STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

August 26, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ricardo Vance, M.D.
1000 Grand Concourse
Bronx, New York 10451

Jeffrey M. Rubin, Esq.
Rubin & Shang, Esqs.
9 East 40th Street
New York, New York 10016

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

RE: In the Matter of Ricardo Vance, M.D.

Dear Dr. Vance, Mr. Rubin and Mr. Smith:

Enclosed please find the Determination and Order (No. BPMC-93-129) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rg
Enclosure

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

IN THE MATTER

OF

RICARDO VANCE, M.D.

DECISION AND ORDER OF THE HEARING COMMITTEE

BPMC No. 93-129

The undersigned Hearing Committee consisting of **JOHN H. MORTON, M.D., Chairperson, MILTON O.C. HAYNES, M.D., and THEA GRAVES PELLMAN,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 230(10) 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 **RICARDO VANCE, 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.

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.

RECORD OF PROCEEDING

Original Notice of Hearing and Statement of Charges:	July 2, 1992
Notice of Hearing returnable:	August 26, 1992
Place of Hearing:	5 Penn Plaza New York, New York
Respondent's answer served:	None
The State Board for Professional Medical Conduct appeared by:	David W. Smith, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York
Respondent appeared in person and was represented by:	Rubin & Shang, Esqs. 9 East 40th Street New York, N.Y. 10016 Jeffrey M Rubin, Esq. of Counsel
Respondent's present address:	1000 Grand Concourse Bronx, New York 10451
Hearings held on:	August 26, 1992 September 16, 1992 September 23, 1992 November 3, 1992 December 9, 1992 February 1, 1993 April 15 and 30 1993 May 12, 1993
Conferences held on:	August 21, 1992 September 16, 1992 September 23, 1992
Closing briefs received:	June 14, 1993
Record closed:	June 14, 1993
Deliberations held:	June 17, 1993

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges Respondent has practiced his profession with negligence on more than one occasion, that he has ordered excessive tests and that he failed to maintain appropriate patient records. The allegations arise from the treatment of four patients in 1986 through 1988. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges.

The State called this witness:

Stephen H. Leslie, M.D. Expert Witness

Respondent testified in his own behalf and called no other witnesses.

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Committee that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state.

The Committee was instructed that with regard to the issue of excessive tests, the question presented was whether under the

facts and circumstances, the practitioner had ordered procedures which were consistent with an appropriate investigation of the conditions and symptoms displayed by a given patient. The standard to be followed was that of a prudent practitioner displaying generally accepted levels of knowledge and expertise.

Finally, with regard to the keeping of medical records, the Committee was instructed that state regulations require a physician to maintain an accurate record of the evaluation and treatment of each patient. The standard to be applied in assessing the quality of a given record is whether a successor physician or reviewing entity could read a given chart and be able to understand a practitioner's course of treatment and the basis for same.

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.

The following findings of fact were made after review of the entire record. Numbers in parentheses (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. The State was required to

meet the burden of proof 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. All findings and conclusions herein were unanimous.

FINDINGS OF FACT WITH REGARD TO PATIENT A

1. Patient A was treated at the clinic with which Respondent was associated beginning June 6, 1986. The patient record discloses limited physical findings and a very limited medical history were taken (Pet. Ex. 3; T. 34, 39, 42-43). Patient A was a heroin abuser and an alcoholic. Respondent prescribed Valium for Patient A. The record discloses no follow-up regarding the use of valium (Pet. Ex. 3; T. 42-45, 705).

2. The next two visits took place almost a year later, April 21 and May 13, 1987. The record discloses a limited physical examination and medical history. Respondent prescribed Ativan, muscle relaxers and tranquilizers for Patient A (Ex. 3; Tr. 46-49).

3. The next visit, on July 10, 1987, discloses no history whatsoever, and no physical examination other than a blood pressure. The prescriptions given on April 21 and May 12 were continued (Ex. 3; Tr. 49).

4. The next three visits were July 27, September 10 and September 12, 1987. On these dates, there were either limited or no physical examinations or medical histories (Ex. 3; T. 50-53).

5. Two weeks later on September 25, 1987, Patient A again saw Respondent. There was a limited physical examination and medical history recorded. There is no justification in the record for the prescriptions given (Ex. 3; T. 53-55).

6. The next visit was October 16, 1987. A limited medical history and physical examination were recorded. Dolobid was prescribed by Respondent but there is no justification indicated in the chart (Ex. 3; T. 55-56).

7. The next visit was November 13, 1987. The medical history and physical examinations recorded were limited. There is no justification in the record for the prescriptions given (Ex. 3; T. 56-57).

8. Respondent performed the following tests on Patient A:

a. An electrophoresis survey (Ex. 3; T. 62).

b. A test for Hepatitis (Ex. 3; T. 63).

c. Pulmonary Function test (Ex. 3; T. 65, 54-156, 159-160, 170).

9. At various times Respondent diagnosed Patient A with stomach problems such as gastritis or gastric tenderness. Respondent prescribed non-steroidal anti-inflammatory drugs such as Naprosyn. Respondent also prescribed Dolobid (Ex. 3, T. 46-49, 55-56).

CONCLUSIONS WITH REGARD TO PATIENT A

In Allegations A.1 and A.2, Respondent is charged with a

failure to obtain and note an adequate history (A.1) and physical examination for this patient throughout the period of treatment. The Committee sustains both these charges. As Respondent's charts were reviewed, the Committee noted a pattern of spotty recording of relevant history and physical findings. On many occasions, Respondent recorded no history or physical examination, even of a cursory nature. Typically, Respondent would record a word or two, sometimes using obscure abbreviations. Indeed, Respondent had to explain virtually every chart to the Committee. When a treating physician must explain a chart to a succeeding reviewer, it defeats the whole purpose of medical record keeping. Medical record keeping presumes the practitioner will not always be available and that successors must be able to discern what objective findings the physician made, what care he rendered and why. Clearly, none of Respondent's records meet this minimum standard.

In addition, the Committee finds Respondent's explanations of his charts to be disingenuous, to say the least. The Committee does not believe that Respondent only wrote "positive findings." Rather, the Committee finds that when Respondent did not make a notation it was either because Respondent did not inquire or because he did not make a physical finding. Furthermore, the Committee does not believe that in a busy clinic situation, Respondent was able to remember these four patients out of the thousands he has seen. Had Respondent stated that he could not remember each individual patient but had certain routine

protocols which he could extrapolate from a given chart, that would have been credible and truthful. Instead, Respondent decided to invent his narration as he proceeded. In this regard, perhaps the most revealing testimony was the exchange on April 12 during which Respondent was asked by Ms. Pellman if he could remember a particular patient. At first he stated "I knew that she was someone that I felt there was a chance of helping. She seemed fairly intelligent." However, when asked specifically, "Do you remember this patient?" Respondent replied, "I could not point her out on a piece of paper, no (emphasis supplied)" (T. 1037).

Therefore:

Allegation A.1 **is SUSTAINED.**
Allegation A.2 **is SUSTAINED.**

In Allegation A.3, Respondent is charged with "inappropriately prescribing controlled substances...including Valium and Ativan." Respondent is also charged in this allegation with the failure to monitor, or follow-up on the effect of the drugs or note such monitoring and follow-up. The Committee finds that prescribing Valium and or Ativan without writing a clear and thoughtful justification is, in and of itself, inappropriate. Moreover, these substances are highly addictive and subject to abuse. Prescribing them without monitoring, follow-up and recording of same is also inappropriate. Nowhere in Respondent's records is there found a clear, succinct statement of the reasons for the prescriptions. Nor is there found any commentary on the effects of these substances on this particular patient. As was stated earlier with regard to histories and physical examinations,

Respondent's notes are incomplete and cryptic. While he supplied explanations for his prescribing during testimony, the Committee concludes that he was merely speculating as to why he prescribed these substances for this particular individual out of the many he has treated.

Therefore:

Allegation A.3 is **SUSTAINED.**

In Allegation A.4, Respondent is charged with inappropriately prescribing non-steroidal anti-inflammatory substances (NSAI) to a patient who complained of abdominal pains, gastric tenderness and diarrhea. Respondent is further charged with a failure to order, perform or note appropriate laboratory and diagnostic tests and procedures. Broken up into its constituent parts, the charge is analyzed by the Committee in this manner: Respondent did prescribe NSAIs to this patient who did complain of gastro-intestinal distress. It is well settled that this family of medications often causes or can exacerbate gastro-intestinal distress. It is also true that Respondent did not order, perform or note appropriate tests and procedures to monitor the progress of the patient. In fact, there is no history or physical examination recorded for this patient. The question then is whether the prescribing was "inappropriate."

Under all the facts and circumstances, the Committee believes that prescribing NSAIs involves clinical judgment which should be based upon the clinical factors found by the practitioner. In some cases, the benefits of a given class of substances outweighs

the burden of any negative side effects. Only the clinician can make an informed decision in such a situation. Clearly, the Committee cannot review these clinical factors since there is virtually no useful information in the chart and Respondent's testimony was not credible. In sum, the Committee believes that absent a useful patient record it is virtually impossible for the State to prove by a preponderance of the evidence that the prescribing was "inappropriate." The presumption of course, is that the prescribing was justified and appropriate. While the chart entries are unquestionably inadequate, that is not the focus of this charge and has been considered above. Based upon the proof adduced and the nature of the charge, the Committee does not sustain the allegation.

Therefore:

Allegation A.4 **is NOT SUSTAINED.**

In Allegation A.5, Respondent is charged with inappropriately performing blood chemistries, spirometry and echocardiograms on this patient. The allegation goes on to state that Respondent noted no justification for the tests in the patient chart and that in fact, the tests were not justified by the condition of the patient. As has been stated previously, Respondent's charts lacked any kind of thoughtful rationale for the care or tests performed. However, as was pointed out in the discussion of Allegation A.4, the essence of this charge is not poor record keeping, but rather, the performance of tests and procedures which were not justified by the condition of the patient.

Of the three stated tests, only spirometry can form the basis of a finding of misconduct. The Committee finds that Respondent was justified in performing blood chemistries to obtain a baseline of results for this patient. The Commitee does not find any excess in the number of chemistries performed. Skipping to echocardiogram, the Committee finds that none were performed. While this may constitute a typographical error (there were electrocardiograms performed), the allegation cannot be sustained as charged. Finally, with regard to spirometry, the Committee can find no basis for performing this test. The purpose of spirometry is to establish lung capacity. In the absence of evidence of chronic lung problems, there was simply no basis for performing this test.

Therefore:

Allegation A.5 **is SUSTAINED.**

FINDINGS OF FACT WITH REGARD TO PATIENT B

1. The first five visits of Patient B to the clinic with which Respondent was associated were April 29, May 18, July 9, July 25, and October 3, 1986. During these visits, Patient B received very limited physical examinations and a very limited medical history was taken (Ex. 4; T. 262-69, 271-273, 276).

2. Respondent had available to him all records of prior patient visits. He read the patient notes and initialed some of them (Ex. 4; T. 784, 50-51).

3. The next visit of Patient B was April 27, 1987. The six month gap between this visit and the last visit warranted a re-examination and review of the patient's history. There was a very limited physical examination and a very limited medical history recorded (Ex. 4; T. 275-76).

4. During the subsequent visits, May 5, June 29, July 30, and October 29, 1987 there was either a very limited physical examination, or none was recorded. The same observations apply to the medical history. Prescriptions for Ativan and Valium were given. There is no medical justification in the patient records for these prescriptions (Ex. 4; T. 276-288).

5. Respondent diagnosed Patient B as an alcoholic but failed to note it (Ex. 4; T. 864-66).

6. The abdominal sonogram of Patient B done in October, 1987, indicated chronic pancreatitis, hepatomegaly and parenchymal disease. There is no notation of any follow-up or treatment of any of these problems (Ex. 4; p. 12).

7. Blood tests that were performed on Patient B in July 1986 show an elevated R.I.A. T3 and T4. Respondent failed to record follow-up or treatment in his subsequent notations (Ex. 4; T. 293-94; p. 13).

CONCLUSIONS WITH REGARD TO PATIENT B

In Allegations B.1 and B.2, Respondent is again charged with failing to obtain and note an adequate history (B.1) and failing to perform and note an adequate physical examination (B.2)

throughout the time he saw this patient. The pattern described above for Patient A applies equally to Patient B. The Committee again noted a pattern of spotty recording of relevant history and physical findings. On many occasions, Respondent recorded no history or physical examination, even of a cursory nature. Typically, Respondent would record a word or two, sometimes using obscure abbreviations. Ultimately, Respondent again had to explain virtually every chart to the Committee. Clearly, none of Respondent's records meet the minimum standards discussed above. The Committee repeats its earlier conclusions regarding Respondent's veracity regarding his charts. The Committee concludes, as it did earlier, that when Respondent did not make a notation it was either because Respondent did not inquire or because he did not make a physical finding. Again, the Committee does not believe that in a busy clinic situation, Respondent was able to remember this patient either. Once again, the Committee believes that Respondent created his explanations as he proceeded. In sum, Respondent neither obtained nor recorded adequate physical examinations or histories for this patient. His explanations are not credible.

Therefore:

Allegation B.1 **is SUSTAINED.**
Allegation B.2 **is SUSTAINED.**

In Allegation B.3, Respondent is charged with "inappropriately prescribing controlled substances...including Valium, Ativan and Theophyllinne (SIC)." Respondent is also charged in this allegation with the failure to monitor, or follow-

up on the effect of the drugs or note such monitoring and follow-up. The Committee begins its analysis by taking notice that Theophylline is not a controlled substance. Therefore, this part of the allegation cannot be sustained. With regard to the prescribing of Valium and or Ativan, which are controlled substances and subject to abuse and addiction, the earlier observations of the Committee apply here as well. It is inappropriate to prescribe these substances without a clear written justification and without appropriate follow-up. Respondent's charts show neither the reason for, nor any sort of ongoing review of these prescriptions.

Therefore:

Allegation B.3 is **SUSTAINED.**

Allegations B.4 and B.5 also concern lapses in appropriate follow-up. In Allegation B.4, Respondent is alleged to have caused blood tests to be performed which show abnormal thyroid functions. Respondent denied he ordered the tests. While this may be so, it is undeniable that Respondent saw this patient after the test results were in the chart. There is no credible evidence of follow-up by Respondent. Where, as here, a treating physician finds abnormal test results, the responsibility falls to that physician to treat the problem or see to it that it is treated by another. Respondent failed to perform or make an appropriate record regarding this basic duty. Likewise, with regard to the sonography results of this patient, upon seeing the results, Respondent had a duty to see to it that appropriate treatment was

arranged. In the alternative, the chart should include an explanation of why treatment was not obtained. Respondent failed in any way to meet this fundamental duty as well.

Therefore:

Allegation B.4 **is SUSTAINED.**
Allegation B.5 **is SUSTAINED.**

FINDINGS OF FACT WITH REGARD TO PATIENT C

1. The first visit of Patient C to the medical office at 1269 Grand Concourse was May 29, 1986 (Ex. 5; T. 342). The patient record discloses a very limited physical examination and medical history were taken. According to Respondent, Patient C was a drug abuser and an alcoholic. Prescriptions were given for Valium and Elavil (Ex. 5; T. 343-46).

2. The next time Respondent saw this patient was July 31, 1986. The physical examination and the medical history recorded were very limited. Respondent prescribed Valium (Ex. 5; T. 346-49).

3. In July, 1986, Respondent diagnosed Patient C with Radiation Dermatitis. Respondent meant such diagnosis to mean sunburn (Ex. 5; T. 349-50, 1017, 1057-59).

4. On July 31, Respondent saw Patient C . At the bottom of the chart he wrote " Hepatitis B surface antigen positive". On the laboratory report of July 15 the hepatitis B surface antigen is listed as negative but the antibody to hepatitis B is listed as positive (T. 1066 Ex. 5).

5. The next time Respondent saw this patient was September 9, 1986. The physical examination and the medical history which were recorded were extremely limited. Prescriptions for Tylenol with codeine and Valium were given. The chart discloses no basis for these prescriptions (Ex. 5; T. 352-55).

6. The next visit was October 7, 1986. The medical history and the physical examination recorded were extremely limited (Ex. 5; T. 355). A prescription for Valium and Tylenol with codeine was given. There is no justification recorded for either of these prescriptions (Ex. 5; T. 357-59).

7. Respondent next saw Patient C on December 16, 1986. The medical history which was recorded was very limited and the physical examination which was recorded was extremely limited. Respondent issued a prescription for Ativan. No basis for the prescription appears in the chart (Ex. 5; T. 366).

8. The next visit was December 30, 1986. The physical examination and medical history were extremely limited. A prescription for Valium was given. The basis for this prescription does not appear in the record (Ex. 5; T. 367-68).

9. The next visits were January 13, January 27 and February 12, 1987. The physical examination and medical history which were recorded were extremely limited. Prescriptions for Valium and Ativan were given. No basis for the prescriptions was recorded (Ex. 5; T. 368-73).

10. Respondent next saw this Patient on February 27. A prescription for Ativan was given. There is no basis for this

prescription stated in the patient record (T. 374-5).

11. The next visit was March 13, 1987. The physical examination which was recorded was extremely limited (Ex. 5; T. 375). Respondent diagnosed Patient C with Pelvic Inflammatory Disease. He did no pelvic examination nor did he take cultures. Ativan was prescribed. There is no basis recorded in the chart for this prescription (Ex. 6; T. 375-77, 1052, 1060-64).

12. The next visit was March 26, 1987. Respondent caused a sonogram to be performed on Patient C. There is no basis for the sonogram recorded in the chart. Ativan was prescribed. There is no basis for this prescription recorded in the chart (Ex. 5; T. 379).

13. The next visit was April 9, 1987. The visit following that is undated. The physical examinations listed and the medical history recorded were extremely limited. Ativan and Valium were prescribed. There is no basis for these prescriptions recorded in the chart (Ex. 5; T. 380-383).

14. The next two visits were May 12 and May 30, 1987. Physical examinations and medical histories were either not taken or were extremely limited. Ativan was prescribed. The basis for this prescription is not recorded in the chart (Ex. 5; T. 384-86).

15. The tests which Respondent caused to be performed on Patient C included a gall bladder sonogram (Ex. 5; T. 388-89); two abdominal sonograms, (Ex. 5; T. 389-90); an echocardiogram (Ex. 5; T. 390-91); and a spirometry test (Ex. 5; T. 393-94).

94; p. 13).

CONCLUSIONS WITH REGARD TO PATIENT C

In Allegations C.1 and C.2, Respondent is again charged with failing to obtain and note an adequate history (C.1) and failing to perform and note an adequate physical examination (C.2) throughout the time he saw this patient. The pattern described above for Patient A and Patient B applies equally to Patient C. The Committee again noted a pattern of spotty recording of relevant history and physical findings. On many occasions, Respondent recorded no history or physical examination, even of a cursory nature. Typically, Respondent would record a word or two, sometimes using obscure abbreviations. Respondent, again, had to explain virtually every chart to the Committee. Clearly, none of Respondent's records met the minimum standards discussed above in that the records could not be understood without the author present to explain them. The Committee repeats its earlier conclusions regarding Respondent's veracity regarding his charts. The Committee finds, as it did earlier, that when Respondent did not make a notation it was either because Respondent did not inquire or because he did not make a physical finding. Again, the Committee does not believe that in a busy clinic situation, Respondent was able to remember Patient C. Once again, the Committee believes that Respondent created his explanations as he proceeded. In sum, Respondent neither obtained nor recorded adequate physical examinations or histories for this patient. His

explanations are not credible.

Therefore:

Allegation C.1 **is SUSTAINED.**
Allegation C.2 **is SUSTAINED.**

In Allegation C.3, Respondent is charged with diagnosing pelvic inflammatory disease without performing appropriate laboratory and diagnostic tests and a failure to properly treat the condition. The Committee sustains this charge. The Committee finds that while Respondent did give this patient anti-biotics, he did not perform a pelvic examination or laboratory cultures. The Committee finds that Respondent treated the patient for a vaginal discharge but did not meet minimum standards of practice in that he made no attempt to ascertain precisely what was causing the discharge. The Committee does not believe Respondent's testimony to the effect he did give this patient a pelvic examination. Certainly, the record does not note such an examination.

Therefore:

Allegation C.3 **is SUSTAINED.**

In Allegation C.4, Respondent is charged with making a diagnosis of "radiation dermatitis" and failing to properly investigate or treat the condition. The Committee finds Respondent referred to sunburn in this instance. As such, his treatment and follow-up were satisfactory in that he met minimum accepted standards.

Therefore:

Allegation C.4 **is NOT SUSTAINED.**

In allegation C.5, Respondent is charged with diagnosing hepatitis but failing to appropriately investigate and treat the condition. The Committee finds that Respondent erroneously diagnosed hepatitis in this patient. Nevertheless, even if the patient did not have the disease, the point is that Respondent failed to follow-up under circumstances in which he thought the patient had the condition.

In his testimony it appeared that Respondent was trying to say the patient did not have hepatitis, that he was merely trying to rule it out. Respondent's testimony in this regard, as in many others, was self contradictory and did not agree with the chart entries. The Committee finds his explanations not credible.

Therefore:

Allegation C.5 **is SUSTAINED.**

In Allegation C.6, Respondent is charged with inappropriately prescribing "controlled substances...including Valium, Elavil, and Motrin." The Committee takes notice that Motrin is not a controlled substance. Therefore, that part of the charge will not be sustained. However, Valium and Elavil are controlled substances. Respondent had diagnosed this patient as a substance abuser and alcoholic. There can be little justification for prescribing controlled substances which, by their very nature are subject to abuse, to a known substance abuser or alcoholic. Certainly, there was insufficient justification recorded by Respondent to warrant prescribing these substances to a person who was not an abuser, much less one who was known to abuse

substances.

Therefore:

Allegation C.6 **is SUSTAINED.**

In Allegation C.7, Respondent is charged with performing spirometry, abdominal sonography and echocardiogram tests on this patient without recording a justification and without any medical justification in fact. The Committee sustains this charge on both theories. There was certainly no written justification in this patient chart for any of these procedures. Moreover, based upon what little information there is in the chart, the Committee concludes that there were, in fact, no medical conditions warranting these tests. Thus the charge is sustained both for the failure to record as well as for the lack of any condition warranting the tests.

Therefore:

Allegation C.7 **is SUSTAINED.**

FINDINGS OF FACT WITH REGARD TO PATIENT D

1. The first visit of Patient D to Respondent was December 12, 1986. There was no medical history taken and the physical examination which was recorded was extremely limited (Ex. 6; T. 399). There is no medical justification in the patient record for the prescription for Valium which was given (Ex. 6; T. 400).

2. Patient D was an alcoholic. Respondent never referred her for counselling or specialized treatment. Respondent

prescribed Valium and Ativan for her (Ex. 6; T. 412-13, 420-21).

3. Respondent saw Patient D on December 22, 1986. The physical examination and medical history which were recorded were extremely limited (Ex. 6; T. 413-15). A prescription was given for Ativan. No basis for this prescription is recorded in the patient record (Ex. 6; T. 413-17).

4. The next visit was January 8, 1987. There was a very brief physical examination recorded. The medical history which was record was also extremely brief. Prescriptions for Ativan and Feldene were given. There is no basis recorded in the chart for these prescriptions (Ex. 6; T. 417-19).

5. The next two visits were February 2, and February 24, 1987. No physical examinations were recorded and the medical histories were extremely limited. Prescriptions were given for Feldene and Ativan. The basis for these prescriptions were not recorded (Ex. 6; T. 419-420).

6. In February, Respondent diagnosed Patient D as having alcoholic gastritis. Respondent prescribed non-steroidal anti-inflammatory drugs for this patient (Ex. 5; T. 419-20, 1207-08).

7. The next three visits were March 9, March 24, and April 10, 1987. The physical examinations were extremely limited and no medical histories were recorded. Prescriptions were given for Ativan. There is no basis for these prescriptions recorded in the chart. (Ex. 6; T. 424-27).

8. The next visits were May 12, May 24 and June 22, 1987. The physical examinations were either extremely limited or non-

existent. There was no medical history recorded. Ativan was prescribed. There is no medical basis in the chart for the prescriptions (Ex. 6; T. 424-27).

9. The next visit was July 6, 1987. The physical examination was extremely limited. There is no medical history recorded. There is a diagnosis of joint stiffness but the chart discloses no basis for this finding. Feldene and Ativan were prescribed but no comprehensive justification for the prescriptions is recorded (Ex. 6; T. 428).

10. The next three visits were August 11, August 25 and November 19, 1987. The physical examinations were either extremely limited or non-existent. There was no medical history recorded. A prescription was given for Ativan. There is no basis for this prescription recorded (Ex. 6; T. 429-32).

11. The last two visits were December 7, 1987 and March 15, 1988. The patient note for December is illegible and extremely limited. More than three months had elapsed between the two visits. The physical examination on March 15 was extremely limited. No medical history was taken on this date. Ativan was prescribed on both dates. No medical justification for the prescriptions was recorded (Ex. 6; T. 432-35).

12. Neither the chief complaint of Patient D on March 15, nor what he was treated for can be ascertained from this record (Ex. 6; T. 534-36).

13. Respondent ordered tests for Patient D including a sickle cell anemia test and a hemoglobin test (Ex. 6; T. 436-38).

14. In addition, the following tests were ordered by Respondent for Patient D: an electrocardiogram; a hepatic sonogram; and spirometry (Ex. 6; T. 440-50).

15. Whether or not Respondent saw Patient D on every visit listed, he did read all the patient notes and was aware of the nature of the care given (T. 1153-55).

CONCLUSIONS WITH REGARD TO PATIENT D

In Paragraph D of the allegations, it is alleged that Respondent treated Patient D twenty-seven times. Due to the inadequate nature of the records kept by Respondent, it is impossible to tell precisely how many times he saw this patient. The Committee finds at least 18 visits. The Committee finds that Respondent reviewed and had available to him the patient records for all the visits of Patient D to the clinic with which Respondent was associated. The Committee does not find that the inability to precisely number the visits effects the outcome of this proceeding.

In Allegations D.1 and D.2, Respondent is again charged with failing to obtain and note an adequate history (D.1) and failing to perform and note an adequate physical examination (D.2) throughout the time he saw this patient. The pattern described above for Patient A, Patient B and Patient C applies equally to Patient D. The Committee again noted a pattern of spotty recording of relevant history and physical findings. On many occasions, Respondent recorded no history or physical examination, even of a

cursory nature. Typically, Respondent would record a word or two, sometimes using obscure abbreviations. Respondent again had to explain virtually every chart to the Committee. Clearly, none of Respondent's records met the minimum standards discussed above in that the records could not be understood without the author present to explain them. The Committee repeats its earlier conclusions regarding Respondent's veracity regarding his charts. The Committee finds, as it did earlier, that when Respondent did not make a notation it was either because Respondent did not inquire or because he did not make a physical finding. Again, the Committee does not believe that in a busy clinic situation, Respondent was able to remember Patient D. Once again, the Committee believes that Respondent created his explanations as he proceeded. In sum, Respondent neither obtained nor recorded adequate physical examinations or histories for this patient. His explanations are not credible.

Therefore:

Allegation D.1 **is SUSTAINED.**
Allegation D.2 **is SUSTAINED.**

In Allegation D.3, Respondent is charged with diagnosing scoliosis without giving the basis for the diagnosis. He is further charged with a failure to order appropriate laboratory and diagnostic tests and a failure to properly treat the condition. The Committee does not sustain this charge. The Committee finds that scoliosis is a curvature of the spine. There is no treatment, beyond the teenage years, which is viable. In sum, there was no treatment Respondent could have ordered. Nor

were there any tests or procedures that were warranted.

Therefore:

Allegation D.3 **is NOT SUSTAINED.**

In Allegation D.4, Respondent is charged with making a diagnosis of "alcoholic gastritis" and prescribing non-steroidal anti-inflammatories. Respondent is also charged with failing to perform any clinical evaluations of the condition or recording same. The Committee sustains this charge. Respondent admitted that he gave this patient Feldene. There is also no dispute that Feldene is a non-steroidal anti-inflammatory (NSAI). NSAIs are known to cause gastric irritation which could be expected to exacerbate gastritis. Nevertheless, the clinical practitioner may, under certain circumstances, find that the benefits to be derived from an NSAI outweigh the side effects. Furthermore, NSAIs may be given empirically, as was done here; that is, a practitioner may prescribe an NSAI for swelling or joint pain, over a short period, without knowing the specific cause of the discomfort so long as there is good follow-up. In this instance however, Respondent diagnosed gastritis, prescribed Feldene and made no follow-up whatsoever vis a vis the gastritis or any additional symptoms caused by the Feldene. The Committee finds that it was inappropriate to prescribe an NSAI to a patient with known or suspected gastritis, without careful follow-up to evaluate the risks versus the benefits.

Respondent failed to meet these basic medical standards.

Therefore:

Allegation D.4 is **SUSTAINED.**

In allegation D.5, Respondent is charged with diagnosing alcoholism but failing to appropriately treat the condition or make an appropriate referral. The Committee finds that Respondent did record a diagnosis of alcoholism in this patient. The committee finds no evidence of any treatment or attempt at referral. The Committee takes note that patients who suffer from this condition are often non-compliant. Nevertheless, Respondent had a duty to treat the condition, or refer the patient and record same. Had the patient failed to follow the treatment offered, Respondent's duty would still have been met. Under the circumstances, there is no record of any effort to assist this patient.

Therefore:

Allegation D.5 **is SUSTAINED.**

In Allegation D.6, Respondent is charged with performing spirometry, abdominal sonography and echocardiogram tests on this patient without recording a justification and without any medical justification in fact. The Committee sustains this charge on both theories. There was certainly no written justification in this patient chart for any of these procedures. Moreover, based upon what little information there is in the chart, the Committee concludes that there were, in fact, no medical conditions warranting these tests. Respondent testified that spirometry was

justified because the patient was a known one pack per day smoker. The Committee finds that spirometry would have served no purpose in relation to the patient's known smoking habits. Likewise, the Committee finds that the existence of transient S1 and S2 in this patient's cardiac history did not justify an echocardiogram. The Committee can find no basis at all for the abdominal sonography. If Respondent had concerns about the effect of alcoholism on this patient's organs, the appropriate place to begin would have been a battery of routine blood tests. Had Respondent written even a limited note in explanation, the Committee would have considered it. Respondent failed to do so. Thus the charge is sustained both for the failure to record as well as for the lack of any condition warranting the tests.

Therefore:

Allegation D.6 **is SUSTAINED.**

CONCLUSIONS WITH REGARD TO THE FIRST SPECIFICATION (NEGLIGENCE ON MORE THAN ONE OCCASION)

The Committee has sustained all allegations except for A.4, C.4 and D.3. Having sustained the majority of factual allegations, the Committee now turns its attention to whether any of the factual allegations constitute medical misconduct as set forth in the specifications

The Hearing Committee concludes that the First Specification is sustained. In the First Specification, Respondent is charged with negligence on more than one occasion based upon each of the

factual allegations. The Committee finds that each of the sustained allegations constitutes acts which fit the definition of negligence stated earlier except for allegations A.5, C.7, and D.6. The Committee excludes these three factual allegations because they relate to excessive testing. The Committee finds that while excessive testing is indeed medical misconduct, it does not fit within the concept of a failure to exhibit that level of care and diligence expected of a prudent practitioner and hence cannot form the basis of a finding of negligence. Allegations A.5, C.7 and D.6 will be considered under the Second through Fourth Specifications, later.

In assessing the specifications in this matter, the Committee was mindful that Respondent practiced in an inner city clinic. The Committee was made aware that such surroundings present special challenges to the practitioner. Often patients are not compliant. Often there is significant pressure to see many patients quickly. Still, even taking the above and more into consideration, there are basic standards of medicine which must be met. The Committee rejects the notion that inner city patients are entitled to a lower standard of medicine than other patients in this state. While allowances for non-compliance, the size of a patient load, and other factors may be made, these allowances cannot be an excuse for substandard medicine.

Turning now to Allegations A.1, A.2, B.1, B.2, C.1, C.2, D.1 and D.2, the Committee finds that these charges show a pattern of extremely sub-standard record-keeping. While the Committee notes

that there is a separate specification which refers solely to record-keeping, the Committee finds that substandard records, such as those seen in this proceeding, can exemplify treatment which fails to demonstrate that level of care and diligence expected of a prudent physician in this state and, hence, negligence, here, on more than one occasion. The records reviewed by this committee show that in the entire period Respondent treated these four patients he made no effort to take even a rudimentary history or perform even a basic physical examination on the part of the body he was treating. As set forth earlier, Respondent's notes are cryptic and usually incomplete. It was often impossible, even for Respondent, to recall what he had seen, done and why. Such a situation is clearly substandard and shows a failure of diligence and attention to the needs of his patients. While physician notes often have some gaps or lapses and thus would not rise to the level of negligence, the notes before this Committee were virtually worthless and the keeping of worthless notes is a serious breach of a physician's duty to his patient.

In Allegations A.3, B.3 and C.6, Respondent was found to have prescribed controlled substances without justification or follow-up. In cases A and C, it was established that the patients were substance abusers during the treatment period in question. It is the conclusion of the Committee that accepted standards of medicine require that when controlled substances are prescribed there must be a clear medical justification, follow-up on the effects of the drugs and a written record of same. Moreover,

controlled substances can never be prescribed, in the setting of an ordinary medical practice, to substance abusers. Respondent failed to live up to these standards.

In Allegations B.4, B.5, C.3, C.5, D.4 and D.5, Respondent either was aware of test results which warranted follow-up or made diagnoses without appropriate investigation or treatment. These cases show a pattern of inattention to significant details in the care and treatment of patients. In the case of Patient B, Respondent thought the patient had Hepatitis. Test results available to respondent, showed chronic pancreatitis and hepatomegaly yet there is no notation of follow-up or treatment. In the case of Patient C, Respondent diagnosed pelvic inflammatory disease, yet performed neither a pelvic examination nor smear culture to ascertain the precise nature of condition. The other charges which were sustained give specific examples of instances in which Respondent did not show that level of care and diligence expected of a prudent physician in that he did not investigate or treat potentially serious conditions in his patients.

Therefore:

The First Specification **is SUSTAINED.**

CONCLUSIONS WITH REGARD TO THE SECOND, THIRD AND FOURTH SPECIFICATIONS (EXCESSIVE TESTS)

The Hearing Committee concludes that the Second Third and Fourth Specifications are sustained. A preponderance of the credible evidence showed that Respondent performed or caused to be performed tests on Patient A, C and D for which there was no

medical justification recorded and for which there was, in fact, no medical justification. These unnecessary tests included spirometry, sonograms and echocardiograms and are more particularly discussed in the conclusions with regard to the specific charges sustained (A.5, C.7 and D.6). The point is that the tests which were alleged and sustained had neither medical basis recorded nor were there any credible facts offered which would have warranted their performance. The ordering of tests or procedures absent a condition which warrants same constitutes medical misconduct.

Therefore:

The Second Specification **is SUSTAINED.**
The Third Specification **is SUSTAINED.**
The Fourth Specification **is SUSTAINED.**

CONCLUSIONS WITH REGARD TO THE FIFTH, SIXTH, SEVENTH AND EIGHTH SPECIFICATIONS (FAILURE TO MAINTAIN RECORDS)

The Hearing Committee concludes that the Fifth, Sixth, Seventh and Eighth Specifications are sustained. A preponderance of the credible evidence established that Respondent kept records which would not have been able to inform a successor physician or reviewing entity the objective findings associated with his patients, the nature of the care rendered and the reasons for the care given. These are basic standards and were discussed at

length under Allegations A.1, A.2, B.1, B.2, C.1, C.2, D.1 and D.2. Therefore:

The Fifth Specification **is SUSTAINED.**
The Sixth Specification **is SUSTAINED.**
The Seventh Specification **is SUSTAINED.**
The Eighth Specification **is SUSTAINED.**

CONCLUSIONS WITH REGARD TO PENALTY AND ORDER

In analyzing each of the charges and specifications against Respondent, the Committee has seen a pattern of clearly sub-standard care. More particularly, Respondent has demonstrated repeated negligence in his attention to patient records. He was also negligent in his failure to follow-up on laboratory results and diagnoses which were suggestive of serious patient ailments. While the Committee is mindful that Respondent worked in an inner city clinic and that such surroundings offer special challenges and patients who cannot always be relied upon to be compliant, that is not an excuse for the kind of shoddy care demonstrated in the four records before this panel. It is one thing for a practitioner to note a condition such as Hepatitis and further note a plan of care where the patient does not return. In such a situation, the patient, not the physician is at fault. But here, the committee saw repeated diagnoses of serious ailments or significant laboratory findings without any effort recorded by Respondent to treat these conditions or at least note instructions given. In addition, Respondent prescribed controlled substances to known substance abusers. This practice is fraught with danger

to the patient, yet the Committee sees no evidence of any thought process undertaken by Respondent to protect the patients in question. Likewise, potentially harmful drugs (NSAIs) were given to persons with compromised gastric systems and there is no notation of follow-up or other efforts to protect the patient from possibly serious side effects. Finally, the Committee has found Respondent to have been less than candid with this body. While his lack of truthfulness is not necessarily directly related to the charges, it does bear some weight upon the Committee's decision as to penalty.

Therefore, it is hereby **ORDERED:**

That the license of Respondent **Ricardo Vance, M.D.** shall be **SUSPENDED** until such time as he shall successfully complete a course of retraining as set forth below; and it is further

ORDERED:

That, at Respondent's expense, Respondent shall complete the phase I Evaluation of the Physician Prescribed Educational Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center, Syracuse, New York, within ninety (90) days of the effective date of this Order; and it is further

ORDERED:

That, if the Phase I Evaluation indicates that Respondent is a candidate for re-education, then Respondent must successfully complete Phase II of the PPEP at Syracuse, the pilot New York

State Physician Retraining Program (PRP), or an equivalent program, such as a residency or mini-residency, and Phase III, the post-training evaluation; and it is further

ORDERED:

That Should Respondent be found unsuitable for training as set forth above; then it is further

ORDERED:

That Respondent shall enroll in and complete a program of retraining in the area of internal medicine and/or family medicine to be equivalent to a six, month residency program; and it is further

ORDERED:

That the Said program of retraining shall be subject to the approval of the director of the Office of Professional Medical Conduct; and it is further

ORDERED:

That this **ORDER** shall take effect 30 days after service upon Respondent or his attorney by personal service or service by mail.

Dated: Rochester, New York

August 23, **1993**

John H. Morton

JOHN H. MORTON, M.D.
Chairperson

MILTON O. C. HAYNES, M.D.
THEA GRAVES PELLMAN

APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
RICARDO VANCE, M.D.	:	CHARGES

----------X

RICARDO VANCE, M.D., the Respondent, was authorized to practice medicine in New York State on October 17, 1983 by the issuance of license number 156327 by the New York State Education Department. The Respondent is not currently registered with the New York State Education Department to practice medicine.

FACTUAL ALLEGATIONS

A. Between in or about June, 1986 and November, 1987, Respondent treated Patient A, a multiple drug and alcohol abuser, for acne and other conditions twelve (12) times at his medical office at 1269 Grand Concourse, Bronx, New York. (All patients are identified in the Appendix).

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

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

3. Throughout the period, Respondent inappropriately prescribed controlled substances for Patient A, including Valium and Ativan, and failed to monitor or follow-up the effect of such drugs on Patient A, or note such monitoring or follow-up, if any.

4. Throughout the period, Patient A complained of abdominal pains, gastric tenderness and diarrhea. Nevertheless,Respondent inappropriately continued to prescribe non-steroidal, anti-inflammatory medication and failed to order, perform or note appropriate laboratory and diagnostic tests and procedures.

5. At various times during the period, Respondent inappropriately performed blood chemistries on Patient A as well as spirometry and echocardiagram. Respondent failed to note a condition which indicated the need for such tests and, in fact, such tests were not warranted by the condition of Patient A.

B. Between April, 1986, and October, 1987, Respondent treated Patient B for anxiety and other conditions twelve (12) times at his medical office at 1269 Grand Concourse, Bronx, New York.

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

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

3. Throughout the period, Respondent inappropriately prescribed controlled substances, including Valium, Ativan and Theophyllinne and failed to monitor or follow-up the effect of such drugs on Patient B, or note such monitoring or follow-up, if any.

4. In or about July, 1986, Respondent caused to be performed blood tests on Patient B, the results

of which suggested hyperthyroidism. Respondent failed to follow-up adequately the results of these tests, or to note such follow-up, if any.

5. In or about October, 1987, Respondent caused to be performed abdominal sonography on Patient B, the results of which appeared to indicate chronic pancreatitis and hepatomegaly with abnormal parenchymal echo texture. Respondent failed to follow-up adequately the results of these tests, or note such follow-up, if any.

C. Between in or about May, 1986 and May, 1987, Respondent treated Patient C, a substance abuser, for anxiety and other conditions twenty-two (22) times in his medical office at 1269 Grand Concourse, Bronx, New York.

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

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

3. In or about March, 1987, Respondent diagnosed Patient C as having pelvic inflammatory disease, but failed to order, perform or note appropriate laboratory and diagnostic tests and procedures and failed to properly treat such condition or to note such treatment, if any.

4. In or about July, 1986, Respondent, without basis, diagnosed Patient C as having radiation dermatitis. Nevertheless, Respondent failed to order, perform or note appropriate laboratory and diagnostic tests and failed to treat such condition or to note such treatment, if any.

5. In or about July, 1986, Respondent diagnosed patient C as having hepatitis. Respondent failed to order, perform or note appropriate laboratory and diagnostic tests and failed to treat such condition or to note such treatment, if any.

6. Throughout the period, Respondent inappropriately prescribed controlled substances for Patient C at almost every visit, including Valium, Elavil, and Motrin.

7. At various times in between May, 1986 and May, 1987, Respondent inappropriately performed or caused to be performed various tests on Patient C including spirometry, abdominal sonography and echocardiagram. Respondent failed to note any condition which indicated the need for such tests and, in fact, these tests were not warranted by the condition of Patient C.

D. Between in or about March, 1986 and March, 1988, Respondent treated Patient D, a substance abuser, for anxiety and other conditions twenty-seven (27) times in his medical offices at 1269 Grand Concourse, Bronx, New York.

1. Respondent failed throughout this period to obtain and note an adequate history.

2. Respondent failed throughout this period to perform and note an adequate physical examination.

3. In or about March, 1986, Respondent diagnosed Patient D as having scoliosis but nevertheless failed to state the basis of such diagnosis and

failed to order, perform or note appropriate tests and diagnostic procedures and to treat such condition or note such treatment, if any.

4. In or about February, 1987, Respondent diagnosed Patient D as having alcoholic gastritis. Nevertheless, Respondent inappropriately continued to give Patient D non-steroidal anti-inflammatory drugs and also failed to do any clinical evaluations of such condition or to note such clinical evaluation, if any.

5. In or about February, 1987, Respondent diagnosed Patient D as having alcoholism. Respondent failed to treat such condition and failed to refer Patient D for specialized care or note such referral, if any.

6. Throughout the period Respondent inappropriately performed or caused to be performed spirometry tests, echocardiagram and abdominal sonography. Respondent failed to note any condition which indicated the need for these tests or procedures and, in fact, such

tests or procedures were not warranted by the condition of Patient D.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more that one occasion under N.Y. Educ. Law, Section 6530(3), (McKinney Supp.1992), in that Petitioner charges that Respondent committed at least two of the following:

1. The facts contained in Paragraphs A and A1-4; B and B1-5; C and C1-6; and/or D and D1-5.

SECOND THROUGH FOURTH SPECIFICATIONS

EXCESSIVE TESTS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(35), (McKinney Supp. 1992), in that he ordered excessive tests, treatment or use of treatment

facilities not warranted by the condition of the patient. Petitioner specifically charges:

2. The facts in Paragraphs A and A5.

3. The facts in Paragraphs C and C7.

4. The facts in Paragraphs D and D6.

FIFTH THROUGH EIGHTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law, Section 6530(32), (McKinney Supp. 1992) in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient. Specifically Petitioner charges:

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

6. The facts in Paragraphs B and B1-5.

7. The facts in Paragraphs C and C1-7.

8. The facts in Paragraphs D and D1-6.

DATED: New York, New York
July 2, 1992

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct