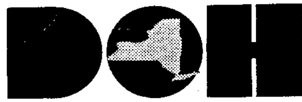


STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower   The Governor Nelson A. Rockefeller Empire State Plaza   Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

August 21, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Marcia Kaplan, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Camille Raia, Esq.
Law Office of Mark A. Longo, Esq.
26 Court Street-Suite 1700
Brooklyn, New York 11242

Mabel Cohen, M.D.
1852 East 52nd Street
Brooklyn, New York 11234

RE: In the Matter of Mabel Cohen, M.D.

Dear Ms. Kaplan, Ms. Raia and Dr. Cohen:

Enclosed please find the Determination and Order (No. 96-194) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

Office of Professional Medical Conduct
New York State Department of Health
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 then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays 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.

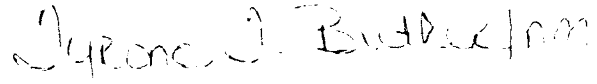
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
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.

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

MABEL COHEN, M.D.

DETERMINATION

AND

ORDER

BPMC-96- 194

CONRAD ROSENBERG, M.D., Chairperson, **RAFAEL LOPEZ, M.D.**, and **MS. EUGENIA HERBST**, 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. **ELLEN B. SIMON, ESQ.**, 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

Statement of Charges dated:	January 17, 1996
Affidavit of Service of Notice of Hearing and Statement of Charges dated:	January 23, 1996
Pre-hearing conference:	February 16, 1996
Hearing dates:	March 4, 1996 March 11, 1996 March 18, 1996 April 15, 1996 April 22, 1996 April 29, 1996 June 10, 1996

Deliberation date:		July 1, 1996
Place of hearing:		NYS Department of Health 5 Penn Plaza New York, New York
Department appeared by:	BY:	Henry M. Greenberg, General Counsel NYS Department of Health Marcia Kaplan, Esq. Associate Counsel
Respondent appeared by:	BY:	Law Office of Mark A. Longo, Esq. 26 Court Street Brooklyn, New York Camille Raia, Esq.

WITNESSES

For the Department: Richard J. Bonforte, M.D.

For the Respondent: David R. Fernandes, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with both negligence and incompetence on more than one occasion and with inaccurate recordkeeping.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to and made a part of this Determination and Order.

FINDINGS OF FACT

Numbers in parentheses refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

1. Mabel Cohen, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 16, 1977 by the issuance of license number 132173 by the New York State Education Department [Department's Exhibit (hereinafter "Dept.") 2A].

PATIENT A

2. Respondent treated Patient A, age four when first seen, at Physicians Medical Group, 4303 14th Avenue, Brooklyn, N.Y. 11219, on approximately 57 occasions from on or about January 24, 1990 through on or about August 27, 1992 and at her office at 1852 East 52nd Street, Brooklyn, N.Y. 11234, on approximately 44 occasions from on or about July 21, 1992 through on or about January 10, 1994. Patient A was treated for repeated strep throat infections and was also followed for allergies and asthma (Dept. 3A, 3B).

3. Respondent repeatedly failed to obtain or note an adequate history. After eliminating consideration of those visits that were only for allergy shots, the overwhelming majority of those remaining evidenced inadequate histories [Dept. 3A, e.g., pp. 13, 17; Dept. 3B, e.g., pp. 5, 7-8; Transcript (hereinafter "T") 30-32, 37-43].

4. Respondent repeatedly failed to perform or note an appropriate physical examination. Of the same remaining visits cited in paragraph 3 above, the majority evidenced inadequate physical examinations (Dept. 3A, e.g., pp. 13-19; Dept. 3B, e.g., pp. 5-9; T 32-33, 44-47).

5. On or about October 9, 1992, Respondent prescribed Epsom salts for Patient A as a soothing bath (T 646-647, 878); such prescription was not appropriate.

6. On or about November 2, 1992, Respondent failed to note an appropriate indication for the use of antibiotics for Patient A. The diagnosis of Patient A's asthma had already been made in the course of the patient's previous four visits, however, and the use of steroids was not inappropriate for that condition (Dept. 3A, pp. 5, 17, 18; T 380-381, 883).

7. On or about November 6, 1993, Respondent failed to provide appropriate care and treatment to Patient A as follows:

   a. Respondent failed to perform or note an adequate workup of Patient A's complaints of increased cough productive of purulent sputum, vomiting, and a temperature of 101 degrees. This child had been diagnosed with bronchitis and asthma and had been prescribed several medications, including theophylline. A reasonably prudent physician would determine whether the child was taking his medicine regularly, would perform and note an appropriate physical examination, and would evaluate and note whether or not the vomiting was associated with a concurrent infection suggested by the purulent sputum or with some underlying specific abdominal problem. In addition, a reasonably prudent physician would have ascertained and noted the cause of the patient's vomiting and would have evaluated this child for theophylline toxicity (Dept. 3A, p. 13; T 55-61, 267-268);

   b. Respondent failed to consider or rule out possible theophylline toxicity or, if she considered it, to note such evaluation and/or failed to order or perform a theophylline level. Respondent's testimony reveals her misguided understanding that the dosage of theophylline can be monitored with "a pulse, side effects or theophylline level" and that theophylline levels were not necessary in this case (Dept. 3A, p. 13; T 58-61, 66-67, 267-268, 382, 650-651, 656-657, 1251-1254);

   c. Respondent failed to ascertain the cause of Patient A's vomiting or to note it. Respondent noted only that the vomiting had been occurring for three days. She did not evaluate for, determine, or note whether the vomiting was related to excess coughing, drug overdose, a concomitant viral infection, or some other cause such as an abdominal complaint that might have co-existed with this child's asthma. She merely assumed that the reason for the vomiting was the cough (Dept. 3A, p. 13; T 61, 406);

   d. Respondent prescribed eight or more medications for Patient A, an excessive number at once, and specifically prescribed Tigan, Phenergan, Tussi-Organidim-DM, cough suppressants, and anti-emetics inappropriately. A reasonably prudent physician identifies symptoms, tries to identify their cause, and then treats specifically. A reasonably prudent physician would not prescribe multiple drugs for the same purpose, as Respondent did here, by prescribing multiple bronchodilators (Proventil and Slo-bid), multiple drugs with antitussive effects (Phenergan and Tussi-Organidim), multiple anti-emetics (Phenergan and Tigan), multiple antihistamines (Phenergan and Tigan), and Mylanta. It is inappropriate to prescribe a drug to eliminate a symptom without ruling out theophylline toxicity and abdominal pathology in the form of an obstruction or central nervous system disease, and medications to suppress the cough, another symptom of a problem. When, as here,

there is sputum, the aim is to have the sputum produced and cleared, not to suppress the cough. In addition to bronchodilators, Respondent gave medications that not only could suppress the cough but could mask the underlying pathology. Tigan was particularly inappropriate because (i) the child was already taking a medication that has some anti-emetic effects and (ii) it is a drug rarely prescribed for children and than only in situations not present in this case, e.g., to relieve intractable vomiting when its source is known [Dept. 3A, p. 13; T 61-66; cf. Respondent's claim that she doesn't believe in polypharmacy and prescribes as little medication as possible (T 1254)].

8. Respondent failed to keep an accurate record of her care and treatment of Patient A (Dept. 3A, 3B; T 66).

PATIENT B

9. Respondent treated Patient B, age two years and nine months when first seen, at Physicians Medical Group on approximately 15 occasions from on or about January 23, 1990 through on or about August 11, 1992 and at her office at 1852 East 52nd Street, Brooklyn, N.Y. 11234, on approximately 12 occasions from on or about September 28, 1982 through on or about September 20, 1993 (Dept. 4A, 4B).

10. Respondent repeatedly failed to obtain or note an adequate history (Dept. 4A, e.g., p. 15; 4B, e.g., pp. 5-6; T 30-32, 75-82).

11. Respondent repeatedly failed to perform or note an appropriate physical examination (Dept. 4A, p. 15; 4B, e.g., pp. 5-6; T 32-33, 77-82).

12. On or about September 28, 1992, Respondent failed to order, perform, or note appropriate laboratory tests, including a hematocrit and/or hemoglobin to evaluate the patient's pallor (Dept. 4A, p. 16; T 82-85, 684-686, 1061-1062).

13. Respondent failed to keep an accurate record of her care and treatment of Patient B (Dept. 3A, 3B; T. 66).

14. On or about October 23, 1992, Respondent failed to provide appropriate care and treatment to Patient B as follows:

    a. Respondent failed to ascertain or note appropriate evaluation leading to a diagnosis of "URI, strep throat" (Dept. 4A, p. 16; T 85-88);

    b. Respondent failed to order, perform, or note a throat culture (Dept. 4A, p. 16; T 87-88);

    c. Respondent failed to prescribe penicillin, but such failure was not inappropriate because Respondent knew that Patient B's mother would not administer penicillin to Patient B since she and his brother were allergic to it. Respondent appropriately prescribed Ceclor as an alternative (Dept. 4A, p. 16; 4B, p. 4; T 688).

15. There is not sufficient credible evidence in the record to reach a definitive finding as to whether Respondent's referral of Patient B to a psychiatrist on or about March 8, 1993 was appropriate. That referral may have been appropriate: Patient B had a family history of schizophrenia and dysfunctional behavior, of which Respondent was aware (T 424), and he had not been sleeping well and had had nightmares (T 414).
Respondent appropriately evaluated this child as to any possible physical abuse concerning his complaint, a few days earlier, that "his teacher hit him" (T 423-425) and then made the referral to a psychiatrist. Respondent did talk with the child's mother and learned that she had already spoken with her son's teacher and principal and had been told that there had been no such abuse. Respondent did tell the mother to advise her of any other allegations or instances of physical abuse (T 422-423, 425-426).

16. On or about June 1, 1993, Respondent noted a previous diagnosis of Patient B's chicken pox and noted his complaint that his ankle hurt. Respondent recorded that the complaint as "arthritis" but had intended instead to write "arthralgia" (Ex. 4A, p. 15; T 427, 694)

17. On or about June 1, 1993, Respondent ordered appropriate laboratory tests in order to rule out that Patient B had infectious mononucleosis (Dept. 4A, pp. 10, 15; T 428, lines 19-24).

18. On or about June 1, 1993, Respondent ruled out arthritis. She noted that Patient B had a sore throat and prescribed Ceclor for it. That prescription was not inappropriate (Dept. 4A, p. 15; T 426-427).

19. On or about June 11, 1993, Respondent failed to order, perform, or note a urinalysis (Dept. 4A, p. 15; T 99-101). As Respondent had prescribed Ceclor for Patient B on June 1, 1993 [see paragraph 18 above], the results of a urine culture ordered on June 11 would not necessarily have been reliable because the antibiotic might have masked an infection (T 299).

20. On or about September 3, 1993, Respondent failed to provide appropriate care and treatment to Patient B as follows:

    a. Respondent failed to ascertain or note a chief complaint (Dept. 4A, p. 14; T 101-102);

    b. Respondent failed to perform or note appropriate evaluation, complaint, or findings leading to a diagnosis of "URI and strep throat" (Dept. 4A, p. 14; T 102-103);

    c. Respondent failed to order, perform, or note a throat culture (Dept. 4A, p. 14; T 103).

21. Respondent's September 3, 1993 prescription of an antibiotic for Patient B was not inappropriate. Respondent had diagnosed a strep throat, and because Respondent knew that Patient B's mother and brother were allergic to penicillin and that the mother would not give plain penicillin to her children even if it were prescribed, she prescribed amoxycillin instead (T 422, lines 6-18, 688).

22. On or about September 20, 1993, Respondent noted that Patient B "needs lead" and noted "lead (next time)" but did not inappropriately defer a lead test. The test was required only to complete a school form and not otherwise, because the child was then six-and-a-half and the New York City Department of Health does not require that children be tested for lead after age six (Dept. 4A, p. 14; T 433-434, 919-921).

23. Respondent failed to keep an accurate record of her care and treatment of Patient B (Dept. 4A, 4B; T 105-107).

PATIENT C

24. Respondent treated Patient C, age eight when first seen, at her office at 1852 East 52nd Street, Brooklyn, N.Y. 11234, from on or about July 19, 1993 through on or about February 3, 1994 (Dept. 5).

25. Respondent repeatedly failed to obtain or note an adequate history (Dept. 5, e.g., pp. 4-5; T 30-32, 108-112).

26. Respondent repeatedly failed to perform or note an appropriate physical examination (Dept. 5, e.g., pp. 4-5; T 32-33, 108-112).

27. On or about August 23, 1993, Respondent provided appropriate care and treatment to Patient C by referring her to a podiatrist as a follow-up for adjustment of orthotics that had previously been prescribed for her (Dept. 5, p. 5; T 456-457).

28. On or about August 23, 1993, Respondent apparently identified Patient C's behavior problem appropriately and referred the child to a psychiatrist, as evidenced by subsequent chart notations of psychiatric care and therapy with Ritalin, but failed on that date adequately to note the fact of or her reasons for such referral (Dept. 5, pp. 3-8; T 927-930).

29. Respondent failed to keep an accurate record of her care and treatment of Patient C (Dept. 5, pp. 4-5; T 115-116).

PATIENT D

30. Respondent treated Patient D, age 17 when seen, at her office at 1852 East 52nd Street, Brooklyn, N.Y. 11234, from on or about July 21, 1993 through on or about December 20, 1993 (Dept. 6).

31. Respondent failed to obtain or note an adequate history (Dept. 6; T 30-32, 126-131).

32. Respondent repeatedly failed to perform or note an appropriate physical examination (Dept. 6, e.g., p. 4; T 32-33, 127, 131-133).

33. On or about July 21, 1993, Respondent failed to provide appropriate care and treatment for Patient D's ear problem as follows:

    a. Respondent failed to note which ear had a greenish discharge (Dept. 6, p. 4; T 127, 133);

    b. Respondent failed to order or perform a culture of the drainage or to gram stain the discharge to identify the specific organism and failed to note such testing (Dept. 6, p. 4; T 133-136).

34. For Patient D's ear infection at his July 21, 1993 visit, Augmentin happened to be an appropriate prescription, but Respondent failed to order suitable tests to establish its appropriateness (Dept. 6, p. 4; T 469-470).

35. On or about July 21, 1993, Respondent failed to perform or note an appropriate physical examination of Patient D and/or failed to rule out the presence of lymphadenopathy or sinus infection or any other systemic findings, or to note such evaluation (Dept. 6, p. 4; T 137-139).

36. Respondent performed an appropriate evaluation but failed to follow up on a positive PPD in Patient D in or about August 1993, especially in view of Respondent's knowledge of a positive PPD in the patient's sister, Patient C (Dept. 5, p. 5, entry of 7-19-93; Dept. 6, p. 4; T 471-475).

Patient D had no history of high-risk behavior; Respondent's failure to order an HIV test was reasonable and thus not inappropriate (T 475-477).

37. Respondent failed to keep an accurate record of her care and treatment of Patient D (Dept. 6; T 126-145).

PATIENT E

38. Respondent treated Patient E, age 13 months when first seen, at Physicians Medical Group on approximately 16 occasions from on or about March 27, 1991 through on or about June 11, 1992 and at her office at 1852 East 52nd Street, Brooklyn, New York 11234, on approximately 14 occasions from on or about December 14, 1992 through on or about November 22, 1993 (Dept. 7A, 7B).

39. Respondent repeatedly failed to obtain or note an adequate history (Dept. 7A, e.g., pp. 4-5; Dept. 7B, e.g., pp. 6, 8; T 30-32, 146-150).

40. On or about January 17, 1992 and on or about December 14, 1992, Respondent repeatedly prescribed Ceclor inappropriately and/or failed to prescribe appropriate medication, i.e., Penicillin V, in connection with the diagnosis of strep throat or failed to establish or note appropriate basis for prescribing a medication other than Penicillin V (Dept. 7A, p. 5; Dept 7B, p. 9; T 150-151).

41. On or about December 28, 1992, Respondent diagnosed that Patient E had acute tonsillitis and mild serous otitis; she also noted a positive throat culture (Dept. 7A, p. 5). Although it is not the drug of choice, Respondent's prescription of Duricef is appropriate for a positive throat culture with an ear infection, especially since Patient E's mother would not give her children plain penicillin (T. 150-151, 486-488).

42. Respondent failed to evaluate Patient E's heart murmur appropriately after it was first identified on or about March 8, 1993 and/or failed to refer Patient E in a timely manner to a cardiologist. Respondent made no such referral until November 20, 1994, a year and a half later, despite subsequent notes of the murmur on June 25 and October 13, 1993 (Dept. 7A, pp. 4, 6; T 154-158, 327-328, 1269).

43. Respondent failed to keep an accurate record of her care and treatment of Patient E (Dept. 7A; T 145-159).

PATIENT F

44. Respondent treated Patient F, age one month when first seen, at Physicians Medical Group on approximately 28 occasions from on or about August 17, 1990 through on or about July 30, 1992 and at her office at 1852 East 52nd Street, Brooklyn, New York 11234, on approximately 9 occasions from on or about September 25, 1992 through on or about December 29, 1993 (Dept. 8A, 8B).

45. Respondent repeatedly failed to perform or note an appropriate physical examination (Dept. 8A, e.g., pp. 4-5; Dept 8B, p. 5; T 32-33, 160-163).

46. Respondent repeatedly prescribed Ceclor inappropriately because Patient F failed to respond to it after a reasonable time and Respondent failed to establish the source of her reinfection (Dept. 8A, p.5; Dept. 8B, pp. 5-6, 9-13; T 163-164, 1270-1271).

47. On or about December 13, 1993, Respondent prescribed Herbalife powder as a "vitamin complement and to improve the Patient's appetite" (Dept. 8A, p.5; T 102) and not as treatment for URI or strep throat. Such prescription was not inappropriate.

48. Respondent failed to keep an accurate record of her care and treatment of Patient F (Dept. 8A; Dept. 8B; T 32-33, 159-166).

PATIENT G

49. Respondent treated Patient G, age seven when first seen, at her office at 1852 East 52nd Street, Brooklyn, New York 11234, on or about January 29, 1993 and on or about December 11, 1993 (Dept. 9).

50. On or about January 29, 1993, Respondent failed to provide appropriate care and treatment to Patient G as follows:

a. Respondent failed to evaluate Patient G appropriately or to note such evaluation and/or follow-up for possible meningitis (Dept. 9, p. 4; T 108-109, 167-172, 313).

b. A CBC was unnecessary in this case. Patient G did not in fact have meningitis, but even if she had had it, the appropriate treatment would have been to admit the child to a hospital for a spinal tap instead of waiting for the results of a CBC (Dept. 9, p. 4; T 313, lines 18-22, 970, lines 2-12).

51. Respondent failed to keep an accurate record of her care and treatment of Patient G (Dept. 9).

PATIENT H

52. Respondent treated Patient H, age two-and-a-half when first seen, at Physicians Medical Group on approximately 45 occasions from on or about May 3, 1983 through on or about April 28, 1991 and at her office at 1852 East 52nd Street, Brooklyn, New York 11234, from on or about February 5, 1993 through on or about September 8, 1993 (Dept. 10A, 10B).

53. Respondent repeatedly failed to obtain or note an appropriate history (Dept. 10A, e.g., p. 4; Dept. 10B, e.g., pp. 3, 4, 6, 9, 10; T 30-32, 172-175).

54. Respondent repeatedly failed to perform or note an appropriate physical examination (Dept. 10A, e.g., p. 4; Dept. 10B, e.g., pp. 3-6, 8, 10, 11; T 32-33, 174-175).

55. On or about February 5, 1993, Respondent failed to provide appropriate care and treatment to Patient H as follows:

a. Respondent failed to obtain or note an appropriate chief complaint. She recorded only a diagnosis of bronchitis and strep throat (Dept. 10A, p. 4; T. 175-176);

b. Respondent failed to order, perform, or note a throat culture despite her diagnosis of bronchitis and strep throat (Dept. 10A, p. 4; T 175-176).

56. On or about March 23, 1993, Respondent failed to provide appropriate care and treatment to Patient H as follows:

a. Respondent failed to evaluate and/or diagnose Patient H appropriately for complaints of abdominal pain, and vomiting and dizziness with abdominal pains, or to note such evaluation and/or diagnosis (Dept. 10A, p. 4; T 176-179);

b. Respondent inappropriately prescribed Phenergan for vomiting and/or failed to render appropriate treatment because she did not first exclude conditions such as a surgical abdomen (Dept. 10, p. 4; T 179-180).

57. On or about September 8, 1993, Respondent failed to render appropriate care and treatment as follows:

a. Respondent failed to obtain, perform, or note appropriate evaluation, history, physical examination, and/or findings leading to her diagnosis of "chronic diarrhea" (Dept. 10A, p. 4; T 1144-1147);

b. Respondent failed to arrange for or note appropriate follow-up of Patient H's symptoms or of laboratory tests ordered on September 8, 1993; there was no follow-up visit after that date (Dept. 10A, p. 4; T 183).

58. Respondent failed to keep an accurate record of her care and treatment of Patient H (Dept. 10A, 10 B; T 172-184).

PATIENT I

59. Respondent treated Patient I, age 18 months when first seen, at her office at 1852 East 52nd Street, Brooklyn, New York 11234, on approximately nine occasions from on or about February 9, 1993 through on or about September 21, 1993 (Dept. 11).

60. Respondent failed to give Patient I his first immunizations in a timely manner or to note appropriately Patient I's immunization history (Dept. 11, pp. 3, 10; T 184-187).

61. On or about February 9, 1993, Respondent failed to provide appropriate care and treatment to Patient I because Respondent failed to obtain or note an appropriate history of Patient I's chief complaint of constipation (Dept. 11, p. 10; T 187-190, 318).

62. In connection with Respondent's notation on February 9, 1993 that Patient I was pale, Respondent reviewed the child's diet with his grandmother and recorded that except for some ear and throat congestion, her physical examination of the child revealed that everything else was within normal limits. Respondent ordered blood tests which included a complete blood count. Although there were two intervening office visits on February 23, and May 4, 1993, Patient I was apparently not taken to have those blood tests until May 5, following the office visit on the preceding day. On May 10 1993, apparently after she had received the laboratory test reports, Respondent again, by telephone, reviewed the child's diet with his grandmother. Respondent then saw him in her office once more on May 12th, at which time she prescribed multivitamins and iron. Respondent's care and treatment of Patient I with respect to his pallor and anemia was appropriate. (Dept. 11, pp. 4-6, 10; T 548, 550-553).

63. Overall, Respondent failed to keep an accurate record of her care and treatment of Patient I (Dept. 11; T 184-192).

PATIENT J

64. Respondent treated Patient J, age two-and-a-half when first seen, at Physicians Medical Group on approximately 105 occasions from on or about April 11, 1988 through on or about August 5, 1992 and at her office at 1852 East 52nd Street, Brooklyn, New York 11234, on approximately 11 occasions from on or about September 14, 1992 through on or about December 22, 1993. Approximately 35 of those occasions were for strep throat (Dept. 12A, 12B).

65. Respondent repeatedly failed to obtain, perform, or note appropriate evaluation, history, physical examination, findings, and treatment in connection with her diagnosis of strep throat and prescribed multiple antibiotics inappropriately (Dept. 12B, p. 8; T 30-33, 193-198).

66. On or about July 25, 1988, Respondent prescribed "touch therapy" for Patient J as an adjunct, not an alternative, to other treatment. Such prescription was not inappropriate (Dept. 12B, p. 8; T 199, lines 12-19).

67. On or about February 2, 1993, Respondent failed to obtain, perform, or note appropriate evaluation, history, physical examination, and/or findings in connection with the complaint of abdominal pain (Dept. 12A, p. 9; T 201-204, 331-332, 556).

68. On May 12, 1993, Respondent noted a referral for tympanometry and hearing tests; no results of tests based upon such referral are in evidence. Respondent failed to perform or note appropriate follow-up concerning those tests and did not refer Patient J to a hearing specialist (Dept. 12A, p. 9).

69. Respondent failed to obtain or note the results of the PPD ordered on May 12, 1993 and/or failed to perform or note appropriate follow-up based upon the results of that test (Dept. 12A, p. 9; T 193-207).

70. Respondent failed to keep an accurate record of her care and treatment of Patient J (Dept. 12A, 12B; T 193-207).

PATIENT K

71. Respondent treated Patient K, age three weeks when first seen, on or about June 29, 1993 and on or about December 11, 1993 (Dept. 13).

72. Respondent failed to obtain or note an adequate history and to perform or note an adequate physical examination on December 11, 1993; both the history and the physical examination recorded for the visit of June 29, 1993 were adequate (Dept. 13, p. 4; T 30-33).

73. Respondent failed to give Patient K his first immunizations in a timely manner. However, when Patient K was first seen by Respondent, he was only three weeks old and therefore too young for his first immunizations. Respondent testified that between then and the child's second visit, by which time he was already six months old, she had telephoned the child's mother to advise that he be immunized, but without success. Respondent further testified that despite subsequent such calls, the last as recently as the week preceding her testimony, as far as she knew the child had still not been vaccinated (Dept. 13, p. 4; T 211-212, 831, 833). That Patient K was not given his first immunizations on time was not the fault of Respondent.

74. On or about December 11, 1993, Respondent inadvertently recorded "acute tonsillitis" when she intended to record "acute pharyngitis" as her diagnosis. Respondent observed that the child had a red, congested throat, and she had been told that his mother was herself being treated for an upper respiratory infection with a strep throat. Respondent's prescription of amoxycillin under those circumstances was not inappropriate (Dept. 13, p. 4; T 581, lines 6-15, 1015-1016).

75. On or about December 11, 1993, Respondent failed to perform or note appropriate evaluation or findings relating to her notation of "r/o anemia" and/or failed to determine or note whether the patient fell within a high-risk group for sickle cell anemia and, if he was in such a high-risk group, failed to order, perform, or note a sickle cell prep and/or failed to follow-up appropriately (Dept. 13, p. 4; T 216-218).

76. Respondent failed to keep an accurate record of her care and treatment of Patient K (Dept. 13; T 30-33, 207-219).

PATIENT L

77. Respondent treated Patient L, age five when first seen, at Physicians Medical Center on approximately 13 occasions from on or about July 2, 1984 through on or about April 15, 1992, and at her office at 1852 East 52nd Street, Brooklyn, New York 11234, on approximately five occasions from on or about October 19, 1992 through on or about June 25, 1993 (Dept. 14A, 14B).

78. Respondent repeatedly failed to obtain or note an adequate history (Dept. 14A, e.g., p. 6; Dept. 14B, e.g., pp. 5-6; T 30-32, 219-221).

79. Respondent repeatedly failed to perform or note an appropriate physical examination (Dept. 14A, e.g., p. 6; Dept. 14B, e.g., p. 5; T 221-222).

80. On or about both October 10, 1992 and November 23, 1992, Respondent noted elevated blood pressure--i.e., 130/90 on October 10th and 140/90 on November 23rd-- and failed to evaluate Patient L appropriately on those dates or to note such evaluation and/or failed to follow-up appropriately by ordering or performing appropriate laboratory tests. There is no credible evidence to establish that referral of Patient L to a cardiologist or a nephrologist was necessary or appropriate. (Dept. 14A, p. 6 (top two entries); T 223, 225-226).

On or about both November 29, 1984 and August 2, 1985, Respondent noted Patient L's blood pressure as 100/70, which, although it may be at the high end of the range, is normal for a five-or six-year-old (Dept. 14B, p. 8; T 1018-1019, 1176).

81. On or about March 30, 1990, Respondent failed to obtain, perform, or note appropriate evaluation, history, or physical examination or render appropriate treatment in connection with a chief complaint of dizziness and questionable fainting (Dept. 14B, p. 5; T 30-33, 228-231).

82. On or about October 10, 1992, Respondent noted a diagnosis of Patient L's strep throat, but there were no noted physical findings to corroborate that diagnosis. Nonetheless, Respondent's therapy with amoxycillin, even if it was not the drug of choice, was adequate and appropriate (Dept. 14A, p. 6; T 601-602).

83. Respondent failed to keep an accurate record of her care and treatment of Patient L (Dept. 14A, 14B; T 219-233).

VOTE OF THE HEARING COMMITTEE

In consideration of the foregoing, the Hearing Committee votes unanimously to sustain the charges as follows:

FIRST SPECIFICATION

(Negligence on more than one occasion) and

SECOND SPECIFICATION

(Incompetence on more than one occasion):

SUSTAINED EXCEPT FOR PARAGRAPHS A3, A4 (not sustained as to failure to perform or note appropriate evaluation or findings leading to a diagnosis of asthma and/or inappropriate prescription of steroids), B4(c), B5, B6 and B6(a) through (d), B7 (not sustained as to failure to order, perform, or note a urine culture), B8(d), B9, C3(a), C3(b) (not sustained as to failure to perform appropriate evaluation, complaint, or findings leading to a referral to a psychiatrist in connection with her diagnosis of "behavioral problem"), D3(c), D4 (not sustained as to failure to perform or note an appropriate evaluation based upon the positive PPD in or about August 1993 and/or failure to consider or evaluate Patient D for possible HIV infection or to note such evaluation), E3 (not sustained as to prescription of Duricef inappropriately for pharyngitis), F2 (not sustained as to failure to prescribe appropriate medication, i.e., Penicillin V, in connection with the diagnosis of strep throat or failure to establish or note appropriate basis to prescribe a medication other than Penicillin V); F3, G1(b), I2(b) and (c), J2, K1 (not sustained as to failure to obtain or note an adequate history on or about June 29, 1993), K2 (not sustained as to failure to perform or note

an appropriate physical examination on or about June 29, 1993), K3, K4, L3 (not sustained as to failure on November 29, 1984 and August 2, 1985 to evaluate Patient L appropriately or note such evaluation and failure to follow up appropriately by performing appropriate laboratory tests; not sustained as to failure to refer Patient L to a cardiologist or a nephrologist in a timely manner), and L5 (not sustained as to failure, on October 10, 1992, to render appropriate treatment).

THIRD SPECIFICATION

(Inaccurate recordkeeping):

SUSTAINED EXCEPT FOR PARAGRAPHS A4 (not sustained as to failure to perform or note appropriate evaluation or findings leading to a diagnosis of asthma), B4(c), B5, B6 and B6(a) through (d), B7 (not sustained as to failure to order, perform, or note a urine culture), B8(d), B9, C3(a), D3(c), D4 (not sustained as to failure to perform or note an appropriate evaluation based upon the positive PPD in or about August 1993 and/or failure to consider or evaluate Patient D for possible HIV infection or to note such evaluation), F2 (not sustained as to failure to prescribe appropriate medication, i.e., Penicillin V, in connection with the diagnosis of strep throat or failure to establish or note appropriate basis to prescribe a medication other than Penicillin V), G1(b), I2(b) and (c), K1 (not sustained as to failure to obtain or note an adequate history on or about June 29, 1993), K2 (not sustained as to failure to perform or note an appropriate physical examination on or about June 29, 1993), K4, and L3 (not sustained as to failure on November 29, 1984 and August 2, 1985 to evaluate Patient L appropriately or note such evaluation).

CONCLUSIONS

Overall, the Hearing Committee concludes that Respondent's misconduct as evidenced in this proceeding consists primarily in poor recordkeeping and at times in substandard practice of medicine.

Although the Hearing Committee has sustained most of the charges against Respondent, the Committee believes that much of Respondent's conduct that is the subject of those charges does not represent such aberrations or departures from acceptable medical practice that it rises to a level warranting revocation of her license.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

In determining an appropriate penalty to impose upon Respondent, the Hearing Committee has seriously considered and weighed all possible penalties. The Committee unanimously concludes that Respondent is hard-working and dedicated to the community that she serves and that, with appropriate and adequate retraining, Respondent's practice of pediatric medicine should be satisfactory.

Accordingly, the Hearing Committee unanimously determines that Respondent's license to practice medicine in New York State should be suspended for 24 months; that the first 12 months of that period of suspension should be stayed, during which time Respondent should actively attend an approved, accredited pediatric residency training program and Respondent's practice and patient charts should be subject to periodic review as determined by the Department of Health.

The Hearing Committee further unanimously determines that if, despite due diligence, Respondent should be unable to find an appropriate pediatric residency training program that she can attend, then, during the first 12 months of the stay of suspension of her license, Respondent should successfully complete an accredited continuing medical education program in the diagnosis and treatment of infectious disease and present proof of such successful completion to the New York State Department of Health.

The Hearing Committee further unanimously determines that if Respondent satisfactorily meets these terms and conditions, then the last 12 months of the suspension of her license to practice medicine should also be stayed, during which time Respondent should practice on probation and her practice and patient records be subject to periodic review as determined by the Department of Health.

Finally, the Hearing Committee unanimously determines that if Respondent should fail satisfactorily to meet the terms and conditions of her penalty during the first 12 months of suspension, her license to practice medicine should be suspended thereafter for two years.

ORDER

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

1. Respondent's license to practice medicine in New York State is **SUSPENDED** for 24 months, except as hereinafter otherwise provided; that

2. The first 12 months of such suspension is **STAYED**, provided that during such stay (a) Respondent actively attend an approved, accredited pediatric residency training program for the purpose of improving her skills in taking medical histories, performing physical examinations, keeping accurate records, and managing patient care and (b) Respondent provide proof of her successful participation in such a program to the Department of Health; that

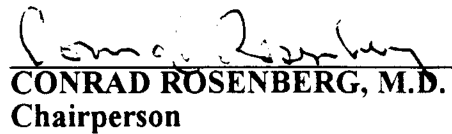
3. During such 12-month stay, Respondent's medical practice and patient records are subject to periodic review as determined by the Department of Health; that

4. In the event that, despite due diligence, Respondent is unable to find an appropriate residence program that she can attend, during the first 12 months of the suspension of her license to practice medicine, Respondent shall successfully complete a continuing medical education program in the diagnosis and treatment of infectious disease and provide proof of such satisfactory completion to the Department of Health; that

5. In the event that Respondent successfully fulfills the foregoing obligations, the second 12 month period of suspension is **STAYED**, during which time Respondent shall practice on **PROBATION**, subject to periodic review of her practice and patient records as determined by the Department of Health; and that

6. In the event that Respondent shall fail satisfactorily to fulfill the terms and conditions of this Order during the first 12-month period of the stay of the suspension of her license to practice medicine in New York, Respondent's license shall, beginning on the day following such 12-month period, be **SUSPENDED** for a period of two years.

DATED: New York, New York
August 20 , 1996



CONRAD ROSENBERG, M.D.
Chairperson

RAFAEL LOPEZ, M.D.
EUGENIA HERBST

TO: Marcia Kaplan, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001

Camille Raia, Esq.
Law Office of Mark A Longo, Esq.
26 Court Street
Brooklyn, New York

Mabel Cohen, M.D.
1852 East 52nd Street
Brooklyn, New York 11234

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

IN THE MATTER OF MABEL COHEN, M.D.	STATEMENT OF CHARGES

Mabel Cohen, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 16, 1977, by the issuance of license number 132173 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, age four when first seen, at Physicians Medical Group, 4303 14th Avenue, Brooklyn, N.Y. 11219, on approximately 57 occasions from on or about January 24, 1990 through on or about August 27, 1992 and at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234, on approximately 44 occasions from on or about July 21, 1992 through on or about January 10, 1994. Patient A was treated for repeated strep throat infections and was also followed for allergies and asthma.

1. Respondent repeatedly failed to obtain or note an adequate history.
2. Respondent repeatedly failed to perform or note an appropriate physical examination.
3. On or about October 9, 1992, Respondent prescribed Epsom salts for Patient A inappropriately.
4. On or about November 2, 1992, Respondent failed to perform or note appropriate evaluation or findings leading to a diagnosis of asthma and/or prescribed antibiotics and steroids inappropriately.
5. On or about November 6, 1993, Respondent failed to provide appropriate care and treatment to Patient A, as follows:

a. Respondent failed to perform or note an adequate work-up of Patient A's complaints of increased cough productive of purulent sputum, vomiting and a temperature of 101 degrees.

b. Respondent failed to consider or rule out possible theophylline toxicity, or to note such evaluation, and/or failed to order or perform a theophylline level.

c. Respondent failed to ascertain the cause of Patient A's vomiting, or to note same.

d. Respondent prescribed ~~nine~~ EIGHT OR MORE medications for Patient A, an excessive number at the same time, and specifically prescribed Tigan, Phenergan, Tussi-Organidim-DM, COUGH SUPPRESSANTS ~~and~~ anti-emetics, for Patient A inappropriately. (DEPT. AMENDMENT 3/4/96 EBS)

6. Respondent failed to keep an accurate record of her care and treatment of Patient A.

B. Respondent treated Patient B, age two years and nine months when first seen, at Physicians Medical Group on approximately 15 occasions from on or about January 23, 1990 through August 11, 1992 and at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 , on approximately 12 occasions from on or about September 28, 1992 through on or about September 20, 1993.

1. Respondent repeatedly failed to obtain or note an adequate history.

2. Respondent repeatedly failed to perform or note an appropriate physical examination.

3. On or about September 28, 1992, Respondent failed to order, perform or note appropriate laboratory tests, including a hematocrit and/or hemoglobin to evaluate the patient's pallor.

4. On or about October 23, 1992, Respondent failed to provide appropriate care and treatment to Patient B, as follows:

   a. Respondent failed to ascertain or note appropriate evaluation leading to a diagnosis of "URI, Strep throat."

b. Respondent failed to order, perform or note a throat culture.

c. Respondent failed to prescribe appropriate medication, i.e. Penicillin V, in connection with the diagnosis of strep throat or failed to establish or note appropriate basis to prescribe a medication other than Penicillin V.

5. On or about March 8, 1993, Respondent referred Patient B to a psychiatrist inappropriately and/or failed to evaluate Patient B for possible physical abuse and/or failed to follow up thereafter the chief complaint that "his teacher hit him," or to note such evaluation or follow-up.

6. On or about June 1, 1993, Respondent failed to provide appropriate care and treatment to Patient B, as follows:

   a. Respondent failed to perform or note appropriate evaluation or findings leading to a diagnosis of chicken pox with rule-outs of strep throat, infectious mono and arthritis of the ankle.

   b. Respondent failed to consider a diagnosis of septic arthritis, or to note same.

   c. Respondent failed to order, perform or note a blood culture or a needle aspiration of the joint.

   d. Respondent prescribed Ceclor inappropriately.

7. On or about June 11, 1993, Respondent failed to order, perform or note a urinalysis and/or a urine culture.

8. On or about September 3, 1993, Respondent failed to provide appropriate care and treatment to Patient B, as follows:

   a. Respondent failed to ascertain or note a chief complaint.

   b. Respondent failed to perform or note appropriate evaluation, complaint or findings leading to a diagnosis of "URI and Strep throat."

   c. Respondent failed to order, perform or note a throat culture.

   d. Respondent prescribed antibiotics inappropriately.

9. On or about September 20, 1993, Respondent noted that the patient "needs lead" and noted "lead(next time)" and failed to note why the test was deferred, and/or deferred the test inappropriately.

10. Respondent failed to keep an accurate record of her care and treatment of Patient B.

C. Respondent treated Patient C, age eight when first seen, at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 from on or about July 19, 1993 through on or about February 3, 1994.

1. Respondent repeatedly failed to obtain or note an adequate history.

2. Respondent repeatedly failed to perform or note an appropriate physical examination.

3. On or about August 23, 1993, Respondent failed to provide appropriate care and treatment to Patient C, as follows:

    a. Respondent failed to perform or note appropriate evaluation, complaint or findings in connection with her notation "needs referral to a POD," and/or failed to make an appropriate referral for a problem with posture and gait, if Patient C had such a problem.

    b. Respondent failed to perform or note appropriate evaluation, complaint or findings leading to a referral to a psychiatrist in connection with her diagnosis of "behavioral problem."

4. Respondent failed to keep an accurate record of her care and treatment of Patient C.

D. Respondent treated Patient D, age 17, at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 from on or about July 21, 1993 through on or about December ~~12,~~ 20, 1993.

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1. Respondent repeatedly failed to obtain or note an adequate history.

2. Respondent repeatedly failed to perform or note an appropriate physical examination.
3. On or about July 21, 1993, Respondent failed to provide appropriate care and treatment for Patient D's ear problem.
    a. Respondent failed to note which ear had a greenish discharge.
    b. Respondent failed to order or perform a culture of the drainage or to gram stain the discharge to identify the specific organism, or to note such testing.
    c. Respondent prescribed Augmentin inappropriately.
    d. Respondent failed to perform or note an appropriate physical examination and/or failed to rule out the presence of lymphadenopathy or sinus infection or any other systemic findings, or to note such evaluation.
4. Respondent failed to perform or note an appropriate evaluation or appropriate follow-up based upon the positive PPD in or about August 1993 and/or failed to consider or evaluate Patient D for possible HIV infection, or to note such evaluation. ~~If Patient D was immunocompromised, Respondent prescribed oral polio vaccine and MMR, live virus preparations, inappropriately to Patient D.~~
5. Respondent failed to keep an accurate record of her care and treatment of Patient D.

E. Respondent treated Patient E, age 13 months when first seen, at Physicians Medical Group on approximately 16 occasions from on or about March 27, 1991 through on or about June 11, 1992 and at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 on approximately 14 occasions from on or about December 14, 1992 through on or about November 22, 1993.

1. Respondent repeatedly failed to obtain or note an adequate history.
2. On or about January 17, 1992 and on or about December 14,

1992, Respondent prescribed Ceclor inappropriately for Patient E and/or failed to prescribe appropriate medication, i.e. Penicillin V, in connection with the diagnosis of strep throat or failed to establish or note appropriate basis to prescribe a medication other than Penicillin V.

3. On or about December 28, 1992, Respondent failed to perform or note appropriate evaluation or findings leading to her diagnosis of "tonsillitis" and/or prescribed Duricef inappropriately for pharyngitis.
4. Respondent failed to evaluate Patient E's heart murmur appropriately after it was first identified on or about March 8, 1993, and/or failed to refer Patient E in a timely manner to a cardiologist.
5. Respondent failed to keep an accurate record of her care and treatment of Patient E.

F. Respondent treated Patient F, age one month when first seen, at Physicians Medical Group on approximately 28 occasions from on or about August 17, 1990 through on or about July 30, 1992, and at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 on approximately nine occasions from on or about September 25, 1992 through on or about December 29, 1993.

1. Respondent repeatedly failed to perform or note an appropriate physical examination.
2. Respondent repeatedly prescribed Ceclor inappropriately and/or failed to prescribe appropriate medication, i.e. Penicillin V, in connection with the diagnosis of strep throat or failed to establish or note appropriate basis to prescribe a medication other than Penicillin V.
3. On or about December 13, 1993, Respondent prescribed "Herbalife powder one tablespoon OD " inappropriately for URI and strep throat.
4. Respondent failed to keep an accurate record of her care and treatment of Patient F.

G. Respondent treated Patient G, age seven when first seen, at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 on or about January 29, 1993 and on or about December 11, 1993.

1. On or about January 29, 1993, Respondent failed to provide appropriate care and treatment to Patient G, as follows:
   a. Respondent failed to evaluate Patient G appropriately for possible meningitis given her complaints of headache, stiff neck and fever of 102 degrees, or to note such evaluation, and/or appropriate follow-up.
   b. Respondent failed to order, perform or note appropriate laboratory tests, specifically a CBC.
2. Respondent failed to keep an accurate record of her care and treatment of Patient G.

H. Respondent treated Patient H, age two and a half years when first seen, at Physicians Medical Group on approximately 45 occasions from May 3, 1983 through on or about April 28, 1991 and at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 from on or about February 5, 1993 through on or about September 8, 1993.

1. Respondent repeatedly failed to obtain or note an appropriate history.
2. Respondent repeatedly failed to perform or note an appropriate physical examination.
3. On or about February 5, 1993, Respondent failed to provide appropriate care and treatment to Patient H, as follows:
   a. Respondent failed to obtain or note an appropriate chief complaint.
   b. Respondent failed to order, perform or note a throat culture despite diagnosing bronchitis and strep throat.

4. On or about March 23, 1993, Respondent failed to provide appropriate care and treatment to Patient H, as follows:
   a. Respondent failed to evaluate and/or diagnose Patient H appropriately for complaints of abdominal pain, vomiting and dizziness with abdominal pains, or to note such evaluation and diagnosis.
   b. Respondent prescribed Phenergan inappropriately and/or failed to render appropriate treatment.
5. On or about September 8, 1993, Respondent failed to provide appropriate care and treatment, as follows:
   a. Respondent failed to obtain, perform or note appropriate evaluation, history, physical examination and/or findings leading to her diagnosis of "chronic diarrhea."
   b. Respondent failed to arrange for or note appropriate follow-up of Patient H's symptoms or of the laboratory tests ordered on September 8, 1993.
6. Respondent failed to keep an accurate record of her care and treatment of Patient H.

I. Respondent treated Patient I, age 18 months when first seen, at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 on approximately nine occasions from on or about February 9, 1993 through on or about September 21, 1993.

1. Respondent failed to give Patient I first immunizations in a timely manner, or to note appropriately Patient I's immunization history.
2. On or about February 9, 1993, Respondent failed to provide appropriate care and treatment of Patient I, as follows:
   a. Respondent failed to obtain or note an appropriate history of Patient I's chief complaint of constipation.
   b. Respondent failed to obtain, perform or note appropriate evaluation, history, physical examination and/or findings in connection with her notation that the child was pale.
   c. Respondent failed to treat appropriately or note

appropriate treatment of Patient I's anemia in a timely manner.

3. Respondent failed to keep an accurate record of her care and treatment of Patient I.

J. Respondent treated Patient J, age two and a half years when first seen, at Physicians Medical Group on approximately 105 occasions from on or about April 11, 1988 through on or about August 5, 1992 and at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 on approximately 11 occasions from on or about September 14, 1992 through on or about December 22, 1993. Approximately thirty-five of the occasions were for strep throat.

1. Respondent repeatedly failed to obtain, perform or note appropriate evaluation, history, physical examination, findings and/or treatment in connection with her diagnosis of strep throat, and/or prescribed multiple antibiotics inappropriately.
2. On or about July 25, 1988, Respondent prescribed "Touch therapy" inappropriately for a chief complaint of hoarseness, slight cough and retracting in the presence of a positive throat culture.
3. On or about February 2, 1993, Respondent failed to obtain, perform or note appropriate evaluation, history, physical examination, and/or findings in connection with the complaint of abdominal pain.
4. Respondent failed to obtain or note the results of the tympanometry and hearing test ordered on May 12, 1993, and/or failed to perform or note appropriate follow-up based on the results of the tests, including referral to a hearing specialist.
5. Respondent failed to obtain or note the results of the PPD ordered on May 12, 1993, and/or failed to perform or note appropriate follow-up based on the results of the test.
6. Respondent failed to keep an accurate record of her care and treatment of Patient J.

K. Respondent treated Patient K, age 3 weeks when first seen, on or about June 29, 1993 and on or about December 11, 1993.

1. Respondent failed to obtain or note an adequate history on either visit.
2. Respondent failed to perform or note an appropriate physical examination on either visit.
3. Respondent failed to give Patient K first immunizations in a timely manner.
4. On or about June 29, 1993, Respondent failed to perform or note appropriate evaluation or findings leading to her diagnosis of acute tonsillitis in a 3-week old, and/or prescribed Amoxicillin inappropriately.
5. On or about December 11, 1993, Respondent failed to perform or note appropriate evaluation or findings relative to her notation of "r/o anemia," and/or and/or failed to determine or note whether the patient fell within a high risk group for sickle cell anemia, and if the patient was in a high risk group, failed to order, perform or note a sickle cell prep, and/or failed to follow up appropriately.
6. Respondent failed to keep an accurate record of her care and treatment of Patient K.

L. Respondent treated Patient L, age 5 when first seen, at Physicians Medical Group on approximately 13 occasions from on or about July 2, 1984 through on or about April 15, 1992 and at her office at 1852 East 52nd St., Brooklyn, N.Y. 11234 on approximately five occasions from on or about October 19, 1992 through on or about June 25, 1993.

1. Respondent repeatedly failed to obtain or note an adequate history.
2. Respondent repeatedly failed to perform or note an appropriate physical examination.
3. On or about November 29, 1984, August 2, 1985, October 10, 1992 and on or about November 23, 1992, Respondent noted elevated blood pressure, i.e. 100/70 on November 29, 1984,

100/70 on August 2, 1985, 130/90 on October 10, 1992 and 140/90 on November 23, 1992, and failed to evaluate Patient L appropriately on those dates, or to note such evaluation, and/or failed to follow up appropriately by ordering or performing appropriate laboratory tests and/or by referring Patient L to appropriate specialists in cardiology or nephrology in a timely manner.

4. On or about March 30, 1990, Respondent failed to obtain, perform or note appropriate evaluation, history or physical examination or render appropriate treatment in connection with a chief complaint of dizziness and questionable fainting.
5. On or about October 10, 1992, Respondent failed to obtain, perform or note appropriate evaluation, history, physical examination, findings and/or failed to render appropriate treatment in connection with her diagnosis of strep throat.
6. Respondent failed to keep an accurate record of her care and treatment of Patient L.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1996) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A.1, A.2, A.3, A.4, A.5 and A.5(a), A.5(b), A.5(c) and/or A.5(d), and/or A.6, B and B.1, B.2, B.3, B.4 and B.4(a), B.4(b) and/or B.4(c), B.5, B.6 and B.6(a), B.6(b), B.6(c) and/or B.6(d), B.7, B.8 and B.8(a), B.8(b), B.8(c) and/or B.8(d), B.9, and/or B.10, C and C.1, C.2, C.3 and C.3(a) and/or C.3(b), and/or C.4, D and D.1, D.2, D.3 and D.3(a), D.3(b), D.3(c) and/or D.3(d), D.4 and/or D.5, E, E.1, E.2, E.3, E.4 and/or E.5, F and

F.1, F.2, F.3 and/or F.4, G and G.1(a) and/or G.1(b), and/or G.2, H and H.1, H.2, H.3 and H.3(a) and/or H.3(b), H.4 and H.4(a) and/or H.4(b), H.5 and H.5(a) and/or H.5(b), and/or H.6, I and I.1, I.2 and I.2(a), I.2(b) and/or I.2(c), and/or I.3, J and J.1, J.2, J.3, J.4, J.5 and/or J.6, K and K.1, K.2, K.3, K.4, K.5 and/or K.6, and/or L and L.1, L.2, L.3, L.4, L.5 and/or L.6.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1996) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A and A.1, A.2, A.3, A.4, A.5 and A.5(a), A.5(b), A.5(c) and/or A.5(d), and/or A.6, B and B.1, B.2, B.3, B.4 and B.4(a), B.4(b) and/or B.4(c), B.5, B.6 and B.6(a), B.6(b), B.6(c) and/or B.6(d), B.7, B.8 and B.8(a), B.8(b), B.8(c) and/or B.8(d), B.9, and/or B.10, C and C.1, C.2, C.3 and C.3(a) and/or C.3(b), and/or C.4, D and D.1, D.2, D.3 and D.3(a), D.3(b), D.3(c) and/or D.3(d), D.4 and/or D.5, E, E.1, E.2, E.3, E.4 and/or E.5, F and F.1, F.2, F.3 and/or F.4, G and G.1(a) and/or G.1(b), and/or G.2, H and H.1, H.2, H.3 and H.3(a) and/or H.3(b), H.4 and H.4(a) and/or H.4(b), H.5 and H.5(a) and/or H.5(b), and/or H.6, I and I.1, I.2 and I.2(a), I.2(b) and/or I.2(c), and/or I.3, J and J.1, J.2, J.3, J.4, J.5 and/or J.6, K and K.1, K.2, K.3, K.4, K.5 and/or K.6, and/or L and L.1, L.2, L.3, L.4, L.5 and/or L.6.

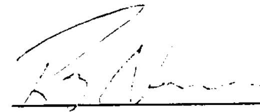
THIRD SPECIFICATION

INACCURATE RECORDKEEPING

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1996) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

3. Paragraphs A and A.1, A.2, A.4, A.5 and A.5(a), A.5(b), and/or A.5(c), and/or A.6, B and B.1, B.2, B.3, B.4 and B.4(a), B.4(b) and/or B.4(c), B.5, B.6 and B.6(a), B.6(b), and/or B.6(c), B.7, B.8 and B.8(a), B.8(b), and/or B.8(c), B.9, and/or B.10, C and C.1, C.2, C.3 and C.3(a) and/or C.3(b), and/or C.4, D and D.1, D.2, D.3 and D.3(a), D.3(b), and/or D.3(d), D.4 and/or D.5, E, E.1, E.2, E.3, and/or E.5, F and F.1, F.2, and/or F.4, G and G.1(a) and/or G.1(b), and/or G.2, H and H.1, H.2, H.3 and H.3(a) and/or H.3(b), H.4 and H.4(a), H.5 and H.5(a) and/or H.5(b), and/or H.6, I and I.1, I.2 and I.2(a), I.2(b) and/or I.2(c), and/or I.3, J and J.1, J.3, J.4, J.5 and/or J.6, K and K.1, K.2, K.4, K.5 and/or K.6, and/or L and L.1, L.2, L.3, L.4, L.5 and/or L.6.

DATED: January 17, 1996
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct