New York State Board for Professional Medical Conduct
433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D.,M.P.H., Dr. P.H.
Commissioner
NYS Department of Health

Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health

Dennis J. Graziano, Director
Office of Professional Medical Conduct

Public

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Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

February 10, 2006

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Eric R. Johnson, M.D.
59 West Avenue
Brockport, NY 14420

RE: License No. 180005

Dear Dr. Johnson:

Enclosed is a copy of Order #BPMC 06-26 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect February 17, 2006.

If the penalty imposed by this Order is a surrender, revocation or suspension, you are required to deliver your license and registration within five (5) days of receipt of this Order to:

Board for Professional Medical Conduct
New York State Department of Health
Hedley Park Place, Suite 303
433 River Street
Troy, New York 12180

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management
New York State Department of Health
Corning Tower, Room 1258
Empire State Plaza
Albany, New York 12237

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

cc: Donald W. O'Brien, Jr., Esq.
Woods, Oviatt, Gilman, LLP
700 Crossroads Building
2 State Street
Rochester, NY 14614

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

IN THE MATTER
OF
ERIC R. JOHNSON, M.D.

CONSENT
ORDER
BPMC No. 06-26

Upon the application of (Respondent) ERIC R. JOHNSON, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and SO ORDERED, and it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, Whichever is first.

SO ORDERED.

DATED: 2-9-06

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

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

IN THE MATTER
OF
ERIC R. JOHNSON, M.D.

CONSENT AGREEMENT AND ORDER

ERIC R. JOHNSON M.D., representing that all of the following statements are true, deposes and says:

That on or about, September 19, 1989, I was licensed to practice as a physician in the State of New York, and issued License No. 180005 by the New York State Education Department.

My current address is 59 West Avenue, Brockport, New York 14420, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct has charged me with thirty-four specifications of professional misconduct.

A copy of the Amended Statement of Charges, marked as Exhibit "A", is attached to and as part of this Consent Agreement.

I do not contest the charge set forth in the thirty-third specification of the Amended Statement of Charges as it relates to factual allegations I. and I.1, I. and I.2 and I. and I.3, in full satisfaction of the charges against me, and deny the remainder of the charges.

Pursuant to §230-a(2) and (9) of the Public Health Law, my license shall be suspended for a period of 36 months, with the entire 36 month period of said suspension to be stayed.

Pursuant to §230-a(9) of the Public Health Law, I shall be placed on probation for a period of 36 months, subject to the terms set forth in attached

Exhibit "B."

I shall be subject to a fine in the amount of $3,000.00, pursuant to §§230-a(7) and (9) of the Public Health Law.

FINE PAYMENTS

Payment of the fine imposed is also a term of probation. Unless otherwise specified herein, the fine is payable in full within thirty (30) days of the effective date of this Order. Payments must be submitted to:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1245
Albany, New York 12237

That Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees. This condition shall take effect thirty (30) days after the Consent Order's effective date and will continue so long as Respondent remains licensed in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in

New York State.

I stipulate that my failure to comply with any conditions of this Order shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first.

I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

DATED 1/25/06

ERIC R. JOHNSON, M.D.
Respondent

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 1-25-06

DONALD W. O'BRIEN, JR., ESQ.
Attorney for Respondent

DATE: 1-25-06

LEE A. DAVIS
Assistant Counsel
Bureau of Professional Medical Conduct

DATE: 2/08/06

DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by New York State Education Law §6530 or §6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York State Public Health Law §230(19).

2. Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that such information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty (30) days of each action.

4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of thirty (30) consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive thirty (30) day period. Respondent shall then notify the Director again at least fourteen (14) days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period will resume and Respondent shall fulfill any unfulfilled probation terms.

7. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records and/or hospital charts; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

8. Respondent shall maintain complete and legible medical records that

accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

9. Respondent shall enroll in and complete a Board Review course in general surgery within the first year of the probation period. This continuing education program is subject to the Director of OPMC's prior written approval.

PRACTICE MONITOR

10. Within thirty (30) days of the effective date of the order, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Nothing shall prohibit Respondent from proposing and the Director of OPMC from approving more than one qualified physician as a monitor.

    a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis on a quarterly basis and shall examine a selection of eight (8) records on a monthly basis maintained by Respondent, including patient records, prescribing information and office records. Respondent shall provide to the monitor and OPMC on a monthly basis, a summary of care he provided to each patient treated during that month, including the identity of the patient, the presenting illness of the patient and the procedures or other treatment provided to the patient by Respondent. In the months the monitor does not visit Respondent's office, (s)he shall determine which records to review on the basis of this summary provided by Respondent. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

    b. Prior to performing the first 100 elective intra-abdominal surgical procedures or for the three (3) year probationary period, whichever is shorter, Respondent shall receive pre-authorization from a licensed, Board Certified surgeon, nominated by Respondent and approved by the Director of OPMC, after the monitor has had an opportunity to review the patient's history and physical examination and other pertinent medical records and has been advised by Respondent of his proposed surgical plan. Elective intra-abdominal surgical procedures will include all procedures which enter the peritoneum, including laparoscopic procedures, and will include umbilical and/or incisional hernias, but not inguinal hernias. Pre-authorization will not be required for urgent or emergent cases, or cases in which there is insufficient time to obtain the pre-authorization without compromising patient care. In these urgent or emergent cases, Respondent will be required to obtain a post-surgical evaluation of his care and treatment from the designated surgeon.

c. Prior to performing the first 10 inpatient colonoscopies or for the three (3) year probationary period, whichever is shorter, Respondent shall receive pre-authorization from a licensed, Board Certified surgeon with GI and/or endoscopy privileges, nominated by Respondent and approved by the Director of OPMC, except in emergent cases or cases with gastrointestinal bleeding, in which case Respondent will be required to obtain a post-surgical evaluation of his care and treatment from such a surgeon.

d. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

e. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

f. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

11. Respondent agrees that he will not admit or manage any medical patients without the approval of the Director of OPMC and will refer all primary care patients to an internist or other qualified primary care physician within three (3) months of the effective date of this Order. It is understood that this provision will not limit my delivery of medical care to surgical patients or to patients Respondent manages as a surgical consultant for whom the differential diagnoses do not require surgery or for patients who do not consent to surgery. It is further understood that this provision will not preclude my foundational work or delivery of medical services on an incidental basis as I have represented to OPMC.

12. Respondent shall comply with this Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.

EXHIBIT A

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

IN THE MATTER

OF

ERIC R. JOHNSON, M.D.

AMENDED STATEMENT OF CHARGES

ERIC R. JOHNSON, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 19, 1989, by the issuance of license number 180005 by the New York State Education Department. Respondent is currently registered with the New York State Education Department through October 31, 2006.

FACTUAL ALLEGATIONS

A Respondent provided medical care and treatment to Patient A (patients are identified in Appendix A, attached hereto), a male patient 85 years old when treated for rectal cancer, with a presenting history of status post radiation therapy for prostate cancer, an irregular nodular density in the left upper lobe, chronic smoker with COPD and Type II Diabetes Mellitus, from on or about September 26, 2000 through his demise on or about October 22, 2000 at Lakeside Memorial Hospital, Brockport, New York 14420. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an adequate history and physical examination of Patient A for his October 4, 2000 admission to Lakeside Memorial Hospital;

2. Respondent failed to consider and/or record preoperative alternatives to surgical treatment;

3. Respondent inappropriately diagnosed Patient A with "near obstructing" colon cancer;

4. Respondent performed an inadequate operation on October 5, 2000 to address his preoperative diagnosis of colon cancer, in light of the preoperative objective data derived from the sigmoidoscopy, tumor biopsy, CT scan and barium enema;

5. Respondent inappropriately addressed Patient A's diverticulosis with surgical intervention, given the presenting medical condition of Patient A; and

6. Respondent failed to open the colon specimen removed during surgery to confirm that the tumor had been resected.

B Respondent provided medical care and treatment to Patient B, a male patient 86 years old when treated for a bowel obstruction with a carcinoma, from on or about June 6, 1997 through on or about September 30, 1997 at Lakeside Memorial Hospital, Brockport, New York 14420. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately ordered a colonoscopy after a barium enema revealed an obstructing lesion at the splenic flexure that had the appearance of a carcinoma;

2. Respondent's ordering of a lavage bowel preparation was contraindicated in light of Patient B's presentation of a suspected bowel obstruction;

3. Respondent failed to address whether Patient B's bowel was perforated in his operative report of June 9,1997, despite the pre-operative diagnosis to "rule out perforated obstructed carcinoma";

4. Respondent failed to discuss the small bowel resection of Patient B in his operative report of June 9, 1997;

5. Respondent failed to discuss his repair of Patient B's abdominal wall hernia in his operative report of June 9, 1997;

6. Respondent failed to obtain and/or record obtaining a timely radiologic evaluation of Patient B's abdomen at the first indication of a post operative abscess;

7. Respondent failed to surgically intervene in a timely fashion

after detecting the dehiscence of Patient B's surgical wound and the suspected abscess;

8. Respondent failed to adjust and/or record the adjustment of the antibiotics administered to Patient B post operatively to a therapeutic level;

9. Respondent failed to adjust the central hyperalimentation and/or record the adjustment of the hyperalimentation to the an appropriate level for approximately three weeks, and/or provide a rationale for not adjusting the hyperalimentation;

10. Respondent failed to manage and/or record the management of Patient B's blood sugars while the patient was receiving hyperalimentation; and

11. Respondent failed to provide a rationale as to why he continued to administer Patient B's medications via the NG tube following the cardiology consult that they be discontinued.

C Respondent provided medical care and treatment to Patient C, a female patient 85 years old when admitted for abdominal pain and constipation to rule out a colonic ileus versus an obstructed bowel from on or about November 19, 1999 through her demise on or about November 23, 1999 at Lakeside Memorial Hospital, Brockport, New York 14420, with a medical history of coronary artery disease, atrial fibrillation, congestive heart failure, Type II Diabetes Mellitus, hypothyroidism, right brachial artery embolism, renal insufficiency, uterine cancer and gallbladder cancer. Respondent's care and treatment of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent failed to make adequate entries into the chart of Patient C upon her admission to Lakeside Memorial Hospital regarding his plan of management for the patient;

2. Respondent misdiagnosed Patient C with a possible bowel obstruction after the initial x-ray and barium enema studies demonstrated no bowel obstruction;

3. Respondent failed to consider and/or record hypothyroidism as a cause of Patient C's potential ileus;

4. Respondent failed to adequately manage and/or record Patient C's potassium levels in response to the high levels of potassium Respondent ordered to be administered to her during the course of her hospitalization;

5. Respondent failed to order and/or record cardiac monitoring of Patient C even though she was receiving more than 60 mEq potassium per day;

6. Respondent failed to adequately manage and/or record Patient C's glucose levels in response to the level of hyperalimentation he had ordered;

7. Respondent's ordering of a lavage bowel preparation was contraindicated in light of Patient C's possible bowel obstruction, colonic ileus or ischemic bowel;

8. Respondent failed to monitor and/or record Patient C's thyroid levels in light of her documented hypothyroidism and bowel dysfunction;

9. Respondent failed to order and/or record the ordering of a CT scan, angiogram or a CT angiogram to rule out an embolism as the cause of her abdominal distention, given Patient C's documented history of atrial fibrillation and brachial artery occlusion due to an embolus; and

10. Respondent failed to document why he did not order a CT scan, angiogram or a CT angiogram to rule out an embolism as the cause of her abdominal distention, given Patient C's documented history of atrial fibrillation and brachial artery occlusion due to an embolus.

D Respondent provided medical care and treatment to Patient D, a female patient 57 years old when treated by Respondent as a surgical consultant for an abdominal mass encountered during repair of a prolapsed vaginal vault, with a presenting history of Type II Diabetes Mellitus, steroid dependent asthma, hypertension, gout and peripheral vascular disease, from on or about May 1, 1995 through her demise on or about May 15, 1995 at Lakeside Memorial Hospital, Brockport, New York 14420. Respondent's care and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent performed a bowel resection and anastomosis in Patient D's unprepared bowel in the presence of an adjacent abscess; and

2. Respondent did not recognize and/or record Patient D's post-surgical complications in a timely fashion.

E Respondent provided medical care and treatment to Patient E, a female patient 73 years old when admitted at Lakeside Memorial Hospital, Brockport, New York 14420 from on or about June 8,1999 through on or about June 18, 1999 after complaining of weakness, dizziness, abdominal pain, hemoptysis and fatigue, to rule out diverticulitis, cholecystitus and sepsis. Respondent's care and treatment of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to timely perform, cause to be performed and/or record a history and physical examination, and plan of care for Patient E:

2. Respondent failed to adequately document his treatment decisions for Patient E, and the bases therefor;

3. Respondent failed to obtain and/or cause to be obtained and/or record therapeutic levels of gentamycin until June 18, 1999, the seventh day she was on the medication;

4. Respondent did not follow the recommendations of the medical consultant, regarding antibiotic therapy for Patient E, and failed to record a basis for his deviations;

5. Respondent failed to adequately manage the hyperalimentation of Patient E, given her history of diabetes mellitus, and/or record the basis for his decisions regarding the hyperalimentation;

6. Respondent failed to obtain and/or record a hematology consult to evaluate Patient E's persistent elevated white blood cell count in the absence of fever, despite the medical consultant's chart entry that the elevated white blood cell count may result from hematologic causes;

7. Respondent failed to chart the reason(s) he did not obtain a hematology consult;

8. Respondent failed to secure a diagnosis of cholecystitis prior to

performing a cholecystectomy on Patient E; and

9. Respondent failed to adequately address and/or record Patient E's acute blood loss following the cholecystectomy of June 15, 1999.

F Respondent provided medical care and treatment to Patient F, a male patient 87 years old when treated for elective gall bladder surgery, from on or about January 22, 2002 through on or about January 24, 2002 at Medina Memorial Hospital, 200 Ohio Street, Medina, New York 14103. Respondent's care and treatment of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent falsely stated in his Operative Report for the cholecystectomy performed on Patient F. that he was assisted by Dr. A., when in fact there was no assistant for the surgery.

G Respondent provided medical care and treatment to Patient G., a female patient 27 years old when treated for acalculous cholecystitis, on or about October 25, 2001 at Medina Memorial Hospital, 200 Ohio Street, Medina, New York 14103. Respondent's care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent falsely stated in his Operative Report for the cholecystectomy performed on Patient G. that he was assisted by Dr. S., when in fact there was no assistant for the surgery.

H Respondent provided medical care and treatment to Patient H., a female patient 81 years old when treated for sepsis, from on or about December 8, 2001 until her demise on or about December 19, 2001 at Medina Memorial Hospital, 200 Ohio Street, Medina, New York 14103. Respondent's care and treatment of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent falsely stated in his Operative Report for the December 14, 2001 cholecystectomy performed on Patient H.

that he was assisted by Dr. S., when in fact there was no assistant for the surgery; and

2. Respondent failed to remove the mediport in a timely fashion after learning that it was reddened with a granulomatous lesion overlying it and blood cultures drawn from the site were positive for Staphylococcus.

I Respondent provided medical care and treatment to Patient I. as her primary care physician, a female patient 80 years old when treated for dementia, diabetes, hypertension and osteoarthritis, from on or about February 7, 2002 through her demise on or about November 27, 2003 at the Medina Memorial Hospital Skilled Nursing Facility, Medina, New York 14103. Respondent's care and treatment of Patient I deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately manage and/or record Patient I's diabetes, whose blood glucose levels fluctuated between the 40's and 700's;

2. Respondent failed to conduct and/or record an adequate number of onsite examinations of Patient I, given her widely fluctuating blood glucose levels; and

3. Respondent failed to order and/or record an adequate number of laboratory tests of Patient I, given her widely fluctuating blood glucose levels.

J Respondent, on or about September 11, 2001, completed, signed and submitted a Request for Reappointment and Renewal of Clinical Privileges at Sailors & Soldiers Memorial Hospital, located in Penn Yan, New York. Respondent provided false information, in that:

1. Respondent was asked: "**Disciplinary Actions:** Since your last appointment, have any of the following ever been or are currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily or involuntarily relinquished? * * * 3. Membership/clinical privileges on any hospital medical staff?" Respondent checked "no," when Respondent had his privileges at Lakeside Memorial Hospital in Brockport, New York summarily restricted on or about January 31, 2001.

K Respondent, on or about October 22, 2002, completed, signed and submitted a Medical Staff Reappointment Information Form at Lakeside Memorial Hospital, in Brockport, New York. Respondent provided false information, in that:

1. Respondent was asked: "5. Have you been under investigation or disciplinary action at any time or are you currently under investigation by a hospital, state licensing agency, or other professional care organization?" Respondent answered "yes," but failed to list OPMC, when Respondent knew he was under investigation by OPMC at the time he completed and signed the Medical Staff Reappointment Information Form.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

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

1. Paragraphs A. and A.4;
2. Paragraphs B. and B.2;
3. Paragraphs C. and C.2;
4. Paragraphs C. and C.4;
5. Paragraphs C. and C.7; and
6. Paragraphs H. and H.2.

SEVENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

7. Paragraphs A. and A.4, B. and B.2, B. and B.9, B. and B.11, C. and C.2, C. and C.4, C. and C.7, and H. and H.2.

EIGHTH THROUGH TWENTY-SECOND SPECIFICATIONS

GROSS NEGLIGENCE

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

8. Paragraphs A. and A.3;
9. Paragraphs A. and A.4;
10. Paragraphs B. and B.2;
11. Paragraphs B. and B.6;
12. Paragraphs B. and B.7;
13. Paragraphs C. and C.4;
14. Paragraphs C. and C.5;
15. Paragraphs C. and C.6;
16. Paragraphs C. and C.7;
17. Paragraphs D. and D.1;
18. Paragraphs D. and D.2;
19. Paragraphs H. and H.2;
20. Paragraphs I and I.1;

21. Paragraphs I. and I.2; and

22. Paragraphs I. and I.3.

TWENTY-THIRD THROUGH TWENTY-SEVENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

23. Paragraphs F. and F.1;

24. Paragraphs G. and G.1;

25. Paragraphs H. and H. 1;

26. Paragraphs J. and J.1; and

27. Paragraphs K. and K.1.

TWENTY-EIGHTH THROUGH THIRTY-SECOND SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

28. Paragraphs F. and F.1;

29. Paragraphs G. and G.1;

30. Paragraphs H. and H. 1;

31. Paragraphs J. and J.1

32. Paragraphs K. and K.1.

THIRTY-THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

33. Paragraphs A. and A.1, A. and A.2, A. and A.3, A. and A.4, A. and A.5, A. and A.6, B. and B.1, B. and B.2, B. and B.3, B. and B.4, B. and B.5, B. and B.6, B. and B.7, B. and B.8, B. and B.9, B. and B.10, B. and B.11, C. and C.1, C. and C.2, C. and C.3, C. and C.4, C. and C.5, C. and C.6, C. and C.7, C. and C.8, C. and C.9, C. and C.10, D. and D.1, D and D.2, E. and E.1, E. and E.2, E. and E.3, E. and E.4, E. and E.5, E. and E.6, E. and E.7, E. and E.8, E. and E.9, H. and H.2, I. and I.1, I and I.2, and I. and I.3.

THIRTY-FOURTH SPECIFICATION
FAILURE TO MAINTAIN RECORDS

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

34. Paragraphs A. and A.1, A. and A.2, B. and B.3, B. and B.4, B. and B.5, B. and B.6, B. and B.8, B. and B.9, B. and B.10, B. and B.11, C. and C.1, C. and C.3, C. and C.4, C. and C.5, C. and C.6, C. and C.8, C. and C.9, C. and C.10, D. and D.2, E. and E.1, E. and E.2, E. and E.3, E. and E.4, E. and E.5, E. and E.6, E. and E.7, E. and E.9, F. and F.1, G. and G.1, H. and H.1, I. and I.1, I. and I.2, and I. and I.3.

DATED: January 5, 2006
Albany, New York

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct