STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 1223?

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

February 23, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cheng-Chi Edward Chu, M.D.
774 East 149th Street
Bronx, New York 10455

Janet M. Connolly, Esq.
Goldberg & Connolly, Esqs.
G & C Building
66 North Village Avenue
Rockville Center, New York 11570

Jeffrey Armon, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower - Room 2438
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Cheng-Chi Edward Chu, M.D.

Dear Dr. Chu, Ms. Connolly and Mr. Armon:

Enclosed please find the Determination and Order (No. BPMC-93-27) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

New York State Department of Health
Office of Professional Medical Conduct
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 than be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law, §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he 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 all action 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
Corning Tower -Room 2503
Empire State Plaza
Albany, New York 12237-0030

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.

Very truly yours,

Tyrone T. Butler/nam

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

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

IN THE MATTER OF CHENG-CHI EDWARD CHU, M.D.	:	**DETERMINATION AND ORDER**

ORDER NO. BPMC-93-27

Leo Fishel, M.D., Chairperson, Sister Mary Theresa Murphy, and **Margery W. Smith, M.D.** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Marilyn S. Reader, Esq.,** duly under contract with the New York State Department of Health as an Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	September 24, 1992
Statement of Charges dated:	September 24, 1992
Pre-hearing conference:	October 16, 1992
Hearing dates:	October 22, 1992 December 3, 1992 December 4, 1992

Deliberation date: January 7, 1993

Place of Hearing: NYS Department of Health
5 Penn Plaza
New York, New York

Petitioner appeared by: Peter J. Millock, Esq.
General Counsel
NYS Department of Health
By: Jeffrey Armon, Esq.
Assistant Counsel

Respondent appeared by: Goldberg and Connolly, Esqs.
G & C Building
66 North Village Avenue
Rockville Center, New York 11570
By: Janet M. Connolly, Esq.

Motions: None

WITNESSES

For the Petitioner:

1) Herbert Porter, M.D.

For the Respondent:

1) Cheng-Chi Edward Chu, M.D., the Respondent

STATEMENT OF CHARGES

Essentially the Respondent is charged with professional misconduct by reason of:

a. Practicing medicine with negligence on more than one occasion;

b. Practicing medicine with incompetence on more than one occasion;

c. Ordering excessive tests and treatment not clinically indicated; and

d. Failing to maintain adequate and accurate records of patients.

The Statement of Charges is annexed hereto as Appendix A.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. Cheng-Chi Edward Chu, M.D., the Respondent, was duly licensed to practice medicine in New York State by the issuance on April 9, 1976 of license number 126964 by the New York State Education Department (Pet's Exs. 1 and 2 and Resp. Ex. A).

2. The Respondent currently is registered with the New York State Education Department to practice medicine through December 31, 1994 from 143-51 Roosevelt Avenue, Suite 1-C, Flushing, New York 11354 (Pet. Ex. 2).

3. In or about January 1986 through December 1989, Respondent practiced medicine at his medical offices at 843 East 149th Street, Bronx, New York, and later, at 774 East 149th Street, Bronx, New York.

4. The Respondent admits to the factual allegations set forth in the Statement of Charges, except for factual allegation B-3 which Respondent denies (T. 31-32).

5. The Respondent admits to the specified charges of

professional misconduct in that he practiced medicine with negligence on more than one occasion, practiced medicine incompetently on more than one occasion, failed to maintain sufficient and adequate patient records, and administered excessive tests to patients not clinically indicated (Tr. 10-11, 21-22 and 31-32).

6. Respondent's patients who came to his office in Bronx, New York live only a few blocks away from the office (Tr. 277).

FINDINGS OF FACT AS TO PATIENT A

1. Respondent treated Patient A on 34 occasions between November 9, 1986 and June 15, 1989. Patient A was two years old when he was first seen by Respondent (Pet. Ex. 3).

2. On November 9, 1986 patient A was brought to Respondent's office and seen by Respondent. The chief complaint was cough with sputum, fever and an epilepsy attack on the previous night (Pet. Ex. 3 and Tr. 43, 114-115).

3. Respondent failed to inquire about the cough, its duration, the specific description of the "sputum" or production from the cough, the existence and duration of any fever and other details necessary to make some kind of diagnosis (Tr. 43-44 and 138-139 and Pet. Ex. 3).

4. Respondent failed to obtain a history of the "epilepsy" attack or to obtain any history which relates to the reported seizure of a two year two month old child such as whether

the child had a sudden onset of high fever, prior history of seizures, the results of any previous diagnostic tests and any preexisting conditions (Tr. 44-47, 81, 83, 102-103, 137-139, 140-142 and 153 and Pet. Ex. 3).

5. Respondent failed throughout the period to adequately perform and note the findings of physical examinations, including the failure to specifically indicate positive and negative findings (Tr. 31-32, 81, 83, 102-103 and 118 and Pet. Ex. 3).

6. At various times throughout the period, Respondent failed to order tests which were clinically warranted such as a culture of a chronic ear problem. When tests were ordered Respondent failed to record the test results in the medical record, and failed to follow up on the results of tests or referrals to other physicians (Tr. 144-145 and 165-166 and Pet. Ex. 3).

7. In February and June, 1989, Respondent made a diagnosis of urinary tract infection in Patient A. Respondent failed to order a urinalysis. There is no record of the result of any urinalysis nor of an inability to collect a urine sample from Patient A on or about these dates. (Tr. 50-51 and 132 and Pet. Ex. 3).

CONCLUSIONS AS TO PATIENT A

1. Between November 1986 and June, 1989, at his medical offices in Bronx, New York, Respondent treated Patient A, a male child who was between the ages of two and five years old during this period, approximately 34 times.

2. Respondent failed to obtain and note an adequate pediatric history for Patient A throughout this period and in particular failed to obtain the history of epilepsy, how many times in the past seizures occurred, what medication if any has been prescribed to Patient A for epilepsy or to inquire about the course of a high fever Patient A was reported to have had.

3. Respondent's assertions that the parents of Patient A brought to his office and showed Respondent a Lifetime Health Record is not credible (Tr. 142 -144, 154-157 and 185-187 and Resp. Ex. B).

4. On numerous occasions, Respondent failed to perform and note an adequate physical examination on this patient and ambiguously reported physical findings sometimes including a diagnosis and other times subjective complaints as physical findings.

5. On November 9, 1986 Respondent failed to perform and record a sufficient neurological examination on Patient A.

6. Respondent failed to order a culture for a chronic ear infection which did not clear after treatment by Respondent from February 14, 1987 to April 12, 1988, during which time Respondent incorrectly diagnosed cellulitis.

7. Respondent throughout this period repeatedly noted a diagnosis of cellulitis which was not supported by the recorded physical findings.

8. Respondent's assertion that Respondent knew Patient A was seen by other physicians or at Lincoln Hospital concurrently

for the same complaint is not noted in Patient A's medical record and is not credible (Tr. 140-142 and Pet. Ex. 3).

9. Despite a complaint of micturition pain and a diagnosis of a urinary tract infection on February 8, 1989, Respondent failed to obtain a urine sample from patient at that time, to record an inability to collect a urine sample or to direct Patient A's parent or guardian to obtain a urine sample at home and bring the urine specimen to Respondent for analysis.

FINDINGS OF FACT AS TO PATIENT B

1. Between April 1, 1987 and March 14, 1988, patient B, went to Respondent's medical office for medical treatment fourteen times. During this time Patient B, a female, was approximately two years nine months to three years eight months old (Pet's Ex. 4 and Tr. 32).

2. On April 1, 1987 the chief complaint of Patient B, then approximately 2 years 9 months, was a contusion with hematoma of head and enuresis. The report indicates a history of no loss of consciousness (Pet's. Ex. 4 and Tr. 52).

3. On April 1, 1987 Respondent failed to obtain and note the history relating to the contusion and hematoma such as the cause of the contusion to the head, how the trauma to the child and resulting head injury occurred, how long before the office visit did the trauma to the head occur, and how the child behaved since the trauma to the head. Nor is there a history of whether the child had been toilet trained, for how long a period of time did

Patient B not wet the bed while sleeping, when did Patient B begin to urinate again while asleep and for how long was this occurring before this first visit to Respondent (Pet's. Ex. 4).

4. On April 1, 1987, Respondent failed to obtain a skull X-ray or to perform and record the results of a full neurologic examination of Patient B (Pet's. Ex. 4 and Tr. 170 and 181).

5. Further, Respondent admits that throughout the period of treating Patient B Respondent failed to obtain and note an adequate pediatric history. (Pet's. Ex. 4 and Tr. 10, 21-22, 31-32 and 40-42).

6. Respondent on April 1, 1987 diagnosed Patient B, then 2 years 9 months old, as having enuresis, which is the inability to control one's bladder while asleep. Wetting a diaper or bed during the night is a common, ordinary phenomenon for a child the age of Patient B, and enuresis is not a professionally reasonable diagnosis for a child less eight or nine years old (Tr. 53, 56 and 183-184).

7. Respondent inappropriately prescribed Tofranil to treat Patient B's diagnosed condition of enuresis. Tofranil should not be prescribed to a child under seven as it may produce cardiac complications and arrhythmias (Tr. 54). Respondent indicates Tofranil is contraindicated for children less than six years old (Tr. 183-184).

8. Respondent took no preliminary tests to determine if the patient could tolerate the medication and took no action to follow Patient B and monitor the patient's reaction to the

medication (Tr. 54-55).

9. On the initial visit, Respondent recorded Patient B's weight as 20 pounds, her length as 23 inches (Pet's. Ex. 4). These measurements indicate a significantly underdeveloped child for her age (Resp. Ex. B). Respondent took no action to further investigate the causes of such underdevelopment (Tr. 178). Respondent fails to recognize Patient B's somatic retardation for a two and a half year old girl (Tr. 178-179).

10. Between July 1987 and March 1988, Patient B made thirteen (13) visits to Respondent for medical treatment and throughout this period Respondent diagnosed Patient B as having cellulitis (Pet's. Ex. 4). Cellulitis is a soft tissue bacterial infection (Tr. 57). On all but two of these visits Respondent noted in the physical exam that Patient B's skin was "ok" (Pet. Ex.4). Respondent noted in his physical findings that Patient B had pus in her ear at each visit, which Respondent considered to be cellulitis of the external ear canal (Tr. 174). A condition of pus in the ear with an intact eardrum is not an anatomic basis for a diagnosis of cellulitis (Tr. 88).

11. Respondent throughout this period incorrectly noted and diagnosed an eczema of the ear or external otitis as cellulitis (Tr. 86-88 and Pet's. Ex. 4).

CONCLUSIONS AS TO PATIENT B

1. Between April 1987 and March 1988 Respondent treated Patient B, a female child born in 1984, a total of fifteen times.

2. Throughout this period, Respondent failed to obtain and note an adequate pediatric history. Respondent's assertions that the parents of Patient B brought to his office and showed Respondent a Lifetime Health Record is not credible (Tr. 142 -144, 154-157 and Resp's. Ex. B). Specifically on April 1, 1987, Respondent failed to obtain and note an adequate history for the contusion and hematoma to Patient B's head and the complaint of Patient B urinating while asleep.

3. Respondent on April 1, 1987 noted a head injury and failed to order a skull X-ray or to perform and record a complete neurologic examination. Moreover, Respondent's assertion that he now recalls Patient B's mother told him Patient B fell off the bed, a fact Respondent on April 1, 1987 did not record in the history portion of Patient B's medical record, is not credible (Tr. 180-181).

4. Respondent throughout this period repeatedly noted a diagnosis of cellulitis which was not supported by the recorded physical findings.

FINDINGS OF FACT AS TO PATIENT C

1. Respondent treated Patient C on 11 occasions between April 30, 1987 and April 29, 1989. At the time of the initial visit to Respondent, Patient C was five years old (Pet. Ex. 5).

2. On April 30, 1987, Respondent diagnosed Patient C as having gastritis based upon a complaint of vomiting (Pet. Ex.5 and Tr. 65).

3. Between April 1987 and April 1989, Respondent failed to obtain and note an adequate pediatric history. (Tr. 10, 21-22, 31-33, 40-42, 102-103, 61-61 and 200 and Pet. Ex. 5). There is no continuing record of height and weight, or comparison to the growth charts. There is no record of immunization. There is an inadequate record of family history, disease and of the patient's past medical history (Pet Ex. 5).

4. Specifically on April 30, 1987, Respondent failed to obtain and note the course of the chief complaint: when did vomiting begin, frequency of vomiting, how long had Patient C had a fever, how high had it gone, any complaints of pain or tenderness in abdomen or elsewhere, when did cough commence and was anything coughed up (Pet. Ex. 5).

5. Respondent failed throughout the period to perform and note adequate physical examinations on Patient C, including the failure to specifically indicate positive and negative findings (Tr. 10, 21-22, 31-32, 81, 83, 102-103 and 118 and Pet. Ex. 5).

6. Throughout the course of treating Patient C, Respondent diagnosed Patient C as having a backache (Pet. Ex. 5). To determine the cause of Patient C's backache a physician would palpate the back muscles, observe whether Patient C has any localized areas of tenderness, a change in the normal curvature of the spine, is limping or has bent posture (Tr. 90), and note if there is inflammation which is hot, painful and/or swollen (Tr. 232). Respondent, however, failed to perform and note any of these steps in his physical examination of Patient C to determine

the cause of the back pain (Pet. Ex. 5).

7. Specifically on April 30, 1987 Respondent failed to perform and note an adequate physical examination to support a diagnosis of gastritis and failed to perform a physical examination and note the specific positive and negative findings necessary to determine whether Patient C was dehydrated (Tr. 62-64 and Pet. Ex. 5). A person experiencing a great deal of vomiting could become dehydrated (Tr. 63). A physician would check the condition of a patient's skin for elasticity, eyes for softness and mouth for dryness to determine if a patient was dehydrated (Tr. 64). The Respondent noted on the medical record that Patient C's mouth, eye and skin as "ok" (Pet. Ex. 5), but Respondent failed to examine these organs and adequately record the results to rule out dehydration (Pet. Ex. 5 and Tr. 62-64).

8. On April 30, 1987 and April 29, 1989, respondent performed an electrocardiogram on Patient C (Pet. Ex. 5 and Tr. 204-205).

9. On April 30, 1987, Respondent ordered an electrocardiogram because the patient had been vomiting to determine if there was an electrolyte imbalance (Tr. 204). A physician generally would obtain a blood test for electrolyte levels to first determine whether there is an electrolyte imbalance (Tr. 65-66). If there was a significant change in the blood level of potassium, then a physician might order an electrocardiogram (65-66). Respondent did not obtain a blood test for electrolyte analysis (Pet. Ex. 5 and Tr. 211). A physician cannot determine

that a patient has an electrolyte imbalance by clinical observation (Tr.211-213). Respondent performed the electrocardiogram on Patient C on April 30, 1987 when such a test was not warranted by Patient C's condition (Pet. Ex. 5 and Tr. 65-66 and 223-231).

10. On April 29, 1989, Respondent performed an electrocardiogram on Patient C to check whether there was any cardiac involvement from a positive strep throat two years before (Tr. 205). During the period from April 30, 1987 to April 29, 1989, Patient C had not exhibited any symptoms or relate any history that made Respondent believe Patient C was suffering from rheumatic fever or other cardiac conditions (Tr. 213 and 220). Respondent performed the electrocardiogram on April 30, 1989 based only on a positive strep culture two years earlier, although during this two year period Patient C showed no other history or symptoms of cardiac problems (Tr. 221).

11. On April 30, 1987 and April 29, 1989, Respondent performed a pulmonary function test with spirometer and bronchodilator on Patient C (Pet Ex. 5 and Tr. 201). Respondent performed the pulmonary function test on April 30, 1987 to confirm a tentative diagnosis of bronchitis (Tr. 20[illegible]); he performed the test on April 29, 1989 as a follow-up of the lung function two years before (Tr. 202).

12. Respondent performed the April 30, 1987 pulmonary function test at a time when Patient C had an acute bronchitis (Tr. 221). Pulmonary function tests with spirometer and bronchodilator should not be done on very young patients (Tr. 82). A child with

acute bronchitis does not require a pulmonary function test; the pulmonary function test would be invalid for a patient with acute bronchitis since a patient such as Patient C, who is coughing and having trouble breathing, is not going to produce a valid test, even if the patient were an adult (Tr. 82).

13. Throughout the period Respondent treated Patient C, Respondent repeatedly diagnosed Patient C as having cellulitis and backache or lumbago (Pet 5). On all these occasions Respondent recorded the skin as "ok" (Pet. Ex. 5). Throughout the period Respondent failed to perform or note any laboratory or diagnostic tests, including taking an X-ray (Tr. 232), to try to determine the source of the backache, nor did Respondent note any referral to a specialist for symptoms which persisted for two years (Pet. Ex. 5).

14. Throughout the period of two years, Respondent recorded in Patient C's medical record: "ear - pus" (Pet. Ex. 5). Respondent diagnosed the pus in the ear as cellulitis (Tr. 209). Pus in the ear with an intact eardrum is not cellulitis (Tr.88) and treatment for an external otitis is different than treatment for cellulitis (Tr. 88). Respondent failed to perform or note any laboratory or diagnostic tests to determine the cause of this chronic condition and failed to refer Patient C to an otolaryngologist (Pet. Ex. 5 and Tr. 83).

CONCLUSIONS AS TO PATIENT C

1. Between April 30, 1987 and April 29, 1989, Respondent treated Patient C, then between the ages of five years and seven

months old, eleven times.

2. Throughout the period, Respondent failed to obtain and note an adequate pediatric history of Patient C, as well as failed to obtain and note an adequate history for specific complaints. There is no continuing record for weight and height growth, an inadequate record of family history and patient C's own medical and immunization history.

3. Throughout the period, Respondent failed to perform and note an adequate physical examination on Patient C, and specifically failed to perform an adequate physical examination to determine the causes of the chronic backache, to rule out dehydration when Patient C was complaining of vomiting and to diagnose gastritis.

4. Respondent at various times during this period inappropriately performed pulmonary function tests and electrocardiograms on Patient C without medical justification.

5. Throughout this period, Respondent failed to order, perform or note appropriate laboratory and diagnostic tests on Patient C to diagnose bronchitis and determine the causes of his chronic backache and cellulitis. On April 30, 1987, when Respondent suspected electrolyte imbalance in Patient C as a result of vomiting, Respondent failed to order a blood test for electrolytes. Despite a complaint of backache for a term of two years, Respondent failed to order an X-ray of the spine or refer Patient C to a specialist.

FINDINGS OF FACT AS TO PATIENT D

1. Between October 24, 1988 and August 22, 1989, Respondent treated Patient D, a female adolescent born in 1976, twelve times at his medical offices in Bronx, New York (Pet. Ex. 6 and Tr. 233).

2. Respondent throughout the period he treated Patient D failed to obtain and note an adequate pediatric history (Tr. 10, 21-22, 30-31, 73-74 and Pet. Ex. 6).

3. Respondent admits that throughout the period he treated Patient D, Respondent failed to perform and note an adequate physical examination (Tr. 10, 21-22, 30-31 and Pet. Ex. 6).

4. On April 28, 1989 Respondent diagnosed Patient D, who then was thirteen years old, as having pelvic inflammatory disease (Pet. Ex. 6). Pelvic inflammatory disease generally refers to a venereal disease and a rectal examination and at least a visual inspection of the patient's external genitalia is very important (Tr.73).

5. On April 28, 1989, Respondent failed to inquire and record any history as to whether Patient D is sexually active or not and whether Patient D has been subjected to sexual abuse (Tr. 73-74 and Pet. Ex. 6).

6. On April 28, 1989, Respondent failed to perform a rectal examination and at least visually inspect Patient D's external genitalia on April 28, 1989 (Tr. 73-74).

7. Although Patient D exhibited no symptoms of an

ectopic pregnancy on April 28, 1989 (Tr. 252), Respondent ordered an echogram of the pelvis to determine if the patient had an ectopic pregnancy (Tr. 246, 251). Respondent did not order a pregnancy test (Pet. Ex. 6). The medical record fails to indicate whether Respondent referred Patient D to a gynecologist (Pet. Ex. 6).

8. On April 28, 1989, Respondent failed to perform an adequate physical examination to rule out appendicitis (Tr. 74, 252).

9. On November 28, 1988, Respondent diagnosed Patient D as having gastritis based on a complaint of epigastric pain with nausea. (Pet. Ex. 6) Although it is not recorded in the medical record Respondent asserts his diagnosis specifically was allergic gastroenteritis (Tr. 237). Either Respondent failed to perform an adequate physical examination to determine tenderness of the abdomen on November 28, 1988 when Patient D complained of epigastric pain or he recorded a physical finding of no tenderness to the abdomen which would be inconsistent with the diagnosis gastritis (Tr. 70-72).

10. On November 28, 1988, Respondent prescribed treatment with an anti-inflammatory steroid, Kenalog, 10 milligrams injection (Pet. Ex. 6 and Tr. 241-4). There is no valid medical reason to give an injection of Kenalog to a person with gastritis (Tr. 72).

11. On November 14, 1988, Respondent diagnosed Patient D as having a urinary tract infection (Pet. Ex. 6). There is

nothing noted in history or physical findings to support a finding of urinary tract infection (Tr. 69). A urinalysis and culture would be a necessary test to diagnose urinary tract infection and on the medical record under laboratory request there is no such requisition (Tr. 69). The record fails to indicate Respondent was unable to obtain a urine specimen from Patient D that day. Nor did Respondent record that he advised Patient D to bring a urine specimen back to Respondent after obtaining one at home. (Pet. Ex. 6).

CONCLUSIONS AS TO PATIENT D

1. Between October 1988 and August 1989, Respondent treated Patient D, a female adolescent born in 1976, twelve times at his medical offices at his medical offices in Bronx, New York.

2. Respondent failed throughout the period to obtain and note an adequate pediatric and medical history of Patient D. Specifically in relation to Respondent's treatment of Patient D on April 28, 1989, Respondent failed to inquire and record in history whether Patient D is sexually active or not and whether she has been subjected to sexual abuse.

3. Respondent failed throughout the period to perform and note an adequate physical examination on Patient D for her complaints at various times of epigastric pain and abdominal pain. In November 1988, Respondent prescribed an injection of Kenalog, an anti-inflammatory steroid, which was not clinically warranted.

4. Respondent diagnosed Patient D on April 28, 1989 as

having pelvic inflammatory disease and Respondent failed to perform and note an adequate physical examination to support this diagnosis. Respondent ordered an echogram to rule out ectopic pregnancy; this echogram was not warranted by the clinical findings.

5. Respondent diagnosed Patient D as having urinary tract infection on November 14, 1988 and failed to conduct an urologic examination or to obtain a urine sample for culture.

FINDINGS OF FACT AS TO PATIENT E

1. Between June 26, 1988 and August 21, 1989, Respondent treated Patient E, a female child who was five years ten months old at the initial visit, ten (10) times at his medical offices in Bronx, New York (Pet Ex. 7).

2. Respondent, throughout the period he treated Patient E, failed to obtain and note an adequate pediatric history (Tr. 10, 21-22, 32, 80-81 and Pet. Ex. 7). There is no continuing record of height and weight, or comparison to the growth charts. There is no record of immunization. There is an inadequate record of family history and disease and of the patient's past medical history (Pet Ex. 7).

3. Throughout the period he treated Patient E, Respondent failed to perform and note an adequate physical examination (Tr. 10, 21-22, 32, 80-81 and Pet. Ex. 7).

4. On August 8, 1988, the Respondent diagnosed Patient E as having otitis externa of the left ear for which Respondent

prescribed an unspecified ear wash and oral antibiotic (Pet. Ex. 7 and Tr. 75-77 and 265-266). Oral antibiotics are not useful in the treatment of otitis externa commonly called swimmer's ear (Tr.76). Otitis externa is a condition of the ear canal and the ear canal has to be properly treated (Tr.76). Eardrops, such as Vosol or other preparations which are effective for otitis external, are instilled into the ear along with a wick extending into the canal, and this is kept moistened with the solution and is changed once or twice daily, until the inflammation completely subsides (Tr.76-77 and 79-80). Nor did Respondent refer Patient E to an otolaryngologist (Pet. Ex. 7).

5. Between August 1988 and August 1989, Respondent at seven out of nine visits noted Patient E's left ear was infected or had pus in it (Pet. Ex. 7). Although the condition persisted without responding to the drops Respondent put in, Respondent failed to cbtain a culture to establish a cause for the infection (Tr. 275-276). Commonly swimmer's ear is caused by a fungus infection or certain bacteria and obtaining a culture is appropriate medical procedure (Tr.80).

6. On October 11, 1988, Respondent diagnosed Patient E as having a urinary tract infection based upon a chief complaint of frequency of urination (Pet. Ex. 7) Respondent prescribed antibiotics for the patient without first performing a urine culture (Tr. 268 and 272-273 and Pet. Ex. 7). It is preferable to obtain a urine culture prior to treatment with antibiotics (Tr. 268).

CONCLUSIONS AS TO PATIENT E

1. Respondent treated Patient E between June 25, 1988 and August 21, 1989 for ten visits at his medical offices in Bronx, New York.

2. Throughout this period Respondent failed to obtain and record an adequate pediatric history of Patient E. There is no continuing record of height and weight, or comparison to the growth charts. There is no record of immunization. There is an inadequate record of family history and disease and of the patient's past medical history.

3. Throughout this period, Respondent failed to perform and record an adequate physical examination on Patient E.

4. Throughout this period, Respondent for more than one year noted Patient E continued to suffer a left ear infection. Although Respondent's course of treatment did not resolve the ear infection, Respondent failed to prescribe the proper treatment, failed to obtain a culture of secretions from the ear and failed to refer Patient E to an otolaryngologist.

5. On October 11, 1988 Respondent diagnosed Patient E as having a urinary tract infection. Respondent, contrary to proper medical procedure, prescribed antibiotics to Patient E without first obtaining the results of a urine culture.

FINDINGS OF FACT AS TO PATIENT F

1. Respondent treated Patient F three times between October 29, 1988 and December 20, 1988. The patient was six years

and four months of age at the first visit (Pet. Ex. 8).

2. On October 19, 1988, Respondent ordered an electrocardiogram based on a chief complaint of mild cough with no fever.

3. On October 19, 1988, Respondent based his performing an electrocardiogram on the fact that Patient E's mother had a history of German measles in her pregnancy and the patient was below the 50 percentile for somatic growth (Tr. 290-1).

4. On that date, Patient F's height was recorded as 48 inches and weight as 54 pounds at that visit (Pet. Ex. 8). Patient F's weight and height were well within normal ranges for a child of that age (Resp. Ex. B).

5. There is no indication in Respondent's medical record of Patient F that Patient F's mother had German measles during her pregnancy, nor is there any notation in the medical history or symptoms noted in physical findings to warrant an electrocardiogram (Pet. Ex. 8 and Tr. 303).

6. Throughout the period Respondent treated Patient F, Respondent failed to obtain and record an adequate pediatric history (Pet. Ex. 8 and Tr. 10, 21-22, 32 and 298-300).

7. Throughout the period Respondent treated Patient F, Respondent failed to perform and note an adequate physical examination (Pet. Ex. 8 and Tr. 10, 21-22, 32 and 289).

8. On December 20, 1988, Respondent diagnosed Patient F as having a urinary tract infection (Pet. Ex. 8). A urinalysis and culture would be a necessary test to diagnose urinary tract

infection (Tr. 69) and no urine culture was performed (Pet. Ex. 8 and Tr. 289). The record fails to indicate Respondent was unable to obtain a urine specimen from Patient F that day. Nor did Respondent record that he advised Patient F to bring a urine specimen back to Respondent after obtaining one at home. (Pet. Ex. 6).

9. On December 20, 1988, Respondent prescribed antibiotics for the patient without first performing a urine culture (Tr. 289 and Pet. Ex. 8). It is medically preferable to obtain a urine culture prior to prescribing treatment with antibiotics (Tr. 268).

CONCLUSIONS AS TO PATIENT F

1. Respondent treated Patient F three times between October 29, 1988 and December 20, 1988. At the first visit, Patient F was six years and four months of age at the first visit.

2. On October 19, 1988, Respondent ordered an electrocardiogram based on a chief complaint of mild cough with no fever, the medical record fails to show any history or symptoms to warrant such a test and ordering and performing an electrocardiogram on Patient F is medically unjustified.

3. Respondent's testimony that he was told Patient F's mother had German measle during the pregnancy, a key fact absent from Patient F's medical record, is not credible (Tr. 300-302 and Pet. Ex. 8).

4. The electrocardiogram strip annexed to Patient F's medical record has a wandering base line and a configuration of various complexes and is inadequate.

FINDINGS OF FACT AS TO PATIENT G

1. Respondent treated Patient G on two occasions between April 6, 1988 and August 21, 1989. Patient G was 5 years 11 months of age at the time of the initial visit (Pet. Ex. 9).

2. On April 6, 1988, Respondent diagnosed Patient G as having bronchitis (Pet. Ex. 9 and Tr. 314).

3. On April 6, 1988, Respondent performed a pulmonary function test with a spirometer and bronchodilator based his diagnosis of bronchitis (Tr. 316).

4. A child with acute bronchitis does not medically warrant a pulmonary function test and the test results would be invalid (Tr. 81-83 and 326-329). The pulmonary function test would be invalid for a patient with acute bronchitis since a patient such as Patient G, who is coughing and having trouble breathing, is not going to produce a valid test, even if the patient were an adult (Tr. 82 and 328-329).

5. Bronchitis is a simple enough diagnosis to make with a stethoscope in a physical examination (Tr. 81-82).

6. There is nothing in the medical record of Patient G to warrant performing a pulmonary function test on April 6, 1988.

CONCLUSIONS AS TO PATIENT G

1. Respondent treated Patient G on two occasions between April 6, 1988 and August 21, 1989. Patient G was 5 years 11 months of age at the time of the initial visit.

2. On April 6, 1988, Respondent diagnosed Patient G as having bronchitis.

3. On April 6, 1988, Respondent ordered and performed a pulmonary function test with a spirometer and bronchodilator without medical justification.

FINDINGS OF FACT AS TO PATIENT H

1. Between on or about April 27, 1988 and on or about December 7, 1988, Respondent treated Patient H at his medical offices in Bronx, New York two times. Patient H was 7 years 5 months of age at the time he was first seen by Respondent (Pet. Ex. 10).

2. On April 27, 1988, Respondent ordered and performed an electrocardiogram on Patient H based on chief complaints of productive cough, runny nose and an allergy on hands and feet (Pet. Ex. 10).

3. Respondent asserts he ordered this test based on concerns about the patient's somatic growth and because a relative had been diagnoses with a cardiac condition necessitating open heart surgery (Tr. 340-341).

4. Patient H was noted as weighing 70 pounds and being 50 inches tall (Pet. Ex. 10).

5. Respondent asserts he believes the relative with a heart condition was a cousin (Tr. 340-341 and 360). There is no record of the cousin nor his cardiac history on the medical record of Patient H, nor is the word "heart" under Family History in Patient H's medical record circled or any other indication of heart disease in the family history written (Pet. Ex. 10).

6. Patient H had no heart murmur (Tr. 360) and there is nothing in Patient H's medical history to indicate a congenital heart condition (Pet. Ex. 10).

7. On April 27, 1988 Patient H had a temperature of 100.5° Fahrenheit together with positive respiratory findings and Respondent did not prescribe antibiotics for Patient H (Pet. Ex. 10 and Tr. 357).

CONCLUSIONS AS TO PATIENT H

1. At his medical offices in Bronx, New York, Respondent treated Patient H twice between on or about April 27, 1988 and on or about December 7, 1988. Patient H was approximately 7 years 5 months old at the initial visit.

2. Patient H's medical record does not indicate any family history of cardiac disease and the physical examination of Patient H fails to suggest Patient H has any cardiac difficulties.

3. Moreover, Respondent's assertion that he now recalls Patient H's cousin had a cardiac condition which required open heart surgery, a crucial fact Respondent on April 27, 1988 did not record in the history portion of Patient H's medical record, is not

credible.

4. Furthermore, during the direct examination of Respondent, while reviewing Respondent's personal copy of Exhibit 10 which lacked a copy of the December 1988 office visit, Respondent recalled treating Patient H only one time (Tr. 338). Only after reviewing the marked Exhibit 10 which included a copy of the December 1988 did Respondent correct his testimony to indicate Patient H made two visits to his office. Respondent's assertion he now remember facts not reported in Patient H's medical record is not credible.

5. On April 27, 1988, Respondent ordered and performed an electrocardiogram on Patient H without medical justification.

VOTE OF THE HEARING COMMITTEE

THE HEARING COMMITTEE VOTES UNANIMOUSLY (3-0) AS FOLLOWS:

FIRST SPECIFICATION:
(Negligence On More Than One Occasion)

SUSTAINED AS TO PARAGRAPHS: A, A1-A4, B, B1-B5, C, C1-C4, D, D1-D5, E, E1-E4, F, F1-F4, G, G1, G3, H, H1 and H3.

NOT SUSTAINED AS TO PARAGRAPHS: B6, G2 and H2.

SECOND SPECIFICATION:
(Incompetence On More Than One Occasion)

SUSTAINED AS TO PARAGRAPHS: A, A1-A4, B, B1-B5, C, C1-C4, D, D1-D5, E, E1-E4, F, F1-F4, G, G1, G3, H, H1 and H3.

NOT SUSTAINED AS TO PARAGRAPHS: B6, G2 and H2.

THIRD THROUGH SEVENTH SPECIFICATIONS:
(Excessive Tests)

SUSTAINED AS TO PARAGRAPHS: C, C3, D, D5, F, F4, G, G3, H and H3.

EIGHTH THROUGH FIFTEENTH SPECIFICATIONS:
(Failure To Maintain Records)

SUSTAINED AS TO PARAGRAPHS: A, A1-A4, B, B1-B5, C, C1-C4, D, D1-D5, E, E1-E4, F, F1-F4, G, G1, G3, H, H1 and H3.

NOT SUSTAINED AS TO PARAGRAPHS: B6, G2 and H2.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

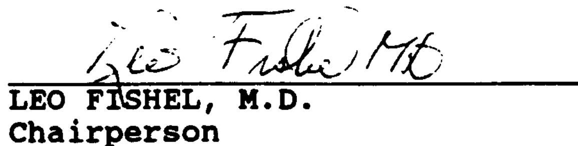
The Hearing Committee unanimously determines because of the serious nature of the charges and the cumulative occurrences of medical misconduct the Respondent's license to practice medicine in the State of New York should be **REVOKED**.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is **REVOKED**.

DATED: New York, New York
February 15, 1992



LEO FISHEL, M.D.
Chairperson

Sister Mary Theresa Murphy
Margery W. Smith, M.D.

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

IN THE MATTER OF CHENG-CHI EDWARD CHU, M.D.	NOTICE OF HEARING

TO: CHENG-CHI EDWARD CHU, M.D.
774 East 149th Street
Bronx, New York 10455

PLAINTIFF'S
DEFENDANT'S
COMPANY'S
DEPARTMENT'S
PETITIONER'S
RESPONDENT'S
EXHIBIT 1
for identification
in evidence
DATE 10/16/92 REPORTER
STERLING REPORTING SERVICE, INC.

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1992) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1992). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 22nd day of October, 1992 at 1:30 in the afternoon of that day at 5 Penn Plaza, 6th Floor, Hearing Room "C", New York City, New York and at such other adjourned dates, times and places as the committee may direct.

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. You shall appear in person at the hearing and may be represented by

counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), 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. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1992), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose

name appears below. Pursuant to Section 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.

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 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 RECOMMENDATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW Section 230-a (McKinney Supp. 1992). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
September 24, 1992

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to: Jeffrey Armon
Assistant Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Room 2429
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Telephone No.: (518) 473-4282

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

---X

IN THE MATTER OF CHENG-CHI EDWARD CHU, M.D.	: STATEMENT OF CHARGES

---X

CHENG-CHI EDWARD CHU, M.D., the Respondent, was authorized to practice medicine in New York State on April 9, 1976 by the issuance of license number 126964 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from 774 East 149th Street Bronx, New York 10455.

FACTUAL ALLEGATIONS

A. Between in or about November, 1986 and June, 1989, Respondent treated Patient A, a male child born in August, 1984, for asthma and other conditions thirty four (34) times at his medical offices at 843 East 149th Street, and later, 774 East 149th Street, Bronx, New York (all patients are identified in the Appendix).

1. Respondent failed throughout the period to obtain and note an adequate pediatric history.

2. Respondent failed throughout the period to perform and note an adequate physical examination.

3. At various times throughout this period, the Respondent diagnosed Patient A as having bronchitis, cellulitis, and conjunctivitis but failed to order, perform or note appropriate laboratory and diagnostic tests and procedures and failed to properly treat such conditions or to note such treatment, if any.

4. In or about February and June, 1989 Patient A complained of urination frequency and pain. Respondent diagnosed the patient as having a urinary tract infection, yet failed to conduct an urologic examination or obtain a culture for evaluation.

B. Between in or about April 1987, and March, 1988, Respondent treated Patient B, a female child born in 1984, for a contusion with hematoma of the head and other conditions fourteen (14) times at his medical offices at 843 East 149th Street, Bronx, New York.

1. Respondent failed throughout the period to obtain and note an adequate pediatric history.

2. Respondent failed throughout the period to perform and note an adequate physical examination.

3. In or about April, 1987, Respondent noted a head injury with hematoma yet failed to order a skull x-ray or any other neurologic exam on behalf of Patient B.

4. In or about April, 1987, Respondent treated Patient B, who was under 34 months old at that date, for enuresis and inappropriately prescribed Tofronil 10mg. for such condition.

5. In or about July, 1987, Respondent diagnosed Patient B as having influenza and cellulitis. No history or physical examination notes provide a basis for such diagnosis, for which Respondent prescribed chewable multivitamins as treatment.

6. In or about August, 1987, Respondent diagnosed Patient B as having conjunctivitis based upon a physical

examination which indicated "right eye itchy". No history or physical examination notes provide a basis for such diagnosis, for which Respondent prescribed chewable multivitamins as treatment.

C. Between in or about April, 1987, and April, 1989, Respondent treated Patient C, a male child born in 1982, for bronchitis and other conditions, eleven (11) times at his medical offices at 843 East 149th Street, Bronx, New York, and later, 774 East 149th Street, Bronx, New York.

1. Respondent failed throughout the period to obtain and note an adequate pediatric history.
2. Respondent failed throughout the period to perform and note an adequate physical examination.
3. At various times during this period, Respondent inappropriately ordered and/or performed pulmonary function, echogram and electrocardiogram tests. Respondent failed to note any condition which indicated the need for such tests and, in fact, such tests were not warranted by the condition of Patient C.
4. Throughout this period, Respondent diagnosed Patient C as having bronchitis, backache and cellulitis, yet Respondent failed to order, perform or note appropriate laboratory and diagnostic tests and procedures to alleviate these conditions.

D. Between in or about October, 1988 and August, 1989, Respondent treated Patient D, a female adolescent born in 1976, for cold symptoms and other conditions twelve (12) times at his medical offices at 843 East 149th Street, and later, 774 East 149th Street, Bronx, New York.

1. Respondent failed throughout the period to obtain and note an adequate pediatric history.

2. Respondent failed throughout the period to perform and note an adequate physical examination.

3. In or about November, 1988, Patient D complained of her frequency of urination, which Respondent diagnosed as urinary tract infection. Respondent failed to conduct an urologic examination, obtain a culture for evaluation or prescribe any treatment.

4. In or about November, 1988, Patient D complained of epigastric pain and nausea, which Respondent diagnosed as gastritis. Respondent inappropriately prescribed a steroidal anti-inflammatory medication and failed to order, perform or note appropriate laboratory and diagnostic tests and procedures.

5. In or about April, 1989, Patient D complained of vaginal discharge and abdominal pain, which Respondent diagnosed as pelvic inflammatory disease. The Respondent inappropriately ordered an echogram and failed to prescribe any treatment for either of Patient D's complaints.

E. Between in or about June, 1988 and August, 1989, Respondent treated Patient E, a female child born in 1982, for cold symptoms and other conditions ten (10) times at his medical offices at 843 East 149th Street, and later, 774 East 149th Street, Bronx, New York.

1. Respondent failed throughout the period to obtain and note an adequate pediatric history.

2. Respondent failed throughout the period to perform and note an adequate physical examination.

3. Throughout the period Respondent noted that Patient E's left ear was infected. Respondent failed to order, perform or note appropriate laboratory and diagnostic tests and procedures, failed to refer Patient E to a specialist to evaluate the condition and failed to

properly treat such condition or to note such treatment, if any.

4. In or about October, 1988, Respondent diagnosed Patient E as having a urinary tract infection, based upon a complaint of frequency of urination. Respondent failed to conduct an urologic examination or to obtain a culture and failed to properly treat such condition.

F. Between in or about October, 1988 and December, 1988, Respondent treated Patient F, a female child born in 1982, for symptoms of a cold and other conditions three (3) times at his medical offices at 843 East 149th Street, Bronx, New York.

1. Respondent failed throughout the period to obtain and note an adequate pediatric history.

2. Respondent failed throughout the period to perform and note an adequate physical examination.

3. In or about December, 1988, Respondent diagnosed Patient F as having a urinary tract infection, based upon a complaint of micturition pain. Respondent failed to conduct an urologic examination or to obtain a culture and failed to properly treat such condition.

4. In or about October, 1988, Respondent inappropriately ordered and and/or performed pulmonary function and electrocardiogram tests. Respondent failed to note any condition which indicated the need for such tests and, in fact, such tests were not warranted by the condition of Patient F.

G. In or about April 1988, Respondent treated Patient G, a female child born in 1982, for a cough and fever at his medical offices at 843 East 149th Street, Bronx, New York.

1. Respondent failed to perform and record an adequate physical examination.

2. Respondent diagnosed Patient G as having bronchitis, backache and cellulitis, yet failed to order, perform or note appropriate laboratory and diagnostic tests

and procedures. Although Patient G was diagnosed as having cellulitis, Respondent noted that her skin condition was "OK.".

3. Respondent inappropriately ordered and/or performed pulmonary function and electrocardiogram tests without recording any condition that would indicate the need for such tests and, in fact, such tests were not warranted by the condition of Patient G.

H. In or about April 1988, Respondent treated Patient H, a male child born in 1980, for an allergy and other conditions at his medical offices at 843 East 149th Street, Bronx, New York.

1. Respondent failed to perform and record an adequate physical examination.

2. Respondent diagnosed Patient H as having lumbago, cellulitis, and bronchitis, yet failed to order, perform or note appropriate laboratory and diagnostic tests and procedures. Although diagnosed as having lumbago and cellulitis, Respondent noted that the condition of Patient H's extremities, joints and skin was "OK".

3. Respondent inappropriately ordered and/or performed pulmonary function and electrocardiogram tests without recording any condition that would indicate the need for such tests and, in fact, such tests were not warranted by the condition of Patient H.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp.1992), formerly N.Y. Educ. Law Section 6509(2) (McKinney 1985), in that

Petitioner charges that Respondent committed at least two of the following:

1. The facts contained in Paragraphs A and A1-4; B and B1-6; C and C1-4; D and D1-5; E and E1-4; F and F1-4; G an G1-3 and/or H and H1-3.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1992), formerly N.Y. Educ. Law Section 6509(2) (McKinney 1985), in that Petitioner charges that Respondent committed at least two of the following:

2. The facts contained in Paragraphs A and A1-4; B and B1-6; C and C1-4; D and D1-5; E and E1-4; F and F 1-4; G and G1-3 and/or H and H1-3.

THIRD THROUGH SEVENTH SPECIFICATIONS

EXCESSIVE TESTS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(35) (McKinney Supp.1992), formerly Section 6509(9) (McKinney 1985) and 8 N.Y.C.R.R. 29.2(a)(7) (1989), in that he ordered excessive tests, treatment or use of

treatment facilities not warranted by the condition of the patient. Petitioner specifically charges:

3. The facts in Paragraphs C and C3.
4. The facts in Paragraphs D and D5.
5. The facts in Paragraphs F and F4.
6. The facts in Paragraphs G and G3.
7. The facts in Paragraphs H and H3.

EIGHTH THROUGH FIFTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6532(32) (McKinney Supp.1992), formerly Section 6509(9) (McKinney 1985) and 8 N.Y.C.R.R. 29.2(a)(3) (1989) in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient. Specifically Petitioner charges:

8. The facts in Paragraphs A and A1-4.
9. The facts in Paragraphs B and B1-6.
10. The facts in Paragraphs C and C1-4.
11. The facts in Paragraphs D and D1-5.
12. The facts in Paragraphs E and E1-4.
13. The facts in Paragraphs F and F1-4,
14. The facts in Paragraphs G and G1-3.
15. The facts in Paragraphs H and H1-3.

DATED: Albany, New York
September 24, 1992

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical
Conduct