STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

April 8, 2008

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Mikhail Makhlin, M.D.

Redacted Address

Gregory J. Gallo, Esq.
The Pellegrino Law Firm
475 Whitney Avenue
New Haven, Connecticut 06511

Daniel Guenzburger, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Division of Legal Affairs
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Mikhail Makhlin, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 08-51) 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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,

Redacted Signature
James F. Horan, Acting Director
Bureau of Adjudication

JFH:nm

Enclosure

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

COPY

IN THE MATTER OF MIKHAIL MAKHLIN, M.D.	DETERMINATION AND ORDER BPMC 08 - 51

Jerry Waisman M.D. (Chairperson), Pradeep Chandra M.D., and Judith Glusko R.N., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law (**P.H.L.**). Marc P. Zylberberg, Esq., Administrative Law Judge, (**ALJ**) served as the Administrative Officer.

The Department of Health (**Department**) appeared by Daniel Guenzburger, Esq., Associate Counsel. Mikhail Makhlin M.D. (**Respondent**) appeared personally and was represented by The Pellegrino Law Firm, Gregory J. Gallo, Esq., of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	October 17, 2007
Date of Answer to Charges:	November 30, 2007
Pre-Hearing Conference Held:	November 21, 2007

Hearings Held: - (First Hearing day): December 11, 2007;
December 20, 2007; January 10, 2008; and January 11, 2008;

Intra-Hearing Conferences Held: December 20, 2007; and January 11, 2008

Location of Hearings: Offices of New York State Department of Health
90 Church St., 4th Floor
New York, NY 10007

Witnesses called by the Department of Health: (in the order they testified) Edward Elliot Telzak, M.D.
Loretta Ruperto, R.N.

Witnesses called by Mikhail Makhlin, M.D.: (in the order they testified) Mikhail Makhlin, M.D.
Vincent N. Jarvis, M.D.

Department of Health's Proposed Findings, Conclusions of Law and Recommended Sanction: Received March 5, 2008

Respondent's Proposed Findings of Fact: Received March 5, 2008

Deliberations Held: (last day of Hearing) Tuesday, March 18, 2008

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 *et seq.* of the Public Health Law of the State of New York. This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct (**Petitioner** or **Department**) pursuant to §230 of the P.H.L. Mikhail Makhlin, M.D. (**Respondent**) is charged with sixteen (16) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York (**Education Law**).

Respondent is charged with professional misconduct by reason of: (1) practicing the profession of medicine fraudulently[1]; (2) willfully making or filing a false report[2]; (3) willful or

[1] Education Law §6530(2) - (First through Sixth Specifications in the Statement of Charges [Department Exhibit # 1]).

[2] Education Law §6530(21) - (Seventh through Twelfth Specifications in the Statement of Charges).

grossly negligent failure to comply with substantial provisions of state law governing the practice of medicine[3]; (4) engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice[4].; practicing the profession of medicine with negligence on more than one occasion[5]; and ordering excessive treatment not warranted by the condition of the patient[6].

The Factual Allegations, Charges, and Specifications of professional misconduct result from Respondent's alleged acts and conduct between 2001 and 2005, involve six (6) specific patients [7], and an application for reappointment to New York Methodist Hospital medical staff.

Respondent basically denies all factual allegations and all specifications of misconduct contained in the Statement of Charges. A copy of the Statement of Charges is attached to this Determination and Order as Appendix 1. A copy of Respondent's Answer is attached to this Determination and Order as Appendix 2.

FINDINGS OF FACT

The following Findings of Fact (**Findings**) were made after a review of the entire record available to the Hearing Committee in this matter. These Findings represent documentary evidence and testimony found persuasive by the Hearing Committee. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable, or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee

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[3] Education Law §6530(16) - (Thirteenth Specification in the Statement of Charges).

[4] Education Law §6530(20) - (Fourteenth Specification in the Statement of Charges).

[5] Education Law §6530(3) - (Fifteenth Specification in the Statement of Charges).

[6] Education Law §6530(35) - (Sixteenth Specification in the Statement of Charges).

[7] In order to maintain patient confidentiality the patients are referenced by letter.

unanimously agreed on all Findings, and all Findings were established by at least a preponderance of the evidence. It is noted that initial Findings are referenced in subsequent Findings to reduce, to some extent, duplication. The Findings referenced should be read together with the subsequent Findings.

1. Respondent was licensed to practice medicine in New York State on July 1, 1997 by the issuance of license number 207258 by the New York State Education Department (Department Exhibit #2).

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's license and this disciplinary proceeding (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d]); [P.H.T-8][8]; (Department Exhibit #1).

3. AIDS is the advanced stage of a disease caused by the human immunodeficiency virus (**HIV**). One of the clinical events that defines AIDS is "wasting". AIDS wasting is the unintentional loss of weight by an HIV infected individual who is being properly treated with AIDs medications and where there is no other concomitant infection or clinical condition that might explain the weight loss [T-25].

4. "wasting" can be defined as an unintentional weight loss of at least ten per cent of the patient's baseline weight or as the unintentional loss of at least five per cent of body weight if the weight loss occurs within one to two months [T-30, 238-242].

5. AIDS wasting was particularly prevalent in the 1980s and early 1990s, during the period that predates HIV treatment with Highly Active Anti-Retroviral Therapy (**HAART**).

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[8] Numbers in brackets refer to Hearing transcript page numbers [T-], or to Pre-Hearing transcript page numbers [P.H.T-], or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee was not present at, and did not review, the Pre-Hearing transcripts or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

Between 2001 to 2004, when Respondent treated Patients A through F, AIDS wasting was an exceedingly unusual condition [T-32-33].

6. HIV infection is diagnosed by doing a relatively simple antibody test, which is a blood test that is sent to a laboratory with the results being generally available within a week [T-26].

Patient A

7. On December 5, 2001, Patient A presented to Respondent's office in Brooklyn, New York. Respondent noted in Patient A's medical records that Patient A was HIV positive, 28 to 30 weeks pregnant, 5 feet 7 inches, weighed 110 pounds and had experienced recent significant weight loss. Respondent described the patient as appearing "tired looking, wasted, and very thin." (Department Exhibit # 3).

8. Patient A's weight, as documented in her medical records, on the report of a pulmonary function test performed at Respondent's office was recorded as 194 pounds (Department Exhibit # 3, p. 6, see also Medicaid identification card of Patent A at p. 7).

9. On December 3, 2001 Patient A's weight was recorded by Interfaith Medical Center to be 195 pounds (Department Exhibit # 4, p. 137).

10. There is insufficient information in the medical record of Patient A, as maintained by Respondent, to substantiate that Patient A had HIV or HIV associated wasting syndrome (Department Exhibit # 3); [T-31, 39-42, 58-60, 71-72].

11. There is information in the medical record of Patient A, as maintained by Respondent, to substantiate that she did not have HIV or HIV associated wasting syndrome (Department Exhibit # 3); [T-38-42, 52, 58-60, 71-72]. Patient A's CD4 and CD8 ratio was normal. The CD4 cell count is a normal number, and this number would indicate that a person is not at risk for developing complications related to HIV [T-52]. Patient A's weight of 194 pounds is consistent with her height and late pregnancy stage [T-60].

Conclusions

A.1. Respondent inappropriately diagnosed Patent A as having HIV related wasting syndrome [See Findings # 3 through # 11]; Factual allegation A.1. is sustained.

Findings

12. Respondent prescribed a three month supply of Serostim (a 28 day supply of Serostim plus two refills). At the time Respondent wrote the prescription Respondent did not have the results of any laboratory testing and he had not adequately excluded other conditions that might have contributed to the patient's complaints (Department Exhibit # 3, p. 10). At the time Respondent wrote the prescription for Serostim Respondent had not confirmed that Patient A had HIV or HIV related wasting syndrome [See Findings # 10 and # 11]; ; [T-34, 45, 48, 65, 75, 597-598, 612].

13. Serostim is synthetic human growth hormone. This medication was approved by the Food and Drug Administration to increase muscle mass and promote weight gain in patients suffering from AIDS related wasting syndrome. According to guidelines promulgated by Serrono, the manufacturer of Serostim, the medication is only indicated for up to a 12 week period (Respondent's Exhibit # C); [T-34-36].

Conclusions

A.2. Respondent inappropriately prescribed Serostim with multiple refills [See Findings # 3 through # 13]; Factual allegation A.2. is sustained. (Independently [partially] admitted by Respondent in his proposed findings of fact at p. 2-3 # 2 and p. 17).

Findings

14. Respondent prescribed for Patient A a 6 month supply of Viracept, a antiretroviral medication and a 3 month supply of Combivir, another antiretroviral medication (Department Exhibit # 3, p. 8 and p. 12); [T-83-84].

15. Respondent should have prescribed no more than a one month supply of antiretroviral medication to cover the Patient until the results of the laboratory work ordered became available. [T-56, 85-86].

Conclusions

A.3. Multiple refills of antiretroviral medication was not appropriate. Respondent inappropriately prescribed antiretroviral medication with multiple refills [See Findings # 3 through # 11 and # 14 through # 15]; Factual allegation A.3. is sustained. (Independently [partially] admitted by Respondent in his proposed findings of fact at p. 3 # 3 and p. 17).

A.4. Respondent knowingly and falsely represented in Patient A's medical records that Patient A was "tired looking, wasted, and very thin" and weighed 110 pounds when Respondent knew that Patient A weighed significantly more than 110 pounds (Department Exhibits # 3 and # 4); [See Findings # 7 through # 9]; Factual allegation A.4. is sustained.

Patient B

16. Between September 27, 2001 and November 27, 2001 Respondent treated Patient B for HIV infection, HIV related wasting syndrome, Hepatitis C, diabetes mellitus and other conditions. At the initial visit Patient B reported that he was HIV infected and had experienced significant weight loss. Patient B was 5 feet 3 ½ inches tall and weighed 170 pounds (Department Exhibit # 6).

17. Patient B provided to Respondent a letter from an AIDS practitioner named Jordan Glaser, M.D. The letter was addressed "to whom it may concern". According to the letter, Dr. Glaser had treated Patient B for HIV with zerit, epivir, viramune and Serostim (Department Exhibit # 6).

18. Respondent made no attempts to contact Dr. Glaser (Department Exhibit # 6); [T-118-119, 123-124, 632].

19. There is insufficient information in the medical record of Patient B, as maintained by Respondent, to substantiate that Patient B had HIV or HIV associated wasting syndrome (Department Exhibit # 6); [T-94-95, 101, 107].

20. At a subsequent patient visit, on October 23, 2001, the laboratory test results indicated that Patient B had a high CD4 count and a low viral load. These tests results, taken in conjunction with Patient B's height and weight, do not support a diagnosis of HIV associated wasting syndrome (Department Exhibit # 6); [T-94-95, 101, 107].

21. There is information in the medical record of Patient B, as maintained by Respondent, to substantiate that he did not have HIV or HIV associated wasting syndrome (Department Exhibit # 6); [T-96]. Patient B's CD4 and CD8 ratio was absolutely normal. There was no evidence of immunodeficiency related HIV in Patient B [T-96].

Conclusions

B.1. Respondent inappropriately diagnosed Patent B as having HIV related wasting syndrome [See Findings # 3 through # 6 and # 16 through # 21]; Factual allegation B.1. is sustained.

Findings

22. Respondent wrote prescriptions for Serostim and a refill on September 27, 2001, October 23, 2001, and November 27, 2001 for a total of 6 months of treatment (Department Exhibit # 6, p. 59, p. 60, and p. 63; and Exhibit # 7).

23. Patient B did not suffer from HIV related wasting syndrome. Respondent took no steps to confirm Patient B's HIV status. There was no legitimate medical purpose served by prescribing Serostim to Patient B (Department Exhibit # 6); [T-95, 107, 116-117].

Conclusions

B.2. Respondent inappropriately prescribed Serostim [See Findings # 3 through # 6 and # 16 through # 23]; Factual allegation B.2. is sustained. (Independently [partially] admitted by Respondent in his proposed findings of fact at p. 5 # 2 and p. 6 # 5 and p. 17).

Findings

24. At the initial visit of September 27, 2001, Respondent wrote prescriptions for antiretroviral medications for Patent B for 30 days with five refills. At the October 23, 2001 visit Respondent again prescribed 30 days of antiretroviral medication with five refills. On October 4, 2001 Respondent reviewed the results of laboratory work ordered at the initial visit. The viral load was reported as non-detectable and Respondent placed a question mark next to the results (Department Exhibit # 6, pp. 20-26); [T-433].

25. Although Respondent had doubts as to whether Patient B was HIV positive, Respondent prescribed an additional six months of antiretroviral therapy on October 23, 2001. The purposes of waiting for the lab data would be to confirm the Patient's HIV status and to ensure that the appropriate HAART regimen for the patient's HIV genotype was selected (Department Exhibit # 6, p. 62); [T-85-86, 435].

Conclusions

B.3. The first month of antiretroviral therapy was acceptable until the laboratory results established HIV status (Respondent did not order an HIV antibody test). Five refills of antiretroviral therapy was not appropriate. The October 23, 2001 continuation of antiretroviral therapy (30 days with five refills) was inappropriate (Department Exhibit # 6); [96-97, 99, 104-105, 122]. Respondent inappropriately prescribed antiretroviral therapy [See Findings # 3 through # 6 and # 16 through # 25]; Factual allegation B.3. is sustained. Independently (partially) admitted by Respondent in his proposed findings of fact at p. 17.

B.4. Respondent should have ordered an HIV antibody test at the first visit but no later than the October 23, 2001 visit to confirm that the Patient was HIV positive [T-97]. In addition, Respondent should have contacted the prior treating physician to obtain Patient B's records. Respondent failed to take appropriate steps to confirm that Patient B was HIV positive [See Findings

3 through # 6 and # 16 through # 25]; Factual allegation B.4. is sustained. (Independently [Partially] admitted by Respondent in his proposed findings of fact at p. 5-6 # 4).

B.5. On October 4, 2001, when Respondent reviewed the results of the laboratory work ordered at the initial visit, Respondent began to question whether Patient B was HIV positive. While he made a notation in Patient B's medical records, Respondent did not take any further steps to rule out or confirm the HIV diagnosis. Respondent continued to treat Patient B with antiretroviral medications although he stopped the Serostim. Respondent also failed to request Patient B's medical records from Dr. Glaser. Either Respondent knew Patient B was not HIV infected or he deliberately avoided taking obvious steps to confirmed the Patient's HIV status. Respondent's actions were indicative of deceit. Factual allegation B.4. is sustained; [See Findings # 3 through # 6 and # 16 through # 25].

Patient C

26. Respondent's treated Patient C on October 9, 2001, October 30, 2001, November 15, 2001, and December 13, for purported HIV infection, significant weight loss and other conditions. Patient C did not report prior use of Serostim treatment (Department Exhibit # 8).

27. There is insufficient information in the medical record of Patient C, as maintained by Respondent, to substantiate that Patient C had HIV or HIV associated wasting syndrome (Department Exhibit # 8); [T-131, 133, 139].

28. There is information in the medical record of Patient C, as maintained by Respondent, to substantiate that Patient C did not have HIV or HIV associated wasting syndrome (Department Exhibit # 8). Patient C was 6 feet tall and weighed 172 pounds. Patient C had laboratory values that one would expect to find in a healthy patient, such as a normal albumin and normal T cell count. There was no clinical evidence of weight loss (Department Exhibit # 8); [T-131,133,139, 146].

Conclusions

C.1. Respondent inappropriately diagnosed Patent C as having HIV related wasting syndrome [See Findings # 3 through # 6 and # 26 through # 28]; Factual allegation C.1. is sustained.

Findings

29. On October 9, 2001 Respondent prescribed to Patient C a 28 day of supply of Serostim with one refill, and on October 30, 2001 Respondent wrote a second Serostim prescription for a one month supply (Department Exhibit # 8).

30. There is no evidence in Patient C's medical records that Patient C suffered from HIV related wasting syndrome. Respondent added Serostim to Patient C's therapeutic regimen without consulting with the physician who had purportedly been treating this Patient with HAART medications [T-131, 133, 137-139].

Conclusions

C.2. Respondent inappropriately prescribed Serostim with a refill [See Findings # 3 through # 6 and # 26 through # 30]; Factual allegation C.2. is sustained. (Independently [partially] admitted by Respondent in his proposed findings of fact at p. 7 # 2 and p. 17).

C.3. Withdrawn by the Department.

Findings

31. On October 9, 2001 Patient C did not present to Respondent with any documentation to support his assertion that he was HIV positive. On review of laboratory testing ordered at the first visit, Respondent suspected that Patient C was not HIV positive. According to Respondent's October 30, 2001 progress note, Respondent instructs the patient to "bring in pills he is taking for HIV." (Department Exhibit # 8, p.2).

32. Respondent should have either ordered an HIV antibody test and/or contacted Patient C's primary HIV physician (Department Exhibit # 8); [T-135-136, 505].

Conclusions

C.4. Respondent failed to take appropriate steps to confirm that Patient C was HIV positive [See Findings # 3 through # 6 and # 26 through # 32]; Factual allegation C.4. is sustained.

Findings

33. November 15, 2001 was Patient C's third visit to Respondent. Patient C was noncompliant in producing his medication list. On further questioning of Patient C by Respondent, Patient C admitted he was not HIV infected. Respondent ceased antiretroviral therapy and Serostim (Department Exhibit # 8).

34. Respondent's doubts regarding Patient C's HIV infection are included in the medical records of Patient C and he acted on those doubts by discontinuing all HIV associated medications by the third visit. Although it is clear that Respondent should have ordered an HIV antibody test, his failure to do so does not result in an intention to deceive (Department Exhibit # 8); [T-128-160, 445-506, 644-674].

Conclusions

C.5. Respondent's prescriptions, to Patient C, for Serostim and antiretroviral therapy for HIV infection was inappropriate. As of the second visit Respondent's started to question whether Patient C had HIV infection. Given the relatively short period of time involved, the Hearing Committee is not convinced, by a preponderance of the evidence, that Respondent knew or deliberately avoided knowing that Patient C did not have HIV infection. Factual allegation C.5. is not sustained; [See Findings # 3 through # 6 and # 26 through # 34].

Patient D

35. Between May 22, 2002 and March 20, 2003, Respondent treated Patient D for purported HIV infection and other issues. Patient D was 5 foot three inches and 124 pounds. Respondent noted that Patient D was HIV positive since 1991 (Department Exhibit # 10).

36. Prior to being treated by Respondent, from October 1999 until July 2002, Patient D received primary care at the South Brooklyn Health Center. During the period of treatment at South Brooklyn Health Center, Patient D's weight ranged between 120 and 130 pounds. On September 15, 2001 Patient D had an HIV antibody test which was negative (Department Exhibit # 12, p.40); [T-183-184].

37. There is insufficient information in the medical record of Patient D, as maintained by Respondent, to substantiate that Patient D had HIV or HIV associated wasting syndrome (Department Exhibit # 10); [T-163, 167].

38. There is information in the medical record of Patient D, as maintained by Respondent, to substantiate that she did not have HIV or HIV associated wasting syndrome (Department Exhibit # 10); [T-163-164]. Patient D's weight is normal and during the 10 office visits to Respondent fluctuated between 120 and 130 pounds. Patent D's CD4 and CD8 ratio was normal and an HIV antibody test came back as negative (Department Exhibit # 10).

39. On the 2 visits subsequent to receiving a negative HIV antibody result, Respondent prescribed Serostim and antiretroviral therapy (Department Exhibit # 10).

Conclusions

D.1. Respondent inappropriately diagnosed Patent D as having HIV related wasting syndrome [See Findings # 3 through # 6 and # 35 through # 39]; Factual allegation D.1. is sustained.

Findings

40. Respondent's reasons for prescribing Serostim are not contained in Patient D's medical records. Respondent did not order an HIV antibody test in a reasonable timely manner. Respondent did not contact Patient D's prior treating physician. Patient D did not suffer from HIV related wasting syndrome (Department Exhibit # 10); [T-163-164, 182].

Conclusions

D.2. Respondent inappropriately prescribed Serostim [See Findings # 3 through # 6 and # 35 through # 40]; Factual allegation D.2. is sustained. Independently (partially) admitted by Respondent in his proposed findings of fact at p. 17.

Findings

41. Respondent should have ordered a T cell count and a viral load. At the latest, by August 2002, Respondent should have ordered an HIV antibody test [T-169, 180].

42. Respondent's physician's assistant ordered an HIV antibody test on December 17, 2002 (Department Exhibit # 10, p. 12); [T-515].

43. On December 27, 2002 Respondent reviewed the HIV antibody test which was negative for HIV infection (Department Exhibit # 10, p. 23).

44. In the face of definitive proof that Patient D did not have HIV infection, Respondent continued to prescribe Serostim for two months. The last Serostim prescription Respondent issued to Patient D was on February 25, 2003 (Department Exhibit # 10, p. 25).

Conclusions

D.3. Respondent failed to take appropriate steps to confirm that Patient D was HIV infected, including but not limited to, failing to order appropriate laboratory testing [See Findings # 3 through # 6 and # 35 through # 44]; Factual allegation D.3. is sustained.

D.4. The first month of antiretroviral therapy was acceptable until the laboratory results established HIV status (Respondent did not order an HIV antibody test until after almost 7 months of treatment). Seven months of antiretroviral therapy without HIV confirmation or testing was inappropriate (Department Exhibits # 10 and # 11); [169, 180]. Respondent inappropriately prescribed antiretroviral therapy [See Findings # 3 through # 6 and # 35 through # 44]; Factual allegation D.4. is sustained. Independently (partially) admitted by Respondent in his proposed findings of fact at p. 17.

D.5. Even after December 27, 2002, when Respondent reviewed the results of the laboratory work which indicated that Patient D was HIV negative, Respondent continued to issue prescriptions for HIV medications, including Serostim. Respondent knew, since June 17, 2002, that Patient D was not HIV infected. Respondent's actions were indicative of deceit. Factual allegation D.5. is sustained; [See Findings # 3 through # 6 and # 35 through # 44].

Findings

45. Between May 2002 through February 2003 Respondent obtained prior Medicaid authorization for 10 Serostim prescriptions. On each occasion Respondent falsely represented to the Medicaid program that Patient D had significant weight loss. The medical records of Patient D, as maintained by Respondent do not indicate that Patient D had significant weight loss but indicate a relatively constant weight over an extended period of time (Department Exhibits # 10, # 10-A, and # 13).

46. On each occasion that Respondent obtained prior Medicaid authorization for Serostim he falsely represented to the Medicaid program that Patient D had a clearly documented HIV diagnosis. As of June 17, 2002, the date Respondent reviewed the May 22, 2002 laboratory report, Respondent could no longer represent that Patient D had a clearly documented HIV diagnosis. The fact that Patient D had an undetected viral load following a period in which she had been non-compliant with her HAART prescriptions raised a serious doubt about the Patient's HIV diagnosis [T-173]. Respondent represented to the Medicaid program that the Patient had a clearly documented HIV diagnosis even after he became aware of the December 2002 negative HIV antibody test result (Department Exhibit # 13).

Conclusions

D.6. Respondent failed to comply with the Medicaid Serostim protocol for prior-authorization by falsely representing to the Medicaid program that Patient D had significant

unintentional weight loss and a confirmed HIV diagnosis (Department Exhibit # 14). Factual allegation D.6. is sustained; [See Findings # 3 through # 6 and # 35 through # 46].

Patient E

47. Between February 5, 2002 and October 1, 2002 Respondent treated Patient E, a 40 year old female. Patient E was 5 feet 5 inches and weighed 216 pounds. Patient E presented to Respondent with two pieces of purported documentation from Cumberland Diagnostic and Treatment Center that supported her assertion that she was HIV positive (Department Exhibit # 15).

48. There is insufficient information in the medical record of Patient E, as maintained by Respondent, to substantiate that Patient E had HIV or HIV associated wasting syndrome (Department Exhibit # 15); [T-202]. Respondent's alleged concern with the patient's organ mass wasting in not contained in Patent E's medical records.

49. There is information in the medical record of Patient E, as maintained by Respondent, to substantiate that she did not have HIV or HIV associated wasting syndrome (Department Exhibit # 15). Patient A's weight of 216 pounds is well beyond the median in BMI (Body Mass Index) to have wasting syndrome. Patient E presented to Respondent on March 23, 2002 with complaint of no appetite and pain in her legs. Patient E reported that she had not taken her HAART medications since March 5, 2002. The first laboratory determinations are from March 23, 2002. Most notable at a period of time when the patient was off therapy for about two-and-a-half weeks, the HIV RNA quantity or HIV viral load is undetectable. The viral load is very sensitive to stopping and starting medications. One would expect after a period of two-and-a-half weeks of not being on medication, that the viral load would begin to approach whatever its pretreatment viral load might have been. The patient's CD4 count, as in the other patients, is completely normal. The absolute CD4 is over fourteen hundred. The laboratory results are what would be expected in a person who is not HIV infected [201-203]; (Department Exhibit # 15, p. 20).

50. Respondent prescribed Serostim for Patient E from February 2002 through October 2002 (Department Exhibit # 15).

51. Respondent failed to take appropriate steps to confirm Patient E's claim that she was HIV infected. Respondent should have been more aggressive in confirming the Patient's HIV status (Department Exhibit # 15); [T-197-223, 549].

52. At the very latest, an HIV antibody test should have been performed on Patient E by her June 2002 office visit. Respondent did not order the HIV antibody test until September 2002 (Department Exhibit # 15, p.27); [222].

Conclusions

E.1. Respondent inappropriately diagnosed Patent E as having HIV related wasting syndrome [See Findings # 3 through # 6 and # 47 through # 52]; Factual allegation E.1. is sustained.

E.2. Respondent inappropriately prescribed Serostim [See Findings # 3 through # 6 and # 47 through # 52]; Factual allegation E.2. is sustained. Independently (partially) admitted by Respondent in his proposed findings of fact at p. 17.

E.3. Respondent failed to take appropriate steps to confirm that Patient E was HIV infected, including but not limited to, failing to order appropriate laboratory testing and failing to contact Patient E's prior treating physician [See Findings # 3 through # 6 and # 47 through # 52]; Factual allegation E.3. is sustained.

E.4. Respondent inappropriately prescribed antiretroviral medications. The first month of antiretroviral therapy was acceptable until the laboratory results established HIV status (Respondent did not order an HIV antibody test until September 2002). More than six months of antiretroviral therapy without HIV confirmation or testing was inappropriate [See Findings # 3 through # 6 and # 47 through # 52]; Factual allegation E.4. is sustained. Independently (partially) admitted by Respondent in his proposed findings of fact at p. 18.

E.5. Respondent ignored unequivocal medical evidence that should have led him to conclude that Patient E was not HIV positive, and in the face of such evidence, inappropriately and inexcusably delayed ordering an HIV antibody test. Respondent knew or deliberately avoided knowing that Patient E was not HIV infected. Respondent's actions were indicative of deceit. Factual allegation E.5. is sustained; [See Findings # 3 through # 6 and # 47 through # 52].

E.6. Respondent failed to comply with the Medicaid Serostim protocol for prior-authorization by falsely representing to the Medicaid program that Patient E had a confirmed HIV diagnosis (Department Exhibits # 15 and # 17). Factual allegation E.6. is sustained; [See Findings # 3 through # 6 and # 47 through # 52].

Patient F

53. Between January 22, 2002 and February 13, 2004, Respondent treated Patient F for HIV related wasting syndrome and other medical issues. Patient F had a confirmed HIV diagnosis. Respondent prescribed Serostim to Patient E through September 24, 2003, when another physician or possibly Respondent's physician's assistant discontinued the medication (Department Exhibit # 18, p.24); [T-248].

54. Patient F first presented to Respondent complaining of a hoarse voice for 2 years and a 40 pound weight loss in 2 months. Her claim was that she weighed 190 pounds 3 years ago. She had a history of being HIV-infected from intravenous drug addiction. Patient F's height was 5 feet, 8 inches and she weighed 164 pounds (Department Exhibit # 18).

55. Patient F's body mass index fell well within the normal range. As a prerequisite for diagnosing HIV wasting syndrome, a physician must rule out other treatable causes of weight loss. Patient F had two causes of weight loss, non-compliance with HAART therapy regimen and substance abuse, which if effectively treated would have controlled her fluctuating weight (Department Exhibit # 18); [T- 247, 256].

56. Immediately prior to being treated by Respondent, Patient F had extensive out patient treatment at the Mount Sinai Medical Center and at the New York Weil Cornell Center of the New York Presbyterian Hospital. Respondent did not have these records and made no attempt to obtain them (Department Exhibit # 18).

57. Although Patient F did have HIV infection, there is insufficient information in the medical record of Patient F, as maintained by Respondent, to substantiate that Patient F had HIV related wasting syndrome (Department Exhibit # 18); [T-247, 250, 256, 258].

58. Respondent prescribed Serostim from January 2002 to September 2003, twenty-one months of treatment. Since Patient F did not have HIV related wasting syndrome, there was no legitimate basis for prescribing Serostim (Department Exhibits # 18 and # 19); [T-256].

Conclusions

F.1. Respondent inappropriately diagnosed Patent F as having HIV related wasting syndrome [See Findings # 3 through # 6 and # 53 through # 58]; Factual allegation F.1. is sustained.

F.2. Respondent inappropriately prescribed Serostim [See Findings # 3 through # 6 and # 53 through # 58]; Factual allegation F.2. is sustained. Independently (partially) admitted by Respondent in his proposed findings of fact at p. 18.

Factual allegation G

59. Respondent made representations to the New York State Medicaid program that Patients D and E had confirmed HIV diagnoses. Respondent knew that these representations were false. (Department Exhibits # 10, # 13, # 15, # 17); [T-722, 756-758]; [See Findings # 3 through # 6 and # 35 through # 52].

Conclusions

G. Factual allegation G. is sustained.

Factual allegation H

60. From December 1999 through December 2005 Respondent held privileges at the New York Methodist Hospital in Brooklyn, New York. Respondent voluntarily surrendered his privileges (resigned) in December 2005 (Department Exhibit # 22); [T-816].

61. Respondent submitted a reappointment application to New York Methodist Hospital which is signed and dated April 17, 2005. On this reappointment application Respondent checked the box "NO" to the following question:

> Since your last reappointment, have any of the following been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily, or involuntarily relinquished, withdrawn, investigated, challenged, or subject to any other disciplinary action such as reprimand, censure or focused review? If yes, please provide a full explanation on the last page of the application. - Indicate "YES" or "NO" to each question listed below:
> Participation in Medicare, Medicaid or other governmental or quasi-government health-related programs or any other third party payor. (Department Exhibit # 22, pp. 6, 7, 9, 13).

62. By letter dated November 14, 2003, the Office of Medicaid Management informed Respondent that he had been excluded (effective twenty [20] days from the date of the letter) from participation in the Medicaid Program for a period of five (5) years. Respondent contested the Medicaid exclusion at a Hearing which took place over four days (August 10, 2004, September 10, 2004, October 27, 2004, and November 5, 2004). At the time Respondent signed the New York Methodist Hospital reappointment application, he was awaiting the decision from the Medicaid Hearing (issued on September 15, 2005). (Department Exhibits # 23 and # 24); [T-819-821].

63. Respondent conceded that his answer NO to the question on his reappointment application about participation in Medicaid was false. On April 17, 2005 Respondent knew that the New York State Department of Health had determined to exclude him from participation in the Medicaid program for a period of five (5) years (Department Exhibit # 22); [T-831].

Conclusions

H. Factual allegation H. is sustained. Independently (partially) admitted by Respondent in his proposed findings of fact at p. 15 # H.

CONCLUSIONS OF LAW

The Hearing Committee makes the conclusions that the following Factual Allegations contained in the October 17, 2007 Statement of Charges are **SUSTAINED**:

Factual Allegations A., and A.1. through A.4.
Factual Allegations B., and B.1. through B.5.
Factual Allegations C., and C.1., C.2., and C.4.
Factual Allegations D., and D.1. through D.6.
Factual Allegations E., and E.1. through E.6.
Factual Allegations F., and F.1. through F.2
Factual Allegation G.
Factual Allegation H.

The Hearing Committee makes the conclusions that the following Factual Allegations contained in the October 17, 2007 Statement of Charges are **NOT SUSTAINED**:

Factual Allegation C.3. (withdrawn).

Factual Allegation C.5.

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee unanimously concludes:

1. The FIRST, SECOND, FOURTH, FIFTH, and SIXTH Specifications of FRAUDULENT PRACTICE contained in the Statement of Charges are **SUSTAINED**.

2. The SEVENTH, EIGHTH, TENTH, ELEVENTH, and TWELFTH Specifications of MAKING OR FILING A FALSE REPORT contained in the Statement of Charges are **SUSTAINED**.

3. The THIRTEENTH Specification of WILLFUL OR GROSSLY NEGLIGENT FAILURE TO COMPLY WITH SUBSTANTIAL PROVISIONS OF STATE LAW GOVERNING THE PRACTICE OF MEDICINE contained in the Statement of Charges is **SUSTAINED**.

4. The FOURTEENTH Specification of CONDUCT EVIDENCING MORAL UNFITNESS contained in the Statement of Charges is **SUSTAINED**.

5. The FIFTEENTH Specification of PRACTICING THE PROFESSION OF MEDICINE WITH NEGLIGENCE ON MORE THAN ONE OCCASION contained in the Statement of Charges is **SUSTAINED**.

6. The SIXTEENTH Specification of UNWARRANTED TESTS OR TREATMENT contained in the Statement of Charges is **SUSTAINED**.

7. The THIRD Specification of FRAUDULENT PRACTICE contained in the Statement of Charges is **NOT SUSTAINED**.

8. The NINTH Specification of MAKING OR FILING A FALSE REPORT contained in the Statement of Charges is **NOT SUSTAINED**.

A further explanation of the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with 16 specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 does not provide definitions or explanations of some of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain verbal instructions and verbal definitions of medical misconduct as alleged in this proceeding. These verbal instructions and definitions were obtained from a memoranda entitled Definitions of Professional Misconduct under the New York Education Law[9] and a one page document encompassing an interpretation and understanding of moral unfitness as used by previous Hearing Committees[10]. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Hearing Committee's determination is limited to the Charges set forth in the Statement of Charges.

Preponderance of the Evidence

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim. The

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[9] Copies of these definitions (ALJ Exhibits # 2 and # 3) were provided to both parties at the Pre-Hearing conference [P.H.T-5-7]; [T-4].

[10] Respondent submitted an alternate definition of moral unfitness (marked as (ALJ Exhibit # 5). This proposal is discussed below.

Specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the Charges by a preponderance of the evidence.

Intent

3. For those charges that require a finding of intent, the Committee must determine the state of mind with which the act was done. If a person acts voluntarily with a desire to bring about a result, he is said to have intended that result. Further, although he has no desire to bring about the result, if he does the act knowing, with substantial certainty, that the result will follow, he is also said to have intended that result.

Witness Testimony

4. The Committee must determine the credibility of the witnesses in weighing each witness's testimony. First, the Hearing Committee must consider whether the testimony is supported or contradicted by other independent objective evidence. When the evidence is conflicting and presents a clear-cut issue as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and base its inference on what it accepts as the truth. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's testimony and, at the same time, reject another. The Hearing Committee also understood that they had the option of completely rejecting the testimony of a witness where they found that the witness testified falsely on a material issue.

Practicing the Profession Fraudulently

5. Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact in connection with the practice of medicine. An individual's knowledge that he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. In order to support the charge that medicine has been practiced fraudulently, the Department must prove by a preponderance of the evidence that (1) Dr. Makhlin

made a false representation, whether by word, conduct, or concealment of that which should have been disclosed; (2) Dr. Makhlin knew that the representation was false; and (3) Dr. Makhlin intended to mislead through the false representation.

There need not be actual reliance, or actual injury, or any actual benefit as the result of the misrepresentation to constitute the fraudulent practice of medicine. The focus is on the licensee's conduct in attempting to induce reliance, and not on whether the physician succeeds in causing reliance or whether any gain to the physician occurs to the detriment of the patient or to others. There is no requirement that someone actually be misled, as long as the intent of the "misrepresentation or concealment of fact" is present. Fraud can also be established from evidence that a person made a statement or representation with reckless disregard as to its truth.

Moral Unfitness

6. To sustain a specification of moral unfitness, the Department must show that Respondent committed an act or acts which "evidences moral unfitness". The act or acts must be "conduct in the practice of the profession of medicine".

Moral unfitness in the practice of medicine constitutes either a violation of the public trust bestowed by virtue of the physician's license as a physician or a violation of the moral standards of the medical community. A physician's poor judgment or mere "foolish" behavior will not sustain a charge of moral unfitness.

The ALJ did not recommend the use of Respondent's alternate definition which was as follows:

> To sustain a charge of moral unfitness, it must be proven that the Respondent committed acts which violate the standards of the medical community. These acts must be greater than negligence or failure to adhere to accepted practice standards in the medical community. Rather, moral unfitness is evinced through fraud, misrepresentation or deplorable conduct. ...

The Hearing Committee used ordinary English usage and understanding for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility.

Credibility Determination

The Hearing Committee found the expert witness presented by the Department, Dr. Edward Elliot Telzak, to be credible, forthright and objective. Dr. Telzak is a physician, board certified in internal medicine and infectious disease. In 1991, Dr. Telzak became the Chief of Infectious Diseases at Bronx-Lebanon Hospital Center. In 2000, Dr. Telzak became the Director of the AIDS Program and Vice-Chair of the Department of Medicine. He is also a professor in the Department of Medicine and Population Health at the Albert Einstein College of Medicine.

Dr. Telzak was flexible and provided a clear review of the medical records presented to him for analysis. Even with substantially defective medical records, Dr. Telzak found reasons to be generous in agreeing to some of the medications issued by Respondent (for example: the first month of antiretroviral medications).

Dr. Vincent N. Jarvis testified on behalf of Respondent. Dr. Jarvis is a physician, board certified in internal medicine, HIV medicine and addiction medicine. In 2001 Dr. Jarvis was the Medical Director of the Special Care Immunology Services at Lutheran Medical Center. Dr. Jarvis had difficulty in providing direct answers to questions and went out of his way to defend Respondent, regardless of the evidence presented in the medical records maintained by Respondent. Dr. Jarvis' testimony included information given to him by Respondent which was not documented in the patients' medical records.

Dr. Mikhail Makhlin obtained his medical education in the former Soviet Union. Dr. Makhlin practiced internal medicine in Russia for 9 years, and in 1989 he emigrated to the United States. From 1993 to 1994 Respondent worked as a physician's assistant in an HIV/AIDS unit at St. Clare's Hospital in Manhattan. Dr. Makhlin was enrolled in an internal medicine residency program at Kingsbrook Jewish Medical Center from 1994 to 1997. In 2001 Dr. Makhlin opened his own medical practice in Brooklyn, New York. A significant portion of his practice was treating patients with HIV infection and AIDS. Dr. Makhlin was certified to treat HIV patients by the American Academy of HIV Medicine. Dr. Makhlin testified that he considered himself aware of the emerging standards for the treatment of HIV infection and AIDS.

Respondent fabricated testimony and was evasive in many of his responses to questions posed, even questions from his own attorney. Respondent was not credible and appeared to lack the ability to be truthful to authorities. Respondent tried to convince the Hearing Committee that he relied on the information provided to him by patients, which he claims to remember, but never indicated in his notes in the patient's medical records. One of the major flaws in Respondent's reliance on the information given to him by the patients is that Respondent could not recall the patients themselves. No one patient made an impression with him and he could not remember any of their physical characteristics or attributes.

Respondent's tactic seem to be that it was the patient's fault for being too savvy, it was the patients who took advantage of Respondent, it was the patients who gave Respondent false information, it was other physicians who did not return his calls, it was his staff who did not secure prior medical information. However none of these "it was" situations was documented in any of the records of the patients.

The Hearing Committee notes that Respondent's proposed findings of fact, conclusions and penalty argument, as submitted by Respondent's counsel, makes a number of what we have referred to as "independently (partially) admitted proposed findings of fact" in our above Findings. These partial admissions are independent of any of our Findings and are only included to provide a complete and thorough review of the information provided by the parties. All of the Factual Allegations contained in the Statement of Charges (except for C.3 and C.5.) were proven by the Department.

The Hearing Committee concludes that Respondent was there to issue any prescriptions to individuals who asked. Respondent was a dispenser and an enabler.

SUMMARY

A. Respondent is charged with committing professional misconduct under Education Law §6530(2) by practicing the profession of medicine fraudulently.

Respondent prescribed HIV medications for Patients B, D, and E. These three patients' medical records indicate that the patients were HIV infected when in fact they were not and they had no legitimate medical need for Serostim and/or antiretroviral medications. Respondent made these false representations, he knew the information to be incorrect, and he made those representations with the intent to mislead.

Respondent knew that Patent A weighed 194 pounds and not 110 pounds but indicated in her medical records the incorrect weight in order to justify the false diagnosis of wasting.

Respondent falsely denied that his participation in the Medicaid program was being investigated or challenged on a New York Methodist Hospital reappointment application.

The false representations by Respondent as to Patients A, B, D, and E were made to the patients themselves (through the patients medical records), to the pharmacists who filled the prescriptions, to the Medicaid program who paid for the prescriptions, and to the people of the State of New York (and of the United States) who pay for the Medicaid program.

Respondent knew that his representations were false and he intentionally misled the patients, the pharmacists, the Medicaid program and the people of New York.

The Hearing Committee finds and determines that Respondent's conduct towards Patients A, B, D, and E constituted the fraudulent practice of medicine. The Hearing Committee finds and determines that Respondent's response on his reappointment application constituted the fraudulent practice of medicine. The First, Second, Fourth, Fifth, and Sixth Specifications of Charges are sustained. The Third Specification of Charges is not sustained because the Hearing Committee was not convinced that as to Patient C, Respondent intended to deceive (see Findings # 33 and # 34).

B. Respondent is charged with committing professional misconduct under Education Law §6530(21) by willfully making or filing a false report.

The false reports made by Respondent were the entries in the medical records for Patients A, B, D, and E, and the false representation made regarding participation in the Medicaid program on the hospital reappointment application (see discussion above and Findings).

Respondent knew that the patients did not have HIV and/or need Serostim and/or antiretroviral medications but he willfully provided information (in the patients' medical records, in the prescribing, and to the Medicaid program) which would allow the patients to obtain said medications. The Seventh, Eighth, Tenth, Eleventh and Twelfth Specifications of Charges are sustained. The Ninth Specification of Charges is not sustained because the Hearing Committee was not convinced that as to Patient C Respondent intended to deceive (see Findings # 33 and # 34).

C. Respondent is charged with committing professional misconduct under Education Law §6530(16) by willful or grossly negligent failure to comply with substantial provisions of state law governing the practice of medicine.

Department of Health Rules and Regulations are found at Title 18 of the New York Code of Rules and Regulations. 18 NYCRR §515.2 is entitled "Unacceptable practices under the medical assistance program". 18 NYCRR §515.2(b)(2) states:

> Conduct included. An unacceptable practice is conduct which constitutes fraud or abuse and includes the practices specifically enumerated in this subdivision. ... (2) False statements. (i) Making, or causing to be made any false, fictitious or fraudulent statements or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment.

Respondent violated 18 NYCRR §515.2(b)2 by making false statements to Medicaid in connection with the information he provided for the prior authorization of Serostim prescriptions issued to Patients D and E. The Thirteenth Specification is sustained.

D. Respondent is charged with committing professional misconduct under Education Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice.

Respondent intentionally submitted false information to Medicaid on Patients D and E. That conduct was a violation of the public trust and a violation of the standards of the medical community.

Respondent submitted false information into the medical records of Patients A through F which had the very real potential of causing grave and serious injury to each patient. That conduct was a violation of the public trust and a violation of the standards of the medical community.

Respondent prescribed Serostim to patients who did not have a legitimate medical need for the medication. Respondent prescribed antiretroviral therapy to patients who did not have a legitimate medical need for the medications. That conduct was a violation of the public trust and a violation of the standards of the medical community.

Respondent provided false information and false statements to Medicaid for use in determining right to payment. That conduct was a violation of the public trust and a violation of the standards of the medical community.

Respondent provided false information to New York Methodist Hospital in a reappointment application he submitted. That conduct was a violation of the public trust and a violation of the standards of the medical community.

The Hearing Committee unanimously agreed that Respondent's conduct, as indicated above, was fraudulent and deplorable. Respondent engaged in conduct in the practice of the profession of medicine that evidences moral unfitness to practice the profession. The Fourteenth Specification of Charges is sustained.

E. Respondent is charged with committing professional misconduct under Education Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion.

Respondent deviated from the accepted standard of care by inappropriately diagnosing patients as having HIV related wasting syndrome, by prescribing Serostim without adequate medical indication, by prescribing antiretroviral medications without adequate medical indication, and by failing to confirm or rule out the patients' HIV status. Respondent committed negligence as to each patient on numerous occasions. The Fifteenth Specification is sustained.

F. Respondent is charged with committing professional misconduct under Education Law §6530(35) by ordering excessive treatment not warranted by the condition of the patient.

Respondent prescribed Serostim to Patients A through F without adequate medical indication or documented need. Respondent prescribed antiretroviral therapy medications to Patients A through E without adequate medical indication or documented need.

Respondent provided excessive treatment not warranted by the condition of the patients. The Sixteenth Specification is sustained.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law, Discussion, and Summary set forth above, the Hearing Committee determines that Respondent's license to practice medicine in New York State should be Revoked. In addition, a $100,000.00 fine should be assessed against Respondent.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including: (1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) A fine not to exceed ten thousand ($10,000.00) dollars on each specification of charges of which the respondent is determined to be guilty; (8) a course of education or training; (9) performance of up to five hundred (500) hours of public service; and (10) probation.

The Hearing Committee has carefully reviewed the multiple medical records, testimony of the respondent, the testimony of the witnesses, and the briefs provided by counsel. There are common themes which emerges when comparing and contrasting the information.

The first theme is that Respondent relied heavily on the subjective information provided by his patients. In Patients A through E, Respondent relied solely on the history taken from the patient without attempting to verify or confirm diagnoses.

Respondent has no documentation to support any attempts to contact prior attending physicians for medical history or confirmation of positive HIV diagnosis. In addition, he did not conduct his own physical examination or order conclusive laboratory tests.

The second theme is that Respondent claims to feel that he was taken advantage of by savvy patients; patients who knew the "system" and knew what terminology and verbiage to use to get what they wanted. The overwhelming evidence in Respondent's testimony and the medical records points to a trend, a pattern of not being aware of what his duties as a physician were. Respondent's claim that he was not accountable for his actions, but rather was at the mercy of his patients is not convincing. Respondent's intentions and actions were purposeful, not accidental. The Hearing Committee does not believe that Respondent was duped by his patients.

Respondent referred to his inability to get physicians to respond to his calls. He also stated that he could not remember or didn't even try to secure this information from prior attending physicians. While he was aware of HIPAA regulations, the Hearing Committee was not convinced that Respondent understood the applicable practices. Respondent seemed unaware of how to request medical information via a disclosure form properly signed by the patient.

The third theme that emerged from the hearing was the Respondent's lack of accountability. Respondent did not take any action to verify or confirm diagnoses of patients that were seen in the clinic and failed to question his patients for further information. He served as a physician who dispensed prescriptions merely at the patient's request and based on their subjective information. He did not conduct the problem solving methodology associated with a physician's code of medical practice. He took information verbatim and acted on it without question. This is a responsibility that every physician is accountable for and cannot give away. It is the physician's sole responsibility to gather information, make a diagnosis, and render treatment. The physician cannot allow the patient to make his diagnosis for him.

Respondent simply wrote prescriptions for the patients because they asked. In essence, he allowed his patients to self prescribe. Respondent relinquished his power and let the patients he was "treating" decide what was best for them.

Based on Respondent's consistent behavior and pattern, it appears he would continue to conduct his medical practices in the same manner. Dr. Makhlin has indicated that he no longer treats HIV patients. He now treats the chronically ill, home bound patients with many of his referrals coming from Visiting Nurses. This raises many concerns. Respondent has just substituted another vulnerable group of patients for treatment. The chronically ill have multiple co-morbidities, take multiple medications, and are a complex group of patients to treat. The Hearing Committee expects that the same behavior testified to by Respondent and indicated by his medical records, will continue with treatment of homebound patients.

The Hearing Committee sees no hope that Respondent's conduct will change in the future. Respondent's misconduct cannot be corrected or remedied by a censure or a reprimand, by probation, by performance of public service, or by retraining. A temporary suspension, limitations on Respondent's license, or monitoring are all inappropriate sanctions in this matter. The Hearing Committee finds Respondent's recommendation of a six (6) month suspension to be insufficient under the circumstances of this Hearing. Six (6) month of suspension does not begin to address Respondent's fraudulent conduct, negligence, false reporting, excessive prescriptions or acts of moral unfitness.

Respondent presented himself as the victim. He tried to present himself as having been taken advantage of and manipulated by savvy patients The Hearing Committee does not accept or believe that Respondent was the victim or the person who was tricked or taken advantage of.

Rehabilitation or continued practice is only appropriate when a person has shown true remorse and wishes to atone. Respondent has not shown true remorse.

Integrity is essential to the practice of medicine. It is imperative that physicians deal truthfully not only with patients and other physicians, but with third party insurers and State regulators. This standard and its enforcement is the foundation on which our health care system rests. Allowing physicians who make a habit of making misrepresentations erodes our health care system for everyone.

Respondent has committed fraud. This act is a serious transgression as it belies a fundamental lack of integrity. Physicians are not infallible nor are they held to that standard; however, honesty and accountability are standards that are inviolate. Their breach corrupts the profession, endangers the public, and taints the trust and respect that society places in their physicians, an effect which cannot be minimized.

In addition to the license revocation, the Hearing Committee believes that the imposition of a monetary penalty is appropriate. A separate fine of $10,000.00 for each separate and distinct act of professional misconduct should be assessed. The Hearing Committee agrees with the Department's recommendation and will assess the fine for the following ten separate acts:

1) Inappropriately prescribing Serostim and/or antiretroviral medication to Patients A through F (six acts); 2) Falsely representing in the medical record of Patient A that she weighed 110 pounds (one act); 3) Failing to comply with the Medicaid Serostim protocol for prior authorization by falsely representing to Medicaid that Patient D and Patient E had confirmed HIV diagnoses (two acts); and 4) misrepresentation to New York Methodist Hospital on Respondent's reappointment application.

The money assessed as the result of the Medicaid Hearing (Department Exhibits # 23 and # 24) was an amount to recover the Medicaid funds expended for unjustified prescriptions issued by Respondent. This amount, $140,472.36 plus interest, involves three patients which were not before the Hearing Committee (it also included three patients that were).

The amount assessed in the Medicaid Hearing is for recovery of money paid by the Medicaid program. The money assessed by the Hearing Committee in this Determination and Order is a fine under P.H.L. §230-a. We note that each prescription for a one month (28 day) supply of Serostim cost the tax payers $6,353.90. For Patients A through F Respondent issued multiple prescriptions of Serostim, many with multiple refills. All of the prescriptions, and refills, for Serostim issued by Respondent were inappropriate and not medically indicated. Patients B, C, D, and E did not have HIV or HIV related wasting and did not need HAART medications. Respondent issued multiple prescriptions of HAART (antiretroviral) medications, most of which were inappropriate and not medically indicated.

The claim that some patients were prosecuted for their role in a scheme to procure Serostim prescriptions does not lessen Respondent's culpability in this alleged scheme. The Hearing Committee also does not agree with Respondent's contention that he did not hurt or endanger any of his patients. Providing unnecessary or excessive medications which are not medically indicated is a potential for patient harm. Fabrication of medical records to justify prescriptions is a potential for patent harm.

The Hearing Committee believes the total fine of $100,000.00 to be an appropriate assessment (in addition to license revocation) for Respondent's fraudulent practice, false reporting, unwarranted treatment, and moral unfitness.

The Hearing Committee concludes that Respondent's use of his license to commit fraud, standing alone, provides sufficient grounds to revoke Respondent's license and to fine him as indicated above.

The treatment ordered by Respondent that was not warranted by the condition presented by Patients A through F standing alone, provides sufficient grounds to revoke Respondent's license and to fine him as indicated above.

Respondent knew that the patients did not require the treatment ordered but indicated to the Medicaid program that those medications were necessary for their care.

The Hearing Committee believes that the penalty imposed should help protect the public, curb future unprofessional practice by Respondent, deter other licensees from similar temptations, and is in the interest of justice.

Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein. Specifically, Respondent's arguments are either rendered academic by the Hearing Committee's decision or have been found to be lacking in merit.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. All Specifications contained in the Statement of Charges (Department Exhibit # 1) are SUSTAINED except for the THIRD and the NINTH Specifications; and

2. The THIRD and the NINTH Specifications contained in the Statement of Charges (Department Exhibit # 1) are **NOT SUSTAINED**; and

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

4. Within thirty (30) days from the effective date of this decision Respondent shall pay a fine of **ONE HUNDRED THOUSAND ($100,000.00) DOLLARS**; and

5. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law 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; referral to the New York State Department of Taxation and Finance for collection; and non renewal of permits or licenses (Tax Law §171[27]; State Finance Law §18; CPLR §5001; Executive Law §32); and

6. This Order shall be effective on personal service on the Respondent or seven (7) days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York**
April, 5 2008

Redacted Signature

JERRY WAISMAN M.D. (Chairperson)
PRADEEP CHANDRA M.D.
JUDITH GLUSKO R.N.

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APPENDIX 1

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

IN THE MATTER OF MIKHAIL MAKHLIN, M.D.	STATEMENT OF CHARGES

MIKHAIL MAKHLIN, M.D., the Respondent, was authorized to practice medicine in New York State on or about 1997, by the issuance of license number 207258 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about December 5,2001, Patient A presented to Respondent's office located at 2433 86th Street, Brooklyn, New York. (Patient A and the other patients in the Statement of Charges are identified in the Appendix). Respondent noted that Patient A was HIV positive, 28 to 30 weeks pregnant, and had recent significant weight loss. He recorded a height of 5 feet 7 inches, weight of 110 pounds and described her appearance as "tired looking, wasted, very thin." Respondent:

1. Inappropriately diagnosed HIV related "wasting syndrome".
2. Inappropriately prescribed Serostim with multiple refills.
3. Inappropriately prescribed antiretroviral medications with multiple refills.
4. Knowingly and falsely represented that Patient A was "very thin" and weighed 110 pounds, when, in fact, he knew that Patient A weighed significantly more than 110 pounds and was a normal

weight for a 28 to 30 week pregnant woman.

B. According to Respondent's office record for Patient B, on or about and between September 17, 2001 and October 22, 2002, the Respondent treated the Patient for HIV infection, Hepatitis C, diabetes mellitus and a variety of other conditions. Respondent noted that Patient B was 5 feet 3 ½ inches and weighed 170 pounds. The chart contains a letter signed by a physician, Jordon Glaser, M.D. addressed "to whom it may concern". According to the letter, Patient B had been treated for HIV with zerit, epivir, viramune, and Serostim. Respondent:

1. Inappropriately diagnosed HIV related "wasting syndrome".
2. Inappropriately prescribed Serostim.
3. Inappropriately prescribed antiretroviral therapy.
4. Failed to take appropriate steps to confirm that Patient B was HIV positive, including but not limited to failing to contact the Patient's purported prior treating physician, Jordon Glaser, M.D..
5. Knowingly created the false impression that he prescribed Serostim and antiretroviral medications for HIV infection, when, in fact, he either knew or deliberately avoided knowing that the Patient did not have HIV infection. Respondent intended to deceive.

C. On or about and between October 14, 2001, and December 13, 2001, the Respondent treated Patient C for purported HIV infection, significant weight loss and several other conditions. Patient C was 6 feet and weighed 172 pounds. Respondent:

1. Inappropriately diagnosed HIV related "wasting syndrome."
2. Inappropriately wrote prescriptions for Serostim with a refill.
3. Inappropriately wrote prescriptions for antiretroviral medications with a refill.
4. Failed to take appropriate steps to confirm that Patient C was HIV positive, including but not limited to failing to contact the Patient's primary care physician and/or ordering laboratory testing.
5. Knowingly created the false impression that he prescribed Serostim and antiretroviral medications for HIV infection, when, in fact, he either knew or deliberately avoided knowing that the Patient did not have HIV infection. Respondent intended to deceive.

D. On or about and between May 22, 2002 and March 20, 2003 the Respondent treated Patient D for purported HIV and other issues. Patient D was 5 foot 3 inches and 124 pounds. Respondent:

1. Inappropriately diagnosed HIV related "wasting syndrome".
2. Inappropriately prescribed Serostim.
3. Failed to take appropriate steps to confirm whether Patient D was HIV infected, including but not limited to failing to order appropriate laboratory testing.
4. Inappropriately prescribed antiretroviral medication.
5. Knowingly created the false impression that he prescribed Serostim and antiretroviral medications for HIV infection, when, in fact, he either knew or deliberately avoided knowing that the Patient did not have HIV infection. Respondent intended to

deceive.

6. Commencing in January 2002 the New York State Medicaid Program ("Medicaid") required physicians prescribing Serostim to obtain prior authorization for each prescription. Respondent failed to comply with the Medicaid Serostim protocol for prior authorization by falsely representing to Medicaid that Patient D had significant unintentional weight loss and a confirmed HIV diagnosis.

E. On or about and between February 5, 2002 and October 1, 2002 the Respondent treated Patient E, a 40 year old female. Patient E was 5 feet 5 inches and weighed 216 pounds. The chart contains a document entitled "Medical Request for Home Care" form which was signed by a Woodhull Hospital physician, Mohammad Hassan, M.D. According to the document Patient D was being treated for HIV with antiretroviral medications and Serostim. The chart also contains a lab report, purportedly from the Cumberland Diagnostic and Treatment Center, that reports an abnormal CD4 count of 130. Respondent:

1. Inappropriately diagnosed HIV related "wasting syndrome".
2. Inappropriately prescribed Serostim.
3. Failed to take appropriate steps to confirm whether Patient ~~C~~ E was HIV infected, including but not limited to failing to contact the Patient's prior treating physician and/or ordering appropriate laboratory tests.
4. Inappropriately prescribed antiretroviral medications.
5. Knowingly created the false impression that he prescribed Serostim and antiretroviral medications for HIV infection, when, in fact, he either knew or deliberately avoided knowing that the

amended 2/11/07 MPZ

Patient did not have HIV infection. Respondent intended to deceive.

6. Respondent failed to comply with the Medicaid Serostim protocol for prior authorization by falsely representing to Medicaid that Patient E had significant unintentional weight loss and a confirmed HIV diagnosis.

F. On or about and between January 22, 2002 and February 13, 2004, the Respondent treated Patient F for HIV, HIV related "wasting syndrome" and other issues. Respondent prescribed Serostim to the patient through September 24, 2003 when another physician discontinued the medication. Respondent:

1. Inappropriately diagnosed HIV related "wasting syndrome".
2. Inappropriately prescribed Serostim.

G. Respondent failed to comply with substantial provisions of state law governing the practice of medicine in that on multiple occasions the Respondent willfully and/or gross negligently violated Department of Health Rules and Regulations governing the Medicaid program. The conduct previously alleged in the Statement of Charges constitutes Medicaid "fraud and abuse" pursuant to Title 18, Section 515.2 of the New York Code of Rules and Regulations.

H. On an application for reappointment to the medical staff of New York Methodist Hospital, Brooklyn, New York, dated April 17, 2005, the Respondent knowingly and falsely represented, with the intent to deceive, that his participation in the Medicaid program had never been, or was not currently in the process of being "denied, revoked, suspended reduced, ... investigated, challenged or subject to any other disciplinary action..." In fact, the Respondent knew that on or about November 14, 2003 the New York State Department of Health had determined to exclude him from participation in the Medicaid program for a period of five (5) years.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH 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:

1. A and A4.
2. B and B5.
3. C and C5.
4. D and D5.
5. E and E5.
6. H.

SEVENTH THROUGH TWELVETH SPECIFICATIONS

FALSE REPORT

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

7. A and A4.
8. B and B5.
9. C and C5.
10. D and D5.
11. E and E5.
12. H.

THIRTEENTH SPECIFICATION

FAILING TO COMPLY WITH STATE LAW

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(16) by his willful or grossly negligent failure to comply with substantial provisions of state law governing the practice of medicine, as alleged in the facts of:

13. Paragraph G.

FOURTEENTH 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:

14. A, A1, A2, A3, A4, B, B1, B2, B3, B4, B5, C, C1, C2, C3, C5, D, D1, D2, D3, D4, D5, D6, E, E1, E,2, E3, E4, E5, E6, F, F1, F2, G and/or H.

FIFTEENTH 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:

15. A, A1, A2, A3, B, B1, B2, B3, B4, C, C1, C2, C3, C4, D, D1, D2, D3, D4, E, E1, E2, E3, E4, F, F1 and/or F2.

SIXTEENTH SPECIFICATION

UNWARRANTED TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(35) by ordering of excessive treatment not warranted by the

condition of the patient, as alleged in the facts of:

16. A, A2, A3, B, B2, B3, C, C2, C3, D, D2, D4, E, E2, E4, F, and/or F2.

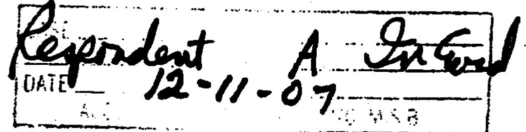
DATE: October 17, 2007
New York, New York

Redacted Signature
Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

NEW YORKSTATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF MIKHAIL MAKHLIN, M.D.	ANSWER



MIKHAIL MAKHLIN, M.D., by his attorney, Gregory J. Gallo, for its Answer to the Statement of Charges, states as follows:

FACTUAL ALLEGATIONS

1. Denies the allegations contained in paragraph and subsections A.1., A.2., A.3., and A.4., of the Statement of Charges.

2. Denies the allegations contained in paragraph and subsections B.1., B.2., B.3., B.4., and B.5., of the Statement of Charges.

3. Denies the allegations contained in paragraph and subsections C.1., C.2., C.3., C.4., and C.5., of the Statement of Charges.

4. Denies the allegations contained in paragraph and subsections C.1., C.2., C.3., C.4., and C.5., of the Statement of Charges.

5. Denies the allegations contained in paragraph and subsections D.1., D.2., D.3., D.4., and D.5., of the Statement of Charges.

6. Respondent admits that portion of paragraph D.6. alleging that in January 2002 the New York State Medicaid Program ("Medicaid") required physicians prescribing Serostim to obtain prior authorization for each prescription; but respondent denies the rest of the allegations contained therein.

7. Denies the allegations contained in paragraph and subsections E.1., E.2., E.3., E.4., E.5., and E.6., of the Statement of Charges.

8. Denies the allegations contained in paragraph and subsections F.1. and F.2. of the Statement of Charges.

9. Denies the allegations contained in paragraph G of the Statement of Charges.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

10. Respondent repeats and realleges its answers set forth in paragraphs "1" through "9" and therefore denies the charge of Fraudulent Practice.

SIXTH THROUGH TENTH SPECIFICATIONS

11. Respondent repeats and realleges its answers set forth in paragraphs "1" through "9" and therefore denies the charge of False Report.

ELEVENTH SPECIFICATION

12. Respondent repeats and realleges its answers set forth in paragraph "9" through "9" and therefore denies the charge of Failing to Comply With State Law.

TWELFTH SPECIFICATION

13. Respondent repeats and realleges its answers set forth in paragraphs "1" through "9" and therefore denies the charge of Moral Unfitness.

THIRTEENTH SPECIFICATION

14. Respondent repeats and realleges its answers set forth in paragraphs "1" through "9" and therefore denies the charge of Negligence on More Than One Occasion.

FOURTEENTH SPECIFICATION

15. Respondent repeats and realleges its answers set forth in paragraphs "1" through "9" and therefore denies the charge of Unwarranted Treatment.

Dated: November 30, 2007
New Haven, Connecticut

Redacted Signature

Gregory J. Gallo, Esq.
Attorney for Respondent
475 Whitney Avenue
New Haven, CT 06511
(203) 787-2225

To: Daniel Guenzburger, Esq., Associate Counsel, New York State Department of Health, Bureau of Professional Medical Conduct, 90 Church Street – 4th Floor, New York, New York 10007

VERIFICATION

STATE OF CONNECTICUT)
COUNTY OF NEW HAVEN) ss.:

I, the undersigned, an attorney admitted to practice in the courts of the State of New York state that I am the attorney of record for Mikhail Makhlin in the within action; that I have read the foregoing Answer, and know the contents thereof; the same is true based on my conversation with and verification over the telephone from Mikhail Makhlin, and as to those matters state therein. I make this verification instead of the Mikhail Makhlin because Mikhail Makhlin reside(s) in a county outside the county where my principal office for the practice of law is located.

Redacted Signature

Gregory J. Gallo

Affirmed this 30 day of November 2007.