STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

October 20, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

William Lynch, Esq.
NYS Department of Health
Corning Tower Room 2438
Empire State Plaza
Albany, New York 12237

Nathan L. Dembin, Esq.
Nathan L. Dembin & Associates PC
225 Broadway, Suite 1400
New York, New York 10007

Oskar Weg, M.D.
110-45 Queens Boulevard
Suite 115
Forest Hills, New York 11375

RE: In the Matter of Oskar Weg, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-247) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

- OF -

OSKAR WEG, M.D.

DECISION AND ORDER OF THE HEARING COMMITTEE

ORDER NO. BPMC 98-247

The undersigned Hearing Committee consisting of **RICHARD D. MILONE, M.D., Chairperson, ZORAIDA NAVARRO, M.D.**, and **MS. DIANE BONANNO,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, ESQ.,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Section 230(10) of the New York State Public Health Law and Sections 301-307 and 401 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 **OSKAR WEG, M.D.** (hereinafter referred to as "Respondent").

The New York State Board for Professional Medical Conduct (Hereinafter referred to as "Petitioner") appeared by **WILLIAM LYNCH, ESQ.,** Senior Attorney, of counsel to **HANK GREENBERG ESQ.**, General Counsel, New York State Department of Health. Respondent appeared in person and by **NATHAN L. DEMBIN, ESQ.**, of counsel to Nathan L. Dembin & Associates.

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.

RECORD OF PROCEEDING

Notice of Hearing/ Statement of Charges Dated/ Served	Dated: March 4, 1998	Served: March 12, 1998
Notice of Hearing returnable:	April 23, 1998	
Location of Hearing:	Five Penn Plaza, New York, New York	
Respondent's answer dated / served:	xx / April 23, 1998	
Petitioner appeared by:	**HENRY M. GREENBERG, ESQ.** General Counsel by **WILLIAM J. LYNCH, ESQ.** Senior Attorney Bureau of Professional Medical Conduct Albany, New York	
Respondent appeared in person and was represented by:	**NATHAN L. DEMBIN, ESQ.** Nathan L. Dembin & Associates, P.C. 225 Broadway, Suite 1400 New York, NY 10007	
Respondent's present address:	Suite 115 110-45 Queens Blvd., Forest Hills, NY 11375	
Respondent's License:	Number: 169375 Registration Date: April 2, 1987 Registration Active: September 30, 1996-August 31, 1998	
Pre-Hearing Conference Held:	April 16, 1998	
Hearings held on:	April 23, May 21, 1998	
Conferences held on:		
Record closed:	July 8, 1998	
Date of Deliberation Scheduled / Held	July 9, 1998	July 9, 1998

SUMMARY OF PROCEEDINGS

The Statement of Charges in this proceeding alleges three grounds of misconduct:

1. Respondent has been found guilty of violating a state statute as set forth in N.Y. Education Law Section 6530 (9)(c)

2. Respondent has failed to provide access to patient information as set forth in N.Y. Education Law Section 6530 (40)

3. Respondent has practiced the profession fraudulently as set forth in N.Y. Education Law Section 6530 (2)

The allegations arise from a stipulation of settlement executed by Respondent and Petitioner as well as the transfer of records of some eight patients. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One.

Respondent entered a written answer which is attached hereto as Appendix Two.

Petitioner called these witnesses:

Mitchell Sassower, Esq.	Fact Witness
Patient L's Father	Fact Witness
Joseph Orlian, Esq.	Fact Witness

Respondent testified and called no other witnesses.

SIGNIFICANT LEGAL DECISIONS

1. Decisions on Motions

Respondent submitted three major motions in this proceeding. In the first motion, Respondent seeks dismissal of the sixth and seventh specifications (failure to provide medical records) on the grounds that Respondent did not receive a "valid request" for the medical records. Respondent argues that in the absence of a valid request, he had no duty to provide the records. Furthermore, in the absence of a valid request, Respondent argues he had a duty to withhold the medical records. The issue then is whether the requests received by Respondent and reviewed herein, were sufficient to constitute "valid requests."

Under Section 18 of the Public Health Law, a health care provider shall furnish a copy of any patient information requested with certain caveats: The request must be made in writing, it must reasonably describe the patient and records sought, and must come from a "qualified person." There is no dispute that the requests were submitted in writing and were sent by attorneys. Attorneys fall into the definition of qualified persons so long as they represent the patient whose records are being sought. Respondent alleges the requests were insufficiently specific to assure him as to the identities of the patients and thus the authority of the attorneys from whom the requests were sent. Hence, Respondent asserts, he was under no duty to supply any materials.

Upon review by the Administrative Law Judge, as a matter of law, the requests were legally sufficient. The Administrative Law Judge finds there was sufficient information in the disputed requests such that a reasonable person in the position of Respondent could be reasonably notified as to the identity of the patients, the incident in question, the records requested and the authority of the person making the request. In this case, each request had the name of the patient, the date of the

alleged incident, a brief description of the records and the name and address of the attorney making the inquiry. The two attorneys who testified in this proceeding stated that they telephoned Respondent's office and there was no mention of confusion as to the identity of the patients, the subject of the request or the authority of those making the request. Clearly, the requests had errors in them. However, none of the errors were sufficient to confuse Respondent's office as to the identity of the patients, the incidents in question, the relevant records or the authority of the persons making the requests.

Having ruled that as a matter of law, the requests were sufficient, the Trier of Fact was directed to consider the patient information requests and the testimony submitted as to whether, as a matter of fact, Respondent had any basis to refuse to provide copies of the records. The Trier of Fact was also instructed to consider whether the quality of the requests or the errors contained in them established any mitigation toward the failure to provide timely copies. As will be more fully developed, the Trier of Fact found the requests to be sufficient to warrant release of information and offered no mitigation. This conclusion was based upon the uncontroverted testimony from the attorneys who requested the records that when they contacted Respondent's office by telephone, the office staff had no difficulty in identifying the patients in question, the incidents in issue, the files wanted or the bona fides of the attorneys making the request.

Respondent also moved to dismiss this proceeding on the grounds that he was not given a pre-hearing interview as required by Section 10(a)(iii) of Part 230 of the Public Health Law. This motion addresses the requirement that Petitioner offer any Respondent a pre-hearing interview as a condition precedent to the conduct of a hearing. Petitioner offered two certified letters which were addressed to Respondent. There is no dispute that these letters offered Respondent an opportunity for the pre-hearing interview in issue However, the letters were returned by the post office as

unclaimed. Respondent asserts that his office does not accept certified mail. Respondent also asserts that the failure of the Board to follow-up the certified mail with a letters sent by ordinary mail constitutes denial of Respondent's right to the pre-hearing interview.

Clearly, the Board had a duty to provide a pre-hearing interview. Respondent was entitled to reasonable notice of the interview. The issue then is whether the Board failed in its duty of reasonable notice by failing to send the letters to Respondent by both certified mail and ordinary mail.

The Board made an offer of proof that an investigator employed by the Board called Respondent's office to offer Respondent a pre-hearing interview. Apparently Respondent was not available for the call and did not return the call. The Administrative Law Judge would not hear the testimony of the investigator and the offer of proof is not part of the evidence herein. Any evidence of a telephone call or even an effort at personal service would have been cumulative and extraneous.

It was the finding of the Administrative Law Judge that upon the uncontroverted proof that the Board had sent two certified letters to Respondent, the Board had more than met its burden. If Respondent refuses certified mail from state authorities, he has waived his right to notice. He cannot then be heard to complain that he did not receive notice of an opportunity for an interview contained in the letters. Respondent also argued that even if he had received the letters, there was too little time between the date of the letters and the hearing to allow the development of an adequate defense. This argument is speculative. If Respondent had accepted the mail, and if he had found too little time to fully prepare, he could have requested an adjournment from the Committee or a rescheduling from the Board. Since Respondent did not accept the mail, we cannot know if his request would have been granted or denied for good cause. Respondent's motion to dismiss this proceeding is denied.

Respondent also moved to preclude any charges relating to Patients A through D and E through H on the grounds that in previous stipulations and settlements, claims arising from these patients had been dismissed "with prejudice." The stipulations alluded to address charges under Section 18 of the Public Health Law. Violation of Section 18 is, in and of itself, a violation of the Public Health Law and can result in a separate administrative proceeding and a separate civil penalty. The stipulations clearly would make it unlawful for the Department of Health to bring another action under Section 18, arising from the failure to provide records to the patients listed.

This proceeding, however, is brought under Part 230 of the Public Health Law. In this proceeding the issue is not solely whether or not Respondent failed to provide records. Rather, the issue is whether Respondent's actions in reference to the records were inappropriate and rise to the level professional misconduct. While a civil penalty can be imposed, Respondent's license to practice medicine is the primary target of any penalty. It is beyond dispute that a given set of facts can give rise to several proceedings in various civil and criminal forums. Hence, while the stipulations insulate Respondent from further charges regarding those patients under Section 18 of the Public Health Law, he has no protection from a proceeding under Part 230 of the Public Health Law. While the underlying facts may be the same, the issues addressed in the stipulation and those to be addressed herein are entirely different. Respondent's motion to preclude is denied.

2. Instructions to the Trier of Fact

1. The standard of proof in this proceeding is "preponderance of the evidence." This means that the Petitioner must prove the elements of the charges to a level wherein the trier of fact finds that a given event is more likely than not to have occurred. All findings of fact made herein by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

2. The Committee was further instructed that if it is found that any witness has willfully testified falsely as to any material fact, that is as to an important matter, the law permits the trier of fact to disregard completely the entire testimony of that witness upon the principle that one who testifies falsely about one material fact is likely to testify falsely about everything. The Committee was told that it is not required, however, to consider such a witness as totally unworthy of belief. The trier of fact may accept so much of his or her testimony as is deemed true and disregard what is found to be false. The Trier of Fact was told that they, as the sole judges of the facts, decide which of the witnesses they will believe, what portion of their testimony will be accepted and what weight that testimony will be given.

3. The Committee was instructed that in deciding this case, the members may consider only the exhibits which have been admitted in evidence and the testimony of the witnesses as it was heard in this hearing. It was pointed out to the Committee that arguments and remarks of the attorneys or the Administrative Law Judge are not evidence.

4. Fraud is an issue in this matter. Therefore the definition of fraud was given to the Committee as follows: The fraudulent practice of medicine can be sustained when it is proven that Respondent made an intentional misrepresentation or concealment of a known fact, in connection with the practice of medicine. The fraudulent practice of medicine is present when:

(1) A false representation is made by Respondent, whether by words, conduct or concealment of that which should have been disclosed accurately;
(2) Respondent knew the representation was false; and
(3) Respondent intended to mislead through the false representation.

5. The Committee was also instructed that where fraud is alleged, Respondent's knowledge and intent may properly be inferred from facts found by the Hearing Committee. However, the Committee must specifically state the inferences and the basis for the inferences it is drawing regarding knowledge and intent.

6. The Committee was instructed that ordinary English usage could be applied to defining the terms: "having been found guilty of violating a state statute."

7. The Committee was instructed that the requests for patient records which were received in evidence were adequate as a matter of law. However, the Committee could consider the nature of the request, the errors pointed out, and anything else about the requests regarding whether a penalty should be imposed, and if so, mitigation of any penalty.

8. The findings of fact in this decision 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 may have been rejected as irrelevant.

FINDINGS OF FACT

VIOLATION OF STATE STATUTE

1. By Stipulation of Settlement and Order effective on February 1, 1995, Respondent was found guilty of violating Section 18 of the Public Health Law (Ex. 11).

FAILURE TO PROVIDE PATIENT RECORDS

PATIENT A

1. Between September 21, 1992 and February 13, 1995, Respondent failed to provide copies of the record of Patient A.

2. A valid request had been made for the records by an authorized Representative. (Ex. 11 at 1-2 and 5, Ex. 12, 13)

3. Respondent made a demand for payment of $175.00 for providing records to Patient A. (Ex. 11 at 1-2 and 5-6, Ex. 12 at 5).

PATIENT B

4. Between March 16, 1994 and February 13, 1995, Respondent failed to provide copies of the record of Patient B.

5. A valid request for the records had been made by an authorized Representative. (Ex. 11 at 1-2 and 6, Ex. 14, 15).

6. Respondent made a demand for payment of $175.00 for providing records to Patient B. (Ex. 11 at 1-2 and 6, Ex. 14 at 2).

PATIENT C

7. Between June 16, 1994 and February 13, 1995, Respondent failed to provide copies of the record of Patient C.

8. A valid request was made by an authorized Representative. (Ex. 11 at 1-2 and 6, Ex. 16, Ex. 17)

9. Respondent made a demand for payment of $178.00 for providing records to Patient C. (Ex. 11 at 1-2 and 6, Ex. 16 at 1-2, Ex. 17).

PATIENT D

10. Between August 2, 1994 and February 13, 1995, Respondent failed to provide copies of the record of Patient D.

11. A valid request had been made by an authorized Representative of this patient. (Ex. 11 at 1-2 and 7, Ex. 18, 19).

12. Respondent made a demand for payment of a fee in excess of that allowed by law for providing records to Patient D. (Ex. 11 at 1-2 and 7, Ex 18 at 4, Ex. 19).

PATIENT I

13. Respondent treated Patient I between approximately March 17, 1994 and May 5, 1994 (Ex. 4).

14. Patient I was represented by Mitchell J. Sassower, Esq. (T. 16, Ex. 3).

15. Respondent was aware of the fact that Patient I was represented by Mitchell Sassower, Esq.

16. Patient I died in February 1998 (T.17).

17. An original authorization by Patient I was sent with a letter requesting the medical records on May 16, 1994 (T. 17-18 and 39-40, Ex. 3 at 7).

18. Mitchell Sassower received a response dated June 14, 1998, from Respondent's office signed by Rachel requesting an original authorization. The letter also stated that a copy of the medical record would be issued after payment of $85.75 was received (T. 18, Ex. 3 at 6).

19. Mitchell Sassower called Respondent's office. He had at least two conversations with Rachel. Rachel did not indicate that there was any problem with the authorization, the date of the accident, or the identity of the patient. (T. 44-45).

20. Mitchell Sassower received a subsequent letter from Respondent's office. This letter did not request a patient authorization for release of records.

21. The letter indicated that a copy of the medical record of Patient I would be issued after payment of $177.25 was received. (Ex. 3 at 4).

22. Mitchell Sassower notified the Department of Health of Respondent's failure to provide the records of Patient I by letter dated February 21, 1995. (Ex. 3).

23. Respondent provided copies of the medical record of Patient I on March 14, 1995. (Ex. 4).

PATIENT J

24. Respondent treated Patient J between January 17, 1994 and February 7, 1994. (Ex. 6).

25. Patient J was represented by the Law Offices of Jacoby and Meyers. (Ex. 5).

26. Jacoby and Meyers were authorized recipients of medical records, and made appropriate requests for the medical records.

27. On November 27, 1994, Jacoby and Meyers made a third request to Respondent for the records of Patient J. (Ex. 6 at 2)

28. Jacoby and Meyers notified the Department of Health of Respondent's failure to provide the records of Patient J by fax transmission dated February 9, 1995. (Ex. 5 at 1).

29. Respondent provided copies of the record of Patient J to an authorized Representative on February 22, 1995. (Ex.6).

PATIENT K

30. Respondent treated Patient K, a ten year old, between approximately September 24, 1996 and October 29, 1996. (Ex. 8).

31. Patient K's mother requested a copy of her daughter's medical record on October 29, 1996. (Ex. 8 at 2).

32. Patient K's mother made a second or third request for her daughter's medical record on February 6, 1997. (Ex. 8 at 3).

33. Patient K's mother made an additional request for her daughter's medical record on March 25, 1997.

34. On the same date, Patient K's mother notified the Department of Health of Respondent's failure to provide the records. (Ex. 7 at 4).

35. Respondent provided copies of the record of Patient K to her mother on April 15, 1997. (T. 47).

PATIENT L

36. Respondent treated Patient L between approximately November 28, 1995 and December 19, 1995. (Ex. 10 at 3-5).

37. Patient L was represented by Joseph Orlian, Esq. (T. 68, Ex. 9, 10).

38. Joseph Orlian made an original request for the medical record of Patient L on May 16, 1994. (T. 69, Ex. 10 at 3).

39. Joseph Orlian called Respondent's office on several occasions to attempt to obtain the medical records. He was told that they do not speak with lawyers and the phone was hung up. (T. 70-73).

40. Respondent failed to provide copies of the record of Patient L to an authorized Representative until April 14, 1997. (Ex. 10 at 1, T. 74).

41. On or before April 14, 1997, Respondent made a entry in the medical record of Patient L alleging that the father of Patient L and his attorney were threatening to report Respondent to various medical bodies if Respondent did not change notes in the medical record of Patient L. (Ex. 10 at 4).

42. The father of Patient L never spoke to Respondent about changing or even obtaining the medical record and spoke only with office staff on the telephone (T. 53).

43. Patient L's attorney spoke to Rhonda at Respondent's office about sending a letter to the Queens Medical Society because of Respondent's failure to provide the medical record, but she hung up the phone. (T.73).

CONCLUSIONS

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATION ONE AND THE FIRST SPECIFICATION

The First Specification in this proceeding alleges Respondent has violated Section 6530 (9)(c) of the Education Law in that he has been found guilty of violating a state statute. The Specification is based upon the fact that Petitioner and Respondent entered into a stipulation in an earlier proceeding. Petitioner has proven by a preponderance of the evidence that Respondent had been found guilty of violating a state statute as set forth in N.Y. Education Law Section 6530 (9)(c). The Board has shown in the stipulation received as exhibit 11 in this proceeding, Respondent admitted four separate violations of Section 18[1] of the Public Health Law. Not only did Respondent fail to provide the medical records upon which the stipulation arose, but he also demanded unlawful fees for providing the records (Exhibit 11). The facts surrounding Respondent's violation of the Public Health Law concerning Patients A through D are contained in Exhibits 12 through 19. These documents show the efforts made by patients and their attorneys to obtain medical records, Respondent's demand for fees in excess of the statutory limit, efforts by the Department of Health to obtain compliance, and the difficulty of communicating directly with Respondent to resolve these issues. The Committee has finds the stipulation to be clear and convincing on its face. It leaves no question as to the issues presented then or herein.

Therefore,

[1]Section 18 sets up the rules for providing access to patient records including the maximum fee that can be charged.

Factual Allegation One is **SUSTAINED**;
The First Specification is **SUSTAINED**

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS TWO THROUGH NINE AND THE SECOND THROUGH NINTH SPECIFICATIONS

In Factual Allegations Two through Nine, Respondent is charged with eight[1] separate counts of violation of Section 18 of the Public Health Law. Petitioner alleges that Respondent failed to provide records to qualified persons representing eight patients. Respondent argues that in seven cases the request submitted was insufficient or otherwise defective. In one case Respondent alleged that he withheld the records because he suspected possible child abuse (Patient L).

The Committee takes notice that under Section 18 of the Public Health Law, absent a written request that provided accurate basic information about the patient, the incident in issue[2] and the qualifications of the party making the request, Respondent would not be required to release the records. However, where there is no doubt about the identity of the patient, the files requested, or the authority of the party making the request, the records requested must be forwarded in a timely manner.

The question presented to the trier of fact is whether Respondent received defective requests such that he was unable to identify the files requested or was unable to affirm the authority of the

[1]The introductory paragraph of this part of the charges states that Respondent is charged with "twelve separate and distinct specifications." While this is clearly an error, it was merely ministerial. There was no prejudice to Respondent since there was never any question as to what the actual number and nature of the allegations in this proceeding were.

[2]Assuming a large patient file covering many prior incidents, only a portion might be appropriate for release.

party making the request. The Committee is unanimous in its conclusion that the office of Respondent had no difficulty in identifying what was sought and further had no question regarding the authority of those making the request.

While Respondent established numerous errors in the record requests, the errors apparently were insufficient to create confusion on the part of Respondent's office. On the occasions when Respondent's office actually communicated with the parties involved, there was never any mention by his office of a defect in the way the request was drafted. That is, the office asserted no difficulty with identifying the patient or the bona fides of the qualified person. The Committee concludes that Respondent fabricated his explanation after the fact, for the purposes of this proceeding. In so finding, the Committee concludes that Respondent was untruthful in his testimony in this proceeding.

Key to the above conclusion is the fact that on the initial day of testimony in this proceeding, Respondent sought, and was granted an adjournment of this matter at mid-day. The purpose of the adjournment, among others, was for Respondent to bring in members of his office staff who would testify in contradiction to the testimony and other evidence elicited (see remarks of Respondent's counsel, Mr. Dembin, Tr. 97). When this matter re-convened, the promised office staff were not present. No explanation for their absence was offered. If an effort was made to locate and produce the witnesses and the effort had failed, Respondent had a duty to inform the Committee. This failure by Respondent to fulfill his promise of corroboration combined with the absence of any reasonable explanation made the Committee suspicious. Ultimately, the failure to provide the promised witnesses was an important factor in bringing the Committee to its conclusions. However, there were other factors as well.

The Committee gave great weight to the testimony and affidavits by the attorneys and patients involved in this matter. The Committee finds that it is extremely unlikely that an attorney would take hours from his schedule to testify falsely at an administrative proceeding about the failure of a physician to release medical records. While the Committee understands that Respondent could not cross-examine the affiant attorneys and patients, they gave considerable weight to the statements. Above all, the Committee gave weight to the testimony and affidavits because the witnesses and affiants had nothing to gain from being untruthful. Respondent had much to gain from a lack of candor.

Furthermore, Great weight was given to the testimony and affidavits because of the similarity of the circumstances and the pattern that emerges from the testimony and affidavits. The submissions came from people who did not know each other. Hence, the common threads found in each of the statements serves as a means of establishing the credibility of the witnesses. The pattern of creating stumbling blocks for people seeking records also adds to the shadow of doubt cast upon the testimony of Respondent who alleged personal oversight of all record requests. (T. 135).

A good example of this similarity can be seen in a review of Exhibit 14, an affidavit that the attorney for Patient B submitted to the Health Department concerning his dealings with Respondent. The affidavit establishes that an initial request was made in March 1994 with the patient's authorization annexed (Ex.14 at 1). A follow-up letter was sent in April with an additional copy of the patient's authorization (Ex. 14 at 2). When he called Respondent's office, he spoke with "Rachel" who denied receiving the prior request. A fee in excess of the lawful amount was required. Rachel also stated that Respondent's handwritten notes had to be transcribed because they were illegible (Ex. 14 at 2). When the attorney for Patient B called the Queens office he was told to call the Manhattan office. When he called the Manhattan office he was told by the receptionist to put all

communications in writing and address them to the office manager at the Queens office. (Ex. 14 at 3).

The similarities contained in this sworn affidavit of this attorney for Patient B provides confirmation of the experiences of attorneys for Patients I and L. The attorneys for Patients I and L provided testimony at this proceeding. Patient I's attorney's experience was nearly identical to that described by Patient B's attorney. The experience of the attorney for Patient L was very similar. In each instance, there was an initial written request, subsequent written requests, and the imposition of fees in excess of the legal limit. Finally, Respondent's office offered no reasonable opportunity to resolve the requests by a telephone call. Indeed, these elements are common to many of the cases charged.

A specific review of Patient I supports the conclusions of the Committee that Respondent fabricated his defense. Respondent testified that his office resolves an average of between 250 and 300 requests per year. (T. 118). Respondent also testified that he personally reviews all authorizations and requests for quality control, when they come in. (T. 135). Respondent asserted that he based his refusal to provide Patient I's attorney with the record upon Respondent's personal finding that the request itself was invalid. (T. 136). Clearly a record request which is invalid cannot be honored. However, a review of the conflicting testimony and documents, primarily produced by Respondent's office, clearly demonstrates that these issues were not apparent to Respondent at the time the requests were made.

Respondent's testimony that he personally reviewed the request and that the request was so filled with errors that "didn't even know who they were talking about" (T. 136) concerning the request made by the attorney for Patient I is belied by a letter dated June 14, 1994. This letter, addressed to Patient I's attorney, stated that the medical record of Patient I would be issued after

payment of $85.75. (Ex. 3 at 6) On October 6, 1994 the office issued a letter stating that Patient I's medical record would be issued after payment of $177.25 was received. (Ex. 3 at 4). Respondent did not deny that these responses were sent. If the request was invalid as claimed by Respondent, he had no authority to release the records at any price.

In addition, Patient I's attorney stated that he spoke to an employee named "Rachel" at Respondent's office. This employee had no question regarding whose record was requested or the authority of the person making the request. Hence, as a practical matter, the request was valid since the only issue was receipt of a fee. Respondent did not produce his employee to refute any assertion. Indeed, the only credible evidence regarding any difficulty in providing the record was raised by Respondent's office and expressed that the notes were hand written and had to be transcribed. (T. 45-46). Again, the Committee cites its finding that the failure of Respondent to provide the testimony of Rachel, Rhonda or any other employee to rebut the testimony provided during Petitioner's case severely erodes the credibility of Respondent's testimony.

Respondent is also charged with a violation of a state statute for a pattern of demanding payment of an unreasonable fee for providing records. The evidence is clear that Respondent asked far in excess of the legally sanctioned fee. Moreover, the fact that he stated in writing that the file would be released for the excessive fee makes his assertion that he was merely a conscientious protector of the confidentiality of his patients records a contradiction and hence a falsehood.

More specifically, Respondent demanded payment of $177.25 for the record of Patient I (Ex. 3 at 4). The record of Patient I comprised four pages (Ex. 4). Section 18 of the Public Health Law states that a physician may charge no more than $0.75 per page to produce a patient record. Hence, the record for Patient I should have cost the patient or his representative no more than $3.00. Respondent's repeated and increasing demand for payment from Patient I's attorney demonstrates

that he had no bona fide concern regarding the validity of the record request but instead was engaged in an unlawful effort to overcharge his patients.

In regard to his failure to provide the records of Patient K, Respondent did not object to the Committee's decision that the testimony of Patient K's mother was not necessary. Exhibits 7 and 8 were received in evidence and spoke for themselves. (T. 47). Respondent's testimony that she did not verbally request the records from his office is not believable. In so finding, the Committee cites the previous observations about Respondent's lack of truthfulness. Furthermore, there is simply no basis for challenging the credibility of the Patient K's mother. In addition, it is noted that Patient K's mother has no possible interest in the outcome of this proceeding against Respondent, while Respondent is faced with very serious consequences. Further, Respondent does not deny that a written request was made but only states that if she did make the request he was personally unaware of it. (T. 166) The Committee takes notice that Respondent's statement serves to undermine his assertion that he reviews each and every record request. The Committee also takes notice that even if true, Respondent is responsible for the actions of his office.

Finally concerning Patient L, Respondent testified that it was related to him by staff members that the father was quite angry on the phone and that he had made five separate appointments but failed to appear for each of them. (T. 177) Respondent did not produce the office staff that allegedly spoke with the father on these various occasions. Respondent then testified that he did not provide the record because he suspected physical abuse of the patient who was a child

The Committee takes notice that the patient in question suffered a spiral fracture which can be indicative of child abuse. Nevertheless, the Committee rejects Respondent's allegation that he withheld the record because he was suspicious of child abuse. In so finding, the Committee notes Respondent made no report to social services that he suspected child abuse. (T. 185) Such a report

is not voluntary. Rather, it is required by law. Respondent asserted he did not wish to make a false accusation. However he did not even mention his concerns to the child's pediatrician despite the opportunity to communicate with him. (T. 188) Given a physician who is suspicious of child abuse but is not firm in his conclusion, consultation with a pediatrician would be minimal evidence of actual concern. Respondent's actions described above are consistent with a finding that his testimony was false and fabricated, for this proceeding, of plausible reasons for the delay of release of patient records.

Therefore,
Factual Allegation Two is SUSTAINED;
Factual Allegation Three is SUSTAINED;
Factual Allegation Four is SUSTAINED;
Factual Allegation Five is SUSTAINED;
Factual Allegation Six is SUSTAINED;
Factual Allegation Seven is SUSTAINED;
Factual Allegation Eight is SUSTAINED;
Factual Allegation Nine is SUSTAINED;
and
The Second Specification is SUSTAINED;
The Third Specification is SUSTAINED;
The Fourth Specification is SUSTAINED;
The Fifth Specification is SUSTAINED;
The Sixth Specification is SUSTAINED;
The Seventh Specification is SUSTAINED;
The Eighth Specification is SUSTAINED;
The Ninth Specification is SUSTAINED

CONCLUSIONS WITH REGARD TO THE FINAL FACTUAL ALLEGATION AND THE TENTH SPECIFICATION

In the Tenth Specification, Respondent is charged with making a false entry in the patient record for Patient L. Patient L is a child who suffered a spiral fracture at his nursery school. It is undisputed that, Respondent made a notation in the patient record that Patient L (through his father) and the attorney of Patient L had threatened to report Respondent to various medical bodies if Respondent did not change the notes in the file of Patient L. Respondent asserts that Patient L wanted Respondent to indicate that the nursery school was responsible for the injury but that Respondent refused to do so. The threat followed Respondent's refusal to comply with the demand to falsify the record. The issue presented is whether any such threats were ever made.

Respondent presented a picture of the father of Patient L as a person who failed to keep numerous appointments, was irate to Respondent's office staff and was suspected by Respondent of child abuse. The suspicion of child abuse arises from the fact that Patient L had suffered a spiral fracture. The Committee is willing, for the sake of argument, to accept that a spiral fracture in a child is suggestive of but not unequivocal proof of child abuse.

Respondent's own entry in the medical on November 28, 1995 (Ex. 10 at 3) states that the child "sustained an injury ... at nursery school." Notwithstanding the assertion of the significance of the nature of the injury, there is no mention of any effort to elicit a reaction from the father in any sort of discussion about spiral fractures. Respondent testified that no notation of his concerns was made in the record because he feared that a parent might become irate. However, this lacks any credibility when one considers that fact that Respondent then proceeded to make a notation in the

medical record alleging that the father was responsible for untoward outcomes because of his failure to bring the child in to the office and that the father wanted him to change the medical record (Ex. 10 at 4). Respondent had ample opportunity to bring in employees from his office to testify regarding the caustic and troublesome nature of the contacts that he alleges occurred with Patient L's father. He did not avail himself of this option.

In comparison, the testimony of Patient L's father appeared essentially credible. While an interest in liability was established on cross examination, there was insufficient evidence of any agenda aimed at Respondent personally. Given the utter lack of credibility on the part of Respondent throughout this proceeding, the Committee finds that the Board has met its burden of proof as to this charge.

Therefore,
The Final Factual Allegation is SUSTAINED;
The Tenth Specification is SUSTAINED

CONCLUSIONS WITH REGARD TO PENALTY

Petitioner has established each element of the charges and specifications herein. Respondent has been found guilty of failure to provide patient records under the laws of this state. The provision of medical records is a fundamental part of medical practice. Patients have a right to expect that their records will be provided in a timely manner for a reasonable fee. The public has a right to

expect physicians to obey the law. Respondent has shown a pattern of contempt for the law, contempt for the rules of medical practice and contempt for this Committee. He has acted in a manner that indicates that he believes he is above the law. Respondent has lied to this Committee. He has lied to his patients and he has lied to the representatives of his patients. He has attempted to take funds from his patients to which he was not entitled.

Respondent has shown not the slightest hint of a basis for leniency. While he has experienced administrative discipline previously, his former experience has had no remedial effect. Instead of remorse for violation of standards, he boldly fabricated a non-existent defense. The Committee notes that the quality of Respondent's medical care has not been called into question.

The question then is this: Of the array of penalties available to this body, what will make a sufficient impression on this practitioner such that he will conform to the fundamental standards of medical practice? The answer established by this body is a stayed suspension, contingent upon completion of probation. However, in reflection of the acts of contempt committed by Respondent and given his utter lack of remorse, a significant civil penalty has also been imposed.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

It is hereby **ORDERED** that:

1. The Factual allegations in the Statement of Charges (Appendix One) are **SUSTAINED**

Furthermore, it is hereby **ORDERED** that;

2. The Specifications of Misconduct contained within the Statement of Charges (Appendix One) are **SUSTAINED**;

Furthermore, it is hereby **ORDERED** that;

3. The license of Respondent to practice medicine in the State of New York is **SUSPENDED**;

Furthermore, it is hereby **ORDERED** that;

4. Respondent shall pay a **CIVIL PENALTY OF $50,000 (FIFTY THOUSAND DOLLARS).**

Furthermore, it is hereby **ORDERED** that;

5. The said **SUSPENSION** is **STAYED** pending successful completion of a period of **PROBATION** of not less than 5 years;

Furthermore, it is hereby **ORDERED** that;

6. The said **PROBATION TERMS** shall consist of strict adherence to Section 18 of the Public Health Law and any other statutes, rules or regulations now existing or promulgated in the future concerning the release of patient records;

Furthermore, it is hereby **ORDERED** that;

7. The said **PROBATION TERMS** shall consist of timely payment of the civil penalty in this matter and strict adherence to directions concerning payment of the civil penalty in this matter as those directions may be issued by the Director of the Office For Professional Medical Conduct;

Furthermore, it is hereby **ORDERED** that;

8. Should Respondent successfully complete his period of probation, the **SUSPENSION** shall be **PERMANENTLY LIFTED**;

Furthermore, it is hereby **ORDERED** that;

9. The said **STAY OF SUSPENSION** shall be **PERMANENTLY LIFTED** upon receipt by the Director of the Office For Professional Medical Conduct of a complaint against Respondent concerning Section 18 of the Public Health Law and any other statutes, rules or regulations now existing or promulgated in the future concerning the release of patient records or any violation of payment terms of the civil penalty as those terms are issued by the Director of the Office For Professional Medical Conduct;

Furthermore, it is hereby **ORDERED** that;

10. The said **STAY OF SUSPENSION** shall be lifted prior to and as a prerequisite for application of any due process proceedings to which Respondent would be eligible;

Furthermore, it is hereby **ORDERED** that;

11. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail.

Dated:
New York, New York

October 14 **1998**

RICHARD D. MILONE, M.D., Chairperson,
ZORAIDA NAVARRO, M.D.,
MS. DIANE BONANNO

To:

WILLIAM LYNCH, ESQ.
Senior Attorney
Bureau of Professional Medical Conduct
Albany, New York

NATHAN L. DEMBIN, ESQ.
Nathan L. Dembin & Associates, P.C.
225 Broadway, Suite 1400
New York, NY 10007

OSKAR WEG, M.D.
Suite 115
110-45 Queens Blvd.
Forest Hills, NY 11375

APPENDIX ONE

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	AMENDED
OF	:	STATEMENT
OSKAR WEG, M.D.	:	OF
		CHARGES

----------X

OSKAR WEG, M.D., the Respondent, was authorized to practice medicine in New York State on April 2, 1987 by the issuance of license number 169375 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period September 30, 1996, through August 31, 1998, with a registration address of Suite 115, 110-45 Queens Blvd., Forest Hills, New York 11375.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A on and about July 10, 1992 (Patients are identified in Appendix A).

1. On or about and between September 21, 1992 when a valid request was made and February 13, 1995, Respondent failed to provide copies of the record of Patient A to an authorized Representative in violation of § 18 of the Public Health Law.

2. By Stipulation of Settlement and Order dated January 30, 1995, Respondent admitted that his office had failed to comply with Section 18 of the Public Health Law in that he had not provided copies of the medical record of Patient A to an authorized representative, and he had demanded the payment of an unreasonable fee.

B. Respondent treated Patient B on and about January 7, 1994.

1. On or about and between March 16, 1994 when a valid request was made and February 13, 1995, Respondent failed to provide copies of the record of Patient B to an authorized Representative in violation of § 18 of the Public Health Law.

2. By Stipulation of Settlement and Order dated January 30, 1995, Respondent admitted that his office had failed to comply with Section 18 of the Public Health Law in that he had not provided copies of the medical record of Patient B to an authorized representative, and he had demanded the payment of an unreasonable fee.

C. Respondent treated Patient C on and about January 28, 1994.

1. On or about and between June 16, 1994 when a valid request was made and February 13, 1995, Respondent failed to provide copies of the record of Patient C to an authorized Representative in violation of § 18 of the Public Health Law.

2. By Stipulation of Settlement and Order dated January 30, 1995, Respondent admitted that his office had failed to comply with Section 18 of the Public Health Law in that he had not provided copies of the medical record of Patient C to an authorized representative, and he had demanded the payment of an unreasonable fee.

D. Respondent treated Patient D on and about April 27, 1993.

1. On or about and between August 2, 1994 when a valid request was made and February 13, 1995, Respondent failed to provide copies of the record of Patient D to an authorized Representative in violation of § 18 of the Public Health Law.

2. By Stipulation of Settlement and Order dated January 30, 1995, Respondent admitted that his office had failed to comply with Section 18 of the Public Health Law in that he had not provided copies of the medical record of Patient D to an authorized representative, and he had demanded the payment of an unreasonable fee.

I. Respondent treated Patient I on and about March 17, 1994.

1. On or about and between May 16, 1994 when a valid request was made and March 1995, Respondent failed to provide copies of the record of Patient I to an authorized Representative in violation of § 18 of the Public Health Law.

J. Respondent treated Patient J on and about January 17, 1994.

1. On or about and between November 27, 1994 when a valid request was made and March 1995, Respondent failed to provide copies of the record of Patient J to an authorized Representative in violation of § 18 of the Public Health Law.

K. Respondent treated Patient K on and about September 24, 1996.

1. On or about and between October 29, 1996 when a valid request was made and April 15, 1997, Respondent failed to provide copies of the record of Patient K to an authorized Representative in violation of § 18 of the Public Health Law.

L. Respondent treated Patient L on and about November 10, 1995.

1. On or about and between March 12, 1996 when a valid request was made and April 14, 1997, Respondent failed to provide copies of the record of Patient L to an authorized Representative in violation of § 18 of the Public Health Law.

2. On or before April 14, 1997, Respondent made a false entry in the medical record of Patient L alleging that Patient L and his attorney were threatening to report Respondent to various medical bodies if Respondent did not change notes in the medical record of Patient L.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

FOUND GUILTY OF VIOLATING
A STATE STATUTE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(9)(c) (McKinney Supp. 1997) by reason of his having been found guilty of violating a state statute in that Petitioner charges the facts in paragraphs A.2, B.2, C.2, and D.2.

SECOND THROUGH NINTH SPECIFICATIONS

FAILURE TO PROVIDE ACCESS TO PATIENT INFORMATION

Respondent is charged with twelve separate and distinct specifications of professional misconduct within the meaning of N.Y. Educ. Law § 6530(40) (McKinney Supp. 1997), in that he failed to provide access by a qualified person to patient information in accordance with the standards set forth in section eighteen of the Public Health Law, as Petitioner specifically alleges:

2. The facts in Paragraphs A and A.1.
3. The facts in Paragraphs B and B.1.
4. The facts in Paragraphs C and C.1.
5. The facts in Paragraphs D and D.1.
6. The facts in Paragraphs I and I.1.
7. The facts in Paragraphs J and J.1.
8. The facts in Paragraphs K and K.1.
9. The facts in Paragraphs L and L.1.

TENTH SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6530(2) (McKinney Supp. 1997), in that he made a false entry into the medical record of Patient L, as Petitioner specifically alleges the facts in Paragraphs L, L.1, and L.2.

DATED: April 17, 1998
Albany, New York

/s/ Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX TWO

RESP
EX. A
4/23/98

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

----------X

In the Matter

ANSWER

Of

OSKAR WEG, M.D.

----------X

Respondent, OSKAR WEG, M.D., by his attorneys, NATHAN L. DEMBIN & ASSOCIATES, P.C., answering the allegations of the Statement of Charges, alleges upon information and belief:

Generally denies the allegations contained in the Statement of Charges.

AS AND FOR A FIRST AFFIRMATIVE DEFENSE TO THE ENTIRE STATEMENT OF CHARGES:

That Dr. Weg has always practiced the profession of medicine within acceptable standards.

AS AND FOR A SECOND AFFIRMATIVE DEFENSE TO THE ENTIRE STATEMENT OF CHARGES:

That Dr. Weg was deprived his right to an interview pursuant to Public Health Law §230(10)(iii).

AS AND FOR A THIRD AFFIRMATIVE DEFENSE TO THE ENTIRE STATEMENT OF CHARGES:

Numerous allegations alleged have already been determined and disposed of by the Department of Health and are improperly reasserted by the Department of Health in this forum.

WHEREFORE, the respondent demands judgment dismissing the Statement of Charges.

NATHAN L. DEMBIN & ASSOCIATES,P.C.
Attorneys for Defendant
225 Broadway, Suite 1400
New York, NY 10007
212-267-0505

TO:

William Lynch, Senior Counsel
Bureau of Professional Medical Conduct
Corning Tower Building, Room 2503
Empire State Plaza
Albany, New York 12237-0032