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

IN THE MATTER : COMMISSIONER'S
OF : ORDER AND
FIDEL R. RAMOS, M.D. : NOTICE OF HEARING

TO: FIDEL R. RAMOS, M.D.
306 East Main Street
Westfield, New York 14787-1127

The undersigned, Barbara A. DeBuono, M.D., M.P.H., as Commissioner of the New York State Department of Health, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by FIDEL R. RAMOS, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1995), that effective immediately FIDEL R. RAMOS, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1995).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1995), and N.Y. State Admin. Proc. Act Sections 301-307

and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on March 15, 1995, March 21, 1995, March 23, 1995 and April 7, 1995 at 9:00 a.m. at the offices of the New York State Department of Health, Buffalo Area Office, 584 Delaware Avenue, 3rd Floor, Room 301, Buffalo, New York and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not

routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
27 February, 1995

BARBARA A. DeBUONO, M.D., M.P.H.
Commissioner of Health

Inquiries should be directed to:

E. Marta Sachey
Associate Counsel
NYS Department of Health
Division of Legal Affairs
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
FIDEL R. RAMOS, M.D.	:	CHARGES

----------X

FIDEL R. RAMOS, JR., M.D., the Respondent, was authorized to practice medicine in New York State on January 22, 1973 by the issuance of license number 115640 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through May 31, 1996 at 306 East Main Street, Westfield, New York 14787-1127.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A [patients are identified in the Appendix] from approximately May 9, 1986 through approximately February 1, 1995 at Respondent's office at 306 East Main Street, Westfield, New York [hereafter "office"] and/or at Westfield Memorial Hospital, Inc., 189 East Main Street, Westfield, New York [hereafter "Westfield Hospital"].

1. Respondent, in his handwritten October 10, 1994 1:00 p.m. note in Patient A's Westfield Hospital record, inserted the phrase "uterus atroph[?] and cervix stenosed." Respondent did so to make it appear

that he wrote that phrase contemporaneously with the rest of the note when, in fact, Respondent had not and Respondent knew such fact.

2. Respondent, in a January 10, 1995 interview with the Office of Professional Medical Conduct, in response to questions regarding the phrase referred to in paragraph 1, above, stated that he wrote that phrase at the same time as the rest of the note and/or with the same pen when, in fact, Respondent had not done so and Respondent knew such facts.

3. Respondent failed to provide adequate routine gynecological care for Patient A including, without limitation, routine breast examinations, during the course of treatment prior to approximately August 24, 1992 and/or document such care.

4. Respondent, although he had not performed a successful dilatation and curettage on October 10, 1994, advised Patient A that she had "no tumor."

5. Respondent failed to provide Patient A appropriate care following the unsuccessful October 10, 1994 dilatation and curettage and/or document such care.

6. Respondent failed to maintain adequate records for Patient A.

B. Respondent provided medical care to Patient B from approximately June 7, 1988 through approximately February 9, 1990 at his office and/or at Westfield Hospital.

1. Respondent discharged Patient B from Westfield Hospital on August 4, 1988 without adequately ruling out that Patient B had an ectopic pregnancy.

2. Respondent failed to adequately evaluate Patient B's July 8, 1988 complaint of vaginal discharge and/or document such evaluation.

3. Respondent on July 8, 1988 diagnosed Patient B as having acute cervicitis without adequate basis and/or without documenting such basis.

4. Respondent, assuming the accuracy of his July 8, 1988 diagnosis of acute cervicitis, failed to appropriately treat this condition.

5. Respondent failed to maintain adequate records for Patient B.

C. Respondent provided medical care to Patient C from approximately December 19, 1988 through approximately March 21, 1994 at his office and/or at Westfield Hospital.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient C and/or during the course of treatment.

2. Respondent failed to adequately monitor Patient C's diabetic control and/or document such monitoring.

3. Respondent failed to place Patient C on insulin and/or strongly recommend such treatment in a timely manner and/or document that he had so recommended.

4. Respondent placed Patient C on two oral hypoglycemic drugs, Glucotrol and Orinase, simultaneously, which was not indicated.

5. Respondent failed to order culture and sensitivity studies in treating on May 28, 1991 Patient C's hand abscess and/or on December 20, 1991 Patient C's abscess of the right post auricular area and/or on November 30, 1992 Patient C's abscess of the right parietal area.

6. Respondent, from approximately January 24, 1994 until approximately Patient C's March 22, 1994 admission to Westfield Hospital, failed to adequately and/or in a timely manner evaluate and/or treat Patient C's problems with his left foot including, without limitation, evaluation of the circulatory status of Patient C's lower extremities.

7. Respondent in his December 13, 1993 office record recorded that Patient C "needed glucometer - he claimed that is expensive." In fact, Respondent never recommended that Patient C use a glucometer, Patient C never told Respondent that a glucometer was expensive and/or Patient C himself raised the issue of using a glucometer and Respondent discouraged its use and Respondent knew such facts.

8. Respondent in his January 31, 1994 and/or March 9, 1994 office record made entries to the effect that Respondent had discussed insulin treatment with Patient C when, in fact, Respondent had never done so and Respondent knew such facts.

9. Respondent failed to maintain adequate records for Patient C.

D. Respondent provided medical care to Patient D from approximately August 28, 1992 through approximately July 18, 1994 at his office.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient D and/or during the course of treatment.

2. Respondent failed to adequately monitor Patient D's diabetic control and/or document such monitoring.

3. Respondent on February 2, 1993 diagnosed Patient D as having diabetic neuropathy without adequate basis and/or without documenting such basis.

4. Respondent on April 26, 1993 diagnosed Patient D as having an active peptic ulcer without adequate basis and/or without documenting such basis.

5. Respondent, assuming the accuracy of his April 26, 1993 diagnosis of active peptic ulcer, on April 26, 1993 prescribed Feldene for Patient D which was not indicated and/or contraindicated.

6. Respondent on April 26, 1993 diagnosed Patient D as having arthritis of the knees and ankles without adequate basis and/or without documenting such basis.

7. Respondent on September 3, 1993 diagnosed Patient D as having gouty arthritis of the ankle and knee without adequate basis and/or without documenting such basis.

8. Respondent on December 21, 1993 diagnosed Patient D as having acute pleuritis without adequate basis and/or without documenting such basis.

9. Respondent, assuming the accuracy of his December 21, 1993 diagnosis of acute pleuritis, failed to appropriately treat this condition.

10. Respondent failed to adequately assess the circulation in Patient D's legs during approximately January 1994 when Respondent was treating Patient D's right leg ulcer and/or failed to document such assessment.

11. Respondent on February 21, 1994 failed to adequately evaluate Patient D's complaint of chest pain and/or document such evaluation.

12. Respondent failed to refer Patient D to an ophthalmologist and/or ascertain that Patient D was seeing one and/or document such facts, despite Respondent's June 20, 1994 observation that Patient D had "slight diabetic fundi."

13. Respondent failed to maintain adequate records for Patient D.

E. Respondent provided medical care to Patient E from approximately February 7, 1992 through approximately June 8, 1994 at his office.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient E and/or during the course of treatment.

2. Respondent on various occasions, including December 11, 1992 and/or February 1, 1993, diagnosed Patient E as having acute pyelonephritis without adequate basis and/or adequate evaluation and/or without documenting such basis or evaluation.

3. Respondent, assuming the accuracy of his diagnosis of acute pyelonephritis, failed to appropriately treat this condition.

4. Respondent failed to adequately evaluate Patient E's complaints of frequency of urination and/or dysuria in a timely manner and/or document such evaluation.

5. Respondent failed to perform a routine prostate examination on Patient E in a timely manner.

6. Respondent failed to adequately follow-up on a February 2, 1993 intravenous pyelogram report

indicating the possibility that Patient E had an enlarged spleen.

7. Respondent failed to maintain adequate records for Patient E.

F. Respondent provided medical care to Patient F from approximately March 5, 1988 through approximately July 5, 1994 at his office and/or at Westfield Hospital.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient F and/or during the course of treatment.

2. Respondent at various times, including September 16, 1988, March 26, 1991 and/or July 5, 1994, failed to adequately evaluate Patient F's complaints of chest pain and/or dyspnea and/or document such evaluation.

3. Respondent failed to adequately evaluate Patient F's February 27, 1990 complaints of black stool and dizziness and/or document such evaluation.

4. Respondent on December 14, 1990 and/or October 8, 1991 diagnosed Patient F as having acute pleuritis without adequate basis and/or without documenting such basis.

5. Respondent, assuming the accuracy of his diagnoses of acute pleuritis on December 14, 1990 and/or October 8, 1991, failed to appropriately treat this condition.

6. Respondent failed to adequately evaluate Patient F's July 19, 1991 complaint of dysuria and/or July 5, 1994 complaint of frequency of urination and/or document such

evaluation.

7. Respondent failed, between approximately October 29, 1991 through December 9, 1991, to adequately evaluate Patient F's complaints of neck pain, headache, dizziness, cough, dyspnea and/or sore throat and/or to adequately evaluate the efficacy of treatment and/or to document such evaluation.

8. Respondent on August 17, 1993, September 14, 1993, October 12, 1993, December 21, 1993, February 2, 1994 and/or February 18, 1994 diagnosed Patient F as having acute diverticulitis without adequate basis and/or without documenting such basis.

9. Respondent, assuming the accuracy of his diagnoses of acute diverticulitis on August 17, 1993, September 14, 1993, October 12, 1993, December 21, 1993, February 2, 1994 and/or February 18, 1994, failed to appropriately treat this condition.

10. Respondent at various times, including November 5, 1991, November 27, 1991, December 3, 1991, December 9, 1991, December 15, 1993, February 8, 1994, February 18, 1994 and/or July 5, 1994, treated Patient F with intramuscular injections of aqueous penicillin which was not indicated and/or without documenting the indications for such treatment.

11. Respondent at various times, including November 3, 1993, February 25, 1994, April 4, 1994, June 14, 1994 and/or June 21, 1994, failed to adequately evaluate Patient F's complaints of shoulder pain and/or the efficacy of treatment and/or document such evaluation.

12. Respondent on March 8, 1994 diagnosed Patient F as having a bulging disk and/or neuritis

of the right lower extremity without adequate basis and/or without documenting such basis.

13. Respondent failed to maintain adequate records for Patient F.

G. Respondent provided medical care to Patient G from approximately May 19, 1993 through approximately July 13, 1994 at his office.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient G and/or during the course of treatment.

2. Respondent at various times, including July 26, 1993, August 9, 1993, September 13, 1993 and/or September 18, 1993, failed to adequately evaluate Patient G's complaints of chest pain and/or document such evaluation.

3. Respondent at various times, including July 26, 1993, August 1, 1993, August 2, 1993 August 9, 1993, August 13, 1993, September 17, 1993, September 18, 1993 and/or September 19, 1993, gave Patient G intramuscular aqueous penicillin injections which were not indicated and/or without documenting the indications for such treatment.

4. Respondent on July 26, 1993 noted that Patient G had a pleural friction rub and/or on August 1, 1993 a bilateral pleural friction rub without adequate basis and/or without documenting such basis.

5. Respondent on July 26, 1993 and/or August 1, 1993 diagnosed Patient G as having acute pleuritis without adequate basis and/or without recording such basis.

6. Respondent on July 26, 1993 diagnosed Patient G as having hypocalcemia and anemia without adequate basis and/or without documenting such basis.

7. Respondent failed to maintain adequate records for Patient G.

H. Respondent provided medical care to Patient H from approximately April 21, 1994 through approximately July 5, 1994 at his office.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient H and/or during the course of treatment.

2. Respondent failed to adequately evaluate Patient H's April 29, 1994 complaint of chest pain and/or document such evaluation

3. Respondent on April 29, 1994 diagnosed Patient H as having acute pleuritis without adequate basis and/or without documenting such basis.

4. Respondent, assuming the accuracy of his April 29, 1994 diagnosis of acute pleuritis, failed to adequately treat this condition.

5. Respondent on April 21, 1994 diagnosed Patient H as having uncontrolled diabetes mellitus and/or on April 29, 1994 unstable diabetes mellitus without adequate basis and/or without documenting such basis.

6. Respondent, assuming the accuracy of his April 21, 1994 and/or April 29, 1994 diagnoses regarding Patient H's diabetes, failed to adequately treat this condition.

7. Respondent on May 27, 1994 diagnosed Patient H as having degenerative disk disease at L5-S1 and/or peripheral neuritis of the lower extremities without adequate basis and/or without documenting such basis.

8. Respondent on June 20, 1994 diagnosed Patient H as having partial intestinal obstruction secondary to adhesions and/or on July 5, 1994 partial intestinal obstruction secondary to peptic esophagitis without adequate basis and/or without documenting such basis.

9. Respondent failed to maintain adequate records for Patient H.

I. Respondent provided medical care to Patient I from approximately January 30, 1991 through approximately April 15, 1992 at his office and/or at Westfield Hospital.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient I and/or during the course of treatment.

2. Respondent failed to adequately evaluate and/or treat Patient I's nonhealing left leg stump and/or document such evaluation and treatment.

3. Respondent failed to maintain adequate records for Patient I.

J. Respondent provided medical care to Patient J from approximately March 7, 1988 through November 30, 1992 at his office and/or Westfield Hospital.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient J and/or during the course of treatment.

2. Respondent on March 7, 1988 diagnosed Patient J as having acute pyelonephritis without adequate basis and/or without documenting such basis.

3. Respondent failed to adequately evaluate the cause of Patient J's knee pain and/or document such evaluation.

4. Respondent at various times from 1989 through 1992 gave Patient J steroid injections which were excessive and/or not indicated and/or contraindicated.

5. Respondent on May 18, 1992 diagnosed Patient J as having malabsorption syndrome without adequate basis and/or without documenting such basis.

6. Respondent failed to maintain adequate records for Patient J.

K. Respondent provided medical care to Patient K from approximately January 17, 1992 through approximately April 9, 1994 at his office.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate

physical examinations when he first began treating Patient K and/or during the course of treatment.

2. Respondent on October 26, 1992, January 26, 1994, January 29, 1994, February 11, 1994 and/or March 9, 1994 diagnosed Patient K as having acute pleuritis without adequate basis and/or without documenting such basis.

3. Respondent, assuming the accuracy of his October 26, 1992, January 26, 1994, January 29, 1994, February 11, 1994 and/or March 9, 1994 diagnoses of acute pleuritis, failed to appropriately treat this condition.

4. Respondent failed to adequately evaluate Patient K's October 26, 1992, May 19, 1993 and/or January 26, 1994 complaints of chest pain and/or document such evaluation.

5. Respondent failed to maintain adequate records for Patient K.

L. Respondent provided medical care to Patient L from approximately July 1993 through July 13, 1994 at his office and/or at Westfield Hospital.

1. Respondent failed to obtain and/or document adequate histories and/or perform and/or document adequate physical examinations when he first began treating Patient L and/or during the course of treatment.

2. Respondent on February 11, 1994 diagnosed Patient L as having acute pleuritis without adequate basis and/or without documenting such basis.

3. Respondent, assuming the accuracy of his February 11, 1994 diagnosis of acute pleuritis, failed to appropriately treat this condition.

4. Respondent failed to maintain adequate records for Patient L.

FIRST SPECIFICATION

CONDUCT EVIDENCING MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(20) (McKinney Supp. 1995) by reason of his conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A and A.2.

SECOND THROUGH THIRD SPECIFICATIONS

PRACTICING FRAUDULENTLY

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530 (2) (McKinney Supp. 1995) by reason of his practicing the professional of medicine fraudulently, in that Petitioner charges:

2. The facts in Paragraphs A and A.1 and/or A and A.2.

3. The facts in Paragraphs C and C.7 and/or C and C.8.

FOURTH THROUGH THIRTEENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) (McKinney Supp. 1995) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges:

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

5. The facts in Paragraphs B and B.1.

6. The facts in Paragraphs C and C.2, and/or C and C.6.

7. The facts in Paragraphs D and D.2, D and D.5, D and D.9, D and D.10 and/or D and D.11.

8. The facts in Paragraphs F and F.2, F and F.3, and/or F and F.5.

9. The facts in Paragraphs G and G.2 and/or G and G.5.

10. The facts in Paragraphs H and H.2, H and H.4, H and H.5 and/or H and H.6.

11. The facts in Paragraphs J and J.4.

12. The facts in Paragraphs K and K.3 and/or K and K.4.

13. The facts in Paragraphs L and L.3.

FOURTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent's charged with professional misconduct under N.Y. Educ. Law §6530(6) (McKinney Supp. 1995) by reason of his practicing the profession of medicine with gross incompetence, in

that Petitioner charges:

14. The facts in Paragraphs A and A.4.

15. The facts in Paragraphs B and B.1.

16. The facts in Paragraphs C and C.2 and/or C and C.6.

17. The facts in Paragraphs D and D.2, D and D.5, D and D.9, D and D.10 and/or D and D.11.

18. The facts in Paragraphs F and F.2, F and F.3, and/or F and F.5.

19. The facts in Paragraphs G and G.2 and/or G and G.5.

20. The facts in Paragraphs H and H.2, H and H.4, H and H.5 and/or H and H.6.

21. The facts in Paragraphs J and J.4.

22. The facts in Paragraphs K and K.3 and/or K and K.4.

23. The facts in Paragraphs L and L.3.

TWENTY-FOURTH SPECIFICATION

PRACTICING WITH NEGLIGENCE
ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) (McKinney Supp. 1995) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

24. The facts in Paragraphs A and A.3,

A and A.4, A and A.5, B and B.1,
B and B.2, B and B.3, B and B.4,
C and C.1, C and C.2, C and C.3,
C and C.4, C and C.5, C and C.6,
D and D.1, D and D.2, D and D.3,
D and D.4, D and D.5, D and D.6,
D and D.7, D and D.8, D and D.9,
D and D.10, D and D.11, D and D.12,
E and E.1, E and E.2, E and E.3,
E and E.4, E and E.5, E and E.6,
F and F.1, F and F.2, F and F.3,
F and F.4, F and F.5, F and F.6,
F and F.7, F and F.8, F and F.9,
F and F.10, F and F.11, F and F.12,
G and G.1, G and G.2, G and G.3,
G and G.4, G and G.5, G and G.6,
H and H.1, H and H.2, H and H.3,
H and H.4, H and H.5, H and H.6,
H and H.7, H and H.8, I and I.1,
I and I.2, J and J.1, J and J.2,
J and J.3, J and J.4, J and J.5,
K and K.1, K and K.2, K and K.3,
K and K.4, L and L.1, L and L.2
and/or L and L.3.

TWENTY-FIFTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON
MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ Law §6530(5) (McKinney Supp 1995) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

25. The facts in Paragraphs A and A.3,
A and A.4, A and A.5, B and B.1,
B and B.2, B and B.3, B and B.4,
C and C.1, C and C.2, C and C.3,
C and C.4, C and C.5, C and C.6,
D and D.1, D and D.2, D and D.3,
D and D.4, D and D.5, D and D.6,
D and D.7, D and D.8, D and D.9,
D and D.10, D and D.11, D and D.12,

E and E.1, E and E.2, E and E.3,
E and E.4, E and E.5, E and E.6,
F and F.1, F and F.2, F and F.3,
F and F.4, F and F.5, F and F.6,
F and F.7, F and F.8, F and F.9,
F and F.10, F and F.11, F and F.12,
G and G.1, G and G.2, G and G.3,
G and G.4, G and G.5, G and G.6,
H and H.1, H and H.2, H and H.3,
H and H.4, H and H.5, H and H.6
H and H.7, H and H.8, I and I.1,
I and I.2, J and J.1, J and J.2,
J and J.3, J and J.4, J and J.5,
K and K.1, K and K.2, K and K.3,
K and K.4, L and L.1, L and L.2
and/or L and L.3.

TWENTY-SIXTH THROUGH THIRTY-SEVENTH SPECIFICATIONS

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1995) by reason of his failing to maintain a record for each patient with accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

26. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.5 and/or A and A.6.

27. The facts in Paragraphs B and B.2, B and B.3 and/or B and B.5.

28. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.7, C and C.8 and/or C. and C.9.

29. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.6, D and D.7, D and D.8, D and D.10, D and D.11, D and D.12 and/or D and D.13.

30. The facts in Paragraphs E and E.1, E and E.2, E and E.4 and/or E and E.7.

31. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.6, F and F.7, F and F.8 F and F.10, F and F.11, F and F.12 and/or F and F.13.

32. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6 and/or G and G.7.

33. The facts in Paragraphs H and H.1, H and H.2, H and H.3, H and H.5, H and H.7, H and H.8 and/or H and H.9.

34. The facts in Paragraphs I and I.1, I and I.2 and/or I and I.3.

35. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.5 and/or J and J.6.

36. The facts in Paragraphs K and K.1, K and K.2, K and K.4 and/or K and K.5.

37. The facts in Paragraphs L and L.1, L and L.2 and/or L and L.4.

DATED: February 27, 1995
Albany, New York

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