STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
*Commissioner*

Dennis P. Whalen
*Executive Deputy Commissioner*

Public

August 1, 2005

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Terrence Sheehan, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Anthony Z. Scher, Esq.
Wood & Scher
222 Bloomingdale Road, Suite 311
White Plains, New York 10605

Allen C. Chamberlin, M.D.
57 West 57th Street – Suite 505
New York, New York 10019

**RE: In the Matter of Allen C. Chamberlin, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 05-160) 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 together with the registration certificate. Delivery shall be by either certified mail or in person to:

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

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

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

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

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

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

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

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

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

Sincerely,

Sean D. O'Brien/nm

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:nm

Enclosure

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



| IN THE MATTER<br>OF<br>ALLEN C. CHAMBERLIN, M.D. | DETERMINATION<br>AND<br>ORDER |
|---|---|

BPMC No. 05-160

**MILTON O.C. HAYNES, M.D.**, Chairperson, **NEIL J. MACY, M.D.** and **JAMES J. DUCEY,** 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 Section 230(10)(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.,** served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **DONALD P. BERENS, Jr.,** General Counsel, **TERRANCE SHEEHAN, ESQ.,** Associate Counsel, of Counsel. The Respondent appeared by **WOOD & SCHER, ESQS., ANTHONY Z. SCHER, ESQ.,** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

## STATEMENT OF CHARGES

The accompanying Statement of Charges alleged Twenty-one (21) specifications of professional misconduct, including allegations of fraudulent practice, negligence, incompetence, making a false report, moral unfitness and failure to maintain accurate medical records. The charges are more specifically set forth in the Statement of Charges dated July 27, 2004, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

## SUMMARY OF PROCEEDINGS

| | |
|---|---|
| Notice of Hearing Date: | July 27, 2004 |
| Pre-Hearing Conference | September 22, 2004 |
| Hearing Dates: | September 30, 2004 |
| | October 7, 2004 |
| | October 14, 2004 |
| | December 9, 2004 |
| | January 6, 2005 |
| | January 19, 2005 |
| | January 21, 2005 |
| | March 2, 2005 |
| | March 16, 2005 |

## WITNESSES

| | |
|---|---|
| For the Petitioner: | William J. Walsh, M.D.<br>Carole Agin, M.D. |
| For the Respondent: | Allen C. Chamberlin, M.D.<br>Stephen L. Brenner, M.D.<br>David Andrews, M.D.<br>Richard S. Blum, M.D. |

## FINDINGS OF FACT

1. Respondent was licensed to practice medicine in New York State on or about November 21, 1958 by issuance of license number 81810 by the New York State Education Department. (Pet. Ex. 1)

**PATIENT A**

2. Patient A was a 39 -year-old woman who sustained injuries as a pedestrian involved in a car accident. The accident took place two weeks before she was first seen by Respondent on July 21, 1998. ( Pet. Ex. 2, p,15; T.28)

3. Respondent' s record includes a report of the orthopaedic examination he conducted. In the report he repeatedly refers to various separate special reports. These include special reports of range of motion of the cervical spine, range of motion of the lumbar spine, muscle testing of the lumbar spine, analysis of muscle power of the left knee and range of motion of the shoulders. None of these reports are in Patient A's chart as they should be. The examination does not distinguish between right and left shoulder. (Pet. Ex. 2, P. 15-16;T. 31-36.

4. Respondent's Chart for Patient A and his billing statements contain diagnoses of a tear of the anterior cruciate ligament, a fracture of the glenohumeral head and traumatic subluxation of the shoulder. (Pet. Ex. 2, p.2)

T. ____ and Ex. _____ indicate a reference to the transcript of the hearing or to an exhibit in evidence.

5. Patient A's MRI dated 7/24/98 did not show a torn anterior cruciate ligament (ACL). There was a discrepancy between Respondent's findings and what the MRI revealed (Pet. Ex. 2, p. 21;T. 113)

6. If the patient's symptoms and physical signs were consistent with a torn ACL and the MRI showed an intact ACL then a diagnostic arthroscopy would be done to visually inspect the ACL and then document the findings at that time prior to proceeding with any definitive surgery on the ligament. (T. 114)

7. Dr. Brenner testified that the indications for using the electro frequency technique to repair an ACL tear would be because clinically you detected a mild laxity in the knee. That when one was looking in with the arthroscope, the ligament was basically a healthy ligament, meaning a little bit lax and stretched, that could lend itself to shrinking. (T. 1373)

8. This procedure would generally be discussed with the patient beforehand because patients don't like to be surprised that all of a sudden you are repairing an ACL on them and they can't run and jump and return to work as soon as they anticipated. (T. 1373-1374)

9. There is nothing in Patient A's record regarding a Lachman test or pivot shift test. (Pet. Ex. 2)

10. Respondent's operative report does not describe a repair of the ACL. It describes only removal of some scar tissue from the ligament. (T. 45)

11. On September 29, 1998, Respondent operated on Patient A's shoulder. (Pet. Ex. 2, p.2)

12. The MRI of Patient A's left shoulder does not show any sign of deterioration. (Pet. Ex.20-B; T. 70)

13. The radiologist's report does not indicate damage of the articular cartilage, therefore the abrasion arthroplasty was not indicated. ( Ex. 20-B; T. 72 )

14. Abrasion arthroplasty is uncommonly performed on the shoulder. (T.67 )

15. The shoulder is different from the knee in that it is not a weight-bearing joint. It is a joint that is particularly designed for providing a range of motion to the upper extremity in positioning the hand to work. Generally, surgeons try to avoid doing procedures that may cause a loss of motion because loss of motion is very disabling in the shoulder joint. (T. 67)

16. On September 10, 1998, Respondent's records indicate that he performed knee surgery consisting of an abrasion arthroplasty, notch plasty and manipulation under general anesthesia. (Pet. Ex. 2)

17. There is no indication in the MRI report of the left knee, dated July 26, 1998, that indicated any significant damage to the articular cartilage in the knee that would warrant an abrasion arthroplasty. ( Pet. Ex. 20-A; T. 54)

18. The abrasion arthroplasty has a definite potential for doing harm, by promoting the development of arthritis. It is something that surgeons would be very hesitant to perform unless there was a good indication for it. (T. 61)

19. Dr. Brenner testified that if there are "no loose pieces" in the knee, you leave them alone. (T. 1376)

20. Respondent's operative report makes no mention of "loose pieces" in the knee. ( Pet. Ex. 2)

21. The MRI indicates a very wide notch, not a narrowing one. Therefore, the notch plasty procedure was not indicated. (Pet. Ex. 14-A, Pet, Ex. 20-A, T. 57)

22. Manipulation is putting the knee through a full range of motion while the patient is asleep. Generally this is a procedure that is done if there is scar tissue or adhesions in the knee so the knee is stiff. The knee may be manipulated to stretch or break up those adhesions to regain full rang of motion in the knee. (T. 63-64)

23. There were no such adhesions in Patient A's knee that warranted the performance of a manipulation. (T. 64)

24. On September 29, 1998, Respondent's record states that he performed shoulder surgery consisting of an abrasion arthroplasty, synovectomy, excision of the subdeltoid bursa, division of coraco acromial ligament, Putti-Platt procedure, and acromioplasty. (Pet. Ex. 2, p.2)

25. Petitioner withdrew the factual allegation and corresponding charges alleging that the portion of the shoulder surgery consisting of excision of the subdeltoid bursa was not indicated.

26. The synovectomy was warranted based on the indication from the MRI that there was tendinitis in the supraspinatus. (T. 77-78)

27. The abrasion arthroplasty of the shoulder was not indicated. (T. 67-72)

28. The Putti-Platt procedure is an operation that may be done to correct a problem of recurrent anterior dislocation of the shoulder. The muscle is tightened up in such a way to try to prevent the shoulder from re-dislocating. (T. 72-73)

29. The indication for that surgery is a recurrent dislocation, i.e. that the ball comes out of the socket on more than one occasion. (T. 73)

30. Since Patient A's history does not include any mention of prior or recurrent anterior dislocations to the shoulder, the Putti-Platt procedure was not indicated. (T.73)

31. If the patient has this procedure, the patient ends up with a restricted range of motion. (T. 74)

32. The procedure noted in Respondent's operative report does not conform with the proper description of a Putti-Platt operation. ( Pet. Ex 2, pp 3-4; T. 74-75)

33. Most people with the type of injuries and symptoms that this patient had can be managed adequately with medication, physical therapy and perhaps steroid injection. (T. 79-80)

**PATIENT B**

34. Patient B was first seen by Respondent on August 18, 1998 with a history of injuries to the right shoulder and left knee as a result of being a passenger in a car accident.(Pet. Ex. 3)

35. Respondent's records lack the referenced "special reports" on significant areas of his examination of Patient B, such as range of motion and muscle testing. (Pet. Ex. 3)

36. Respondent's records state that a number of procedures were performed on Patient B's right shoulder. They included an abrasion arthroplasty, division of the coraco acromial

ligament, excision of the subacromial bursa, Putti Platt, repair of rotator cuff, acromioplasty, arthrocentisis, synovectomy and manipulation under general anesthesia. (Pet. Ex. 3, p.11-14)

37. There were two diagnoses listed under the impression of the MRI findings. The first was an intra substance tear involving the supraspinatus tendon. This type of damage did not require surgery because there was no gap at the ends of the tendon. This was considered a partial tear which is capable of healing with time and therapy. (Pet. Ex. 15A; T. 184-185)

38. The second MRI finding is possible glenoid labral tear that could not be ruled out by the radiologist. However, if there was such a tear, it would be minor. (Pet. Ex.15A; T. 185)

39. The procedures that Respondent performed were not indicated because this 20 year-old patient should have been offered a course of conservative therapy to allow her injury to heal naturally over time. (T.188 )

40. On September 22, 1998, Respondent's records indicate that he performed knee surgery consisting of an abrasion arthroplasty, synovectomy, debridement of scar tissue, arthrocentesis, notch plasty and manipulation under anesthesia. (Pet. Ex.3, p. 22)

41. Respondent' s operative report made no mention of loose bodies that would require abrasion arthroplasty of the knee. (Pet. Ex. 3, p. 23)

42. These procedures performed on Patient B's knee were not indicated. (T. 195)

43. Abrasion arthroplasty and notchplasty are procedures which have a high degree of risk of leading to development of arthritis of the knee. (T. 196)

44. Chondral plasty is the removal of cartilaginous tissue without going down to the bone. (T. 248)

45. A chondral plasty was performed on Patient B. (T. 1405)

46. An ACL tear is not listed as a diagnosis at the end of the history and physical and it is not listed as a pre-operative diagnosis.(Pet. Ex. 3, pp.2-4, 22)

47. The radiologist report states that both the posterior and the anterior cruciate ligaments were noted to be intact. (Pet. Ex. 3, p. 7; T. 192)

48. The ACL repair is listed on the consent form although it is not in the radiological work up. (Pet. Ex. 3, p.28; T.192)

49. Respondent billed the insurance company for an ACL repair. (Pet. Ex. 3, p. 26; T. 192-193)

50. Respondent's operative report describes debriding of some scar tissue from the central portion of the ACL. There was no repair done. (Pet. Ex. 3, p. 24, par. 3; T. 193)

51. The ACL repair procedure described for Patient B contains the same wording as the procedure described for Patient A. (T. 194)

52. Dr. Brenner concurs that Respondent's report does not specify the exact manner in which the ACL was repaired. (T. 1403)

**PATIENT C**

53. Patient C is an 18 year-old female who was injured as a passenger in a motor vehicle accident on 7/18/98. Her chief complaint was right shoulder pain. (Pet. Ex. 4, p.2)

54. Special reports on range of motion and muscle testing although referenced in the consultation are not included in Respondent's record.(Pet. Ex. 4, p.3, T. 303)

55. The impression on Patient C's MRI is an intrasubstance tear involving the supraspinatus tendon in the right shoulder. (Ex. 4, p. 5, Ex. 16; T. 305)

56. Supraspinatus tendon is the most important part of the rotator cuff, which is deep muscle structure that is responsible for the ability to raise the arm. (T. 305)

57. Intrasubstance would mean that the tendon had some abnormality, but it was not physically disrupted. In other words, there was no complete tear or no separation of the fragments. (T. 305-306)

58. The patient's films show a very normal shoulder except there is a little irregularity of the supraspinatus tendon. (Pet. Ex. 16; T. 308)

59. An injury of this nature would heal on its own even without physical therapy. (T. 309)

60. Respondent performed abrasion arthroplasty, division of coraco acromial ligament, excision of subacromial bursa, Putti-Platt procedure, repair rotator cuff, acromioplasty, arthrocentesis, synovectomy and manipulation under general anesthesia. These procedures were not indicated. (T. 311)

61. Respondent's report describes the abrasion arthroplasty for Patient C in the same exact manner as this procedure was described for Patient A. (Pet. Ex. 4, p.12; Pet. Ex. 2, p.5; T. 312-313)

**PATIENT D**

62. Patient D suffered knee pain as a result of a car accident on July 18, 1998 in which he was the driver. He was examined by Dr. Levin's office. A clinical examination was

performed. X-rays were performed. Imaging studies were performed showing a torn meniscus, medial. (Pet. Ex. 5)

63. Respondent again refers to special reports. These reports are not found in Patient D's chart. (Pet. Ex. 5, p.3)

64. At the time Respondent first saw Patient D, an MRI had already been done. The MRI showed a horizontal tear of the anterior horn of the medial meniscus. This finding would justify the performance of a meniscectomy, which in fact was performed by Respondent. Pet. Ex. 5, p.10; T.359)

65. The MRI had no other positive findings. The cruciate ligaments were found to be intact and no fractures were noted. (Pet. Ex. 5, p.10)

66. Respondent recorded several diagnoses in the chart. One is "chondral fractures, left knee." There is no basis for this diagnosis. It is incorrect and unsubstantiated by the medical record. (Pet. Ex. 5, p.4; T. 355-6 )

67. There was no indication in the description of the knee to warrant an abrasion arthroplasty. (T. 360)

68. On September 3, 1998, Respondent performed a debridement of scar tissue from the anterior cruciate ligament, not an ACL repair. (Pet. Ex. 5, p.7; T. 360)

69. The ACL repair was not indicated and it was not appropriate for Respondent to bill the insurance company for an ACL repair given the description in the operative report. (T. 360-361)

70. The notchplasty is a procedure that is done in association with an ACL reconstruction. There is no purpose in performing a notchplasty in the absence of an ACL repair. (T. 361)

71. When faced with an inadequate film, there is nothing to prevent an orthopedic surgeon from ordering additional films. (T. 368-369)

72. Dr. Brenner stated that a chondralplasty was performed on Patient D. (T. 1448)

**PATIENT E**

73. Patient E gave a history of being involved in a car accident as a passenger on 4/4/95 while employed by the NYC Police Department. As a result of the accident, he developed pain in the lumbar spine. Pain radiated into the pelvic area. . (Pet. Ex. 6, p.2-3)

74. The radiologist report indicates that there is straightening of the normal lordotic curvature. There is also a bulge of the intervertebral discs at L4-L5 and L5-S1 in the midline with compression of the subarachnoid space and a desiccated disc at L4-5. (Pet. Ex. 6, p.5: T. 401)

75. In a six week period from February 16th through April 2nd , Patient E underwent 12 epidural steroid injections. (Ex. 6; T. 631)

76. Patient E received four injections within eleven days. (Pet. Ex. 6; T. 415-416)

77. Epidural steroid injections can stay in the blood stream anywhere from one to three weeks. They are repeated at a minimum of two week intervals or higher. (T. 636)

78. Two week intervals allow the body to clear the previous steroid use. Otherwise the patient may develop Cushing's Syndrome which is what happens when the body does not

produce its own steroids. (T. 636-637) The patient can also be at risk for bone demineralization. (T. 694)

79. If the block is administered sooner than 5 to 7 days, the practitioner cannot evaluate the effectiveness of the prior block . (T. 637)

80. Typically, epidural steroid injections are done in a series of three, a couple of weeks apart. If the patient has no benefit, then some other modality should be tried. (T. 417,626, 636, 695, 2029)

81. Respondent's medical record for Patient E lacks justification for continuing the epidural blocks after the initial series. Referenced special reports on range of motion and muscle testing were not included in Respondent's record.

**PATIENT F**

82. Patient F was involved in an automobile accident as a driver on November 4, 1997. (Pet. Ex. 7, p.2)

83. Patient F complained of pain in the cervical spine, lumbar spine, pelvis and interscapular area. He also complained of muscle spasms. Respondent's record also states that Patient F suffered a "serious injury" and his prognosis was "significantly guarded." (Pet. Ex. 7, 3-4)

84. Respondent's record states that x-rays were ordered and a clinical exam was performed in Dr. Sonn's office. (Pet. Ex. 7, pp.2-4)

85. No imaging studies were ordered for Patient F. (Pet. Ex.7, p.3: T. 445)

86. In view of the extensive nature of Patient F's complaints, an MRI should have been ordered to determine the patient's sources of pain. (T. 446, 650)

87. Patient F was reported as having straight leg raise at 70 and 90 degrees , which is basically a negative test for radiculitis. (T. 656-657)

88. The epidural nerve block described in Respondent's operative note was not indicated. (Pet. Ex. 7, p.8; T. 448, 451, 710-711)

89. Patient F was treated for a symptom and not for a specific diagnosis. (T. 474)

90. Respondent's records fail to establish a definite diagnosis for the underlying pathology that was causing Patient F's pain. (T. 449) Referenced special reports were also not included. (T. 451)

**PATIENT G**

91. Patient G was a 20 year-old female who was involved in an automobile accident as a passenger on June 23, 1998. (Pet. Ex. 8, p. 2)

92. On August 13, 1998, Respondent operated on Patient G's shoulder. The procedures included an abrasion arthroplasty, division of coraco acromial ligament, excision of subacromial bursa, Putti-Platt, rotator cuff repair, acromioplasty, arthrocentesis, synovectomy and manipulation under anesthesia. (Pet. Ex. 8, p. 7-9)

93. Patient G's MRI is negative for evidence of shoulder dislocation. (Pet. Ex. 8, p.5; T. 481)

94. The radiologist's report noted an intrasubstance tear of the rotator cuff. However, there was no abnormal fluid collections observed in the subdeltoid bursa. There was also no

significant joint effusion seen and no evidence of rotator cuff impingement. (Pet. Ex. 8, p.5; T. 481-482)

95. None of the above listed surgeries were warranted for Patient G. (T. 483-485)

96. Patient G's partial or incomplete tear of the rotator cuff should have been managed with conservative care including physical therapy, anti-inflammatory medication and given time to heal. (T. 483)

97. There is nothing in the history or in the orthopedic examination that would indicate that the patient suffered from a recurrent dislocation of the shoulder. (T. 486)

98. Respondent's records make no distinction between the right and left shoulder in the initial clinical exam. The special reports are also omitted from the record. (Pet. Ex. 8, p.3)

**PATIENT H**

99. Patient H was a 52 year-old male who was involved in a car accident as a driver on 5/15/95.

100. Reference range of motion and muscle testing reports are missing from Patient H's record. (Pet. Ex. 9; p.3)

101. Respondent's record regarding the history of the shoulder between the time of the accident and Respondent's consultation is sketchy and confusing. (T. 550)

102. The MRIs of Patient H's shoulder showed fairly severe arthritic changes involving the shoulder joint and acromioclavicular joint and some secondary changes affecting the rotator cuff. (Pet. Ex. 9, p.9; T. 551-552)

103. These abnormalities are not reflective of a traumatic incident but are from a progressive degenerative process. (T. 552)

104. Respondent performed an abrasion arthroplasty, division of coraco acromial ligament, excision of subacromial bursa, Putti-Platt procedure and synovectomy.

105. These procedures were not indicated because the MRI showed arthritic changes of the shoulder, not instability and no changes consistent with instability. ( Pet. Ex. 9; T. 554)

106. The better therapeutic option for Patient H would have been a Mumford procedure for excision of the distal clavicle. This would relieve the pressure from the rotator cuff and lessen the symptoms relating to the arthritic portion of the collar bone. (T. 556-7)

## CONCLUSIONS OF LAW

Respondent is charged with twenty-one (21) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do 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 the 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, incompetence and the fraudulent practice of medicine.

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

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

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

Fraudulent practice is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine. The Hearing Committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation. The licensee's knowledge and intent may properly be inferred from facts found by the Hearing Committee, but the Committee must specifically state the inferences it is drawing regarding knowledge and intent.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that sixteen (16) of the twenty-one (21) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties. William J. Walsh, M.D.

testified for the Department. Dr. Walsh is a board certified orthopedist who is in private practice primarily at Westchester Medical Center. (Pet. Ex. 12; T. 25-27) The Hearing Committee found Dr. Walsh to be an experienced physician and credible witness. Carole W. Agin, M.D., MPA also testified for the Department. Dr. Agin is board certified in anesthesiology and pain management. She is currently an Associate Professor of Anesthesiology at SUNY Stony Brook as well as the Director of the Center for Pain Management at Stony Brook. The Hearing Committee found Dr Agin to be a credible witness.

The Respondent called Stephen L. Brenner, M.D., a retired physician who had a general practice with a sub-specialty in sports medicine. A large part of his practice involved operative arthroscopy. (T. 1289-1290) The Hearing Committee found Dr. Brenner to be a credible witness. They note that Dr. Brenner struggled to justify some of Respondent' actions. They also note that he admitted that many areas of Respondent's record was confusing and that he would have done things differently. Respondent also offered the testimony of David Andrews, M.D., who is board certified in orthopedic surgery and who was associated with Columbia University for most of his career. (T.1773-1774) The Hearing Committee is unclear what his experience was at the Columbia trauma center. The Hearing Committee found Dr. Andrews to be a flamboyant, testy, biased witness who overall was not very credible. Respondent also offered the testimony Richard S. Blum, M.D. an internist who also has a Master's degree in pharmaceutical science. Dr. Blum has served on numerous committees and boards since

his retirement. (T.1989-1992) The Hearing Committee found him to be a very erudite witness.

Respondent also took the stand on his own behalf. The Hearing Committee found that large segments of Respondent's testimony lacked credibility. This was particularly evident in his testimony relating to the ACL repairs in his patients using "manual instrumentation." The operative reports do not state what was done, only what instruments were used. Respondent testified that "manual instrumentation referred to the repair by heat using radio frequency (T. 1037) and that this procedure was taught at the American Academy of Orthopedic Surgeons in the late 1990's. He also testified that this was " **the best way to deal with the ACL when it was torn, rather than take every injured ACL and do a reconstruction, which can be very dangerous and difficult.**" He also testified that he had "every belief that since the **only way you can repair the ACL in 1998 was by heat, that is what I billed for.**" (T. 1039-1042)

The Hearing Committee read the two published articles submitted by Respondent (Resp. Exs. H and I) and the Committee concludes that these articles do not support his testimony. Respondent's Exhibit H, "The Arthroscopic Monopolar Radiofrequency Treatment of Chronic Anterior Cruciate Ligament Instability", was published in 1996. This paper discusses management of patients with "chronic" ACL instability. The indications for use of this procedure were "Patients with previously primarily repaired and previously reconstructed ACLs, whether with autogenous or allograft tissue." These patients "must show a history of instability, failure of previous nonsurgical and/or surgical management, a positive Lachman and pivot shift maneuver, and abnormal side-

to-side KT 1000 values." (Pet. Ex. H, p. 158). None of the patients that are the subject of these charges and treated by Respondent met the indications cited. The paper concludes that :The thermal repair of ACL-insufficient knees represents an **emerging alternative** to standard ACL reconstructive techniques. The minimal morbidity of ACL thermal repair must be counter-balanced by the success rate of **well- documented ACL reconstructive techniques."** (Resp. Ex H, p. 160)

Respondent's Exhibit I, "Radio frequency Electrothermal Shrinkage of the Anterior Cruciate Ligament" is a paper which was first presented in 2000 and published in 2002. The authors of this paper stated that in a review of the English literature they found **"only one published series in which electrothermal energy was used to treat patients with ACL instability."** (Resp. Ex. I, p.6) There were only 25 patients in that study and is the study previously cited. (Resp. Ex. H) This current paper, which was based on 18 patients, concludes that "it is evident that thermal shrinkage using radio frequency technology has limited application for patients with anterior cruciate ligament laxity." (Resp. Ex. I, p.1) The paper also concludes that "surgeons should be very selective in their use of radio frequency electrothermal shrinkage of lax ACL's... a greater number of cases and a longer follow up are needed to compare the results of such treatment with that achieved through the time-tested methods of ACL reconstruction." (Resp. Ex. I, p.7).

Given the available evidence in this case, the Hearing Committee finds it hard to accept that radio frequency electrothermal shrinkage of torn ACLs in 1998-1999 was the standard of care and was not experimental. (T. 1393-1394) The findings of these two

papers are consistent with the credible opinions presented by Petitioner's expert witness, Dr. Walsh on ACL repair. If the Hearing Committee accepts Respondent's testimony that "manual instrumentation " refers to ACL repair using radio frequency electrothermal shrinkage, this should have been clearly stated in the operative report. (T. 1395-1396) If this procedure was used, then the need for a notchplasty, as outlined by Respondent, is not credible. Even Respondent's expert witness, Dr. Brenner, struggled to justify the performance of a notchplasty, and stated he did not believe that "much of a notchplasty was done here." (T. 1391-1392)

**FRAUDULENT PRACTICE**

**Factual Allegations A ., A.2, and A.4; B and B.4 ; D and D.4 : SUSTAINED**

**Factual Allegations E and E.2; F and F.3 : NOT SUSTAINED**

The Hearing Committee believes that Respondent deliberately concealed information in his records and reports so that he could bill the insurance company for procedures that he did not perform. In the case of Patient A, the Hearing Committee finds that Respondent's diagnoses of a torn ACL to be knowingly false. There is no tear indicated on the MRI . There is nothing in the patient' s record regarding a Lachman test or pivot shift test which could have been done to support a clinical diagnosis of a torn ACL. Respondent also could have resolved any discrepancies with a diagnostic arthroscopy prior to surgery. (T. 114) The diagnosis for the shoulder is also knowingly false because the MRI shows a normal shoulder except for some fluid and there is no history of recurrent dislocation. (T. 73)

The Hearing Committee further believes that Respondent, with intent to deceive, falsely billed Patient A's carrier for an ACL repair which he did not perform. This is based on the fact that the ACL was not torn on the MRI, that there are no special reports on muscle power for the knee and there is no discussion with the patient before surgery regarding post operative restrictions of an ACL repair. It is also noted that the operative report contains no description of "loose pieces" of the knee and that it merely describes the removal of scar tissue. Finally, the Hearing Committee rejects Respondent's testimony that he performed radio frequency electrothermal shrinkage to repair the ACL for the reasons previously discussed regarding Respondent's credibility.

The Hearing Committee finds intentional false billing for Patient B because a similar pattern of the same factors are present. No positive findings of a tear on the MRI, no special report on the knee and no reference to a torn ACL in the pre-operative diagnosis. Again there are no loose bodies noted in the operative report, just a description of debriding of scar tissue. Even Dr. Brenner, Respondent's expert notes that the operative report does not specify the exact manner in which the ACL was repaired. (T.1403 )

Fraud is also sustained for intentional false billing of Patient D's ACL repair again noting that the MRI found the ACL intact and that only a debridement was described in the operative report. The Hearing Committee notes that Respondent could have ordered additional films if he believed the MRI was inadequate. The Hearing Committee found insufficient evidence to support the Department's allegations of fraud regarding Patient's E and F.

**NEGLIGENCE ON MORE THAN ONE OCCASION**

**Factual Allegations : A, A.1,A.3, A.5, A.6; B, B.1-B.3, B.5; C. A.1-C.3; D, D.1-D.2, D.6; E, E.1,E.3, F, F.1-F.2, F.4, G-G.3, H-H.4 : SUSTAINED**

**Factual Allegations D.5 : NOT SUSTAINED**

Except for Charge D.5, the Hearing Committee sustains all charges of negligence for Patients A through H. Respondent referenced special reports regarding range of motion and analysis of muscle power, but none were ever found in these patient's records. Most of the surgery that he performed on these patients was not indicated. Patients whose shoulders exhibited no deterioration were subjected to abrasion arthroplasty. Patients whose knees showed no significant damage to the articular cartilage were subjected to abrasion arthroplasty and notch plasty. These procedures create a high risk of arthritis. More troubling was the performance of a Putti Platt procedure on young patients who had no history of recurrent anterior dislocation. This would result in a permanent restricted range of motion, when many of the injures would have healed with conservative treatment. Finally the Hearing Committee found that Respondent violated the standard of care by giving excessive epidural steroid injections to Patient E without adequate medical justification.

**INCOMPETENCE ON MORE THAN ONE OCCASION**

**All Allegations : NOT SUSTAINED**

The Hearing Committee found insufficient proof in the record to sustain this specification.

**FALSE REPORT**

**Factual Allegations : A, A.2 , A.4; B, B.4, D and D.3: SUSTAINED**

**Factual Allegations D.4, E, E.2, F and F.3: NOT SUSTAINED**

The Hearing Committee sustains the same charges sustained under fraudulent practice for wilfully making or filing false reports within the patients' records as well as in the bills submitted to the patients' insurance carriers. (See discussion under Fraudulent Practice)

**MORAL UNFITNESS**

**Factual Allegations A, A.2, A.4 B, B.4, D and D.3 : SUSTAINED**

**Factual Allegations D.4, E, E.2, F and F.3: NOT SUSTAINED**

The Hearing Committee finds that Respondent's filing of false reports and fraudulent insurance billing constitutes moral unfitness.

**FAILURE TO MAINTAIN RECORDS**

**Factual Allegations A A.1,A.2,A.6;B,B.1B.5;C,C.1,C.3; D,**

**D.1D.4,D.6;E,E.3,F,F.4,G,G.1,G.3;H,H.1,H.4: SUSTAINED**

The Hearing Committee found all of Respondent's records to be missing information, confusing and lacking medical justification for the procedures he performed.

**DETERMINATION AS TO PENALTY**

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote 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, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for revocation because they found a clear pattern of serious misconduct. In each case Respondent failed to perform a full diagnostic evaluation and failed to consider the concept of physical therapy. He took a one size fits all approach that is reflected in his standardized "cook book" operative reports. He subjected all the patients to unneeded surgeries or excessive epidural blocks notwithstanding the potential risks. The Hearing Committee found no mitigating circumstances to offset the penalty imposed. The multiple acts of fraud not only merits revocation but the Hearing Committee imposes a $10,000 penalty for each of the three sustained fraudulent acts. Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

## ORDER

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

1. The First, Second, Third, Sixth, Eighth, Ninth, Tenth and Thirteenth through Twenty-First of the Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The Fourth, Fifth, Seventh, Eleventh and Twelfth of the Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;**

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

4. A fine in the amount of **THIRTY THOUSAND DOLLARS ($30,000)** be and hereby is imposed against Respondent. Payment of the aforesaid penalty shall be made to the Bureau of Accounts Management, New York State Department of Health, Corning Tower Building, Room 1258, Empire State Plaza, Albany, N.Y. 12237 within thirty (30) days of the effective date of this Order.

5. That any civil penalty not paid by the date prescribed herein shall be subject to all provisions of laws relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; and non-renewal of permits or licenses (Tax Law, section 171(27); State Finance Law, section 18; CPLR, section 5001; Executive Law, section 32)

6. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

**DATED: New York, New York**

7/22/2005

**MILTON O.C. HAYNES, M.D.**

**(Chairperson)**

**NEIL J. MACY, M.D.**

**JAMES J. DUCEY**

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# APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

ALLEN C. CHAMBERLIN, M.D.

STATEMENT

OF

CHARGES

Allen C. Chamberlin, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 21, 1958, by the issuance of license number 81810 by the New York State Education Department.

## FACTUAL ALLEGATIONS

A. In 1998 Respondent treated Patient A for knee and shoulder pain at his medical office known as Carnegie Hill Orthopedic Service, 57 West 57th Street, New York, New York. (Patient names are contained in the attached Appendix). Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to perform and note a complete orthopaedic examination of Patient A's knee and shoulder.

2. Respondent's chart for Patient A and his billing statements contain diagnoses of a tear of the anterior cruciate ligament, a fracture of the glenohumeral head and traumatic subluxation of the shoulder. These diagnoses are knowingly false and were made by Respondent in order to deceive Patient A's carrier concerning the nature of Patient A's injuries and the resultant need for surgery.

3. On or about September 10, 1998, Respondent performed knee surgery consisting of an abrasion arthroplasty, notch plasty and manipulation under general anesthesia. These procedures were not indicated.

4. Respondent, with intent to deceive, falsely billed Patient A's carrier for an anterior cruciate ligament repair which procedure Respondent did not in fact perform.

5. On or about September 29, 1998, Respondent performed shoulder surgery consisting of an abrasion arthroplasty, synovectomy, ~~excision of subdeltoid bursa~~, division of corico acromion ligament, Putti-Platt procedure, and acromioplasty. These procedures were not indicated.

withdrawn - Cat

6. Respondent did not maintain a record for Patient A which accurately reflects his examination, including precise range of motion findings and mechanism of injury, history, diagnoses, operative notes and billing records.

B. In 1998, Respondent treated Patient B for shoulder and knee pain at his medical office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to perform and note complete orthopaedic examinations of Patient B's knee and shoulder.

2. On or about August 25, 1998, Respondent performed an abrasion arthroplasty, division of corico acromion ligament, excision of subacromial bursa, Putti-Platt procedure, repair of rotator cuff, acromioplasty, arthrocentesis, synovectomy, and manipulation under general anesthesia. These procedures were not indicated.

3. On or about September 22, 1998, Respondent performed knee surgery consisting of an abrasion arthroplasty, synovectomy, debridement of scar tissue, arthrocentesis, notch plasty and manipulation under anesthesia. These procedures were not indicated.

4. Respondent, with intent to deceive, falsely billed Patient B's third party carrier for a ~~reconstruction~~ repair (amended) of the anterior cruciate ligament, which procedure Respondent did not in fact perform.

5. Respondent did not maintain a record for Patient B which accurately reflects his examination, including precise range of motion findings and mechanism of injury, history, diagnoses, operative notes and billing records.

C. In 1998, Respondent treated Patient C, an 18 year old female, in his medical office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to perform and note a complete orthopaedic examination and complaint history of Patient C's shoulder.

2. On or about August 27, 1998, Respondent performed an abrasion arthroplasty, division of corico acromnial ligament, excision of subacromial bursa, Putti-Platt procedure, repair rotator cuff, acromioplasty, arthrocentesis, synovectomy and manipulation under general anesthesia. These procedures were not indicated.

3. Respondent did not maintain a record for Patient C which accurately reflects his examination, including precise range of motion findings and mechanism of injury, history, diagnoses, operative notes and billing records.

D. In 1998, Respondent treated Patient D, a 30 year old male, for injury to his left knee. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to perform and note a complete orthopaedic examination of Patient D's knee.

2. On or about September 3, 1998, Respondent performed an abrasion arthroplasty and notchplasty. These procedures were not indicated.

3. Respondent, with intent to deceive, falsely billed Patient D's carrier for an anterior cruciate ligament repair, which procedure Respondent did not in fact perform.

4. The chart maintained by Respondent contains a notation that a torn ACL was identified by Respondent during the procedure. This entry was knowingly false and designed to deceive Patient D's carrier

about the extent of the Patient's injuries and the resultant need for surgery.

5. In the alternative, Respondent's notation about the existence of a torn ACL is accurate. In that case Respondent's care was deficient in that he failed to perform or attempt to perform, an ACL repair procedure.

6. Respondent did not maintain a record for Patient D which accurately reflects his examination, including precise range of motion findings and mechanism of injury, history, diagnoses, operative notes and billing records.

E. In 1995 and 1996, Respondent treated Patient E for low back pain at his medical office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. On approximately 14 occasions Respondent administered epidural nerve blocks or injections of steroids into the muscle tissue around the vertebral column. These blocks or injections were not medically indicated.

2. Respondent, with intent to deceive, falsely billed Patient E's third party carrier for approximately 14 epidural nerve blocks, which services Respondent did not in fact perform.

3. Respondent did not maintain a medical record for Patient E which accurately reflects the rationales for injections administered, the

location of the injections and volume of injectate.

F. In 1997, Respondent treated Patient F for a spine injury at his medical office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent improperly undertook to treat this Patient prior to ordering or reviewing any MRI studies or other imaging studies or reports.

2. Respondent administered an epidural nerve block or injection of steroids into the muscle tissue around the vertebral column. This block or injection was not medically indicated.

3. Respondent, with intent to deceive, falsely billed Patient F's third party carrier for the administration of an epidural nerve block, which service Respondent did not in fact perform.

4. Respondent did not maintain a medical record for Patient F which accurately reflects the rationales for injections administered, the location of the injections and volume of injectate.

G. In 1998, Respondent treated Patient G a 20 year old female, for a shoulder injury in his medical office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to perform and note a complete orthopaedic examination and complaint history of Patient G's shoulder.

2. On or about August 13, 1998, Respondent performed abrasion arthroplasty, division of corico acromnial ligament, excision of subacromial bursa, Putti-Platt procedure, rotator cuff repair, acromioplasty, arthrocentesis, synovectomy and manipulation under general anesthesia. These procedures were not indicated.

3. Respondent did not maintain a record for Patient G which accurately reflects his examination, including precise range of motion findings and mechanism of injury, diagnoses, operative notes and billing records.

H. In 1995-6, Respondent treated Patient H for shoulder pain, in his medical office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to perform and note a complete orthopaedic examination and complaint history of Patient H's shoulder.

2. On or about April 6, 1996, Respondent performed an abrasion arthroplasty, division of corico acromnial ligament, excision of subacromial bursa, Putti-Platt procedure, and synovectomy. These procedures were not indicated.

3. Respondent improperly failed to consider or recognize the indications for performing a Mumford Procedure for excision of the distal clavicle.

4. Respondent did not maintain a record for Patient H which accurately reflects his examination, including precise range of motion findings and mechanism of injury, diagnoses, operative notes and billing records.

## SPECIFICATION OF CHARGES

### FIRST TO FIFTH SPECIFICATIONS

### FRAUDULENT PRACTICE

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

1. A and A(2), (4)
2. B and B(4)
3. D and D(3), (4)
4. E and E(2)
5. F and F(3)

### SIXTH SPECIFICATION

### NEGLIGENCE ON MORE THAN ONE OCCASION

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

6. A and A(1), (3), (5), (6); B and B(1), (2), (3), (5); C and C(1), (2), (3); D and D(1), (2), (5), (6); E and E(1), (3); F and F(1), (2), (4); G and G(1), (2), G(3); H and H(1), (2), (3), (4).

### SEVENTH SPECIFICATION

### INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined

in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

7. A and A(1), (3), (5), (6); B and B(1), (2), (3), (5); C and C(1), (2), (3); D and D(1), (2), (5), (6); E and E(1), (3); F and F(1), (2), (4); G and G(1), (2), G(3); H and H(1), (2), (3), (4).

**EIGHTH TO TWELFTH SPECIFICATION**

**FALSE REPORT**

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

8. A and A(2), (4)
9. B and B(4)
10. D and D(3), (4)
11. E and E(2)
12. F and F(3)

**THIRTEENTH SPECIFICATION**

**MORAL UNFITNESS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following paragraphs:

13. A and A(2), (4), B and B(4), D and D(3), (4), E and E(2) and F and F(3).

## FOURTEENTH TO TWENTY-FIRST SPECIFICATION

## FAILURE TO MAINTAIN RECORDS

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

14. A and A(1), (2), (6)
15. B and B(1), (5)
16. C and C(1), (3)
17. D and D(1), (4), (6)
18. E and E(3)
19. F and F(4)
20. G and G(1), (3)
21. H and H(1), (4)

DATED: July 27, 2004
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct