Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

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

C. Maynard Guest, M.D.
Executive Secretary

September 15, 1993

Mr. Robert Bentley
Director
Division of Professional Licensing Services
New York State Eduation Department
Empire State Plaza-Cultural Education Center
Albany, New York 12230

RE: License No. 126702
Effective Date: 8/23/93

Dear Mr. Bentley:

Enclosed please find Order #93-115 of the New York State Board for Professional Medical Conduct concerning Dr. Kenneth Swire.

Neither the Department of Health nor the Respondent has requested an administrative review in this matter. The failure to request a review exhausts the administrative remedies in this matter.

Sincerely,

C. Maynard Guest

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

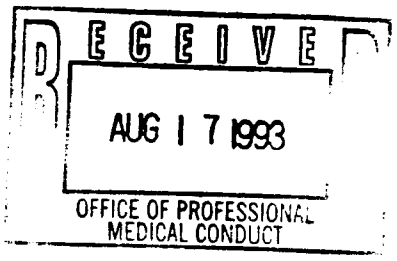
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Paula Wilson
*Executive Deputy Commissioner*

August 16, 1993

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**




Kenneth M. Swire, M.D.
111 Sholhayara 14
P.O. Box 23567
Jerusalem, Israel

Paul Stein, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

**RE: In the Matter of Kenneth M. Swire, M.D.**

Dear Dr. Swire and Mr. Stein:

Enclosed please find the Determination and Order (No. BPMC-93-115) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Very truly yours,

Tyrone T. Butler/nam

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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| | | |
|---|---|---|
| IN THE MATTER | : | **DETERMINATION** |
| OF | : | **AND** |
| KENNETH M. SWIRE, M.D. | : | **ORDER** |
| ----------X | | No. BPMC-93-115 |

**Irwin J. Cohen, M.D., Chairperson, Kenneth Kowald,** and **Edward C. Zaino, M.D.** 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 Section 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. **Marilyn S. Reader, Esq.,** duly under contract with the New York State Department of Health as an 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

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|---|---|
| Notice of Hearing dated: | April 14, 1993 |
| Statement of Charges dated: | April 14, 1993 |
| Pre-hearing conference: | June 10, 1993 |
| Hearing date: | June 10, 1993 |

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|---|---|
| Deliberation dates: | June 10, 1993<br>July 21, 1993 |
| Place of Hearing: | NYS Department of Health<br>5 Penn Plaza<br>New York, New York |
| Petitioner appeared by: | Peter J. Millock, Esq.<br>General Counsel<br>NYS Department of Health<br>By: Paul Stein, Esq.<br>Associate Counsel |

The Respondent failed to appear.

Motions: None

**WITNESSES**

For the Petitioner:

1) Dorothy Kunstadt, M.D.

**STATEMENT OF CHARGES**

Essentially the Respondent is charged with professional misconduct by reason of:

a. Practicing medicine with gross negligence.

b. Practicing medicine with gross incompetence.

c. Practicing medicine with negligence on more than one occasion;

d. Practicing medicine with incompetence on more than one occasion;

e. Failing to maintain adequate and accurate records of patients.

f. Practicing medicine fraudulently.

The Statement of Charges is annexed hereto as Appendix A.

## FINDINGS OF FACT

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. Kenneth M. Swire, M.D., the Respondent, was duly licensed to practice medicine in New York State by the issuance on March 5, 1976 of license number 126702 by the New York State Education Department (Pet. Ex. 2).

2. The Respondent is not currently registered with the New York State Education Department to practice medicine in New York State (Pet. Ex. 2).

3. In or about May 1983 through October, 1983, Respondent practiced medicine at Peninsula Hospital Center, 51-15 Beach Channel Drive, Far Rockaway, New York 11691-1074 (Pet. Exs. 3 and 4).

4. On May 13, 1993, the Notice of Hearing, Statement of Charges and SAPA Summary (Ex. 1) were duly served upon Respondent in Efrat, Israel.

## FINDINGS OF FACT AS TO PATIENT A

1. Between on or about May 3, 1983 and June 21, 1983, Respondent treated Patient A, a 70 year old woman, at Peninsula Hospital Center, 51-15 Beach Channel Drive, Far Rockaway, New York

(Pet. Ex. 3).

2. During this period, Respondent admitted Patient A to the hospital for three admissions from May 3 to May 10, 1983, from May 12 to May 24, 1983, and from June 6 to June 21, 1983. On the first admission on May 3, 1983, Patient A presented with acute shortness of breath; on the second admission on May 12, 1983, Patient A presented with respiratory distress; and on the third admission on June 6, 1983, Patient A presented with mild distress. (Pet. Ex. 3).

3. Patient A died on June 21, 1983 of cardiopulmonary arrest (Pet. Ex. 3 at p. 150 and Tr. 65-66 L.20-4).

4. Patient A suffered from shortness of breath during her first admission and Respondent's initial diagnosis was myocardial infarction. That diagnosis was not substantiated (Tr. 31 L.17-25 and Tr. 33 L.9-13). Throughout his course of treating Patient A on the first admission, Respondent never speculated that a mechanical obstruction may be responsible for Patient A's shortness of breath nor did Respondent order any diagnostic procedures to rule out a mechanical obstruction (Ex. 3 and Tr. 39).

5. On May 12, 1983, the first day of the second admission, Respondent determined Patient A had a tracheal tumor (Tr. 43-44 and 55 L. 6-13; and Ex. 3 at pp. 55, 102 and 105).

6. Although Respondent had physical findings of laryngeal stridor and respiratory distress, and Respondent knew Patient A had a tracheal tumor, Respondent failed to recognize the Patient A's medical problems were caused by mechanical obstruction

rather than other medical problems (Tr. 66 L.6-22 and Ex. 3 at 102, 156 and 173-177).

7. Although it was determined Patient A had a tracheal tumor, Respondent failed to treat Patient A for the tracheal tumor during the second and third admissions to the hospital (Ex. 3 at 102, 156 and 173-177; and Tr. 66 L.6 - 66 L.9).

8. Respondent's failure to treat Patient A's tracheal tumor contributed markedly to her death as Patient A developed acute respiratory distress due to obstruction and not being able to breath (Tr. 67 L.5-20).

9. During the admissions of Patient A, Respondent failed to obtain and note an adequate history. The history failed to specifically include the fact that Patient A had diabetes mellitus, an infarct in the past which might have explained the finding of an abnormal electrocardiogram and a description of previous electrocardiograms. (Ex. 3; and Tr. 23 L.9-13, Tr.29-30).

10. During the course of treating Patient A, Respondent repeatedly failed to perform and note an adequate physical examination of Patient A. (Tr. 22-24, 61-62; and Ex. 3).

11. Respondent failed to adequately perform and note Patient A's vital signs in his admission notes for her May 3, 1983 admission. Such information was necessary for Respondent to assess the proper treatment for Patient A (Tr. 21-24).

12. Throughout the course of the third hospital admission of Patient A, Respondent failed to adequately perform or note physical examinations of Patient A. Other medical personnel

noted the presence of a stridor and respiratory distress on June 18 and 19, 1983 (Ex. 3 at 149, 152 and 153). Specifically on June 19, 1983, Respondent's note is inadequate, not informative and fails to address Patient A's medical problems reported by hospital personnel in the immediately preceding notes and demonstrates Respondent failed to appreciate Patient A's serious medical difficulties (Tr. 61-62 and Ex. 3 at 149).

13. During the period of time Respondent treated Patient A, Respondent failed to record adequate progress notes. The notes failed to address Patient A's medical problem, her progress during the course of the hospital admissions and lacked treatment plans designed to treat her medical problems (Ex. 3; and Tr. 31 L.17-25, Tr. 33 L.9-13, Tr. 37-38 L.18-5, Tr. 44-46, Tr. 54 L.7-14, and Tr. 61-63).

14. On May 2, 1983 an electrocardiogram was performed on Patient A (Ex. 3 at 47). In his progress notes on May 3, 1983, Respondent inadequately and inaccurately reported "EKG-NSR," when the EKG indicated important gross abnormalities which Respondent failed to report and evaluate in the physician's progress record (Tr. 24-26, 35-36, and 70-71).

15. On May 6, 1983, Patient A's laboratory tests indicated an abnormal blood sugar of 395 (Ex. 3 p. 54). As good medical practice would require, Respondent failed to note and comment on the abnormal blood sugar, since such an abnormality requires treatment and influences the patient's condition (Tr. 34-35 and 70-71).

16. Respondent incorrectly noted Patient A's condition on discharge for the third admission as "improved" when Patient A had in fact died (Ex. 3 at 129 and 156).

17. Throughout Respondent's course of treatment of Patient A, Respondent failed to treat the tumor in Patient A's trachea, even after the tumor was noted on May 12, 1983 by a laryngoscopy (Ex. 3 and Tr. 54-55). The discharge summary and the physician notes for the second admission fail to note a treatment plan or any indication as to how Respondent would treat Patient A's tumor (Tr. 54-55 and Ex. 3 at 102).

18. Beginning on June 6, 1983 and throughout the course of Patient A's third hospital admission, Respondent failed to treat the tumor in Patient A's trachea (Tr. 59-60).

19. Eventhough Respondent knew since May 12, 1983 that Patient A had a tracheal tumor, symptoms of laryngeal stridor and episodes of respiratory distress, Respondent failed to appreciate Patient A's mechanical obstruction was a serious medical problem that needed to be treated in the hospital (Tr. 64-65).

## CONCLUSIONS AS TO PATIENT A

1. Between May 3, 1983 and June 21, 1983, Respondent admitted Patient A three times to Peninsula Hospital Center in Far Rockaway, New York.

2. Patient A was admitted for the first time because of acute shortness of breath. Between May 3 and May 10, 1983, during the course of the first admission, Respondent failed to consider a

mechanical obstruction as the cause of Patient A's shortness of breath, even after the initial diagnosis of myocardial infarction was not substantiated.

3. Although a tumor in Patient A's trachea was determined on the first day of her second admission to the hospital and despite a recurring stridor and episodes of respiratory distress, Respondent failed to establish a treatment plan to treat the tumor during Patient A's second and third admissions to the hospital.

4. Moreover, throughout Patient A's admissions to the hospital, Respondent failed to treat Patient A for the tumor in her trachea.

5. Respondent failed to indicate in progress notes that he recognized Patient A's respiratory distress was caused by the mechanical obstruction of a tumor in her trachea.

6. Throughout Respondent's course of treatment of Patient A, Respondent failed to obtain and record an adequate history, including but not limited to, specifically failing to note Patient A's prior history of a heart condition and abnormal EKG results.

7. Throughout Respondent's course of treatment of Patient A, Respondent failed to perform and note an adequate physical examination, including but not limited to, recording Patient A's vital signs in his admission notes on May 3, 1983 for the first admission. Respondent's June 19, 1983 note is inadequate, uninformative and fails to demonstrate Respondent

appreciated the seriousness of Patient A's condition and the persistent presence of respiratory stridor and distress as noted in reports by other hospital personnel.

8. Respondent repeatedly failed to note and evaluate abnormal laboratory results such as EKG readings and elevated blood sugars reported in diagnostic tests of Patient A.

**FINDINGS OF FACT AS TO PATIENT B**

1. Between August 21 and September 2, 1983, and September 23 and October 3, 1983, Respondent treated Patient B, an 80 year old woman, at Peninsula Hospital Center, 51-15 Beach Channel Drive, Far Rockaway, New York. On the first admission Patient B was suffering from cardio-respiratory arrest, congestive heart failure and hypoglycemic coma. On the second admission, Patient B presented with edema of the body, drowsiness, lethargy and sluggishness in responding. A cerebral vascular accident was suspected (Ex. 4 at 2-5 and 106-107; and Tr. 83 and 97-98).

2. On the first admission on August 21, 1983, Respondent failed to obtain and note an adequate history including the circumstances and/or duration of the symptoms causing Patient B's admission (Ex. 4 at 106).

3. On the first admission of Patient B, Respondent failed to adequately perform and note a physical examination of Patient B. Respondent failed to take and note Patient B's vital signs such as blood pressure and pulse and failed to adequately

describe Patient B's neurologic status (Ex. 4 at 106 and Tr. 85 and 97-98).

4. On the second admission of Patient B with a suspected cerebral vascular accident, Respondent failed to adequately determine and note whether Patient B had paralysis on the right side, left side or not at all. (Ex. 4 at 2-4 and Tr. 97-98).

5. Throughout the two hospital admissions, and most particularly during the second admission, Respondent failed to record adequate progress notes. His progress notes are not adequately informative. They insufficiently record Patient B's status and progress during the course of her treatment at the hospital. Without reading the nurse's notes and the notes of other hospital personnel, another professional would be unable to determine the status and progress of Patient B during her hospitalization (Ex. 4; and Tr. 95-96 and 97-98).

6. The treatment plans designed by Respondent for each admission were general and minimally adequate to provide proper medical care to patient B (Ex. 6 at 106-107; and Tr. 91 and 92-93).

## CONCLUSIONS AS TO PATIENT B

1. Respondent treated Patient B during two hospital admissions at Peninsula Hospital Center in Far Rockaway, New York. On the first admission on August 21, 1983, Patient B was suffering from cardio-respiratory arrest, congestive heart failure and hypoglycemic coma. On the second admission, Patient B presented

with edema of the body, drowsiness, lethargy, sluggishness in responding and a cerebral vascular accident was suspected.

2. Respondent failed to obtain and note an adequate history describing the circumstances and duration of the symptoms that caused Patient B's admissions to the hospital.

3. During the two admissions, Respondent failed to perform and note an adequate physical examination. In the first admission, Respondent did not obtain and note the blood pressure and pulse of Patient B nor did he describe with specificity the neurological status of Patient B.

4. Although the second admission was for a cerebral vascular accident, Respondent failed to perform and note an adequate neurological examination. Moreover, the significant information of paralysis on the right side, left side or none at all is absent from the medical record.

5. During the two admissions, Respondent's medical records insufficiently and inadequately report Patient B's progress and status. In order to determine the status and progress of Patient B during the course of her admissions, it is necessary to read the notes of nurses and other hospital personnel.

6. Respondent designed general plans for the treatment of Patient B that, at best, are minimally adequate to provide proper medical care. Although not a specification in the Statement of Charges, the Hearing Committee is impressed by the lack of adequate treatment afforded to Patient B during her two admissions under Respondent's care.

**FINDINGS OF FACT AS TO RESPONDENT'S MAY 5, 1983 APPLICATION TO FLUSHING HOSPITAL AND MEDICAL CENTER**

1. On May 5, 1983, Respondent applied to Flushing Hospital and Medical Center in Queens, New York for appointment to the medical staff (Ex. 5 at 6-7).

2. In the Flushing Hospital application, Respondent answered "None" to the question about "Professional Sanctions: Clinical Privilege limitations imposed by any hospital" (Ex. 5 at 6).

3. Between July 1, 1976 and June 30, 1977, Respondent was an orthopedic resident at Maimonides Hospital (Ex. 6).

4. On May 6, 1977, in a memorandum from Hubert Pearlman, M.D., Respondent was relieved from all activity in patient care areas for the period from May 9, 1977 to June 30, 1977 and was required to perform a research project until June 30, 1977, the end of the academic year (Ex. 6 at 6).

5. On May 6, 1977, Respondent submitted his resignation to the Maimonides Hospital orthopedic surgery residency program, effective June 30, 1977. On the same day, George Degenshein, M.D., Director of the Department of Surgery at Maimonides Hospital and Hubert Pearlman, M.D. accepted his resignation (Ex. 6 at 5 and 7).

**CONCLUSIONS AS TO RESPONDENT'S MAY 5, 1983 APPLICATION TO FLUSHING HOSPITAL AND MEDICAL CENTER**

1. On May 5, 1983, Respondent applied for admission to the medical staff of Flushing Hospital and Medical Center in Queens, New York.

2. Respondent answered "None," in response to a question about "Professional Sanctions: Clinical Privilege limitations imposed by any hospital."

3. Respondent did not inform Flushing Hospital that in May 1977 while an orthopedic resident at Maimonides Hospital, he was relieved of all patient care and required to perform research for the remainder of the academic year.

4. Although it is clear Respondent would not have been permitted to complete the orthopedic surgery residency program at Maimonides Hospital, he was not terminated from the program. Respondent completed the year and voluntarily withdrew from the program. The fact that he was relieved from all activity in patient care areas and required to perform research does not constitute a professional sanction. Respondent had no reason to believe the question on the Flushing Hospital application about "Professional Sanctions" applied to the May 6, 1977 letter from the Maimonides Hospital Department of Surgery relieving him of all activity in patient care areas.

## VOTE OF THE HEARING COMMITTEE

THE HEARING COMMITTEE VOTES UNANIMOUSLY (3-0) AS FOLLOWS:

**FIRST SPECIFICATION:** (Practicing with Gross Negligence) We find the Respondent did not practice medicine with gross negligence.

**SECOND SPECIFICATION:** (Practicing with Gross Incompetence) We find the Respondent did not practice medicine with gross incompetence.

**THIRD SPECIFICATION:** (Practicing with Negligence on More Than One Occasion) We find that the Respondent practiced medicine negligently on more than one occasion in that our findings of fact support Allegations A, A1 through A6, B and B1 through B3.

**FOURTH SPECIFICATION:** (Practicing with Incompetence on More Than One Occasion) We find that the Respondent practiced medicine incompetently on more than one occasion in that our findings of fact support Allegations A, A1 through A6, B and B1 through B3.

**FIFTH SPECIFICATION:** (Failing to Maintain a Record) We find that the Respondent is guilty of professional misconduct because he failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that our findings of fact support Allegations A, A1 through A6, B and B1 through B3.

**SIXTH SPECIFICATION:** (Fraudulent Practice) We find the Respondent did not fraudulently practice medicine in that Allegations C and C1 are not sustained.

## DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee unanimously determines because Respondent persistently obtained and noted an inadequate patient history, performed and noted an inadequate physical examination, failed to maintain sufficient and adequate medical charts, failed to properly and competently evaluate and note significant laboratory results, failed repeatedly to recognize the importance of Patient A's tracheal obstruction, failed to treat Patient A's tracheal tumor, knew or should have known of the need to treat Patient A for the tumor in her trachea, and failed during the first and longest admission of Patient A to recognize the need to rule out a mechanical obstruction as causing Patient A's difficulty in breathing and to order the necessary tests to determine the

existence of a mechanical obstruction compromising Patient A, the Respondent's license to practice medicine in the State of New York should be **REVOKED**.

**ORDER**

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

1. Respondent's license to practice medicine in the State of New York is **REVOKED**.

DATED: New York, New York
August 11, 1993

IRWIN J. COHEN, M.D.
Chairperson

Kenneth Kowald
Edward C. Zaino, M.D.

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

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| IN THE MATTER | : | STATEMENT |
| OF | : | OF |
| KENNETH M. SWIRE, M.D. | : | CHARGES |

----------X

KENNETH M. SWIRE, M.D., Respondent, was authorized to practice medicine in New York State on January 24, 1975 by the issuance of license number 126702 by the New York State Education Department. Respondent is not currently registered with the New York State Education Department to practice medicine in the State of New York. His most recent registration address is 227 Fox Meadow Road, Scarsdale, New York 10513.

## FACTUAL ALLEGATIONS

A. Between on or about May 3 and May 10, 1983, May 12 and May 24, 1983, and June 6 and June 21, 1983, Respondent treated Patient A (all patients are identified in Appendix A), a 70 year-old woman, at Peninsula Hospital Center, 51-15 Beach Channel Drive, Far Rockaway, New York, on the first admission presenting with acute shortness of breath, on the second admission presenting with respiratory

distress, and on the third admission presenting with mild distress. Patient A died on June 21, 1983.

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

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

3. Respondent failed throughout the period of treatment to record adequate progress notes.

4. Respondent failed to note and evaluate abnormal laboratory data.

5. Respondent failed to recognize that Patient A's respiratory distress was caused by mechanical obstruction by a tumor in her trachea.

6. Respondent failed to treat the tumor in Patient A's trachea.

B. Between on or about August 21 and September 2, 1983, and September 23 and October 3, 1983, Respondent treated Patient B, an 80 year-old woman, at Peninsula Hospital Center, 51-15 Beach Channel Drive, Far Rockaway, New York, on

the first admission to the hospital suffering from cardio-respiratory arrest, congestive heart failure and hypoglycemic coma, and on the second admission suffering from edema of the body, drowsiness, lethargy and sluggishness in responding.

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

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

3. Respondent failed throughout the period of treatment to record adequate progress notes.

4. Respondent failed to develop or record an adequate treatment plan for Patient B.

C. On or about May 5, 1983, Respondent filled out an Application For Appointment to the Medical Staff (the Application), swore to the truth of the contents of the Application before a Notary Public, and submitted it to the Flushing Hospital and Medical Center, 45th Avenue and Parsons Boulevard, Flushing, New York 11355.

1. In response to the question "Professional Sanction: c. Clinical Privilege limitations imposed by any hospital:", Respondent answered "None." Although Respondent knew at the time he filled out the Application that while in his second year of an orthopedic surgery residency at Maimonides Hospital, he had been relieved from all activity in patient care areas for the period May 9, 1977 to June 30, 1977, Respondent intentionally answered "None" with intent to deceive Flushing Hospital and Medical Center.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1993), in that Petitioner charges:

1. The facts in Paragraphs A and A1-6.

## SECOND SPECIFICATION

**PRACTICING WITH GROSS INCOMPETENCE**

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1993), in that Petitioner charges:

2. The facts in Paragraphs A and A1-6.

## THIRD SPECIFICATION

**PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION**

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993), in that Petitioner charges that Respondent committed at least two of the following:

3. The facts in Paragraphs A and A1-6; and/or B and B1-4.

## FOURTH SPECIFICATION

## PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1993), in that Petitioner charges that Respondent committed at least two of the following:

4. The facts in Paragraphs A and A1-6; and/or B and B1-4.

## FIFTH THROUGH SIXTH SPECIFICATIONS

## FAILING TO MAINTAIN A RECORD

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1993), in that he failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Specifically, Petitioner charges:

5. The facts in Paragraphs A and A1-4.

6. The facts in Paragraphs B and B1-4.

## SEVENTH SPECIFICATION

## FRAUDULENT PRACTICE

Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1993), in that Petitioner charges:

7. The facts in Paragraphs C and C1.

DATED: New York, New York
April 14, 1993

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct