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

IN THE MATTER : COMMISSIONER'S
: ORDER AND
OF : NOTICE OF HEARING
ALAN M. BURKE, M.D.

TO: ALAN M. BURKE, M.D.
510 West Union St.
Newark, N.Y.

201 Church Street
Newark, N.Y. 14513

The undersigned, Mark R. Chassin, M.D., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by ALAN M. BURKE, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1994), that effective immediately ALAN M. BURKE, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or

vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1994).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994), and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 10th and 17th days of March, 1994 at 10:00 A.M. at Suite 1500, Alliance Building, 183 E. Main Street, Rochester, N.Y. and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 301(5) of the

State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
February 25, 1994

MARK R. CHASSIN, M.D.
Commissioner of Health

Inquiries should be directed to:
Kevin C. Roe
Associate Counsel
N.Y.S. Department of Health
Bureau of Professional
Medical Conduct
Corning Tower, Room 2429
Empire State Plaza
Albany, New York 12237

(518) 474-8266

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
ALAN M. BURKE, M.D.	:	CHARGES

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ALAN M. BURKE, M.D., the Respondent, was authorized to practice medicine in New York State on June 11, 1982, by the issuance of license number 150222 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, 1993 through December 31, 1994 from 201 Church St., Newark, New York.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the appendix) from on or about June of 1987 to on or about February 27, 1993 at his office, 510 West Union Street, Newark, N.Y., and at her home. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. On or about February 11, 1993, Respondent prescribed Coumadin without adequate medical justification.

2. Respondent failed to physically examine Patient A prior to prescribing Coumadin.

3. Respondent failed to obtain prothrombin time tests prior to prescribing Coumadin.

4. Respondent failed to monitor prothrombin time after ordering Coumadin.

5. Respondent failed to hospitalize Patient A on or about February 14, 1993.

6. Respondent failed to conduct an adequate physical examination of Patient A on or about February 14, 1993.

7. Respondent failed to order venous flow studies.

8. Respondent failed to physically examine and/or hospitalize Patient A on or about February 22, 1993.

9. Respondent prescribed phentermine and/or fenfluramine without adequate medical justification.

10. Respondent prescribed phentermine and fenfluramine in combination without adequate medical justification.

11. Respondent failed to discontinue phentermine and/or fenfluramine in a timely manner.

12. Respondent failed to perform or order routine preventive health maintenance measures including pap smears, breast exams and/or mamograms.

13. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient A.

B. Respondent treated Patient B from on or about April 5, 1990 to on or about September 21, 1992 at his office. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent diagnosed mitral valve prolapse without adequate medical justification.

2. Respondent prescribed Inderal without adequate medical justification.

3. Respondent failed to perform or order routine preventive health maintenance measures including pap smears, breast exams and/or mamograms.

4. Respondent failed to maintain a record which accuratly reflects the evaluation and treatment of Patient B.

C. Respondent treated Patient C from on or about February 7, 1992, to on or about May of 1993 at his office. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that

1. Respondent diagnosed hyperthyroidism without adequate medical justification.

2. On or about May 27, 1992 and June 17, 1992, Respondent ordered/administered Vitamin B-12 shots without adequate medical justification.

3. Respondent prescribed phentermine and/or fenfluramine without adequate medical justification.

4. Respondent prescribed phentermine and fenfluramine in combination without adequate medical justification.

5. Respondent failed to discontinue phentermine and/or fenfluramine in a timely manner.

6. Respondent failed to perform an adequate risk evaluation prior to prescribing phentermine and/or fenfluramine.

7. Respondent failed to adequately monitor blood pressure, cardiac status and mental status during appetite suppression therapy.

8. Respondent failed to perform or order routine preventive health maintenance measures including pap smears, breast exams and/or mamograms.

9. Respondent failed to maintain a record which accurately reflects the evaluation and care of Patient C.

D. Respondent treated Patient D from on or about April of 1990 until mid-1993 at his office. Respondent's care and

treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed phentermine and/or fenfluramine without adequate medical justification.

2. Respondent prescribed phentermine and fenfluramine in combination without adequate medical justification.

3. Respondent failed to discontinue phentermine and/or fenfluramine in a timely manner.

4. Respondent failed to order an EKG.

5. Respondent administered numerous Vitamin B-12 shots without adequate medical justification.

6. Respondent prescribed thyroid supplements without adequate medical justification.

7. Respondent prescribed Prozac 60 mg. a day without adequate medical justification.

8. Respondent failed to perform or order routine preventive health maintenance measures including pap smears, breast exams and/or mamograms.

9. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient D.

E. Respondent treated Patient E from 1989 through mid-1993 at his office. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed phentermine and/or fenfluramine without adequate medical justification.

2. Respondent prescribed phentermine and fenfluramine in combination without adequate medical justification.

3. Respondent failed to discontinue phentermine and/or fenfluramine in a timely manner.

4. Respondent failed to perform or order routine preventive health maintenance measures including pap smears, breast exams and/or mamograms.

5. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient E.

F. Respondent treated Patient F from mid-1989 through 1993 at his office. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed Synthroid without adequate medical justification.
2. Respondent prescribed fenfluramine without adequate medical justification.
3. Respondent failed to perform pulmonary function tests.
4. Respondent prescribed Prozac without adequate medical justification.
5. Respondent failed to perform or order routine preventive health maintenance measures including pap smears, breast exams and/or mamograms.
6. Respondent failed to maintain a record which adequately reflects the evaluation and care of Patient F.

G. Respondent treated Patient G from on or about May of 1986 to on or about of September of 1993 at his office. Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care, in that:

1. Respondent diagnosed hypothyroidism without adequate medical justification.
2. Respondent prescribed phentermine and/or fenfluramine without adequate medical justification.
3. Respondent prescribed phentermine and fenfluramine in combination without adequate medical justification.
4. Respondent failed to discontinue phentermine and/or fenfluramine in a timely manner.

5. Respondent failed to perform or order routine preventive health maintainence measures including pap smears, breast exams and/or mamograms.

6. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient G.

H. Respondent treated Patient H from late 1991 through the end of 1992 at his office. Respondent's care and treatment of Patient H failed to meet acceptable standards of medical care, in that:

1. Respondent diagnosed hypothyroidism without adequate medical justification.

2. Respondent diagnosed anemia without adequate medical justification.

3. Respondent prescribed Synthroid without adequate medical justification.

4. Respondent prescribed phentermine and/or fenfluramine without adequate medical justification.

5. Respondent prescribed fenflurmine and phentermine in combination without adequate medical justification.

6. Respondent failed to discontinue fenflurmine and phentermine in a timely manner.

7. Respondent failed to perform or order routine preventive health maintenance measures including pap smears, breast exams and/or mamograms.

8. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient H.

I. Respondent treated Patient I in May of 1988 and February 1987 at various locations. Respondent's care and treatment of Patient I failed to meet acceptable standards of medical care, in that:

1. On or about May 5, 1988 Respondent ordered and preformed a bone scan without adequate medical justification.

2. Respondent failed to accurately interpret the May 5 1988 bone scan.

3. On or about February 5, 1987, Respondent ordered and performed a biliary tract study and/or liver flow study without adequate medical justification.

4. Respondent inappropriately interpreted the February 5, 1987 studies as showing "prompt prefusion of the liver by renal artery, hepatic flow and the portal vein".

5. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient I.

J. Respondent treated Patient J in 1987 at various locations. Respondent's care and treatment of Patient J failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed Synthroid without adequate medical justification.

2. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient J.

K. Respondent treated Patient K from on or about June 4, 1986, to on or about February 4, 1987 at various locations. Respondent's care and treatment of Patient K failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed Synthroid without adequate medical justification.

2. Respondent failed to perform a TSH immunoassay.

3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient K.

L. Respondent treated Patient L from on or about February 6, 1988 to on or about October 24, 1990 at various locations. Respondent's care and treatment of Patient L failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed excessive amounts of diazepam.
2. Respondent prescribed more than a thirty day supply of diazepam.
3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient L.

M. Respondent treated Patient M from on or about January 22, 1990 to on or about November 8, 1990 at various locations. Respondent's care and treatment of Patient M failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed excessive amounts of diazepam.
2. Respondent prescribed more than a thirty day supply of diazepam.
3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient L.

N. Respondent's records for Patients A, B, C, D, E, F, G, H, I, J, K, L, and M do not reflect current complaints, patient histories, physical examinations, diagnostic impressions, treatment plans and medications prescribed for office visits and/or dates of treatment.

SPECIFICATIONS

FIRST THROUGH THIRTEENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of N.Y. Educ. Law §6530(4)(McKinney's Supp. 1994) in that Petitioner charges:

1. The facts in paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, A.9, A.10, A.11, A.12, and/or A.13.

2. The facts in paragraphs B and B.1, B.2, B.3, and/or B.4.

3. The facts in paragraphs C and C.1, C.2, C.3, C.4, C.6 C.7, C.8, and/or C.9.

4. The facts in paragraphs D and D.1, D.2, D.3., D.4, D.6, D.7, D.8 and/or and/or D.9.

5. The facts in paragraphs E and E.1, E.2, E.3, E.4, and/or E.5.

6. The facts in paragraphs F and F.1, F.2, F.3, F.4, F.5, and/or F.6.

7. The facts in paragraphs G and G.1, G.2, G.3, G.4, G.5, and/or G.6.

8. The facts in paragraphs H and H.1, H.2, H.3, H.4, H.5, and/or H.8.

9. The facts in paragraphs I and I.1, I.2, I.3, I.4, and/or I.5.

10. The facts in paragraphs J and J.1, and/or J.2.

11. The facts in paragraphs K and K.1, K.2, and/or K.3.

12. The facts in paragraphs L and L.1, L.2, and/or L.3.

13. The facts in paragraphs M and M.1, M.2, and/or M.3.

FOURTEENTH THROUGH TWENTY-SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of N.Y. Educ. Law §6530(6)(McKinney's Supp 1994) in that, Petitioner charges:

14. The facts in paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, A.9, A.10, A.11, A.12, and/or A.13.

15. The facts in paragraphs B and B.1, B.2, B.3, and/or B.4.

16. The facts in paragraphs C and C.1, C.2, C.3, C.4, C.6 C.7, C.8, and/or C.9.

17. The facts in paragraphs D and D.1, D.2, D.3., D.4, D.6, D.7, D.8 and/or and/or D.9.

18. The facts in paragraphs E and E.1, E.2, E.3, E.4, and/or E.5.

19. The facts in paragraphs F and F.1, F.2, F.3, F.4, F.5, and/or F.6.

20. The facts in paragraphs G and G.1, G.2, G.3, G.4, G.5, and/or G.6.

21. The facts in paragraphs H and H.1, H.2, H.3, H.4, H.5, and/or H.8.

22. The facts in paragraphs I and I.1, I.2, I.3, I.4, and/or I.5.

23. The facts in paragraphs J and J.1, and/or J.2.

24. The facts in paragraphs K and K.1, K.2, and/or K.3.

25. The facts in paragraphs L and L.1, L.2, and/or L.3.

26. The facts in paragraphs M and M.1, M.2, and/or M.3.

TWENTY-SEVENTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of N.Y. Education Law §6530(3)(McKinney's Supp. 1994) in that, Petitioner charges two or more of the following:

27. The facts in paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, A.9, A.10, A.11, A.12, A.13; B and B.1, B.2, B.3, B.4; C and C.1, C.2, C.3, C.4, C.5, C.6, C.7, C.8, C.9; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9; E and E.1, E.2, E.3, E.4, E.5; F and F.1, F.2, F.3, F.4, F.5, F.6; G and G.1, G.2, G.3, G.4, G.5, G.6; H and H.1, H.2, H.3, H.4, H.5, H.6, H.7, H.8; I and I.1, I.2, I.3, I.4, I.5; J and J.1, J.2; K and K.1. K.2, K.3; L and L.1, L.2, L.3; and/or M and M.1, M.2, M.3.

TWENTY-EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASON

Respondent is charged with incompetence on more than one occasion in violation of N.Y. Educ. Law §6530(5)(McKinney's Supp. 1994) in that Petitioner charges two or more of the following:

28. The facts in paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, A.9, A.10, A.11, A.12, A.13; B and B.1, B.2, B.3, B.4; C and C.1, C.2, C.3, C.4, C.5, C.6, C.7, C.8, C.9; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9; E and E.1, E.2, E.3, E.4, E.5; F and F.1, F.2, F.3, F.4, F.5, F.6; G and G.1, G.2, G.3, G.4, G.5, G.6; H and H.1, H.2, H.3, H.4, H.5, H.6, H.7, H.8; I and I.1, I.2, I.3, I.4, I.5; J and J.1,

J.2; K and K.1. K.2, K.3; L and L.1, L.2, L.3; and/or M and M.1, M.2, M.3.

TWENTY-NINTH THROUGH FOURTY-SECOND SPECIFICATIONS

RECORD KEEPING

Respondent is charged with failing to maintain a record which accurately reflects the care and treatment of Patients A through M in violation of N.Y. Educ. Law §6530(32)(McKinney's Supp. 1994) in that, Petitioner charges the facts in Paragraph N.

DATED: Albany, New York
February 03, 1994

Peter D. Van Buren

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