STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

December 14, 1995

RECEIVED
DEC 14 1995
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

E. Marta Sachey, Esq.
NYS Dept. of Health
Corning Tower-Room 2429
Albany, New York 12237

Fidel R. Ramos, M.D.
306 East Main Street
Westfield, New York 14787-1127

Alan Lambert, Esq.
Lifshutz, Polland & Associates, P.C.
675 Third Avenue, Suite 2400
New York, New York 10017

RE: In the Matter of Fidel R. Ramos, M.D.

Dear Ms. Sachey, Dr. Ramos and Mr. Lambert:

Enclosed please find the Determination and Order (No. 95-304) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must 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 all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

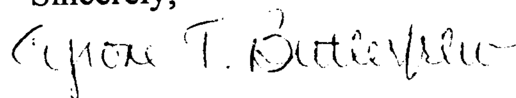
The notice of review served on the Administrative Review Board should be forwarded to:

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

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

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

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

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

IN THE MATTER OF FIDEL R. RAMOS, M.D.	DETERMINATION AND ORDER

BPMC-95-304

A Commissioner's Order and Notice of Hearing, and a Statement of Charges, both dated February 27, 1995, were served upon the Respondent, Fidel R. Ramos, M.D. **MICHAEL R. GOLDING, M.D. (Chair), WILLIAM K. MAJOR, JR., M.D., and DENNIS R. HORRIGAN**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by E. Marta Sachey, Esq., Associate Counsel. The Respondent appeared by Walter D. Kogut, Esq., P.C. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	March 6, 1995
Answer to Statement of Charges:	None
Pre-Hearing Conference:	March 15, 1995
Dates of Hearings:	April 7, 1995 April 10, 1995 April 17, 1995

	April 18, 1995 May 8, 1995 May 9, 1995 May 16, 1995 June 9, 1995 June 28, 1995 June 29, 1995 June 30, 1995
Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendation:	August 15, 1995
Received Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendation:	August 4, 1995
Witnesses for Department of Health:	Nancy N. Nielsen, M.D. Patient C John M. Antkowiak, M.D. Angel Gutierrez, M.D. Dwight Howes
Witnesses for Respondent:	Ronald J. Foote, M.D. Richard H. Heibel, M.D. Fidel R. Ramos, M.D.
Deliberations Held:	September 19, 1995

STATEMENT OF CASE

These proceedings commenced with the service of a Commissioner's Order which summarily suspended Respondent's license to practice medicine, upon a finding by the Commissioner of Health that Respondent's continued practice presented an imminent danger to the health of the people of New York State. The Order was accompanied by a Statement of Charges setting forth thirty-seven specifications of professional misconduct, regarding Respondent's medical care and treatment of twelve patients. The charges include allegations of fraud, gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, and a failure to maintain accurate

medical records.

Following eleven days of testimony, the Hearing Committee found that Respondent does present an imminent danger, and recommended that the Summary Order be continued. By an Interim Order, dated July 7, 1995, the Commissioner of Health determined that the Summary Order shall remain in effect pending the final resolution of the case.

A copy of the Commissioner's Order, Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

Respondent was represented at the hearing by Walter D. Kogut, Esq., P.C. Following the close of the hearing, Respondent discharged his counsel. Thereafter, Respondent was represented by Lifshutz, Polland & Associates, P.C., Alan Lambert, Esq., of Counsel.

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

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

General Findings

1. Fidel R. Ramos, Jr., M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State 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. (Pet. Ex. #3).

2. Accepted standards of medical care dictate that adequate histories should be obtained when a physician first begins seeing a patient and during the course of treatment. An initial history is not only a means for a physician to get information regarding a patient's current symptoms and medical history but to learn about the patient in areas such as family and employment which may also affect the patient's medical status. An initial history should include:

* why the patient is seeking treatment or the current complaint and the history of that complaint
* previous medical history, including past illness, health problems, treatment, surgeries, medications, allergies
* family history, including medical and psychiatric problems
* education and employment history
* alcohol, drug, smoking history

Supplemental histories regarding every new complaint during the course of treatment are also required. These should include such things as the duration, location, alleviating and aggravating

factors and associated symptoms of the complaint. A patient's history is probably the most important element in diagnosis. It provides a frame of reference for the context of the patient's illness. It provides a framework to build a diagnostic impression. (T.246-248).

3. Accepted standards of medical care require that when a primary care physician first begins seeing a patient that a complete physical examination be performed. This provides a baseline on the patient's first visit. It may elicit new things not obtained during the history. An initial physical examination should include an examination of all systems, vital signs, height and weight, and a description of the patient's general appearance. Adequate physical examination of a patient during the course of treatment is also required. (T.248, 251).

4. A patient's records should be sufficient to enable another physician to understand the patient and the care provided and to assume that care if the need arises. Generally accepted standards of practice require that patient histories and physical examinations, treatment, medication regimens and referrals to or treatment by other physicians be documented. Adequate record keeping is important for the treating physician to assess treatment. Good record keeping is a means to assess the patient and the efficacy of treatment in a broader context than the single office visit. (T. 248-249,280-283,325-326,650).

5. Pleuritis is an inflammation of the pleura, the lining of the lung. Its symptoms are pain and perhaps cough, fever or general malaise. If there is an effusion, there will be

decreased breath sounds on physical examination. Palpation and percussion of the chest produce pain. Deep breaths cause pain which is typically described as knife-like. Splinting would be expected. There may be a pleural friction rub which occurs when the two layers of the pleura, one against the chest and one against the lung, rub against each other. The incidence of a single pleural friction rub is infrequent in a primary care practice; bilateral rubs are even more infrequent. The presence of a pleural friction rub is of significant concern. Evaluation should include blood work, to include a screen for rheumatologic disorders and a blood count and a chest x-ray. There are numerous causes for pleuritis; anything that can inflame the pleura can cause pleuritis. It is often a fairly ominous condition. Among the possible causes are a virus or bacteria, tuberculosis, a collagen disease, cancer or a pulmonary embolism. The most common cause of a rub is pneumococcal pneumonia - the most threatening cause is pulmonary embolism. Pleuritis can be identified by the history of the pain, cough and/or fever, the character of the patient's breathing and pain associated with respiration, the observation of a pleural friction rub, and a chest x-ray that shows inflammation of the pleura with an effusion or just thickening of the pleura. The occurrence of pleuritis in a rural practice is fairly rare. Treatment for pleuritis depends on its cause. Before treating the condition a diagnosis for its underlying cause should be established. (T.424-426,428,458-460,592, 624-625,786-792, 1143,1158-1160, 1179-1180, 1193).

6. Proper evaluation of chest pain entails, most importantly, a thorough history. The nature of the discomfort, the duration, location, radiation and aggravating or alleviating factors should be ascertained. The physician should determine whether the pain is worsened by muscular activity or breathing, and whether the pain is related to other symptoms such as shortness of breath, sweating, nausea or vomiting. A patient's risk factors should be identified and considered. These would include, among others, family history, prior history of chest pain or heart problems and diabetes. Diabetes is recognized as a major risk factor for coronary heart disease. If warranted by the history and/or physical findings further assessment, including an electrocardiogram, should be undertaken. (T.432, 1046, 1048-1049, 1139).

7. Use of intramuscular injections of penicillin has been obsolete since at least the early 1990's, if not before. Such injections have no recognized valid use in view of oral antibiotics. Aqueous penicillin is almost exclusively used for intravenous injection in a hospital setting to treat serious sepsis-like conditions where a high and steady level for a prolonged time period is needed. (T.534,1144].

Patient A

8. Respondent provided medical care to Patient A at various times from approximately May 9, 1986 through approximately February 1, 1995 at Respondent's office and at Westfield Memorial Hospital. Respondent was Patient A's primary

care physician, as well as her surgeon. (T.20, 145-146; Ex.5, 6 and 7).

9. Patient A is a seventy-six year old woman who was admitted to Westfield Memorial Hospital on October 10, 1994 under Respondent's admission. She was admitted due to episodes of postmenopausal bleeding for a diagnostic D and C to rule out endometrial cancer. This procedure was recommended by the patient's oncologist. He had been following her since 1992 when the patient had a left radical mastectomy for breast cancer which Respondent performed. The patient had been on Tamoxifen since 1992 for her breast cancer. (Ex.5, pp 2, 4-5; Ex. 6, p.4).

10. A written operative note in Respondent's progress notes, dated and timed October 10, 1994 1:00 p.m., stated that a D and C and cervical biopsies were done under general anesthesia. The patient was noted to tolerate the procedure well. The uterus was described as atrophic and the cervix stenosed. Respondent's 1:30 p.m. progress note of the same date described his post-operative evaluation of the patient. (Ex.5, p.8; Ex. 8).

11. There are two operative reports of the October 10, 1994 procedure. One was dictated by Respondent on October 10, 1994 and the other on November 16, 1994. The first report described a routine D and C with dilation of the cervix and uterine curettage. Cervical biopsies were also noted. The second report described the uterus as small and atrophic and the cervix stenotic. It indicated that attempts at dilating the cervix were unsuccessful so a curettage was done along the area of the cervix. (Ex.5, pp.10-11).

12. Respondent agreed that he dictated both reports. However, he had no explanation as to why he dictated the first one which did not accurately reflect the procedure Respondent claimed that he performed. Respondent had no other surgeries on October 10, 1994 so there was no chance that he confused one patient's surgery with another's. Respondent dictated the second operative report in November, 1994 when the patient's record was given to him to sign the chart cover sheet. (T. 21-22, 24, 59, 1418-1419,1423; Ex. D, pp.27-34).

13. The pathology report, dated October 13, 1994, noted that two specimens, marked "endometrial curettings" and "cervical biopsy" were received. However, the report noted that no endocervical or endometrial tissue was identified. (Ex.5, p.12).

14. Respondent inserted the phrase "uterus atrophic and cervix stenosed" in his 1:00 p.m. October 10, 1994 handwritten operative note in Patient A's progress notes, at some time the after 1:00 P.M. Respondent testified that he made the addition after 1:30 p.m. before he left the hospital that day. The phrase was not initialed or timed by Respondent, which is the accepted way to add after the fact entries to a medical record. Respondent was aware of this procedure. Respondent inserted the phrase in the limited space available before his signature. On its face the phrase appears to have been written contemporaneously with the rest of the note. (T. 95, 1320-1322, 1374-1377, 1409-1410; Ex. 5, p.8; Ex. 8).

15. Respondent's 1:00 and 1:30 p.m. progress notes were

examined in the New York State Police Crime Laboratory with a video spectral comparitor. The examination showed that the phrase "uterus atrophic and cervix stenosed" is in a different black ink than the black ink of the rest of the 1:00 p.m. note and Respondent's signature. The phrase is in a different black ink than the black ink of Respondent's 1:30 p.m. note. The 1:30 note and the 1:00 note, other than the phrase "uterus atrophic and cervix stenosed," are in black ink of the same composition. (828-838; Ex.8; Ex.9 A-D).

16. Respondent's testimony that he added the subject phrase after 1:30 p.m. before leaving the hospital, and his explanation of the circumstances surrounding this action were not credible. Respondent conceded that the proper method for making additions to progress notes was something any medical student would know. Nevertheless, Respondent stated that although he was very late for his office appointments, and after he had dictated the operative report, he returned to the chart to make an addition. He further stated that he remembered the omission while changing his clothes. (T.1320-1322, 1374-1376, 1409, 1435-1436).

17. Notably, Respondent's addition to his note was the only extrinsic evidence in the patient's record, prior to Respondent dictating a second operative report in November, 1994, that Respondent may have had difficulty with performing a D and C or knew that he had not performed one. The note itself states that a D and C was done. The pathology report shows that a specimen was characterized as "endometrial

curettings" which would be an appropriate description if a D and C had, in fact, been done. Respondent's first operative report clearly recites that a D and C was done. (Ex.5, pp. 8, 10, 12).

18. On January 10, 1995, Respondent had an interview with the Office of Professional Medical Conduct to discuss, in part, issues relating to Patient A. He met with, among others, Dr. Nancy Nielsen, an OPMC Medical Coordinator. (T.18-19).

19. Dr. Nielsen asked Respondent whether he wrote the subject phrase at the same time as the rest of the note or added it at a later time. Respondent told Dr. Nielsen that he absolutely wrote it at the same time. (T.29-31, 60-61).

20. Respondent undertook to provide Patient A gynecological care in his role as her primary care physician. This occurred until approximately August 1992. At that time the patient was diagnosed with breast cancer and subsequently followed by an oncologist. (T.1336, 1381-1382).

21. A primary care physician providing gynecological care to a patient, at a minimum, should perform yearly pelvic and breast examinations. Pap tests should also be done on a yearly basis. Mammograms should be done once a year in women over fifty. Standards of practice require that a physician document the components of the routine gynecological care provided. (T. 78-81, 878).

22. Respondent failed to provide Patient A adequate routine gynecological care during the course of his treatment

prior to approximately August 27, 1992. The care rendered did not meet accepted standards of care. There was no documentation of any breast examinations or pelvic examinations. There was no reference to any mammograms or pap smears or the results of such tests in Respondent's records. The only pelvic examination documented through August 24, 1992 was not an adequate examination for the purposes of routine gynecological care; there was no evidence that there was a speculum examination, a pap smear or a rectal examination as part of this examination. (T.79-81; Ex. 6).

23. Respondent claimed that he performed breast and pelvic examinations on the patient at least "every three or four years." This was not corroborated by Respondent's records. There was no reference to such examinations although on numerous occasions throughout the course of treatment Respondent recorded examinations of other areas, such as the abdomen, lungs and extremities (T. 1336, 1381-1382, 1982; Ex. 6).

24. Respondent attempted but did not perform a D and C on Patient A on October 10, 1994. There was no entry into the uterine cavity, attempts to dilate the cervix were unsuccessful and no intrauterine curettings were obtained. The pathology report noted that no endometrial tissue was received. The goal of the D and C, to rule out endometrial cancer, was not achieved. Respondent testified that he has done hundreds of D and Cs during his practice of medicine.

However, during the approximate four and one half years before attempting a D and C on Patient A, Respondent had only done ten such procedures. (T. 83-84, 877, 1317, 1341, 1365-1367; Ex. 5, pp. 11-12).

25. Although he failed to perform a D and C, Respondent told the patient that she had "no tumor." The transcription of Respondent's explanations of what he told the patient reveals that Respondent told the patient that she had no tumor. Importantly, Respondent did not tell the patient that a D and C was not performed. In his comments to Dr. Nielsen, it is clear he told the patient that "they don't get much cells." He did not tell the patient he got no cells. In regard to the cross-examination question "Did you tell the patient you did not perform a D and C?" Respondent effectively answered no: "I told her that I did endocervical scrapings and cervical biopsy." (T.29, 1388; Ex. D, pp. 40-41).

26. Uterine cancer was not ruled out. A patient with postmenopausal bleeding has a significant chance of having uterine cancer, even with the most minute amounts of bleeding. The second risk was that the misinformation might keep the patient from a treatment that may benefit her with regard to the breast cancer, specifically the Tamoxifen she had discontinued when she started to have vaginal bleeding. (T.84-86, 142-143; Ex.D, p.48).

27. Respondent's follow-up care of Patient A after the unsuccessful October 10, 1994 D and C was inadequate. Since

a D and C was not actually done, there was no assurance that the patient did not have endometrial cancer. (T. 142-144).

28. Other diagnostic alternatives should have been pursued. At a minimum, if the patient refused a D and C, an ultrasound examination of the uterus to measure the endometrial stripe could have been done. A referral to a gynecologist would have been appropriate. A hysterectomy might be an alternative to give the patient the substantial benefit of using Tamoxifen if a diagnosis of endometrial cancer could not be ruled out. (T.142-144).

29. Respondent noted in his November 2, 1994 office entry that the patient was to see a gynecologist. His record contains a January 11, 1995 note typed by his office staff and signed by the patient that the patient did not want to see a gynecologist or pursue other care. The note was prepared the day following Respondent's interview with OPMC regarding Patient A. Respondent's follow-up care and advice to the patient, as documented by him, did not satisfy the requirements of acceptable care. (T.86-94, 143-144, 1330-1332; Ex. 6, p. 16; Ex. 7, p.3).

30. A reasonably prudent physician would have specifically documented a patient's refusal to undergo further care in the circumstances of Patient A's case. Respondent's testimony that he emphasized to the patient on November 30 and December 21, 1994 that she should see a gynecologist was not corroborated in his record. (T. 93, 1327-1329; Ex.6 pp.7, 10).

31. Respondent did not maintain adequate records for Patient A. (T.93-94, 895).

Patient B

32. Respondent provided medical care to Patient B at various times from approximately June 7, 1988 through approximately February 9, 1990 at Respondent's office and at Westfield Memorial Hospital. Respondent was the patient's primary care physician. (T. 1451; Ex. 11 and 12).

33. Patient B was then a woman in her late teens. Respondent treated her for vaginal discharge in his office in July 1988 and for an ectopic pregnancy during two hospital admissions in August 1988. The patient had one child and a history of a prior ectopic pregnancy. (Ex.11 and 12).

34. Patient B was admitted to the hospital from the emergency room on July 31, 1988 with complaints of abdominal pain, vaginal bleeding and dizziness when standing up. She had a history of a right ectopic pregnancy in January, 1988 and was treated for pelvic infection in July 1988. Respondent discharged the patient on August 4, 1988. The patient was readmitted to the hospital on August 11, 1988 with a ruptured right ectopic pregnancy. (Ex.11).

35. During Patient B's first hospital admission there were symptoms and signs of an ectopic pregnancy. In addition, the patient's history was suggestive of an ectopic pregnancy. She had a previous ectopic pregnancy, which significantly increases the risk of another. She had a history of pelvic inflammatory disease. The patient had

abdominal pain and abnormal vaginal bleeding. There was a positive pregnancy test. In the admission day ultrasound report of July 31, 1988, the radiologist listed pelvic inflammatory disease as a first possibility but indicated that an ectopic pregnancy could not be ruled out. The radiologist changed his focus in the report of the August 2, 1988 ultrasound: "with the recently reported positive pregnancy test a high degree of suspicion is placed on an ectopic pregnancy...". (T.336-343, 924-925; Ex. 11).

36. Respondent discharged the Patient on August 4, 1988 without adequately ruling out that the patient had an ectopic pregnancy. He was aware of the patient's history of a prior ectopic pregnancy. He knew that the symptoms of a ruptured ectopic pregnancy can wax and wane. Despite this fact and the ultrasound reports and other information highly suggestive of an ectopic pregnancy, Respondent discharged the patient without undertaking further studies to rule out the ectopic pregnancy. Respondent discharged her before getting serial quantitative HCG's. Moreover, culdocentesis or a laparoscopy could have led to a definitive diagnosis. Respondent could also have gotten a gynecologic consultation. (T. 340-343, 1453, 1461, 1487).

37. Respondent discharged the patient with a final diagnosis that included "R/O early ectopic pregnancy." He indicated a repeat sonogram and CBC and pregnancy test would be done the next week on an outpatient basis. Respondent did not have the patient's true hemoglobin on discharge since the

patient did not have another hemoglobin beyond the post-transfusion one. A repeat pregnancy test would have to be quantitated and done, if not daily, at least every forty-eight hours. (T.341; Ex. 11, pp. 62, 71).

37. Respondent's discharge exposed the patient to the life-threatening risks of rupture and hemorrhage in a non-medical setting. (T.341-342).

39. Patient B presented at Respondent's office on July 8, 1988 with a complaint of vaginal discharge. Respondent documented a pelvic examination and noted a tender cervix, negative adnexa and normal ovaries. (Ex.12, p.3).

40. Respondent's evaluation of the complaint of vaginal discharge was inappropriate. There was no indication in Respondent's record that he did anything more than a digital vaginal examination. The most common cause of vaginal discharge is a vaginal infection which should be assessed by visualization. However, there was no record that Respondent did a speculum examination or examined the discharge either visually, microscopically or by culture. (T.347-348,386-387).

41. Respondent diagnosed the vaginal discharge as acute cervicitis. There was no adequate basis to do so. Although the presenting complaint could be associated with cervicitis, that is a diagnosis which can only be made by visual examination, pathologic examination or a culture. Based on Respondent's record, his only finding was cervical tenderness upon digital examination. That finding is not really

associated with cervicitis. (T.348).

42. Respondent, assuming the accuracy of his diagnosis of acute cervicitis, failed to appropriately treat this condition. Respondent's treatment consisted of one injection of penicillin 300,000 units. There were no recorded instructions for the patient to return for more care. Acute cervicitis is treated with a more broad spectrum antibiotic. One of its most common causes is chlamydia which is not covered by penicillin. Further, since most often vaginal cervical pelvic infection is caused by more than one organism, penicillin may address some of the organisms that are not as critical but leave untreated organisms such a chlamydia or gonorrhea, which might be more dangerous. (T.348,374-374,375,388; Ex.12, p.3).

43. Respondent failed to maintain adequate records for Patient B. As one example, in the August 11, 1988 hospital history and physical examination Respondent reported that he performed a pelvic examination on the patient in his office the previous evening. There was no notation of this visit in Respondent's office records. Respondent testified that he did not see the patient the previous evening. He offered no explanation as to why his hospital report indicated that he had. (T.1446-1447; Ex. 11, p. 9).

<u>Patient C</u>

44. Respondent, as reflected in his office records, provided medical care to Patient C at various times from approximately December 19, 1988 through March 21, 1994 at his

office and at Westfield Memorial Hospital. Respondent also provided care to Patient C before the date the office records begin. Respondent estimated that he diagnosed the patient's diabetes in the early 1980's or 1985 or 1986. In January 1983 Respondent referred the patient to a hospital dietician for a diabetic diet. In December 1985 Respondent verified in writing that the patient was legally blind. In December 1987, approximately one year before Respondent's office records begin, Respondent ordered an outpatient blood test for the patient. Respondent was the only physician the patient saw for his diabetes from approximately 1982 through March 1994. (T. 234, 1524-1525; Ex. 14, 16, 17, 41, 42).

45. Patient C is a man in his fifties who has been diagnosed as a diabetic for at least over a decade. He received primary care from Respondent, including care for diabetes and its complications and hypertension. Respondent was also the patient's surgeon in March of 1994 for toe amputations. Patient C testified that he has brought a lawsuit against Respondent because he feels that if Respondent had managed his diabetes properly he might not have suffered the untoward results of the disease. (T. 221, 246, 326; Ex. 16, 17, 41, 42).

46. Respondent failed to obtain adequate histories and perform adequate physical examinations of Patient C when he first began treating the patient and during the course of treatment and failed to document these. The first record of an office visit Respondent has is dated December 19, 1988.

There was absolutely no history documented at that visit. There was no documentation of a complete physical examination. It is apparent that Respondent treated the patient before that date. However, throughout the office records that Respondent did maintain for the patient there was never a documented complete physical examination or history. Respondent's supplemental histories of the patient were inadequate. The patient's complaints or symptoms usually were just listed without indication of important specifics. (T.250-252; see e.g., Ex.17, pp.48-47).

47. Accepted standards of medical care mandate that, at a minimum, a diabetic patient be monitored once a year by a blood sugar or glycohemoglobin, urinalysis, eye examination and examination of the feet. Periodic monitoring of the status of peripheral arterial circulation should also be done. Both blood sugar and urine testing are required. The blood sugar gives one a sense of the main chemical manifestation of diabetes, hyperglycemia. Urinalysis tests the level of sugar excretion and whether there is any evidence of renal complications. These requirements are for a stable, uncomplicated and well-controlled diabetic. More frequent monitoring is required when a patient's diabetes is uncontrolled or when complications arise. Appropriate diabetic monitoring is a matter of basic primary care medicine. Tight control of diabetes has been shown to reduce the complications of diabetes, including peripheral neuropathy, retinopathy, and may help renal problems.

Appropriate monitoring of diabetic control can delay the untoward effects of diabetes. (T. 252-253, 257-258, 311-312, 1007, 1016, 1018, 1023).

48. Respondent failed to adequately monitor Patient C's diabetic control. There were no yearly urinalyses or blood sugars. Respondent's monitoring of the patient did not even meet the standards for a stable, controlled diabetic. Yet, Patient C, by Respondent's own assessment, at times was uncontrolled or unstable. In the only outpatient laboratory test result secured by Respondent for the patient prior to March 1, 1994, the patient's blood glucose was a high 272. The first office record after this test was almost a year later on December 19, 1988. The next office record date was April 3, 1989. Respondent listed the diagnosis of diabetes on these dates. He did not order a blood sugar or urinalysis. On September 28, 1992 Respondent noted "Diabetes mellitus unstable." However, no monitoring tests were ordered. Laboratory tests done shortly before the patient's March 1994 hospital admission for amputation of gangrenous toes showed a blood glucose of 388. The patient was significantly out of control and hyperglycemic. In 1989, the Respondent had the patient on a drug to address peripheral circulation. However, there was no evaluation of the patient's vascular system to support use of the drug. If there were circulation problems as early as 1989, Respondent did not monitor them appropriately. (T. 253-257, 1020-1021; Ex. 16 and 17).

49. Respondent admitted that he did not order enough blood sugars for the patient. There was no documentation of any urinalysis ordered by Respondent. Respondent never ordered outpatient urine tests for the patient, never told him to test his urine with a dipstick and never tested his urine at the office. (T. 165-166, 184, 214, 1484).

50. Respondent's failure to adequately monitor Patient C's diabetic control was a significant deviation from accepted standards. The patient was exposed to risks as a result of hyperglycemia, such as diabetic acidosis, coma, ophthalmological complications. He was exposed to the risk of kidney impairment and problems with circulation to target organs like the heart and to the limbs. In fact, the patient did develop gangrene which may have been delayed by keeping the patient's diabetes controlled. (T. 257-258,405-406).

51. Insulin treatment compensates for the abnormal insulin secretion of the pancreas in a diabetic. Respondent never placed Patient C on insulin, despite the patient's status. The patient had a significantly high blood sugar level as early as December 1987. In 1991 he had abscesses on various parts of his body. In late January 1994 he began to have problems with his left foot. Respondent should have placed the patient on insulin but did not. Respondent never discussed insulin treatment with the patient. (T. 170, 259-260, 262; Ex. 17).

52. Even assuming the veracity of Respondent's notes, Respondent's approach to insulin treatment for the patient,

as reflected in those notes, was not consistent with accepted standards of care. On January 3, 1994 Respondent noted: "may need insulin if unable to control with Glucotrol." (Ex. 17, p.37) On February 16, 1994 he noted "Glucotrol and possibly insulin". On March 9, 1994 there was a notation "Discussed insulin". Given the patient's diabetic instability and complications, a much more forceful approach than that reflected in Respondent's records should have been taken. Notably, the patient was placed on insulin immediately upon his hospital admission on March 22, 1994. The patient has been on insulin since that admission and never put back on oral agents. (T. 174, 214, 259-260; Ex. 17, pp. 26, 33, 37).

53. Orinase and Glucotrol are oral hypoglycemic drugs of the same class. They stimulate the pancreas' secretion of insulin. On October 2, 1989 Respondent placed Patient C on Glucotrol in addition to the Orinase the patient was already on. At that time Respondent already had the patient on Orinase for at least the prior two to five years. The dual prescribing was accidental because Respondent did not realize he also had the patient on Orinase. Respondent continued the patient on both drugs. (T. 1496-1497, 1507-1508, 1536, 1543; Ex. 17).

54. Respondent's placement of the patient on two hypoglycemic drugs at the same time was not consistent with accepted standards of care. If one is not getting control with one hypoglycemic agent insulin is needed. (T. 261-262, 328, 1003-1004).

55. Respondent treated Patient C for an abscess of the hand on May 28, 1991, the right postauricular area on December 20, 1994 and the right parietal area on November 30, 1992. Respondent treated the abscesses with antibiotics and incisions and drainage. He ordered no culture and sensitivity studies of the abscesses. Respondent's failure to culture the abscesses was not consistent with accepted standards of care. Cultures should be taken before instituting antibiotics so that the bacteria can be identified and the course of treatment varied if the initial antibiotic is not effective. Standard practice is to take a culture, start antibiotic treatment and when the culture results come back modify the antibiotic if necessary. In a diabetic patient a rigorous approach to infection is even more crucial. (T. 262-264, 307, 404; Ex. 17).

56. Respondent, from approximately January 24, 1994 until approximately Patient's C's March 22, 1994 hospital admission, treated Patient C's left foot problems. On January 24, 1994 the patient complained of left leg and foot pain with numbness. Respondent diagnosed diabetic neuropathy and respiratory tract infection. Oral penicillin was given. (Ex. 17, pp. 21-39).

57. Two days later the patient complained of pain and swelling of the left foot. A superficial wound on the left toe was observed. The diagnosis was infected wound left third toe, one centimeter. An injection of penicillin and a wound dressing with Neosporin were given. (Ex. 17, p. 35).

58. Five days later on January 31, 1994, it was noted that wound of the left middle toe was healing slowly. The wound was cleaned with Betadine and Neosporin and dressed with Neosporin. There was a notation to continue with antibiotics and Cipro was prescribed. Instructions for the patient to stop working and bed rest with elevated left leg were noted. There were also notations that diabetic foot care was given and that insulin may be needed if unable to control with Glucotrol. (Ex. 17, p.37).

59. On February 7, 1994, a week later, it was noted that the pain and swelling on the left foot middle toe were subsiding and the wound was healing. Findings were poor peripheral pulsations, no cyanosis, reflexes intact, no sensory deficit. The diagnosis was acute cellulitis of the left foot, infected wound third toe healing slowly. An injection of penicillin was given and Cipro prescribed. (Ex. 17, p.35).

60. On February 11, 1994, four days later, less swelling of left foot was noted but painful swelling of the left middle toe was also noted. Findings were no cyanosis of toes and poor peripheral pulsations. The diagnosis was cellulitis of left foot subsiding, rule out impending gangrene left middle toe. A penicillin injection was given. (Ex. 17, p.36).

61. Three days later, on February 14, 1994, less swelling and pain with left foot and middle toe and no fever or chills were noted. The wound of the left middle toe was

described as "no drainage and healing." Findings were no pitting leg edema, no sensory deficit and palpable pulsations with dorsalis pedis and posterior tibialis arteries. The diagnosis was subsiding cellulitis infection of the left foot and third toe. The wound was cleaned with Betadine and Neosporin and instructions were to continue with Phisohex and Neosporin daily. (Ex. 17, p.34).

62. On February 16, 1994, two days later, no more pain on left foot and less pain and swelling of the left third toe were noted. The diagnosis was cellulitis of the foot subsiding and wound left middle toe. A penicillin injection was given and instruction to continue with medications, rest at home and avoid wearing hard, wet boot. Diabetic diet, Glucotrol and possibly insulin were noted to have been discussed. (Ex. 17, p.33).

63. Two days later on February 18, 1994 the patient was described as feeling better. The diagnosis was healing wound of the left third toe. Penicillin and vitamin B12 injections were given and the instruction to continue with antibiotic. (Ex. 17, p.32).

64. Three days later, on February 21, 1994, less pain on the left third toe and no cyanosis of the toe were noted. The wound was described as healing slowly and penicillin and vitamin B12 injections were given. Instructions were to continue with topical wound care and other medications. "CBC" and "FBS" were written. (Ex. 17, p.31).

65. Two days later, on February 23, 1994, less pain on

the left foot, no leg pain and left third toe wound healing were noted. Findings were no edema left leg, slight swelling at the base of the third toe, left third toe wound with minimal drainage, no cyanosis, poor peripheral pulsations, no sensory deficit left foot, and able to flex and extend all toes. The diagnosis was healing wound left third toe. Penicillin and vitamin B12 injections were given and the instruction to continue with medications. (Ex. 17, p.30).

66. On February 28, 1994 less pain in left third toe was noted. Findings were less swelling and redness left third toe, no wound drainage and no cyanosis. The diagnosis was healing wound left third toe. Penicillin and vitamin B12 injections were given. Instructions were to continue with Trental, Maxaquin and Glucotrol and topical wound care. (Ex. 17, p.29).

67. On March 4, 1994 the patient was described as feeling better with less pain in the left third toe. Findings were no more swelling left foot, good femoral and popliteal artery pulsation, poor peripheral pulsations in the left posterior tibial and dorsalis pedis arteries, left third toe wound minimal discharge and swelling subsiding, no cyanosis and plantar surface of foot no tenderness or swelling. The diagnoses were subsiding cellulitis and wound infection left third toe and peripheral vascular insufficiency left lower extremity. Treatment was wound dressing with Polymyxin cream and a penicillin injection. Instructions were to continue with medication. It was noted

"discussed vascular workup with Dr. DeAngelo in Erie." The patient was to return in one week. (Ex. 17, p.28).

68. However, three days later, on March 7, 1994, the patient had another office visit. Less swelling of the left foot was noted. There is an unreadable description of peripheral pulsation. The diagnosis was pregangrenous third toe. Penicillin and vitamin B12 injections were given. A CBC and SMA were ordered. The patient's medication was listed as Trental. The patient was to return in one week. (Ex. 17, p.27).

69. The patient returned two days later. On March 9, 1994 the patient complained of tiredness. The diagnoses were wound infected right [sic] middle toe and unstable diabetes mellitus. The wound was cleaned. Glucotrol was the listed medication. It was noted that diabetic instructions were given, discussed insulin and diabetic diet. Laboratory reports showed the patient's blood sugar at 388 and a low albumin of 3.5. (Ex. 17, pp.25-26).

70. On March 11, 1994 the left third toe was described as "slight cyanotic and tender." The diagnosis was subsiding cellulitis of the third toe, rule out pregangrene changes left middle toe. Treatment was continue with medication, Trental three times a day, penicillin. A CBC and SMA were noted. Instructions were to stop work, bed rest, and strict diabetic diet 1200 calories. (Ex. 17, p.24).

71. March 14, 1994 laboratory reports showed a blood sugar of 288 and a low albumin of 3.5. On March 16, 1994 it

was noted that there was less swelling and subsiding cellulitis of the left foot and the left third toe was pregangrenous. The wound was cleaned. Penicillin and vitamin B injections were given. The patient's medications were Trental and Maxaquin. Instructions were Phisohex soaks, stop working, bed rest and strict diet. (Ex. 17, pp. 22-23).

72. On March 21, 1994 more swelling of the left foot and pregangrenous changes of the third toe with slight drainage were noted. The findings included gangrene left middle toe without demarcation. The patient was to be admitted to the hospital. (T. 265-271; Ex. 17, p. 21).

73. Patient C was admitted to Westfield Memorial Hospital on March 22, 1994 where he underwent amputation of his left third and fourth toes. He was transferred to another hospital on March 28, 1994 where he underwent amputation of his left foot. (Ex. 14 and 15).

74. The patient knew that he needed an amputation. He described his left toe: "...it had been gangrenous for a couple of months. It smelled terrible and the bones had separated and it needed removal... it was quite obvious." A left foot x-ray was taken the day of Patient C's hospital admission and one day after March 21, 1994, his last office visit with Respondent. The report reads "[a]dvanced osteitis of the third toe is demonstrated. There is marked demineralization. There is loss of alignment and dislocation of the proximal IP joint." (T. 210; Ex.14, p.79; Ex. 17, p. 20).

75. Respondent's evaluation and treatment of Patient C's problems with his left foot significantly deviated from accepted standards of care. The appropriate skills needed to provide adequate care were within the realm of basic primary care medicine. The patient was seen sixteen times from January 24, 1994 when he first presented with problems with his left foot until his last visit in March 1994. It was clear that he had developed serious difficulties with the left foot, which began with pain and numbness on January 27, 1994 and ended with gangrene and eventual amputation. Respondent's evaluation of the foot problem was inadequate. He diagnosed cellulitis but no patient temperatures were recorded and no timely white blood count tests ordered. There was no record of a timely consideration or order given regarding a vascular workup until March 1994, the end of the treatment period, when Respondent recorded that he discussed vascular work-up with another physician. Respondent should have considered an arterial Doppler study, which is a noninvasive test of the arterial circulation of the legs. Respondent did not prescribe insulin. He recorded consideration of this drug but there was no documentation that he emphasized or strongly explained to the patient the need for insulin. Antibiotics were prescribed without a culture being obtained. The spectrum of antibiotics prescribed was conflicting and overlapping. While the patient was taking oral antibiotics he was given intramuscular penicillin injections. There was no evidence

of any thought given to an x-ray of the foot to rule out osteomyelitis. It was not until the end of the treatment period that there were laboratory blood tests. There was no evidence that explanations for the patient's low albumin levels, indicative of nephropathy, were explored. (T. 271-274, 305-306, 315-316, 322; Ex. 17).

76. Respondent's inadequate evaluation and treatment of the patient's foot problem exposed the patient to the risks of infection, sepsis, gangrene and amputation. (T.273-274).

77. Respondent, in his December 13, 1993 office record, recorded that Patient C "needed glucometer - he claimed that is expensive." However, Respondent never recommended to Patient C that he use a glucometer. Patient C never told Respondent that a glucometer was expensive. In fact, Patient C raised the issue of use of a glucometer with Respondent. The patient's daughter was a pharmacy technician. She told him about glucometers. Thereafter, Patient C broached the subject of a glucometer with Respondent and asked whether he should get one. Respondent told the patient that a glucometer would not be necessary and that it would just cause the patient undue anxiety. The patient accepted Respondent's advice; "...he was my doctor and he knew what was best for me and I didn't do anything about it." (T. 166-167, 169; Ex. 17, p. 41).

78. The patient was a good historian regarding his medical treatment generally and with regard to Respondent's treatment. The patient owns a construction company, which he

founded; he had health insurance. It is unreasonable to believe that Patient C would not use a glucometer because of "expense" if Respondent had, in fact, recommended its use. Notably, since the patient came under the care of another physician he has been using a glucometer. (T. 166-167, 174).

79. The veracity of Respondent's office note regarding the use of a glucometer is undermined by the rest of his office records, the general pattern of his care of the patient's diabetes and Respondent's own testimony. Initially, it should be noted that Respondent knew Patient C was dissatisfied with Respondent's care in March, 1994, during the patient's hospitalization and before Respondent's records for Patient C would have been requested by anyone acting on the patient's behalf or by the Department of Health. Respondent testified that he felt the patient really needed to use a glucometer and told the patient he needed to use one. However, at no time after the supposed discussion on December 13, 1993, did Respondent document any further discussion regarding glucometer use. Respondent did not know and did not ascertain the cost of a glucometer for the patient. Had he done so he would have been able to inform the patient of the true cost of using a glucometer. (T. 171, 1513, 1533-1534; Ex. 17).

80. Respondent, in his January 31, 1994 office entry recorded: "May need insulin if unable to control with Glucotrol. Discussed treatment with patient." In his March 9. 1994 office entry Respondent noted "Discussed insulin."

In fact, Respondent never discussed use of insulin with Patient C. Notably, since coming under the care of another physician, Patient C has been on insulin. (T. 170, 214; Ex. 17).

81. Respondent failed to maintain adequate records for Patient C. For example, a concern which is evident with other patients, Respondent's hospital records are contradicted by his office records. In the March 22, 1994 hospital report of history and physical examination, Respondent recorded that the patient's condition started "about three weeks prior to admission." In fact, it started about two months previously in January 24, 1994. Respondent recorded that the patient had a "history of diabetes mellitus which has been controlled with diet and also hypoglycemic agent (Glucotrol 20 mg daily). He had no other clinical manifestations." However, the patient's diabetes was not controlled, he had complications such as diabetic neuropathy and retinopathy and he had been on Orinase in addition to Glucotrol. (T. 274, 321-322; Ex. !4, p. 12).

Patient D

82. Respondent provided medical care to Patient D at various times from approximately August 28, 1992 through approximately July 18, 1994 at Respondent's office. Respondent also provided care to Patient D before the date of the first office visit entry. On April 8, 1991 Respondent signed a disability claim form for the patient. On the form Respondent indicated that he had first treated the patient

for his disability on September 20, 1988 and most recently treated him on April 8, 1991. Respondent was Patient D's primary care physician. (T.1574; Ex. 19).

83. Patient D was a man in his late fifties with multiple diagnoses. He had diabetes, leg ulcers and hypertension. On the 1991 claim form Respondent listed the patient's disabilities as stasis ulcers secondary to peripheral vascular disease and diabetes mellitus unstable. Additional diagnoses made by Respondent included arthritis of the knee, gouty arthritis of the knee, ASHD, obesity, chronic hyperlipidemia and anxiety reaction, among others. (T. 412-413; Ex.19).

84. Respondent failed to obtain adequate histories and perform adequate physical examinations of Patient D when he first began treating the patient and during the course of treatment and failed to document these. The first record of an office visit is August 28, 1992. That was sixteen months following Respondent's apparent last contact with the patient on April 8, 1991, as reflected in the disability claim form. No complete history was documented in the August 28, 1992 office entry or anywhere else in the record. Supplemental histories during the course of treatment were inadequate. The patient's complaints were merely listed without any further description, such as duration or aggravating factors. Initial and subsequent physical examinations were deficient. For example, there were no statements regarding the patient's general appearance, complete vital signs or rectal and

prostate examinations. There were no vascular and neurologic examinations of this patient who had complications relating to leg ulcers. (T.413-414; Ex. 19).

85. Respondent failed to adequately monitor Patient D's diabetic control. On April 8, 1991 Respondent listed diabetes mellitus unstable as one of the patient's disabilities. Thereafter, the first record of an office visit was August 28, 1992. However, there were no blood sugar tests until March 1993. The patient's sugar level was a high 161. Respondent failed to meet the minimum requirements for monitoring a diabetic patient, whom Respondent described as an unstable diabetic. A blood sugar should have been ordered before March 1993. No urinalyses were done or ophthalmologic evaluations during the course of treatment. (T.415-417; Ex.19).

86. On February 2, 1993 Respondent diagnosed Patient D as having diabetic neuropathy without adequate basis. The diagnosis was not mentioned again in Respondent's records. There were no patient complaints, history, physical findings or signs and symptoms documented to support the diagnosis. Neuropathy could be suspected based on certain symptoms, but none were noted. Even with symptoms suggestive of diabetic neuropathy, further evaluation would be necessary to confirm the diagnosis. A neurological examination, testing of reflexes, strength and tactile and vibratory sensation should have been done. They were not. (T.417-419, 463; Ex.19, p. [illegible]).

87. On April 26, 1993 Respondent diagnosed Patient D [illegible]

having an active peptic ulcer without adequate basis. That diagnosis was not noted at any time before or after this occasion. On April 26, 1993 there was a notation that the patient had epigastric pain. However, that could have many different causes. A complaint of epigastric pain without more is insufficient to support the diagnosis. The history and numerous symptoms associated with an active peptic ulcer were not described by Respondent. There was no history regarding the periodicity of the pain or what aggravated or alleviated it. There was no indication of whether this was a new problem or recurrence of a diagnosis established in the past. An adequate history may have supported the diagnosis but none was noted. (T.419-421, 464; Ex.19, p.12).

88. On April 26, 1993, Respondent prescribed Feldene for Patient D's arthritis although on he had diagnosed the patient as having an active peptic ulcer. The Feldene was contraindicated. Feldene is a nonsteroidal anti-inflammatory agent used to treat joint diseases and inflammations. Such agents are known to cause ulcers or aggravate existing ulcers. Respondent considered the patient to have an active ulcer, yet he exposed the patient to a drug which could aggravate it. Alternatives were available to address the patient's arthritis. The patient could have been treated with Tylenol. In addition, local treatment or a referral to a rheumatologist could have been made. Prescribing Feldene in this circumstance was a significant deviation from accepted standards of medical care. (T.421-422,465-466,

1060; Ex.19, p.12).

89. On September 3, 1993, Respondent diagnosed Patient D as having gouty arthritis of the right ankle and knee without adequate basis. Respondent noted patient complaints of ankle swelling and pain and findings of tenderness and swelling in the ankle and knees. Gouty arthritis is diagnosed by history, physical examination and laboratory testing of uric acid levels. Other than pain and tenderness, none of the other symptoms associated with gout were noted. No history consistent with the diagnosis was noted. No laboratory studies were obtained to confirm the diagnosis. It is important to accurately diagnose gouty arthritis since it has a specific treatment and is treatable. At the patient's next visit, two weeks later, Respondent apparently diagnosed osteoarthritis of the ankle and knee. Notably, approximately two months before Respondent made the diagnosis of gouty arthritis, a June 29, 1993 X-ray showed advanced osteoarthritis of the right knee and ankle. (T.423-424,466-468, 1044; Ex.19, pp. 16, 20-21).

90. On December 21, 1993, Respondent diagnosed Patient D as having acute pleuritis without adequate basis. All that was noted was that the patient complained of coughing. Examination of the lungs showed no rales. There was no reference to any of the signs and symptoms associated with pleuritis, such as chest pain worsened by breathing, fever or general malaise. (T.427, 469-470; Ex. 19, p.25).

91. Respondent failed to appropriately treat the acute

pleuritis he diagnosed. He prescribed an antibiotic, Floxin. However, he did not establish a diagnosis of the underlying cause. Given the range of causes and the seriousness of them, such as tuberculosis, Respondent's blind treatment was a significant deviation from accepted standards. Floxin would have no effect if the pleuritis was caused by tuberculosis. Patient D was a diabetic. He had a stasis ulcer of the right leg at the time Respondent diagnosed acute pleuritis. Respondent admitted that diabetics have a high risk of tuberculosis. However, he did not order a chest x-ray or Tine test to rule this out. Respondent admitted that due to the leg ulcer, Patient D was at risk for pulmonary emboli. However, Respondent did not order a chest x-ray or EKG to rule this out. On the patient's next office visit on January 3, 1993, there was no follow-up noted for the diagnosis of acute pleuritis which Respondent had made about two weeks previously. There was just a notation of "no rales" in the lungs. (T.427-429, 1609, 1611; Ex.19).

92. Respondent treated Patient D for a stasis ulcer of the right leg during January 1994, as well as at other times. A stasis ulcer is caused by poor venous drainage usually related to venous stasis. When the veins are not draining the legs properly, the leg swells and an ulcer develops as the skin breaks down. Respondent failed to adequately assess the circulation in Patient D's legs while treating the ulcer in approximately January 1994. On December 21, 1993 Respondent diagnosed a ulcer right leg with infection. The

finding was "stasis dermatitis of the right leg." On January 3, 1993 Respondent noted "extremities [?] stasis ulcer right leg." On January 31, 1994 Respondent noted a slight ulcerated stasis ulcer of the right leg. Respondent's evaluation did not include an assessment of the vascular system. There were no descriptions of the presence or absence of pulses or varicosities. There was no neurological examination. Respondent's failure to assess the status of the circulation in Patient D's legs was a significant deviation from accepted standards of care. The patient was a diabetic with a leg ulcer which put him at risk for further complications such as infection and gangrene. (T. 429-431; Ex.19, pp. 25,26,27).

93. On February 21, 1994 Patient D complained of chest pain. Respondent's evaluation of this, complaint, was inadequate. There was no history regarding the pain or further categorization, such as duration and radiation. The inadequate evaluation of chest pain in this diabetic patient was a deviation from accepted standards of care. (T.431-432; Ex.19).

94. On June 20, 1994, Respondent observed that Patient D had "slight diabetic fundi" but did not adequately follow-up on this. Diabetic fundi result from diabetic retinopathy, a complication of diabetes. The retinal vessels weaken and hemorrhages develop. This bleeding, depending on its severity, can cause small changes visible by examination or major problems such as retinal detachment and blindness.

Despite Respondent's observation of diabetic fundi, Respondent did not refer the patient to an ophthalmologist or ascertain that the patient was seeing one. Referral to an optometrist or knowing the patient had been to one (which was not documented) would be inadequate. The observation of diabetic fundi would require the expertise of a physician, not an optometrist. (T. 432-434, 454-455, 1058-1059; Ex. 19., p. 40).

95. Respondent failed to maintain adequate records for Patient D. (T. 434, 1579).

Patient E

96. Respondent provided medical care to Patient E at various times from approximately February 7, 1992 through June 8, 1994 at his office. Respondent was Patient E's primary care physician. (T. 1633; Ex.21).

97. Patient E was a man in his sixties. Respondent treated him for urinary complaints and back pain. The patient has hypertension. (T. 477; Ex.21).

98. Respondent failed to obtain adequate histories and perform adequate physical examinations of Patient E when he first began treating the patient and during the course of treatment and failed to document these. The first record of an office visit was February 7, 1992. There was no documentation at all of the elements of an initial history there, or anywhere in the record. Supplemental histories were deficient, without adequate descriptions of the patient's complaints. For example, on numerous visits the

patient complained of dysuria. However, Respondent never adequately documented the history of that complaint. The physical examination described in the first record of an office visit was deficient. (T. 478-479; Ex.21).

99. Pyelonephritis is an infection of the collecting system of the kidneys. It is associated with pain, fever, dysuria and/or frequency of urination. On examination pain will be noted in the lumbar area and occasionally the abdomen. Pus, bacteria or blood will be present in the urine. The diagnosis of pyelonephritis is made by history, physical examination and laboratory test. It is not solely a clinical diagnosis. (T. 479-480,494-495).

100. Respondent at various times, including December 11, 1992 and February 1, 1993, diagnosed Patient E as having acute pyelonephritis. On December 11, 1992 and February 1, 1993 Respondent's diagnosis of that condition was made without adequate basis and adequate evaluation. There was no indication of whether the patient had a fever or not. No urinalysis was ordered. Respondent did not order a urinalysis until April 12, 1993. Respondent did not evaluate the prostate until the February office visit. This should have been done approximately six weeks before at the December visit. A February 2, 1993 report of an intravenous pyelogram showed no radiological evidence of pyelonephritis. However, it showed that the patient did not empty his bladder completely, indicating the need to address the prostate. Despite the February 2, 1993 IVP report, Respondent

maintained the diagnosis until a third office visit. On May 24, 1993 he diagnosed urinary tract infection. In fact, the patient had an obstructive uropathy and cystitis. (T. 480-483, 489-490, 494-497; Ex. 21).

101. Respondent failed to appropriately treat the acute pyelonephritis he diagnosed. On December 11, 1992 he prescribed Cipro. On December 16, 1992 fluid intake was recommended and a drug, possibly Floxin, was prescribed. Respondent made a notation of benign prostatic hypertrophy. The patient was told to return in three weeks. On December 30, 1992 a drug, perhaps Floxin 500 mg., was prescribed, fluid intake encouraged and the patient told to return in three weeks. (Ex. 21, pp. p.23-25).

102. For an elderly man such as Patient E, acute pyelonephritis is a serious disease. It required more intensive treatment than that provided by Respondent. He should have ordered culture and sensitivity studies and should have considered intravenous antibiotics. (T. 483-485; Ex.21).

103. Patient E first complained of frequency of urination on April 3, 1992. Four visits later on December 11, 1992 the complaint was dysuria. On December 16, 1992 Respondent noted an apparent diagnosis of benign prostatic hypertrophy. However, it was not until February 1993 that Respondent noted that a prostate examination was done, and that the prostate was not enlarged. (Ex. 21, pp. 22, 25, 31).

104. Respondent's evaluation of the patient's complaints

of dysuria or frequency of urination was not timely. In this sixty-six year old man, a much more detailed history of the symptomatology should have been obtained and documented. Respondent's apparent diagnosis of benign prostatic hypertrophy should have been addressed. (T. 485-486).

105. Assuming, *arguendo*, that Respondent performed a prostate examination when he diagnosed benign prostatic hypertrophy on December 16, 1992, it was still eight months after the initial complaint. (T. 485-486).

106. Following the February 1, 1993 prostate examination, no routine prostate examinations were documented although Respondent treated the patient for approximately one and one-half years. (T. 485-486).

107. A February 2, 1993 report of an intravenous pyelogram noted: "the splenic shadow is rather prominent and splenic enlargement could be present." An x-ray of the abdomen on that date also showed a large splenic shadow. Respondent did not address this at all until over a year later on February 5, 1994 when he noted "spleen not palpable." The abnormality described in the radiology report required timely follow-up. There should have been an initial evaluation, including palpation of the spleen on physical examination, to determine whether further workup was indicated. That should have been done at the first opportunity. (T. 486-487,492,503-504; Ex.21).

108. Respondent failed to maintain adequate records for Patient E. (T.487).

Patient F

109. Respondent provided medical care to Patient F at various times from at least approximately March 5, 1988 through July 5, 1994 at Respondent's office and at Westfield Memorial Hospital. Respondent was Patient F's primary care physician. Respondent, in a note in the office record, indicated that the patient had his own cardiologist. There were no references to this cardiologist contemporaneous with the patient's office visits. (T. 513, 517, 1131; Ex. 23, 24 & 25).

110. Patient F was a man in his late seventies. The patient had numerous problems, including orthopedic complaints, anxiety, dysuria and diverticulitis. Respondent diagnosed numerous conditions, including acute peptic esophagitis, ASHD, hypertension, anemia, malabsorption syndrome, urinary tract infection, colitis, pleuritis and partial intestinal obstruction secondary to adhesions. (Ex. 24 & 25).

111. In February 1992 the patient suffered a myocardial infarction. He had coronary angioplasty and was operated on for an abdominal aortic aneurysm. (T. 513; Ex. 23, 24 & 25).

112. Respondent failed to obtain and document adequate histories and perform adequate physical examinations initially, and throughout the course of treatment. The first office record date in Respondent's records was March 25, 1988. No initial history was documented. Supplemental

histories were inadequate. Respondent invariably only listed the patient's complaint without any description of the history of the complaint. There was no evidence of a complete initial physical examination having been performed. Respondent's office records contain a March 23, 1994 report of a hospital history and physical examination, which was well after Respondent began treating the patient. Hospital records contain a November 30, 1990 report of history and physical examination, again much after Respondent began treatment. (T. 513-515; Ex. 23, 24 & 25).

113. Respondent at various times, including September 16, 1988, March 26, 1991 and July 5, 1994, failed to adequately evaluate Patient F's complaints of chest pain and/or dyspnea. On those dates the patient presented with, among other things, complaints of chest pain and/or dyspnea. (Ex.25, pp.9, 55; Ex.24, p.3 [office record]) Respondent found the heart to be essentially normal and took the patient's blood pressure. There was no evidence that Respondent undertook adequate evaluation of the complaint of chest pain. There was no categorization of the nature of the pain or elements, such as duration and associated symptoms, to ascertain whether the pain was cardiac in origin. Such an evaluation was necessary. If warranted, further evaluation, such as an electrocardiogram and x-rays, should have been done. The inadequate evaluation constituted a significant deviation from accepted standards of care. This patient in his seventies, diagnosed with ASHD

and hypertension, was at risk for a myocardial infarction and/or sudden death. The fact that the patient may have had his own cardiologist did not relieve Respondent from the responsibility of adequately evaluating the patient. He presented at Respondent's office with chest pain and dyspnea and had a history of heart disease. Further evaluation was required. (T.515-519, 1165; Ex. 24 & 25).

114. There is further evidence that Respondent did not know how to properly and safely address chest pain. Respondent's inadequate evaluation of the patient's chest pain on September 16, 1988 was compounded by the drugs he prescribed. He prescribed Halcion, Talwin and Librium - all are central nervous system depressants and can be associated with the incidence of cardiac problems. On February 14, 1992 Respondent noted that the patient had chest pain. The diagnosis (peptic esophagitis) and treatment were not directed toward a possible coronary problem. However, at the end of the office entry, Respondent recorded that he discussed the clinical situation with the patient and advised that the patient needed hospitalization and diagnostic tests which could be delayed until the patient's return from a trip. There was a note written by the patient on Respondent's letterhead, dated February 14, 1992. In it Patient F noted that Respondent said the patient had no symptoms of a heart problem but "to be safe" Respondent said to have some tests done. The patient further noted that Respondent and the patient decided to have the tests on the

patient's return from a February 15, 1992 trip to New York City. Respondent had read the patient's note. The day following the February 14, 1992 office visit, the patient was admitted to the hospital from the emergency room having suffered a myocardial infarction. (T. 586-587, 1166-1168, 1172-1174, 1660; Ex. 23 & 25).

115. Patient F complained of abdominal discomfort, dizziness and black stool at his February 27, 1990 office visit. Respondent's evaluation of the complaints of dizziness and black stool was a significant deviation from accepted standards of care. A thorough history should have been elicited regarding any symptoms of epigastric discomfort or vomiting of blood. A rectal examination with testing of the stool for occult blood should have been done. Blood pressures with the patient lying and standing should have been done. As the patient may have had orthostatic hypotension, a hemoglobin and hematocrit should have been ordered. The symptoms suggested a possible gastrointestinal bleed. This possibility should have been explored. Respondent undertook none of these steps. (T.519-521, 579-580, 1175; Ex.25).

116. On December 14, 1990 and October 8, 1991 Respondent diagnosed Patient F as having acute pleuritis. On each of those dates Respondent noted that the patient had a pleural friction rub. Respondent's basis for this diagnosis was inadequate. The history was insufficient to support the diagnosis and the signs and symptoms which could

have supported such a diagnosis were not described. The patient's clinical picture was not indicative of pleuritis. Respondent's observations of pleural friction rubs did not necessarily support the diagnosis. Pleural friction rubs have many underlying causes. (T.521-523; Ex. 25, pp. 41, 65).

117. Respondent failed to appropriately treat the acute pleuritis that he diagnosed on December 14, 1990 and October 8, 1991. On December 14, 1990 he gave the patient a vitamin B12 injection and prescribed Minocin, an antibiotic. A blood chemistry was ordered the next day. On October 8, 1991 the treatment was an injection of vitamin B complex, a cough medicine, and apparently Doxacillin, an antibiotic. Respondent's treatment on these occasions was significantly below accepted standards of care. Respondent treated the condition blindly; he did not know or take reasonable steps to ascertain the cause of what he diagnosed. If the patient, in fact, did have pleural friction rubs, the treatment should have been directed by their cause. The patient could have had an untreated tuberculosis, an undiscovered cancer, or pulmonary embolism. (T.523-524; Ex. 25).

118. Respondent failed to adequately evaluate Patient F's July 19, 1991 complaint of dysuria and July 5, 1994 complaint of frequency of urination. On the first occasion Respondent diagnosed acute pyelonephritis and on the second acute urinary tract infection. A thorough history of the

complaints should have been elicited, including such information as the duration of the symptoms. Respondent should have examined the patient's prostate. A urinalysis should have been obtained and, if necessary, a urine culture. Notably, despite Respondent's July 5, 1994 diagnosis of urinary tract infection, the only treatment documented was an intramuscular injection of penicillin. No other antibiotic was noted. (T. 524-526, 580-581, 1119-1120; Ex. 24 & 25).

119. Patient F, through an approximate forty day period from October 29, 1991 through December 9, 1991, saw Respondent five times with varying complaints of neck pain, headache, dizziness, cough, dyspnea and/or sore throat. On October 29, 1991 the complaint was tenderness in the nuchal area of the neck, headaches, dizziness and coughing; the diagnosis was acute cervical strain. Robaxin and a vitamin B injection were given. A week later on October 5, 1991 the complaints were neck pain and headaches. The diagnosis was acute bronchitis and a vitamin B and intramuscular injection of penicillin was given and Midrin prescribed. Three weeks later on November 27, 1991 the patient presented with coughing and slight dyspnea. Respondent diagnosed an acute respiratory tract infection. A penicillin and vitamin B complex injection was given. Six days later, on December 3, 1991, the patient's complaints were coughing and dyspnea. A penicillin and vitamin B complex injection was given. Geocillin 250 mg., an oral antibiotic, was prescribed. On

December 9, 1991 the patient complained of a sore throat and dyspnea, in addition to chest pain. The diagnosis was acute tracheobronchitis. A vitamin B complex and penicillin injection was given. The oral antibiotic was changed from Geocillin to Minocin and apparently Vicodan was prescribed. (T.527-529; Ex.25, pp.66-70).

120. Respondent's evaluation of the patient's complaints and the efficacy of treatment was inadequate in view of accepted standards of care. The patient presented five times with symptoms which Respondent made no attempt to correlate. There was no evidence that Respondent attempted to relate the current complaints to those of the prior visit. Four different diagnoses were made by Respondent. Yet, there was no evidence that Respondent questioned or tried to confirm his diagnoses. For example, the patient complained of symptoms that could have resulted from an infection, but no blood work was done to confirm or deny this. There was no attempt to evaluate the efficacy of treatment. In the last four visits it was the same - intramuscular penicillin. At the last two visits, two different oral antibiotics were prescribed. Respondent's care of the patient during this time period was fragmented and disjointed; it lacked continuity. (T.529-531).

121. 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 July 5, 1994, treated Patient F with intramuscular

injections of aqueous penicillin. He did this for diagnoses of acute bronchitis (11-5-91, 12-3-91, 12-15-93), acute respiratory tract infection (11-27-91, 7-5-94), acute tracheobronchitis (12-9-91), acute diverticulitis of the colon (2-8-94 and 2-18-94) and acute pleuritis and acute urinary tract infection (7-5-94). The treatment with intramuscular penicillin was not indicated. Respondent's use of intramuscular penicillin was inappropriate. The patient was taking oral antibiotics. (T.531-536, 570-572, 1181; Ex. 24 & 25).

122. Respondent at various times evaluated and treated Patient F's complaints of shoulder pain. On November 3, 1993 the complaint was severe shoulder pain. Examination showed tenderness in the left shoulder joint. Respondent diagnosed acute bursitis of the shoulder and treated with a shoulder injection of Dexamethasone and Xylocaine. On February 25, 1994 the patient complained of pain in the shoulder. The finding was tenderness in the shoulder and scapula. Respondent diagnosed acute fibromyositis of the shoulder. He treated with an injection of Dexamethasone and Xylocaine in the right shoulder. On April 6, 1994 the complaint was right shoulder pain aggravated by physical activities. Findings were tenderness of the shoulder with limited flexion and extension. Respondent diagnosed acute bursitis and treated with an injection of Dexamethasone and Xylocaine. About two months later on June 14, 1994 the complaint was right shoulder pain aggravated by physical

activities. The finding again was tenderness of the shoulder and the diagnosis acute bursitis. Treatment was an injection of Dexamethasone and Xylocaine. A week later on June 21, 1994 the complaint was painful right shoulder aggravated by physical activities. Findings were tenderness of the right shoulder and neck. Diagnosis was acute bursitis and treatment an injection of Dexamethasone and Xylocaine. (Ex.24, pp. 5-6, 12, 21, 32).

123. Respondent's evaluation of the patient's shoulder pain and the efficacy of his treatment was inadequate in view of accepted standards of medical care. The patient was given frequent injections of the steroid Dexamethasone. However, that treatment course was not successful as the patient was still frequently complaining of shoulder pain. There was no evidence that Respondent attempted to confirm the diagnoses or seek another with further examination, further history or additional tests such as an x-ray. There was no referral to or consultation with a specialist. Frequent injections of a steroid to a joint are dangerous, even when indicated for a disease like bursitis. There is no evidence that Respondent evaluated the efficacy of his treatment. There was no comparison of the patient's status before and after treatment. There were no comments regarding whether the patient improved or not with treatment. There was no testing of objective signs of improvement such as range of motion. (T. 536-539, 581-584, 1153-1155).

124. Respondent on March 8, 1994 diagnosed Patient F as having a bulging disc at the L4/L5 level and peripheral neuritis of the right lower extremity. Respondent's findings related to these diagnoses were [?] of the hip, neurological reflexes intact and tenderness at the L4/L5 level. The diagnoses were without adequate basis. There was no patient complaint of pain. A diagnosis of bulging disc is made by a CT scan or MRI. One could suspect such a diagnosis on clinical evaluation. However, there was no support for such a diagnosis in Respondent's clinical evaluation. There was no history recorded of anything related to the back or leg. There was no reference to anything indicative of radiculopathy or nerve compression. There was only the notation that reflexes were intact. Respondent's diagnosis of neuritis of the right lower extremity was also without adequate basis. There were no history, symptoms or physical findings consistent with that diagnosis. There were no patient complaints, such as pain, paresthesia or numbness, that would be expected with this diagnosis. The neurological examination did not list poor sensation, loss of vibratory sensation or weakness which would be expected with neuritis. There was no description of any nerve distribution area involved. The very nonspecificity of the diagnosis, "right lower extremity," raises suspicions about the diagnosis. If a neuritis existed there would be a specific nerve involved and effects of the neuritis discernible in a specific area. Notably, in

the patient's office visit two weeks later on March 22, 1994, there was no mention of the bulging disc or the peripheral neuritis. Given this and the fact that it is likely that a bulging disc would not resolve itself in two weeks, the patient's problem may have been a transient back or muscle problems, not what Respondent diagnosed. (T. 539-543, 1125, 1157; Ex.24).

125. Respondent failed to maintain adequate records for Patient F. For example, on March 8, 1994 Respondent noted that the patient had no more rectal bleeding. Rectal bleeding is a significant complaint and something a physician should track. Yet, Respondent did not document when the bleeding had begun. Another example is the incongruity between Respondent's February 1992 office record and the emergency room consultation report of February 15, 1992. The consultation report indicated that the patient had been to Respondent twice during the week and had been having chest pain for the past week. Respondent's office record memorialized only one patient visit and was silent with regard to the duration of the chest pain. On February 27, 1989 Patient F was admitted to the hospital for an inguinal hernia repair. Respondent's hospital discharge summary noted that there was a bulging mass in the right inguinal area. However, Respondent's record of the patient's February 17, 1989 office visit and his records prior to that are silent with regard to an inguinal mass. (T. 543, 577-578, 1131-1133; Ex. 23, 24 & 25).

Patient G

126. Respondent provided medical care to Patient G, as reflected in his office records, at various times from May 19, 1993 through July 13, 1994 at Respondent's office. Respondent apparently treated the patient before this date, as evidenced in a January 12, 1993 letter to Respondent from another physician. (Ex.27.

127. Patient G was a man in his late sixties. He was known to have had carcinoma of the prostate, diverticulitis of the colon and coronary artery disease. The patient had a physician in Florida where he resided during most of the year. He saw Respondent and had a local cardiologist in the summers when he resided in upstate New York. (Ex. 27).

128. Respondent failed to obtain adequate histories and perform and document adequate physical examinations when he first began treating the patient and throughout the course of treatment. The first record of an office visit is dated May 19, 1993. There was no history noted. Subsequent histories were inadequate as Respondent merely listed the patient's complaints but did not elicit their history. There is no complete physical examination documented by Respondent anywhere in the record. (T. 601-602; Ex.27).

129. Respondent evaluated Patient G's complaints of chest pain on various occasions. On July 26, 1993 the complaints were left chest pain, headaches, leg or hip cramps and stiffness of the hand. Respondent took a blood pressure and noted a left pleural friction rub and that th

heart was essentially normal. On August 9, 1993 the patient complained of chest pain and coughing; there was no dyspnea. A blood pressure was taken. The lungs showed "few rales bilaterally" and the heart was described as essentially normal. On September 13, 1993 there was a complaint of chest pain. A blood pressure was taken, lungs showed no rales and the heart was described as essentially normal. Six days later on September 18, 1993, the patient presented with dyspnea, chest pain, coughing and a sore throat. The lungs were described as having moist rales bilaterally and the heart was described as essentially normal. A chest X-ray was done on August 2, 1993 to rule out early pneumonia or congestive heart failure. There was no x-ray evidence of overt congestive heart failure. (T. 602-604; Ex. 27, pp. 9, 12-13, 16, 19).

130. Respondent's evaluation of the patient's complaints of chest pain deviated from accepted standards of care. Patient G was known to have coronary heart disease; Respondent listed a diagnoses of "coronary insufficiency" on May 19, 1993. He also listed hyperlipidemia. A detailed history of the chest pain was necessary, given the patient's risk factor. If warranted by history, further evaluation, including an electrocardiogram, should have been undertaken. The x-ray, taken between two periods of complaints of chest pain, did not constitute an adequate evaluation. There was no evidence that Respondent considered in any meaningful way that the chest pain had a cardiac origin. Notably,

Respondent's September 18th finding of bilateral moist rales was not explained by his diagnosis of acute bronchitis. The finding would suggest congestive heart failure or restrictive lung disease. (T. 604-607, 1205; Ex.27).

131. Respondent, on various occasions, gave Patient G intramuscular injections of aqueous penicillin. On August 1, 1993 a diagnosis of acute pleuritis was made and a penicillin injection given. Cipro was also prescribed. On the next day, August 2, 1993, the diagnosis again was acute bronchitis. A penicillin injection, advice to continue with other medications, and Floxin 200 mg twice a day, were given. On August 9, 1993 the diagnosis was again acute bronchitis. A penicillin injection was given. The instructions were to continue with medication and antibiotic. Four days later, on August 13th, acute bronchitis again was the diagnosis. Treatment was a penicillin injection. Floxin was prescribed. On September 17, 1993 the diagnoses were acute pleuritis and acute bronchitis. Treatment was a penicillin injection. Advice was to continue with medication. On September 18 and 19, 1993 the diagnosis was acute bronchitis. On the 18th Respondent also noted rule out pneumonia. Treatment on these dates was penicillin injection and Floxin. Respondent's treatment of the patient with intramuscular aqueous penicillin was not indicated. (T. 607-610, 1200; Ex. 27).

132. On July 26, 1993, Respondent observed that

Patient G had a pleural friction rub and on August 1, 1993, bilateral pleural friction rubs. On August 2, 1993 no rubs were noted and the lungs were described "few rales bilaterally." An x-ray report of August 2, 1993 noted that there was "no evidence of pleural effusion or acute parenchymal consolidation." Respondent's observations of pleural friction rubs were without adequate basis. The infrequency of either unilateral or bilateral rubs, in primary care practice raises serious doubts about the accuracy of Respondent's observations. Respondent observed no rubs the very day after having heard bilateral friction rubs. This reaffirms that Respondent, in fact, did not accurately interpret what he heard the prior day. The x-ray was negative for signs of pleural friction rubs. One would expect the vast majority of patients with pleural friction rubs to have some finding on their chest x-ray. (T. 611-612, 623-624, 1196-1197, 1211-1212; Ex. 27).

133. On July 26, 1993 and August 1, 1993, Respondent diagnosed Patient G as having acute pleuritis. He did so without adequate basis. There was no appropriate history obtained to justify such a diagnosis. The expected signs and symptoms of pleuritis were not present. There was no attempt to search for its underlying causes if, in fact, the patient had pleuritis. The observation of pleural friction rubs was inaccurate. (T.612-613; Ex. 27).

134. On July 26, 1993, Respondent diagnosed Patient G as having hypocalcemia and anemia. Respondent did so

without an adequate basis. In fact, the only evidence available was clearly contrary to Respondent's diagnoses. Hypocalcemia and anemia have clinical manifestations but are laboratory diagnoses. About two months prior to Respondent's July 26, 1993 diagnoses, laboratory testing showed that the patient had a normal hemoglobin and a normal calcium level. Three months after Respondent's July 1993 diagnoses, laboratory tests again showed the patient to have normal hemoglobin and calcium. Unless there had been a marked change in the patient's clinical condition, which was not documented in the record, Patient G could not have been either anemic or hypocalcemic on July 26, 1993. (T. 614-616, 1191; Ex. 27).

135. Respondent failed to maintain adequate records for Patient G. (T. 616; Ex.27).

Patient H

136. Respondent provided medical care to Patient H at various times from April 21, 1994 through July 5, 1994 at Respondent's office. Respondent was Patient H's primary care physician. (T. 655, 1233; Ex. 29).

137. Patient H is a woman in her seventies. Diagnoses made by Respondent included uncontrolled diabetes, ASHD with hypertension, anemia secondary to iron deficiency, disc disease, intestinal obstruction and anxiety reaction. (T. 634; Ex.29).

138. Respondent failed to obtain and document adequate histories and perform adequate physical examinations of

Patient H initially and throughout the course of treatment. No initial history was documented on the date of Respondent's first office record for the patient, April 21, 1994. No complete history was documented elsewhere in the record. Supplemental histories were inadequate, containing no exploration of the history of the patient's presenting complaints. There was no evidence of a complete physical examination in Respondent's record. (T. 634-636; Ex.29).

139. Patient H complained of right chest pain on April 29, 1994. Respondent documented no history of the complaint. He took a blood pressure, observed bilateral pleural friction rubs and described the heart as essentially normal. Respondent's evaluation of the patient was significantly below accepted standards of medical care. The patient was in her seventies and had diabetes and hypertension. Her status mandated a thorough elucidation of the history of the chest pain and a determination as to whether it was cardiac in origin. (T. 636-638, 680-681; Ex.29).

140. On April 29, 1994 Respondent, diagnosed Patient H as having acute pleuritis. He did so without adequate basis. The patient had complained of right chest pain. There was no elucidation of any history of the pain or other signs and symptoms that would be expected with that diagnosis, such as fever or pain worsened by breathing or cough. There was no evaluation of the bilateral pleural friction rubs Respondent noted. (T. 638, 682; Ex.29).

141. Respondent treated the acute pleuritis he diagnosed on April 29, 1994 with Cipro, 500 mg. bid. The patient was advised to return in three weeks. This treatment and advice were significantly below accepted standards. Notably, on April 29th Respondent also made the diagnosis of unstable diabetes (glucose 234), in addition to the acute pleuritis. Both these factors made it incumbent on Respondent to provide better treatment than an antibiotic and advice to return in three weeks. The diabetes should have been rigorously monitored because of the possible interplay with pleuritis. The finding of bilateral pleural friction rubs carries a significant differential diagnoses list. It should have prompted a search for the cause of the rubs so that treatment could be intelligently directed. Respondent undertook none of these steps. (T. 638-640, 1235; Ex.29).

142. Respondent diagnosed Patient H as having uncontrolled diabetes on April 21, 1994. On April 29, 1994 he diagnosed unstable diabetes and recorded a 234 glucose. An April 25, 1994 blood test showed a glucose of 236, characterized as "hi." Respondent's treatment of Patient H was significantly below accepted standards. He placed the patient on Glucotrol and recommended a 1500 calorie diabetic diet. The elderly patient, with a dual diagnosis of pleuritis and unstable diabetes, should have had tighter control of the diabetes than that which could be achieved with Glucotrol and diet. Insulin should have been

considered. Infections, which could cause pleuritis, are more difficult to address in an uncontrolled diabetic. (T. 640-641, 669-670, 1234-1235; Ex. 29).

143. On May 27, 1994, Respondent diagnosed Patient H as having a degenerative disc at L5-S1 and peripheral neuritis of the lower extremities. The patient's complaint was severe back pain radiating to the lower extremities. Respondent found tenderness in the lumbar area at L5-S1 and no muscle atrophy. (Ex.29, p.6).

144. Respondent did not have an adequate basis for these diagnoses, which were not supported by the history of the complaint. There was no indication whether the pain was in the front or back of the leg, whether it was more pronounced in one leg or whether there were effects such as sensitivity changes, weakness, anesthesia or paresthesia. Physical findings were insufficient. There was no evidence that sensitivity testing was done. There could be many causes of the patient's complaint, such as sciatica, compression fractures, an aortic dissection, even diabetic neuropathy. Degenerative disc disease is an imaging diagnosis but can be suggested clinically. However, degenerative disc disease at L5-S1 would more likely cause unilateral pain rather than the bilateral pain the patient described. Peripheral neuritis is usually associated with some deprivation, such as paresthesia or anesthesia, yet the patient made no such complaint and none was elicited. (T. 641-644, 667; Ex.29, p.6).

145. On June 20, 1994, Respondent diagnosed Patient H as having partial intestinal obstruction secondary to adhesions. The patient complained of nausea but no vomiting. She had a bowel movement that day. Physical examinations showed a slightly distended abdomen, which was tympanitic, with audible slightly hyperactive peristalsis. No masses were palpable and there was no muscle guarding. There was no history documented of surgery or other abdominal problems that would have caused adhesions. A radiology report of June 22, 1994 listed clinical data as abdominal pain with nausea and vomiting. The patient had not complained of vomiting on her office visit two days earlier. The radiologist noted a slightly air distended loop of bowel in the lower abdominal region which could represent a loop of small bowel. The impression was that findings could be in keeping with an early partial bowel obstruction. (Ex.29, pp. 4-5).

146. Respondent's diagnosis of partial intestinal obstruction, whether secondary to adhesions or otherwise, did not have an adequate basis. There was no documentation of a history consistent with an intestinal obstruction. There was no history regarding flatus, frequency of bowel movements or other indications that transit from the intestine was slowed down. The impression of the radiologist does not change the fact that Respondent's diagnosis was without adequate basis. Notably, the radiologist listed vomiting in clinical data which

Respondent did not note when he saw the patient. There were insufficient reasons in the history and physical examinations, as well as the radiology report, to make the diagnosis of partial bowel obstruction. In fact, Respondent prior to ordering the x-ray, should have performed a rectal examination and ordered a CBC. (T. 664-648, 659-679; Ex.29, pp.4-5).

147. Respondent did not maintain adequate records for Patient H. (T. 650; Ex.29).

Patient I

148. Respondent provided medical care to Patient I at various times from approximately January 30, 1991 through April 15, 1992 at Respondent's office and at Westfield Memorial Hospital. Respondent was also the patient's surgeon and had performed bilateral below the knee amputations. The first amputation was before January 1991, the time Respondent's office records for the patient begin. (Ex.31).

149. Patient I was a diabetic male in his early seventies. He had severe peripheral vascular disease which resulted in bilateral below the knee amputations. Respondent also diagnosed the patient as having ASHD, hypertension, reactive depression and anemia. (T. 695; Ex.31).

150. Respondent failed to obtain and document adequate histories and perform adequate physical examinations of Patient I. The first office record, dated January 30, 1991

contains no history and an inadequate physical examination. A March 1991 hospital history and physical examination were more complete. However, that was approximately six weeks after Respondent's first recorded office visit date. It was incumbent on Respondent to obtain a complete history and perform a complete physical examination prior to the patient's hospitalization. Supplemental histories of the patient's complaints were inadequate. They consisted invariably only of a listing of a complaint without further categorization or description. (T. 695-696; Ex. 31).

151. On March 21, 1991, Respondent performed a left below-the-knee amputation on Patient I. Respondent subsequently described the leg stump wound as healing well on four office visits from March 26, 1991 through April 23, 1991. On May 7, 1991 the wound apparently was described as healing slowly. (Ex. 31).

152. From May 14, 1991 through March 18, 1992 Respondent evaluated and treated Patient I's non-healing leg stump. On May 14, 1991 there was drainage from the wound. Respondent's diagnosis was infection of the left leg amputation. Respondent prescribed Terramycin, an oral antibiotic, and Polymyxin, a topical antibiotic. (Ex. 31).

153. On the next visit of May 28, 1991, Respondent described a draining wound with necrotic tissue and the diagnosis of infected amputated stump. The wound was debrided and Floxin prescribed. (Ex. 31, p.36).

154. On June 4, 1991 swelling and redness of the left

leg stump with necrotic tissue were noted. The diagnosis was cellulitis of the left foot stump. The wound was debrided and Floxin prescribed. (Ex. 31, p.37).

155. On June 14, 1991 swelling of the left stump and redness and drainage were noted. The diagnosis was cellulitis. Respondent again debrided the wound and prescribed Floxin. On August 6, 1991 the wound was described as healing slowly. The diagnosis was wound infection and the treatment was to continue with antibiotic (Ex. 31, pp. 38-39).

156. On August 20, 1991 less swelling and drainage of the stump was noted. The stump was described as having multiple slightly draining wounds. The skin was described as slightly pale. The diagnosis was infected wound and treatment continue with [?]. On the next visit of September 3, 1991 there was no reference to the stump; extremities were described as "no edema." The treatment, in addition to an antidepressant, included continue with medication. (Ex. 31, pp. 40-41).

157. On September 6, 1991 the patient complained of numbness and paresthesia of the "lower extremities stump[s?]." Findings noted included poor peripheral pulsations of the leg stump and skin slightly pale. The diagnosis was peripheral vascular insufficiency and Respondent instructed the patient to continue with medication. (Ex. 31, p.42).

158. On September 24, 1991 the stump was described as

nonhealing. The diagnosis and treatment are not completely decipherable. (Ex. 31, p. 43).

159. A September 26, 1991 letter from a prosthetic company to Respondent indicated that on September 13, 1991 the patient could not be fitted with a left below knee prosthesis prescribed by Respondent. The fitting was impossible because "the distal tibia is exposed through the skin." (Ex. 31, p. 45).

160. On November 19, 1991 the stump was not described. The finding was poor peripheral pulsation with left amputated stump and the diagnosis was peripheral vascular insufficiency. Respondent's treatment plan was continue with Vasodilan. (Ex. 31, p. 44).

161. On December 3, 1991 the patient complained of pain in the left knee. Respondent found erythematous skin lesion in the left amputated stump and skin slightly pale. Respondent diagnosed an infected amputated stump and continued the treatment with antibiotics. (Ex. 31, p. 46).

162. On March 18, 1992, the next recorded office visit, it was noted that the left "amputated stump not healing yet with raw surface of the edge of the stump, poor peripheral pulsation." The finding was no swelling with stump. There was no treatment specifically directed for the leg stump. (T. 696-702; Ex. 31, p. 48).

163. Respondent's evaluation and treatment of Patient I's nonhealing left leg stump did not comport with accepted standards of care. Respondent did not at any time obtain a

culture of the drainage from the stump. That was absolutely necessary, especially in view of the patient's diabetes. Culture and sensitivity studies should have been ordered on May 14, 1991 - the date Respondent first noted that the wound was infected. Respondent made no attempt to explain the lack of healing during the approximate ten months of treatment. No x-ray was ordered to rule out osteomyelitis, the presence of a sequestrum (necrosed tissue, usually bone, separated from surrounding healthy tissue) or other evidence of bone infection. (T. 702-703).

164. Patient I had severe peripheral vascular disease. Respondent should have undertaken a more careful evaluation, including a Doppler study, of the status of peripheral circulation. Respondent noted poor pulsations of the stump, several times. However, it is not known what pulsations Respondent meant since one cannot feel pulsations in a leg stump. Patient I was not fitted with a left leg prosthesis until over a year after the amputation. (T. 702-703, 708, 709, 712 1247).

165. Respondent failed to maintain adequate records for Patient I. (T. 703-704; Ex.31).

<u>Patient J</u>

166. Respondent provided medical care to Patient J on various occasions from approximately March 7, 1988 through November 30, 1992 at Respondent's office and at Westfield Memorial Hospital. Respondent indicated that Patient J first became his patient in approximately 1985. He

testified that he may have misplaced the patient's records from this earlier period. Respondent provided primary care to the patient. (T. 1754-1755; Ex. 33 & 34).

167. Patient J was a woman in her eighties. She had severe osteopenia and a compression fracture of the spine. Respondent treated her for joint and urinary problems, among other things. His diagnoses for her included pyelonephritis, joint disease with several diagnoses, ASHD, hypertension, peripheral neuritis, anemia secondary to malabsorption syndrome, acute vaginitis and peptic esophagitis. (T. 716-717; Ex.34).

168. Respondent failed to obtain adequate histories and perform adequate physical examinations of Patient J initially and during the course of treatment. The first office visit date in records maintained by Respondent was March 7, 1988. There was no initial history documented other than the fact that the patient had no allergies. There was an incomplete physical examination. The patient had a subsequent hospital admission during which Respondent did document a more complete history and physical examination. However, those should have been done when treatment began. Moreover. supplemental histories and physical examinations were deficient. There were no adequate histories of the patient's complaints, just mere listings of them. (T. 716-718).

169. There was no documentation that the patient saw a gynecologist, in addition to seeing Respondent. There were

no routine gynecological examinations or screenings, documented by Respondent, although Respondent apparently was providing gynecological care to the patient. (T. 716-719; Ex.34).

170. On March 7, 1988, Respondent diagnosed Patient J as having acute pyelonephritis without an adequate medical basis. There were no documented patient complaints that would be related to such a diagnosis, such as frequency of urination, lumbar pain or fever. No urinalysis or urine culture was ordered to confirm the diagnosis. (T. 719-720; Ex.34, p. 3).

171. Respondent evaluated Patient J's knee pain and diagnosed its cause for over a year during nine office visits, from March 7, 1988 through May 17, 1989. On March 7, 1988 the patient complained of pain and numbness of the lower extremities. The findings were tenderness and swelling of the left knee. Respondent's diagnosis was osteoarthritis of the knees. On May 27, 1988 the complaint was pain with right knee. Findings were tenderness, swelling and deformity of the right knee with minimal limitation of flexion and extension and good peripheral pulses. Respondent diagnosed acute gouty arthritis, knees severe. On June 23, 1988 the diagnosis again was acute gout. On July 13, 1988 the patient complained of severe pain in the knees which was aggravated by walking. Findings included tenderness and swelling of the knees. Respondent diagnosed acute tenosynovitis. (Ex. 34, pp. 3-6).

172. On August 3, 1988 the diagnosis again was acute tenosynovitis. The finding was bilateral tenderness of the knees. On August 10, 1988 the patient reported pain in the knees subsiding. The finding was tenderness in the knees and the diagnosis severe arthritis of the knees. (Ex. 34, pp. 7-8).

173. On August 31, 1988 Respondent diagnosed acute tenosynovitis of the knees. The patient's complaint was severe pain in the knees and the findings were tenderness and swelling of the knees. On December 21, 1988 the patient complained of pain in the knees. The findings were tenderness and swelling of the knees. Respondent's diagnosis now was severe bursitis of the knees. (Ex. 34, pp. 9-10).

174. On March 17, 1989 the patient complained of pain in the knees. Tenderness in the left knee was noted. Respondent diagnosed rheumatoid arthritis of the left knee. (Ex. 34, p. 11).

175. A report of a right knee x-ray taken over two years later, on June 18, 1991, noted degenerative changes in the right knee. The report also indicated that the changes were similar to those demonstrated in a left knee x-ray done in 1985. (T. 720-722; Ex.34, pp. 3-11, 26).

176. Respondent's evaluation of Patient J's knee pain was not consistent with accepted standards of care. During the more than one year of treating the patient for knee pain, Respondent never elicited an adequate history relevant

to the knee pain. He made five different diagnoses: osteoarthritis, gouty arthritis, tenosynovitis, bursitis and rheumatoid arthritis. (T. 720-723).

177. He did not obtain any laboratory confirmation of any of the diagnoses or a contemporary x-ray. If Respondent suspected rheumatoid arthritis, a sed rate, rheumatoid factor, and perhaps an ANA would be important to obtain. Given Respondent's diagnosis of gout, a uric acid level should have been obtained. (T. 722-723).

178. Some of the diagnoses Respondent made to account for the patient's knee pain have very specific treatment, such as gout. It was important for Respondent to establish the correct diagnosis in order to provide appropriate treatment. (T.722-723).

179. Respondent administered intra-articular Dexamethasone injections in Patient's J's knees at various times from 1989 through 1992. Specifically, the injections were given on May 17 and August 2 in 1989, July 23 and September 4 in 1990, September 3, 1991, and July 13, August 10, and November 30 in 1992. (Ex.34).

180. The patient had osteopenia, which was evident in late 1991 and early 1992. A June 18, 1991 x-ray report of the right knee noted "generalized osteopenia." A January 13, 1992 lumbosacral spine x-ray showed "severe osteopenia with compression of the bodies of L2 and 3, and to a lesser extent, L1 and 4. A January 16, 1992 orthopedic consultation noted "marked osteopenia" and an acute

compression fracture in the lower thoracic and upper lumber spine. Respondent in 1992 office entries noted that the patient complained of severe lumbar pain and that the spinal compression fracture was healing. The patient also was diagnosed by Respondent as having peptic esophagitis in early 1992. (Ex.34).

181. Dexamethasone is a synthetic steroid used as an anti-inflammatory agent. In a primary care practice steroid injections should not be administered more frequently than every six months - in severe circumstances, perhaps every four months. More frequent use should not be undertaken without consultation with an orthopedist or rheumatologist. An injection of a steroid, such as Dexamethasone, has local and systemic effects. The drug can weaken the structure of the joint itself. It can damage the tendons and ligaments or produce a septic necrosis of the bone. It can aggravate stomach problems and exacerbate osteoporosis. (T. 724, 732-733, 757-758, 759).

182. Respondent's administration of Dexamethasone injections to Patient J in 1989, 1991 and 1992 constituted a deviation from accepted standards of care. The frequency of the injections was not appropriate without consulting with a specialist. In 1989 the injections were two and one half months apart. In 1990 they were about six weeks apart. In 1992 three injections were given, two within one month and the last three and one half months later. Respondent gave the injections in 1992, beginning on July 13, 1992, despite

having diagnosed peptic esophagitis in March 1992. (T. 731-733).

183. Respondent administered the injections less than a month apart on July 13, 1992 and August 10, 1992. The patient had suffered a compression fracture of the spine and was diagnosed as having marked osteopenia in the beginning of 1992. (Ex. 34).

184. She presented at Respondent's office complaining of severe lumbar pain. Respondent noted that she had a healing compression fracture. Despite these factors, Respondent gave the patient three Dexamethasone injections within four and one half months, two of which were within one month of each other. Respondent should have gotten a consultation for this patient. (T. 731-733, 758, 760-765;).

185. On May 18, 1992, Respondent diagnosed Patient J as having malabsorption syndrome without adequate basis. There were no patient complaints or history of the expected symptoms and signs of this problem. There were no laboratory data to confirm the diagnosis. The usual signs - presence of diarrhea, weight loss and wasting away - were not documented. Laboratory test results six weeks before Respondent's diagnosis did not confirm the diagnosis. The patient was not anemic. Her cholesterol and total protein were normal. (T. 733-736; Ex.33, pp. 33, 35; Ex.34, p.35).

186. Respondent failed to maintain adequate records for Patient J. (T. 736 [Dr. Gutierrez]).

Patient K

187. Respondent provided medical care to Patient K at various times from approximately January 17, 1992 through approximately April 9, 1994 at Respondent's office. Respondent was Patient K's primary care physician. (T. 1783; Ex.36).

188. Patient K was a man in his fifties. He suffered from Crohn's disease and was followed by a colo-rectal surgeon. He also had persistent leukocytosis for which no clear diagnosis was established. Patient K is the husband of Patient L. (T. 772-773; Ex.36).

189. Respondent failed to obtain and document adequate histories and perform adequate physical examinations when he initially saw Patient K and during the course of treatment. The first dates of treatment documented, January 17 and 20, 1992, contained no history and demonstrated inadequate physical examinations. Thereafter, supplemental histories were also inadequate. Respondent did not describe or categorize new patient complaints or symptoms but merely listed them. (T. 773-774; Ex.36).

190. Respondent diagnosed Patient K as having acute pleuritis on numerous occasions. For example, on October 26, 1992 Respondent diagnosed acute pleuritis. The patient's complaint was chest pain. The findings were left lung rales with pleural friction rub. However, on the next visit of November 1, 1992 there was no mention of a rub and the diagnosis was changed to acute bronchitis, rule out

COPD. (Ex.36).

191. On January 26, 1994 acute pleuritis was diagnosed, in addition to acute bronchitis. The patient's complaints were chest pain, tiredness and coughing. The lungs showed moist [?] rales. On January 29, 1994 acute pleuritis was again diagnosed. The patient's complaints were chest pain and slight dyspnea. Bilateral pleural friction rubs were noted. (Ex.36).

192. On February 11, 1994 the patient complained of chest pain and coughing. Bilateral pleural friction rubs were noted and acute pleuritis diagnosed. (Ex.36).

193. A March 1, 1994 chest x-ray was negative for pleural disease and pleural friction rubs. On March 9, 1994 the patient complained of coughing and chest pain. The finding was bilateral pleural friction rubs with a diagnosis of acute pleuritis. (T. 774-777; Ex. 36).

194. Respondent did not have an adequate basis for his diagnoses of acute pleuritis in view of accepted standards of care. The histories documented did not support the diagnoses. A March 1, 1994 x-ray did not support the diagnosis of acute pleuritis. (T. 777).

195. Respondent treated the acute pleuritis he diagnosed on October 26, 1992 with an injection of penicillin. He also advised the patient to continue with medication. On January 26, 1994, the treatment for acute pleuritis was a penicillin injection. On January 29, 1994 the treatment was a penicillin injection and Cipro. On

February 11, 1994, Cipro was again prescribed and a penicillin injection given. This treatment was repeated on March 9, 1994. (Ex. 36).

196. Respondent's treatment of the acute pleuritis he diagnosed was significantly below accepted standards of medical care. Pleuritis requires a comprehensive workup. Patient K had Crohn's disease and was taking steroids. Steroid use lowers resistance to bacterial infections and is a risk factor for tuberculosis. Respondent should have explored whether the pleuritis resulted from the patient's use of steroids. Moreover, the patient was having repeated episodes of what Respondent diagnosed as acute pleuritis. However, he never adequately attempted to find the underlying cause for the pleuritis. (T. 778-779, 1279-1280; Ex. 36).

197. Notably, on February 11, 1994 Respondent noted that Patient K had bilateral pleural friction rubs and that his wife, Patient L, had a single pleural friction rub. This could be a matter of real concern. However, Respondent undertook no measures to ascertain the underlying cause and direct his treatment appropriately. (T. 1289; Ex. 38).

198. On October 26, 1992, May 19, 1993 and January 26, 1994, Patient K complained of chest pain. On each of these occasions Respondent failed to obtain a history of the patient's complaint and the nature of the pain in order to rule out whether the pain was cardiac in origin. This failure was a significant deviation from accepted standards.

(T. 779-781, 1271-1272; Ex. 36).

199. Respondent failed to maintain adequate records for Patient K. (T. 781).

Patient L

200. Respondent provided medical care to Patient L at various times from approximately July 1993 through July 13, 1994 at Respondent's office and at Westfield Memorial Hospital. A record of Patient L's treatment by Respondent in Patient K's records indicates that Respondent also treated the patient on July 7, 1992 for bursitis of the hip. (Ex. 38 and 38-A).

201. Patient L was a woman in her late fifties. She has a history of vascular headaches. Respondent operated on her for carpal tunnel syndrome and performed a muscle biopsy. Respondent's diagnoses for the patient included, among others, hypertension, migraine headaches, carpal tunnel syndrome, peptic esophagitis, degenerative disc and bursitis. (Ex. 38 and 38-A).

202. Respondent failed to obtain and document adequate histories and perform adequate physical examinations of Patient L initially and during the course of treatment. The first recorded dates of treatment at Respondent's office were July 7, 1992 and November 22, 1993. There was no history and no complete physical examination documented on either of those dates. Respondent's supplemental histories were deficient. The patient's complaints and symptoms were listed with no history of the complaint or symptoms. The

physical examinations were incomplete. (T. 794-796; Ex. 38; Ex. 38-A).

203. On February 11, 1994, Respondent diagnosed Patient L as having acute pleuritis. He also noted a pleural friction rub. On this same day, Respondent heard bilateral friction rubs in Patient L's husband, Patient K. However, Respondent took no measures to ascertain the underlying cause and focus his treatment appropriately. Patient L's complaints were coughing, chest pain, dyspnea and epigastric pain. There was an insufficient basis for Respondent's diagnosis of acute pleuritis. (T. 796-797; Ex. 38; Ex. 38-A).

204. Given that Respondent failed to search for the underlying cause of the patient's symptoms, he therefore failed to find and appropriately treat the underlying cause for the acute pleuritis he diagnosed. This failure was a significant deviation from accepted standards of care. The treatment for Patient L, as well as Patient K, was unfocused and based upon an inadequate evaluation. (T. 796-799).

205. Respondent failed to maintain adequate records for Patient L. For example, Respondent noted in his March 28, 1994 hospital history that the patient had wrist pain which started a few months prior to the hospital admission. However, Respondent's office records are silent with regard to this. (T. 799, 1815-1817; Ex. 38).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained.[1] The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A: (8-31);

Paragraph A.1: (10-19);

Paragraph A.2: (10-19);

Paragraph A.3: (20-23);

Paragraph A.4: (24-25);

Paragraph A.5: (10-13, 24-30);

Paragraph A.6: (4, 31);

Paragraph B: (32-43);

Paragraph B.1: (33-37);

Paragraph B.2: (39-41);

Paragraph B.3: (40-41);

Paragraph B.4: (42);

Paragraph B.5: (4, 40, 43);

Paragraph C: (44-81);

Paragraph C.1: (2-3, 46);

[1]During the course of the hearing, the Department withdrew Factual Allegations D.6, F.8, F.9 and H.5. Consequently, the Hearing Committee did not address these allegations.

Paragraph C.2: (47-50);

Paragraph C.3: (51-52, 75, 80);

Paragraph C.4: (53-54);

Paragraph C.5: (55);

Paragraph C.6: (56-76);

Paragraph C.7: (77-79);

Paragraph C.8: (51, 80);

Paragraph C.9: (4, 46, 53, 81);

Paragraph D: (82-95);

Paragraph D.1: (2-3, 84);

Paragraph D.2: (85);

Paragraph D.3: (86);

Paragraph D.4: (87);

Paragraph D.5: (88);

Paragraph D.7: (89);

Paragraph D.8: (5, 90);

Paragraph D.9: (91);

Paragraph D.10: (92);

Paragraph D.11: (6, 93);

Paragraph D.12: (94);

Paragraph D.13: (4, 82, 84, 95);

Paragraph E: (96-108);

Paragraph E.1: (2-3, 98);

Paragraph E.2: (99-100);

Paragraph E.3: (99-102);

Paragraph E.4: (103-107);

Paragraph E.5: (103-106);

Paragraph E.6: (107);

Paragraph E.7: (4, 96-108);

Paragraph F: (109-125);

Paragraph F.1: (2-3, 109-112);

Paragraph F.2: (6, 113-114);

Paragraph F.3: (115);

Paragraph F.4: (5, 116);

Paragraph F.5: (117);

Paragraph F.6: (118);

Paragraph F.7: (119-120);

Paragraph F.10: (7, 121);

Paragraph F.11: (122-123);

Paragraph F.12: (124);

Paragraph F.13: (4, 125);

Paragraph G: (126-135);

Paragraph G.1: (2-3, 126-128);

Paragraph G.2: (6, 129-130);

Paragraph G.3: (7, 131);

Paragraph G.4: (5, 132-133);

Paragraph G.5: (5, 132-133);

Paragraph G.6: (134);

Paragraph G.7: (4, 126-135);

Paragraph H: (136-147);

Paragraph H.1: (2-3, 138);

Paragraph H.2: (6, 139);

Paragraph H.3: (5, 140);

Paragraph H.4: (5, 141);

Paragraph H.6: (141-142);

Paragraph H.7: (143-144);

Paragraph H.8: (145-146);

Paragraph H.9: (4, 136-147);

Paragraph I: (148-165);

Paragraph I.1: (2-3, 148-150);

Paragraph I.2: (151-164);

Paragraph I.3: (4, 148-165);

Paragraph J: (166-186);

Paragraph J.1: (2-3, 166-169);

Paragraph J.2: (170);

Paragraph J.3: (171-178);

Paragraph J.4: (179-184);

Paragraph J.5: (185);

Paragraph J.6: (4, 166-186);

Paragraph K: (187-199);

Paragraph K.1: (2-3, 187-189);

Paragraph K.2: (5, 190-194. 197);

Paragraph K.3: (193-196);

Paragraph K.4: (6, 198);

Paragraph K.5: (4, 187-199);

Paragraph L: (200-205);

Paragraph L.1: (2-3, 200-202);

Paragraph L.2: (5, 203);

Paragraph L.3: (204);

Paragraph L.4: (4, 200-205).

The Hearing Committee further concluded that the

following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each Specification:

First Specification: (Paragraphs A, A.1 and A.2);

Second Specification: (Paragraphs A, A.1 and A.2);

Third Specification: (Paragraphs C, C.7 and C.8);

Fourth Specification: (Paragraphs A and A.4);

Fifth Specification: (Paragraphs B and B.1);

Sixth Specification: (Paragraphs C, C.2 and C.6);

Seventh Specification: (Paragraphs D, D.2, D.5, D.9, D.10 and D.11);

Eighth Specification: (Paragraphs F, F.2, F.3 and F.5);

Ninth Specification: (Paragraphs G, G.2 and G.5);

Tenth Specification: (Paragraphs H, H.2, H.4 and H.6);

Eleventh Specification: (Paragraphs J and J.4);

Twelfth Specification: (Paragraphs K , K.3 and K.4);

Thirteenth Specification: (Paragraphs L and L.3);

Fourteenth Specification: (Paragraphs A and A.4);

Fifteenth Specification: (Paragraphs B and B.1);

Sixteenth Specification: (Paragraphs C, C.2 and C.6);

Seventeenth Specification: (Paragraphs D, D.2, D.5, D.9, D.10 and D.11);

Eighteenth Specification: (Paragraphs F, F.2, F.3 and F.5);

Nineteenth Specification: (Paragraphs G, G.2 and G.5);

Twentieth Specification: (Paragraphs H, H.2, H.4 and

H.6);

Twenty-First Specification: (Paragraphs J and J.4);

Twenty-Second Specification: (Paragraphs K, K.3 and K.4);

Twenty-Third Specification: (Paragraphs L and L.3);

Twenty-Fourth Specification: (Paragraphs A, A.3, A.4, A.5, B, B.1, B.2, B.3, B.4, C, C.1, C.2, C.3, C.4, C.5, C.6, D, D.1, D.2, D.3, D.4, D.5, D.7, D.8, D.9, D.10, D.11, D.12, E, E.1, E.2, E.3, E.4, E.5, E.6, F, F.1, F.2, F.3, F.4, F.5, F.6, F.7, F.10, F.11, F.12, G, G.1, G.2, G.3, G.4, G.5, G.6, H, H.1, H.2, H.3, H.4, H.6, H.7, H.8, I, I.1, I.2, J, J.1, J.2, J.3, J.4, J.5, K, K.1, K.2, K.3, K.4, L, L.1, L.2 and L.3);

Twenty-Fifth Specification: (Paragraphs A, A.3, A.4, A.5, B, B.1, B.2, B.3, B.4, C, C.1, C.2, C.3, C.4, C.5, C.6, D, D.1, D.2, D.3, D.4, D.5, D.7, D.8, D.9, D.10, D.11, D.12, E, E.1, E.2, E.3, E.4, E.5, E.6, F, F.1, F.2, F.3, F.4, F.5, F.6, F.7, F.10, F.11, F.12, G, G.1, G.2, G.3, G.4, G.5, G.6, H, H.1, H.2, H.3, H.4, H.6, H.7, H.8, I, I.1, I.2, J, J.1, J.2, J.3, J.4, J.5, K, K.1, K.2, K.3, K.4, L, L.1, L.2 and L.3);

Twenty-Sixth Specification: (Paragraphs A, A.1, A.2, A.3, A.5 and A.6);

Twenty-Seventh Specification: (Paragraphs B, B.2, B.3 and B.5);

Twenty-Eighth Specification: (Paragraphs C, C.1, C.2, C.3, C.7, C.8 and C.9);

Twenty-Ninth Specification: (Paragraphs D, D.1, D.2, D.3, D.4, D.7, D.8, D.9, D.10, D.11, D.12 and D.13);

Thirtieth Specification: (Paragraphs E, E.1, E.2, E.4 and E.7);

Thirty-First Specification: (Paragraphs F, F.1, F.2, F.3, F.4, F.6, F.7, F.10, F.11, F.12, F.13);

Thirty-Second Specification: (Paragraphs G, G.1, G.2, G.3, G.4, G.5, G.6 and G.7);

Thirty-Third Specification: (Paragraphs H, H.1, H.2, H.3, H.7, H.8 and H.9);

Thirty-Fourth Specification: (Paragraphs I, I.1, I.2 and I.3);

Thirty-Fifth Specification: (Paragraphs J, J.1, J.2, J.3, J.5 and J.6);

Thirty-Sixth Specification: (Paragraphs K, K.1, K.2, K.4 and K.5);

Thirty-Seventh Specification: (Paragraphs L, L.1, L.2 and L.4).

DISCUSSION

Respondent is charged with thirty-seven specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., former 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 gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

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

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

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

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

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

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of the profession.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously

concluded, by a preponderance of the evidence, that the Department has sustained its burden of proof with respect to each of the specifications of professional misconduct set forth in the Statement of Charges. The rationale for the Committee's conclusions is set forth below.

At the outset, the Hearing Committee made a determination as to the credibility of the witnesses presented by both parties. Petitioner presented as medical experts John M. Antkowiak, M.D. with regard to Patients A and Patient B, and Angel Gutierrez, M.D. with regard to the other ten patients. Petitioner's experts were well qualified by experience and education to evaluate Respondent's care of the patients.

Dr. Antkowiak is certified by the American Board of Obstetrics and Gynecology. He has been involved in the active practice of obstetrics from 1977 through 1990 and gynecology from 1977 to date. Currently, Dr. Antkowiak provides gynecologic services in urban, suburban and rural settings in Western New York, where he sees approximately five hundred patients a month. Dr. Antkowiak is also an assistant clinical professor at the State University of New York. (T.71-73; Ex. 39).

Dr. Gutierrez was Board certified in Internal Medicine in 1972 and recertified in 1980. He has been engaged in the active practice of medicine for approximately twenty-three years. Specifically, Dr. Gutierrez practices primary care medicine. Currently, he is an internist with a health care

plan where he sees about one hundred and twenty patients a week. His patients range from ages sixteen to one hundred and four. Prior to his current practice, Dr. Gutierrez practiced primary care medicine for sixteen and one half years in a rural community in New York State. He applied the standards of care of a rural general practitioner in reviewing Respondent's care. (T.310-311). Dr. Gutierrez teaches as a clinical associate professor and is the Chief of Medicine and Director of the Community Academic Practice Sites for the health plan with which he is associated. Dr. Gutierrez also serves as a reviewer for the National Committee on Quality Assurance. (T.242-244; Ex. 40).

Both Dr. Antkowiak and Dr. Gutierrez were well qualified to review Respondent's practice of medicine. Both have experience practicing in rural communities. Dr. Gutierrez practiced in a rural community similar to Respondent's for over sixteen years. Dr. Antkowiak and Dr. Gutierrez both have active practices, seeing numerous patients on a regular basis, as did Respondent. These physicians' evaluation of Respondent's care of the subject patients, as reflected in their testimony, was in-depth and detailed. Their testimony was forthright and their opinions rational. The Hearing Committee gave great weight to their testimony.

The Hearing Committee also gave credence to the testimony of the other witnesses called by the Department, especially Patient C.

Respondent presented two expert witnesses to testify on

his behalf. Ronald J. Foote, M.D. testified with regard to Patients A and B. Richard H. Heibel, M.D. testified with regard to the remaining patients. The Hearing Committee found their testimony to be unpersuasive. They afforded Respondent every conceivable benefit of doubt. They based their opinions on numerous assumptions unsubstantiated by Respondent's patient records.

For example, Dr. Foote's testimony regarding Patient A was disingenuous. Only when pressed on cross-examination did he concede that Respondent had not performed a D and C. (T. 855). Dr. Foote also condoned Respondent's evaluation of Patient B's complaint of vaginal discharge. He did so on the assumption that Respondent visually examined the cervix, although there was no evidence to support this assumption in the records. (T. 913, 923; Ex. 12).

Dr. Heibel testified for Respondent with regard to Patients C through L. Dr. Heibel's main area of experience is cardiology. Until recently, he had primarily practiced invasive cardiology. (T. 959). As such, his familiarity with standards of practice applicable to a primary care practitioner is questionable. Further, in many instances Dr. Heibel's excuses for Respondent were unsupported and even contraindicated by the medical records.

Dr. Heibel testified that since it was his "understanding" that Patient D brought in urine sugars regularly, he wondered whether that was not also the recommendation for Patient C. (T. 969). No such

recommendation was noted in Patient C's records. Respondent also prescribed Feldene to Patient D the same day he diagnosed an active peptic ulcer. This action was excused by Dr. Heibel "...if we make the assumption that the patient was told to hold on the Feldene until the stomach discomfort cleared...." (T. 1029). This assumption was not supported by the records.

With regard to Patient G, Dr. Heibel excused Respondent's July 26, 1993 diagnoses of anemia and hypocalcemia which were contradicted by prior and subsequent laboratory reports. He conjectured that either a hospital clerk or office employee misplaced laboratory reports because "that is really the only logical explanation... when the only evidence available is clearly to the contrary." (T. 1191). The Hearing Committee concluded that a far more likely explanation is that Respondent's diagnoses were incorrect. Based on the foregoing, the Hearing Committee unanimously concluded that the expert testimony of Drs. Foote and Heibel would be given little credence.

The Hearing Committee also concluded that Respondent's testimony was not credible. Respondent has an obvious interest in the outcome of these proceedings. His memory of events was selective, often to his benefit. His testimony regarding undocumented facts strained all reason and frequently was contradicted by other extrinsic evidence. Moreover, Respondent's explanations of his patient care showed his flawed medical judgment and lack of basic medical knowledge.

Moral Unfitness and Fraud

The First through Third Specifications raise allegations of moral unfitness and fraud. They are based on false statements made by Respondent in medical records, as well as a false statement made during an interview with representatives of the Office of Professional Medical Conduct.

Respondent added the words "uterus atrophic and cervix stenosed" to a hospital progress note for Patient A dated and timed October 10, 1994, 1:00 P.M. An analysis of the inks used in the notes prove that the additional words were written by a different pen than was used to write the rest of the note. His explanation for the addition was not believable.

Respondent testified that he made the addition sometime after 1:30 P.M. before leaving the hospital. At that time, Respondent was late for his office appointments, had already dictated the operative report and had entered a 1:30 P.M. progress note. Nevertheless, Respondent claimed that while changing his clothes he realized that he had forgotten to put the added phrase in the note. He made the addition without indicating that it was an addition and by inserting it in the limited space remaining before his signature. Respondent testified that the information added was something every medical student would know. If that were the case, it would have been unnecessary to make the alteration of the note at the time.

However, there were reasons for Respondent to do so at a later date, either when he saw the pathology report showing

that no endometrial tissue was received or in November, 1994 when he dictated the second operative report. The Hearing Committee concluded that Respondent knowingly altered the record at some time after October 10, 1994.

Respondent was interviewed by representatives of the Office of Professional Medical Conduct on January 10, 1995. Dr. Neilsen testified that Respondent told her that he had written the phrase at the same time as the rest of the note. Respondent argued that there is no accurate record of the interview to substantiate her testimony. He submitted a tape recording and typed transcript of the interview. (Ex. D and E). Nothing in these exhibits contradicts Dr. Neilsen's testimony. The Hearing Committee therefore concluded that Respondent knowingly attempted to mislead the Office of Professional Medical Conduct regarding his alteration of the medical record. The Committee unanimously concluded that Respondent's actions constituted the fraudulent practice of medicine, as defined above, and voted to sustain the Second Specification. The Committee also concluded that Respondent's actions in this regard constituted a significant breach of the ethical standards of the profession, and evidenced moral unfitness to practice the profession. Accordingly, the Committee sustained the First Specification as well.

Respondent also made false entries into the medical record of Patient C. Respondent recorded a note dated December 13, 1993 that indicates that Patient C "needed glucometer - he claimed that is expensive." In addition,

Respondent twice made entries in the record to the effect that Respondent had discussed insulin treatment with the patient.

However, Patient C testified that Respondent never recommended that Patient C use a glucometer, nor did he discuss insulin treatment. The Hearing Committee carefully evaluated the testimony of Patient C, who acknowledged that he is suing Respondent. After consideration of the patient's testimony, as well as that of Respondent, the Committee concluded that the patient was a credible witness. Accordingly, the Hearing Committee concluded that Respondent made fraudulent statements in the patient's record, and voted to sustain the Third Specification.

Gross Negligence/Gross Incompetence
Negligence/Incompetence on More Than One Occasion

Respondent has been charged with gross negligence and gross incompetence with regard to the medical care and treatment rendered to Patients A, B, C, D, F, G, H, J, K and L (Fourth through Twenty-Third Specifications). He has also been charged with negligence on more than one occasion (Twenty-Fourth Specification) and incompetence on more than one occasion (Twenty-Fifth Specification) with regard to Patients A through L. The Hearing Committee unanimously concluded that the Department has sustained its burden of proof with respect to each and every one of these specifications.

Each of the twelve patients represented problems commonly found in a rural primary care practice. Respondent repeatedly

failed to meet even minimal standards of care with regard to their proper management. He failed to provide and document adequate routine gynecological care for Patients A and B. He improperly advised Patient A that she did not have a tumor, although he didn't actually obtain adequate tissue samples to make that claim. Respondent discharged Patient B from the hospital without adequately ruling out an ectopic pregnancy. He also failed to adequately diagnose and treat Patient B's complaints of vaginal discharge.

Respondent failed to obtain and document adequate histories and physical examinations regarding Patients C through L. Respondent repeatedly entered diagnoses for patients which were not supported by the objective data recorded. For example, Respondent diagnosed acute pleuritis at various times for Patients D, F, G, H, K and L. In each instance, he made the diagnosis without adequate justification. Moreover, given the diagnoses rendered, Respondent then failed to appreciate the significance of the condition and initiate appropriate treatment.

The patient records clearly demonstrate that there was no continuity in the care rendered by Respondent to his patients. Diagnoses appear and disappear without follow-up. Virtually every patient encounter was recorded on a separate sheet of paper. There was no evidence that Respondent attempted to correlate patient complaints, objective findings, and treatment with his patients' past medical history. For example, Respondent prescribed Glucotrol for Patient C in

addition to the Orinase which he had been prescribing for two to five years. He did this because he did not realize (and could not readily ascertain from his records) that the patient was already on Orinase.

The record also established that Respondent employed drug therapies, particularly antibiotics, in a scatter-shot approach. He frequently changed his patients' antibiotics without giving them adequate time to show their effectiveness. Moreover, he did not perform laboratory cultures which might have made it possible for Respondent to make a reasoned decision as to the appropriate drug for specific circumstances.

The Hearing Committee unanimously concluded that Respondent's medical care and treatment of Patients A through L demonstrated both negligence and incompetence. In the cases of Patients A, B, C, D, F, G, H, J, K and L, Respondent's actions constituted both gross negligence and gross incompetence, as defined above. Consequently, the Committee voted to sustain the Fourth through Twenty-Fifth Specifications of professional misconduct.

<u>Inadequate Medical Records</u>

The Department has also charged Respondent with twelve specifications of professional misconduct for failing to maintain medical records which accurately reflect the evaluation and treatment of Patients A through L, inclusive. The evidence overwhelmingly demonstrated the inadequacy of Respondent's records. All of the experts (including

Respondent) acknowledged that Respondent's record-keeping was seriously deficient. Respondent repeatedly failed to document histories and physical examinations. The descriptions of patient complaints were sketchy. A patient's records should be sufficient to enable another physician to understand the patient and the care provided, and to assume that care if the need arises. Generally accepted standards of practice require that patient histories and physical examinations, treatment, medication regimens and referrals to or treatment by other physicians be accurately documented.

Respondent testified on numerous occasions that histories were taken, examinations performed and laboratory data (such as urine sugars) were obtained, yet none of it is reflected in the records. Assuming the accuracy of such testimony, Respondent's records represent a serious breach of his professional responsibilities. Consequently, the Hearing Committee voted to sustain the Twenty-Sixth through Thirty-Seventh Specifications of professional misconduct.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the

imposition of monetary penalties.

The Hearing Committee was extremely troubled by the lack of fundamental medical knowledge demonstrated by Respondent's treatment of the twelve patients at issue in this case. Respondent was unable to manage common problems encountered by a primary care physician. He mismanaged dysuria in adult males, chest pain in patients at risk for cardiovascular disease, diabetes mellitus, peripheral vascular disease, musculoskeletal complaints and common infections. Respondent's diagnostic and therapeutic skills were grossly substandard. He did not provide patients with any meaningful continuity of care. Diagnoses made on one visit were frequently not addressed on the next visit regardless of the condition. He paid little attention to consultants. He ignored objective data, such as X-rays or laboratory reports, and clung to his unsubstantiated diagnoses. Respondent's medical records were woefully lacking. Moreover, records prepared by Respondent during hospital admissions were frequently inconsistent with the patients' office records.

Respondent was trained as a surgeon. He had no formal training in internal medicine or family practice beyond his rotating internship. He practiced in Westfield, New York, a rural community approximately sixty miles west of Buffalo. Respondent claimed that he began to see primary care patients because he was not getting enough surgical referrals. Having determined to place himself in the role of a primary care practitioner, it was incumbent on Respondent to practice

within the applicable standards of the profession. The evidence overwhelmingly demonstrates that Respondent is unable or unwilling to conform to those standards.

The Hearing Committee was also concerned about Respondent's lack of veracity and unethical behavior. He made an after-the-fact addition to Patient A's hospital chart and lied about it in an interview with the Office of Professional Medical Conduct. In addition, Respondent made entries in Patient C's office records regarding medical advice which Respondent, in fact, had never given. Further, the Committee found Respondent's testimony to be wholly unpersuasive and lacking in credibility.

Respondent's failures and deficiencies relate to every aspect of medical practice. It was the unanimous determination of the Hearing Committee that Respondent's deficiencies are so great that rehabilitation through re-training is not possible. The only sanction which will adequately protect the public is revocation.

ORDER

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

1. The First through Thirty-Seventh Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;

2. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order.

DATED: Albany, New York
, 1995

MICHAEL R. GOLDING, M.D.

WILLIAM K. MAJOR, JR., M.D.
DENNIS R. HORRIGAN

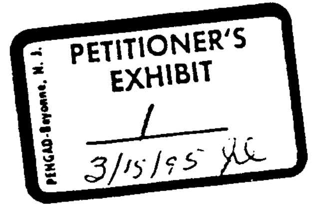
TO: E. Marta Sachey, Esq.
Associate Counsel
New York State Department of Health
Corning Tower Building - Room 2429
Empire State Plaza
Albany, New York 12237

Fidel R. Ramos, M.D.
306 East Main Street
Westfield, New York 14787-1127

Alan Lambert, Esq.
Lifshutz, Polland & Associates, P.C.
675 Third Avenue, Suite 2400
New York, New York 10017

APPENDIX I

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



---X

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

---X

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

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

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.

withdrawn by Petitioner 4/17/95 [initials]

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.

withdrawn by Petitioner. 4/18/95 [initials]

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.

Amended by Petitioner 6/29/95 → [initials]

11. Respondent at various times, including November 3, 1993, February 25, 1994, April 6 ~~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.

withdrawn by Petitioner 5/8/95 JJS

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