THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

February 16, 1990

Henry J. Zackin, Physician
895 Park Avenue
New York, N.Y. 10021

Re: License No. 101457

Dear Dr. Zackin:

Enclosed please find Commissioner's Order No. 10271. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: Stephen J. Fallis, Esq.
Carb, Luria, Glassner, Coole & Kufeld
529 5th Avenue
New York, N.Y. 10017

REPORT OF THE REGENTS REVIEW COMMITTEE

HENRY J. ZACKIN

CALENDAR NO. 10271

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

HENRY J. ZACKIN **No. 10271**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

HENRY J. ZACKIN, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on March 8, April 24, and May 3, 1989 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of the first through eighth specifications of the charges to the extent indicated in its report, and recommended that respondent be Censured and Reprimanded.

The Commissioner of Health recommended to the Board of Regents that the findings of fact, conclusions, and recommendation of the hearing committee be accepted, except that the hearing committee's conclusion with regard to the first specification of the charges be modified to read that respondent's care and treatment of patients A and B constitute negligence on more than one occasion. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On November 2, 1989 respondent appeared before us in person and was represented by his attorney, Stephen J. Fallis, Esq., who presented oral argument on behalf of respondent. Terrence J. Sheehan, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent be Censured and Reprimanded.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was no penalty.

We have considered the record as transferred by the

Commissioner of Health in this matter, as well as respondent's October 12, 1989 submission.

We note that the hearing committee in its report found as fact number five that the respondent "performed a reconstruction of the lower lip deformity with scar revision, facial suspension and submental lipectomy", with respect to patient A. Upon a careful and independent review of the record, we see no reason to doubt the accuracy of this finding of fact. Therefore, we reject as speculation the portions of the hearing committee's conclusions in which it questions whether patient A's lower lip deformity existed.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 21 findings of fact and recommendation as to the measure of discipline be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact and recommendation be accepted;
2. The hearing committee's conclusions as to the question of respondent's guilt be accepted as modified by the Commissioner of Health, and the hearing committee's following statements not be accepted: "The Committee is convinced that the presence of a 'lower lip deformity' in patient A was not demonstrated by the testimony and

the documents received in evidence," and "The Committee, however, is doubtful whether such condition existed as diagnosed";

3. The Commissioner of Health's recommendation as to the hearing committee's conclusions be accepted to the same extent as described in paragraph No. 2 above;

4. Respondent be found guilty, by a preponderance of the evidence, of all eight specifications of the charges to the extent indicated by the Commissioner of Health; and

5. Respondent be Censured and Reprimanded upon each specification of the charges of which we recommend respondent be found guilty.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith
Chairperson

Dated: December 19, 1989

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

IN THE MATTER	:	STATEMENT
OF	:	OF
HENRY J. ZACKIN, M.D.	:	CHARGES

HENRY J. ZACKIN, M.D., the Respondent, was authorized to practice medicine in New York State on June 24, 1968 by issuance of license number 101457 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 January 1, 1986 through December 31, 1988 at 525 Park Avenue, New York, N.Y. 10021.

FACTUAL ALLEGATIONS

A. From on or about September 23, 1980 through on or about November 22, 1980, Respondent rendered care and/or treatment to Patient A (the identity of the patients referred to herein appear in the attached Appendix), for a "trap door deformity" of the chin and a "lower lip deformity". This care and treatment was rendered at Respondent's office, as well as during the patient's admission to Medical Arts Center Hospital (October 12, 1980 through October 15, 1980). In this regard:

EXHIBIT #A

1. Respondent failed to perform the required and accepted procedure indicated to correct Patient A's "lower lip deformity".

2. Respondent knowingly made a false claim in both his office chart and the hospital chart for Patient A, as well as in the insurance claim form he submitted for reimbursement, that he performed a "facial sling" procedure on Patient A, when in fact he performed a simple face lift procedure.

3. The face lift procedure which Respondent actually performed was not the required and accepted procedure to correct Patient A's "lower lip deformity."

4. There were no indications for the performance of a face lift procedure.

5. A facial sling procedure, even if performed, would not have been indicated nor would it have been the accepted procedure to correct Patient A's "lower lip deformity".

6. Respondent failed to perform the required and accepted procedure indicated to correct the "trap door deformity" of Patient A's chin.

7. Respondent performed a submental lipectomy which has no relationship to, nor is it indicated for, the correction of the "trap door deformity" of Patient A's chin.

8. Respondent failed to maintain an office record for Patient A which accurately reflects his examination, care, treatment, surgery and/or follow-up of Patient A.

B. From on or about June 3, 1981 through on or about March 29, 1982, Respondent rendered care and/or treatment to Patient B at his office. In this regard:

1. Respondent knowingly made a false diagnosis of ptosis of Patient B's eyes, when in fact Patient B, who is oriental, presented desiring a westernized look to her eyes.

2. Respondent failed to substantiate his diagnosis of ptosis, bilaterally, with the

appropriate examination and failed to document the degree of ptosis present.

3. Respondent failed to conduct a complete and proper examination, evaluation, and pre-operative screening of the patient prior to performing surgery.

4. Respondent performed a levator resection which was not the correct nor accepted procedure to westernize Patient B's eyes.

5. Respondent was negligent in his performance of the levator resection causing a deformity of Patient B's left eye.

6. Respondent knowingly made a false claim, in both his medical chart and in the insurance claim form he submitted for reimbursement, that he excised multiple facial lipomas from Patient B's face when in fact he never did.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE AND/OR INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence and/or incompetence on more than one occasion under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges that Respondent has committed two or more of the following:

1. The facts in paragraphs A-1, A-3 through A-8, B-1 through B-5.

SECOND THROUGH FOURTH SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent practiced the profession fraudulently under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges:

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2. The facts in paragraph A-1 through A-8.

3. The facts in paragraphs B-1, B-2, and B-3.

4. The facts in paragraph B-6.

FIFTH AND SIXTH SPECIFICATION

WILLFULLY MAKING OR FILING A FALSE REPORT

Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law Section 6509(9)(McKinney 1985) in that he willfully made and filed false reports within the meaning of 8 N.Y.C.R.R. Section 29.1 (b)(6)(1987) in that Petitioner alleges:

5. The facts in paragraphs A-1 through A-8.

6. The facts in paragraphs B-1, B-2, B-3, and B-6.

SEVENTH AND EIGHTH SPECIFICATION

FAILING TO MAINTAIN AN ACCURATE RECORD

FOR EACH PATIENT

Respondent is charged with committing unprofessional conduct under N.Y. Educ Law Section 6509(9)(McKinney 1985) in that he failed to maintain a record for each patient which accurately reflects the evaluation and treatment of that patient within the meaning of 8 N.Y.C.R.R. Section 29.2(a)(3)(1987), in that Petitioner alleges:

7. The facts in paragraphs A-1 through A-8.

8. The facts in paragraphs B-1, B-2, B-3, and B-6.

Dated: New York, New York
January 24, 1989

CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct

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

IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
HENRY J. ZACKIN, M.D.	:	COMMITTEE

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Leo Fishel Jr., M.D., Chairman, Steven M. Lapidus, M.D. and Fr. Daniel Morrissey designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Tyrone T. Butler, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this report.

SUMMARY OF PROCEEDINGS

Service of Notice of Hearing and Statement of Charges:	February 8, 1989
Prehearing conferences:	March 8, 1989
Hearing Dates:	March 8, 1989 April 24, 1989 May 3, 1989
Deliberations were held on:	June 6, 1989 June 27, 1989

EXHIBIT "B"

Place of hearing:	8 East 40th Street New York, New York 33 West 34th Street New York, New York
Department of Health appeared by:	Peter J. Millock, Esq., General Counsel by Terrence Sheehan, Esq. Office of Professional Medical Conduct 8 East 40th Street New York, New York
Respondent appeared by:	Carb, Luria, Glassner & Kufeld, Esqs. by Stephen J. Fallis, Esq. 529 Fifth Avenue New York, New York 10017
Witnesses for Department of Health:	Armand Simone, M.D.
Witnesses for Respondent:	Mitch Kaplan, M.D. Michael Heller, Ph.D. Henry J. Zackin, M.D. David Arluck, M.D. Judith Zackin Richard Kaye, Esq.
Petitioner (Department) filed Proposed Findings of Fact, Conclusions of Law on:	May 30, 1989

Respondent filed Proposed
Findings of Fact, Conclusions
of Law on: May 30, 1989

On February 8, 1989, the Respondent was served with the Notice of Hearing and Statement of Charges. The Department of Health and the Respondent presented their entire cases and the record was closed on May 3, 1989. On June 6, 1989 and June 27, 1989 the Hearing Committee held deliberations.

SUMMARY OF CHARGES

In the Statement of Charges (Dept's. Ex. 1 - copy attached), the Respondent, Henry J. Zackin, M.D., was charged with professional misconduct pursuant to Education Law §6509. The specific charges were: practicing the profession with negligence and/or incompetence on more than one occasion [Education Law §6509(2)] (First specification), practicing the profession fraudulently [Education Law §6509(2)] (Second through Fourth specifications), willfully making or filing a false report [Education Law §6509(9) and 8 NYCRR §29.1(b)(6)] (Fifth and Sixth specifications) and failing to maintain an accurate record for each patient [Education Law §6509(9) and 8 NYCRR §29.2(a)(3)] (Seventh and Eighth specifications).

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. The Pre-hearing transcript was not made available to the Hearing Committee at the time of deliberations.

1. Henry J. Zackin, M.D., the Respondent, was authorized to practice medicine in the State of New York on June 24, 1968, by the issuance of license number 101457 by the New York State Education Department. (Ex. 1).

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988, at 525 Park Avenue, New York, New York 10021. (Ex. 1).

FINDINGS OF FACT PATIENT "A"

3. Patient A was referred to the Respondent, on or about September or October of 1980, for surgical treatment of a previous injury received in an automobile accident. (T. 319, Ex.2).

4. The Respondent examined and took polaroid photos of Patient A. He diagnosed her injuries as a prominent trap-door type scar on her chin and a scar on her lower lip with the lower lip being pulled down. (T. 319-320).

5. The Respondent performed a reconstruction of the lower lip deformity with scar revision, facial suspension and submental lipectomy. (T. 322-330, Ex.2).

6. The Respondent stated in his 10/13/80, operative report, re: Patient A, that the lower lip deformity was corrected by means of a "Facial suspension procedure". (T. 115-118, 330, Ex. 2).

7. A "facial suspension" or "sling" procedure is a procedure where the patient's muscle or tendon is fixed to a muscle or deep structure (bone). This usually is a procedure done to correct facial paralysis. (T. 115-116, 211-212).

8. In the procedure that the Respondent performed on Patient A he stated that he "pulled the skin up to correct the deformity". The operation as described was a face lift and not a "sling" or "suspension". A face lift is a cosmetic procedure and a sling or suspension is reconstructive. (T. 115-116, 118, 211-212, 329-330, 385).

9. The Respondent submitted insurance claims dated: 10/25/80, for reimbursement, re: Patient A, from Blue Cross/Blue Shield, Traveler's Insurance and Liberty Mutual. These forms include, among other procedures, the performance of a "facial sling bilaterally". (Ex. 2).

10. A trap-door deformity is a scar that contracts during the healing process and causes a buckling, bubbling or swelling above it. Patient A had an obvious trap-door deformity on her chin before the Respondent surgically treated her. (T. 118-119, 325, Ex. 2).

11. A trap-door deformity is corrected by using either "Z" plastys, multiple "Z" plastys or "W" plastys. The designation "Z" or "W" plasty refers to the type of incision that is made to change the direction of the scar. The Respondent makes no mention of "W" plastys either in his operative report or in later testimony. (T. 119, 326-327).

12. The Respondent performed a submental lipectomy to correct Patient A's trap-door deformity of the chin. A submental lipectomy is not the required and accepted procedure to correct a trap-door deformity and is a cosmetic procedure. (T. 121-122, 213-214, 327-328).

13. The Respondent's office records for Patient A do not document: the scar length, a diagram of the scar, medically suitable photos of the patient, a lip deformity, a physical examination, prior medical history and/or any paralysis. (T. 162-163, Ex. 2).

FINDINGS OF FACT - PATIENT "B"

14. Patient B was an 18 year old oriental female. She was referred to the Respondent on or about June 3, 1981. She wanted her folds placed in her upper eyelids to achieve a more "westernized" look. (T. 413-415, 456, Ex. 4).

15. The Respondent examined Patient B and diagnosed her condition as "ptosis". The Respondent performed surgery on Patient B on June 15, 1981, in his office. (T. 456-457, Ex. 4).

16. Ptosis, as it relates to Patient B, is a lowering or drooping of the eyelids which can cause an impairment of vision. (T. 63, 457).

17. There is no data in the Respondent's office records for Patient B that would support a diagnosis of ptosis. An examination for ptosis should include a visual field test, measurement of the eyelid opening and excursion of the eyelid. (T. 20-22, 246-247, Ex. 4).

18. The Respondent's office records for Patient B do not indicate entries for past medical history or performance of a physical examination before surgery. (T. 20, 277, Ex. 4).

19. The Respondent performed a levator resection on Patient B on June 15, 1981. A levator resection is not the acceptable medical procedure to achieve "westernization" of the eyes. (T. 23-24, 53-54, 56-57, 236, 464, Ex. 4).

20. Approximately nine (9) months after surgery, Patient B's left eyelid was significantly higher than her right eyelid. (T. 26, Ex. 7).

21. The Respondent submitted an operative report, for the June 15, 1981 procedure performed on Patient B, to Traveler's and Blue Cross/Blue Shield insurance companies, requesting reimbursement for the removal of multiple facial lipomas. (T. 467-468, Ex. 4)

CONCLUSIONS

The Hearing Committee unanimously reached each of the following conclusions:

PATIENT A

From on or about September 23, 1980 through on or about November 22, 1980, the Respondent rendered care and/or treatment to Patient A, for a "trap door deformity" of the chin and a "lower lip deformity". This care and treatment was rendered at the Respondent's office, as well as during the patient's admission to Medical Arts Center Hospital.

The Committee is convinced that the presence of a "lower lip deformity" in Patient A was not demonstrated by the testimony and the documents received in evidence. In addition, no evidence was presented that indicated paralysis of the patient's lower lip. However, the Respondent proceeded to perform an operation to correct a "lower lip deformity".

The Committee Concludes that the Respondent performed a face lift procedure along with a submental lipectomy for solely cosmetic reasons and then billed the insurers for a covered reconstructive procedure. The Respondent did not perform the medically required and/or accepted procedure to correct Patient A's "lower lip deformity". The Committee, however, is doubtful whether such condition existed as diagnosed.

The record clearly indicates that the Respondent made claims to the insurers requesting reimbursement for the performance of a "facial sling/suspension" procedure. The Committee concludes that the Respondent actually performed a simple face lift and submental lipectomy which are cosmetic procedures not reimbursible by insurance. We are unconvinced that the evidence presented substantiates the allegation that there were no indications for the performance of a face lift procedure. However, as noted supra, face lifts are cosmetic and not reimbursible.

There was no evidence in the record that Patient A suffered from facial paralysis. The facial sling/suspension procedure is one that is utilized to correct facial paralysis. Therefore, a facial sling procedure was not indicated and we conclude that one was not performed. Facial sling procedures are not performed to alleviate simple lower lip deformities.

The accepted procedure to correct a trap door deformity requires the performance of a "Z" or "W" plasty procedure on the existing scar. The Respondent did not follow the accepted procedure and instead performed a submental lipectomy. A submental lipectomy was not the standard medically accepted procedure for the correction of Patient A's "trap door deformity".

Examination of the Respondent's office records, in evidence, for Patient A did not reveal data which accurately reflected his treatment of her. The were no entries in the office record that detailed, among other things, the scar length, medically acceptable photos, a physical examination or even an adequate prior medical history.

Therefore, as regards Patient A, the Committee concludes that allegations: A1 - A3 and A5 - A8, as delineated in the attached Statement of Charges have been sustained. Allegation A4 has not been sustained.

PATIENT B

From on or about June 3, 1981 through on or about March 29, 1982, the Respondent rendered care and/or treatment to Patient B at his office.

The Committee finds that the Respondent did not perform the proper tests in order to substantiate a diagnosis of ptosis. A proper workup should have included an opthomologist's examination for visual field defects. In addition, there was no indication in the patient's record of any complaint of vision reduction. Ptosis that qualifies as a reimbursible condition should have as at least one of its results a diminution of vision.

The Respondent, personally, performed a gross field of vision test that was not adequate to substantiate a diagnosis of ptosis. Further, the Committee does not agree with the defense that the test performed were capable of even minimally determining the limits of Patient B's field of vision.

The office records for Patient B fail to document, among other things, past medical history or the performance of a physical examination. The Committee finds that this record is also inadequate in regard to the minimal acceptable standards for a pre-operative laboratory workup.

The Committee finds that based upon the expert testimony received at the hearing and evidence in the record, a levator resection was not the proper surgical procedure to achieve the "westernization" of Patient B's eyes.

The Committee is unable to conclude from the evidence in the record whether or not the post-operative deformity of Patient B's eyes was caused by any negligence on the part of the Respondent.

The Respondent prepared separate operative reports regarding the procedures performed on Patient B. One operative report describes the eye operation, solely, and the other refers specifically to lipomas allegedly removed from the patient's cheeks. What is significant is that the Respondent in his testimony seriously contradicted his written operative report regarding the location and removal of the lipomas. In addition, the insurance forms are in disagreement in that the three separate submissions each contains a different description of the nature of the lesions removed and their location. Therefore, because of these myriad and various contradictions the Committee concludes that the insurance claims are not valid indications of the events as they actually occurred.

Therefore, as regards Patient B, the Committee concludes that allegations: B1 - B4 and B6, as delineated in the attached Statement of Charges have been sustained. Allegation B5 is not sustained.

Practicing the Profession with Negligence and/or Incompetence on more than one occasion (First Specification)

The Committee concludes that the Respondent has practiced the profession with negligence and/or incompetence on more than one occasion. Specification 1 is sustained.

Practicing the Profession Fraudulently (Second through Fourth specifications)

The Committee concludes that the Respondent practiced the profession fraudulently. Specifications 2 through 4 are sustained.

Willfully Making or Filing a False Report (Fifth and Sixth specifications)

The Committee concludes that the Petitioner willfully made and filed a false report. Specifications 5 and 6 are sustained.

Failing To Maintain An Accurate Record For Each Patient

(Seventh and Eighth specifications)

The Committee concludes that the Petitioner failed to maintain accurate records for Patients A and B. Specifications 7 and 8 are sustained.

RECOMMENDATION

The Committee recommends unanimously that the Respondent be censured and reprimanded. We feel that the passage of time since the violations sustained occurred, without further occurrences is significant mitigation which must be considered in our determination of a suitable recommendation. Therefore, we conclude that censure and reprimand of the Respondent is adequate in this instance.

DATED: New York, N.Y.
July 7 1989

Respectfully submitted

Leo Fishel, Jr., M.D.
Chairman
Steven M. Lapidus, M.D.
Fr. Daniel Morrissey

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

IN THE MATTER	:	
OF	:	COMMISSIONER'S
HENRY J. ZACKIN, M.D.	:	RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on March 8, April 24, and May 3, 1989. Respondent, Henry J. Zackin, M.D., appeared by Stephen J. Fallis, Esq. The evidence in support of the charges against the Respondent was presented by Terrence Sheehan, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full except that the Committee's Conclusion with respect to the First Specification should be modified to read that Respondent's care and treatment of Patients A and B constitute negligence on more than one occasion. Respondent failed to exercise the care that would be exercised by a reasonably prudent licensee under the circumstance.

EXHIBIT "C"

B. The Recommendation of the Committee should be accepted; and

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation as described above.

The entire record of the within proceeding is transmitted with this Recommendation.

Dated: Albany, New York

September 15, 1989

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

HENRY J. ZACKIN

CALENDAR NO. 10271

The University of the State of New York

IN THE MATTER

OF

HENRY J. ZACKIN
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 10271

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10271, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (January 17, 1990): That, in the matter of HENRY J. ZACKIN, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 21 findings of fact and recommendation as to the measure of discipline be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact and recommendation be accepted;
2. The hearing committee's conclusions as to the question of respondent's guilt be accepted as modified by the Commissioner of Health, and the hearing committee's following statements not be accepted: "The Committee is convinced that the presence of a 'lower lip deformity' in patient A was not demonstrated by the testimony and the documents received in evidence," and "The Committee, however, is doubtful whether such condition existed as diagnosed";
3. The Commissioner of Health's recommendation as to the

hearing committee's conclusions be accepted to the same extent as described in paragraph No. 2 above;

4. Respondent is guilty, by a preponderance of the evidence, of all eight specifications of the charges to the extent indicated by the Commissioner of Health; and

5. Respondent be Censured and Reprimanded upon each specification of the charges of which respondent was found guilty;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 29th day of January, 1990.

Thomas Sobol

Commissioner of Education