. Such a history and examination are not noted in the medical record (Ex. 6), but

lack of notation does not necessarily mean that they were not done. Additional proof, such as testimony by the patient, would be necessary to convince the hearing committee that an adequate history and examination were not done for this patient.

22. Respondent did not keep adequate records regarding Patient D. She did not deny this failure (Ex. 6; T. 568-569).

23. Patient D was a substance abuser as reflected in Respondent's records (Ex. 6 at p. 2). Therefore, Respondent's prescribing of a controlled substance, valium, (Ex. 6 at pp. 2, 4), was inappropriate (T. 181, 195-196).

REGARDING THE INAPPROPRIATE STORING OF PRESCRIPTIONS - SECOND SPECIFICATION

24. Respondent inappropriately kept completed prescription blanks signed by her with the dosage and the identity of a controlled substance stated thereon, but with the name of the patient left blank. She kept said prescriptions both at her office and at her home at 90-58 51st Avenue, Elmhurst, New York (Ex. 7; T. 637-639, 672-678).

CONCLUSIONS

The following conclusions were reached pursuant to the findings of fact herein. All conclusions resulted from a unanimous vote of the hearing committee. Negligence, for purposes of the hearing committee's conclusions, was defined as a failure to exercise the care that would be exercised by

a reasonably prudent physician under the circumstances. Incompetence was defined as a lack of the skill or knowledge necessary to perform a particular act.

REGARDING PATIENT A

Findings of Fact 2 through 6 herein concern Patient A. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph A(1)	not sustained as to failing to obtain an adequate history and sustained as to failing to note an adequate history (Findings of Fact 3 and 4)
paragraph A(2)	not sustained as to failing to perform an adequate physical examination and sustained as to failing to note an adequate physical examination (Findings of Fact 3 and 4)
paragraph A(3)	sustained as to inappropriately prescribing valium, a controlled substance, to a substance abuser (Finding of Fact 5)
paragraph A(4)	sustained (Finding of Fact 6)

It is concluded that Respondent's conduct regarding Patient A constituted negligence (paragraph A(3) - FIRST SPECIFICATION), ordering excessive tests and treatment (paragraphs A(3) and A(4) - FOURTH SPECIFICATION), and failing to maintain a record for Patient A which accurately reflected the evaluation and treatment of the patient

(paragraphs A(1), A(2) and A(4) - EIGHTH SPECIFICATION). It is concluded that Respondent's conduct did not constitute incompetence (THIRD SPECIFICATION), because it was not proved by a preponderance of the evidence that Respondent lacked skill or knowledge.

REGARDING PATIENT B

Findings of Fact 7 through 12 herein concern Patient B. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph B(1)	not sustained as to failing to obtain an adequate history and sustained as to failing to note an adequate history (Findings of Fact 8 and 9)
paragraph B(2)	not sustained as to failing to perform an adequate physical examination and sustained as to failing to note an adequate physical examination (Findings of Fact 8 and 9)
paragraph B(3)	sustained as to inappropriately prescribing valium, a controlled substance, to a substance abuser (Finding of Fact 10)
paragraph B(4)	sustained as to inappropriately causing an abdominal ultrasound to be performed and failing to note any condition indicating the need for such test; not sustained as to proving that the test was not ultimately warranted by the condition of the patient (Finding of Fact 11)

paragraph B(5)	sustained (Finding of Fact 12)

It is concluded that Respondent's conduct regarding Patient B constituted negligence (paragraph B(3) - FIRST SPECIFICATION), ordering excessive tests and treatment (paragraphs B(3) and B(4) - FIFTH SPECIFICATION), and failing to maintain a record for Patient B which accurately reflected the evaluation and treatment of the patient (paragraphs B(1), B(2), B(4) and B(5) - NINTH SPECIFICATION). It is concluded that Respondent's conduct did not constitute incompetence (THIRD SPECIFICATION), because it was not proved by a preponderance of the evidence that Respondent lacked skill or knowledge.

REGARDING PATIENT C

Findings of Fact 13 through 19 herein concern Patient C. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph C(1)	not sustained as to failing to obtain an adequate history and sustained as to failing to note an adequate history (Findings of Fact 14 and 15)
paragraph C(2)	not sustained as to failing to perform an adequate physical examination and sustained as to failing to note an adequate physical examination (Findings of Fact 14 and 15)

paragraph C(3)	sustained as to inappropriately prescribing valium, a controlled substance, to a substance abuser (Finding of Fact 16)
paragraph C(4)	sustained as to inappropriately causing a sonogram to be performed and failing to note an indicating condition for the sonogram (Finding of Fact 17)
paragraph C(5)	sustained (Finding of Fact 18)
paragraph C(6)	sustained as to Patient C having had elevated blood pressure for which Respondent failed to order, perform or note indicated laboratory and diagnostic tests, and not sustained as to failing to treat the condition entirely (Finding of Fact 19)

It is concluded that Respondent's conduct regarding Patient C constituted negligence (paragraphs C(3), C(5) and C(6) - FIRST SPECIFICATION), ordering excessive tests and treatment (paragraphs C(3) and C(4) - SIXTH SPECIFICATION), and failing to maintain a record for Patient C which accurately reflected the evaluation and treatment of the patient (paragraphs C(1), C(2), C(4) and C(6) - TENTH SPECIFICATION). It is concluded that Respondent's conduct did not constitute incompetence (THIRD SPECIFICATION), because it was not proved by a preponderance of the evidence that Respondent lacked skill or knowledge.

REGARDING PATIENT D

Findings of Fact 20 through 23 herein concern Patient D. The hearing committee reached the following

conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph D(1)	not sustained as to failing to obtain an adequate history and sustained as to failing to note an adequate history (Findings of Fact 21 and 22)
paragraph D(2)	not sustained as to failing to perform an adequate physical examination and sustained as to failing to note an adequate physical examination (Findings of Fact 21 and 22)
paragraph D(3)	sustained as to inappropriately prescribing valium, a controlled substance, to a substance abuser (Finding of Fact 23)

It is concluded that Respondent's conduct regarding Patient D constituted negligence (paragraph D(3) - FIRST SPECIFICATION), ordering excessive treatment (paragraph D(3) - SEVENTH SPECIFICATION), and failing to maintain a record for Patient D which accurately reflected the evaluation and treatment of the patient (paragraphs D(1) and D(2) - ELEVENTH SPECIFICATION). It is concluded that Respondent's conduct did not constitute incompetence (THIRD SPECIFICATION), because it was not proved by a preponderance of the evidence that Respondent lacked skill or knowledge.

REGARDING INAPPROPRIATELY STORING PRESCRIPTIONS

Finding of Fact 24 herein concerns this charge. The hearing committee reached the following conclusions

regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph E	sustained (Finding of Fact 24)

It is concluded that Respondent's conduct regarding the storing of prescriptions constituted negligence (paragraph E - SECOND SPECIFICATION) on one occasion.

DETERMINATION AND ORDER

Pursuant to the hearing committee's conclusions herein, the following Specifications have been sustained:

1. **FIRST SPECIFICATION - NEGLIGENCE ON MORE THAN ONE OCCASION** regarding Patients A, B, C and D

2. **FOURTH SPECIFICATION - ORDERING EXCESSIVE TESTS AND TREATMENT** regarding Patient A

3. **FIFTH SPECIFICATION - ORDERING EXCESSIVE TESTS AND TREATMENT** regarding Patient B

4. **SIXTH SPECIFICATION - ORDERING EXCESSIVE TESTS AND TREATMENT** regarding Patient C

5. **SEVENTH SPECIFICATION - ORDERING EXCESSIVE TREATMENT** regarding Patient D

6. **EIGHTH SPECIFICATION - FAILING TO MAINTAIN AN ACCURATE RECORD** regarding Patient A

7. **NINTH SPECIFICATION - FAILING TO MAINTAIN AN ACCURATE RECORD** regarding Patient B

8. **TENTH SPECIFICATION - FAILING TO MAINTAIN AN ACCURATE RECORD** regarding Patient C

9. **ELEVENTH SPECIFICATION - FAILING TO MAINTAIN AN ACCURATE RECORD** regarding Patient D

The following Specifications have not been sustained:

1. **SECOND SPECIFICATION - NEGLIGENCE ON MORE THAN ONE OCCASION** regarding the storage of prescriptions. Although Respondent's conduct was found to be negligent, it is considered by the hearing committee to have been, in effect, one act of recurring negligence rather than separate and discrete acts of negligence on more than one occasion as required to sustain this charge.

2. **THIRD SPECIFICATION - INCOMPETENCE ON MORE THAN ONE OCCASION** regarding Patients A, B, C and D.

Respondent's acts of professional misconduct involving negligence on more than one occasion, ordering excessive tests and treatment, and inaccurate recordkeeping warrant a serious penalty in order to deter Respondent from engaging in such conduct in the future. However, it is unanimously determined by the hearing committee that Respondent's acts do not warrant the revocation of her

license to practice medicine in that these acts did not rise to the level of being gross or shocking in nature.

IT IS HEREBY ORDERED:

1. **THAT** Respondent's license to practice medicine in the State of New York be wholly suspended for a period of four (4) months; and

2. **THAT** Respondent be fined a total of three thousand dollars ($3,000.00) for her nine acts of professional misconduct.

DATED: **New York, New York**
January 25, 1993

JERRY WAISMAN, M.D.,
Chairperson

CYRIL J. JONES, M.D.
SISTER MARY THERESA MURPHY

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
KOSHI PADNANI, M.D.	:	CHARGES

----------X

KOSHI PADNANI, M.D., the Respondent, was authorized to practice medicine in New York State on July 30, 1984 by the issuance of license number 159535 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 to December 31, 1992.

FACTUAL ALLEGATIONS

A. Between in or about July, 1986, and in or about May, 1987, Respondent treated Patient A, (this patient and all other patients are identified in the Appendix attached hereto), for back pain and other medical conditions at her office at 100 West 113th Street, New York City.

1. Respondent failed throughout this period to obtain and note an adequate history.

2. Respondent failed throughout this period to perform and note an adequate physical examination.

3. Respondent's notes indicate that Patient A was a substance abuser. Respondent, nevertheless at each visit, inappropriately prescribed controlled substances for Patient A.

4. In or about July, 1986, Respondent inappropriately caused an abdominal ultrasound to be performed on Patient A. Respondent failed to note any condition which indicated the need for such test and, in fact, such test was not warranted by the condition of Patient A.

B. Between in or about January, 1987 and in or about August, 1987, Respondent treated Patient B for cough and other medical conditions at her office at 100 West 113th Street, New York City.

1. Respondent failed throughout the period to obtain and note an adequate history.

2. Respondent failed throughout the period to perform and note an adequate physical examination.

3. Respondent's notes reflect that Patient B was a substance abuser. Nevertheless, Respondent inappropriately prescribed controlled substances for Patient B.

4. In or about January, 1987, Respondent inappropriately caused an abdominal ultrasound to be performed on Patient B. Respondent failed to note any condition which indicated the need for such test and, in fact, such test was not warranted by the condition of Patient B.

5. The results of the ultrasound reflected liver and spleen enlargement. Nevertheless, Respondent failed to perform, order or note indicated laboratory and diagnostic tests and failed to appropriately follow up the results of the ultrasound.

C. Between in and about March, 1987 and in or about September, 1987, Respondent treated Patient C for backache and other medical conditions at her office at 100 West 113th Street, New York City.

1. Respondent failed throughout the period to obtain and note an adequate history.

2. Respondent failed throughout the period to perform and note an adequate physical examination.

3. Respondent's notes reflect that Patient C was a substance abuser. Despite this, Respondent inappropriately prescribed controlled substances for Patient C.

4. In or about April, 1987, Respondent inappropriately caused to be performed an abdominal sonogram on Patient C. Respondent failed to note any condition which indicated the need for such test and, in fact, such test was not warranted by the condition of Patient C.

5. In or about March, 1987, a laboratory test ordered by Respondent indicated that

Patient C had a substantially elevated T4 level. Nevertheless, Respondent failed to order, perform, or note indicated laboratory and diagnostic tests and failed to treat the condition.

6. Beginning in or about March of 1987, Respondent's records reflect that Patient C had elevated blood pressure readings. Nevertheless, Respondent failed to order, perform or note indicated laboratory and diagnostic tests and failed to treat the condition.

D. Between in or about April, 1987, and in or about May, 1987, Respondent treated Patient D for backache and other medical conditions at her office at 100 West 113th Street, New York City.

1. Respondent failed throughout the period to obtain and note an adequate history.

2. Respondent failed throughout the period to perform and note an adequate physical examination.

3. Respondent's records reflect that Patient D was a substance abuser. Nevertheless, Respondent inappropriately prescribed controlled substances to Patient D.

E. Respondent inappropriately kept completed prescription blanks, signed by her with the dosage and identity of a controlled substance stated thereon but the name of the patient left blank, both at her office and at her home at 90-58 51st Avenue, Elmhurst, New York.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1992) in that Petitioner charges that Respondent committed at least two of the following:

1. The facts In Paragraphs A and A1-3; B and B1-3, 5; C and C1-3, 5, 6; and/or D and D1 - 3.

2. The facts in Paragraphs E.

THIRD SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1992) in that Petitioner charges that Respondent committed at least two of the following:

3. The facts in Paragraphs A and A1-3; B and B1-3,5; C and C1-3,5,6; and/or D and D1-3.

FOURTH THROUGH SEVENTH SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1992) in that she ordered excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient. Petitioner charges:

4. The facts in Paragraphs A and A3 - 4.

5. The facts in Paragraphs B and B3 - 4.

6. The facts in Paragraphs C and C3 - 4.

7. The facts in Paragraphs D and D3.

EIGHTH THROUGH ELEVENTH SPECIFICATIONS

FAILURE TO KEEP RECORDS

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1992) in that she failed to maintain a record for each patient which accurately reflects her evaluation and treatment of the patient. Specifically, Petitioner charges:

8. The facts in Paragraphs A and A1,2,4.

9. The facts in Paragraphs B and B1,2,4,5.

10. The facts in Paragraphs C and C1,2,4,6.

11. The facts in Paragraphs D and D1,2.

DATED: New York, New York
April 23, 1992

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct