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

IN THE MATTER

OF

ANTHONY NAPPI, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: ANTHONY NAPPI, M.D.
1402 Genesee Street
Suite 202
Utica, New York 13502

The undersigned, Wendy E. Saunders, Chief of Staff, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by ANTHONY NAPPI, M.D. the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12), that effective immediately, Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401 . The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on May 15 and 16, 2008, at 10:00 a.m., at the Wingate by Wyndham - Syracuse / Fairgrounds 6946 Winchell Rd. Warners, NY 13164, (315) 701-5000, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York

May 6, 2008

Redacted Signature

Wendy E. Saunders
Chief of Staff
State of New York Department of Health

Inquiries should be directed to:

Michael A. Hiser
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
(518) 473-4282

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name_____Date of Proceeding_____

Name of person to be admitted_____

Status of person to be admitted_____
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

_____
Signature (of licensee or licensee's attorney)

This written notice must be sent to:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

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

IN THE MATTER

OF

ANTHONY NAPPI, M.D.

STATEMENT

OF

CHARGES

ANTHONY NAPPI, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 9, 1973, by the issuance of license number 115906 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A, [patients are identified in the attached Appendix], a 31 year old female patient, at various times from on or about August 24, 2007, to September 24, 2007, at Respondent's Office at 1402 Genesee Street, Suite 202, Utica, New York, 13502 [hereafter, "Respondent's Office"]. Respondent's care of Patient A failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient A, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient A, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient A, failed to perform a physical examination of Patient A, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

(A) Respondent told the patient that he liked "pussy", or words to that effect, in the context that the patient understood to be a sexual reference.

(B) Respondent told Patient A that, if she had trouble coming up with money to pay his office visit fee, that they could "work something out", or words to that effect. Patient A interpreted this to mean sexual favors, since Respondent kept mentioning how much he "liked pussy", and he winked at her and licked his lips when he made this proposal.

(C) Respondent, during the first visit with Patient A, bragged about his connections to organized crime, mentioned sexual matters, laughed and joked and displayed excitement, followed by sadness and crying.

(D) Respondent breached patient confidentiality by putting other patients on a speaker phone when they called in and allowing Patient A and her husband to hear the calling patients discuss their medical histories.

(E) Respondent was observed and heard by Patient A telling other patient(s) "don't come here unless you have my fucking money", or words to that effect.

(F) Respondent was observed and heard by Patient A commenting on his hatred of religious or ethnic groups.

6. Respondent required Patient A, a patient whose care with Respondent was to be reimbursed by Medicaid, to pay him an additional amount of between $100 to $150 for each office visit with Respondent on or about the following dates: August 24, 2007, and September 24, 2007, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8) and/or 515.2(b)(9).

B. Respondent provided medical care to Patient B, a 29 year old female patient, on at various times from on or about August 2006 to September 2006 at Respondent's Office. Respondent's care of Patient B failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient B, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable

medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient B, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient B, failed to perform a physical examination of Patient B, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent documented that he discharged Patient B from care due to her missing 3 appointments, contrary to the Respondent's medical record.

6. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent, after being told by the patient that she had only $50 to pay him in addition to the Medicaid fee, told her she could "suck him or play around with his penis", or words to that effect.

   (B) Respondent, after the patient refused to engage in the conduct described in paragraph (A), above, then cursed at the patient, calling her "a fucking drug addict, a fucking junkie", and told her to "get out of [his] fucking office"; or words to that effect.

7. Respondent required Patient B, a patient whose care with Respondent was to be reimbursed by Medicaid, to pay him additional amounts of between $50 to $150 for each office visit with Respondent in August and September 2006, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8) and/or 515.2(b)(9).

C. Respondent provided medical care to Patient C, a 25 year old female patient, at various times from on or about October 19, 2007, to February 8, 2008, at Respondent's office. Respondent's care of Patient C failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient C, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient C, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient C, failed to perform a physical examination of Patient C, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent started or stopped the prescription of various anti-depressant medications to Patient C without adequate medical indication, and/or without documenting such indication.

6. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent took the patient's hand with his own and moved the patient's hand to the area of the Respondent's genitals.

   (B) Respondent told the patient that he had a bad back, and indicated to her that she could come in every week and give him massages.

   (C) Respondent requested that the patient manipulate his penis in exchange for a reduction in the office fee charged by Respondent.

   (D) Respondent breached patient confidentiality by seeing Patient C along with other patients in groups, and/or by putting other patients on a speaker phone when they called in and allowing the patient to hear the calling patients discuss their medical histories, without adequate consent or medical indication.

   (E) Respondent allowed and/or requested Patient C to obtain her own medical records from file cabinets where she had access to other patient's medical information.

   (F) Respondent told patients in the presence of Patient C, "bring my fucking money," or "get the fuck out of here if you don't have my money", or words to that effect.

   (G) Respondent was observed by Patient C commenting on his hatred of religious or ethnic groups.

   (H) Respondent, in the presence of Patient C and another patient and that patient's father, disclosed personal information about Patient C to the other patient and his father.

7. Respondent required Patient C, a patient whose care with Respondent was to be reimbursed by Medicaid, to pay him an additional amount of between $100 to $150 for each office visit with Respondent on or about the following dates: October 19, 2007, December 10, 2007,

January 11, 2008, January 25, 2008, and February 8, 2008, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8) and/or 515.2(b)(9).

D. Respondent provided medical care to Patient D, a 32 year old female patient, at various times from on or about September 2005 to February 2006, at Respondent's office. Respondent's care of Patient D failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient D, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient D, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient D, failed to perform a physical examination of Patient D, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent made comments of a personal sexual nature to the patient, such as mentioning his inability to get an erection.

   (B) Respondent breached patient confidentiality by seeing Patient D along with other patients in groups, and/or by putting other patients on a speaker phone when they called in and allowing the patient to hear the calling patients discuss their medical histories, without adequate consent and/or medical indication.

   (C) Respondent allowed and/or requested Patient D to obtain her own medical records from file cabinets where she had access to other patient's medical information.

6. Respondent required Patient D, a patient whose care with Respondent was being reimbursed by Medicaid, to pay him an additional amount of

between $150 in cash for her initial office visit, and an additional $100 in cash for each office visit thereafter, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8).

E. Respondent provided medical care to Patient E, a 29 year old female patient, at various times from on or about March 2006 to August 2006 at Respondent's office. Respondent's care of Patient E failed to accord with accepted standards of practice in that:

1. Respondent failed to maintain a medical record of his care and treatment of Patient E.

2. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent, at the patient's initial visit, and under the guise of performing a physical exam, fondled her breasts on two occasions, and also crept his hand toward her crotch and thigh.

   (B) Respondent breached patient confidentiality by seeing Patient E along with other patients in groups, and/or by putting other patients on a speaker phone when they called in and allowing the patient to hear the calling patients discuss their medical histories, without proper consent and/or adequate medical indication.

   (C) Respondent allowed and/or requested Patient E to obtain her own medical records from file cabinets where she had access to other patient's medical information.

3. Respondent required Patient E, a patient whose care with Respondent was being reimbursed by Medicaid, to pay him an additional amount of between $100 to $150 for several office visits with Respondent in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8).

F. Respondent provided medical care to Patient F, a 37 year old female patient, at various times from on or about October 6, 2006, to August 11, 2007, at Respondent's Office. Respondent's care of Patient F failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient F, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient F, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient F, failed to perform a physical examination of Patient F, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent increased and decreased suboxone doses without assessing the rationales for such increases or decreases, and/or without documenting the rationales.

6. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent placed his hands on Patient F's breast to "demonstrate" the way that he had touched another person's breasts.

   (B) Respondent breached patient confidentiality by seeing Patient F along with other patients in groups, and/or by putting other patients on a speaker phone when they called in and allowing the patient to hear the calling patients discuss their medical histories, without adequate consent or medical indication.

   (C) Respondent allowed and/or requested Patient F to obtain her own medical records from file cabinets where she had access to other patient's medical information, and also to obtain other patient's records at his request.

   (D) Respondent on several occasions told Patient F, "all you are is a fucking junkie", and "no fucking money, no fucking pills", or words to that effect.

7. Respondent required Patient F, a patient whose care with Respondent was to be reimbursed by Medicaid, to pay him an additional amount of between $100 to $150 for several office visits with Respondent, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8).

G. Respondent provided medical care to Patient G, a 29 year old female patient, at various times from on or about January 2006 to January 2007, at Respondent's office. Respondent's care of Patient G failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient G, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient G, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient G, failed to perform a physical examination of Patient G, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent increased and decreased suboxone doses without assessing the rationales for such increases or decreases, and/or without documenting the rationales.

6. Respondent prepared two notes of his care of Patient G for a visit of December 18, 2006, which are directly contradictory in terms of future plans for the patient's care in that one indicates a next visit for the patient in "1/07", and the other indicates "Pat. discharged. Last Rx."

H. Respondent provided medical care to Patient H, a 37 year old female patient, at various times from on or about September 2004 to February 2008 at Respondent's Office. Respondent's care of Patient H failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient H, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient H, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient H, failed to perform a physical examination of Patient H, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent started or stopped the prescription of various anti-depressant medications to Patient H without adequate medical indication, and/or without documenting such indication.

6. Respondent increased and decreased suboxone doses without assessing the rationales for such increases or decreases, and/or without documenting the rationales.

I. Respondent provided medical care to Patient I, a 26 year old female patient, at various times from on or about February 2007 and November 2007 at Respondent's office. Respondent's care of Patient I failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient I, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient I, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient I, failed to perform a physical examination of Patient I, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent failed to assess the patient and/or document an adequate assessment of the patient prior to diagnosing her with "bipolar disorder", and beginning treatment for same.

J. Respondent provided medical care to Patient J, a 38 year old female patient, at various times from on or about April 2006 to February 2008, at Respondent's office. Respondent's care of Patient J failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient J, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient J, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient J, failed to perform a physical examination of Patient J, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent increased and decreased suboxone doses without assessing the rationales for such increases or decreases, and/or without documenting the rationales.

6. Respondent documented that the patient's status on 8/3/07 and 9/14/07 was of "maintaining abstinence from all illegal and controlled substances since our last session", despite the fact that the patient was in-patient at the St. Lawrence Addiction Treatment Center as of August 7, 2007.

7. Respondent's note of his care of Patient J for a visit of February 4, 2008 repeatedly mentions that the patient is male. Patient J is female.

8. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

(A) Respondent repeatedly used profane language and racial slurs, and told the patient that all his patients were "fucking junkies", or words to that effect.

(B) Respondent often made sexual comments to or in the presence of Patient J, such as, "do you think this girl would give me a blowjob", or words to that effect.

(C) Respondent allowed and/or requested Patient J to obtain her own medical records from file cabinets where she had access to other patient's medical information, and also to obtain to copy or file other patient's medial records.

K. Respondent provided medical care to Patient K, a 27 year old female patient, on at various times from on or about November 26, 2007, to February 11, 2008 at Respondent's Office. Respondent's care of Patient K failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient K, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient K, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient K, failed to perform a physical examination of Patient K, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent's documented note for the patient's visit of Dec. 19, 2007, inconsistently notes that the patient has a normal mental status exam, and also that she shows "bi-polar" symptoms for which medication, including Seroquel, is given.

SPECIFICATION OF CHARGES

FIRST TO SEVENTH SPECIFICATIONS

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 following:

1. The facts in Paragraphs A and A.5(A), A and A.5(B), A and A.5(C), A and A.5(E), A and A.5(F), and/or A and A.6.
2. The facts in Paragraphs B and B.6(A), B and B.6(B); and/or B and B.7.
3. The facts in Paragraphs C and C.6(A), C and C.6(B), C and C.6(C), C and C.6(F), C and C.6(G), C and C.6(H) and/or C and C.7.
4. The facts in Paragraphs D and D.5(A) and/or D and D.6.
5. The facts in Paragraphs E and E.2(A) and/or E and E.3.
6. The facts in Paragraphs F and F.6(A), F and F.6(D) and/or F and F.7.
7. The facts in Paragraphs J and J.8(A), and/or J and J.8(B).

EIGHTH TO FOURTEENTH SPECIFICATIONS

WILFUL PHYSICAL AND VERBAL ABUSE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(31) by wilfully harassing, abusing, or intimidating a patient either physically or verbally, as alleged in the following:

8. The facts in Paragraphs A and A.5(A), A and A.5(B), A and A.5(C), A and A.5(E), and/or A and A.5(F).
9. The facts in Paragraphs B and B.6(A) and/or B and B.6(B).
10. The facts in Paragraphs C and C.6(A), C and C.6(B), C and C.6(C), C and C.6(F), C and C.6(G), and/or C and C.6(H).

11. The facts in Paragraphs D and D.5A.

12. The facts in Paragraphs E and E.2(A).

13. The facts in Paragraphs F and F.6(A) and/or F and F.6(D).

14. The facts in Paragraphs J and J.8(A) and/or J and J.8(B).

FIFTEENTH TO TWENTIETH 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 following:

15. The facts in Paragraphs A and A.6.

16. The facts in Paragraphs B and B.7.

17. The facts in Paragraphs C and C.7.

18. The facts in Paragraphs D and D.6.

19. The facts in Paragraphs E and E.3.

20. The facts in Paragraphs F and F.7.

TWENTY-FIRST TO THIRTY-FIRST 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 following:

21. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, and/or A and A.5(D).

22. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

23. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6(D), C and C.6(E), and/or C and C.6(H).

24. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5(B), and/or D and D.5(C) .

25. The facts in Paragraphs E and E.1, E and E.2(B) and/or E and E.2(C).

26. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6(B), and/or F and F.6(C).

27. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, and/or G and G.6.

28. The facts in Paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, and/or H and H.6.

29. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, and/or I and I.5.

30. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, and/or J and J.8(C).

31. The facts in Paragraphs K and K.1, K and K.2, K and K.3, K and K.4, and/or K and K.5.

THIRTY-SECOND TO FORTY-SECOND 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 following:

32. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, and/or A and A.5(D).

33. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

34. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6(D), C and C.6(E), and/or C and C.6(H).

35. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5(B), and/or D and D.5(C) .

36. The facts in Paragraphs E and E.1, E and E.2(B) and/or E and E.2(C).

37. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6(B), and/or F and F.6(C).

38. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, and/or G and G.6.

39. The facts in Paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, and/or H and H.6.

40. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, and/or I and I.5.

41. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, and/or J and J.8(C).

42. The facts in Paragraphs K and K.1, K and K.2, K and K.3, K and K.4, and/or K and K.5.

FORTY-THIRD 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 two or more of the following:

43. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.5(D), B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6(D), C and C.6(E), C and C.6(H), D and D.1, D and D.2, D and D.3, D and D.4, D and D.5(B) and D and D.5(C), E and E.1, E and E.2(B), E and E.2(C), F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6(B), F and F.6(C), G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8(C), K and K.1, K and K.2, K and K.3, K and K.4, and/or K and K.5.

FORTY-FOURTH 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 two or more of the following:

44. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.5(D), B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6(D), C and C.6(E), C and C.6(H), D and D.1, D and D.2, D and D.3, D and D.4, D and D.5(B) and D and D.5(C), E and E.1, E and E.2(B), E and E.2(C), F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6(B), F and F.6(C), G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8(C), K and K.1, K and K.2, K and K.3, K and K.4, and/or K and K.5.

FORTY-FIFTH SPECIFICATION

CONFIDENTIALITY

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(23) by revealing of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, as alleged in the following:

45. The facts in Paragraphs A and A.5(D), C and C.6(D), C and C.6(E), C and C.6(H), D and D.5(B), D and D.5(C), E and E.2(B), E and E.2(C), F and F.6(B), and/or F and F.6(C).

FORTY-SIXTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

46. The facts in Paragraphs A and A.1, A and A.2, B and B.1, B and B.2, B and B.5, C and C.1, C and C.2, C and C.5, D and D.1, D and D.2, E and E.1, F and F.1, F and F.2, F and F.5, G and G.1, G and G.2, G and G.5, G and G.6, H and H.1, H and H.2, H and H.5, H and H.6, I and I.1, I and I.2, I and I.5, J and J.1, J and J.2, J and J.5, J and J.6, J and J.7, K and K.1, K and K.2, and/or K and K.5.

DATE: May 6, 2008
Albany, New York

Redacted Signature

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