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

February 24, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Claudia Morales Bloch, Esq.
New York State Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Alice Piasecki, M.D.
853 Seventh Avenue at 54th Street
New York, New York 10015

Richard E. Hershenson, Esq.
750 Third Avenue
New York, New York 10017

RE: In the Matter of Alice Piasecki, M.D.

Dear Ms. Bloch, Mr. Hersenson and Dr. Piasecki:

Enclosed please find the Determination and Order (No. BPMC-97-45) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:crc
Enclosure

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

IN THE MATTER

OF

ALICE MARY PIASECKI, M.D.

DETERMINATION AND ORDER

BPMC-97-45

A Notice of Hearing and a Statement of Charges, dated September 26, 1996, were served upon the Respondent, Alice Mary Piasecki, M.D. **RICHARD N. PIERSON, JR., M.D. (Chair), ROBERT J. O'CONNOR, 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 (hereinafter "the Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Claudia Morales Bloch, Esq., Associate Counsel. The Respondent appeared by Richard E. Hershenson, Esq. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	September 26, 1996
Respondent's Answer:	October 29, 1996
Date of Prehearing Conference:	October 29, 1996
Dates of Hearing:	November 6, 1996

November 20, 1996

Witnesses for Department of Health:	Diane M. Sixsmith, M.D.
	Mary Lou Clifford
Witness for Respondent:	Alice Mary Piasecki, M.D.
Deliberations Held:	December 30, 1996

STATEMENT OF CASE

The Respondent was charged with thirty-three specifications of professional misconduct. The specifications include practicing with incompetence on more than one occasion, negligence on more than one occasion, ordering of excessive tests and/or treatment, failure to maintain records, practicing fraudulently and having been found guilty of violating a state regulation. The charges arose from the Respondent's treatment of ten patients in 1988. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All Findings and Conclusions herein are the unanimous determination of the Committee. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact. Conflicting evidence, if any, was considered

and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence.

GENERAL FINDINGS

1. ALICE MARY PIASECKI, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on February 1, 1967, by the issuance of license number 098309 by the New York State Education Department. (Department Exhibit [hereinafter Dept. Ex.] 2)

2. On or about February 28, 1994, a Decision After Hearing was issued by the New York State Department of Social Services (DSS) which found Respondent guilty of violating New York State Regulations. This finding was appealed to the Appellate Division, First Department, which affirmed the finding of the Hearing Officer that the Respondent had violated New York State Regulations. No further appeal is pending. (Transcript [hereinafter T.] page 24, 288; Dept. Exs. 5-7)

3. Respondent was found to have violated the New York State Regulations, Title 18 NYCRR §515.2(b)(1)(i), (causing the submission of false claims, as defined by this section as claims for unfurnished medical care, services, or supplies and claims for medical care, services or supplies at a frequency or in an amount not medically necessary) and § 515.2(b)(6), (failing to maintain records necessary to fully disclose the necessity for and the nature and extent of services the Respondent

billed for and ordered). (Dept. Exs. 5-7)

4. Patients A through J were the Respondent's patients and that the records for these patients were prepared by her. (T. 344 ; Dept. Exs. 4A-4J)

5. On each of the charts for Patients A through J, Respondent recorded an almost identical history which includes peptic ulcer disease (PUD), bronchial asthma, a complaint of pain, and/or nervousness. (Dept. Exs. 4A-4J; T. 154, 189, 196-197)

6. With a patient presentation of PUD, a proper history should include a note of the patient's symptoms, whether the patient is currently symptomatic, when the diagnosis of PUD was made and on what basis it was made, The Respondent's history for the 10 patients in question did not include this information. (Exh. 4A-4J, T. 49, 81)

7. With a patient presentation of a history of asthma, a proper history should include an inquiry as to how long the patient has had asthma, whether the asthma is allergic in nature, whether the patient requires constant or episodic medication, whether the patient is under a physician's care and is currently on medication, whether the patient has ever been on steroids or required hospitalization for their asthma and whether there is a family history of asthma. The Respondent's history for the 10 patients in question did not include this information . (Exh. 4A-4J; T. 53, 103)

8. A comprehensive patient office visit consists of: a history which includes the chief complaint, history of present illness, past personal history, family history,

and, in women, a reproductive history; a complete physical examination and review of systems; a patient assessment, and treatment plan including prescriptions, laboratory tests and other necessary diagnostic evaluation. The components of a comprehensive exam must be documented, including pertinent negative as well as positive findings. (T. 54, 94-95, 213-215)

9. Respondent billed the Medical Assistance Program (hereinafter referred to as "the Program"), and received reimbursement for comprehensive examinations on Patients A-I. (Exh. 4A-4I & 8; T. 326, 329, & 350)

10. An electrocardiogram (EKG) is generally indicated on an immediate basis in a patient who presents complaining of chest pain and/or with events related to heart trouble. Additionally, EKGs are indicated as part of an initial comprehensive history and physical evaluation of a patient who might have risk factors for heart disease. A physician should note in the patient's chart the indications the physician determined for performing an EKG. The Respondent's charts did not contain such indications. (T. 45, 62-63; Dept. Exs. 4A-J & 8)

11. If an EKG is performed, it is medically appropriate to include a copy of the EKG in the chart, even if normal, for future reference. Additionally, it is necessary for a physician to either include a full report or, at a minimum, a note indicating how he or she interpreted the EKG. Respondent did not do this. (T.58-59, 142; Dept. Exs. 4A-J)

12. A bronchospasm evaluation is indicated on an urgent basis for a patient who presents experiencing an acute asthma or emphysema attack. It may also be done as part of a physician's evaluation of a patient's response to therapy for these conditions

and/or as part of a comprehensive history and physical workup in a patient who presents with risk factors for, or known, lung disease. Bronchospasm evaluations are not routinely done on asthma patients unless there is a documented respiratory problem. A physician should note in the patient's chart the indications the physician determined for performing a brochospasm evaluation. The Respondent's charts did not contain such indications. (T. 45-46, 51-53, 62-63; Dept. Exs. 4A-J & 8)

13. If a bronchospasm evaluation is performed, it is medically appropriate to include a copy of the test results in the patient's chart, even if those results are normal. The Respondent did not do this. (T. 59; Dept. Exs. 4A-J & 8)

14. At the clinic where the Respondent was employed from 1987 through 1989 the phlebotomist performed the EKG's and spirometry (bronchospasm evaluation) on every patient. The Respondent did not do either test on any of the clinic patients, yet she billed and was reimbursed by the Program for having performed both tests. (T.307-308, 322-325, 329, & 394; Dept. Exs. 4A-4J, & 8)

15. A patient must present with indications to justify a physician ordering certain laboratory tests. (T. 55)

16. When laboratory tests are performed a note should be made in the patient's record about the results. The Respondent never made any note in any chart regarding laboratory results. (T. 61, 73; Dept.Exs. 4A-C, E, G-J)

17. A laboratory cannot perform any tests without a doctor's order to do so. Respondent's name appears as the referring physician on each of the laboratory results sheets, with a date the sample was received corresponding to a visit by the

patient to the Respondent. (T. 76; Dept. Exs. 4A-C, E, G-J & 8)

18. A physician should not prescribe two tranquilizers, such as Ativan and Buspar, or Valium and Buspar, at the same time, especially in a patient who has a history of substance abuse, because to do so creates the possibility for untoward side effects, such as overdose and abuse. (T. 90)

19. Respondent did not at the time of the hearing nor at the times in 1988 when she was seeing Patients A through J, have an independent recollection of each individual patient beyond what she recorded in their charts. (T. 276, 345-349)

PATIENT A

20. Between on or about May 5, 1988 and on or about May 19, 1988, Respondent undertook the care and treatment of Patient A at her medical offices, known as Doctors' Office, located in New York, N.Y. (hereinafter referred to as "her medical offices"). (Dept. Ex. 4A; T. 344)

21. The chart for the initial visit of May 5, 1988, notes Patient A's age as 28 years old and an abnormally high blood pressure reading of 160/120 and a note of a "sprained ankle," PUD, and bronchial asthma. A patient with an elevated blood pressure should have it evaluated and a history, including an assessment of risk factors, family history, prior incidence of hypertension and/or past treatment should be obtained. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient A contained no evaluation or history of his elevated blood pressure nor a

chief complaint or any history regarding any of the conditions noted. (T. 48-50, 71-73; Dept. Ex. 4A)

22. On May 19, 1988, Patient A saw the Respondent for a follow up visit. On such a visit a history and the reason for the return should be noted. Additionally with a patient with a record of a previously elevated blood pressure where medication had been prescribed the physician should inquire as to the patient's management of his blood pressure and reaction to the medications prescribed. The Respondent did not note any of this information in the patient's record. (T. 60-61; Dept. Ex. 4A)

23. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the May 5, 1988, office visit for this patient did not contain this information and her record for the May 19, 1988, follow up visit contained no record of a physical examination having been performed. (T. 50, 60-61, 63, 71-75; Dept. Ex. 4A)

24. On May 19, 1988, Respondent prescribed, without an adequate indication, Clinoril and BuSpar. (T.59-61; Dept. Ex. 4A & 8)

25. On or about May 5, 1988, Respondent ordered laboratory blood work, for which there was no indication, including a sickle cell test, hemoglobin electrophoresis, rheumatoid factor, zero active protein, ANA, Anti-DNA, ASO and thyroid function test. (T. 55-56; Dept. Ex. 4A)

26. If a physician receives an abnormal laboratory test result he should follow up with his patient. A laboratory test report dated May 10, 1988, indicated Patient A tested positive for syphilis yet on the patient's return visit on May 19, 1988, the

Respondent did not explore this matter with the patient or follow up this abnormal test result in any manner. (T. 61-62; Dept. Ex. 4A)

27. An adequate evaluation of a patient with elevated blood pressure, as this patient presented, would include the ordering of a chest x-ray, urinalysis and EKG. The respondent did not order these for this patient. (T. 48; Dept. Ex. 4A)

28. Respondent billed the Program for having performed an "Electrocardiogram, 12 lead, with interpretation and report," (hereinafter "EKG") and a "Bronchospasm evaluation, before and after bronchodilation or exercise," (hereinafter "Bronchospasm") on May 5, 1988 and on May 19, 1988. There is no indication in the record that either test was performed on those dates nor is there any indication that the Bronchospasm was medically indicated on either visit or an EKG on the second visit.. (T. 50-53, 58-59, 62-63; Dept. Ex. 4A & 8)

PATIENT B

29. Between on or about April 19, 1988 and on or about May 20, 1988, Respondent undertook the care and treatment of Patient B, a female, at her medical offices. (T. 344; Dept. Ex. 4B)

30. The chart for the initial visit of April 19, 1988, notes a history including PUD, Bronchial Asthma, AIDS, injured back, and drug abuse. A history for an adult female patient should include a reproductive history. Other than recording the onset of the patient's menses, Respondent did not obtain a reproductive history. A patient's office visit record should note a chief complaint and a history with regard

to any other conditions noted. The Respondent's record for Patient B contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 77-81, 94; Dept. Ex. 4B)

31. On May 20, 1988, Patient B saw the Respondent for a follow up visit. On such a visit a history and the reason for the return should be noted. The Respondent did not note any of this information in the patient's record. (T. 91-94; Dept. Ex. 4B)

32. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the April 19, 1988, office visit for this patient did not contain this information and her record for the May 20, 1988, follow up visit contained no record of a physical examination having been performed. (T. 50, 84-85, 94-95; Dept. Ex. 4B)

33. On April 19, 1988 and/or May 20, 1988, Respondent prescribed, without an adequate indication, Tagamet, Naprosyn, Proventil, BuSpar, Ativan and Lotrimin. (T.89-93; Dept. Ex. 4B)

34. On or about April 19, 1988, Respondent ordered laboratory blood work, for which there was no indication, including a sickle cell test, hemoglobin electrophoresis, ferritin, vitamin B-12, folic acid and hepatitis serology. (T. 87-88; Dept. Ex. 4B)

35. If a physician receives an abnormal laboratory test result he should follow up with his patient. A laboratory test report dated April 23, 1988, indicated Patient B tested positive for syphilis and had a critically low hematocrit. Yet on the patient's return visit on May 20, 1988, the Respondent did not explore this matter with the

patient or follow up this abnormal test results in any manner. (T. 93; Dept. Ex. 4B)

36. Respondent billed the Program for providing the services of a comprehensive office visit on May 20, 1988, listed under the Program as a "comprehensive service, established patient," (hereinafter "comprehensive established"). There is no indication in the record that such a service was provided on that date. (T. 95; Dept. Ex. 4B & 8)

37. Respondent billed the Program for having performed an EKG and a Bronchospasm on April 19, 1988. There is no indication in the record that either test was performed nor is there any indication that either test was medically indicated. (T. 85-86; Dept. Ex. 4B & 8)

PATIENT C

38. Between on or about April 21, 1988 and on or about May 24, 1988, Respondent undertook the care and treatment of Patient C, at her medical offices. (T. 344; Dept. Ex. 4C;)

39. The chart for the initial visit of April 21, 1988, notes a history which includes PUD, bronchial asthma, cough with yellow sputum, and a dislocated toe. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient C contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 108-110; Dept. Ex. 4C)

40. On May 24, 1988, Patient C saw the Respondent for a follow up visit. On

such a visit a history and the reason for the return should be noted. The Respondent did not note any of this information in the patient's record. (T. 118-119; Dept. Ex. 4C)

41. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the April 21, 1988, office visit for this patient did not contain this information and her record for the May 24, 1988, follow up visit contained no record of a physical examination having been performed. (T. 110-113, 118-119; Dept. Ex. 4C)

42. On April 21, 1988 and/or May 24, 1988, Respondent prescribed, without an adequate indication, Zantac, Proventil, Buspar, Lotrimin, Valium, Motrin, BuSpar and Tetracycline. (T. 116-117, 119-120; Dept. Ex. 4C & 8)

43. On or about April 21, 1988, Respondent ordered laboratory blood work, for which there was no indication, including a sickle cell test, hemoglobin electrophoresis, thyroid function test, ferritin, vitamin B-12, folic acid and hepatitis serology. (T. 115-116; Dept. Ex. 4C)

44. Respondent billed the Program for having performed an EKG and a Bronchospasm on April 21, 1988 and May 24, 1988. There is no indication in the record that either test was performed on those dates nor is there any indication that either test was medically indicated. (T. 113-114, 120; Dept. Ex. 4B & 8)

PATIENT D

45. Between on or about February 19, 1988 and on or about May 5, 1988,

Respondent undertook the care and treatment of Patient D at her medical offices. (T. 344; Dept.Ex. 4D & 8)

46. On April 19, 1988, Respondent recorded a history including a borderline B/P of 130/90, gastritis, shortness of breath for two months, and "Bad nerves". The patient was also recorded as using crack and alcohol. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient D contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 130-133, 135; Dept. Ex. 4D)

47. On May 5, 1988, Patient D saw the Respondent for a follow up visit. On such a visit a history and the reason for the return should be noted. The Respondent did not note any of this information in the patient's record. (T. 136; Dept. Ex. 4D)

48. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the February 19, 1988, office visit for this patient did not contain this information and her record for the May 5, 1988, follow up visit contained no record of a physical examination having been performed. (T. 133-134; Dept. Ex. 4D)

49. On April 21, 1988, Respondent prescribed, without an adequate indication, Catapres, Zantac, Clinoril, Proventil, Valisone, and Valium. (T. 134-135; Dept. Ex. 4D)

50. Respondent billed the Program for providing the services of a comprehensive office visit on May 5, 1988, listed under the Program as a

"comprehensive service, new patient," (hereinafter "comprehensive new patient"). There is no indication in the record that such a service was provided on that date. (T. 136; Dept. Ex. 4D & 8)

51. Respondent billed the Program for having performed an EKG and a Bronchospasm on February 19, 1988 and May 5, 1988. There is no indication in the record that either test was performed on those dates nor is there any indication that either test was medically indicated. (T. 133, 136-137; Dept. Ex. 4D & 8)

PATIENT E

52. Between on or about February 24, 1988 and May 18, 1988, Respondent undertook the care and treatment of Patient E at her medical offices. (T. 344; Dept.Ex. 4E)

53. On February 24, 1988, Respondent recorded a history which included an elevated blood pressure of 150/95, PUD, bursitis, bronchial asthma, on NPH, and substance abuse of cocaine and alcohol. On April 18, 1988, Respondent recorded a history which includes bad nerves, bronchial asthma, PUD and colds frequently. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient E contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 130-133, 135, 146-147; Dept. Ex. 4E)

54. On May 18, 1988, Patient E saw the Respondent for a follow up visit. On such a visit a history and the reason for the return should be noted. The Respondent did not note any of this information in the patient's record. (T. 150-152; Dept. Ex.

4E)

55. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the February 24, 1988, and April 18, 1988 office visits for this patient did not contain this information and her record for the May 18, 1988, follow up visit contained no record of a physical examination having been performed. (T. 140-142, 151; Dept. Ex. 4E)

56. On February 24, 1988, April 18, 1988 and/or May 18, 1988, Respondent prescribed, without an adequate indication, Zantac, Proventil, Buspar, Lotrimin, Valium, BuSpar Aldomet, Ceclor, Diabenese and Clinoril. (T. 142-143, 150-151; Dept. Ex. 4E)

57. On or about April 18, 1988, Respondent ordered laboratory blood work, for which there was no indication, including a sickle cell test, hemoglobin electrophoresis, thyroid function test, vitamin B-12, folic acid and hepatitis serology. (T. 149-150; Dept. Ex. 4E)

58. Respondent billed the Program for providing the services of a comprehensive office visit on April 18, 1988, listed under the Program as a comprehensive new patient. Respondent also billed the Program for providing the services of a comprehensive office visit on February 24, 1988 and May 18, 1988, listed under the Program as a comprehensive established. There is no indication in the record that such services were provided on those dates. (T. 148-150, 152; Dept. Ex. 4E & 8)

59. Respondent billed the Program for having performed an EKG and a

Bronchospasm on February 24, 1988 and April 18, 1988. There is no indication in the record that either test was performed on those dates nor is there an indication in the record that either test was medically indicated. (T. 141; Dept. Ex. 4E & 8)

PATIENT F

60. Between on or about February 24, 1988 and on or about May 5, 1988, Respondent undertook the care and treatment of Patient F at her medical offices. (T. 344; Dept. Ex. 4F)

61. On February 24, 1988, Respondent recorded a history which included PUD, bronchial asthma, collapsed lung 5 years ago, "on Motrin for pain in upper back," and cough with yellow sputum. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient F contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 157-159; Dept. Ex. 4F)

62. On May 5, 1988, Patient F saw the Respondent for a follow up visit. On such a visit a history and the reason for the return should be noted. The Respondent did not note any of this information in the patient's record. (T. 162; Dept. Ex. 4F)

63. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the February 24, 1988, office visit for this patient did not contain this information and her record for the May 5, 1988, follow up visit contained no record of a physical examination having been performed. (T. 159-160, 161-162; Dept. Ex. 4F)

64. On February 24, 1988, and/or May 5, 1988, Respondent prescribed, without an adequate indication, Zantac, Proventil, BuSpar, Lotrimin, Valium, Benadryl, Ceclor, Motrin and Clinoril. (T. 160,162-163 ; Dept. Ex. 4F)

65. Respondent billed the Program for having performed an EKG and a Bronchospasm on February 24, 1988 and May 5, 1988. There is no indication in the record that either test was performed on those dates. (T. 158-159, 162; Dept. Ex. 4F & 8)

PATIENT G

66. Between on or about April 18, 1988 and on or about May 16, 1988, Respondent undertook the care and treatment of Patient G at her medical offices. (T. 344; Dept. Ex. 4G)

67. On April 18, 1988, Respondent recorded a history which included Bronchial asthma, low back pain, PUD, nervous problem with hallucinations, on thorazine 1975-1981, drinks wine daily. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient G contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 164-166; Dept.Ex. 4G)

68. On May 16, 1988, Patient G saw the Respondent for a follow up visit. On such a visit a history and the reason for the return should be noted. The Respondent did not note any history in the patient's record. (T. 168-169; Dept. Ex. 4G)

69. A physical examination should address the symptoms, complaints, and/or

history. Respondent's record for the April 18, 1988, office visit for this patient did not contain this information and her record for the May 16, 1988, follow up visit contained no record of a physical examination having been performed. (T. 166, 169; Dept. Ex. 4G)

70. On April 18, 1988, and/or May 16, 1988, Respondent prescribed, without an adequate indication, Zantac, Proventil, Buspar, Lotrimin, Valium and Clinoril. (T. 167-168, 170; Dept. Ex. 4G)

71. On or about April 18, 1988, Respondent ordered laboratory blood work, for which there was no indication, including a sickle cell test, hemoglobin electrophoresis, thyroid function test, rheumatoid factor, CRP, an ANA, an anti-DNA, an LE prep, an ASO, vitamin B-12 and folic acid. (T. 167; Dept. Ex. 4G)

72. If a physician receives an abnormal laboratory test result he should follow up with his patient. A laboratory test report dated April 21, 1988, indicated Patient G tested positive for syphilis. Yet on the patient's return visit on May 16, 1988, the Respondent did not explore this matter with the patient or follow up this abnormal test results in any manner. (T. 169-170; Dept. Ex. 4G)

73. Respondent billed the Program for providing the services of a comprehensive office visit on May 16, 1988, listed under the Program as a comprehensive established. There is no indication in the record that such a service was provided on that date. (T. 168-169; Dept. Ex. 4G & 8)

74. Respondent billed the Program for having performed an EKG on April 18 , 1988 and a Bronchospasm on May 16, 1988. There is no indication in the record

that either test was performed or was indicated on those dates. (T. 166, 169; Dept. Ex. 4G & 8)

PATIENT H

75. Between on or about April 25, 1988 and on or about May 23, 1988, Respondent undertook the care and treatment of Patient H at her medical offices. (T. 344; Dept. Ex. 4H)

76. On April 25, 1988, Respondent recorded a history which included Bronchial asthma, PUD, low back pain, and substance abuse. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient H contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 173-174; Dept.Ex. 4H)

77. On May 23, 1988, Patient H saw the Respondent for a follow up visit. On such a visit a history and the reason for the return should be noted. The Respondent did not note any history in the patient's record. (T. 176-177; Dept. Ex. 4H)

78. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the April 25, 1988, office visit for this patient did not contain this information and her record for the May 23, 1988, follow up visit

contained no record of a physical examination having been performed. (T. 174-175, 177; Dept. Ex. 4H)

79. On April 25, 1988, and/or May 23, 1988, Respondent prescribed, without an adequate indication, Proventil, Zantac, Buspar, Ceclor, Ativan and Clinoril. (T. 176, 178; Dept. Ex. 4H & 8)

80. On or about April 25, 1988, Respondent ordered laboratory blood work, for which there was no indication, including a sickle cell test, hemoglobin electrophoresis, thyroid function test, ferritin test, vitamin B-12, hepatitis serology and folic acid. (T. 175; Dept. Ex. 4H)

81. Respondent billed the Program for providing the services of a comprehensive office visit on May 23, 1988, listed under the Program as a comprehensive established. There is no indication in the record that such a service was provided on that date. (T. 177; Dept. Ex. 4H & 8)

82. Respondent billed the Program for having performed an EKG and a Bronchospasm on April 25, 1988. There is no indication in the record that either test was performed or was indicated on that date. (T. 175; Dept. Ex. 4H & 8)

PATIENT I

83. On or about May 3, 1988, Respondent undertook the care and treatment of Patient I at her medical offices. (T. 344; Dept. Ex. 4I)

84. On May 3, 1988, Respondent recorded a history which included PUD,

bronchial asthma, and back pain. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient I contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 181; Dept.Ex. 4I)

85. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the May 3, 1988, office visit for this patient did not contain this information. (T. 181-182; Dept. Ex. 4I)

86. On May 3, 1988, Respondent prescribed, without an adequate indication, Ativan, Zantac, Clinoril, Buspar, Proventil, and Lotrimin. (T. 183; Dept. Ex. 4I)

87. On or about May 3, 1988, Respondent ordered laboratory blood work, for which there was no indication, including a rheumatoid factor, the CRP, the ANA, the anti-DNA, the LE, the ASO, the thyroid function test, the ferritin, the vitamin B-12, and the folic acid. (T. 182; Dept. Ex. 4I)

88. Respondent billed the Program for having performed an EKG and a Bronchospasm on May 3, 1988. There is no indication in the record that either test was performed or was indicated on that date. (T. 182; Dept. Ex. 4I & 8)

PATIENT J

89. On or about May 4, 1988, Respondent undertook the care and treatment of Patient J at her medical offices. (T. 344; Dept. Ex. 4J)

90. On May 4, 1988, Respondent recorded a history which included, low back

pain, PUD, ulcers on legs for one week, bronchial asthma, elevated blood pressure, a substance abuse history of cocaine and daily alcohol use. A patient's office visit record should note a chief complaint and a history with regard to any other conditions noted. The Respondent's record for Patient I contained no evaluation nor any history regarding any of the conditions noted nor a chief complaint. (T. 184-185; Dept.Ex. 4J)

91. A physical examination should address the symptoms, complaints, and/or history. Respondent's record for the May 4, 1988, office visit for this patient did not contain this information. (T. 185-186; Dept. Ex. 4J)

92. On May 4, 1988, Respondent prescribed, without an adequate indication, Valium, Lopressor, Zantac, Proventil, and Ceclor. (T. 185-186; Dept. Ex. 4J)

93. On or about May 4, 1988, Respondent ordered laboratory blood work, for which there was no indication, including a sickle cell, hemoglobin electrophoresis, thyroid function test, ferritin, vitamin B-12, folic acid, and hepatitis serology. (T. 186; Dept. Ex. 4J)

PARAGRAPH K

94. N.Y. Education Law § 6530(32) includes within the definitions of professional misconduct failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.

Conclusions

The following conclusions were made pursuant to the Findings of Fact listed above. The Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A.: (20) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph A.1.a.: (6,7,21,22);

Paragraph A.1.b.: (23);

Paragraph A.2.a.-b.: (24);

Paragraph A.3.: (15,17,25);

Paragraph A.4.: (26);

Paragraph A.5.a.-c.: (27);

Paragraph A.6.a.: (28);

Paragraph A.6.b.: (28);

Paragraph A.7.: (21-26,28);

Paragraph A.8.: (21-26,28);

Paragraph B.: (29) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph B.1.a.: (6,7,30,31);

Paragraph B.1.b.: (32);

Paragraph B.2.a.-f.: (33);

Paragraph B.3.: (15,17,34);

Paragraph B.4.: (35);

Paragraph B.5.a.: (8,36);

Paragraph B.5.b.: (10,11,37);

Paragraph B.5.c.: (12,13,37);

Paragraph B.6.: (30-37);

Paragraph B.7.: (30-37);

Paragraph C.: (38) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph C.1.a.: (6,7,39,40);

Paragraph C.1.b.: (41);

Paragraph C.2.a-g.: (42);

Paragraph C.3.: (15,17,43);

Paragraph C.4.a.: (10,11,44);

Paragraph C.4.b.: (12,13,44);

Paragraph C.5.: (39-44);

Paragraph C.6.: (39-44);

Paragraph D.: (45) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph D.1.a.: (46,47);

Paragraph D.1.b.: (48);

Paragraph D.2.a.-f.: (49);

Paragraph D.3.a.: (8,50);

Paragraph D.3.b.: (10,11,51);

Paragraph D.3.c.: (12,13,51);

Paragraph D.4.: (46-51);

Paragraph D.5.: (46-51);

Paragraph E.: (52) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph E.1.a.: (6,7,53,54)

Paragraph E.1.b.: (55)

Paragraph E.2.: (56) except for that part of the factual allegation which alleges the inappropriate prescribing of motrin;

Paragraph E.3.: (15,57);

Paragraph E.4.a.: (8,58);

Paragraph E.4.b.: (8,58);

Paragraph E.4.c.: (10,11,59);

Paragraph E.4.d.: (12,13,59);

Paragraph E.5.: (53-59);

Paragraph E.6.: (53-59);

Paragraph F.: (60) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph F.1.a.: (6,7,61,62);

Paragraph F.1.b.: (63);

Paragraph F.2.: (64) except for that part of the factual allegation which alleges the inappropriate prescribing of Tussiorganidin;

Paragraph F.3.a.: (10,11,65) except for that part of the factual allegation which states the EKG was not medically indicated;

Paragraph F.3.b.: (12,13,65) except for that part of the factual allegation which states the Brochospasm was not medically indicated;

Paragraph F.4.: (61-65);

Paragraph F.5.: (61-65);

Paragraph G.: (66) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph G.1.a.: (6,7,67,68);

Paragraph G.1.b.: (69);

Paragraph G.2.: (70) except for that part of the factual allegation which alleges the inappropriate prescribing of augmentin;

Paragraph G.3.: (15,17,71);

Paragraph G.4.: (16,72);

Paragraph G.5.a.: (8,73);

Paragraph G.5.b.: (10,11,74);

Paragraph G.5.c.: (12,13,74);

Paragraph G.6.: (67-74);

Paragraph H.: (75) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph H.1.a.: (6,7,76,77);

Paragraph H.1.b.: (78);

Paragraph H.2.: (79);

Paragraph H.3.: (15,17,80);

Paragraph H.4.a.: (8,81);

Paragraph H.4.b.: (10,11,82);

Paragraph H.4.c.: (12,13,82);

Paragraph H.5.: (76-82);

Paragraph H.6.: (76-82);

Paragraph I.: (83) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph I.1.a.: (6,7,84);

Paragraph I.1.b.: (85);

Paragraph I.2.: (86);

Paragraph I.3.: (15,17,87);

Paragraph I.4.a.: (10,11,88);

Paragraph I.4.b.: (12,13,88);

Paragraph I.5.: (84-88);

Paragraph I.6.: (84-88);

Paragraph J.: (89) except for that part of the factual allegation which states the exact address of the medical offices;

Paragraph J.1.a.: (6,7,90);

Paragraph J.1.b.: (91);

Paragraph J.2.: (92);

Paragraph J.3.: (15,17,93);

Paragraph J.4.: (90-93);

Paragraph J.5.: (90-93);

Paragraph K.: (2);

Paragraph K.1.a.: (3);

Paragraph K.1.b.: (3);

Paragraph K.2.: (3,94).

The Committee further concluded that the following Specifications should **be sustained**. The citations in brackets refer to the Factual Allegations from the Statement of Charges, which support each specification. An asterisk denotes part of the factual allegation was not proven, as noted supra :

NEGLIGENCE ON MORE THAN ONE OCCASION

First Specification: [A*, A(1)(a), A(1)(b), A(2)(a), A(2)(b), A(3), A(4), A(5)(a)-(c), A(6)(a), A(6)(b), A(7), A(8), B*, B(1)(a), B(1)(b), B(2)(a)-(f), B(3), B(4), B(5)(a)-(c), B(6), B(7), C*, C(1)(a), C(1)(b), C(2)(a)-(g), C(3), C(4)(a), C(4)(b), C(5), C(6), D*, D(1)(a), D(1)(b), D(2)(a)-(f), D(3)(a)-(c), D(4), D(5), E*,

E(1)(a), E(1)(b), E(2)(a)-(b) and (c)-(j), E(3), E(4)(a)-(d), E(5), E(6), F*, F(1)(a), F(1)(b), F(2)(a)-(g) and (i)-(j), F(3)(a)*, F(3)(b)*, F(4), F(5), G*, G(1)(a), G(1)(b), G(2)(a)-(f), G(3), G(4), G(5)(a)-(c), G(6), G(7), H*, H(1)(a), H(1)(b), H(2)(a)-(f), H(3), H(4)(a), H(4)(b), H(4)(c), H(5), H(6), I*, I(1)(a), I(1)(b), I(2)(a)-(f), I(3),I(4)(a), I(4)(b), I(5), I(6), J*, J(1)(a), J(1)(b), J(2)(a)-(e), J(3), J(4) and J(5).

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Second Specification: [A*, A(1)(a), A(1)(b), A(2)(a)-(b), A(3), A(4), A(5)(a)-(c), A(6)(a), A(6)(b), A(7), A(8), B*, B(1)(a), B(1)(b), B(2)(a)-(f), B(3), B(4), B(5)(a)-(c), B(6), B(7), C*, C(1)(a), C(1)(b), C(2)(a)-(g), C(3), C(4)(a), C(4)(b), C(5), C(6), D*, D(1)(a), D(1)(b), D(2)(a)-(f), D(3)(a)-(c), D(4), D(5), E*, E(1)(a), E(1)(b), E(2)(a)-(b) and (c)-(j)*, E(3), E(4)(a)-(d), E(5), E(6), F*, F(1)(a), F(1)(b), F(2)(a)-(g) and (i)-(j)*, F(3)(a)-(b)*, F(4), F(5), G*, G(1)(a), G(1)(b), G(2)(a)-(f)*, G(3), G(4), G(5)(a)-(c), G(6), G(7), H*, H(1)(a), H(1)(b), H(2)(a)-(f), H(3), H(4)(a), H(4)(b), H(4)(c), H(5), H(6), I*, I(1)(a), I(1)(b), I(2)(a)-(f), I(3),I(4)(a), I(4)(b), I(5), I(6), J*, J(1)(a), J(1)(b), J(2)(a)-(e), J(3), J(4) and J(5)].

UNNECESSARY TESTS AND TREATMENT

Third Specification: [A(2)(a), A(2)(b), A(3) and A(6)(a)-(b)].

Fourth Specification: [B(2)(a)-(f), B(3) and B(5)(b)-(c)].

Fifth Specification: [C(2)(a)-(g), C(3) and C(4)(a)-(b)].

Sixth Specification: [D(2)(a)-(f) and D(3)(b)-(c)].

Seventh Specification: [E(2)(a)-(b) and (c)-(j)*, E(3) and E(4)(c)-(d)].

Eighth Specification: [F(2)(a)-(g) and (i)-(j)* and F(3)(a)-(b)*].

Ninth Specification: [G(2)(a)-(f)*, G(3) and G(5)(b)-(c)].

Tenth Specification: [H(2)(a)-(f), H(3) and H(4)(b)-(c)].

Eleventh Specification: [I(2)(a)-(f), I(3) and I(4)(a)-(b).]

Twelfth Specification: [J(2)(a)-(e) and J(3)].

PRACTICING FRAUDULENTLY

Thirteenth Specification: [A*, A(1)(a), A(1)(b), A(2)(a)-(b), A(3), A(4), A(5)(a)-(c), A(6)(a), A(6)(b), A(7) and A(8)].

Fourteenth Specification: [B*, B(1)(a), B(1)(b), B(2)(a)-(f), B(3), B(4), B(5)(a)-(c), B(6) and B(7)].

Fifteenth Specification: [C*, C(1)(a), C(1)(b), C(2)(a)-(g), C(3), C(4)(a), C(4)(b), C(5) and C(6)].

Sixteenth Specification: [D*, D(1)(a), D(1)(b), D(2)(a)-(f), D(3)(a)-(c), D(4) and D(5)].

Seventeenth Specification: [E*, E(1)(a), E(1)(b), E(2)(a)-(b) and (c)-(j)*, E(3), E(4)(a)-(d), E(5) and E(6)].

Eighteenth Specification: [F*, F(1)(a), F(1)(b), F(2)(a)-(g) and (i)-(j)*, F(3)(a)-(b)*, F(4) and F(5)].

Nineteenth Specification: [G*, G(1)(a), G(1)(b), G(2)(a)-(f)*, G(3),

G(4), G(5)(a)-(c), G(6) and G(7)].

Twentieth Specification: [H*, H(1)(a), H(1)(b), H(2)(a)-(f), H(3), H(4)(a), H(4)(b), H(4)(c), H(5) and H(6)].

Twenty-first Specification: [I*, I(1)(a), I(1)(b), I(2)(a)-(f), I(3),I(4)(a), I(4)(b), I(5) and I(6)].

Twenty-second Specification: [J*, J(1)(a), J(1)(b), J(2)(a)-(e), J(3), J(4) and J(5)].

FAILURE TO MAINTAIN RECORDS

Twenty-third Specification: [A*, A(1)(a), A(1)(b), A(3), A(4), A(5)(a)-(c), A(6)(a), A(6)(b), A(7) and A(8)].

Twenty-fourth Specification: [B*, B(1)(a), B(1)(b), B(3), B(4), B(5)(a)-(c), B(6) and B(7)].

Twenty-fifth Specification: [C*, C(1)(a), C(1)(b), C(3), C(4)(a), C(4)(b), C(5) and C(6)].

Twenty-sixth Specification: [D*, D(1)(a), D(1)(b), D(3)(a)-(c), D(4) and D(5)].

Twenty-seventh Specification: [E*, E(1)(a), E(1)(b), E(3), E(4)(a)-(d), E(5) and E(6)].

Twenty-eighth Specification: [F*, F(1)(a), F(1)(b), F(3)(a)-(b)*, F(4) and F(5)].

Twenty-ninth Specification: [G*, G(1)(a), G(1)(b), G(3), G(4), G(5)(a)-(c), G(6) and G(7)].

Thirtieth Specification: [H*, H(1)(a), H(1)(b), H(3), H(4)(a), H(4)(b), H(4)(c), H(5) and H(6)].

Thirty-first Specification: [I*, I(1)(a), I(1)(b), I(3),I(4)(a), I(4)(b), I(5)

and I(6)].

Thirty-second Specification: [J*, J(1)(a), J(1)(b), J(2)(a)-(e), J(3), J(4) and J(5)].

HAVING BEEN FOUND GUILTY OF VIOLATING A STATE REGULATION

Thirty-third Specification: [K, K(1)(a), K(1)(b) and K(2)].

DISCUSSION

Respondent was charged with thirty-three specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for negligence, incompetence and fraud in the practice of medicine.

The following definitions were utilized by the Committee during its deliberations:

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

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Fraudulent Practice of Medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge of making a

misrepresentation or concealment may be inferred from certain facts.

Using the above-referenced definitions as a framework for its deliberations, the Committee, based on a preponderance of the evidence, concluded that the above noted specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Diane Sixmith, M.D. as its expert witness. Dr. Sixsmith is a physician who is board certified in internal medicine and is also board certified in emergency medicine. Dr. Sixsmith is the Chair of the Department of Emergency Medicine at the New York Medical Hospital Medical Center. Additionally she is a Clinical Assistant Professor of Medicine at Cornell University. There was no evidence of any bias on the part of Dr. Sixsmith or of her unsuitability as an expert witness. Respondent did not offer any expert testimony on her behalf.

The Committee finds that Dr. Sixsmith was credible and accurate in her testimony, which was confined to her review of the Respondent's office records for Patients A through J. She has the requisite training, knowledge, and experience to render an expert opinion. In her review and testimony, Dr. Sixsmith applied her years of experience in both private practice and as an experienced emergency room physician who has dealt widely with a poor and substance abusing patient population. As an emergency room physician who is currently Chairperson of an Emergency Department in a large metropolitan hospital, Dr. Sixsmith is well accustom to a busy practice setting, where in a day, she is called upon to see numerous patients. The Respondent did not offer any expert opinion on her behalf.

Respondent admitted that the charts for Patients A through J were randomly selected, sometime in 1988, by DSS from all of her charts at the Medicaid clinic. Respondent's room had only a desk, two chairs, and a side table for laboratory

requisition forms. She did not have an examining table, nor any equipment.

The Committee found that each chart reflects an inadequate or no physical examination. Respondent never recorded a diagnosis or treatment plan, and, in most instances, prescribed medications which were not supported by the record. Respondent's failure, on each visit, to obtain and note an adequate history for Patients A through J is a departure from accepted standards of care. Respondent's failure, on each visit, to perform and note an adequate physical examination for Patient A through J is also a departure from accepted standards of care. In many cases the Respondent noted a complaint but did not conduct any physical examination relating to the noted complaint. In all cases where there was a follow-up visit there was no indication that the Respondent made any inquiry into prior noted conditions or the efficacy of previously prescribed medications.

Respondent failed to maintain a record for Patients A through J which accurately reflects the patients' history, physical conditions, diagnosis, tests, and treatment rendered. Furthermore, she created a record for each of these patients which does not reflect legitimate patient care and treatment.

The Committee finds that, with regard to Patients A through J, Respondent knowingly falsely billed the Program for services which were never legitimately rendered by her, to wit: comprehensive examinations, EKGs, and bronchospasm evaluations. The fraudulent aspect of Respondent's practice in claiming to have performed EKGs is further evidenced by the fact that she lacks the knowledge to interpret this test. Respondent answered incorrectly a series of questions posed by the Committee Chairperson, concerning major patterns of abnormalities found on an EKG. Respondent admits that she did not note, in any of the patient charts, her orders for laboratory work. Respondent claims that it was her practice to communicate orally her laboratory orders to the clinic manager, who was not a healthcare provider, but rather the businessman who Respondent testified ran the

clinic. Respondent also claims that she did not order the elaborate tests indicated in the charts in evidence. She testified that it was her custom and practice to order the same laboratory work on each patient, thereby, in her mind, obviating the need for writing a note of her orders in the chart. She also testified, however, that when she ordered a test other than her usual set, she would simply tell the clinic manager and not record it in the patient chart because it was too burdensome to write it down. The Committee finds Respondent's practice as testified to in this regard both a gross deviation from accepted standards of medical practice and evidence of her lack of skill and knowledge to practice the profession. It is the Committee's firm belief that Medicaid patients are entitled to the same level of care as all other patients.

On all the office visits for each patient the Respondent prescribed a number of medications without any medical indication for these prescriptions. Additionally some of the prescriptions were contraindicated given the patient's medical history, thus creating a danger for the patient. A number of the patients had a history of substance abuse and yet were given prescriptions for tranquilizers without any assessment of the patient, diagnosis or treatment plan. On each visit by Patients A through J, Respondent prescribed on an average of 5-7 of the medications. A prudent physician would know that the chances of a patient taking all of these medications properly within a 24-hour period is very small yet she repeatedly prescribed numerous medications.

The Committee finds that Respondent knowingly placed herself in the position of treating a population of patients who came to her seeking the medications described above. A physician's responsibility to provide an acceptable level of care, including taking a sufficient history, performing a sufficient physical examination, arriving at a diagnosis and treatment plan, and prescribing only indicated and appropriate medication, is the same regardless of whether the patient's primary motive for a visit is to obtain a prescription or not .

Medical records are kept by a physician to memorialize what the patient has reported and the treatment rendered. It is vitally important for the patient's care that enough information is in the record so that not only the primary physician, but a subsequent treating physician may know what has gone on with the patient. The failure of a physician to make an adequate record of a patient's visit, including a notation of medication dosages prescribed, is not only a departure from accepted standards of practice, but is a danger to the patient. This is especially true if the physician has a busy practice and is seeing more that 20 to 30 patients a day. A busy practice does not absolve a physician of the responsibilities of individualizing medical care and the necessity for adequate recordkeeping. In fact, when in a busy practice, where it is impossible to relay on one's memory of individuals and their history, care and treatment, a physician has a greater duty to make certain that a record is accurate and includes all of the necessary information for future reference and follow-up.

The Committee finds that the preponderance of evidence supports the conclusion that the Respondent knowingly created a false record for Patients A through J so as to attempt to justify her prescriptions for various street valued medications, diagnostic tests and laboratory work, and to bill DSS for her own financial gain.

In a number of cases the laboratory test results indicated an abnormal result yet the Respondent did not follow up in any of these cases. The Committee finds that to be dangerous medical care.

In all but one of the cases presented, the Respondent billed the Program for a comprehensive examination, an EKG and a Brochospasm. There is no indication that any of these were provided and in most cases the EKG and/or Bronchospasm was not medically indicated.

The Committee concludes that Respondent's records for Patients A through J demonstrate that Respondent knowingly engaged in a pattern of practice without thought to appropriate care and treatment nor actual relationship to the individual patients involved.

The Department also introduced evidence which included a listing of paid claims by Respondent for comprehensive visits, EKGS, and bronchospasm evaluations regarding Patients A through J. Based on the medical records the Committee concluded that these services were never actually rendered by Respondent.

The Respondent's own testimony and the other evidence, such as he patient records, (Exh. 4A-4J), and the DSS documentation of her paid claims and billing practices supports the conclusion that Respondent knowingly participated in a scheme to defraud the Program. Respondent admitted to billing and being reimbursed for EKGs and bronchospasms which she never performed and for which she never wrote a report. Her own testimony proved she could not correctly interpret an EKG. Her failure to follow-up and explore abnormal laboratory test results with her patients was not explained and her explanation for the elaborate laboratory tests ordered was both incredible and negligent.

The Committee concludes that in the process of engaging in a scheme to defraud the Medicaid Program the Respondent failed to render any legitimate patient care and acted negligently to the point of exposing her patients to risk of harm from medications prescribed and such poor practice.

DETERMINATION AS TO PENALTY

The Committee concludes that the Respondent knowingly created records for Patients A through J without any thought to true patient care and treatment. Respondent intentionally misrepresented her services in billing and receiving reimbursement from DSS, in the number of comprehensive examinations which did not occur and in the EKG and bronchospasm evaluations which she did not perform. She knowingly participation in a scheme to defraud the Medicaid system. The Commiftee concludes that the Respondent's sole purpose in working at the clinic was to make money from her fraudulent billings to the Program. Respondent's conduct represents the a fundamental breach of the public trust by a physician, whose high moral integrity must be a distinguishing characteristic. She disregarded her responsibilities as a physician to render care and treatment to a patient. Instead, Respondent knowingly prescribed unnecessary medications to insure that Program recipients would return to the clinic. Furthermore she allowed her Program provider number to be used so that unwarranted, elaborate and expensive laboratory tests could be billed to Medicaid by the respective laboratories.

The Commiftee concludes that the medical records of her care and treatment of Patients A through J, demonstrate in every instance, negligence and incompetence; in that she failed to obtain any meaningful or true history; failed to perform any meaningful or appropriate physical examination; never arrived at a diagnosis or treatment plan; prescribed unwarranted, expensive, and potentially dangerous medications, and, sometimes, in dangerous combinations; ordered and/or caused to be ordered excessive, unwarranted, and expensive laboratory blood tests; failed in any way to address and/or follow-up on abnormal laboratory re Its; and never meaningfully responded to what may have been some legitimate and serious patient

illnesses.

The Commiftee further concludes that the violations Respondent was found guilty of by DSS are further evidence of the nature of her practice at this time, beyond just Patients A through J. While those violations go to documentation, they demonstrate her failure to disclose the necessity for extensive services billed for and her falsification of claims submitted.

The Commiftee concludes that the kind of conduct by a physician evidenced in this case warrants revocation. Further, this Commiffee can impose a fine of $10,000 for each specification of misconduct which is sustained. Because the Respondent's financial gain was at a cost to the taxpayer of the State the Commiffee finds that a fine of $100,000.00 should be imposed on the Respondent.

ORDER

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

1. The First through Thirty-third Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I) are **SUSTAINED**;

2. Respondent's license to practice medicine in New York State be and hereby is **REVOKED.**

3. A fine of **One Hundred Thousand Dollars ($100,000.00)** is imposed upon the Respondent.

DATED: New York, New York
2-21-, 1997

Richard N. Pierson Jr.

RICHARD N. PIERSON, JR.,M.D.,(CHAIR)
ROBERT J. O'CONNOR, M.D.
MICHAEL A. GONZALEZ, R.P.A.

TO: Claudia Morales Bloch, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Richard E. Hershenson, Esq.
750 Third Avenue
New York, New York 10017

Alice Piasecki, M.D.
853 Seventh Avenue at 54th St.
New York, New York 10015

APPENDIX I

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

IN THE MATTER OF ALICE MARY PIASECKI, M.D.	STATEMENT OF CHARGES

ALICE MARY PIASECKI, M.D., the Respondent, was authorized to practice medicine in New York State on or about February 1, 1967, by the issuance of license number 098309 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between on or about May 5, 1988 and on or about May 19, 1988, Respondent undertook the care and treatment of Patient A at her medical offices, known as Doctors' Office, located at 2228 Frederick Douglas Blvd., New York, N.Y. 10027 (hereinafter referred to as "her medical offices"). (The identity's of Patients A through J are listed in the Appendix annexed hereto)

1. On each visit by Patient A, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

a. Clinoril

b. Buspar

3. The laboratory blood work ordered by Respondent on or about the first visit of May 5, 1988, was ordered inappropriately and without legitimate medical purpose.

4. Respondent failed to follow-up on abnormal laboratory test results.

5. Respondent failed to adequately and appropriately work-up and evaluate Patient A's hypertension in that, Respondent failed to order:

a. Urinalysis

b. EKG

c. Chest X-ray

6. On or about May 5, 1988 and on or about May 19, 1988, Respondent knowingly falsely billed the Medical Assistance Program (hereinafter referred to as "the Program") for the following services which were never rendered:

a. Electrocardiogram , 12 leads, with interpretation and

report, DSS Code 93000 (hereinafter referred to as "EKG 93000").

b. Bronchospasm evaluation, before and after bronchodilation or exercise, DSS Code 94060, (hereinafter referred to as "Bronchospasm evaluation"). This test, additionally, was not medically indicated.

7. Respondent failed to maintain a record for Patient A which accurately reflects the patient's history, examination, diagnosis, test, and treatment rendered.

8. Respondent created a record for Patient A which is false and inaccurate and does not reflect legitimate patient care and treatment.

B. Between on or about April 19, 1988 and on or about May 20, 1988, Respondent undertook the care and treatment of Patient B at her medical offices.

1. On each visit by Patient B, Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Tagamet

   b. Naprosyn

   c. Proventil

   d. Buspar

   e. Ativan

   f. Lotrimin

3. The laboratory blood work ordered by Respondent on or about the first visit of April 19, 1988, was ordered inappropriately and without legitimate medical purpose.

4. Respondent failed to follow-up on the abnormal laboratory results.

5. Respondent knowingly falsely billed the Program for the following services which were never rendered and not medically indicated:

   a. Comprehensive Service, established (hereinafter referred to as "Comprehensive, established") patient

on April 19, 1988 and May 20, 1988,

b. EKG 93000 on April 19, 1988,

c. Bronchospasm evaluation on April 19, 1988.

6. Respondent failed to maintain a record for Patient B which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

7. Respondent created a record for Patient B which is false and inaccurate and does not reflect legitimate patient care and treatment.

C. Between on or about April 21, 1988 and on or about May 24, 1988, Respondent undertook the care and treatment of Patient C at her medical offices.

1. On each visit by Patient C, Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

a. Zantac

b. Proventil

c. Valium

d. Lotrimin

e. Motrin

f. Buspar

g. Tetracycline

3. The laboratory blood work ordered by Respondent on or about the first visit of April 21, 1988, was ordered inappropriately and without legitimate medical purpose.

4. On or about April 21, 1988 and on or about May 24, 1988, Respondent knowingly falsely billed the Program for the following services which were never rendered and not medically indicated:

a. EKG 93000

b. Bronchospasm evaluation

5. Respondent failed to maintain a record for Patient C which

accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

6. Respondent created a record for Patient C which is false and inaccurate and does not reflect legitimate patient care and treatment.

D. Between on or about February 19, (upon information and belief, 1988) and on or about May 5, 1988, Respondent undertook the care and treatment of Patient D at her medical offices.

1. On each visit by Patient D, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Catapres

   b. Zantac

   c. Clinoril

   d. Proventil

e. Valisone

f. Valium

3. Respondent knowingly falsely billed the Program for the following services which were never rendered and not medically indicated:

a. Comprehensive Service, new patient (hereinafter referred to as "Comprehensive, new") on May 5, 1988,

b. EKG 93000 on April 19, 1988 and May 5, 1988,

c. Bronchospasm evaluation on April 19, 1988 and May 5, 1988.

4. Respondent failed to maintain a record for Patient D which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

5. Respondent created a record for Patient D which is false and inaccurate and does not reflect legitimate patient care and treatment.

E. Between on or about February 24, 1988 and May 18, 1988, Respondent undertook the care and treatment of Patient E at her medical offices.

1. On each visit by Patient E, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Aldomet

   b. Zantac

   c. Motrin

   d. Proventil

   e. Lotrimin

   f. Ceclor

   g. Valium

   h. Clinoril

   i. Buspar

j. Diabenese

3. The laboratory blood work ordered by Respondent on or about April 18, 1988, was ordered inappropriately and without legitimate medical purpose.

4. Respondent knowingly falsely billed the Program for the following services which were never rendered and not medically indicated:

a. Comprehensive , new on April 18, 1988,

b. Comprehensive, established on February 24, 1988 and May 18, 1988,

c. EKG 93000 on February 24, 1988 and April 18, 1988,

d. Bronchospasm evaluation on February 24, 1988 and April 18, 1988.

5. Respondent failed to maintain a record for Patient E which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

6. Respondent created a record for Patient E which is false and inaccurate and does not reflect legitimate patient care and

treatment.

F. Between on or about February 24, 1988 and on or about May 5, 1988, Respondent undertook the care and treatment of Patient F at her medical offices.

1. On each visit by Patient F, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Zantac

   b. Proventil

   c. Motrin

   d. Lotrimin

   e. Clinoril

   f. Valium

g. Ceclor

h. Tussiorganidin

i. Buspar

j. Benadryl

3. On or about February 24, 1988 and on or about May 5, 1988, Respondent knowingly falsely billed the Program for the following services which were never rendered and not medically indicated:

a. EKG 93000

b. Bronchospasm evaluation.

4. Respondent failed to maintain a record for Patient F which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

5. Respondent created a reccord for Patient F which is false and inaccurate and does not reflect legitimate patient care and treatment.

G. Between on or about April 18, 1988 and on or about May 16, 1988, Respondent undertook the care and treatment of Patient G at her medical offices.

1. On each visit by Patient G, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent in appropriately and without legitimate medical purpose prescribed:

   a. Zantac

   b. Clinoril

   c. Proventil

   d. Lotrimin

   e. Valium

   f. Buspar

   g. Augmentin

3. The laboratory blood work ordered by Respondent on or about the first visit of April 18, 1988, was ordered inappropriately and without legitimate medical purpose.

4. Respondent failed to follow up on abnormal laboratory test results.

5. Respondent knowingly falsely billed the Program for the following services which were never rendered and not medically indicated:

   a. Comprehensive , new on May 16, 1988,

   b. EKG 93000 on April 18, 1988,

   c. Bronchospasm evaluation on May 16, 1988.

6. Respondent failed to maintain a record for Patient G which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

7. Respondent created a record for Patient G which is false and inaccurate and does not reflect legitimate patient care and treatment.

H. Between on or about April 25, 1988 and on or about May 23, 1988, Respondent undertook the care and treatment of Patient H at her medical offices.

   1. On each visit by Patient H, Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

a. Proventil

b. Zantac

c. Clinoril

d. Ceclor

e. Ativan

f. Buspar

3. The laboratory blood work ordered by Respondent on or about the first visit of April 25, 1988, was ordered inappropriately and without legitimate medical purpose.

4. Respondent knowingly falsely billed the Program for the following services which were never rendered and not medically indicated:

a. Comprehensive, established on May 23, 1988,

b. EKG 93000 on April 25, 1988,

c. Bronchospasm evaluation on April 25, 1988.

5. Respondent failed to maintain a record for Patient H which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

6. Respondent created a record for Patient H which is false and inaccurate and does not reflect legitimate patient care and treatment.

I. On or about May 3, 1988, Respondent undertook the care and treatment of Patient I at her medical offices.

1. On each visit by Patient I, Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

a. Ativan

b. Zantac

c. Clinoril

d. Buspar

e. Proventil

f. Lotrimin

3. The laboratory blood work ordered by Respondent on or about the first visit of May 3, 1988, was ordered inappropriately and without legitimate medical purpose.

4. Respondent knowingly falsely billed the Program for the following services which were never rendered and not medically indicated:

a. EKG 93000,

b. Bronchospasm evaluation.

5. Respondent failed to maintain a record for Patient I which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

6. Respondent created a record for Patient I which is false and inaccurate and does not reflect legitimate patient care and treatment.

J. On or about May 4, 1988, Respondent undertook the care and treatment of Patient J at her medical offices.

1. On each visit by Patient J, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Valium

   b. Lopressor

   c. Zantac

   d. Proventil

   e. Ceclor

3. The laboratory blood work ordered by Respondent on or about the first visit of May 4, 1988, was ordered inappropriately and without legitimate medical purpose.

4. Respondent failed to maintain a record for Patient J which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

5. Respondent created a record for Patient J which is false and inaccurate and does not reflect legitimate patient care and treatment.

K. On or about February 28, 1994, a Decision After Hearing was issued by the New York State Department of Social Services which found the Respondent guilty of unacceptable practices pursuant to New York State Regulations. An Article 78 Proceeding resulted in the Appellate Division, First Department, affirming the violations found by the Hearing Officer. No further appeal is pending. [Piasecki v. Department of Social Services, 639 N.Y.S. 2d 319 (A.D. 1 Dept. 1996)]

1. The Respondent was found to have violated the following Department of Social Services Regulations:

a. Section 515.2(b)(6), in failing to maintain records necessary to fully disclose the necessity for and the nature and extent of services the Respondent billed for and ordered.

b. Section 515.2(b)(1)(i), in that Respondent caused the submission of false claims, as defined by this section as claims for unfurnished medical care, services, or

supplies and claims for medical care, services or supplies at a frequency or in an amount not medically necessary.

2. The violations Respondent was found guilty of would constitute professional misconduct pursuant to Educ. Law Section 6530(32), failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.

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. 1996) 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. The facts in paragraphs A, A(1)(a), A(1)(b), A(2)(a), A(2)(b), A(3), A(4), A(5)(a) A(5)(b), A(5)(c), A(6)(a), A(6)(b), A(7), A(8), B, B(1)(a), B(1)(b), B(2)(a) through B(2)(f), B(3), B(4), B(5)(a), B(5)(b), B(6), B(7), C, C(1)(a), C(1)(b), C(2)(a) through C(2)(g), C(3), C(4)(a), C(4)(b), C(5), C(6), D, D(1)(a), D(1)(b), D(2)(a) through D(2)(f), D(3)(a), D(3)(b), D(3)(c), D(4), D(5). E, E(1)(a), E(1)(b), E(2)(a) through E(2)(j), E(3), E(4)(a) through E(4)(d), E(5), E(6), F, F(1)(a), F(1)(b), F(2)(a) through F(2)(j), F(3)(a), F(3)(b), F(4), F(5), G, G(1)(a), G(1)(b), G(2)(a) through G(2)(g),

G(3), G(4), G(5)(a), G(5)(b), G(5)(c), G(6), G(7), H, H(1)(a), H(1)(b), H(2)(a) through H(2)(f), H(3), H(4)(a), H(4)(b), H(4)(c), H(5), H(6), I, I(1)(a), I(1)(b), I(2)(a) through I(2)(f), I(3),I(4)(a), I(4)(b), I(5), I(6), J, J(1)(a), J(1)(b), J(2)(a) through J(2)(e), and J(3) through J(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. 1996) 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. The facts in paragraphs A, A(1)(a), A(1)(b), A(2)(a), A(2)(b), A(3), A(4), A(5)(a) A(5)(b), A(5)(c), A(6)(a), A(6)(b), A(7), A(8), B, B(1)(a), B(1)(b), B(2)(a) through B(2)(f), B(3), B(4), B(5)(a), B(5)(b), B(6), B(7), C, C(1)(a), C(1)(b), C(2)(a) through C(2)(g), C(3), C(4)(a), C(4)(b), C(5), C(6), D, D(1)(a), D(1)(b), D(2)(a) through D(2)(f), D(3)(a), D(3)(b), D(3)(c), D(4), D(5). E, E(1)(a), E(1)(b), E(2)(a) through E(2)(j), E(3), E(4)(a) through E(4)(d), E(5), E(6), F, F(1)(a), F(1)(b), F(2)(a) through F(2)(j), F(3)(a), F(3)(b), F(4), F(5), G, G(1)(a), G(1)(b), G(2)(a) through G(2)(g), G(3), G(4), G(5)(a), G(5)(b), G(5)(c), G(6), G(7), H, H(1)(a), H(1)(b), H(2)(a) through H(2)(f), H(3), H(4)(a), H(4)(b), H(4)(c),

H(5), H(6), I, I(1)(a), I(1)(b), I(2)(a) through I(2)(f), I(3),I(4)(a), I(4)(b), I(5), I(6), J, J(1)(a), J(1)(b), J(2)(a) through J(2)(e), and J(3) through J(5).

THIRD THROUGH TWELFTH SPECIFICATIONS

UNNECESSARY TESTS AND TREATMENT

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1996) by ordering excessive tests and/or treatments no warranted by the condition of the patient, as alleged in the facts of the following:

3. The facts in paragraph A(2)(a), A(2)(b), A(3), and A(6)(b).

4. The facts in paragraphs B(2)(a) through B(2)(f), B(3), B(5)(b), and B(5)(c).

5. The facts in paragraphs C(2)(a) through C(2)(g), C(3), C(4)(a), and C(4)(b).

6. The facts in paragraphs D(2)(a) through D(2)(f), D(3)(b), and D(3)(c).

7. The facts in paragraphs E(2)(a) through E(2)(j), E(3), E(4)(c) and E(4)(d).

8. The facts in paragraphs F(2)(a) through F(2)(j), F(3)(a) and F(3)(b).

9. The facts in paragraphs G(2)(a) through G(2)(g), G(3), G(5)(b), and G(5)(c).

10. The facts in paragraphs H(2)(a) through H(2)(f), H(3), H(4)(b), and H(4)(c).

11. The facts in paragraphs I(2)(a) through I(2)(f), I(3), I(4)(a) and I(4)(b).

12. The facts in paragraphs J(2)(a) through J(2)(e) and J(3).

THIRTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS

PRACTICING FRAUDULENTLY

The Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ Law Section 6530(2) (McKinney) Supp. 1996) by practicing medicine fraudulently as alleged in the facts of the following:

13. The facts in paragraph A, A(1)(a), A(1)(b), A(2)(a), A(2)(b), A(3), A(4), A(5)(a), A(5)(b), A(5)(c), A(6)(a), A(6)(b), A(7), and A(8).

14. The facts in paragraphs B, B(1)(a), B(1)(b), B(2)(a) through B(2)(f), B(3), B(4), B(5)(a), B(5)(b), B(6), and B(7).

15. The facts in paragraphs C, C(1)(a), C(1)(b),C(2)(a) through C(2)(g), C(3), C(4)(a), C(4)(b), C(5) and C(6).

16. The facts in paragraphs D, D(1)(a), D(1)(b), D(2)(a) through D(2)(f), D(3)(a), D(3)(b), D(3)(c), D(4), and D(5).

17. The facts in paragraphs E, E(1)(a), E(1)(b), E(2)(a) through E(2)(j), E(3), E(4)(a) through E(4)(d), E(5), and E(6).

18. The facts in paragraphs F, F(1)(a), F(1)(b), F(2)(a) through F(2)(j), F(3)(a), F(3)(b), F(4), and F(5).

19. The facts in paragraphs G, G(1)(a), G(1)(b), G(2)(a) through G(2)(g) and G(3), G(4), G(5)(a), G(5)(b), G(5)(c), G(6), and G(7).

20. The facts in paragraphs H, H(1)(a), H(1)(b), H(2)(a) through H(2)(f) and H(3), H(4)(a), H(4)(b), H(4)(c), H(5), and H(6).

21. The facts in paragraphs I, I(1)(a), I(1)(b), I(2)(a) through I(2)(f), I(3), I(4)(a), I(4)(b), I(5), and I(6).

22. The facts in paragraphs J, J(1)(a), J(1)(b), J(2)(a) through J(2)(e) and J(3) through J(5).

TWENTY-THIRD THROUGH THIRTY-SECOND SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1996) 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 the following:

23. The facts in paragraph A(1)(a), A(1)(b), A(3), A(4), A(5)(a), A(5)(b), A(5)(c), A(6)(a), A(6)(b), A(7), A(8).

24. The facts in paragraphs B(1)(a), B(1)(b), B(3), B(4), B(5)(a), B(5)(b), B(5)(c), B(6), B(7).

25. The facts in paragraphs C(1)(a), C(1)(b), C(3), C(4)(a), C(4)(b), C(5) and C(6).

26. The facts in paragraphs D(1)(a), D(1)(b), D(3)(a), D(3)(b), D(3)(c), D(4) and D(5).

27. The facts in paragraphs E(1)(a), E(1)(b), E(3), E(4)(a) through E(4)(d), E(5) and E(6).

28. The facts in paragraphs F(1)(a), F(1)(b), F(3)(a), F(3)(b), F(4), and F(5).

29. The facts in paragraphs G(1)(a), G(1)(b), G(3), G(4), G(5)(a), G(5)(b), G(5)(c), G(6), and G(7).

30. The facts in paragraphs H(1)(a), H(1)(b), H(3), H(4)(a), H(4)(b),

H(4)(c), H(5) and H(6).

31. The facts in paragraphs I(1)(a), I(1)(b), I(3), I(4)(a), I(4)(b), I(5) and I(6).

32. The facts in paragraphs J(1)(a), J(1)(b), J(3), J(4), and J(5).

THIRTY-THIRD SPECIFICATION

HAVING BEEN FOUND GUILTY OF VIOLATION OF STATE REGULATIONS

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(9)(c) (McKinney Supp. 1996) by having been found guilty in an adjudicatory proceeding of violating a state regulation, pursuant to a final determination, and when no appeal is pending and the violation constitutes professional misconduct pursuant to N.Y. Educ. Law Section 6530, as alleged in the following:

33. The facts in paragraphs K, K(1)(a), K(1)(b), and K(2).

DATED: September 26, 1996
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct