



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

PUBLIC

Dennis P. Whalen  
Executive Deputy Commissioner

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

January 13, 2005

Matthew Friedman, M.D.  
Budget Suites of America  
611 West Indian School Road  
Room 306  
Phoenix, Arizona 85013

Valerie B. Donovan, Esq.  
NYS Department of Health  
Division of Legal Affairs  
Corning Tower, Room 2509  
Empire State Plaza  
Albany, New York 12237

Matthew Friedman, M.D.  
429 Cuprite Street  
Globe, Arizona 85501

Matthew Friedman, M.D.  
4301 North 24<sup>th</sup> Street  
Phoenix, Arizona 85016

**RE: In the Matter of: Matthew Friedman, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 05-09 ) 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.

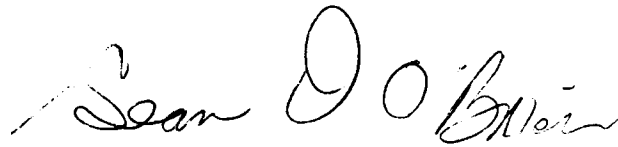
The notice of review served on the Administrative Review Board should be forwarded to:

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,

A handwritten signature in cursive script that reads "Sean D. O'Brien". The signature is written in black ink and is positioned above the printed name and title.

Sean D. O'Brien, Director  
Bureau of Adjudication

SDO:djh  
Enclosure

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

**COPY**

-----X  
IN THE MATTER :  
OF :  
MATTHEW FRIEDMAN, M.D. :  
-----X

DETERMINATION

AND

ORDER

BPMC NO. 05-09

A Notice of Hearing and Statement of Charges, both dated October 29, 2004, were served upon the Respondent, Matthew Friedman, M.D. GERALD M. BRODY, M.D. (CHAIR), JAGDISH M. TRIVEDI, M.D., AND FRANK J. KING, R.P.A.-C, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10) (Executive) of the Public Health Law. LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer. The Department of Health appeared by Valerie B. Donovan, Esq., Assistant Counsel. The Respondent failed to appear in person and was not represented by 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 issues this Determination and Order.

PROCEDURAL HISTORY

|                              |                   |
|------------------------------|-------------------|
| Date of Substituted Service: | November 23, 2004 |
| Date of Hearing:             | December 17, 2004 |
| Answer filed by Respondent:  | None              |
| Witnesses for Petitioner:    | None              |
| Witnesses for Respondent:    | None              |
| Deliberations Held:          | December 17, 2004 |

STATEMENT OF CASE

Petitioner has charged Respondent with eleven specifications of professional misconduct. The charge relates to Respondent's medical treatment of three patients. The charges include allegations of gross negligence, negligence on more than one occasion, incompetence on more than one occasion, fraud, and the failure to maintain records which adequately reflect the evaluation and treatment of patients. Respondent failed to file a written answer to the charges as required by Public Health Law §230(10)(c).

Petitioner was unable to personally serve Respondent with the Notice of Hearing and Statement of Charges. Petitioner submitted evidence of due diligence in the attempted service through an affidavit of non-service. (See, Ex. #1). Petitioner also sent the Notice of Hearing and Statement of Charges to

Respondent by certified mail, registered mail, and first class mail to multiple addresses, including his last known address, as well as the address listed on his current Education Department registration renewal. (See, Ex. #1B; #1C; ; #2; #13).

Accordingly, the Administrative Law Judge ruled as a matter of law that Petitioner has obtained jurisdiction over Respondent through substituted service.

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

#### FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Matthew Friedman, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State on or about May 22, 1996 by the issuance of license number 203063 by the New York State Education Department. Respondent's registered address is Budget Suites of America, 611 West Indian School Road, Room 306, Phoenix, Arizona 85013-0000. (Ex. #2).

Patient A

2. On or about April 23, 2002, Respondent provided medical care to Patient A, a 66 year old female, at Seton Health Services, Troy, New York. (Ex. #4; #8; #9).

3. Respondent failed to perform an adequate physical examination of Patient A. (Ex. #8; Ex. #9).

4. Respondent failed to appropriately examine Patient A's abdomen despite her complaint of abdominal pain and nausea. (Ex. #4; #8; #9).

5. Respondent documented that Patient A had positive bowel sounds, no tenderness, no organomegaly, mass or hernias, when he knew that he had not examined the patient's abdomen. (Ex. #4; #8; #9).

6. Respondent fraudulently documented in the Emergency Department record that he had performed an examination that he did not in fact perform. (Ex. #4; #8; #9).

7. Patient A subsequently visited her primary physician later that morning and was diagnosed as having acute appendicitis, and was admitted by her physician to Samaritan Hospital for surgery. (Ex. #5; #8).

Patient B

8. On or about March 16, 2002, Respondent provided medical care at Seton Health Services to Patient B, a 17 year old female. (Ex. #6).

9. Respondent failed to perform an adequate initial physical examination of Patient B. (Ex. #10; #11).

10. Respondent failed to perform an adequate neurological examination of Patient B. (Ex. #10; #11).

11. Respondent documented that Patient B's cranial nerves two through twelve were within normal limits when he knew that he had not performed the examination required to reach this conclusion. (Ex. #6; #10; #11).

12. Respondent fraudulently documented in the Emergency Department record that he had performed an examination that he did not in fact perform. (Ex. #6; #10; #11).

Patient C

13. On or about April 21, 2001, Respondent provided medical care to Patient C, a 48 year old female, at Seton Health Services. (Ex. #7).

14. Respondent failed to perform an adequate physical examination of Patient C. (Ex. #12).

15. Respondent documented that Patient C's heart rate was regular, her lungs were clear and her abdomen was



unremarkable when he knew that he had not examined Patient C's chest, lungs and/or stomach. (Ex. #7; #12).

16. Respondent fraudulently documented in the Emergency Department record that he had performed an examination that he did not in fact perform. (Ex. #7; #12).

#### CONCLUSIONS OF LAW

Respondent is charged with eleven specifications alleging professional misconduct within the meaning of Education Law §6530. He failed to file an answer addressing each of the factual allegations and specifications, as required by Public Health Law §230(10)(c). Accordingly, the factual allegations and specifications set forth in the Statement of Charges are deemed admitted.

The Hearing Committee was troubled by the failure of Respondent to appear and contest the allegations brought against him, as well as by several apparent discrepancies in the evidence presented. The documentation in the medical records is very detailed and specific, and would ordinarily demonstrate careful thought on the part of the practitioner. (For example, the documented examination of Patient A's cranial nerves found in Ex. #4, p.3). However, the clear language of PHL § 230(10)(c) requires that we conclude that the First through

Eleventh Specifications of professional misconduct have been sustained.

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 as a physician 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.

Under normal circumstances, this Committee would have entertained a lesser sanction, such as a stayed suspension, with a period of probation and a practice monitor. However, due to his unwillingness to inform the Department of his whereabouts, the Board cannot monitor Respondent's medical practice in any meaningful manner. Moreover, Respondent's failure to appear at the hearing, or to present any credible evidence which might mitigate the sanction imposed by this Committee, left us with no choice. Under the circumstances, the Hearing Committee unanimously determined that revocation is the only appropriate sanction which can adequately protect the public.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The First through Eleventh Specifications of professional misconduct, as set forth in the Statement of Charges, (Petitioner's Exhibit #1) are SUSTAINED;
2. Respondent's license to practice medicine as a physician in New York State be and hereby is REVOKED;
3. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Troy, New York

January " ,2004

  
GERALD M. BRODY, M.D. (CHAIR)

JAGDISH M. TRIVEDI, M.D.  
FRANK J. KING, R.P.A.-C

TO: Valerie B. Donovan, Esq.  
Assistant Counsel  
New York State Department of Health  
Corning Tower Building - Room 2509  
Empire State Plaza  
Albany, New York 12237

Matthew Friedman, M.D.  
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611 West Indian School Road  
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Matthew Friedman, M.D.  
429 Cuprite Street  
Globe, AZ 85501

Matthew Friedman, M.D.  
4301 North 24<sup>th</sup> Street  
Phoenix, AZ 85016

# APPENDIX I

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

IN THE MATTER  
OF  
MATTHEW FRIEDMAN, M.D.

STATEMENT  
OF  
CHARGES

MATTHEW FRIEDMAN, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 22, 1996 and was issued license number 203063, by the New York State Education Department. The Respondent is currently registered with the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. On or about April 23, 2002, Respondent provided medical care to Patient A (patients are identified in Appendix A, attached hereto), a 66-year old female, at Seton Health Services (SHS), Troy, New York. Respondent's care and treatment of Patient A failed to meet acceptable standards of care in that:
1. Respondent failed to perform an adequate physical examination of Patient A.
  2. Respondent failed to appropriately examine Patient A's abdomen despite her complaint of abdominal pain and nausea.
  3. Respondent documented that Patient A had positive bowel sounds, no tenderness, no organomegaly, mass or hernias, when he knew that he had not examined Patient A's abdomen.
  4. Respondent fraudulently documented in the Emergency Department record that he performed an examination that he did not in fact perform.

5. Patient A subsequently visited her primary physician later that morning and was diagnosed as having acute appendicitis, and was admitted by her physician to Samaritan hospital for surgery.

B. On or about March 16, 2002, Respondent provided medical care at SHS to Patient B, a 17-year old female. Respondent's care and treatment of Patient B failed to meet acceptable standards of care in that:

1. Respondent failed to perform an adequate initial physical examination of Patient B.
2. Respondent failed to perform an adequate neurological examination of Patient B.
3. Respondent documented that Patient B's cranial nerves two through twelve were within normal limits when he knew that he had not performed the examination required to reach this conclusion.
4. Respondent fraudulently documented in the Emergency Department record that he had performed an examination that he did not in fact perform.

C. On or about April 21, 2001, Respondent provided medical care to Patient C, a 48-year old female, at SHS. Respondent's care and treatment of Patient C failed to meet acceptable standards of care in that:

1. Respondent failed to perform an adequate physical examination of Patient C.
2. Respondent documented that Patient C's heart rate was regular, her lungs were clear, and her abdomen was unremarkable when he knew that he had not examined Patient C's chest, lungs and/or stomach.
3. Respondent fraudulently documented in the Emergency Department record that he had performed an examination that he did not in fact perform.

## **SPECIFICATIONS OF MISCONDUCT**

### **FIRST THROUGH THIRD SPECIFICATIONS PRACTICING THE PROFESSION FRAUDULENTLY**

Respondent is charged with committing professional misconduct as defined in New York Education law § 6530(2) by practicing the profession fraudulently as alleged in:

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

### **FOURTH SPECIFICATION**

#### **NEGLIGENCE**

Respondent is charged with committing professional misconduct as defined in New York Education 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:

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

### **FIFTH SPECIFICATION**

#### **INCOMPETENCE**

Respondent is charged with committing professional misconduct as defined in New York Education 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:

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

### **SIXTH THROUGH EIGHTH SPECIFICATIONS**

#### **GROSS NEGLIGENCE**

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

6. The facts in paragraphs A and A.3 and/or A and A.4.
7. The facts in paragraphs B and B.3 and/or B and B.4.
8. The facts in paragraphs C and C.2 and/or C and C.3.

### **NINTH THROUGH ELEVENTH SPECIFICATIONS**

#### **FAILURE TO MAINTAIN ADEQUATE RECORDS**

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in:

9. The facts in paragraphs A and A.3 and/or A and A.4.
10. The facts in paragraphs B and B.3 and/or B and B.4.
11. The facts in paragraphs C and C.2 and/or C and C.3.

DATED: *October 29*, 2004  
Albany, New York

*Peter D. Van Buren*

Peter D. Van Buren  
Deputy Counsel  
Bureau of Professional  
Medical Conduct