STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

January 7, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Denise LePecier, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001

Gladys Saget, M.D.
114 Sterling Road
Elmont, New York 11003

RE: In the Matter of Gladys Saget, M.D.

Dear Ms. LePecier and Dr. Saget:

Enclosed please find the Determination and Order (No. BPMC-98-5) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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

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

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc

Enclosure

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

COPY

IN THE MATTER

OF

GLADYS SAGET, M.D.

DETERMINATION

AND

ORDER

BPMC-98-5

ROBERT S. BERNSTEIN, M.D., CHAIRPERSON, EDMUND O. ROTHSCHILD, M.D. and **CHARLOTTE S. BUCHANAN,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10) (e) and 230 (12) of the Public Health Law. **JANE B. LEVIN, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	July 25, 1997
Statement of Charges dated:	July 25, 1997
Hearing date:	October 7, 1997
Deliberation Date:	November 6, 1997
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.

Petitioner Appeared By:

Henry M. Greenberg, Esq.
General Counsel
NYS Department of Health
By: Denise LePecier, Esq.

The Respondent did not appear.

WITNESSES

For the Petitioner:

1) Diane Sixsmith, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with negligence on more than one occasion; incompetence on more than one occasion; fraudulent practice and conviction of a crime under Federal law. The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page number 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. Respondent was authorized to practice medicine in the State of New York by the issuance of license number 129039 (Pet. Ex. 1) . She is not currently registered to practice medicine in this state (Pet. Ex. 10).

2. The Respondent was convicted on January 30, 1996, in the United States Court for the Southern District of New York of three counts of mail fraud related to her participation in New York State's Medicaid Program. She did not appear for sentencing. A warrant was issued for her arrest and she is a fugitive from justice (T. 16-18; Pet. Exs. 4, 5, 6, 9).

3. The Respondent treated Patients A, B, C, D, and E at her medical office located at 2838 Third Avenue, Bronx, New York.

4. Respondent employed and supervised a Registered Physician's Assistant ("RPA"), Marie A. McKenzie, in her practice. Ultrasound requisition forms in certain medical records indicate Respondent is the referring physician, although the forms are signed by Marie McKenzie (T. 49-51,/84-45; Pet. Exs. 7A, 7B, 7C, 7D, 7E).

5. Respondent countersigned the medical records for each patient. Physicians are responsible for the supervision of RPA's and the care they provide (T. 49-50, 87; Pet. Exs. A, B, C, D, E).

6. Laboratory reports are addressed to the Respondent as the physician ordering the tests for each patient (Ex. 7A, 7B, 7C, 7D, 7E). The Respondent's answer to the New York State Department of Social Services audit of her patient records acknowledges that she was the provider of services and that the records are hers (Pet. Ex. 8).

7. A blood test to measures levels of Vitamin B12 is normally ordered for a patient with a known history of B12 deficiency or pernicious anemia, or as part of an overall evaluation when anemia had been detected on an initial blood test. It is also useful in patients whose mental status or neurological findings may be due to a B12 deficiency (T. 27).

8. Serum electrophoresis is an analysis of certain proteins in the blood associated with certain diseases, including cancer of the blood, multiple myeloma, and other fairly rare conditions. The test is appropriate for patients with a known history of these diseases, or if the patient's symptoms or physical findings suggest the patient might have one of these conditions (T. 27-28).

9. The carcinoembryonic antigen test is an expensive blood test used to detect whether a patient, who has already been treated for cancer of the digestive tract, has had a metastatic recurrence. It is not useful as a screening test for these cancers (T. 29, 67).

10. Abdominal ultrasound is a procedure used to determine the size and quality of a mass in the abdomen, normally performed following the palpation of a mass on physical examination (T. 32-33).

11. When a physician orders tests such as an EKG (Patients A, B, C, D, and E), audiogram (Patients A, C, and E) and spirometry (Patients A, B, and C) for a patient, an interpretation of these tests should appear in the patient's record (T. 30-32, 55-56, 63, 67, 73-74, 83).

FINDINGS OF FACT AS TO PATIENT A

12. On or about January 16, 1990, Respondent saw Patient A, a 38 year old male at her office. A history of smoking, drug abuse, alcohol abuse, ulcers, back pain, rash and "sinus" were recorded for this patient. Tender sinuses and a groin rash were noted on physical examination. Multiple blood tests, an EKG, an audiogram and spirometry were ordered (Pet. Ex. 7A).

13. Respondent did not record an adequate history or physical for this patient (T. 51-53).

14. Respondent did not record a diagnosis or a treatment plan for this patient (T. 54) .

15. Respondent did not record any attempt to counsel or instruct this patient with a history of multiple substance abuse (T. 54-55).

16. Respondent ordered blood tests for Vitamin B12 levels, serum electrophoresis and carcinoembryonic antigen without noting any indications for such tests (Pet. Ex. 7A).

17. Respondent performed an EKG, audiogram and spirometry but did not provide any interpretation of these tests (Pet. Ex. 7A).

CONCLUSIONS OF LAW AS TO PATIENT A

The Hearing Committee concludes that Respondent's treatment of Patient A did not meet acceptable medical standards. There is no record of the performance of an adequate history or physical, and no interpretation of test results, many of which lacked medical indication. There is no record of a diagnosis or treatment plan, nor any attempt at substance abuse counselling or referral.

FINDINGS OF FACT AS TO PATIENT B

18. On or about February 12, 1990, Respondent saw Patient B, a 28 year old male at her office. A history of smoking, drug abuse, ulcers, back pain, groin rash and "sinus" was recorded for this patient. A groin rash was noted on physical examination (Pet. Ex. 7B).

19. Respondent did not take and record an adequate history and physical for this patient (T. 57).

20. Respondent did not record a diagnosis or treatment plan for this patient (T. 58).

21. Respondent did not record any attempt to counsel or instruct this patient with a history of multiple substance abuse (T. 61).

22. Respondent ordered blood tests for Vitamin B12 levels, serum electrophoresis and carcinoembryonic antigen without noting any indications for them (Pet. Ex. 7B; T. 61).

23. Respondent performed an EKG and spirometry but did not provide any interpretation of these tests (Pet. Ex. 7B).

CONCLUSIONS OF LAW AS TO PATIENT B

The Hearing Committee concludes that Respondent's treatment of Patient B did not meet acceptable medical standards. There is no record of the performance of an adequate history or physical, and no interpretation of test results, many of which lacked medical indication. There is no record of a diagnosis or treatment plan, nor any attempt at substance abuse counselling or referral.

FINDINGS OF FACT AS TO PATIENT C

24. From on or about December 21, 1989 to on or about March 1, 1990, Respondent saw Patient C, a 27 year old male, at her office. On the first visit, a history of ulcer, back pain, asthma and chest infection was recorded for this patient. Tender sinuses were noted on physical examination. Multiple blood tests were ordered. Nothing was documented on the second visit except prescriptions for Zantac, Motrin, Carafate and other medications (Pet. Ex. 7C).

25. Respondent did not record an adequate history and physical for this patient (T. 64).

26. Respondent did not formulate a diagnosis or treatment plan for this patient (Pet. Ex. 7C).

27. Respondent ordered blood tests for Vitamin B12 levels, serum electrophoresis and carcinoembryonic antigen without noting any indications for them (Pet. Ex. 7C).

28. Respondent performed an EKG, an audiogram and spirometry, but did not note any interpretation of these tests (T. 65-66).

29. Respondent ordered an abdominal ultrasound without any medical indication. It will not demonstrate the presence or severity of an ulcer (T. 68).

30. Respondent prescribed Motrin for this patient with a history of ulcer, which is contraindicated in patients with peptic ulcer disease (T. 68).

CONCLUSIONS OF LAW AS TO PATIENT C

The Hearing Committee concludes that Respondent's treatment of Patient C did not meet acceptable medical standards. There is no record of the performance of an adequate history or physical, and no interpretation of test results, many of which lacked medical indication. There is no record of a diagnosis or treatment plan, and inappropriate medications were prescribed.

FINDING OF FACT AS TO PATIENT D

31. On or about April 12, 1990, Respondent saw Patient D, a 48 year old male at her office. A history of smoking, alcohol abuse, ulcers, hypertension, left knee surgery and spitting up phlegm was recorded for this patient. The patient had a slightly elevated blood pressure of 140/100. The patient was diagnosed with bronchitis, asthma, hypertension and peptic ulcer disease. Multiple blood tests were ordered. The record notes prescriptions for Calan, Pepcid, Voltaren, an Isuprel inhaler, Ceclor and other medications (Pet. Ex. 7D).

32. Respondent did not record an adequate history and recorded a minimally adequate physical for this patient (T. 70-71).

33. Respondent did formulate a diagnosis and treatment plan for this patient (Pet. Ex 7D).

34. Respondent did not adequately counsel, instruct or follow-up with this patient who had a history of substance abuse (T. 72).

35. Respondent performed an EKG, but did not record an interpretation of the test (Pet. Ex. 7D; T. 73).

36. Respondent inappropriately prescribed Voltaren for this patient with a history of ulcer. Voltaren is part of a class of drugs called nonsteroidal anti-inflammatory drugs, typically prescribed for osteoarthritis (T. 34-35). Voltaren is contraindicated in patients with known active peptic ulcer because nonsteroidal drugs can irritate or exacerbate an ulcer (T. 35).

37. Respondent's prescription for pepcid was also inappropriate for this patient (T. 36-37).

CONCLUSION OF LAW AS TO PATIENT D

The Hearing Committee concludes that Respondent's treatment of Patient D did not meet acceptable medical standards. Although the Respondent did record a minimally adequate physical, and formulate a diagnosis and treatment plan, there is no record of the performance of an adequate history and no interpretation of test results, many of which lacked medical indication. There were prescriptions for medications which were contraindicated for this patient, and no attempt at substance abuse counselling or referral.

FINDINGS OF FACT AS TO PATIENT E

38. On or about December 20, 1989, Respondent saw Patient E, a 37 year old male at her office. A history of ulcer, high cholesterol, back pain, and "sinus" was recorded for this patient. No vital signs were recorded. Multiple blood tests were ordered. The chart recorded diagnoses of back pain, asthma, "sinus", elevated cholesterol and peptic ulcer disease (Pet. Ex. 7E)

39. The Respondent did not record an adequate history and physical for this patient (T. 80-81).

40. The Respondent inappropriately diagnosed peptic ulcer disease, elevated cholesterol, back pain, "sinus" and asthma (T. 81-82).

41. The Respondent performed an EKG and an audiogram but did not record any interpretation of these tests (T. 83).

42. The Respondent ordered blood tests for serum electrophoresis and carcinoembryonic antigen (Pet. Ex. 7E).

43. The Respondent ordered an abdominal ultrasound without medical indication (Pet. Ex. 7E).

CONCLUSIONS OF LAW AS TO PATIENT E

The Hearing Committee concludes that Respondent's treatment of Patient E did not meet acceptable medical standards. There is no record of the performance of an adequate history or physical, and no interpretation of test results, many of which lacked medical indication. The diagnoses recorded were inappropriate and there is no record of a treatment plan.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise indicated.)

FIRST SPECIFICATION (Negligence on more than one occasion)

A1	SUSTAINED
A2	SUSTAINED
A3	SUSTAINED
A5	SUSTAINED
B1	SUSTAINED
B2	SUSTAINED
B3	SUSTAINED
B5	SUSTAINED
C1	SUSTAINED
C2	SUSTAINED
C4	SUSTAINED
C6	SUSTAINED
D1	SUSTAINED as to the failure to take an adequate history; NOT SUSTAINED as to performance of an adequate physical.
D2	SUSTAINED
D3	SUSTAINED
D4	SUSTAINED
D5	SUSTAINED
D6	SUSTAINED
D7	SUSTAINED
E1	SUSTAINED

E2	SUSTAINED
E3	SUSTAINED

SECOND SPECIFICATION (Incompetence on more than one occasion)

A1	SUSTAINED
A2	SUSTAINED
A3	SUSTAINED
A5	SUSTAINED
B1	SUSTAINED
B2	SUSTAINED
B3	SUSTAINED
B5	SUSTAINED
C1	SUSTAINED
C2	SUSTAINED
C4	SUSTAINED
C6	SUSTAINED
D1	SUSTAINED
D2	SUSTAINED
D3	SUSTAINED
D4	SUSTAINED
D5	SUSTAINED
D6	SUSTAINED
D7	SUSTAINED
E1	SUSTAINED
E2	SUSTAINED
E3	SUSTAINED

THIRD THROUGH SIXTH SPECIFICATIONS (Fraudulent Practice)

A4	NOT SUSTAINED
A4a	NOT SUSTAINED
B4	NOT SUSTAINED
B4a	NOT SUSTAINED
C3	NOT SUSTAINED
C3a	NOT SUSTAINED
C5	NOT SUSTAINED
C5a	NOT SUSTAINED
E4	NOT SUSTAINED
E4a	NOT SUSTAINED
E5	NOT SUSTAINED
E5a	NOT SUSTAINED

SEVENTH SPECIFICATION (Criminal conviction)

F	SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Respondent failed to appear personally or by counsel. For this reason, the Committee was extremely cautious in reviewing all of the evidence and testimony. The Hearing Committee found Petitioner's expert witness to be highly credible and agreed with her testimony that the quality of medical care provided for all of the patients was grossly inadequate. The Respondent failed to

document the performance of histories and physicals, of diagnoses and treatment plans. She ordered inappropriate tests for these patients, and then failed to interpret the results. The evidence of her criminal conviction is clear. However, the Committee felt that without evidence of the Respondent's intent, it was unable to reach the conclusion of fraudulent practice by the Respondent.

Under the circumstances, the Hearing Committee unanimously agrees that the only option appropriate in this matter is the revocation of the Respondent's license.

DATED: New York, New York
7 January, 1998

ROBERT S. BERNSTEIN, M.D., Chairperson

EDMUND O. ROTHSCHILD, M.D.
CHARLOTTE S. BUCHANAN

TO: Denise LePecier, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - 6th Floor
New York, New York 10001

Gladys Saget, M.D.
114 Sterling Road
Elmont, New York 11003

APPENDIX I

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

IN THE MATTER

OF

GLADYS SAGET, M.D.

STATEMENT

OF

CHARGES

GLADYS SAGET, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 8, 1976, by the issuance of license number 129039 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a male born on January 4, 1952, at her office at 2838 3rd Avenue in the Bronx, N.Y., on or about January 16, 1990. (All patients are identified in the attached Appendix.) A history of smoking, drug abuse, alcohol abuse, ulcers, back pain, rash, and sinus was recorded for this patient. Tender sinuses and groin rash were noted on physical examination. Multiple blood tests were ordered.

1. Respondent failed to take and record an adequate history and to perform and record an adequate physical for this patient.

2. Respondent failed to adequately formulate a diagnosis or plan for the treatment of this patient.

3. Respondent failed to adequately counsel, instruct or follow up with this patient with a history of multiple substance abuse.

4. Respondent inappropriately ordered blood tests for vitamin B12 levels, serum electrophoresis, and carcinoembryonic antigen.

   a. Respondent ordered these tests knowingly, without adequate medical indication, and with the intent to defraud.

5. Respondent performed an EKG, audiogram and spirometry and inappropriately failed to provide interpretations of these tests.

B. Respondent treated Patient B, a male born on June 28, 1962, at her office at 2838 3rd Avenue in the Bronx, N.Y., on or about February 12, 1990. A history of smoking, drug abuse, ulcers, back pain, groin rash, and sinus was recorded for this patient. Groin rash was noted on physical examination.

1. Respondent failed to take and record an adequate history and to perform and record an adequate physical for this patient.

2. Respondent failed to adequately formulate a diagnosis or plan for the treatment of this patient.

3. Respondent failed to adequately counsel, instruct, or follow-up with this patient with a history of multiple substance abuse.

4. Respondent inappropriately ordered blood tests for vitamin B12 levels, serum electrophoresis, and carcinoembryonic antigen.

a. Respondent ordered these tests knowingly, without adequate medical indication, and with the intent to defraud.

5. Respondent performed an EKG and spirometry and inappropriately failed to provide interpretations of these tests.

C. Respondent treated Patient C, a male born on June 8, 1962, at her office at 2838 3rd Avenue in the Bronx, N.Y., from on or about December 21, 1989 to on or about March 1, 1990. A history of ulcer, back pain, asthma, and chest infection was recorded for this patient. Tender sinuses were noted on physical examination. Multiple blood tests were ordered. Respondent treated Patient C at a second visit on or about March 1, 1990. Nothing was documented on this second visit except prescriptions for Zantac, Motrin, Carafate and other medications.

1. Respondent failed to take and record an adequate history and to perform and record an adequate physical for this patient.

2. Respondent failed to adequately formulate a diagnosis or plan for the treatment of this patient.

3. Respondent inappropriately ordered blood tests for vitamin B12 levels, serum electrophoresis, and carcinoembryonic antigen.

a. Respondent ordered these tests knowingly, without adequate medical indication, and with the intent to defraud.

4. Respondent performed an EKG, audiogram, and spirometry and inappropriately failed to provide written interpretation of the tests ordered.

5. Respondent inappropriately ordered an abdominal ultrasound.

   a. Respondent ordered this test knowingly, without adequate medical indication, and with the intent to defraud.

6. Respondent inappropriately prescribed Motrin for this patient with a history of ulcer.

D. Respondent treated Patient D, a male born on March 19, 1942, at her office at 2838 3rd Avenue in the Bronx, N.Y., on or about April 12, 1990. A history of smoking, alcohol abuse, ulcers, hypertension, left knee surgery, and spitting up phlegm was recorded for this patient. The patient had a slightly elevated blood pressure of 140/100. The patient was diagnosed with bronchitis, asthma, hypertension, and peptic ulcer disease. Multiple blood tests were ordered. This patient was written prescriptions for Calan, Pepcid, Voltaren, an Isuprel inhaler, Ceclor and other medications.

1. Respondent failed to take and record an adequate history and to perform and record an adequate physical for this patient.

2. Respondent failed to adequately formulate a diagnosis or plan for the treatment of this patient.

3. Respondent failed to adequately counsel, instruct or follow-up with this patient with a history of substance abuse.

4. Respondent performed an EKG and inappropriately failed to provide interpretation of this test.

5. Respondent inappropriately prescribed Voltaren for this patient with a history of ulcer.

6. Respondent inappropriately prescribed Calan, Pepcid, Voltaren, an Isuprel inhaler, and Ceclor for this patient.

7. Respondent inappropriately diagnosed bronchitis, asthma, hypertension, and peptic ulcer disease.

E. Respondent treated Patient E, a male born on June 12, 1952, at her office at 2838 3rd Avenue in the Bronx, N.Y., on or about December 20, 1989. A history of ulcer, high cholesterol, back pain, and sinus was recorded for this patient. No vital signs were recorded. Multiple blood tests were ordered. The patient was diagnosed with back pain, asthma, sinus, elevated cholesterol, and peptic ulcer disease.

1. Respondent failed to perform and record an adequate history and physical for this patient.

2. Respondent inappropriately diagnosed peptic ulcer disease, elevated cholesterol, back pain, sinus, and asthma.

3. Respondent performed an EKG and audiogram and inappropriately failed to provide interpretations of these tests.

4. Respondent inappropriately ordered blood tests for serum electrophoresis and carcinoembryonic antigen.

   a. Respondent ordered these tests knowingly, without adequate medical indication, and with the intent to defraud.

5. Respondent inappropriately ordered an abdominal ultrasound.

   a. Respondent ordered this test knowingly, without adequate medical indication, and with the intent to defraud.

F. On or about August 15, 1995, the Respondent was charged in indictment number 95 Cr. 733 with one count of conspiracy in violation of Title 18, United States Code, Section 371, and three counts of mail fraud in violation of Title 18, United States Code, Section 1341. All these charges related to Respondent's participation in the Medicaid Medical Assistance Program in the state of New York. On or about January 30, 1996, Respondent was found guilty after a jury trial of three counts of mail fraud. Respondent did not appear for her sentencing and a warrant has issued for her arrest.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1997) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1, A2, A3 and A5; B and B1, B2, B3 and B5; C and C1, C2, C4 and C6; D and D1, D2, D3, D4, D5, D6 and D7; E and E1, E2, and E3.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1997) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A and A1, A2, A3 and A5; B and B1, B2, B3 and B5; C and C1, C2, C4 and C6; D and D1, D2, D3, D4, D5, D6 and D7; E and E1, E2, and E3.

THIRD THROUGH SIXTH SPECIFICATIONS

FRAUDULENT PRACTICE

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

3. Paragraphs A, A4 and A4a;
4. Paragraphs B, B4 and B4a;
5. Paragraphs C, C3 and C3a and C5 and C5a;
6. Paragraphs E, E4 and E4a and E5 and E5a.

SEVENTH SPECIFICATION

CRIMINAL CONVICTION (Federal)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(a)(ii)(McKinney Supp. 1997) by having been convicted of committing an act constituting a crime under federal law as alleged in the facts of the following:

7. Paragraph F.

DATED: July 25, 1997
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct