STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

December 8, 1994

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe
Associate Counsel
NYS Dept. of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower-Room 2438
Albany, New York 12237

James F. Foley, Esq.
Foley and Foley
P.O. Box 211
235 East Main Street
Palmyra, New York 14522

Alan M. Burke, M.D.
Pro-May Mall
Newark, New Jersey 14513

RE: In the Matter of Alan M. Burke, M.D.

Dear Mr. Roe, Mr Burke and Mr. Foley :

Enclosed please find the Determination and Order (No.94-256) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must 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), "(t)he determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm

Enclosure

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

IN THE MATTER

OF

ALAN M. BURKE, M.D.

DETERMINATION

AND

ORDER

BPMC-94-256

A Commissioner's Order and Notice of Hearing, dated February 25, 1994, and a Statement of Charges, dated February 23, 1994, were served upon the Respondent, Alan M. Burke, M.D.

DAVID T. LYON, M.D., Chairperson, **KENDRICK A. SEARS, M.D.**, and **CLAUDIA GABRIEL**, duly 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 Sections 230(1)(e) and 230(12) of the Public Health Law. **JEFFREY ARMON, ESQ**, served as Administrative Officer for the Hearing Committee on all dates but March 27 and May 11, 1994 when **TYRONE T. BUTLER, ESQ.,** served as Administrative Officer.

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

SUMMARY OF PROCEEDINGS

Commissioner's Order and Notice of Hearing:	February 25, 1994
Statement of Charges:	February 23, 1994
Amended Statement of Charges:	April 21, 1994
Pre-hearing Conference:	March 9, 1994

Dates of Hearing:	March 10, 1994 March 17, 1994 March 31, 1994 April 12, 1994 April 25, 1994 May 11, 1994 June 16, 1994
Department of Health appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Kevin C. Roe, Esq. Associate Counsel
Respondent appeared by:	James F. Foley, Esq. P.O. Box 211 235 East Main Street Palmyra, New York 14522
Witnesses for Department of Health:	Roger K. Vince, M.D. Barbara Rivera G. Winston Dobbins David T. Hannan, M.D. Richard Sadovsky, M.D. Alan M. Burke, M.D. (Respondent) Patient C Dwight R. Howes
Witnesses for Respondent:	Donald R. Charles, Jr. Nicolas Forbes, M.D. Patient H Alan M. Burke, M.D. (Respondent)
Hearing Committee's Report on Imminent Danger:	June 16, 1994
Date of Commissioner's Interim Order to Continue Summary Suspension:	July 14, 1994
Deliberations Held:	July 15, 1994

AMENDMENTS TO THE STATEMENT OF CHARGES

The Parties stipulated on April 25, 1994 to substitute an Amended Statement of Charges (Ex. 1-A) dated April 21, 1994 for the Original Statement of Charges (Ex. 1) dated February 23, 1994.

The Department stipulated on June 16, 1994 to withdraw all Factual Alegations and

Specifications of professional misconduct as related to Respondent's care and treatment of Patients I, J, K. L and M.

STATEMENT OF CASE

By an Order dated February 25, 1994, the Commissioner of Health summarily suspended the medical license of the Respondent, Alan M. Burke, M.D., upon a finding that his continued practice of medicine would constitute an imminent danger to the health of the people of this state. More specifically, the accompanying Statement of Charges alleged forty-two Specifications of professional misconduct, including allegations of practicing the profession of medicine with gross negligence on a particular occasion, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion and the failure to maintain adequate records. Following the hearings on this matter, which commenced on March 10, 1994 and concluded on June 16, 1994, the Hearing Committee issued its report on imminent danger, on the record. The Hearing Committee recommended that the summary suspension of Respondent's license be maintained pending the ultimate resolution of the case. By an Order dated July 14, 1994, the Commissioner ordered that the summary suspension be continued.

A copy of the Amended Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.

Respondents Exhibits are designated by Letters.

T. = Transcript

GENERAL FINDING

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 through December 31, 1994.

FINDINGS AS TO PATIENT A

1. Respondent treated Patient A, a female aged 61 at her initial treatment, from June, 1987 through February, 1993. (Ex. 2)

2. From on or about March 11, 1992 to on or about March 17, 1992, Patient a was treated in-patient at the Newark-Wayne Community Hospital in Newark, New York. She was discharged with a diagnosis of acute myocardial infarction, diabetes mellitus, and peripheral vascular disease. In July of 1987, Patient A underwent a femoral popliteal bypass for treatment of a pre-gangrenous left great toe and left superficial femoral artery occlusion. (Ex. 5, p. 2, Ex. 2, pp. 6-7)

3. On February 11, 1993, Patient A complained of a swollen left leg and an inability to walk. Her leg was observed to be red, warm to the touch and very swollen and a black spot about the size of a nickel was seen at the ball of her foot. (T. 62, 65-67)

4. Respondent prescribed Coumadin for Patient A on February 11, 1993 without first examining her or ordering prothrombin time tests. (Ex. 7; T. 73, 116-118) On that date he also prescribed Keflex, an antibiotic. (Ex. 7, T. 140)

5. Coumadin (warfaran) in an anticoagulation medication which inhibits the production of Vitamin K-dependent clotting factors, thus thinning the blood and preventing clotting. Prior to

administration of Coumadin, prothrombin time tests should be done to evaluate whether a patient has pre-existing clotting factor deficiencies, to assess liver function. During administration of Coumadin regular monitoring of prothrimbin time is necessary to prevent over anticoagulation, a life threatening condition, and to assist in adjusting the dosage of medication to bring it to a therapeutic level that will help and not harm the patient. (T. 206-7, 212-4, 216-7)

6. Dr. Sadovsky testified that a physical examination would be crucial prior to prescribing Coumadin as treatment for a patient and stated that prescribing such medication without a physical examination would not meet acceptable standards of medical care. (T. 211-12, 303-4) He further testified that prescribing Coumadin to a patient without performing a prothrombin time test first would not meet acceptable standards of medical care. (T. 214, 218-20)

7. Respondent's medical record for Patient A does not contain any entries after January 28, 1993, except notations that Patient A allegedly missed appointments on February 12, and March 1, 1993. The record contains no orders for, or results of, prothrombin time tests. There is no evidence that Respondent drew blood or monitored prothrombin time levels after ordering Coumadin for Patient A (Ex. 2; T. 79-80, 120). Dr. Sadovsky testified that the Respondent's failure to monitor prothrombin time levels during Coumadin therapy was an extreme deviation from acceptable standards of medical care (T. 214-220).

8. On February 14, 1993, after several telephone calls from Patient A's daughter, Respondent saw and examined Patient A at her home. Patient A's left lower extremity was observed to be extremely painful, swollen and reddened with peeling skin. A nickel sized black spot on the bottom of her foot continued to be visible. Respondent visually examined and palpated the left extremity and determined that Homan's sign was positive. Respondent advised Patient A's daughter to continue medications and prescribed a salve for the patients's foot. (T. 79-85) Respondent failed to examine the patients' heart, lung or abdomen and did not test her blood pressure or draw any blood for testing. (T. 79-86, 120)

9. Respondent failed to order Patient A hospitalized on February 14, 1993. Dr. Sadovsky testified that based upon the patient's history, symptoms and condition on that date, the failure of the

Respondent to order her hospitalized did not meet acceptable standards of medical practice. (T. 228-30)

10. Between February 14 and February 27, 1993, Patient A's foot continued to cause her great pain and discomfort. The patient was bedridden and, at some point during this period, was physically carried to her daughter's home for close monitoring of her condition. During this period, family members of the patient made several telephone calls to the Respondent informing him of her continuing pain and immobility. Respondent did not return to examine the patient again although repeatedly requested to do so. Respondent requested on several occasions that the patient be brought to his office for his examination, but was advised that the patient could not travel because she experienced great pain whenever her foot was not elevated. (T. 87-94)

11. On February 27, 1993, Patient A was seen at the emergency department of the Newark-Wayne Community Hospital. Her prothrombin time was 50.4 seconds with a control of 11.6 seconds, a markedly prolonged prothrombin time demonstrating marked depletion of Vitamin K-dependent clotting factors. The appropriate range for prothrombin time was between 14 and 16 seconds. (Ex. 3, p. 20; T. 304-305)

12. On February 27, 1993, Patient A died from an acute myocardial infarction. The cause of death was listed on the Certificate of Death as being due to or as a consequence of a severe gastrointestinal hemorrhage which was due to or as a consequence of over anticoagulation therapy. (Ex. 4, pp. 2. 8; T. 171-176)

13. Respondent prescribed phentermine and/or fenfluramine on several occasions during the period of July of 1992 through December of 1992 to control Patient A's weight. (Ex. 2, Ex. 6, Ex. 8)

14. Phentermine and fenfluramine are sympathomimetic amines,amphetamine like medications used as a short term adjunct to diet therapy to suppress appetite. The side effects of these medications include increased blood pressure, rapid heart beat, excitability, lethargy, depression and increased episodes of cerebral ischemia. There is also a risk of abuse and addiction. (T. 235-238)

15. Dr. Sadvosky testified that based on Patient A's history of heart and vascular disease, diabetes, hypertension and obesity, her treatment with phentermine and/or fenfluramine was contraindicated. (T. 239-42)

16. Dr. Sadovsky testified that phentermine and/or fenfluramine is used as a temporary adjunct to diet therapy for a period of less than twelve weeks and to treat Patient A for at least a six month period with these medications was not within acceptable standards of medical care. (T. 243-5)

17. The medical record of Patient A, as maintained by the Respondent, contained no indication that Respondent ordered or obtained pap smears, breast examination or mammogram results at any time during the period of his treatment of her. (Ex. 2; T. 248) Dr. Sadovsky testified that the regular performance of such tests should have been undertaken for Patient A based on her age and medial history and that to not order or obtain those test results was a deviation from acceptable standards of medical practice. (T. 246-9)

18. Dr. Sadovsky testified that Respondent's medical record for Patient A did not adequately reflect current complaints, patient histories, physical examinations, diagnostic impressions, treatment plans and medications prescribed for office visits and/or dates of treatment. (Ex. 2, T. 250-252)

FINDINGS AS TO PATIENT B

19. Respondent treated Patient B, a female aged 21 at the time of her initial office visit, from on or about April 5, 1990 to on or about September 21, 1992. (Ex. 9)

20. On or about September 14, 1992 and September 21, 1992, Patient B complained of dizziness and lightheadness. No history of this problem is recorded in Respondent's records. No physical examination of the patient is reflected in Respondent's records, and he did not record that any abnormality was heard upon auscultation of the heart. Respondent performed an electrocardiogram and a Dopler ultrasound test on Patient B on September 21, 1992. Respondent

recorded "shows...MVP", indicating a diagnosis of mitral valve prolapse. (Ex. 9, p. 2-3, Ex. 10, pp. 6-10; T. 309-10)

21. On October 2, 1992, Patient B was seen by Roger K. Vince, M.D., F.A.C.C., a board certified cardiologist, seeking a second opinion regarding Respondent's diagnosis of mitral valve prolapse. Upon an examination of the patient, Dr. Vince heard no heart sound abnormality suggestive of mitral valve prolapse. (Ex. 10, p. 2; T. 21, 51-2) He testified that the clinical sign of mitral valve prolapse is an extra heart sound. (T. 20)

22. Dr. Vince testified that neither an electrocardiogram nor a Doppler ultrasound test is diagnostic of mitral valve prolapse. (T. 24) He further testified that he reviewed the results of Respondent's tests performed on September 21, 1992 and concluded that Patient B's electrocardiogram results were normal and the Doppler ultrasound was not diagnostic of a specific entity. (T. 23)

23. On October 2, 1992, Dr. Vince performed an echocardiogram on Patient B. He concluded that the results of this test were completely normal and that there was no evidence of mitral valve prolapse or any other disease. (Ex. 9, p. 2, Ex. 29; T. 21, 317)

24. Dr. Sadovsky testified that in the absence of any physical findings of an unusual heart sound and in the absence of any diagnostic test result indicating any abnormality, the diagnosis by the Respondent of mitral valve prolapse was made without medical justification and did not meet acceptable standards of medical care. (T. 312-6)

25. On September 21, 1992, Respondent prescribed for Patient B, Inderal, a beta blocker which slows down the heart rate and lowers the blood pressure, "for arrhythmia and mitral valve." (Ex. 11; T. 314-315, 325). Inderal is used to treat symptomatic complaints in people with mitral valve prolapse, including complaints of arrhythmia. (T. 31, 318)

26. Respondent's medical record of Patient B contains no clinical or laboratory evidence of mitral valve prolapse or arrythmia. (Ex. 9) Dr. Sadovsky testified that the prescription of Inderal for Patient B was not indicated and that such treatment by Respondent did not meet acceptable standards of medical care. (T. 315-8, 325, 329)

27. Dr. Sadovsky testified that the records for Patient B did not meet minimally accepted standards for record keeping in that Respondent's record for Patient B did not accurately reflect current complaints, patient history, physical examinations, diagnostic impressions, treatment plans and/or medications prescribed for each office visit. (Ex. 9; T. 319-320).

FINDINGS AS TO PATIENT C

28. Respondent treated Patient C, a female aged 29 at the time of her initial visit, from on or about February 7, 1992 through approximately October, 1992. (Ex. 12)

29. Patient C was initially seen by Respondent on February 7, 1992. She complained of an addiction to crystal methamphetamine, an illegal street drug. She also requested an appetite suppressant as she believed she was overweight. Her weight was approximately 140 pounds at that time. (T. 85-7)

30. On February 10, 1992 Respondent ordered and obtained thyroid studies for Patient C. The results were that the total T4 was 5.8 (normal), the free T4 index was 2.7 (normal) and T3 uptake was 48. The range of normal for T3 uptake is 33-45. T3 uptake is an indirect measurement of the amount of circulating thyroid hormone in the blood stream, and depends on many other factors and conditions to have an accurate result. (Ex. 12; T. 4/12/94; 16-18)

31. On February 21, 1992, Respondent diagnosed hyperthyroidism in Patient C (Ex. 12) Dr. Sadovsky testified that the slightly elevated T3 uptake result did not justify a diagnosis of hyperthyroidism, in view of the otherwise normal T4 results. (T. 4/12/92, 16-8)

32. On February 21, 1992, Respondent prescribed Euthroid for Patient C. (Ex. 12) Euthroid is a thyroid hormone used to supplement thyroid activity. Euthroid is specifically used as treatment of hypothyroid, when the thyroid is underactive. (T. 4/12/92, 20) Dr. Sadovsky testified that the prescribing of Euthroid for Patient C did not meet acceptable standards of medical practice. (T. 4/12/94, 21)

33. On or about May 27 and June 17, 1992, Respondent administered Vitamin B12 shots

to Patient C. (Ex. 12) Vitamin B12 is justified for the treatment of pernicious anemia, megaloblastic anemia and deficiencies of Vitamin B12 or folic acid in the body. (T. 4/12/94, 23)

34. Blood studies done February 10, 1992, showed Patient C's hematocrit to be 46.8 and hemoglobin 15.8, each result within the normal range for a female. Respondent's medical record for Patient C does not include any test results regarding Vitamin B12 or folic acid levels. (Ex. 12) Dr. Sadovsky testified that based upon the blood test results of Patient C, the administration of Vitamin B12 shots did not meet acceptable standards of medical practice. (T. 4/12/94, 23-4)

35. During the approximately 8 1/2 month period, from February through October, 1992, in which Respondent provided medical care to Patient C, he prescribed phentermine and/or fenfluramine for her on repeated occasions. (Ex. 12, 13, 14, 15, 16, 17, 32)

36. Prior to the use of sympathomimetic amines, a risk evaluation should be performed which would include a complete history, physical examination and electrocardiogram. (T. 4/12/94, pp. 25-27). Respondent's records for Patient C do not indicate that such a risk evaluation was performed. Dr. Sadovsky testified that the failure by Respondent to perform such an evaluation on Patient C prior to prescribing appetite suppression medication did not meet acceptable standards of medical practice. (Ex. 12, T. 4/12/94, 26-7)

37. Dr. Sadovsky testified that the treatment of Patient C with phentermine and fenfluramine was not justified based upon her weight and the fact that such medications are specifically contraindicated for an individual with a history of drug addiction or who is diagnosed as being hyperthyroid. He stated that the prescription of such medications for Patient C did not meet acceptable standards of medical practice. (T. 4/12/94, 27, 30).

38. During the course of sympathomimetic amine therapy, blood pressure, cardiac status and mental status should be monitored. Respondent's records do not indicate that such monitoring was carried out and Dr. Sadovsky testified that the failure to undertake such monitoring did not meet acceptable standards of medical care. (Ex. 12; T. 4/12/94, 32-34)

39. Dr. Sadovsky testified that the appropriate length of time to prescribe phentermine and fenfluramine would be up to twelve weeks, and that the prescription of such medications over about

an eight month period was excessively long. (T. 4/12/94, 31-2)

40. During her care and treatment by Respondent, Patient C was 29 or 30 years old. Routine preventive health maintenance should have included yearly pap smears and breast exams. There is no indication in the patient's medical record that such procedures were performed. Dr. Sadovsky testified that the failure of Respondent to either perform such procedures or to have other health professionals perform them did not meet acceptable standards of practice. (Ex. 12; T. 4/12/94, 34-5)

41. Respondent's record for Patient C does not adequately or accurately reflect current complaints, patient history, physical examinations, diagnostic impressions, treatment plans or medications prescribed for each office visit and/or date of treatment. (Ex. 12; 4/12/94, pp. 34-6)

FINDINGS AS TO PATIENT D

42. Respondent treated Patient D, a female aged 45 at the time of the initial office visit, from approximately April, 1990 until approximately May, 1993.

43. In 1990 and 1991, Patient D experienced episodes of rapid heartbeat, or paroxysmal atrial tachycardia. (Ex. 18; T. 332, 334-6)

44. Respondent prescribed phentermine and/or fenfluramine to Patient D on a regular basis for approximately an 11 month period in 1992 and 1993. (Ex. 18, Ex. 19; T. 331-2)

45. The most useful means to evaluate paroxysmal atrial tachycardia is through an electrocardiogram. (T. 335) Respondent failed to order or perform an electrocardiogram for Patient D before prescribing appetite suppression medication. (Ex. 18, T. 335-6) Dr. Sadovsky testified that Respondents' failure to order or perform such a test for Patient D did not meet acceptable standards of medical care. (T. 336)

46. Intermittent tachycardia is a contraindication for the use of sympathomimetic amines. Dr. Sadovsky testified that the prescription of such medications for Patient D did not meet

acceptable standards of medical care. (T. 332).

47. Dr. Sadovsky testified that Respondent's prescription of appetite suppression medications for Patient D over at least an 11 month period was excessive and that Respondent failed to meet acceptable standards of medical care by not discontinuing those medications sooner. (T. 332-3)

48. Respondent administered Vitamin B12 to Patient D on various occasions during her care and treatment. Laboratory studies for Patient D did not demonstrate pernicious anemia, megalobastic anemia or Vitamin B 12 deficiency. A B12 test in August of 1990 was normal. (Ex. 18, T. 336)

49. Dr. Sadovsky testified that there was no medical justification for the administration of vitamin B12 shots to Patient D. (T. 337)

50. Thyroid test results for Patient D in April, 1990 showed normal TSH and T4 levels and a slightly low T3 uptake. A T3 uptake test is not as sensitive for diagnosing either hyper or hypothyroidism as is TSH and T4. (Ex. 18, p. 6; T. 337-9)

51. Respondent prescribed Synthroid, a thyroid supplement, to Patient D (Ex. 18) Dr. Sadovsky testified that the treatment of Patient D with a thyroid supplement was not medically justified based upon her thyroid test results. (T. 338-9)

52. During his period of care of Patient D, Respondent prescribed Prozac, an antidepressant, as treatment. The medical record for Patient D contains no notation of symptoms or a diagnosis of depression. (Ex. 18)

53. Dr. Sadovsky testified he saw nothing in the medical record of Patient D to justify the treatment of her with Prozac and further stated that the prescription of such medication did not meet acceptable standards of medical care. (T. 340-2; T. 4/12/94, 6-8)

54. During her care and treatment by Respondent, Patient D was in her mid 40's. Routine preventive health maintenance measures should have included yearly pap smears and breast exams and at least one mammogram. (T. 343-346) There is nothing in Patient D's medical record to indicate pap smears, breast exams or mammograms were performed by Respondent during his care and treatment of Patient D. (Ex. 18)

55. Dr. Sadovsky testified that Respondent's failure to order or perform such tests did not meet acceptable standards of medical care. (T. 346)

56. Respondent's medical record for Patient D did not accurately or adequately reflect current complaints, patient history, physical examinations, diagnostic impressions, treatment plans and medications prescribed for office visits and/or dates of treatment. (Ex. 18; T. 346-347)

FINDINGS AS TO PATIENT E

57. Respondent treated Patient E, a female aged 44 at the time of her initial office visit, from 1989 through mid - 1993. (Ex. 20)

58. Respondent treated Patient E for high blood pressure, congestive heart failure and intermittent episodes of depression. (Ex. 20, T. 4/12/92, 74)

59. Respondent prescribed phentermine and/or fenfluramine as appetite suppressants to Patient E from approximately February, 1992 to April, 1993. (Ex. 20, Ex. 21) Appetite suppressants are contraindicated for a patient who has a history of high blood pressure and symptomatic cardiovascular disease. Dr. Sadovsky testified that the prescription of these medications for Patient E did not meet acceptable standards of medical practice. (T. 75)

60. In March of 1993, Patient E was seen at the local emergency room complaining of a rapid heart beat. A cardiogram showed supraventricular tachycardia. (Ex. 20, pp. 70-6; T. 4/12/94, 74)

61. Patient C was seen by a cardiologist on March 29, 1993, about two weeks following her emergency room visit. The cardiologist's report to the Respondent noted that "Ionamin can cause tachycardia, palpitations and elevation of blood pressure." Ionamin is a sympathomimetic amine containing phentermine. Respondent prescribed Ionamin for Patient E on April 28, 1993. (Ex. 20 pp. 79-80, Ex. 21) Dr. Sadovsky testified that Respondent failed to meet acceptable standards of medical care by not discontinuing Patient C's treatment with phentermine and/or feruramine sooner, based on her underlying medical condition. (T. 76, 91)

62. During her care and treatment by Respondent, Patient E was in her mid 40's. Routine preventive health maintenance should have included yearly pap smears and breast exams. (T. 4/12/94 77-78) There is no notation in Patient E's medical record to indicate that Respondent either ordered or performed pap smears and/or breast examinations. (Ex. 20, T. 77)

63. Respondent's medical record for Patient E does not adequately or accurately reflect current complaints, patient history, physical examinations, diagnostic impressions, treatment plans and medications prescribed for office visits and/or dates of treatment. (Ex. 20; T. 4/12/94, 79)

FINDINGS AS TO PATIENT F

64. Respondent treated Patient F, a female aged 29 at the time of her initial office visit, from approximately August, 1989 through July, 1993. (Ex. 22)

65. Laboratory studies done August 25, 1989, September 15, 1989, June 18, 1990, November 29, 1990, January 23, 1991 and October 17, 1991 showed normal thyroid function. (Ex. 22, pp. 6, 11, 31, 55, 59, 88; T. 4/12/94, 105).

66. Respondent prescribed Synthroid and/or Euthroid, thyroid supplement medications, on a regular basis to Patient F. (Ex. 22)

67. Respondent treated Patient F for high blood pressure and depression. (Ex. 22, T. 4/12/94, 105-6)

68. Respondent prescribed fenfluramine to Patient F as an appetite suppressant. This medication is contraindicated for individuals with high blood pressure or depression. (Ex. 22, Ex. 23; T. 106-8) There is nothing in the medical record to indicate that Respondent evaluated Patient F prior to his treatment of her with fenfluramine. (Ex. 22)

69. Patient F presented to Respondent's office with episodes of wheezing and a diagnosis of bronchitis was made. Respondent prescribed inhaled bronchodilators for an extended period of time. Pulmonary function tests were not ordered or performed. (Ex. 22; T. 4/12/94, 108) Dr. Sadovsky testified that pulmonary function tests should have been performed based on the extended

period of time that Patient F was placed on bronchodilators and that the failure to order or perform such tests did not meet acceptable standards of medical care. (T. 4/12/94, 108-9)

70. Respondent prescribed Prozac to Patient F starting in May of 1990. Respondent's medical records for Patient F do not include any signs, symptoms or diagnosis which would justify the use of this antidepressant medication. (Ex. 22; T. 4/22/94, pp. 109-110) Dr. Sadovsky testified that the prescription of Prozac based upon the information contained in Patient F's medical record did not meet the acceptable standards of medical care. (T. 4/12/94, p. 110)

71. During her care and treatment by Respondent, Patient F was in her late 20's and early 30's. Routine preventive health maintenance should have included yearly pap smears and breast examinations. (Ex. 22; T. 4/24/94, pp. 110-111) There is no indication in Patient F's medical record that pap smears or breast examinations were ordered or performed by Respondent during the four years of Patient F's treatment. (Ex. 22) Dr. Sadovsky testified that the failure to order or perform such tests did not meet acceptable standards of medical care. (T. 4/12/94, p. 111)

72. Respondent's medical record of Patient F did not adequately or accurately reflect current complaints, patient history, physical examinations, diagnostic impressions, treatment plans and medications prescribed for office visits and/or dates of treatment (Ex. 22; T. 4/12/94, pp/110-112).

FINDINGS AS TO PATIENT G

73. Respondent treated Patient G, a female aged 30 at the time of her initial office visit, from approximately May, 1986 through approximately September, 1993. (Ex. 25)

74. Laboratory studies performed on June 3, 1986 and July 28, 1992 showed normal thyroid function and no abnormality. (Ex. 25, 4, 42; T. 4/12/94, 119)

75. In a note in the medical record dated August 31, 1992, Respondent diagnosed Patient G as being hypothyroid. (Ex. 25, p. 43) Dr. Sadovsky testified that such diagnosis by Respondent did not meet acceptable standards of medical care. (T. 4/12/94, p 120)

76. Respondent treated Patient G for anxiety neurosis and hypertension and a cardiogram

of the patient had indicated episodes of tachycardia. (Ex. 25; T. 4/12/94, 121-2)

77. Respondent prescribed phentermine and /or ferfluramine to Patient G from approximately July through December, 1992. Sympathominetic amines are contraindicated for individuals with hypertension, rapid heartbeat or anxiety neurosis. (Ex. 25, Ex. 26; T. 4/12/94, pp. 121-2) Dr. Sadovsky testified that prescribing such medications to Patient G did not meet acceptable standards of medial care. (T. 4/12/94, p. 122)

78. Dr. Sadovsky testified that the prescription of phentermine and/or fenfluramine for Patient G over a period of at least six months did not meet acceptable standards of medical practice in that the appetite suppression medication was prescribed for too long a period of time. (T. 4/12/94, 122-3)

79. During her care and treatment by Respondent, Patient G was in her late 20's and early 30's. Routine preventive health care measures should have included yearly pap smears and breast examinations. (T. 4/12/94, 123-124) There is no indication in Patient G's medical record that Respondent performed or ordered pap smears or breast examinations on the patient from May of 1986 to September of 1993. (Ex. 25) Dr. Sadovsky testified that Respondent's failure to order or perform such tests did not meet acceptable standards of medical practice. (T. 4/12/94, 124)

80. Respondent's medical record for Patient G did not adequately or accurately reflect current complaints, patient histories, physical examinations, diagnostic impressions, treatment plans and medication prescribed for office visits or dates of treatment (T. 4/12/94, 124-125)

FINDINGS AS TO PATIENT H

81. Respondent treated Patient H, a female aged 28 at the time of the initial office visit, from approximately November, 1991 through approximately May, 1993. (Ex. 27)

82. Seven laboratory studies of Patient H's thyroid activity were performed on October 30, 1991, November 11, 1991, May 18, 1992, December 19, 1991, January 28, 1992, March 31, 1992 and April 9, 1993. (Ex. 27, pp. 1, 9, 16, 29-30, 32, Ex. E) The results of each of these tests

indicated a normal or high-normal range of thyroid function. (T. 4/12/94, 145-7)

83. At the initial office visit of Patient H on or about November 11, 1991, Respondent diagnosed the patient as being hypothyroid and prescribed Synthroid, a thyroid supplement, as treatment. Respondent subsequently continued this diagnosis and treatment throughout the period of his providing medical care to Patient H. (Ex. 27)

84. Dr. Sadovsky testified that the treatment of Patient H with Synthroid did not meet acceptable standards of medical care. (T. 4/12/94, 148)

85. Respondent diagnosed Patient H on November 11, 1991 as having anemia and noted "B12" as treatment. The medical record of the patient contains no blood count results of the patient for that period of time. (Ex. 27, p 3; T. 4/12/94, 150-1)

86. Patient H had a history of hypertension and was treated by Respondent for hypertension. (Ex. 27)

87. Respondent prescribed phentermine and/or ferfluramine for Patient H for approximately a five month period beginning in July, 1992. (Ex. 28) Sympathominetic amines are contraindicated for individuals with moderate high blood pressure and emotional instability. There is no indication in the medical record of a cardiogram or of pulse rates for the patient. (Ex. 27, T. 4/12/94, 152-3)

88. Dr. Sadovsky testified that the treatment of Patient H with phentermine and/or fenfluramine and the failure to discontinue such treatment after an appropriate period of time was not within acceptable standards of medical practice. (T. 4/12/94, p. 152-4)

89. During her care and treatment by Respondent, Patient H was followed by the local Planned Parenthood office for routine preventive health maintenance including gynecological examinations. (T. 6/16/94, 8-9)

90. Respondent's record for Patient H did not adequately or accurately reflect current complaints, patient histories, physical examinations, diagnostic impressions, treatment plans and medications prescribed for office visits and/or dates of treatment. (T. 4/12/94, 157)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(1-18);
Paragraph A.1.:	(2-6);
Paragraph A.2.:	(2-6);
Paragraph A.3.:	(4-6);
Paragraph A.4.:	(5-7, 11-12);
Paragraph A.5.:	(2-3, 8-9);
Paragraph A.7.:	(2, 13-15);
Paragraph A.8.:	(13, 16);
Paragraph A.9.:	(7, 17);
Paragraph A.10.:	(18);
Paragraph B:	(19-27);
Paragraph B.1.:	(20-24);
Paragraph B.2.:	(21-23, 25-26);
Paragraph B.3.:	(20, 26-27);
Paragraph C:	(28-41);
Paragraph C.1.:	(29-31);
Paragraph C.2.:	(29-32);
Paragraph C.3.:	(33-34);
Paragraph C.4.:	(35-37);
Paragraph C.5.:	(35, 39);
Paragraph C.6.:	(36);
Paragraph C.7.:	(38);
Paragraph C.8.:	(40);
Paragraph C.9.:	(34, 36, 38, 40-41);
Paragraph D:	(42-56);
Paragraph D.1.:	(43-46);
Paragraph D.2.:	(44, 47);
Paragraph D.3.:	(45);
Paragraph D.4.:	(48-49);
Paragraph D.5.:	(50-51);
Paragraph D.6.:	(52-53);
Paragraph D.7.:	(54);
Paragraph D.8.:	(45, 54, 56);
Paragraph E:	(57-63);
Paragraph E.1.:	(58-59);
Paragraph E.2.:	(60-61);
Paragraph E.3.:	(62);

Paragraph E.4.:	(62-63);
Paragraph F:	(64-72);
Paragraph F.1.:	(65-66);
Paragraph F.2.:	(67-68);
Paragraph F.3.:	(69);
Paragraph F.4.:	(70);
Paragraph F.5.:	(71);
Paragraph F.6.:	(68, 70-72);
Paragraph G:	(73-80);
Paragraph G.1.:	(74-75);
Paragraph G.2.:	(76-77);
Paragraph G.3.:	(78);
Paragraph G.4.:	(79);
Paragraph G.5.:	(79-80);
Paragraph H:	(81-90);
Paragraph H.1.:	(82-84);
Paragraph H.2.:	(85);
Paragraph H.3.:	(82-84);
Paragraph H.4.:	(86-88);
Paragraph H.5.:	(87-88);
Paragraph H.7.:	(85, 87, 90).

The Hearing Committee concluded that the following Factual Allegations should not be sustained:

Paragraph A.6.;
Paragraph H.6.;

The Hearing Committee further concluded that the following Specifications should be sustained The citations in parentheses refer to the Factual Allegations which support each Specification:

PRACTICING WITH GROSS NEGLIGENCE

First Specification: (Paragraphs A and A.2 through A.4);
Third Specification: (Paragraphs C and C.4 and C.6).

NEGLIGENCE ON MORE THAN ONE OCCASION

Twenty-Seventh Specification: (Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.7, A.8, A.9, A.10; B and B.1, B.2, B.3; 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; E and E.1, E.2, E.3, E.4; 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; H and H.1, H.2, H.3, H.4, H.5, H.7.

INCOMPETENCE ON MORE THAN ONE OCCASION

Twenty-Eighth Specification: (Paragraphs A and A.7, A.8; B and B.1, B.2; C and C.4, C.5, C.6; D and D.1, D.2; E and E.1, E.2; F and F.2; G and G.2, G.3; H and H.4, H.5.

FAILURE TO MAINTAIN ACCURATE RECORDS

Twenty-Ninth through Thirty-Sixth Specifications: (Paragraph N)

DISCUSSION

Respondent is charged with multiple specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, and incompetence.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that part or all of twelve specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Hearing Committee made an initial evaluation as to the credibility of the various

witnesses who presented testimony. The Department's primary witnesses were Dr. Richard Sadovsky, M.D., the daughter of Patient A and Patient C. Dr. Sadovsky has a clinical practice at the State University of New York Health Science Center at Brooklyn. He also instructs and is an administrator at the same institution with the position of Associate Chairman of the Department of Family Practice and Associate Professor. Dr. Sadovsky is Board Certified in Family Practice and has practiced in that area for approximately twenty years. The Committee found him to be highly qualified to address the medical issues raised in this proceeding and considered his testimony to be clear, direct and persuasive. The Hearing Committee believed Dr. Sadovsky to be an extremely credible witness and gave his testimony great weight.

The Committee also considered the testimony of the daughter of Patient A and of Patient C to be credible it related to the medical treatment provided by the Respondent for Patients A and C. Patient A's daughter testified plausibly as to the events of February, 1993 which ended in her mother's death. No testimony was provided on behalf of the Respondent to rebut that testimony and her recollection of those events remained consistent during cross-examination. Furthermore, while both parties presented evidence related to the proximate cause of Patient A's death, the Committee felt it was an irrelevant factor in determining whether Respondent's treatment of the patient constituted misconduct.

In a similar vein, the Committee found Patient C to be credible in her testimony concerning Respondent's treatment of her for weight control and other medical conditions. It felt that issues regarding her criminal conviction for passing forged prescriptions and allegations of an exchange of leniency for information damaging to the Respondent were completely irrelevant to the charges against Respondent for professional misconduct in his care of her. The Committee further concluded that there was no evidence to indicate that Patient C's medical record (Ex. 12) was anything but the medical record maintained by Respondent.

In contrast, the Respondent failed to testify on his own behalf. The Committee felt he did little to defend himself against the serious charges alleged by the Department. The Respondent did not call a medical expert to dispute the opinions offered by Dr. Sadovsky. The Hearing Committee

therefore relied upon the testimony of all other witnesses in addition to the opinions of the Department's expert witness in reaching its' determinations.

PRACTICING WITH GROSS NEGLIGENCE

The Committee concluded that the record clearly established that the Respondent's treatment of Patient A in prescribing Coumadin prior to physically examining her and prior to obtaining prothrombin time tests and his failure to monitor the prothrombin time levels constituted gross negligence. The Committee agreed that Respondent's prescribing such medication by telephone on or about February 11, 1993 without first examining Patient A, knowing her history of acute myocardial infarction, vascular disease and diabetes and her complaints of severe leg pain and the presence of a black spot on her foot, was an egregious failure to exercise the care expected of a physician under the circumstances. It further concluded that the failure to obtain prothrombin time test results either before or after prescribing the Coumadin was also gross negligence. There was agreement with Dr. Sadovsky's testimony that it was essential to obtain test results to establish Patient A's clotting ability at a specific time so that the dosage of Coumadin could be adjusted to a therapeutic and safe level. There was no evidence in the patient's medical record that the Respondent ever obtained prothrombin time test results.

The Hearing Committee similarly felt that Respondent's prescription of phentermine and/or fenfluramine as appetite suppressants for Patient C was gross negligence in view of his knowledge of her history of substance abuse. Dr. Sadovsky testified that one of the contraindications to the use of fenfluramine and/or phentermine is a history of drug addiction. (T. 4/12/94, 27) There is no evidence in the medical record of Patient C that the Respondent attempted to wean the patient from her addiction through the use of decreasing strengths of medication. (Ex. 12, T. 4/12/94, p.29) Dr. Sadovsky also testified that the period of time over which Respondent prescribed phentermine and/or fenfluramine was an excessive period to wean Patient C from her addiction, if that was Respondent's intent. The Committee also concluded that not performing a risk evaluation on the

patient, based on her history of substance abuse, prior to prescribing such medications was a gross deviation from accepted standards of medical practice. It agreed with Dr. Sadovsky's testimony that an electrocardiogram and complete physical exam should have been performed prior to the prescribing of appetite suppressants.

The Committee specifically determined to not sustain all other Specifications of gross negligence (Specifications One; as regards A.1, A.5 through A.10, Two, Three; as regards C1 through C.3 and C.7 through C.9, and Four through Eight). It felt that while it was clear that Respondent's treatment of the eight patients at issue was not within acceptable standards of practice, the failure to exercise the care expected of a reasonable prudent physician was not egregious or conspicuously bad. The two exceptions were his treatment of Patients A and C, as specified above.

GROSS INCOMPETENCE

Gross incompetence has been defined, as noted above, as an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. The Hearing Committee believed it was prevented by Respondent's failure to testify and address substantive issues concerning his practice from arriving at an accurate assessment of his level of skill and knowledge in the practice of medicine. For example, the Committee felt it could not determine whether Respondent's prescription of Coumadin for Patient A without first examing her or obtaining prothrombin time test results was due to his lack of skill or knowledge of the necessity to do so or whether such action was based solely on his failure to exercise the reasonable level of care expected of a physician in such circumstances. The Hearing Committee felt it was not able to draw the inferences that would be necessary for it to make findings of gross incompetence due to the absence of information as to the Respondent's level of skill and knowledge. Therefore, it chose to not sustain Specifications Fourteen through Twenty-One as they related to violations of Education Law Section 6530(6).

NEGLIGENCE ON MORE THAN ONE OCCASION

The Committee unanimously agreed that all Factual Allegations of professional misconduct constituted negligence, with the exceptions of Paragraphs A.6 and H.6. It was determined that it was not negligent for the Respondent to fail to order venous flow studies for Patient A. While Dr. Sadovsky testified that the failure to order such tests did not meet acceptable standards of practice, he also stated that the procedure is primarily performed in a physician's office, a medical laboratory or a hospital. (T. 230-3, 267, 270) The Committee concluded that the Respondent was negligent in not ordering the patient hospitalized and believed it to be repetitive to also charge him with the failure to order a procedure that likely would have been undertaken in the hospital. The Committee also felt that the test would not have been an essential procedure to undertake at the time and would have only assisted in confirming whether anticoagulation treatment was appropriate. (T.232)

Patient H testified at this hearing that she was provided with gynecological care by a nurse practitioner at the local Planned Parenthood Office. (T. 6/16/94, 8-9) It would be reasonable to assume that routine preventive health maintenance procedures would have been performed by that health care provider and not by the Respondent. It was determined that Respondent was not negligent in ordering or performing health maintenance procedures for Patient H and therefore allegation H.6 was not sustained.

The Committee agreed with the Department's expert in his repeated opinions that Respondent's medical treatment for Patients A through H did not meet the minimally accepted standard of medical care. Respondent provided numerous medications for patients with no justification. Patient A, who had a history of circulatory complications, was prescribed an anticoagulant by a telephone order without a physical examination. Patient B was diagnosed as having mitral valve prolapse based upon the results of inappropriate diagnostic tests. Respondent misdiagnosed Patient C as being hyperthyroid and compounded this error by prescribing medication specifically used to treat hypothyroidism. He treated Patient D with Vitamin B12 although blood test results did not indicate that the patient was anemic. Appetite suppressants were routinely

prescribed for extended periods for individuals with contraindications, such as hypertension and depression, for such medications. The Committee believed this pattern of misdiagnoses and inappropriate treatments to be clear, repetitive examples of negligence on the part of Respondent.

Respondent's records were grossly deficient and would not have enabled any subsequent treating caregiver to properly continue treatment. The inadequate record-keeping in and of itself was below the level that would be expected of a reasonably prudent physician. Other than entries related to two missed appointments, there was no information in Patient A's medical record after January 28, 1993. This is remarkable in light of his prescription of Coumadin on February 11, his visit to her home on February 14 and multiple telephone calls received by him from the Respondent's family during a two week period. The record-keeping for all patients clearly deviated from the most minimal level of acceptable practice as a result of the inadequate or non-existent notation of complaints, histories, diagnoses and treatments.

The Respondent also consistently failed to order and/or perform routine preventive health measures for his female patients. There is no evidence in the medical records for Patients A through G that they underwent routine exams such as pap smears, breast examinations or mammograms with other health care providers and the records of the Respondent indicate that he was their primary care physician. The Committee concluded that Respondent's failure to either order, perform or indicate in the medical records the fact that he ordered and/or performed such routine measures was clearly negligent practice.

INCOMPETENCE ON MORE THAN ONE OCCASION

As discussed above in the Specification of Gross Incompetence, the Hearing Committee felt hampered in its' assessment of Respondent's skills and knowledge as a result of his choice to not testify. Again, the Committee found itself unable to draw the inferences necessary to determine whether his acts or omissions of alleged misconduct were the result of a lack of skill or knowledge in the practice of medicine. Consequently, the Committee determined to not sustain those Factual

Allegations upon which Specification Twenty-Eight was based which were not related to Respondent's diagnosis and treatment of Patient B for mitral valve prolapse or to his treatment of Patients A through H for weight control.

The Hearing Committee believed that Respondent's actions in diagnosing Patient B as having mitral valve prolapse demonstrated a clear lack of skill or knowledge. It relied upon the testimony of Dr. Vince, from whom the patient sought a second opinion, and who testified that Respondent used inappropriate tests to diagnose such condition. Dr. Vince also concluded that the results of the inappropriate tests were normal, based upon his review of such tests as performed by the Respondent. He futher testified that the results of an echocardiogram which he performed indicated that there was no evidence that Patient B suffered from a mitral valve prolapse or any other disease. The Committee determined that both this misdiagnosis and subsequent treatment with Inderal provided convincing evidence of Respondent's lack of that skill and knowledge necessary to practice medicine.

The Hearing Committee concluded that Respondent's prescription of fenfluramine and/or phentermine in his practice constituted a pattern which provided clear evidence of a lack of skill or knowledge in treatment for weight control. The Respondent repeatedly failed to evaluate his patients for potential contraindications prior to prescribing the medications. There is no evidence that he adequately monitored the patients while they were being treated with the medications. Respondent also continued to renew the prescriptions for periods of time well in excess of the approximately three month period which Dr. Sadovsky testified was an appropriate length of treatment. An obvious example of Respondent's lack of knowledge in this area was his prescription of Ionamin for Patient E subsequent to his receipt of a report from a cardiologist who was treating the patient for tachycardia and who advised that such medication could cause cardiac complications. The Committee therefore determined that the repeated administration of sympathomimetic amines without evaluating or monitoring patient tolerance indicated a clear lack of knowledge on the part of the Respondent and constituted the practice of medicine with incompetence on more than one occasion.

FAILURE TO MAINTAIN ADEQUATE RECORDS

As previously stated above, the Hearing Committee concluded that Respondent's record-keeping was extremely inadequate. The level of information contained in a medical record must be sufficient enough to enable a subsequent treating physician to obtain a knowledge of a patient's medical history. The Committee strongly agreed with Dr. Sadovsky's opinions that the records of Patients A through H were not within acceptable levels of practice. The records contained little information relevant to the patients' complaints or histories, minimal physical findings were noted and relationships between diagnoses and treatments were frequently absent. Based upon the limited information contained in the charts, there was no medical indication for many prescriptions issued by the Respondent. As a result, the Hearing Committee concluded that Respondent failed to maintain medical records for Patients A through H which accurately reflected the medical care and treatment rendered to those patients. Therefore, the Committee voted to sustain the Twenty-ninth through Thirty-Sixth Specifications of professional misconduct.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee sustained multiple specifications of professional misconduct including practicing with gross negligence and negligence on more than one occasion, practicing with incompetence on more than one occasion and failing to maintain accurate records. Respondent's practice, as set forth in the record of this proceeding, was determined to demonstrate such a lack of skill and such a deviation from acceptable standards that rehabilitation through counseling and/or

retraining was considered to be impractical. The Committee had an opportunity to observe Respondent's demeanor when he was called to testify by the Department. He appeared combative and argumentative and expressed no remorse or contrititon concerning his treatment of his patients. Respondent's position at this hearing, as presented primarily through cross-examination of the Department's witnesses, was to shift the blame for any errors and to accept no responsibility for his repeated mistakes in judgement and failures to practice within acceptable standards of care.

Respondent's position concerning his treatment of Patient A was found to be particularly disturbing by the Committee. Patient A's family repeatedly contacted Respondent during a two week period to report that she continued to be in pain and unable to put weight on her foot. Respondent insisted that the patent be brought to his office even though he was advised that she could not lower her foot from an elevated position without incurring great pain and therefore could not travel. (T. 87-94) Despite these facts and Respondent's knowledge of the patients' medical history, he placed the burden on the patient for failing to come to his office and delaying in being taken for medical care and characterized the patient as "recalcitrant". This denial by the Respondent of any responsibility in failing to monitor the patients' condition and order her hospitalized during the period of February 14 through February 27 provided a clear basis for the Committee to conclude that any penalty other than revocation of Respondent's license to practice medicine in New York State would be inappropriate.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT**:

1. The following Specifications of professional misconduct, as set forth in the Statement of Charges (Ex. 1A) are **SUSTAINED**:

a. First Specification, as it relates to Paragraphs A and A.2 through A.4;

b. Third Specification, as it relates to Paragraphs C and C.4 and C.6;

c. Twenty-Seventh Specification, as it relates to Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.7, A.8, A.9, A.10; B and B.1, B.2, B.3; 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; E and E.1, E.2, E.3, E.4; 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; H and H.1, H.2, H.3, H.4, H.5, H.7;

d. Twenty-Eighth Specification, as it relates to Paragraphs A and A.7, A.8; B and B.1, B.2; C and C.4, C.5, C.6; D and D.1, D.2; E and E.1, E.2; F and F.2; G and G.2, G.3; H and H.4, H.5;

e. Twenty-Ninth through Thirty-Sixth Specifications.

2. Respondent's license to practice medicine in New York State be and hereby is **REVOKED**.

DATED: SCHENECTADY
~~Albany~~, **New York**
12/1, **1994**

DAVID T. LYON, M.D., Chairman

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

----------X

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

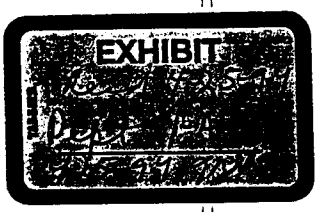
----------X

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.



APPENDIX I

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 order venous flow studies.

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

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

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

10. 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 maintain a record which accuratly reflects the evaluation and treatment of Patient B.

C. Respondent treated Patient C from on or about February 7, 1994, to on or about October of 1992 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. Respondent prescribed Euthroid without adequate medical justification.

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

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

3. Respondent failed to order an EKG.

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

5. Respondent prescribed thyroid supplements without adequate medical justification.

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

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

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

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

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

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

H. Respondent treated Patient H from late 1991 to on or about May of 1993 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 failed to discontinue fenflurmine and phentermine in a timely manner.

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

7. 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 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, and/or A.10.

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

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, and/or D.8.

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

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, and/or G.5.

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

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 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, and/or A.10.

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

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, and/or D.8.

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

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, and/or G.5.

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

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 SPECIFICATION

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 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; B and B.1, B.2, B.3; 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; E and E.1, E.2, E.3, E.4; 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; H and H.1, H.2, H.3, H.4, H.5, H.6, H.7; 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

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; B and B.1, B.2, B.3; 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; E and E.1, E.2, E.3, E.4; 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; H and H.1, H.2, H.3, H.4, H.5, H.6, H.7; 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 Supp. 1994) in that, Petitioner charges the facts in Paragraph N.

DATED: Albany, New York
April 21, 1994

S PDVB/KGP

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

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

July 18, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2429
Albany, New York 12237

Alaln M. Burke, M.D.
Pro-May Mall
Newark, New York 14513

James F. Foley, Esq.
P.O. Box 211
235 East Main Street
Palmyra, New York 14522

RE: In the Matter of Alan M. Burke, M.D.

Dear Mr. Roe, Mr. Foley and Dr. Burke:

Enclosed please find the Interim Order signed by the Commissioner in the above referenced matter.

Very truly yours,

Tyrone T Butler/crc

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc

Enclosure

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

IN THE MATTER OF ALAN M.BURKE, M.D.	INTERIM ORDER

I have reviewed the transcript pages constituting the Report of the Hearing Committee in the issue of Imminent Danger in this matter, the Committee's finding that ALAN M. BURKE, M.D., Respondent, does present an imminent danger to the health of the people of the State of New York, and the Hearing Committee's recommended action that the Summary Order prohibiting ALAN M. BURKE, M.D. from practicing medicine in the State of New York remain in effect.

Now, upon reading and filing the transcript of the hearing, the exhibits, and other evidence introduced at the hearing, the conclusions and recommendations of the Hearing Committee as set forth in the hearing transcript dated June 16, 1994,

I HEREBY ORDER THAT:

The Summary Order, dated February 25, 1994, imposed upon Respondent, ALAN M. BURKE, M.D., shall remain in effect, pending the final resolution of this matter.

DATED: Albany, New York
July 14, 1994

MARK R. CHASSIN, M.D.
Commissioner of Health
State of New York

TO: KEVIN C. ROE, Esq.
Associate Counsel
New York State Department of Health
Empire State Plaza
Corning Tower, Room 2589
Albany, New York 12237-0032

JAMES F.FOLEY, Esq.
P.O. Box 211
235 East Main Street
Palmyra, New York 14522

ALAN M. BURKE, M.D.
Pro-May Mall
Newark, New York 14513

responsible for the death of that patient.

He has shown throughout the care and treatment of all these patients a lack of appropriate knowledge and understanding necessary to treat patients. When you put the two together, that's where imminent danger is. We ask that you extend the order at this time. At this point we ask that you recommend to the Commissioner to extend the summary order.

CHAIRPERSON LYON: Thank you, Mr. Roe.

(The hearing recessed at 12:25 p.m.)

(The hearing reconvened at 12:45 p.m.)

CHAIRPERSON LYON: Dr. Burke, the panel has decided to recommend that the order be extended. Your license will remain suspended. We will, however, be deliberating as to a final decision regarding the charges very shortly. We have set a date for deliberations of July 15. Mr. Armon will be instructing the attorneys as to what we will require from them prior to our deliberations, but it is our intention to move expeditiously to resolve this matter in a final fashion.

I would like to suggest that any