Public

New York State Board for Professional Medical Conduct
433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

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Office of Professional Medical Conduct

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Vice Chair
Katherine A. Hawkins, M.D., J.D.
Executive Secretary

April 6, 2010

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Sergio A. Castillo, M.D.

Re: License No. 176200

Dear Dr. Castillo:

Enclosed is a copy of Order BPMC #10-57 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect April 13, 2010.

If the penalty imposed by this Order is a surrender, revocation or suspension, you are required to deliver your license and registration within five (5) days of receipt of this Order to: Office of Professional Medical Conduct, c/o Physician Monitoring Unit, New York State Department of Health, 433 River Street, Suite 303, Troy, NY 12180-2299.

If the document(s) are lost, misplaced or destroyed, you are required to submit to this office an affidavit to that effect. Enclosed for your convenience is an affidavit. Please complete and sign the affidavit before a notary public and return it to the Office of Professional Medical Conduct.

Sincerely,

Katherine A. Hawkins, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Wilfred T. Friedman, Esq.
60 East 42nd Street, 40th Floor
New York, NY 10165

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

IN THE MATTER

OF

SERGIO CASTILLO, M.D.

CONSENT

ORDER

BPMC No. 10-57

Upon the application of (Respondent) SERGIO CASTILLO, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 4-6-2010

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

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

IN THE MATTER
OF
SERGIO CASTILLO, M.D.

CONSENT AGREEMENT AND ORDER

SERGIO CASTILLO, M.D., represents that all of the following statements are true:

That on or about September 16, 1988, I was licensed to practice as a physician in the State of New York, and issued License No. 176200 by the New York State Education Department.

My current address is

and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with 48 specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I admit the eleventh specification as it relates to A.2 and F.2, in full satisfaction of the charges against me, and agree to the following penalty:

Pursuant to N.Y. Pub. Health Law § 230-a(2), my license to practice medicine in New York State shall be suspended for 36 months, with the first 9 months to be served as a period of actual suspension and with the last 27 months stayed.

During the period of actual suspension, I shall be subject to a condition that I obtain a clinical competency assessment and comply

with the provisions set forth in attached Exhibit "D."

The period of my actual suspension shall cease upon my compliance with paragraphs 1 and 2 (a) of Exhibit "D," and the period of stayed suspension shall then become effective. The combined period of actual and stayed suspension shall be 36 months.

The effective date for the term of actual suspension shall be either April 1, 2010, or the effective date of this Order, whichever is later.

Pursuant to N.Y. Pub. Health Law § 230-a(9), I shall be placed on probation for 36 months, subject to the terms set forth in attached Exhibit "B."

I shall be subject to a Condition that I comply with attached Exhibit "C," "Requirements For Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension (Of 6 Months or More) of a Medical License."

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent

remains a licensee in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 3/18/10

SERGIO CASTILLO, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 3/19/10

WILFRED T. FRIEDMAN, ESQ.
Attorney for Respondent

DATE: 3-22-10

LEE A. DAVIS
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 4/5/10

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

EXHIBIT "A"

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

IN THE MATTER

OF

SERGIO CASTILLO, M.D.

STATEMENT

OF

CHARGES

SERGIO CASTILLO, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 16, 1988, by the issuance of license number 176200 by the New York State Education Department. Respondent is currently registered to practice medicine with the New York State Education Department through July 31, 2010.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (The patients are identified in the Appendix), a 25 year old woman, at Ellis Hospital Emergency Department in Schenectady, New York on May 25, 2004. Patient A presented to the Ellis Emergency Department complaining of sudden abdominal pain, pinkish vaginal discharge, a negative pelvic ultrasound five days previous and reporting a miscarriage on April 29, 2004. Patient A's serum beta HCG was recorded at 2397 mU mL while at the emergency department. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient A's condition, including, but not limited to adequate considering a diagnosis of ectopic pregnancy, and/or failed to adequately document an evaluation, placing the patient at risk of harm of increased morbidity and mortality.
2. Respondent failed to adequately evaluate Patient A's condition, including, but not limited to inappropriately diagnosing Patient A

with "Abdominal Pain - acute; s/p miscarriage 3 weeks ago" without adequately ruling out a diagnosis of ectopic pregnancy or other diagnoses, and/or failed to adequately document an evaluation, placing the patient at risk of harm of increased morbidity and mortality.

3. Respondent failed to perform an adequate physical examination of Patient A given her signs and symptoms, and/or failed to adequately document that he performed an adequate physical examination of Patient A, placing the patient at risk of harm of increased morbidity and mortality.
4. Respondent failed to communicate with Patient A's obstetrician to learn whether Patient A's beta HCG level was increasing or decreasing, and/or failed to adequately document that he communicated with Patient A's obstetrician, placing the patient at risk of harm of increased morbidity and mortality.
5. Respondent inappropriately discharged Patient A from the emergency department, placing the patient at risk of harm of increased morbidity and mortality.

B. Respondent provided medical care to Patient B, a 20 year old woman, at Ellis Hospital Emergency Department in Schenectady, New York on July 20, 2005. Patient B presented to the emergency department with a history of urinary tract infections, kidney stones, right flank pain for approximately one week, a three day course of antibiotics, intermittent fever, and elevated pulse rate, respiration, and white blood count. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient B's condition, including, but not limited to adequately addressing the cause of her tachycardia, and/or failed to document that he adequately evaluated the cause of the patient's tachycardia, placing the

patient at risk of harm of increased morbidity and mortality.

2. Respondent failed to adequately consider other indicated differential diagnoses, including, but not limited to pyelonephritis, and/or failed to adequately document that he considered such appropriate differential diagnoses, placing the patient at risk of harm of increased morbidity and mortality.
3. Respondent failed to adequately manage Patient B's care, including, but not limited to adequately addressing her tachycardia and/or failed to adequately document that he adequately addressed her tachycardia, placing the patient at risk of harm of increased morbidity and mortality.
4. Respondent failed to coordinate Patient B's care with her primary care provider and/or failed to adequately document that he coordinated Patient B's care with her primary care provider, placing the patient at risk of harm of increased morbidity and mortality.
5. Respondent inappropriately discharged Patient B from the emergency department, placing the patient at risk of harm of increased morbidity and mortality.

C. Respondent provided medical care to Patient C, a 34 year old man, at Ellis Hospital Emergency Department in Schenectady, New York on January 14, 2005. Patient C presented to the emergency department with complaints of fever, cough, vomiting and diarrhea for one week and a history of smoking. Respondent's care and treatment of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient C's condition, including, but not limited to ruling out the diagnosis of pneumonia, and/or failed to adequately document that he adequately evaluated Patient C's condition, placing the patient at risk of harm of increased morbidity and mortality.

2. Respondent failed to adequately manage Patient C's care, including, but not limited to failing to read the chest x-ray demonstrating bilateral infiltrates, and/or failed to adequately document that he adequately managed Patient C's condition.

3. Respondent failed to adequately manage Patient C's care, including, but not limited to failing to diagnose and treat Patient C's pneumonia, and/or failed to adequately document that he adequately managed Patient C's condition.

D. Respondent provided medical care to Patient D, a 33 year old man, at Ellis Hospital Emergency Department in Schenectady, New York on November 23, 2004. Patient D presented to the emergency department complaining of chest wall pain for 2 weeks radiating to his left arm but worse on that day, shortness of breath, a history of smoking and a blood pressure of 154/73. Respondent's care and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient D's condition, including, but not limited to ruling out cardiac disease, and/or failed to adequately document that he evaluated Patient D's condition, placing the patient at risk of harm of increased morbidity and mortality.

2. Respondent, despite the patient's signs and symptoms of cardiac factors, failed to obtain a cardiology consult.

3. Respondent, despite the patient's signs and symptoms of cardiac factors, inappropriately discharged Patient D from the emergency department, placing the patient at risk of harm of increased morbidity and mortality.

E. Respondent provided medical care to Patient E, a 61 year old man, at Ellis Hospital Emergency Department in Schenectady, New York on October 28, 2004. Patient E presented to the emergency department with a one inch laceration behind his left ear of unknown origin, a blood pressure of 102/64 and pulse of 49. An ECG demonstrated a bradycardia of 40. Respondent's care and treatment of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to obtain an adequate history of Patient E, and/or failed to adequately document that he obtained an adequate history of the patient.
2. Respondent failed to adequately evaluate Patient E's condition by including, but not limited to, the patient's documented vital signs, ECG and presenting symptoms and complaints, and/or failed to adequately document that he adequately evaluated the patient's condition, placing the patient at risk of harm of increased morbidity and mortality.
3. Respondent failed to adequately manage Patient E's condition, including, but not limited to, adequately address the potential cardiac issues raised by the recorded blood pressure, bradycardia and scalp laceration of an unknown origin, and/or failed to adequately document that he adequately managed the patient's condition, placing the patient at risk of harm of increased morbidity and mortality.
4. Respondent inappropriately discharged Patient E from the emergency department without considering and/or obtaining a cardiology consult, placing the patient at risk of harm of increased morbidity and mortality.

F. Respondent provided medical care to Patient F, an 84 year old woman, at Ellis Hospital Emergency Department in Schenectady, New York on September 22, 2005. Patient F presented to the emergency department complaining of pain in her right hip and right upper leg following a fall, and reported that she was unable to bear weight on the leg. Respondent's care and treatment of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately manage Patient F's care by failing to admit her to the hospital for the supportive care needed to minimize her risk of harm associated with a fractured pelvis and inability to ambulate.
2. Respondent failed to provide for adequate care for Patient F upon her discharge home via ambulance with a fractured right pubic rami, with walker and without the ability to ambulate, including but not limited to determining that she received adequate supportive care needed to minimize her risk of harm of increased morbidity and mortality, and/or failed to adequately document that he provided adequate care.
3. Respondent failed to adequately provide for Patient F upon her discharge, including but not limited to failing to make adequate arrangements for her to be safely cared for at home, arranging a DVT prophylaxis, and/or arranging for her rehabilitation at an appropriate rehabilitation facility, and/or failed to adequately document that he provided for such arrangements.

G. Respondent provided medical care to Patient G, a 39 year old woman, at Ellis Hospital Emergency Department in Schenectady, New York on February 12, 2005. Patient G presented to the emergency department at term of her 6th pregnancy and experiencing contractions approximately one to one and one-half minutes apart. Respondent's care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient G's condition, including but not limited to performing a pelvic examination, and/or failed to document that he performed an adequate evaluation of the patient.
2. Respondent failed to admit Patient G.
3. Respondent inappropriately permitted Patient G to leave the emergency department without providing stabilizing care, placing her at risk of harm of increased morbidity and mortality.

H. Respondent provided medical care to Patient H, a 57 year old woman, at Ellis Hospital Emergency Department in Schenectady, NY on December 8, 2005. Patient H had a colonoscopy and polypectomy earlier that day, followed by a syncopal event at home. Patient H presented to the emergency department with a pulse of 126, a respiration rate of 16, a blood pressure of 77/53, reporting weakness, lightheadedness and nausea. Her skin was cyanotic, pale and cool. Lab values obtained while she was in the emergency department revealed a white blood cell count of 18.1, hemoglobin 11.1 and hematocrit 31.8. Respondent's care and treatment of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient H's condition in light of her signs and symptoms by not ruling out differential diagnoses, including, but not limited to gastrointestinal perforation and/or hemorrhage, sepsis and/or cardiac event before admitting Patient H to a medical bed for "dehydration," and/or failed to document that he adequately evaluated the patient's condition, placing the patient at risk of harm of increased morbidity and mortality.
2. Respondent, despite the patient's signs and symptoms, failed to adequately manage Patient H's care by not obtaining a surgical consult, and/or failing to adequately document that he ordered

or obtained a surgical consult, placing the patient at risk of harm of increased morbidity and mortality.

3. Respondent, despite the patient's signs and symptoms, failed to adequately manage Patient H's care by not admitting her to a monitored bed upon admission, placing her at risk of harm of increased morbidity and mortality.

4. Respondent, despite the patients signs and symptoms, failed to adequately manage Patient H's care including, but not limited to ordering and or initiating the administration of antibiotics, and/or failing to adequately document that he ordered or initiated antibiotic treatment, placing the patient at risk of harm of increased morbidity and mortality.

I. Respondent provided medical care to Patient I, a 29 year old man, at Ellis Hospital Emergency Department in Schenectady, New York on January 9, 2008. Patient I presented to the emergency department for medical clearance prior to a psychiatric admission, with complaints of hearing voices, with a history of abdominal pain and diarrhea, blood pressure of 84/64, a history of congestive heart failure, cardiomyopathy, gastroesophageal reflux disease, deep vein thrombosis, chronic renal disease and had stopped taking his cardiac medications. Laboratory results demonstrated a BUN of 53, potassium of 3.2 a creatinine of 2.1 and a BNP of 17,795. Hours after Patient I's admission to the psychiatric unit, he became hypotensive, complained of continued abdominal pain and shortness of breath. Patient I was transferred to the ICU, where it was also documented that he had mitral valve disease, an internal cardiac defibrillator, and was being considered for a heart transplant. Respondent's care and treatment of Patient I deviated from accepted standards of medical care in the following respects:

1. Respondent failed to obtain an adequate history of Patient I including, but not limited to his abdominal pain and diarrhea, and/or failed to adequately document the nature of his abdominal pain and diarrhea.

2. Respondent failed to adequately evaluate Patient I, given his presenting signs and symptoms, labs and medical history, including, but not limited to the patient's hypotension, abdominal pain, renal function and cardiac status, and/or failed to adequately document his evaluation, placing the patient at risk of harm of increased morbidity and mortality.

3. Respondent inappropriately provided medical clearance for Patient I's inpatient psychiatric referral despite indications that the patient was not medically stable, including, but not limited to the patient's hypotension, abdominal pain, renal function and cardiac status, placing the patient at risk of harm of increased morbidity and mortality.

4. Respondent inappropriately provided medical clearance for Patient I's inpatient psychiatric referral without providing appropriate medical management for Patient I's presenting symptoms and history, including, but not limited to the patient's hypotension, abdominal pain, renal function and cardiac status, and/or failed to adequately document his medical management, placing the patient at risk of increased morbidity and mortality.

J. Respondent provided medical care to Patient J, a 76 year old woman, at Ellis Hospital Emergency Department in Schenectady, New York on April 2, 2007. Patient J presented to the emergency department after having been previously examined and discharged from the Ellis ED three days earlier, at which time she had complained of weakness and an inability to ambulate. Upon her return to the ED on April 2, 2007, she presented with complaints of new weakness, frequent falls and a decreased ability to walk. Her initial blood pressure on April 2, 2007 was 101/50. Patient J also had a history of hypertension, atrial fibrillation and mitral valve disease. Upon examination, Respondent documented her cardiac exam as "regular rhythm rate and normal heart sounds," and a normal motor exam. Respondent's care and

treatment of Patient J deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform an adequate physical examination of Patient J, including, but not limited to failing to address the patient's hypotension on presentation, by documenting a normal motor examination and by failing to perform a cerebellar examination, and/or failed to document that he obtained an adequate physical examination.
2. Respondent failed to adequately manage Patient J's presenting symptoms, including, but not limited to failing to order and/or obtain appropriate tests to identify the etiology of her hypotension and/or failing to perform an appropriate neurological examination, and/or failed to adequately document the management of her symptoms, placing the patient at risk of increased morbidity and mortality.
3. Respondent failed to adequately manage Patient J's presenting symptoms by not coordinating her care with her primary physician prior to her discharge, and/or failed to adequately document the coordination of care with the patient's physician, placing the patient at risk of increased morbidity and mortality.

SPECIFICATION OF CHARGES
FIRST THROUGH TENTH 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 the facts of the following:

1. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4 and/or A and A.5.
2. The facts set forth in paragraphs B and B.1, B and B.2, B and B.3, B and B.4,and/or B and B.5.
3. The facts set forth in paragraphs C and C.1, and/or C and C.3.
4. The facts set forth in paragraphs D and D.1 and/or D and D.3.
5. The facts set forth in paragraphs E and E.2, E and E.3,and/or E and E.4.
6. The facts set forth in paragraphs F and F.1, F and F.2,and/or F and F.3.
7. The facts set forth in paragraphs G and G.1, G and G.2, and/or G and G.3.
8. The facts set forth in paragraphs H and H.1, H and H.2 H and H.3, and/or H and H.4.
9. The facts set froth in paragraphs I and I.2, I and I.3 and/or I and I.4.
10. The facts set forth in paragraphs J and J.2, and/or J and J.3.

ELEVENTH 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:

11. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4 and/or A and A.5, B and B.1, B and B.2, B and B.3, B and .4, and/or B and B.5, C and C.1, C and C.2 and/or C and C.3, D and D.1, D and D.2, and/or D and D.3, E and E.1, E and E.2, E and E.3, and/or E and E.4, F and F.1, F and F.2, and/or F and F.3, G and G.1, G and G.2, and/or G and G.3, H and H.1, H and H.2, H and H.3,and/or H and H.4, I and I.1, I and I.2, I and I.3, and/or I and I.4, J and J.1, J and J.2, and/or J and J.3.

TWELFTH THROUGH TWENTY-FIRST SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

12. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, and/or A. and/or A.5.
13. The facts set forth in paragraphs B and B.1, B and B.2, B and B.3, B and B.4,and/or B and B.5.
14. The facts set forth in paragraphs C and C.1 and/or C and C.3.
15. The facts set forth in paragraphs D and D.1, and/or D and D.3.
16. The facts set forth in paragraphs E.2, E and E.3,and/or E and E.4.
17. The facts set forth in paragraphs F and F.1, F and F.2,and/or F and F.3.
18. The facts set forth in paragraphs G and G.1, G and G.2, and/or G and G.3.
19. The facts set forth in paragraphs H and H.1, H and H.2, H and H.3, and/or H and H.4.
20. The facts set froth in paragraphs I and I.2, I and I.3 and/or I and I.4.
21. The facts set forth in paragraphs J and J.2, and/or J and J.3.

TWENTY-SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

22. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4,and/or A and A.5, B and B.1, B and B.2, B and B.3, B and .4, and/or B and B.5, C and C.1, C and C.2 and/or C and C.3, D and D.1, D and D.2, and/or D and D.3, E and E.1, E and E.2, E and E.3, and/or E and E.4, F and F.1, F and F.2, and/or F and F.3, G and G.1, G and G.2, and/or G and G.3, H and H.1, H and H.2, H and H.3,and/or H and H.4 I and I.1, I and I.2, I and I.3, and/or I and I.4, J and J.1, J and J.2, and/or J and J.3.

TWENTY-THIRD THROUGH FORTY-EIGHTH SPECIFICATIONS
FAILURE TO MAINTAIN RECORDS

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

23. The facts set forth in paragraphs A and A.1
24. The facts set forth in paragraphs A and A.2.
25. The facts set forth in paragraphs A and A.3.
26. The facts set forth in paragraphs A and A.4.
27. The facts set forth in paragraphs B and B.1.
28. The facts set forth in paragraphs B and B.2.
29. The facts set forth in paragraphs B and B.3.
30. The facts set forth in paragraphs B and B.4.
31. The facts set forth in paragraphs C and C.1.
32. The facts set forth in paragraphs C and C.2.
33. The facts set forth in paragraphs C and C.3.
34. The facts set forth in paragraphs D and D.1.
35. The facts set forth in paragraphs E and E.1.
36. The facts set forth in paragraphs E and E.2.
37. The facts set forth in paragraphs E and E.3.
38. The facts set forth in paragraphs F and F.2.
39. The facts set forth in paragraphs F and F.3.
40. The facts set forth in paragraphs H and H.1.
41. The facts set forth in paragraphs H and H.2.
42. The facts set forth in paragraphs H and H.4.
43. The facts set forth in paragraphs I and I. 1.
44. The facts set forth in paragraphs I and I.2.
45. The facts set forth in paragraphs I and I.4.
46. The facts set forth in paragraphs J and J.1.
47. The facts set forth in paragraphs J and J.2.
48. The facts set forth in paragraphs J and J.3.

DATE: February 16, 2009
Albany, New York

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

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2. Respondent shall maintain active registration of Respondent's license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.

4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

6. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

7. Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

8. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

PRACTICE MONITOR

9. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

    a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

    b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

    c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

    d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

10. Respondent shall enroll in and complete a continuing education program for a minimum of 50 credit hours during each year of probation. This continuing education program is subject to the Director of OPMC's prior written approval.

11. Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.

EXHIBIT "C"

Requirements for Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension of a Medical License

1. Licensee shall immediately cease and desist from engaging in the practice of medicine in New York State, or under Licensee's New York license, in accordance with the terms of the Order. In addition, Licensee shall refrain from providing an opinion as to professional practice or its application and from representing that Licensee is eligible to practice medicine.

2. Within 5 days of the Order's effective date, Licensee shall deliver Licensee's original license to practice medicine in New York State and current biennial registration to the Office of Professional Medical Conduct (OPMC) at Hedley Park Place, 433 River Street 4th Floor, Troy, NY 12180-2299.

3. Within 15 days of the Order's effective date, Licensee shall notify all patients of the cessation or limitation of Licensee's medical practice, and shall refer all patients to another licensed practicing physician for continued care, as appropriate. Licensee shall notify, in writing, each health care plan with which the Licensee contracts or is employed, and each hospital where Licensee has privileges, that Licensee has ceased medical practice. Within 45 days of the Order's effective date, Licensee shall provide OPMC with written documentation that all patients and hospitals have been notified of the cessation of Licensee's medical practice.

4. Licensee shall make arrangements for the transfer and maintenance of all patient medical records. Within 30 days of the Order's effective date, Licensee shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate and acceptable contact persons who shall have access to these records. Original records shall be retained for at least 6 years after the last date of service rendered to a patient or, in the case of a minor, for at least 6 years after the last date of service or 3 years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information in the record is kept confidential and is available only to authorized persons. When a patient or a patient's representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient (not to exceed 75 cents per page.) Radiographic, sonographic and similar materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of an inability to pay.

5. If Licensee holds a Drug Enforcement Administration (DEA) certificate, within 15 days of the Order's effective date, Licensee shall advise the DEA in writing of the licensure action and shall surrender to the DEA any DEA controlled substance privileges issued pursuant to Licensee's New York license. Licensee shall promptly surrender to the DEA any unused DEA #222 U.S. Official Order Forms Schedules 1 and 2.

6. Within 15 days of the Order's effective date, Licensee shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement of the New York State Department of Health. Licensee shall destroy all prescription pads bearing Licensee's name. If no other licensee is providing services at Licensee's practice location, Licensee shall properly dispose of all medications.

7. Within 15 days of the Order's effective date, Licensee shall remove from the public domain any representation that Licensee is eligible to practice medicine, including all related signs, advertisements, professional listings (whether in telephone directories, internet or otherwise), professional stationery or billings. Licensee shall not share, occupy, or use office space in which another licensee provides health care services.

8. Licensee shall not charge, receive or share any fee or distribution of dividends for professional services rendered by Licensee or others while Licensee is barred from engaging in the practice of medicine. Licensee may be compensated for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Order's effective date.

9. If Licensee is a shareholder in any professional service corporation organized to engage in the practice of medicine, Licensee shall divest all financial interest in the professional services corporation, in accordance with New York Business Corporation Law. Such divestiture shall occur within 90 days. If Licensee is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of the Order's effective date.

10. Failure to comply with the above directives may result in a civil penalty or criminal penalties as may be authorized by governing law. Under N.Y. Educ. Law § 6512, it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when a professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, which include fines of up to $10,000 for each specification of charges of which the Licensee is found guilty, and may include revocation of a suspended license.

EXHIBIT "D"

Clinical Competency Assessment

1. Respondent shall obtain a clinical competency assessment performed by a program for such assessment as directed by the Director of OPMC. Respondent shall cause a written report of such assessment to be provided directly to the Director of OPMC.

    a. Respondent shall be responsible for all expenses related to the clinical competency assessment and shall provide to the Director of OPMC proof of full payment of all costs that may be charged. This term shall not be satisfied in the absence of actual receipt, by the Director, of such documentation.

2. Upon the completion of the clinical competency assessment (CCA) and in accordance with any recommendation of the CCA, Respondent shall identify a Preceptor, preferably a physician who is board certified in the same specialty, to be approved in writing, by the Director of OPMC. The Respondent shall cause the Preceptor to:

    a. Develop and submit to the Director of OPMC for written approval a remediation plan, which addresses the deficiencies /retraining recommendations identified in the CCA. Additionally, this proposal shall establish a timeframe for completion of the remediation program.

    b. Submit progress reports at periods identified by OPMC certifying whether the Respondent is fully participating in the personalized continuing medical education program and is making satisfactory progress towards the completion of the approved remediation plan.

    c. Report immediately to the Director of OPMC if the Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by the Respondent.

    d. At the conclusion of the program, submit to the Director of OPMC a detailed assessment of the progress made by the Respondent toward remediation of all identified deficiencies.

3. Respondent's period of actual suspension shall cease upon his compliance with paragraphs 1 and 2 (a) above, and the period of stayed suspension shall then become effective. The combined period of actual and stayed suspension shall be 36 months.

Respondent shall be solely responsible for all expenses associated with these terms, including fees, if any, for the clinical competency assessment, the personalized continuing medical education program, or to the monitoring physician.