STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 17, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lourdes D. Talvy, M.D.
270 Waverly Avenue
East Rockaway, New York 11518

Henry DeGreef, Esq.
270 Waverly Avenue
East Rockaway, New York 11518

Denise Lepicier, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

RE: In the Matter of Lourdes D. Talvy, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-85) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:nm
Enclosure

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

COPY

IN THE MATTER

OF

LOURDES D. TALVY, M.D.

DETERMINATION
AND
ORDER

BPMC – 00 -85

MR. KENNETH KOWALD (Chair), **FILIPPO DI CARMINE, M.D.**, and **RALPH LEVY, D.O.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health appeared by **DENISE LEPICIER, ESQ.**, Associate Counsel.

Respondent, **LOURDES D. TALVY, M.D.**, appeared personally and was represented by **SEGAL & TESSER, LEWIS TESSER, ESQ.**, of counsel, on the first day of Hearing and **HENRY DEGREEF, ESQ.**, on the last day of Hearing. **DR. TALVY** was *pro se* the second day of Hearing.

Hearings were held on November 17, December 1, and December 20, 1999. Evidence was received and examined. Transcripts of the proceeding were made. Deliberations were held on February 9, 2000. After consideration of the full record, the Hearing Committee issues this Determination and Order pursuant to the Public Health Law and the Education Law of the State of New York.

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq. of the Public Health Law of the State of New York [hereinafter "**P.H.L.**"]).

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Petitioner**" or "**Department**") pursuant to §230 of the P.H.L. LOURDES D. TALVY, M.D., ("**Respondent**") is charged with fifteen (15) specifications of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with: (a) professional misconduct by reason of practicing the profession with negligence on more than one occasion[1]; (b) professional misconduct by reason of practicing the profession with gross negligence[2]; (c) professional misconduct by reason of practicing the profession with incompetence on more than one occasion[3]; (d) professional misconduct by reason of practicing the profession with gross incompetence[4]; (e) professional misconduct by reason of failing to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient[5]; and (f) professional misconduct by reason of sharing fees for professional services with someone other than authorized[6].

The charges brought forward from the Department concern the medical care, treatment and services provided by Respondent to ten (10) patients (A through J)[7]. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

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[1] Education Law § 6530(3) and First Specification of Department's Exhibit # 1 (10 patients).

[2] Education Law § 6530(4) and Second Specification of Department's Exhibit # 1 (10 patients).

[3] Education Law § 6530(5) and Third Specification of Department's Exhibit #1 (10 patients).

[4] Education Law § 6530(6) and Fourth Specification of Department's Exhibit # 1 (10 patients).

[5] Education Law § 6530(32) and Fifth through Fourteenth Specifications of Department's Exhibit # 1 (10 patients).

[6] Education Law § 6530(19) and Fifteenth Specification of Department's Exhibit # 1.

[7] Patients are identified in an Appendix to the Statement of Charges, Department's Exhibit # 1.

Respondent admits to being licensed to practice medicine in New York; admits she treated all of the patients indicated in the Statement of Charges; admits she ordered the various tests; and that she prescribed the various medications. Respondent admits to having an agreement with her landlord which included the expenses of the practice. Respondent denies the remainder of the Statement of Charges. Respondent denies each specification of misconduct (Respondent's Exhibit # A).

The Hearing consisted of three (3) separate days. The Department called two (2) witnesses, including Dr. Talvy. Respondent called one (1) witness (herself).

PROCEDURAL HISTORY

Date of Notice of Hearing:	September 20, 1999
Date of Service of Notice of Hearing:	October 2, 1999
Date of Statement of Charges:	September 20, 1999
Date of Service of Statement of Charges:	October 2, 1999
Answer to Statement of Charges:	November 9, 1999
Pre-Hearing Conference Held:	October 25, 1999
Hearings Held: - (First Hearing day):	November 17, 1999 December 1, 1999; and December 20, 1999
Department's Proposed Findings of Fact, And Conclusions of Law:	Received January 19, 2000
Respondent's Proposed Findings And Conclusions of Law:	Received January 20, 2000
Deliberations Held: - (Last Hearing day):	February 9, 2000
Hearing Committee's Recommendation to the Commissioner	February 14, 2000
Commissioner's Order	February 18, 2000

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. **Where there was conflicting evidence or testimony, the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence.** All Findings and Conclusions herein were unanimous. The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was licensed to practice medicine in New York State on August 1, 1972 by the issuance of license number 113962 by the New York State Education Department (Department's Exhibits # 1 and # 13)[8].

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent had no objection regarding personal service effected on her); (P.H.L. §230[10][d]); (Department's Exhibit # 1); [P.H.T-44-45][9].

GENERAL FINDINGS

Perform, take, or record adequate history of the patient

3. On an initial visit with a physician, the physician should record in the patient's medical record the patient's chief complaint or immediate problem, or some explanation of the reason for the visit. The patient's medical record should also include information concerning the patient's medical history of the immediate presenting complaint, a medical history of any prior

[8] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit) or submitted by Dr. Lourdes D. Talvy (Respondent's Exhibit).

[9] Numbers in brackets refer to Hearing transcript page numbers [T-]; to Pre-Hearing transcript page numbers [P.H.T-] or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee did not review the Pre-Hearing or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

diagnoses or chronic problems, a history of prior surgical procedures, a history of the medications the patient is currently taking, an allergy history, a history of the use of alcohol, tobacco, or illegal drugs, and a social and family history of the patient [T-354-357, 362].

Perform, take, or record adequate physical of the patient

4. A reasonably prudent physician performs a general physical examination of the patient at the first visit. At minimum, the physical examination should include: pulse rate; weight; height; examination of the complaining area [T-364-365].

Record adequate findings, diagnoses or treatment plan for the patient

5. A reasonably prudent physician records her findings, diagnoses and/or treatment plans or options in the patient's medical record at the first visit [T-366-367].

Electrocardiograms - EKG

6. A reasonably prudent physician, who orders electrocardiograms ("**EKG**") performed on her patients would include a written interpretation of the EKG in the patient's medical record. The purpose of having a written interpretation of an EKG in a patient's medical record includes: (a) so that the physician may recall her interpretation at a subsequent time; (b) for the benefit of other medical professionals or physicians who may need to review the interpretation; (c) for purposes of making a referral to another physician; and (d) for purposes of transfer of care [T-358-359, 368-369].

7. It is a deviation from the standard of care for a physician who reads an EKG not to create a written report of the reading [T-397-398, 406].

Buspar

8. Buspar is a medication generally prescribed for anxiety. Buspar does not have an immediate anti-anxiety quality; it does not take effect for several days. Buspar needs to be prescribed chronically. Buspar is not appropriate for insomnia [T-357, 386].

9. The starting dose of Buspar is generally 7.5 milligrams, 2 times a day (or 5 milligrams, 3 times a day and goes up to 60 milligrams per day) (Respondent's Exhibit D); [T-358].

10. When a medication is being used for placebo effect, or in a sub-clinical dose, or for any purpose other than its indicated purpose, a note to that effect should be made in the patient's medical record explaining the reason for the non-typical use [T-382].

11. Respondent ordered Buspar for insomnia on the incorrect assumption that all insomnia is related to anxiety and/or depression [T 62, 67-70, 109, 185, 374-376].

Pelvic exam and pap smear

12. It is appropriate for a general practitioner to inquire of a female patient when she had her last pap smear and whether she had gynecological complaints in the past to determine whether a pap smear or pelvic exam is indicated [T-360-361, 364-365, 432].

13. Pap smears should be performed up to the age of 65, but generally into the 60's being an acceptable range, with frequency determined by a patient's history [T-360].

14. It is not acceptable for a physician to unilaterally decide that she is not going to address gynecological issues without informing her patients that they should be seeking gynecological care elsewhere. There should be some documentation in the patient's medical record regarding the status of her last pap smear and pelvic exam [T-360-361].

15. A pap smear is a screening test and a physician should ensure that it is performed, whether by the physician or by a referral. A specific complaint is not necessary for a pap smear to be indicated. [T-377-378, 380].

Names of other (prescribing) physicians of Respondent's patients

16. Respondent claimed she would never change a patient's prescriptions from those being prescribed by another physician, but recorded no other physician's name in the record of any of the ten (10) patients reviewed [T-214-215].

PATIENT A (FACTUAL ALLEGATIONS A.1. through A.4.)

17. Respondent treated Patient A from November 15, 1993, to February 22, 1994. Respondent ordered blood testing and an EKG for Patient A (Department's Exhibit # 2).

18. Respondent failed to perform, take or record an adequate history of Patient A (see Finding # 3 above); (Department's Exhibit # 2); [T-39-41, 362-363].

19. Respondent failed to perform, take, or record an adequate physical of Patient A (see Finding # 4 above); (Department's Exhibit # 2); [T-42, 363-365].

20. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient A (see Finding # 5 above); (Department's Exhibit # 2); [T-366-367].

21. Respondent did not note a primary physician's name in Patient A's medical record (see Finding # 16 above); (Department's Exhibit # 2); [T-367].

22. It is unclear from Respondent's records what Patient A's chief complaint was on the first office visit (Department's Exhibit # 2); [T-363].

23. Patient A returned for an EKG on November 17, 1993. Respondent did not note an order for an EKG in Patient A's medical record. Respondent did not note her order for blood testing in Patient A's medical record (Department's Exhibit # 2).

24. Respondent did not create a written report or interpretation of the EKG she ordered for Patient A (see Findings # 6 & 7 above); (Department's Exhibit # 2); [T-71-72, 74-75, 110-111, 369, 541-542].

25. Respondent did not note the history of Patient A's sleep problem [T-370].

26. Respondent did not record any information concerning possible causes of Patient A's reported insomnia [T-62-63].

27. Respondent did not ask if Patient A had had an EKG or blood testing in the previous twelve months [T-97, 120-121].

28. Respondent did not take Patient A's pulse at the February 22, 1994, visit despite the fact that Respondent had prescribed Atenolol (a medication which slows the pulse), at the previous office visit (Department's Exhibit # 2); [T-61-62].

29. Respondent should have taken Patient A's pulse at the February 22, 1994 office visit [T-371].

30. Respondent prescribed a different medication for the patient's hypertension at the February 22, 1994 office visit. Respondent did not record the reason for the change in medication anywhere in Patient A's medical record (Department's Exhibit # 2); [T-63, 372].

31. Respondent ordered Buspar for insomnia on the assumption that all insomnia is related to anxiety and/or depression [T 62, 67-70, 109, 185, 374-376].

32. Respondent did not note anxiety or depression as one of Patient A's symptoms [T-70, 370].

33. Respondent ordered one 5 milligram dose of Buspar at bedtime daily (Department's Exhibit # 2); [T-69].

34. Respondent's dose of 5 milligrams of Buspar at bedtime was an ineffective dose and of no clinical value (Respondent's Exhibit # D); [T-109, 386].

35. Based on the information in Patient A's medical record, a reasonably prudent physician would not have prescribed Buspar for Patient A (see Findings # 8, 9, 10 & 11 above); (Department's Exhibit # 2); [T-370-371].

36. Respondent did not inform Patient A's other physician of what Respondent described as an enlarged heart and "ischemic changes" in Patient A's EKG (Department's Exhibit # 2); [T-70-73, 111].

37. Respondent's testimony that she told Patient A that her EKG was abnormal and that Patient A should follow up with her doctor is not credible given Respondent's other testimony concerning: (a) the difficulty of communicating with this patient; (b) the fact that Respondent did not note the name of the other physician in Patient A's medical record; (c) the fact that Respondent never wrote an interpretation of the EKG to send to the other physician; and (d) the fact that Respondent did not inquire or record why Procardia had been prescribed to Patient A (Department's Exhibit # 2); [T-78-79, 372].

PATIENT B (FACTUAL ALLEGATIONS B.1. through B.3.)

38. Respondent treated Patient B from January 8, 1994, to February 6, 1994. Respondent ordered blood testing and an EKG for Patient B (Department's Exhibit # 3).

39. Respondent failed to perform, take or record an adequate history of Patient B (see Finding # 3 above); (Department's Exhibit # 3); [T-388-389].

40. Respondent failed to perform, take, or record an adequate physical of Patient B (see Finding # 4 above); (Department's Exhibit # 3); [T-143, 389, 391-392].

41. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient B (see Finding # 5 above); (Department's Exhibit # 3).

42. Respondent did not note a primary physician's name in Patient B's medical record (Department's Exhibit # 3).

43. Patient B returned for an EKG on January 11, 1994. Respondent did not note an order for an EKG in Patient B's medical record. Respondent did not note her order for blood testing in Patient B's medical record (Department's Exhibit # 3).

44. Respondent did not ask if Patient B had had an EKG or blood testing in the previous twelve months [T-97, 120-121].

45. Respondent did not create a written report or interpretation of the EKG she ordered for Patient B (see Findings # 6 & 7 above); (Department's Exhibit # 3); [T-71-72, 74-75, 146, 393, 541-542].

46. Respondent did not record any current medications for this patient, although she prescribed Lopressor (Department's Exhibit # 3); [T-388, 390].

47. Respondent did not take or record sufficient information concerning Patient B's complaint of headaches and nose bleeds (Department's Exhibit # 3); [T-148-149].

48. It is important to take a patient's pulse when a patient is on a beta blocker such as Lopressor [T-390-391].

49. Respondent did not perform or record a neurological examination or a head, eyes, ears, nose, and throat examination on a patient complaining of headache and nose bleeding [T-142, 144].

50. Respondent did not perform a rectal examination on a patient with a colon resection in 1990 [T-142].

51. Respondent did not indicate how much Lopressor she prescribed for Patient B (Department's Exhibit # 3); [T-391].

52. On January 12, 1994, the results of Patient B's blood testing revealed that she had elevated SGOT and SGPT levels, which generally indicates some liver inflammation. The elevated SGOT and SGPT levels could be related to Patient B's colon resection, if the colon resection was related to cancer. Respondent did not elicit or record any further information in Patient B's medical record concerning Patient B's colon resection (Department's Exhibit # 3); [T-146-147, 392, 395].

53. Respondent should have tried to ascertain from history, and subsequently from additional evaluation or testing, the explanation for Patient B's abnormal blood tests [T-392-393].

54. Respondent did not conduct any additional evaluation or testing on Patient B after Respondent received the results of the blood tests (Department's Exhibit # 3).

55 Respondent noted no referral (for a Gastroenterology consultation or to Patient B's primary care physician) in Patient B's medical record as a result of Patient B's elevated liver enzymes (Department's Exhibit # 3); [T-147].

56. Respondent testified that she believed that Patient B's EKG evidenced "borderline ischemic changes" because of negative T waves [T-144, 397].

57. Patient B's EKG was basically normal, but if Respondent believed that there was any abnormality in the EKG, she should have noted the problems in her record and in a written interpretation of the EKG [T-395-396].

PATIENT C (FACTUAL ALLEGATIONS C.1. through C.5.)

58. Respondent treated Patient C from September 29, 1993, to February 22, 1994. Respondent ordered blood testing, an EKG and a mammogram for Patient C (Department's Exhibit # 4).

59. Respondent failed to perform, take or record an adequate history of Patient C (see Finding # 3 above); (Department's Exhibit # 4); [T-403].

60. Respondent failed to perform, take, or record an adequate physical of Patient C (see Finding # 4 above); (Department's Exhibit # 4); [T-403-404, 409, 414].

61. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient C (see Finding # 5 above); (Department's Exhibit # 4).

62. Respondent did not note a primary physician's name in Patient C's medical record (Department's Exhibit # 4); [T-161-162].

63. Respondent did not ask if Patient C had had an EKG or blood testing in the previous twelve months [T-97, 120-121].

64. Although Respondent ordered an EKG for Patient C, there is nothing in the record to show whether an EKG was done on Patient C (Department's Exhibit # 4); [T-405].

65. Respondent elicited no additional information from Patient C concerning the pain the patient perceived in her left scapula. Respondent should have explored this symptom to attempt to gather additional information (Department's Exhibit # 4); [T-403-404].

66. Respondent did not record a weight or pulse or examine the patient's lungs at the second office visit (Department's Exhibit # 4); [T-408].

67. Respondent never took or recorded a pulse rate on this patient (Department's Exhibit # 4); [T 414].

68. On January 5, 1994, Patient C returned with a complaint of coughing. Respondent noted that she "advised" the patient at this January 5, 1994, visit, but did not record what the advice was (Department's Exhibit # 4); [T 159-160].

69. Respondent's management note that she "advised" the patient without more does not comport with minimum standards of care [T-409].

70. At the February 22, 1994, office visit the Respondent noted that Patient C complained of chest pain (Department's Exhibit # 4).

71. Respondent should have taken a more detailed history of the symptom of chest pain including information concerning whether it was related to exertion, whether anything was related to the initiation of the pain, what relieved the pain, whether it had been previously evaluated [T-410-411].

72. At the February 22, 1994 visit by Patient C, Respondent noted a heart murmur (grade 3 - a significant murmur) for the first time (Department's Exhibit # 4); [T-157, 411, 418].

73. No additional information is contained in Patient C's medical record regarding her chest pain and heart murmur even though Respondent had not heard a heart murmur on this patient in her prior visits (Department's Exhibit # 4).

74. Respondent should have tried to immediately follow up on the chest pain and heart murmur by either ordering some additional testing to begin the evaluation herself, or by making an appropriate referral for evaluation [T-412, 414, 422].

75. There is no indication in Patient C's medical record that Respondent either undertook additional evaluation of this murmur herself or made an appropriate referral (Department's Exhibit # 4).

76. At the March 21, 1994, office visit the patient complained of a fracture of left wrist three days previously (Department's Exhibit # 4).

77. Respondent should have recorded additional information on how the fracture occurred, should have inquired and noted whether there were any predisposing factors, and should have determined whether the patient was getting appropriate treatment [T-413].

78. The failure to elicit further information about Patient C's fracture was a deviation from accepted medical standards [T-413].

79. Respondent believes that her finding of "a regular sinus rhythm" means that the person has a normal pulse [T-418-419].

80. In order to diagnose a regular sinus rhythm it is necessary to perform an EKG at the time of diagnosis [T-421].

81. Respondent did not perform an EKG on Patient C at any visit at which she noted a regular sinus rhythm (Department's Exhibit # 4).

82. Regular sinus rhythm does not refer to a pulse rate. A pulse rate is taken by recording the patient's pulse [T-419].

83. Respondent testified that she diagnosed arteriosclerotic heart disease on the basis of the patient's bronchitis, hypertension and age [T-153].

84. Respondent admitted that, although she diagnosed arteriosclerotic heart disease at the patient's first office visit, Respondent did not hear the murmur until the third visit (Department's Exhibit # 4); [T-153-154].

85. There is insufficient information in the medical record of Patient C to conclude that Patient C had arteriosclerotic heart disease (Department's Exhibit # 4); [T-404-405].

PATIENT D (FACTUAL ALLEGATIONS D.1. through D.4.)

86. Respondent treated Patient D from October 11, 1993, to February 27, 1994. Respondent ordered blood testing and an EKG for Patient D (Department's Exhibit # 5).

87. Respondent failed to perform, take or record an adequate history of Patient D (see Finding # 3 above); (Department's Exhibit # 5); [T-424].

88. Respondent failed to perform, take, or record an adequate physical of Patient D (see Finding # 4 above); (Department's Exhibit # 5); [T-424].

89. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient D (see Finding # 5 above); (Department's Exhibit # 5).

90. Respondent did not note a primary physician's name in Patient D's medical record (Department's Exhibit # 5).

91. Respondent did not ask if Patient D had had an EKG or blood testing in the previous twelve months [T-97, 120-121].

92. It is unclear from Respondent's records what Patient D's chief complaint was on the first office visit (Department's Exhibit # 5); [T-424].

93. Respondent did not note in Patient D's medical record her order for blood testing for this Patient (Department's Exhibit # 5).

94. Respondent did not record any information concerning the possible causes of Patient D's reported insomnia [T-62-63, 185, 428-429].

95. Respondent prescribed Zantac for Patient D. There is insufficient information in Patient D's medical record to conclude that Zantac was indicated or appropriate for Patient D (Department's Exhibit # 5); [T-425-426, 435].

96. Respondent ordered one 10 milligram dose of Buspar per day for Patient D (Department's Exhibit # 5).

97. Respondent's dose of 10 milligrams of Buspar per day was an ineffective dose and of no clinical value (Respondent's Exhibit # D); [T-109, 386].

98. Based on the information in Patient D's medical record, a reasonably prudent physician would not have prescribed Buspar for Patient D (see Findings # 8, 9, 10 & 11 above); (Department's Exhibit # 5); [T-429].

99. Patient D was 63 years old at her first office visit to Respondent. The lack of performance of a pelvic exam or a pap smear was within minimally accepted medical standards (see Finding # 13); (Department's Exhibit # 5).

PATIENT E (FACTUAL ALLEGATIONS E.1. through E.6.)

100. Respondent treated Patient E from October 4, 1993, to March 13, 1994. Respondent ordered blood testing, a pulmonary function test and an EKG for Patient E (Department's Exhibit # 6).

101. Respondent failed to perform, take or record an adequate history of Patient E (see Finding # 3 above); (Department's Exhibit # 6); [T-440].

102. Respondent failed to perform, take, or record an adequate physical of Patient E (see Finding # 4 above); (Department's Exhibit # 5); [T-440].

103. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient E (see Finding # 5 above); (Department's Exhibit # 6).

104. Respondent did not ask if Patient E had had an EKG or blood testing in the previous twelve months [T-97, 120-121].

105. Respondent did not note in Patient E's medical record her order for an EKG, blood testing, or pulmonary function test for this Patient (Department's Exhibit # 5).

106. There is no written interpretation of Patient E's EKG in Patient E's medical record (see Findings # 6 & 7 above); (Department's Exhibit # 6); [T-442].

107. Respondent prescribed Glucotrol for Patient E purportedly because the patient was already being prescribed Glucotrol, but Respondent did not record the name of the patient's other (prescribing) physician in the Patient E's medical record (Department's Exhibit # 6); [T-214-215].

108. Respondent never recorded any information concerning the possible causes of Patient E's reported insomnia (Department's Exhibit # 6).

109. Respondent did not take or record adequate information concerning Patient E's complaint of cough at the January 8, 1994 office visit (Department's Exhibit # 6); [T-443-444].

110. Respondent noted that Patient E had chronic coughing at the January 8, 1994 visit and diagnosed chronic bronchitis (Department's Exhibit # 6); [T-203-204].

111. Respondent had also noted in Patient E's medical record that Patient E was taking Vasotec, a medicine used to treat hypertension, when Patient E first came to Respondent (Department's Exhibit # 6).

112. Respondent prescribed Vasotec for Patient E at every office visit (Department's Exhibit # 6); [T443-444].

113. The most common side effect of Vasotec is cough [T-209, 443].

114. Respondent noted in the history of this patient at the first office visit that Patient E had long term complaints of chronic bronchitis and hypertension (Department's Exhibit # 6); [T-448].

115. It is important to clarify a diagnosis of chronic bronchitis through an appropriate history and physical examination [T-448-456].

116. There is no indication in Patient E's medical record that Respondent ever reviewed the pulmonary function test to either confirm or rule out chronic bronchitis for Patient E (Department's Exhibit # 6); [T-456-457].

117. Patient E had diabetes (Department's Exhibit # 6); [T-444-445].

118. Respondent prescribed Glucotrol for Patient E throughout the period of time that Respondent treated her (Department's Exhibit # 6).

119. Respondent never tried to contact any other physician concerning Patient E's diabetes [T-207, 445-446].

120. Patient E had a blood sugar of 230 on January 11, 1994, yet Respondent continued to prescribe the same medication that the patient was taking on January 11th and at each subsequent office visit (Department's Exhibit # 6); [T-211, 446].

121. Respondent should have ordered additional testing to determine the general level of control that this patient had over her diabetes [T-446].

122. Respondent never repeated the blood glucose test or performed any other testing (Department's Exhibit # 6); [T-211-212, 446].

123. Respondent should have intervened in some manner to address Patient E's high blood sugar and diabetes [T-446].

124. Patient E was 61 years old at her first office visit to Respondent. The lack of performance of a pelvic exam or a pap smear was within minimally accepted medical standards (see Finding # 13); (Department's Exhibit # 6).

125. Respondent ordered one 10 milligram dose per day of Buspar for Patient E (Department's Exhibit # 6).

126. Respondent's dose of 10 milligrams per day of Buspar was an ineffective dose and of no clinical value (Respondent's Exhibit # D); [T-442, 447-448, 109, 386].

127. Based on the information in Patient E's medical record, a reasonably prudent physician would not have prescribed Buspar for Patient E (see Findings # 8, 9, 10 & 11 above); (Department's Exhibit # 6).

PATIENT F (FACTUAL ALLEGATIONS F.1. through F.6.)

128. Respondent treated Patient F from November 6, 1993 to January 10, 1994. Respondent ordered blood testing and an EKG for Patient F (Department's Exhibit # 7).

129. Respondent failed to perform, take or record an adequate history of Patient F (see Finding # 3 above); (Department's Exhibit # 7); [T-458, 460].

130. Respondent failed to perform, take, or record an adequate physical of Patient F (see Finding # 4 above); (Department's Exhibit # 7); [T-234, 460, 464].

131. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient F (see Finding # 5 above); (Department's Exhibit # 7).

132. Respondent did not ask if Patient F had had an EKG or blood testing in the previous twelve months [T-97, 120-121].

133. Respondent did not note in Patient F's medical record her order for an EKG and blood testing for this Patient (Department's Exhibit # 7).

134. Respondent did not create a written report or interpretation of the EKG she ordered for Patient F (see Findings # 6 & 7 above); (Department's Exhibit # 7); [T-71-72, 74-75, 110-111, 463-464, 541-542].

135. Respondent prescribed Isosorbide for Patient F purportedly because the patient was already being prescribed Isosorbide, but Respondent did not record the name of Patient F's prescribing physician in Patient F's medical record (Department's Exhibit # 7); [T-214-215].

136. Respondent made no inquiry concerning the patient's complaint of bad nerves for one year and the patient's emotional state (Department's Exhibit # 7); [T-460].

137. Respondent did not adequately explore Patient F's chief complaint of chest pain at the November 3, 1993 visit (first visit); (Department's Exhibit # 7); [T-471-472].

138. Respondent did not adequately explore the issue of the patient's complaint of headaches (in terms of history) (Department's Exhibit # 7); [T-461-462].

139. Respondent did not conduct a head, neck or neurological examination of Patient F at any office visit (Department's Exhibit # 7) [T-461-462].

140. At a bare minimum, Respondent should have conducted a head and neck and a limited neurological exam [T-461].

141. Respondent's explanation that she heard a regular sinus rhythm is inadequate to explain Respondent's failure to take and record a pulse rate on a patient who is on several drugs for hypertension and angina [T-234].

142. Respondent failed to take the patient's blood pressure, in a patient for whom she had prescribed hypertensive medication, on the patient's visit on January 10, 1994 (Department's Exhibit # 7).

143. Patient F passed a stone in her urine on January 10, 1994 (Department's Exhibit # 7); [T-227, 464-465].

144. Respondent should have ordered a urinalysis to determine whether there was any infection associated with the stone, or whether there was any blood in the urine which might have indicated that the stone may not have completely passed [T-465].

145. Respondent did not order a urinalysis (Department's Exhibit # 7); [T 227-230].

146. Either a urinalysis or other diagnostic workup might have been able to help identify the type of stone the patient had and could have helped in the treatment plan for this patient [T-466].

147. It was a deviation from accepted medical standards not to have ordered a urinalysis, other diagnostic workup or a referral for this patient [T-466-470].

148. Respondent testified that Patient F told her that her headaches were related to the nitroglycerin the patient was taking, but there is no note to this effect in Patient F's medical record (Department's Exhibit # 7); [T-580-581].

149. Respondent did not explore the manner in which this patient took her nitroglycerin (Department's Exhibit # 7).

150. Respondent did not adequately explore the issue of the patient's complaint of headaches (in terms of history) [T-461-462].

151. Respondent did not conduct a head, neck or neurological examination of this patient at any office visit (Department's Exhibit # 7); [T 461-462].

152. If Respondent's testimony that this patient was already on Lopressor and Procardia before she came to see Respondent is true, then Respondent failed to record those medications as current medications at the patient's first office visit (Department's Exhibit # 7); [T-235-236, 462-463, 473].

153. There is no indication in Patient F's medical record why Respondent prescribed both Procardia and Lopressor at the same time (Department's Exhibit # 7); [T-462-463].

154. It cannot be determined from the medical record of this patient whether it was appropriate or not to prescribed Patient F both medications [T-463].

PATIENT G (FACTUAL ALLEGATIONS G.1. through G.2.)

155. Respondent treated Patient G from October 6, 1993 to February 21, 1994. Respondent prescribed antidepressant medication for Patient G (Department's Exhibit # 8).

156. Respondent failed to perform, take or record an adequate history of Patient G (see Finding # 3 above); (Department's Exhibit # 8); [T-263-264, 474-475].

157. Respondent failed to perform, take, or record an adequate physical of Patient G (see Finding # 4 above); (Department's Exhibit # 8); [T-476].

158. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient G (see Finding # 5 above); (Department's Exhibit # 8); [T-267-268].

159. Respondent should have recorded some further information to clarify the patient's present illness information (Department's Exhibit # 8); [T-475].

160. Respondent took no psychiatric history from a patient complaining of depression, including but not limited to whether she had ever had any treatment (Department's Exhibit # 8); [T-475-476, 480].

161. Respondent should have described the patient's present mood or mental status [T-476].

162. Respondent changed Patient G's antidepressant medication from Prozac to Zoloft and then back to Prozac. Respondent should have recorded her reasons for changing this patient's medication. (Department's Exhibit # 8); [T-214-215, 242, 476].

163. Respondent's claim that this patient was being seen by a psychiatrist is not credible in light of the many months of treatment she provided this patient, the fact that the psychiatrist's name is not noted in the patient's medical record, and the fact that at the last recorded visit Respondent referred Patient G to a psychiatrist (Department's Exhibit # 8); [T-261-263, 586].

164. Respondent did not inquire of Patient G (53 years old) when her last pap smear was performed or about her gynecological history of complaints (Department's Exhibit # 8).

165. Respondent did not perform a pelvic exam or a pap smear on Patient G nor refer the patient to another physician for gynecological care (see Findings # 12, 13, 14 & 15 above); (Department's Exhibit # 8); [T-478].

PATIENT H (FACTUAL ALLEGATIONS H.1. through H.4.)

166. Respondent treated Patient H from December 14, 1993 to February 13, 1994. Respondent ordered blood testing, an EKG and a mammogram for Patient H (Department's Exhibit # 9).

167. Respondent failed to perform, take or record an adequate history of Patient H (see Finding # 3 above); (Department's Exhibit # 9); [T-481-482].

168. Respondent failed to perform, take, or record an adequate physical of Patient H (see Finding # 4 above); (Department's Exhibit # 9); [T-482].

169. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient H (see Finding # 5 above); (Department's Exhibit # 9).

170. Respondent did not ask if Patient H had had an EKG or blood testing in the previous twelve months [T-97, 120-121].

171. Respondent did not note in Patient H's medical record her order for an EKG and blood testing for this Patient (Department's Exhibit # 9).

172. Respondent did not create a written report or interpretation of the EKG she ordered for Patient H (see Findings # 6 & 7 above); (Department's Exhibit # 9); [T-483].

173. It is unclear from Respondent's medical records what Patient H's chief complaint was on the first office visit (Department's Exhibit # 9); [T-482].

174. Although Patient H complained of back pain when she returned to Respondent's office on February 5, 1994, Respondent apparently only examined Patient H's breasts on that date (Department's Exhibit # 9).

175. Patient H had a high cholesterol level as reported as part of her blood testing on December 15, 1993 (Department's Exhibit # 9); [T-284-285, 484].

176. Respondent did not note anywhere in the medical record of Patient H that Respondent had called the patient, or spoke to the patient, about the patient's high cholesterol level (Department's Exhibit # 9); [T-484-485, 494].

177. Respondent should have addressed this patient's high cholesterol level in some manner [T-485-486].

PATIENT I (FACTUAL ALLEGATIONS I.1. through I.3.)

178. Respondent treated Patient I from January 15, 1994 to March 11, 1994. Respondent ordered blood testing, a urinalysis and EKGs for Patient I (Department's Exhibit # 10).

179. Respondent failed to perform, take or record an adequate history of Patient I (see Finding # 3 above); (Department's Exhibit # 10); [T-494-495].

180. Respondent failed to perform, take, or record an adequate physical of Patient I (see Finding # 4 above); (Department's Exhibit # 10); [T-495-496].

181. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient I (see Finding # 5 above); (Department's Exhibit # 10).

182. Respondent noted that Patient I had a cardiologist, but ordered an EKG without any additional or immediate indication noted in the patient's medical record. The first EKG was performed on January 25, 1994 (Department's Exhibit # 10); [T-311, 496].

183. A second EKG was performed on Patient I on February 23. 1994 without any noted reason (Department's Exhibit # 10); [T-315-316, 496-497].

184. Respondent did not note in Patient I's medical record her orders for EKGs and blood testing for this Patient (Department's Exhibit # 10).

185. Respondent did not note the cardiologist's name in Patient I's medical record (Department's Exhibit # 10).

186. Respondent should have taken a more detailed history of Patient I's previous diagnoses and the medications she was taking [T-495].

187. Although Respondent testified that she advised this patient of her high cholesterol and high triglyceride level, advised her of an appropriate diet, and advised her to go back to her cardiologist, there is no note anywhere in Patient I's medical record of that information (Department's Exhibit # 10); [T-320-321].

188. Respondent noted in this patient's complaints for the February 17, 1994, that the patient noted a slow pulse and extrasystoles for a few weeks, but Respondent never took the patient's pulse at any visit (Department's Exhibit # 10); [T-312-313, 498].

189. Respondent diagnosed Arteriosclerotic Heart Disease at the patient's first visit on January 15, 1994 (Department's Exhibit # 10).

190. There is insufficient evidence in Patient I's medical record, including the two EKGs, that Patient I had Arteriosclerotic heart disease (Department's Exhibit # 10); [T-496-497, 499-500].

191. Respondent did not inquire of Patient I (55 years old) when her last pap smear was performed or about her gynecological history of complaints (Department's Exhibit # 10); [T-498].

192. Respondent did not perform a pelvic exam or a pap smear on Patient I nor refer the patient to another physician for gynecological care (see Findings # 12, 13, 14 & 15 above); (Department's Exhibit # 10); [T-377-378, 498].

PATIENT J (FACTUAL ALLEGATIONS J.1. through J.4.)

193. Respondent treated Patient J from January 8, 1994 to March 18, 1994. Respondent ordered blood testing and an EKG for Patient J (Department's Exhibit # 11).

194. Respondent failed to perform, take or record an adequate history of Patient J (see Finding # 3 above); (Department's Exhibit # 11); [T-502-503].

195. Respondent failed to perform, take, or record an adequate physical of Patient J (see Finding # 4 above); (Department's Exhibit # 11); [T-502-503].

196. Respondent failed to record adequate findings, diagnoses or a treatment plan for Patient J (see Finding # 5 above); (Department's Exhibit # 11).

197. Respondent did not ask if Patient J had had an EKG or blood testing in the previous twelve months [T-97, 120-121].

198. Respondent did not note an order for an EKG in Patient J's medical record. Respondent did not note her orders for blood testing in Patient J's medical record (Department's Exhibit # 11).

199. Respondent did not create a written report or interpretation of the EKG she ordered for Patient J (see Findings # 6 & 7 above); (Department's Exhibit # 11); [T-503-504].

200. Respondent did not note the history of Patient J's sleep problem (Department's Exhibit # 11).

201. On March 6, 1994 Respondent recorded a possible diagnosis of chickenpox in Patient J, but Respondent did not record whether this patient had previously had chickenpox (Department's Exhibit # 11); [T-347].

202. Respondent ordered a PSA test for this patient, but did not perform a rectal examination or feel the patient's prostate (Department's Exhibit # 11); [T-348].

203. Respondent ordered Buspar for insomnia on the assumption that all insomnia is related to anxiety and/or depression [T 62, 67-70, 109, 185, 374-376].

204. Respondent ordered one 10 milligram dose of Buspar at bedtime daily and reduced it to 5 milligram at the March 6, 1994 visit (Department's Exhibit # 11); [T-69].

205. Respondent's dose of 5 milligrams or 10 milligram dose per day of Buspar was an ineffective dose and of no clinical value (Respondent's Exhibit # D); [T-386].

206. Based on the information in Patient J's medical record, a reasonably prudent physician would not have prescribed Buspar for Patient J (Department's Exhibit # 11); [T-370-371, 503].

FACTUAL ALLEGATION K

207. Respondent worked at The Brighton Beach Clinic in Brooklyn ("**Clinic**"), New York, in 1993 and 1994 [T-18-19].

208. Respondent entered into an agreement, with non-medical professional individuals from the Brighton Beach Clinic, to split her Medicaid billing in return for office and billing services and overhead expenses [T-21-24, 101-107].

209. The agreement by Respondent and the non-medical professional individuals was that they would receive forty percent of the billing and Respondent would receive sixty percent of the billing [T-23, 522-523].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions as to the allegations contained in the Statement of Charges were by unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the September 20, 1999, Statement of Charges, are **SUSTAINED:**[10]

First Paragraph [preamble - not numbered]		:[1]
Paragraphs: A., A.1., A.2., and A.3.	(Patient A)	:[3-11, 16-37]
Paragraphs: B., B.1., and B.2.	(Patient B)	:[3-7, 38-57]
Paragraphs: C., C.1., C.2. (in part), and C.4.	(Patient C)	:[3-5, 58-85]
Paragraphs: D., D.1., D.2., and D.3.	(Patient D)	:[3-5, 8-11, 86-98]
Paragraphs: E., E.1., E.2., E.3., E.4., and E.6.	(Patient E)	:[3-11, 100-126]
Paragraphs: F., F.1., F.2., F.3., and F.5.	(Patient F)	:[3-7, 128-154]
Paragraphs: G., G.1., and G.2.	(Patient G)	:[3-5, 12-15, 155-165]
Paragraphs: H., H.1., H.2., and H.4.	(Patient H)	:[3-7, 166-177]
Paragraphs: I., I.1., I.2., and I.3.	(Patient I)	:[3-5, 12-15, 178-192]
Paragraphs: J., J.1., J.2., and J.3.	(Patient J)	:[3-11, 193-206]
Paragraph: K.		:[207-209]

The Hearing Committee unanimously concludes that the following Factual Allegations, from the September 20, 1999 Statement of Charges, are **NOT SUSTAINED:**

Paragraph: A.4. (withdrawn)	(Patient A)	
Paragraph: B.3. (withdrawn)	(Patient B)	
Paragraphs: C.3. (withdrawn), and C.5.	(Patient C)	:[64]

[10] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee.

Paragraph: D.4.	(Patient D)	:[12-15, 99]
Paragraph: E.5.	(Patient E)	:[12-15, 127]
Paragraphs: F.4., and F.6. (withdrawn)	(Patient F)	:[152-154]
Paragraph: H.3. (withdrawn)	(Patient H)	
Paragraph: J.4. (withdrawn)	(Patient J)	

Based on the above, the complete Findings of Fact, and the entire record, the Hearing Committee concludes that the following Specifications of Charges are **SUSTAINED:**

FIRST SPECIFICATION: (NEGLIGENCE ON MORE THAN ONE OCCASION): Patients A, B, C, D, E, F, G, H, I and J.

SECOND SPECIFICATION: (GROSS NEGLIGENCE): Patients B, C, E H, and J.

THIRD SPECIFICATION: (INCOMPETENCE ON MORE THAN ONE OCCASION):): Patients B, C, E H, and J.

FOURTH SPECIFICATION: (GROSS INCOMPETENCE):): Patients B, C, E H, and J.

FIFTH THROUGH FOURTEENTH SPECIFICATIONS: (FAILING TO MAINTAIN RECORDS): Patients A, B, C, D, E, F, G, H, I and J.

FIFTEENTH SPECIFICATION: (SHARING FEES FOR PROFESSIONAL SERVICES): Paragraph K.

Based on the above, the complete Findings of Fact, and the entire record, the Hearing Committee concludes that the following Specifications of Charges are **NOT SUSTAINED:**

SECOND SPECIFICATION: (GROSS NEGLIGENCE): Patients A, D, F, G, and I.

THIRD SPECIFICATION: (INCOMPETENCE ON MORE THAN ONE OCCASION): Patients A, D, F, G, and I.

FOURTH SPECIFICATION: (GROSS INCOMPETENCE):): Patients A, D, F, G, and I.

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with fifteen (15) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a variety of forms or types of conduct which constitute professional misconduct.

The ALJ discussed with the Hearing Committee the types of medical misconduct alleged in this proceeding. These definitions were obtained from a memorandum, prepared by Henry M. Greenberg, General Counsel for the New York State Department of Health, dated November 25, 1999[11]. This document, entitled Definitions of Professional Misconduct under the New York Education Law, ("**Misconduct Memo**"), sets forth some suggested definitions of practicing the profession: (1) fraudulently; (2) with negligence on more than one occasion; (3) with gross negligence; (4) with incompetence on more than one occasion; and (5) with gross incompetence.

During the course of its deliberations on these charges, the Hearing Committee consulted the relevant definitions contained in the Misconduct Memo, which are as follows:

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

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence is negligence which involves serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences to the patient.

[11] A copy was provided to Respondent.

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 medicine. Gross Incompetence is incompetence that is significantly or seriously substandard and poses potentially grave consequences to the patient.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. All findings by the Hearing Committee were established on their own merits and based on the evidence presented. If evidence or testimony was presented which was contradictory, the Hearing Committee made a determination as to which evidence was more believable based on its observations as to credibility, demeanor, likelihood of occurrence and reliability.

The ALJ told the Hearing Committee, that under present law, injury, damages and proximate cause are not essential legal elements to be proved in a medical disciplinary proceeding. The State does not need to present evidence of injury to demonstrate that negligence has occurred or that substandard care was given; Matter of Morfesis v. Sobol, 172 A.D. 2d 897, leave to appeal denied 78 N.Y. 2d 856 (1991); Matter of Loffredo v. Sobol, 195 A.D. 2d 757, leave to appeal denied 82 N.Y. 2d 658 (1993).

Acceptable medical standards are based on what a reasonably prudent physician, possessed of the required skill, training, education, knowledge or experience to act as a physician, would do under similar circumstances (and having the same information, i.e.: without the benefit of hindsight). Proof that a physician failed to exercise the care that a reasonably prudent physician would exercise under the circumstances is sufficient to sustain a finding of negligence in a medical

misconduct proceeding; Matter of Bogdan v. NYS-BPMC, 195 A.D.2d 86 appeal dismissed and leave to appeal denied, 83 N.Y.2d 901 (1994).

A physician can make a mistake or an error in medical judgment without being negligent. However, a physician's decision or act which is without proper medical foundation or not the product of careful examination or deviates from acceptable medical standards or knowledge is more than a mere error in medical judgment; Krapvika v. Maimonides Medical Center, 119 A.D.2d 801, 805 (2d Dep't., 1986) (dissent- citing Bell v. New York City Health & Hosps. Corp. and Huntley v. State of New York [citations omitted]).

A medical record that fails to convey objectively meaningful medical information concerning the patient treated to other physicians is inadequate Matter of Bogdan v. NYS-BPMC, (*supra*). Where there is a relationship between inadequate record keeping and patient treatment, the failure to keep accurate records may constitute negligence. However, a record keeping violation which does not affect patient treatment will not constitute negligence Matter of Bogdan v. NYS-BPMC, (*supra*); Matter of Corines v. SBPMC, ___ A.D.3d ___ (3rd Dep't. 12/23/99); Matter of Schoenbach v. DeBuono, ___ A.D.3d ___ (3rd Dep't. 6/17/99).

The Hearing Committee used ordinary English usage and understanding for all other terms, allegations and charges. Other issues raised are addressed where appropriate.

With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility.

Dr. Richard J. Bonanno testified as the State's expert. The standards of care relevant to the ten patients and their presentation were articulated by Dr. Bonanno. Dr. Bonanno was Board Certified in Family Medicine in 1975 and has been recertified three times. He has medical staff appointments at 3 hospitals in New York. Dr. Bonanno testified that the patient records did not

meet the minimum standard of care. He discussed the importance of written interpretations of EKGs. He explained how Respondent did not understand the appropriate use and prescription of Buspar, or how to diagnose chronic bronchitis and Arteriosclerotic heart disease. Dr. Bonanno also explained how Respondent failed to respond appropriately when confronted with significant findings, whether of a heart murmur, high glucose in a diabetic, or in blood testing.

Dr. Bonanno was clear that in his opinion, the care provided by Respondent was well below the minimally accepted standard of care. Dr. Bonanno testified specifically about the patients in this case and rendered an opinion based on Respondent's records for these patients. The Hearing Committee did not find that Dr. Bonanno was biased against Respondent nor that he had any animus towards Respondent. The Hearing Committee accepts the testimony of Dr. Bonanno in its entirety. The Hearing Committee believes that Dr. Bonanno was fair in his review of the medical records and was not overly critical or faultfinding.

Obviously Respondent had the greatest amount of interest in the results of these proceedings. Although Respondent appeared to be sincere in her testimony, much of what she indicated was not supported by her medical records. In addition, the Hearing Committee could not accept Respondent's seesaw regarding her responsibilities as a physician to the 10 patients in issue (as well as to all of the patients she treated at the clinic). Respondent could not abdicate her role as a physician to non-physicians in the clinic. As a physician, Respondent could not be told who to see, what to do, and what tests to order. Respondent's excuses of language barrier is not believable in light of the numerous inconsistencies in the record. Except under an obvious emergency, if you cannot communicate with the patient you cannot treat the patient or prescribe medications to the patient. It is not adequate medical practice to prescribe medications and treat the conditions Respondent was treating, if she could not elicit proper medical histories or perform proper physicals.

Respondent failed to document, and could not state, who the referring physicians were, what other evaluations or treatments the patients had and, even though she testified that she sometimes communicated with the patients or other physicians, there is no such evidence in her records.

Using the above definitions and understanding, including the relevant portions of the remainder of the Misconduct Memo and the legal understanding set forth above, the Hearing Committee concludes by a unanimous vote that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State.

There are accepted standards of medical care that every physician must adhere to. When evaluating any patient, a reasonably prudent physician must thoroughly and appropriately assess the patient by taking an adequate history, performing an appropriate physical examination, ordering appropriate laboratory tests and, by considering and ruling out alternative diagnoses. Once the patient has been appropriately evaluated, a reasonably prudent physician makes a diagnosis and treats the patient accordingly. The entire evaluation process must be documented. Respondent failed to comply with these basic principles in caring for each of the patients in this case.

By failing to appropriately evaluate and diagnose her patients, Respondent failed to determine what conditions they had so she could appropriately treat them. By treating them inappropriately, with prescription refills, Respondent subjected them to non-treatment and unnecessary or undocumented testing.

A reasonably prudent physician must maintain records that accurately reflect the care and treatment rendered to a patient. One of the major purposes of medical records is to clearly document the clinical findings of the patient and the specific care and treatment rendered by the

physician. Records need to reflect this treatment to refresh the memory of the treating physician and so a subsequently treating physician knows the medical history of the patient.

Respondent failed to maintain records that accurately reflect the care and treatment rendered to her patients. No subsequently treating physician would be able to treat Respondent's patients by using her records; they would have to start over again. Respondent's records are substandard and evidence substandard medical care. Respondent failed to document a diagnostic and management plan for her patients. Respondent failed to document what medications she ordered and when and why she changed the medications. In fact, Respondent had difficulty reading her own records and answering questions based on her records.

The Hearing Committee looked at whether a reasonably prudent physician under similar circumstances to the facts in the instant case, would have acted as Respondent did. The preponderance of the evidence in this case supports an answer that a reasonably prudent physician, under similar circumstances, would not have acted as Respondent did in dealing with each of the ten patients in this case.

The facts presented evidenced an overall pattern of sub-standard medical care, regardless of the type of condition the patients presented. Respondent did not adequately work-up the patients, recorded very little information about them and failed to do independent evaluations on them.

On a number of occasions, the Hearing Committee found that Respondent was cavalier about the treatment she provided to her patients.

The Hearing Committee also determines that Respondent's failure to maintain proper medical records resulted in poor, inadequate and, at times, dangerous patient care. Respondent's lack of adequate medical records, by itself, constitutes findings of negligence on more than one occasion. These acts of negligence are separate and apart from the negligent acts committed by Respondent for the 10 patients discussed above.

The Department of Health has met its burden of proof as to: five (5) acts of gross negligence; five (5) acts of gross incompetence; five acts of incompetence; ten (10) acts of negligence; and ten (10) acts of failing to maintain accurate records as charged in the September 20, 1999 Statement of Charges. The Department of Health has proved a pattern and practice of sub-standard patient care. The Hearing Committee also sustains the charge that Respondent shared fees for professional services with non-professionals in violation of §6530(19) of the Education Law.

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with multiple instances of negligence with regard to the ten patients charged in this matter. In every case she has been charged with a failure to perform, take, or record adequate histories, physicals, findings and diagnoses or treatment. As discussed above Respondent's record keeping rises to the level of negligence. In addition, numerous charges of other specific instances of negligence with respect to each patient are sustained.

Respondent's testimony offered in mitigation of many of the charges in this matter that she was not the patients' primary care physician was unpersuasive. The Hearing Committee was particular troubled with Respondent's assertion that she prescribed sub-clinical doses of medications because she was "afraid" of medications; and/or that she was giving medications for, undocumented, placebo reasons. It would appear that with respect to the allegations involving negligent treatment and diagnoses that Respondent was not clear about the appropriate uses of medications, how to introduce medications, or the criteria for making certain diagnoses. Her failure to perform pelvic examinations and/or pap smears or arrange for same, on several occasions , and to follow up on significant patient complaints or test findings bespeak a physician who is not sufficiently astute to recognize the need to address certain problems either on a screening basis or as the result of findings.

The Hearing Committee finds and determines that Respondent has committed negligence on more than one occasion in all ten patients.

GROSS NEGLIGENCE AND GROSS INCOMPETENCE

On January 12, 1994, the results of Patient B's blood testing revealed that she had elevated SGOT and SGPT levels, which generally indicates some liver inflammation. If a proper history of Patient B had been taken and performed a reasonably prudent physician would be able to determine if Patient B's elevated SGOT and SGPT levels could be related to Patient B's colon resection (if the colon resection was related to cancer the most likely indication would be liver inflammation). Respondent did not elicit or record any further information in her record concerning Patient B's colon resection nor did Respondent send the patient to a specialist nor did Respondent do anything with that information. Respondent was grossly negligent in the treatment and care she provided to Patient B.

Respondent testified that she believed that Patient B's EKG evidenced "borderline ischemic changes" because of negative T waves. Considering this patient's other evidence in the medical record and if Respondent believed what she thought the EKG showed then she should have immediately sent this patient to the hospital. Respondent did nothing. Respondent was grossly negligent and grossly incompetent in the treatment and care she provided to Patient B.

On physical examination of Patient C at the February 22, 1994, visit the Respondent noted a heart murmur for the first time. Combined with this patient's other "history" (chest pains) and medication use, Respondent should have called an ambulance and sent the patient to the hospital. Respondent did nothing. Respondent was grossly negligent and grossly incompetent in the treatment and care she provided to Patient C.

As to Patient E, Respondent abdicated her responsibilities, was incompetent or was motivated by greed. The testing results are replete with contradictions. Respondent claims that she never changed prescriptions but she had no problem in changing this patient's prescriptions for no apparent reason. There is no indication in the medical record of this patient that Respondent ever

reviewed the pulmonary function test to either confirm or rule out a diagnosis. Respondent's conduct was a serious deviation from the standard of care. Respondent was grossly negligent and grossly incompetent in the treatment and care she provided to Patient E.

Patient H was found to have a lump on her breast. This is a woman who is in this country 2 months and who allegedly does not speak English. To have this woman sign the medical record is meaningless and wholly inadequate. Respondent was grossly negligent and grossly incompetent in the treatment and care she provided to Patient H.

Respondent diagnosed Patient J with chickenpox. Respondent admitted that chickenpox was a rare diagnosis for this adult. Respondent thought that Patient J had chickenpox because at the "same time [her] brother was having chickenpox and [she] thought it was running around the area". Subsequently, the patient came in and told her she had scabies. First, chickenpox and scabies looks entirely different. Second, 63 year old patients do not get chickenpox but if they do a reasonably prudent physician better make sure it is chickenpox. Third Respondent found out from the patient that her diagnosis was incorrect and that she really has scabies (which is "something similar to what my friend has" [T-347-348]). Respondent was grossly negligent and grossly incompetent in the treatment and care she provided to Patient J.

INCOMPETENCE ON MORE THAN ONE OCCASION

Since Respondent was found to be grossly incompetent in her care and treatment of Patients B, C, E, H, and J, she was incompetent on more than one occasion. Respondent's lack of knowledge of the appropriate use and dose of Buspar, a medication she repeatedly prescribed, was troubling. Respondent's failure to take pulse rates on patients who were on hypertensive medications which could slow their pulse rates was dangerous. Also dangerous was her failure to address abnormal test results in her patients. Respondent's failure to recognize the importance of

writing an interpretation of an EKG, a fundamental practice in medicine, also evidences her lack of ability and skill as a physician.

FAILING TO MAINTAIN RECORDS

Ample evidence has been presented that Respondent failed to maintain records which accurately reflect the evaluation and treatment of her patients (see discussions above and below). For all the reasons cited previously concerning the deficiency of Respondent's records, charges fifth through fourteenth are sustained.

SHARING FEES FOR PROFESSIONAL SERVICES

Respondent admitted that she entered into an agreement with the three women who hired her to split the Medicaid fees with them. One important reason fee splitting is strictly prohibited is because it gives a non-professional a financial interest in the professional's earnings and may compromise the professional's independent judgment. Indeed, it would appear that this is exactly what happened to Respondent. Respondent was told to order EKGs and blood testing on all patients apparently to allow the non-professionals to employ their ambulette service for their gain. Respondent testified variously about the number of patients she saw when she was at the Brighton Beach Clinic, but it would appear that she was very busy. A physician is licensed and trusted to make medical decisions solely in the best interest of the patient. When a physician's judgment is compromised by others, that physician has betrayed the trust invested in her. Respondent should have known that her agreement to split fees was wrong. A physician must understand the ethical parameters of her profession and must adhere to them. The Fifteenth Specification is sustained.

CHARGES NOT SUSTAINED

The Hearing Committee does not find that Respondent lacked the skill or knowledge of proper medical care as to Patients A, D, F, G, and I or that Respondent's conduct regarding Patients A, D, F, G, and I was egregious or posed potentially grave consequences as to those patients and we

do not sustain the charges of gross incompetence or the charge of incompetence on more than one occasion as to those patients. The Hearing Committee also does not sustain the charges of gross negligence as to those five patients (A, D, F, G, and I) because Respondent's conduct was short of being egregious.

DETERMINATION AS TO PENALTY

The Hearing Committee pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above determines, by a unanimous vote, determines that Respondent's license to practice medicine in the State of New York should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

Respondent did not want to take responsibility for the medications she was prescribing, stating that she only prescribed what had previously been prescribed by another physician. Respondent did not want to take responsibility for the patients' overall care, sometimes stating that these were not her patients, that each of the patients had another primary care physician, and that she only saw patients for minor complaints. Despite Respondent's denial that she was treating these patients for anything but their most immediate complaint, Respondent ordered EKGs and other tests on almost every patient at issue.. Respondent even claimed that she was unsure about her responsibility for the EKGs' and the blood testing ordered on virtually all of the patient's. Respondent blamed her inability to take appropriate histories and physicals on the fact that she could not speak to these Russian-speaking patients. Yet, Respondent admitted that the clinic managers

spoke Russian and English and that she failed to insist that one of them help translate for her in every case.

Respondent's persistent refrain that each of these patients had another physician who would have been their primary care physician, is belied by the fact that she never noted the primary physician's name in the patient's medical records, never informed the other physician of her findings, prescribed medications over prolonged periods of time, and noted a referral for a surgical consult when that was appropriate. Respondent's explanation that she only gave prescriptions for medications that had previously been prescribed by another physician is not credible.

It became apparent to the Hearing Committee that the central purpose of Dr. Talvy's practice, at the clinic, was to bill Medicaid. Contrary to Respondent's assertions, it did not appear that the health of the patients was of great significance.

The Hearing Committee believes that the conduct of Respondent in treating her patients, specifically Patients B, C, E, H and J, indicated a grave lack of understanding of patient care and medical requirements. The Hearing Committee believes, based on the testimony and the medical records presented, that these 5 patients were in potentially life threatening situations, unrecognized and unaddressed by Respondent.

The lack of documentation does not necessarily result in inadequate medical care or negligence. However, in the cases presented in this proceeding, the lack of documentation was so pervasive that it showed a pattern of not thinking thoroughly through the patient's medical problems and being careless, inattentive and inaccurate. All of these factors results in poor, inadequate and dangerous patient care.

Respondent's records deviated significantly from accepted medical standards both because of their deficiencies and their lack of accurate information. The negligence and inaccurate

records taken together would result in a finding by the Hearing Committee that the only appropriate sanction is revocation.

The five acts of gross negligence and gross incompetence by themselves would result in a finding by the Hearing Committee that the only appropriate sanction is revocation.

The Hearing Committee also believes that Respondent only decided to leave the clinic after she found out that the clinic was being investigated. The Hearing Committee believes that it is mere chance or a miracle that the patients at issue were not harmed or injured by Respondent's medical care or lack thereof (in reality, the Hearing Committee does not know that any of the patients did not suffer harm as a result of Respondent's conduct).

As a careless physician, Respondent is a unacceptable potential danger to the people of the State of New York. Respondent's conscious disregard of the tenets of good medicine was egregious and fell well below the degree of care that a reasonably prudent physician would have exercised under the same circumstances

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines the above to be the appropriate sanction under the circumstances. The Hearing Committee concludes that the sanction of revocation strikes the appropriate balance between the need to punish Respondent, deter future misconduct, and protect the public.

The Hearing Committee considers Respondent's misconduct to be very serious. No other available sanction is deemed sufficient to address Respondent's numerous acts of gross negligence, gross incompetence, negligence on at least 10 occasions, bad record keeping and fee splitting.

It must be noted and emphasized that the Hearing Committee determined that the penalty of revocation was the appropriate penalty **before** the ALJ shared with us a copy of Respondent's prior disciplinary action (1986) and the letters from the Department and from Respondent. The combination of this proceeding (and our findings) and the allegations of the prior actions and prior consent by Respondent caused the Hearing Committee to make the unusual recommendation, of immediate suspension, to the Commissioner of Health (Appendix II).

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

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

ORDER

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

1. The Specifications of professional misconduct contained within the Statement of Charges (Department's Exhibit # 1) as discussed herein are **SUSTAINED,** and

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

DATED: New York, New York
March 13 , 2000

KENNETH KOWALD
FILIPPO DI CARMINE, M.D.
RALPH LEVY, D.O.

Lourdes D. Talvy
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APPENDIX I

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

IN THE MATTER

OF

LOURDES D. TALVY, M.D.

STATEMENT

OF

CHARGES

LOURDES D. TALVY, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 1, 1972, by the issuance of license number 113962 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A from on or about November 15, 1993 to on or about February 22, 1994. Respondent ordered blood testing and an EKG for Patient A.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent inappropriately prescribed Buspar;
3. Respondent failed to interpret the EKG;
4. ~~Respondent failed to perform a pelvic or to perform a pap smear.~~

B. Respondent treated Patient B from on or about January 8, 1994, to on or about February 6, 1994. Respondent ordered blood testing and an EKG for Patient B.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent failed to interpret the EKG;
3. ~~Respondent failed to perform a pelvic or to perform a pap smear.~~

C. Respondent treated Patient C from on or about September 29, 1993, to on or about February 22, 1994. Respondent ordered blood testing, an EKG, and a mammogram for Patient C.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent inappropriately diagnosed arteriosclerotic and peripheral vascular disease;
3. ~~Respondent failed to perform a pelvic or to perform a pap smear;~~
4. Respondent failed to adequately follow up on a heart murmur;
5. Respondent failed to interpret the EKG she ordered.

D. Respondent treated Patient D from on or about October 11, 1993, to on or about February 27, 1994. Respondent ordered blood testing and an EKG.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent inappropriately prescribed Zantac;
3. Respondent inappropriately prescribed Buspar;
4. Respondent failed to perform a pelvic or to perform a pap smear.

E. Respondent treated Patient E from on or about October 4, 1993, to on or about March 13, 1994. Respondent ordered blood testing, a pulmonary function test, and an EKG.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent failed to interpret the EKG;
3. Respondent inappropriately diagnosed chronic bronchitis;
4. Respondent inadequately addressed Patient A's diabetes;
5. Respondent failed to perform a pelvic or to perform a pap smear;
6. Respondent inappropriately prescribed Buspar.

F. Respondent treated Patient F from on or about November 6, 1993, to on or about January 10, 1994. Respondent ordered blood testing and an EKG.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent failed to order a urinalysis and/or an appropriate abdominal X-ray;
3. Respondent failed to adequately explore the cause of Patient F's headaches;
4. Respondent inappropriately prescribed Procardia and Lopressor;
5. Respondent failed to interpret the EKG;
6. ~~Respondent failed to perform a pelvic or to perform a pap smear;~~

G. Respondent treated Patient G from on or about October 6, 1993, to on or about February 21, 1994. Respondent prescribed antidepressant medication.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent failed to perform a pelvic or to perform a pap smear.

H. Respondent treated Patient H from on or about December 14, 1993, to on or about February 13, 1994. Respondent ordered blood testing, an EKG, and a mammogram.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent failed to interpret the EKG;
3. ~~Respondent failed to perform a pelvic or to perform a pap smear;~~
4. Respondent failed to adequately address abnormal testing results.

I. Respondent treated Patient I from on or about January 15, 1994, to on or about March 11, 1994. Respondent ordered blood testing, a urinalysis and EKGs.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent inappropriately diagnosed arteriosclerotic heart disease;
3. Respondent failed to perform a pelvic or to perform a pap smear.

J. Respondent treated Patient J from on or about January 8, 1994, to on or about March 18, 1994. Respondent ordered blood testing, and an EKG.

1. Respondent failed to perform, take, or record adequate histories, physicals, findings, diagnoses or treatment;
2. Respondent inappropriately prescribed Buspar;
3. Respondent failed to interpret the EKG;
4. ~~Respondent failed to perform a pelvic or to perform a pap smear.~~

11/17/99

K. Respondent worked at The Brighton Beach Clinic in Brooklyn, New York, in or about 1993 and 1994, pursuant to an agreement with the owners of the clinic by which Respondent would have no administrative or business expenses and would receive sixty percent of all professional fees collected for her services.

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. 1999) 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 and/or A2 and/or A3 and/or ~~A4~~; and/or Paragraphs B and B1 and/or B2 and/or ~~B3~~; and/or Paragraphs C and C1 and/or C2 and/or ~~C3~~ and/or C4 and or C5; and/or Paragraphs D and D1 and/or D2 and/or D3 and/or D4; and/or Paragraphs E and E1 and/or E2 and/or E3 and/or E4 and/or E5 and/or E6; and/or Paragraphs F and F1 and/or F2 and/or F3 and/or F4 and/or F5 and/or ~~F6~~; and/or Paragraphs G and G1 and/or G2; and/or Paragraphs H and H1 and/or H2 and/or ~~H3~~ and/or H4; and/or Paragraphs I and I1 and/or I2 and/or I3; and/or Paragraphs J and J1 and/or J2 and/or J3 and/or ~~J4~~

SECOND SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

2. Paragraphs A and A1 and/or A2 and/or A3 and/or ~~A4~~; and/or Paragraphs B and B1 and/or B2 and/or ~~B3~~; and/or Paragraphs C

and C1 and/or C2 and/or C3 and/or C4 and or C5; and/or Paragraphs D and D1 and/or D2 and/or D3 and/or D4; and/or Paragraphs E and E1 and/or E2 and/or E3 and/or E4 and/or E5 and/or E6; and/or Paragraphs F and F1 and/or F2 and/or F3 and/or F4 and/or F5 and/or F6; and/or Paragraphs G and G1 and/or G2; and/or Paragraphs H and H1 and/or H2 and/or H3 and/or H4; and/or Paragraphs I and I1 and/or I2 and/or I3; and/or Paragraphs J and J1 and/or J2 and/or J3 and/or J4

THIRD 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. 1999) 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:

3. Paragraphs A and A1 and/or A2 and/or A3 and/or A4 and/or Paragraphs B and B1 and/or B2 and/or B3; and/or Paragraphs C and C1 and/or C2 and/or C3 and/or C4 and or C5; and/or Paragraphs D and D1 and/or D2 and/or D3 and/or D4; and/or Paragraphs E and E1 and/or E2 and/or E3 and/or E4 and/or E5 and/or E6; and/or Paragraphs F and F1 and/or F2 and/or F3 and/or F4 and/or F5 and/or F6; and/or Paragraphs G and G1 and/or G2; and/or Paragraphs H and H1 and/or H2 and/or H3 and/or H4; and/or Paragraphs I and I1 and/or I2 and/or I3; and/or Paragraphs J and J1 and/or J2 and/or J3 and/or J4

FOURTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

4. Paragraphs A and A1 and/or A2 and/or A3 and/or ~~A4~~; and/or Paragraphs B and B1 and/or B2 and/or ~~B3~~; and/or Paragraphs C and C1 and/or C2 and/or ~~C3~~ and/or C4 and or C5; and/or Paragraphs D and D1 and/or D2 and/or D3 and/or D4; and/or Paragraphs E and E1 and/or E2 and/or E3 and/or E4 and/or E5 and/or E6; and/or Paragraphs F and F1 and/or F2 and/or F3 and/or F4 and/or F5 and/or ~~F6~~; and/or Paragraphs G and G1 and/or G2; and/or Paragraphs H and H1 and/or H2 and/or ~~H3~~ and/or H4; and/or Paragraphs I and I1 and/or I2 and/or I3; and/or Paragraphs J and J1 and/or J2 and/or J3 and/or ~~J4~~.

FIFTH THROUGH FOURTEENTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) by failing to maintain a record for

each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

5. Paragraphs A and A1;
6. Paragraphs B and B1;
7. Paragraphs C and C1;
8. Paragraphs D and D1;
9. Paragraphs E and E1;
10. Paragraphs F and F1;
11. Paragraphs G and G1;
12. Paragraphs H and H1;
13. Paragraphs I and I1;
14. Paragraphs J and J1.

FIFTEENTH SPECIFICATION

SHARING FEES FOR PROFESSIONAL SERVICES

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(19)(McKinney Supp. 1999) by sharing the fees for professional services, as alleged in the facts of:

15. Paragraph K.

DATED: September 20, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

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

IN THE MATTER OF LOURDES D. TALVY, M.D.	HEARING COMMITTEE'S RECOMMENDATION TO THE COMMISSIONER

MR. KENNETH KOWALD (Chair), **FILIPPO DI CARMINE, M.D.**, and **RALPH LEVY, D.O.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health appeared by **DENISE LEPICIER, ESQ.**, Associate Counsel.

Respondent, **LOURDES D. TALVY, M.D.**, appeared personally and was represented by **SEGAL & TESSER, LEWIS TESSER, ESQ.**, of counsel, for the first day of Hearing and **HENRY DEGREEF, ESQ.**, for the last day of the Hearing. **DR. TALVY** was *pro se* the second day of the Hearing.

Hearings were held on November 17, December 1, and December 20, 1999. Evidence was received and examined. Transcripts of the proceeding were made. Deliberation was held on February 9, 2000. After consideration of the record, the Hearing Committee issues this Hearing Committee's Recommendation to the Commissioner of the New York State Department of Health.

LOURDES D. TALVY, M.D., ("**Respondent**") is charged with professional misconduct within the meaning of §§6530(3), (4), (5), (6), (19), and (32) of the Education Law of the State of New

A copy of the Statement of Charges is attached to this Hearing Committee Recommendation to the Commissioner as Appendix I

On February 9, 2000 the Hearing Committee deliberated after 3 days of Hearings and receipt of proposed findings and conclusions of law from the parties. The Hearing Committee unanimously decided to sustain a number of the specifications of gross negligence and gross incompetence. The Hearing Committee also unanimously sustained all of the remaining specifications of negligence on more than one occasion, incompetence on more than one occasion, failure to maintain adequate medical records and sharing fees for professional services. The Hearing Committee will be issuing its Determination and Order as required under Public Health Law §230(10). The Hearing Committee has determined that the only appropriate penalty in this matter is revocation of Respondent's license to practice medicine in the State of New York. A full discussion of the facts, conclusions and reasons for the penalty will be set forth in the Hearing Committee's Determination and Order.

During discussions of the 10 patients presented, the Hearing Committee was concerned that the conduct of Respondent in treating her patients, specifically, Patients B, C, E, H and J, indicated a grave lack of understanding of patient care and medical requirements. These Patients were in potentially life threatening situations, unrecognized and unaddressed by Respondent.

After the Hearing Committee had made its determination of the facts, conclusions and appropriate penalty, the ALJ provided to the Hearing Committee a copy of Respondent's prior disciplinary action (1986), together with a letter from the Department of Health, dated January 18, 2000, and a letter from Respondent, dated January 8, 2000 (copies are attached as Appendix II).

Based on the evidence presented in this proceeding, and reinforced by the information contained from the prior disciplinary action, the Hearing Committee strongly believes that Respondent has engaged, and continues to be engaged in conduct (the practice of medicine) which constitutes an imminent danger to the People of New York. The Hearing Committee strongly believes that it would be prejudicial to the interest and health of the People of New York to permit Respondent to continue to practice medicine. The Hearing Committee believes that Respondent's license should be immediately suspended pending the issuance of the Determination and Order.

Therefore, the Hearing Committee makes this unusual request and recommendation to the Commissioner of the Department of Health. The Hearing Committee recommends that Lourdes D. Talvy's license to practice medicine in the State of New York be immediately suspended.

By execution of this document, by the Chair, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding and are unanimous in their request.

DATED: **New York, New York**
February 14, 2000

MR. KENNETH KOWALD
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