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. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

November 10, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anthony Velez, M.D.
420 East 64th Street
New York, New York 10021-7853

Anthony Velez, M.D.
5 Beekman Street
New York, New York 10038

Marcia E. Kaplan, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

Nathan Dembin & Associates, P.C.
225 Broadway, Suite 1400
New York, New York 10007

RE: In the Matter of Anthony Velez, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-307) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:cah
Enclosure

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

COPY

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IN THE MATTER

OF

ANTHONY VELEZ, M.D.

---X

DETERMINATION

AND

ORDER

BPMC #00-307

The undersigned Hearing Committee consisting of **RICHARD D. MILONE M.D.**, chairperson, **JAMES J. DUCEY**, and **SHELDON GAYLIN, M.D.**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by ANTHONY VELEZ M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

SUMMARY OF PROCEEDINGS

Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Pre-Hearing Conferences:	July 12, 2000

Hearing dates:	August 9, 2000 August 21, 2000 September 15, 2000
Date of Deliberation:	October 5, 2000
Petitioner appeared by:	NYS Department of Health
	by: Marcia E. Kaplan, Esq. Associate Counsel
Respondent appeared:	Nathan Dembin & Associates, P.C.
	225 Broadway, Suite 1400 New York, N.Y. 10007 by: Nathan Dembin

WITNESSES

For the Department:	Alan Medina, M.D.
For the Respondent:	Anthony Velez, M.D. Leo Maniace, M.D.

SIGNIFICANT LEGAL RULINGS

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct. The Administrative Law Judge issued instructions to the Committee when asked regarding to the definitions of medical misconduct as alleged in this proceeding.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

FINDINGS OF FACT

1. Anthony Velez, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 2, 1972, by the issuance of license number 114448 by the New York State Education Department and was registered to practice medicine. (Dept. 2, 2-A and 2-B)

2. The Commissioner of Health Issued an Order summarily suspending Respondent's license to practice medicine on June 29, 2000. Respondent was personally served with the Commissioner's Order on July 6, 2000. (Dept. 1-A, Dept 1-B)

3. The Committee upheld the summary suspension of Respondent's license in an order dated October 30, 2000.

FINDINGS OF FACT AS TO PATIENTS A THROUGH L

4. Department's expert, Alan Medina M.D. is a board certified psychiatrist, who testified that he reviewed the medical records of Patients A through L and the interview of Dr. Velez with the Office of Professional Medical Conduct. (T. 54, 55)

5. Dr. Medina testified that it is routine for a reasonably prudent psychiatrist to perform a psychiatric evaluation of a patient. Such evaluation consists of asking the patient what is their chief complaint, past psychiatric history, past medical history, psychosocial evaluation consisting of patient's personal background (like a biography), history of substance abuse, alcohol abuse, history of physical or sexual abuse, suicidality and then a standard mental status examination which tests for alertness, orientation, questions about effect, cognition, perception, memory, impulse control

and judgment. From the facts received, there would be follow-up questions of suspected illnesses. (T. 55, 56)

6. Dr. Medina testified that the Respondent failed to note such an evaluation for any of Patients A through L. (T. 62; Dept. 5A, 6A, 7A, 8A, 9A, 10A, 11A, 12A, 13A, 14A, 15A, 16)

7. Dr. Medina testified that it is prudent that a psychiatrist rule out medical conditions which can contribute to the symptoms. For example, if a patient complains of feeling nervous, one should first rule out any reversible medical cause for that symptom. A prudent psychiatrist wants to make sure that the patient is (physically) healthy before that psychiatrist treats him for a psychiatric condition.(T. 58, 59)

8. Respondent's records of Patient's A through L contain no documentation of any physical examination or laboratory tests.(Dept. 5A, 6A, 7A, 8A, 9A, 10A, 11A, 12A, 13A, 14A, 15A, 16)

9. Dr. Medina testified that the Respondent's records for Patients A through L included the prior treating physician Dr. Jimenez. (T. 63)

10. Dr. Medina testified that Dr. Jimenez's evaluation of these Patients is minimal. Since there is a lapse of about a year before the Respondent saw the Patients, the absence of such examination is even more critical. (T. 63, 64)

11. Dr. Medina testified that a psychiatrist must formulate a diagnosis and treatment plan based upon the history obtained and taking into consideration the patient's social background. (T. 58;)

12. Respondent's records of Patient A through L failed to state a diagnosis and treatment plan. (Dept. 5A, 6A, 7A, 8A, 9A, 10A, 11A, 12A, 13A, 14A, 15A, 16). Dr. Medina testified that reading both Dr. Jimenez and Dr. Velez's notes and by piecing together the histories, many of the Patients were suffering from either depression and/or anxiety. However, the records were never clear, in an organized formal way. (T. 160, 161)

13. Dr. Medina testified that when a psychiatrist prescribes medications, the physician must evaluate the potential risks and benefits of treating the particular patient with the medicine. (T. 61)

14. Dr. Medina testified that the Respondent repeatedly prescribed medications without adequate medical indications to do so. (T. 55, 62, 66 - 67, 157 - 161, 192 - 193, 322, Dept. 5A, 6A, 7A, 8A, 9A, 10A, 11A, 12A, 13A, 14A, 15A, 16)

15. Dr. Medina testified that IV (intravenous) Valium is never appropriately prescribed by a psychiatrist in an office setting. He further stated that IV Valium is indicated for use in an emergency to treat status epilepticus, pre-medication for operative procedures, such as colonoscopies and endoscopies, or in hospital settings for cardiac procedures and to induce anterograde amenesia, to help the patient after the procedure to forget what happened to them (T. 66 - 67)

16. Respondent administered IV Valium (Diazepam, the generic name) inappropriately to Patients B, C, D, F, G, I and J. (Dept. 6A, 7A, 8A, 10A, 11A, 13A, 14A) Respondent's statements during his interview at OPMC about his reasons for administering IV Valium are as follows: (Dept. 3)

a. that Patient B was "extremely shaky and jittery and apprehensive" and

"10 milligrams IV a week equals 30 milligrams PO a week" (T. 115-116)

b. that Patient C "has a tendency to fall in love with young men, they threaten her and she gets shaky" and "by mouth it doesn't have the same effect."

c. that "every time [Patient D] goes to BCW, Bureau of Child Welfare, she gets extremely shaky. I give it to her to make it possible for her to pick up her child.... She sees me in the morning and goes about 3:00 in the afternoon."

d. that Patient F "causes trouble in the street, bothering people. It is the only way to get him into some kind of organized behavior. [The effect lasts] three days."

e. That Patient G "was crying, weeping, sobbing, because of early infantile trauma... She shut up with her crying and whimpering."

f. That Patient J "has a son in jail. Every time she goes to visit him, she goes crazy. I give it to her every time she was going for a visit to see him...[PO medication] doesn't have such an impact."

Dr. Medina testified that Respondent's answers to OPMC (Exhibit 3) as to the basis for administering IV Valium to his Patients is unacceptable medical practice. (T. 115 - 124)

17. Dr. Medina testified that minimum resuscitation equipment consists of blood pressure cuff, stethoscope. medication such as epinephrine and some way of maintaining an airway such as an Ambu Bag. (T. 153)

18. In February 2000, during an OPMC interview the Respondent was asked about his ability to resuscitate patients. The Respondent answered: "Oxygen and a mask. I threw it, the mask, away because it was very dirty. I discarded it last month." (Exhibit 3)

19. Dr. Medina stated that the combination of Valium and Demerol is contraindicated (T. 149) and could be life-threatening. (T. 142)

20. Dr. Medina testified that the Respondent deviated from acceptable minimal standards of care by inappropriately administering IV Valium along with IM (intramuscular) Demerol to Patients C, G, and J. (T. 93 - 94; 125 - 127, 132, 142 - 143, 148 - 149)

21. Dr. Medina testified that the Respondent deviated from acceptable minimal standards of care by inappropriately administering IV Valium together with oral benzodiazepines to Patients B, (T. 94 - 96, Dept. 6A) D, (T. 85 - 86, Dept. 8A) F, (T. 86 - 88, Dept 10A) G, (T. 88- 89, Dept. 11A) I (T. 89 - 91, Dept. 13A) and J. (T. 92 - 92)

22. Dr. Medina testified that the Respondent over-medicated these patients and put them at risk for the side effects of the combined treatment, specifically over-sedation and related problems of walking, ataxia, or decreased blood pressure. (T. 84)

23. Dr. Medina testified that the Respondent deviated from acceptable minimal standards of care by inappropriately administering IM Valium without appropriate medical indication to Patients C (T. 65, 96 - 98, Dept 7A), D (T. 65, 96 - 98; Dept. 8A), F (T. 65, 96 - 98, 102, 104 - 105; Dept. 10A) G (T. 65, 97 - 98, 102, 104 - 105, Dept. 11A).

24. Dr. Medina testified that there is no indication for the use of IM Demerol in an outpatient private psychiatric office. Administration of IM Demerol subjects patients to serious unnecessary risks, such as respiratory arrest. (T. 131 - 132, 142 - 143)

25. Dr. Medina testified that the Respondent deviated from acceptable minimal standards of care by inappropriately administering IM Demerol to Patients C (T. 129 - 131, Dept 7A), F (T. 131 - 132, Dept 10A), G (T. 134 - 136, Dept. 11A), H (T. 136 - 138, Dept. 12A), I (T. 139, Dept. 13A), J (T. 140 - 142, Dept. 14A).

26. Dr. Medina testified that the Respondent deviated from acceptable minimal standards of care by inappropriately administering and prescribing narcotics to Patients C, F, G, H, I and J, without appropriate medical justification and when such prescribing was beyond his competence and expertise. The Respondent prescribed Demerol to Patients C, F, G, H, I, J, as well as Tylenol with Codeine, which he inappropriately prescribed to Patient G (Dept. 7A) and Patient J (Dept. 10A) (T. 105, 126 - 127, 169 - 170, 363 - 369)

27. Dr. Medina testified that the Respondent deviated from acceptable minimal standards of care by inappropriately administering and prescribing antibiotics to Patients C, (Dept. 7A) E, (Dept. 9A) F, (Dept. 10A) G, (Dept. 11A) and H (Dept. 12kA) without medical justification and when such prescribing was beyond his competence and expertise. It is outside the practice of psychiatry for a psychiatrist to treat infectious diseases and to prescribe antibiotics. (T. 173 - 177, 368 - 369)

28. Dr. Medina testified that the Respondent deviated from acceptable minimal standards of care by inappropriately administering and prescribing Dexamethasone, a corticosteriod to Patients G, (Dept. 11A) and I (Dept. 13A) without appropriate medical justification and when such prescribing was beyond his competence and expertise. (T. 177 - 180, 368 - 369)

29. Dr. Medina testified that the Respondent deviated from acceptable minimal standards of care by inappropriately administering injectable Toradol to Patients C, (Dept. 7A) H (Dept. 12A) and J (Dept. 14A) without appropriate medical justification and when such prescribing was beyond his competence and expertise and outside the practice of psychiatry. (T. 180 - 184, 369 - 370)

30. Dr. Medina testified that on repeated occasions, Patients A through L presented with non-psychiatric medical complaints, including pain syndromes of various types, headaches, foot problems and symptoms consistent with infection (T. 161).

31. Dr. Medina testified it is outside the practice of psychiatry to treat non-psychiatric complaints on a routine basis and a reasonably prudent psychiatrist would refer the patient to the appropriate practitioner for appropriate treatment of the patient's non-psychiatric medical complaints. (T. 161 - 163, 186 - 187, 376 - 379)

32. Dr. Medina testified that Respondent failed to keep adequate records for Patients A through L. Specifically, he stated "The problems are not laid out or specified at any point, chief complaints, symptoms that are being treated or the progress of those symptoms as to treatment. On many instances all that is noted are the medications prescribed that day, not anything to do with the patient at all as far as how they are doing." (T. 192)

DISCUSSION

The Committee listened to the testimony of the Department's expert, Dr. Alan Medina and the Respondent's expert, Dr. Leo Maniace. The Committee found Dr. Medina's testimony to be credible and expert in the area of psychiatry. The Committee gave minimal weight to the testimony of Dr. Maniace for the following reasons: he is an anesthesiologist, who has never practiced in the area of psychiatry (T. 905 - 905) and he has always practiced anesthesiology within a hospital setting (T. 883). Dr. Maniace testified, "I do not know the standards of administering medicine for psychiatry.... I know the standards for administering IV medicine for anesthesia." (T. 851) Dr. Maniace was asked a question regarding the adequacy of the Respondent's records for Patients A through L, he testified, "I don't know what is adequate for a psychiatrist." (T. 909) Dr. Maniace testified that he has never administered IV Valium in an office setting and would not prefer to do so. (T. 915)

The Committee found the Respondent practices of administering IV Valium, and/or IM Demerol either alone or with other medications to place his patients at unnecessary life threatening risks. (T. 84, 93, 125, 126, 156, 157, 184) Dr. Medina testified that the dangers of administering such medications may result in catastrophic complications such as cardiovascular collapse, airway obstruction and respiratory arrest. (T. 105, 126, 142, 152, 153) The Respondent failed to recognize the risks in which he placed his patients and failed to take responsibility for his dangerous practices. (T. 660 - 665, 670) The Respondent failed to take even the most rudimentary precautions associated with the risks of administering IV Valium, IM Demerol, Torodol (T. 723, 724) and other medications. The Respondent was unable to recognize that there may be other safer ways to treat patients without posing such severe risk. The Respondent placed his patients at life-threatening risk without providing necessary life support systems such as a mask to administer oxygen, (Dept. 3, T. 721) a lack of certification in advanced cardiac life support or basic cardiac life support, (T. 726) no other professional staff present to observe previously medicated patients, (T. 742) and even the absence of a sink and running water where intravenous medications were being administered. (T. 715)

The Respondent's actions and testimony also raise questions as to his overall medical judgment. (T. 683, 685, 704, 744, 747) Throughout the hearing the Respondent testified he took his patient's blood pressures, (T. 639) although when the Committee requested he bring in the records with the pressures he never provided same. (T. 738) Respondent cited a Mayo Clinic article to support his practices of treating patients with IV Valium. (T. 644) The Committee requested he bring in the Mayo literature (T. 731), he never provided same. The

Respondent's patient records consisted of one page with dates, medications and at times several words. It was implausible for the Committee to believe the Respondent's testimony that he could remember all the necessary information for each patient. Respondent's testimony was not credible. (T. 700, 720, 730, 731, 757, 767)

The Committee, after giving consideration to all possible penalties has unanimously decided on revocation. The basis for such severe penalty is the Respondent's medical care and treatment of the patients in the statement of charges indicates a severe lack of competence and skill necessary to practice medicine safely. The Respondent's lacks insight into any problems with his medical care.

AS TO THE FACTUAL ALLEGATIONS

The following allegations have been sustained (charges not listed are not sustained)

A1a, A1b, A1c, A1d, A1e, A1f, A1g, A1h,

A2aii, A2iii(A), A2iii(B), A2b, A2c, A2d,

A3

B

The following allegation has been partially sustained as to Patients C, G, and J

A2ai

AS TO THE SPECIFICATION OF CHARGES

GROSS NEGLIGENCE:

A and A. 1 through A.3 including all subparagraphs -

Except as to Charge A2ai which is partially sustained as to Patients C, G, and J

GROSS INCOMPETENCE:

Paragraphs A and A1 through A 3 including all subparagraphs - Sustained

Except as to Charge A2ai which is partially sustained as to Patients C, G, and J

NEGLIGENCE ON MORE THAN ONE OCCASION:

Paragraphs A and A.1 through A.3 including subparagraphs and B - Sustained

Except as to Charge A2ai which is partially sustained as to Patients C, G, and J

INCOMPETENCE ON MORE THAN ONE OCCASION:

Paragraphs A and A.1 through A.3 including subparagraphs - Sustained

Except as to Charge A2ai which is partially sustained as to Patients C, G, and J

UNWARRANTED TREATMENT:

Paragraph A and A.2 - Sustained

Except as to Charge A2ai which is partially sustained as to Patients C, G, and J

PERFORMING BEYOND COMPETENCE:

Paragraph A and A.2(d) and A.3

Except as to Charge A2ai which is partially sustained as to Patients C, G, and J

FAILURE TO MAINTAIN RECORD:

Paragraphs A and A.1 and B - sustained

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee, unanimously, after giving due consideration to all the penalties available have determined that the Respondent's license to practice medicine in the state of New York should be **REVOKED.**

ORDER

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

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

2. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Harrison, New York
November 6 , 2000

RICHARD D, MILONE, M.D.
Chairperson

JAMES J. DUCEY
SHELDON GAYLIN, M.D.

APPENDIX I

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

IN THE MATTER OF ANTHONY VELEZ, M.D.	COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: ANTHONY VELEZ, M.D.
420 E. 64th Street
New York, N.Y. 10021-7853

5 Beekman Street, Room 234
New York, N.Y. 10038

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by Anthony Velez, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 2000), that effective immediately Anthony Velez, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 2000).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 2000), and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 2000). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on July 12, 2000, at 10:00 a.m., at the offices of the New York State Health Department, 5 Penn Plaza, Sixth Floor, New

York, NY 10001, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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

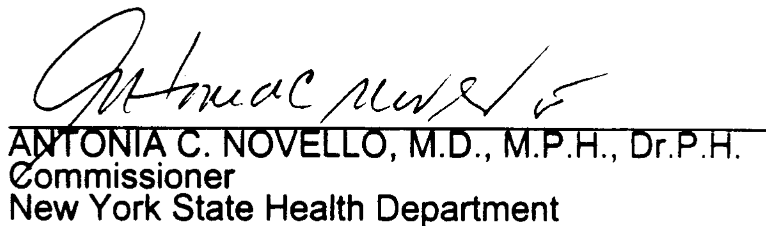
The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed

or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a (McKinney Supp. 2000). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
June 29 ,2000



ANTONIA C. NOVELLO, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Health Department

Inquiries should be directed to:

Marcia E. Kaplan
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
5 Penn Plaza, Suite 601
New York, New York 10001
(212) - 268-6816

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name________________Date of Proceeding________

Name of person to be admitted__________________________________

Status of person to be admitted__________________________________
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

____
Signature (of licensee or licensee's attorney)

This written notice must be sent to either:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

New York State Health Department
Bureau of Professional Medical Conduct
5 Penn Plaza
New York, NY 10001
Fax: 212-268-6735

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

IN THE MATTER OF ANTHONY VELEZ, M.D.	STATEMENT OF CHARGES

ANTHONY VELEZ, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 2, 1972, by the issuance of license number 114448 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. During the period from on or about May 16, 1998 through on or about October 20, 1999, Respondent failed to provide appropriate care and treatment to Patients A-L, as follows:

1. Respondent repeatedly failed to perform and/or note appropriate psychiatric or medical evaluation of Patients A-L. Respondent repeatedly failed to:
   a. Obtain and/or note a chief complaint.
   b. Obtain and/or note a medical or psychosocial history.
   c. Perform and/or note appropriate mental status examinations.
   d. Perform and/or note appropriate review of symptoms.
   e. Order, perform or obtain the results of indicated laboratory tests, and/or note having done so.

f. Diagnose the patients' conditions, and/or note multiaxial diagnoses.

g. Formulate and/or note treatment plans or appropriate rationale for the treatments he selected.

h. Give appropriate consideration to the possible side effects of medication, or note having done so.

2. Respondent repeatedly prescribed or administered medications inappropriately to Patients A-L. Respondent specifically:

a. Administered intravenous Diazepam/Valium inappropriately to Patients B, C, D, F, G, I, and/or J in that he did so:

i. without appropriate medical indication to Patients B, C, D, F, G, I, and/or J.

ii. without proper resuscitation capability to Patients B, C, D, F, G, I, and/or J.

iii. in conjunction with the administration or prescription of other medications, including:

(A) Meperidine/Demerol IM to Patients C, F, G, I, and/or J; and

(B) oral benzodiazepines to Patients B, D, F, G, I, and/or J.

b. Administered intramuscular injections of Diazepam/Valium without appropriate medical indication to Patients C, D, F, and/or G.

c. Administered intramuscular injections of Meperidine/Demerol without appropriate medical indication to Patients C, F, G, H, I, and/or J.

d. Prescribed or administered medications including narcotics, antibiotics, corticosteroids and non-steroidal anti-inflammatory drugs inappropriately to patients, without appropriate medical justification and/or when such prescribing was beyond his competence and expertise.

3. Respondent repeatedly failed to refer Patients A-L with non-psychiatric presenting complaints to appropriate physicians for indicated medical treatment, and instead provided non-psychiatric medical treatment to these patients inappropriately, as further set forth in 2(d) above.

B. Respondent failed to maintain records for each of patients A-L that accurately reflect the care and treatment of that patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2000) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A.1 - A.3 and their respective subparagraphs, and/or B.

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2000) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

2. Paragraphs A and A.1-A.3 and their respective subparagraphs, and/or B.

THIRD 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. 2000) 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:

3. Paragraphs A and A.1 - A.3 and their respective subparagraphs, and/or B.

FOURTH 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. 2000) 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:

4. Paragraphs A and A.1 - A.3 and their respective subparagraphs, and/or B.

FIFTH SPECIFICATION

UNWARRANTED TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 2000) by ordering of excessive treatment not warranted by the condition of the patient, as alleged in the facts of:

5. Paragraphs A and A.2 and its subparagraphs.

SIXTH SPECIFICATIONS

PERFORMING BEYOND COMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(24)(McKinney Supp. 2000) by performing professional responsibilities which the licensee knows or has reason to know that he is not competent to perform, as alleged in the facts of the following:

6. Paragraphs A and A.2(d) and/or A.3.

SEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2000) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

7. Paragraphs A and A.1 and/or B.

DATED: June , 2000
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct