NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

Public

March 8, 2012

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cynthia M. Fascia, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2505
Albany, New York 12237

Robert Nicaise, M.D.
REDACTED ADDRESS

Michael Paul Ringwood, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street – Suite 600
Syracuse, New York 13202-1252

RE: In the Matter of Robert Nicaise, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 12-39) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

REDACTED SIGNATURE
James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah
Enclosure

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

In the matter of

Robert Nicaise, M.D.
NYS license # 155535

regarding charges of violations of NYS Ed.L 6530

Determination and Order

BPMC #12-39

COPY

Before a hearing committee for the State Board for Professional Medical Conduct:

Richard F. Kasulke, M.D., Chair
Edmund A. Egan II, M.D.
Heidi B. Miller, M.P.H.

John Harris Terepka, Administrative Law Judge

Held at: Mahoney State Office Building
65 Court Street
Buffalo, New York 14202
August 2, 3, 2011
New York State Department of Health
259 Monroe Avenue
Rochester, New York 14607
September 28, 29, 2011
Briefs: November 18, 2011
Deliberations: December 23, 2011

Parties: New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2505
Empire State Plaza
Albany, New York 12237
By: Cynthia M Fascia, Esq.

Robert Nicaise, M.D.
REDACTED ADDRESS

By: Michael Paul Ringwood, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street, Suite 600
Syracuse, New York 13202-1252

JURISDICTION

As is set forth in Public Health Law 230(1)&(7) and Education Law 6530, the legislature created the State Board for Professional Medical Conduct (the Petitioner) in the Department of Health, and authorized it to conduct disciplinary proceedings in matters of professional medical conduct.

A notice of hearing and statement of charges, both dated March 1, 2011, were served on Respondent Robert Nicaise, M.D. The statement of charges alleged professional misconduct in violation of Ed.L 6530. A hearing was scheduled pursuant to the provisions of PHL 230(10) and hearing procedures set forth in Department of Health regulations at 10 NYCRR Part 51.

The Respondent submitted an answer to the charges pursuant to 10 NYCRR 51.5. (Exhibit B.) A pre-hearing conference pursuant to 10 NYCRR 51.9(c)(9) was held on July 19, 2011.

EVIDENCE

Witnesses for the Petitioner:	Mary Mayerat, R.N. William Canavan, M.D. Barbara Franklin Celestine Szulewski, R.P.A. Sheila Kee Thomas Small, M.D. Patient A Lee Ruotsi, M.D. Karen Reichert
Petitioner exhibits:	Exhibits 1-23, 30
Witnesses for the Respondent:	Catherine Gale, Esq. Robert Nicaise, M.D.
Respondent exhibits:	Exhibits A-D

A transcript of the proceedings was made. (Prehearing conference transcript, pages 1-85; Hearing transcript, pages 1-1096.)

FINDINGS OF FACT

The statement of charges (Exhibit 1) included thirty nine specifications in support of eight charges of misconduct as defined in various subsections of Ed.L 6530, including fraudulent practice, incompetence, negligence and recordkeeping violations. The charges were based on factual allegations made in connection with the Respondent's representations on six employment or hospital appointment applications (allegations A – F), applications for a North Dakota medical license and to renew his New York medical license registration (allegations G, H), and with regard to his treatment of seven patients (allegations I – O.)

The following findings of fact were made upon unanimous vote of the Hearing Committee. Citations are to evidence found persuasive by the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence supporting the Committee determination.

1. Respondent Robert Nicaise, M.D., was authorized to practice medicine in New York State on August 22, 1983 under license number 155535.

2. The Respondent was employed as a physician at Mid-State Correctional Facility in Marcy, New York, from October 2002 to March 2003. He was hired as a permanent, half time state employee on probation, and not *locum tenens*. (Exhibit 23, page 4.) He was terminated for failure to satisfactorily complete his probationary period. (Exhibit 23, pages 3, 8.)

3. The Respondent was employed as a physician at E.J. Noble Hospital in Gouverneur, New York, in November 2003. (Exhibit 4, page 36.) He was a full time employee, and not *locum tenens*. (Transcript, pages 695, 822, 926.) He was terminated, for cause, in February

2004. The reasons for his termination included a "confrontational attitude and approach to resolving day-to-day patient care needs" and an "attitude and clinical practice style [that was] not beneficial to maintain this relationship." (Exhibit 4, page 49.)

4. The Respondent was employed by the Community Health Center of Buffalo (CHCB) in November 2004 as a consultant on the implementation of electronic medical records. (Exhibit 5, pages 6-7.) He was not credentialed to and did not provide patient care in this position. (Transcript, pages 738, 741.)

5. The Respondent was employed as a physician at Sheehan Memorial Hospital in Buffalo, New York, in February 2007. (Exhibit 7, pages 39-43; Transcript, pages 173, 747.) He resigned effective March 22, 2007. (Transcript, pages 186, 748; Exhibit 7, pages 2, 12-15.) His resignation was immediately accepted because Sheehan was actively considering terminating him because of patient complaints. (Transcript, pages 268-71, 782.) Respondent's employment at Sheehan was marked by numerous problems in his performance, including patient complaints and conflicts with the staff. (Transcript, pages 181-86, 211-12, 269, 774-75, 779-80; Exhibit 7, pages 16-36, Exhibit 20, page 2.)

6. The Respondent was employed as a physician at Hudson River Health Care, in Walden, New York, from March 26 until May 2007. (Exhibit 8, pages 8, 9, 34.)

7. The Respondent was employed as a physician at Springville Pediatrics and Adult Care, in Springville, New York, commencing March 10, 2008. (Exhibit 10, page 96.) His position was as a full time employee and not *locum tenens*. (Exhibit 10, pages 92-93; Transcript, page 45.) He was terminated, for cause, on July 28, 2009. (Exhibit 10, pages 135-37; Transcript, pages 133-34.) The reasons for his termination included incomplete records, clinical decision making concerns, refusal to work with another physician, verbal

abuse of staff, confrontations with patients and patient complaints, and failure to keep up with even a reduced work load. (Transcript, pages 152-55.)

MISREPRESENTATIONS ON APPLICATIONS

8. **Factual allegations A.** The Respondent applied for employment as a physician at Kenmore Mercy Hospital in Kenmore, New York, in July 2007. (Exhibit 9, pages 15-34.) In his application the Respondent:

Allegations 1,4: Failed to disclose his employment at Sheehan Memorial Hospital. (Transcript, page 770.)

Allegations 2,3: Represented that he resigned from E.J. Noble. (Exhibit 9, page 19.) He had in fact been terminated for cause. (Exhibit 4, page 49.) He also failed to disclose his termination from E.J. Noble when asked. (Exhibit 9, pages 21-23.)

Allegation 5: Represented the length of his employment at Hudson River Health Care as including the period from January through March 2007. During this time he had actually been employed at Sheehan. (Exhibit 9, page 31.)

Allegation 6: Described his employment at Mid-State Correctional Facility as "locums" employment. He had in fact been hired as a state employee and terminated for failure to satisfactorily complete his probationary period. (Exhibit 9, page 32.)

9. **Factual allegations B.** The Respondent applied for employment and was hired as a physician at Springville Pediatrics and Adult Care in March 2008. (Exhibit 10, page 96.) In his application the Respondent:

Allegation 1: Failed to disclose his employment at Sheehan Memorial Hospital. (Exhibit 10, pages 2-7.)

Allegation 2 Represented the length of his employment at Hudson River Health Care as including the period from January through March, 2007. This period covered the time actually employed at Sheehan. (Exhibit 10, page 3.)

Allegation 3: Described his employment at Mid-State Correctional Facility as "locums" employment. He had in fact been hired as a state

employee and terminated for failure to satisfactorily complete his probationary period. (Exhibit 10, page 4.)

10. **Factual allegations C**. The Respondent submitted an application for employment as a physician at TLC Health Network, in Irving, New York, in January 2009. (Exhibit 11, pages 5-12.) In his application the Respondent:

Allegations 1,3: Failed to disclose his employment at Sheehan Memorial Hospital. (Transcript, pages 813, 825-6.)

Allegation 2: Failed to disclose, when asked, that he had been terminated from E.J. Noble. (Exhibit 11, pages 7-9.)

Allegation 4: Described his employment at Mid-State Correctional Facility as "locums" employment. He had in fact been hired as a state employee and terminated for failure to satisfactorily complete his probationary period. (Exhibit 11, page 150.)

Allegation 5: Represented his employment at Springville Pediatrics and Adult Care as "locums." He had in fact been hired as a full time employee and terminated for cause. (Exhibit 11, page 149.)

11. **Factual allegations D**. The Respondent submitted an application for employment as a physician at Kaleida Health, in Buffalo, New York, in March 2009. (Exhibit 12, pages 3-18.) In his application the Respondent:

Allegations 1, 3-5: Failed to disclose his employment at Sheehan Memorial Hospital. (Transcript, pages 829-30, 873-76.)

Allegation 2: Failed to disclose, when asked, that he had been terminated from E.J. Noble. (Exhibit 12, pages 5, 8-9.)

Allegation 6: Described his employment at Mid-State Correctional Facility as "locums" employment. He had in fact been hired as a state employee and terminated for failure to satisfactorily complete his probationary period. (Exhibit 12, page 15.)

Allegation 7: Represented his employment at Springville Pediatrics and Adult Care as "locums." He had in fact been hired as a full time employee and terminated for cause. (Exhibit 12, page 14.)

12. **Factual allegations E.** The Respondent submitted an application for employment as a physician at Hudson River Health Care in March 2007. (Exhibit 8, pages 18-33.) In his application the Respondent:

Allegation 1: Failed to disclose his employment at Sheehan Memorial Hospital. (Exhibit 8, pages 28-33.)

Allegation 2: Described his employment at Mid-State Correctional Facility as "locums" employment. He had in fact been hired as a state employee and terminated for failure to satisfactorily complete his probationary period. (Exhibit 8, page 30.)

13. **Factual allegations F.** The Respondent submitted an application for employment as a physician and for appointment to the medical staff at Clifton-Fine Hospital, in Star Lake, New York, in September 2005. (Exhibit 6, pages 14-59.) In his application the Respondent:

Allegation 1: Described his employment at Mid-State Correctional Facility as "locums" employment. He had in fact been hired as a state employee and terminated for failure to satisfactorily complete his probationary period. (Exhibit 6, page 32.)

14. **Factual allegations G.** The Respondent submitted an application for a medical license to the North Dakota State Board of Medical Examiners in May 2009. (Exhibit 14, pages 2-11.) In his application the Respondent:

Allegation 1: Failed to disclose his employment at Sheehan Memorial Hospital. (Exhibit 14, pages 6-9; Transcript, pages 901, 909.)

Allegation 2: Failed to disclose his employment at Mid-State Correctional Facility, where he had been terminated. (Exhibit 14, pages 6-9; Transcript, pages 901, 909.)

Allegation 3: Described his employment at E.J. Noble as "locums" employment. He had in fact been hired as a full time employee and then terminated for cause. (Exhibit 14, page 8; Transcript, pages 695, 822.)

Allegation 4: Represented that he had resigned from Springville Pediatrics and Adult Care. He had in fact been terminated for cause. (Exhibit 14, pages 17-19; Transcript, pages 41, 134.)

15. **Factual allegations H.** The Respondent submitted an application to the New York State Education Department for renewal of registration of his New York medical license in July 2004. (Exhibit 15, pages 4-5.) In his application the Respondent:

Allegation 1: Answered "no" to the question whether any hospital or licensed facility had, since his last registration, terminated his employment. (Exhibit 15, page 5.) Respondent had last registered in 2002. (Exhibit 15, pages 6-7.) Respondent knew that he had in fact been terminated by E.J. Noble Hospital in February 2004. (Exhibit 4, page 49.)

PATIENT CARE CRITICISMS

16. **Factual allegations I. Patient A.** The Respondent provided medical care to Patient A on March 31, 2008 at Springville Pediatrics and Adult Care. (Exhibit 16, page 8; Transcript, pages 50, 328.) The Respondent's treatment of Patient A failed to meet an appropriate standard of professional care in that he:

Allegation 1: failed to address and document the patient's primary complaint
Allegation 2: failed to perform and document an adequate physical examination
Allegation 3: failed to obtain and document an adequate history
Allegation 4: failed to formulate and document an appropriate treatment plan

17. **Factual allegations J. Patient B.** The Respondent provided medical care to Patient B on March 22, 2007 at Sheehan Memorial Hospital. (Exhibit 17; Transcript, page 57.) The Respondent's treatment of Patient B failed to meet an appropriate standard of professional care in that he:

Allegation 1: failed to address and document the patient's primary complaint
Allegation 2: failed to perform and document an adequate physical examination
Allegation 3: failed to obtain and document an adequate history
Allegation 4: failed to refill needed blood pressure medications
Allegation 5: failed to document a reason for not refilling blood pressure medications

18. **Factual allegations K. Patient C.** The Respondent provided medical care to Patient C on May 15, 2008 at Springville Pediatrics and Adult Care. (Exhibit 18, page 6.) The

Respondent's treatment of Patient C failed to meet an appropriate standard of professional care in that he:

Allegation 1: failed to address and document the patient's primary complaint
Allegation 2: failed to perform and document an adequate physical examination
Allegation 3: failed to obtain and document an adequate history
Allegation 4: failed to refill needed medications
Allegation 5: failed to document a reason for not refilling medications

19. **Factual allegations L. Patient D.** The Respondent provided medical care to Patient D on May 23 and June 23, 2008 at Springville Pediatrics and Adult Care. (Exhibit 19, pages 5, 9, 10; Transcript, pages 60-61, 62.) The Respondent's treatment of Patient D failed to meet an appropriate standard of professional care in that he:

Allegations 1, 2: failed to perform and document adequate physical examinations
Allegation 3: failed to refill the patient's amiodarone prescription
Allegation 4: failed to document a reason not to refill the amiodarone

20. **Factual allegations M. Patient E.** The Respondent provided medical care to Patient E on April 7, May 5 and May 22, 2008 at Springville Pediatrics and Adult Care. (Exhibit 20, pages 12, 15, 16; Transcript, pages 66, 68.) Respondent's treatment of Patient E failed to meet an appropriate standard of professional care in that he:

Allegation 1: failed to address the patient's primary complaint April 7, 2008
Allegation 2: failed to perform and document an adequate physical examination
Allegation 3: failed to obtain and document an adequate history
Allegation 4: failed to formulate and document an appropriate treatment plan
Allegation 6: failed to address the patient's primary complaint May 5, 2008
Allegation 7: failed to perform and document an adequate physical examination
Allegation 8: failed to obtain and document an adequate history
Allegation 9: failed to formulate and document an appropriate treatment plan
Allegation 11: failed to address the patient's primary complaint May 22 2008
Allegation 12: failed to perform and document an adequate physical examination
Allegation 13: failed to obtain and document an adequate history
Allegation 14: failed to formulate and document an appropriate treatment plan

21. **Factual allegations N. Patient F.** The Respondent provided medical care to Patient F on June 23, 2008 at Springville Pediatrics and Adult Care. (Exhibit 21, page 7.) The

Respondent's treatment of Patient F failed to meet an appropriate standard of professional care in that he:

Allegation 1: failed to perform and document an adequate physical examination
Allegation 2: failed to document his intention to reduce patient's pain medication
Allegation 3: failed to document a justification for reducing pain medication
Allegation 4: failed to engage in and document a discussion with the patient about the reduction of pain medication

22. **Factual allegations O. Patient G.** The Respondent provided medical care to Patient G on March 8, 2007 at Sheehan Memorial Hospital. (Exhibit 22, page 3.) The Respondent's treatment of Patient G failed to meet an appropriate standard of professional care in that he:

Allegation 2: failed to document a justification for reducing narcotic pain medication
Allegation 3: failed to engage in and document a discussion with the patient about the reduction of pain medication

DISCUSSION OF FACTUAL ALLEGATIONS

A – H. Misrepresentations on applications.

The Respondent's many misrepresentations on applications included:

1. In five instances (allegations A-2&3, C-2 D-2, G-3, H-1) the Respondent represented on applications that he had resigned from E.J. Noble Hospital and failed to disclose that he had been terminated for cause.

The Respondent's application to Kenmore Mercy Hospital stated that he left E.J. Noble by "resignation for personal financial reasons." (Exhibit 9, page 19.) At the hearing, he claimed that this statement was accurate even though he had also been terminated. He defended his claim of "personal and financial reasons" on the grounds that it was inconvenient to get to the bank to cash his paycheck, and that sometimes the facility was short of cash. (Transcript, pages 761-62.) At the same time, however, he acknowledged the resignation claim was a misrepresentation, saying:

> Or the bottom line is probably [sic] could be characterized as a misrepresentation, because Mr. Conole, quite frankly, said we don't need you here anymore and it was implied he wasn't going to pay me anymore either. (Transcript, pages 762-63.)

According to the Respondent, he did not know he was terminated at E.J. Noble because:

> After having a heated discussion with the CEO of the hospital about a patient care issue... he told me your services are no longer needed here. He did not tell me you're fired, he did not tell me you are terminated, and he never gave me anything in writing. He did ask for my keys to the clinic... (Transcript, pages 687-88.)

> I understood it to mean that I was about to be replaced or that I was being, at the very least, timed out because of the incident that had occurred within the day prior to that. (Transcript, page 705.)

> My position is if someone says to me point blank in English, you are fired, you are terminated, then I am fired and I am terminated. Plain as can be. No room for equivocation. If somebody says your services are no longer needed here, we have a substitute physician now available, I don't know how to take that. (Transcript, page 715.)

The Respondent denied that he ever received the termination letter sent to him, pointing out that it was addressed to him at the facility itself. (Exhibit 4, page 49.) By the time it was delivered he had not only cleared out of the clinic, he had vacated his rental apartment and returned to Syracuse – acts inconsistent with a claim not to know he had been fired. (Transcript, pages 703-704.)

The practice monitor the Respondent was required by the Office of Professional Medical Conduct to have, and the Medical Society of New York with which he was working in connection with his medical license probation, were also sent copies of the termination letter. (Exhibit 4, pages 49, 82.) Respondent's claim that neither of these ever communicated with him about his firing is difficult to believe. (Transcript, pages 696-700.)

Even at the hearing, confronted with his termination letter, the Respondent persisted in equivocating about whether he was fired even as he acknowledged he had been "involuntarily separated," as if there were a difference:

> Dr. Egan: ... I mean, did you view yourself voluntarily or involuntarily separated from Noble?
>
> Dr. Nicaise: Well, if you use the word separation, I definitely separated, and if you use the words involuntary and voluntary, it definitely falls under the category of involuntary. (Transcript, page 711.)

The Respondent maintained that if he did not actually receive the termination letter he did not have to report his termination to the New York State Education Department on his registration application: "I checked [the answer on the form] no because, actually, I never got notified in writing that I was terminated." (Transcript, page 713.) This patently inadequate excuse is rejected. The Hearing Committee concluded that he knowingly gave a false answer to the New York State Education Department (Exhibit 15, page 3) with intent to conceal that he had been terminated.

The Respondent's attempts to suggest that he did not know or did not think he had been fired are preposterous and this reinforces the Hearing Committee's conclusion of fraudulent intent in his concealment of that information from potential employers or licensing authorities.

2. In six instances (allegations A-6, B-3, C-4, D-6, E-2, F-1), the Respondent represented on applications that he was *locum tenens* (a temporary, substitute or short term engagement) at Mid-State. (Exhibit 6, page 32; Exhibit 8, page 30.) The documentary evidence plainly shows, in language that is not reasonably subject to dispute, that the Respondent was given a two year contract for a permanent halftime position and was terminated for failure to satisfactorily complete his probation. (Exhibit 23, pages 3, 4.) He

signed a copy of the termination letter to acknowledge his termination. (Exhibit 23, page 8; Transcript, page 724.)

At the hearing the Respondent admitted he was fired by Mid-State, and acknowledged that he was not in a "locums" position. (Transcript, page 723.) Nevertheless, he continued to maintain that it was appropriate to describe the position as *locum tenens* on the basis of a casual conversation he claims to have had with Dr. Ramineni, the medical director at Mid-State. (Transcript, page 727.) He testified:

> Q. What was your reason for describing [the Mid-State position] as locum's employment?
>
> A. My medical director at the Mid-State Correctional Facility simply stated that I was a half-time fill in until they could engage the services of a more suitable full-time physician. (Transcript, page 718.)
>
> ...
>
> Q. Would it have been appropriate to describe your employment at Mid-State Correctional Facility from which you were terminated prior to completing your year of probation as a locum tenens position?
>
> A. Given my conversation with Dr. Ramineni, I would say absolutely it was appropriate. (Transcript, page 723.)

The Respondent rightly pointed out that it is not a misrepresentation to describe an employment history on a resume without mentioning how the employment ended. (Transcript, pages 735-36.) It is a serious misrepresentation, however, to describe permanent employment as a physician to be "locums" because doing so can deflect inquiry into how the position ended. In this case the description was clearly a misrepresentation for which no other reason than deception is plausible or evident.

The Respondent also falsely represented his Springville employment as "locums" in the resume submitted with his applications to TLC Health and Kaleida Health, and falsely represented his E.J. Noble employment as "locums" in his application to the North Dakota

State Board. (Allegations C-5, D-7, G-4.) The Hearing Committee concluded that these were fraudulent misrepresentations as well, made for the same obvious reason that he was attempting to disguise, conceal, or divert inquiry into employment from which he had been fired under circumstances that reflected poorly upon him.

There is a clear and consistent pattern in this case of the Respondent misrepresenting his employment history, and the reasons for that pattern were obvious. The Hearing Committee did not credit his denial (Transcript, page 718) that his characterization of permanent positions on employment applications as "locums" in these instances were not fraudulent.

3. In six instances (allegations A-7, B-4, C-6, D-8, E-3, F-2), Respondent submitted a resume with applications to facilities that described his position at Community Health Center of Buffalo as "staff physician" when he was not credentialed to and did not provide patient care. The Respondent acknowledged that he provided no patient care in this position. (Transcript, page 719.) His job was to assist the facility in transferring from paper to electronic medical records. (Transcript, page 720.) CHCB, responding to a reference inquiry by Kenmore Mercy Hospital, stated that his job title was "consultant." (Exhibit 9, page 73.)

The Respondent maintained that he was hired as and his job title was staff physician. (Transcript, page 720.) He was issued an employee identification badge that read "staff physician." (Transcript, pages 720, 742.) His engagement letter specified he would be required to "conform to the CHCB Medical/Dental Staff Bylaws." (Exhibit 5, page 7.) His human resources data sheet at CHCB listed his position as "staff physician." (Exhibit 5, page 13.)

Giving himself the title "staff physician" at CHCB was arguably a misrepresentation, but it was a minor one. The Respondent did not misrepresent or conceal the nature of his actual duties in the position. He did not represent on any employment or other application in this hearing record that he provided patient care in it. Although resumes he submitted to Springville and Clifton-Fines list his job as "staff physician," the job description on those resumes are clearly about his software work and nowhere do they imply that he provided patient care. (Exhibit 6, page 31; Exhibit 10, page 4.) The Hearing Committee concluded that the Petitioner failed to establish that Respondent's use of the title "staff physician" on his resume constituted a fraudulent misrepresentation. The Committee did not sustain the allegations.

4. In six instances (allegations A-1&4, B-1, C-1&3, D-1,3,4,5, E-1, G-1), the Respondent submitted applications that failed to disclose he was ever employed at Sheehan Memorial Hospital. In two of these instances (allegations A-5 & B-2), he exaggerated his time of employment at Hudson River Health Care to cover the time he was actually at Sheehan.

The Respondent claimed that he was "traumatized" by his bad experience at Sheehan and so did not want to revisit it by mentioning it on applications. He also claimed that he failed to mention Sheehan because an employment recruiter advised that the employment was so brief that he did not need to include it on his history. (Transcript, pages 759-60, 783-84.) The Hearing Committee rejected these excuses as both inadequate and unbelievable.

The Respondent claimed that the incorrect starting date at Hudson River Health Care on his application to Kenmore Mercy Hospital (allegation A-5) was a typographical error. (Transcript, page 766.) The "typo," however, precisely covers the employment gap created

by his concealment of his time at Sheehan Memorial Hospital. It is, furthermore, telling that he did not correct the "typo" when he later updated his resume to include the end date of his Hudson River employment. In the application he later made to Springville Pediatrics (allegation B-2), he corrected the end date but continued to misrepresent the Hudson River starting date. (*compare*, Exhibit 9, page 31 and Exhibit 10, page 3.)

The Respondent did ultimately acknowledge that he intentionally left Sheehan Memorial Hospital off of his resume when he should not have done so. (Transcript, page 770.) The Hearing Committee concluded that these were intentional misrepresentations, made in an attempt to forestall inquiry into his poor record at Sheehan.

The Respondent's medical license application to the North Dakota Board omitted both his Sheehan and his Mid-State employment. (Allegations G-1, G-2.) The Respondent claims the omission of the Mid-State employment was "just a simple error." (Transcript, pages 901, 909.) The Hearing Committee did not find this credible in light of his many other misrepresentations. The Committee concluded that the omission of his Mid-State employment from his North Dakota license application also constituted an intentional misrepresentation and not a "simple error."

5. Springville Pediatrics and Adult Care terminated the Respondent for a number of reasons having to do with his poor performance in the position. (Transcript, pages 152-55.) When the North Dakota Board inquired about the circumstances, the Respondent instead attempted to characterize his termination as a response to his "resignation intent." (Exhibit 14, page 17.) Dr. Canavan, the member of the practice who had arranged to hire him, fired him on July 28, 2008. (Transcript, pages 122, 133-34; Exhibit 10, page 135.) The

Respondent, however, sent the North Dakota Board a copy of a resignation letter from his Springville employment, signed and dated July 26, 2008. (Exhibit 14, page 18.)

At the hearing the Respondent claimed that he placed this resignation letter in Dr. Canavan's mailbox on July 26. (Transcript, page 905.) There is no such letter in the Springville records. The Hearing Committee fully credited Dr. Canavan's and Ms. Mayerat's testimony that no such letter was ever submitted, and that no resignation was ever offered. (Transcript, pages 40-41, 134-35, 144.) (Allegation G-4.)

The Respondent's own evidence of his communications with an attorney in contemplation of preparing a letter of resignation are inconsistent with his claim that he actually completed and submitted a resignation letter or that he resigned from Springville before he was fired. The Respondent had been corresponding by email with the attorney, Catherine Gale, and he asked her to review a "draft" of a resignation letter. (Exhibits C, D.) On July 28, he sent her an email telling her he had been fired and so there was "no need for me to finalize the draft." (Exhibit C; Transcript, page 615.) This "draft" that there was "no need to finalize," with a signature and date of July 26 added, is the very letter that he sent to the North Dakota Board. No such letter was ever submitted to Springville. (Transcript, pages 40-41, 134-35, 144.) The Hearing Committee concluded that the July 26 letter of resignation he submitted to the North Dakota Board is a fabrication.

The Respondent's written account of these matters to the North Dakota Board was not, strictly speaking, inaccurate. It is clear that the North Dakota Board was aware of his termination. (Exhibit 14, pages 9, 14.) The Respondent wrote in his application that he contemplated resigning, and that "his intent," which he did not actually say was communicated to Springville, was countered with termination. (Exhibit 14, pages 17-19.)

This account was arguably simply disingenuous. It was unquestionably misleading and fraudulent, however, to have submitted with that account a copy of a fabricated resignation letter, signed and dated two days before he was fired. (Exhibit 14, page 18.)

6. The Respondent's testimony was in general evasive, inconsistent, unpersuasive, and not worthy of belief. His occasional candor in admitting some of the misconduct charged did not alter this general impression. The Hearing Committee did not credit his explanations for his misrepresentations about his employment history as either genuine or adequate to answer the charges. They amount to a collection of very poor and unconvincing excuses for the obvious: that he misrepresented his employment history on applications because it was so poor.

The Respondent's disturbing ability to admit the truth and yet still profess to be excused by a lie was particularly evident in his attempts to suggest that he somehow resigned before he was fired by Springville, in his testimony about his E.J. Noble termination, and in his insistence that "absolutely it was appropriate" to describe his Mid-State employment as *locum tenens*.

Whatever "intentions" he may have had, he clearly was fired from Springville before he communicated them. He admitted he was fired by E.J. Noble, but then went on at the hearing to talk about the inconveniences of cashing his check as pertinent to the "personal reasons" misrepresentation, to further suggest he could legitimately think it was not a termination but rather some way of being "timed out," and to quibble about whether he actually received the termination letter. He was hired for a permanent position at Mid-State, subject only to a probationary period, and was fired. *Locum tenens* had nothing to do with it. The Respondent's testimony on these matters was persuasive evidence of his continuing

inability to be honest. Indeed, some lack of contact with reality is suggested by his ability to maintain these things and offer these views even as he admits the real facts.

Allegations A-1,2,5,6, B-1,2,3, C-1,2,4,5, D-1,2,6,7, E-1,2, F-1, G-1,2,3,4, and H-1 were sustained. Allegations A-3,4, C-3, D-3,4,5, although sustained, were considered to be redundant to the other allegations. Allegations A-7, B-4, C-6, D-8, E-3 and F-2 were not sustained.

I – O. Patient care criticisms.

Patient evaluations.

Patient A, a patient at Springville for several years, had a family and personal history of cardiac disease. She made an appointment for an urgent care visit on March 31, 2008 because she was experiencing chest pain and shortness of breath. (Exhibit 16, page 8; Transcript, pages 326-29.) The Respondent failed to evaluate her complaint or document any physical examination, history or treatment plan. He did not listen to her chest and did not order an ekg or any other tests. (Transcript, page 330.) He left blank and unsigned the forms intended to be used to document the patient visit. (Exhibit 16, page 8.) He only filled out the billing sheet indicating what to bill. (Transcript, pages 54-55.) Patient A, who testified at the hearing, was so dismayed by her encounter with the Respondent that she later made an appointment to return and present her complaints. (Transcript, pages 196-97; Exhibit 16, page 2.)

Upon reviewing the patient record, Patient A's and the Respondent's testimony, and Dr. Ruotsi's testimony, the Hearing Committee unanimously agreed with Dr. Ruotsi's conclusions (Transcript, pages 357-60) that the Respondent failed to address the patient's

primary complaint, failed to document an adequate physical examination or history, and failed to formulate an adequate treatment plan.

Upon reviewing the patient records for Patients B, C, D, E and F and the Respondent's and Dr. Ruotsi's testimony, the Hearing Committee unanimously agreed with Dr. Ruotsi's conclusions about those records as well. (Transcript, pages 383-84, 410-14, 435-39, 474-78, 491-92.) The Committee sustained similar allegations that the Respondent failed to adequately document evaluations, examinations, histories and treatment plans, and further concluded that he failed to adequately conduct evaluations and examinations, take histories or formulate treatment plans.

In the Hearing Committee's view, the requirements for the adequate conduct and the adequate documentation of a patient encounter are coextensive obligations. If something is not adequately documented then presumptively it was not adequately done. Although the burden of proof is on the Petitioner, the Respondent had an affirmative duty to document that he did not fulfill. The evidence of Patient A affirmatively established that the Respondent's failure to document an adequate evaluation of a patient also reflected a failure to perform an adequate evaluation. The Hearing Committee did not credit that in any of these cases he performed adequate services that were not documented.

In seven of the ten patient encounters under review, the Respondent failed to make any note in the chart about the visit. He acknowledged that he failed to document his encounter with Patient B on March 22, 2007 (Transcript, pages 943-44), Patient D on June 23, 2008 (Transcript, page 976) or Patient E on any of three office visits (Transcript, pages 983-85). He also failed to document his encounter with Patient A on March 31, 2008 (Exhibit 16, page 8) or Patient C on May 15, 2008 (Exhibit 18, page 6).

These were not isolated incidents in just a few cases selected for this proceeding. After the Respondent was fired from Springville, Ms. Mayerat reviewed all of his patient charts and found that there were approximately 200 missing notes among the 980 patient visits the Respondent conducted.[1] (Transcript, page 104.)

The Hearing Committee rejected the Respondent's excuse that he had an overwhelming workload at Springville. (Transcript, page 985.) The evidence is that the Respondent was actually given a reduced workload at Springville to enable him to catch up with his documentation backlog. Dr. Canavan made extensive attempts to accommodate the Respondent with a relatively light schedule and time to catch up, but there was no improvement. (Transcript, pages 32, 127-31, 150.) The Hearing Committee also rejected the Respondent's excuse that because March 22, 2007 was his last day of employment at Sheehan, he never had an opportunity to complete the Patient B chart entry. (Transcript, pages 944, 1019.)

Although the Respondent dictated a note for Patient D's May 23 visit (Exhibit 19, page 9), Dr. Ruotsi pointed out (allegation L-1) that it contained no physical examination findings. (Transcript, page 435.) The Hearing Committee rejected the Respondent's explanation that he failed to document a physical examination because it was a medication management visit. (Transcript, page 970.) As Dr. Ruotsi pointed out, this was a cardiac patient yet there is no indication the Respondent took her blood pressure or pulse or even listened to her heart or lungs. (Transcript, page 436.)

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[1] The substantive notes that appear on the copies of the patient charts in the hearing record are reconstructions Ms. Mayerat added to the charts after the Respondent left, in an effort to complete Springville's records as much as possible. (Transcript, pages 50-51, 54-55, 58-59, 61-63, 66-67, 70.)

The Hearing Committee also rejected as inadequate the Respondent's excuse that he did an "extremely limited" physical examination of Patient F because she had been seen within the last month and had no complaints. (Transcript, pages 991-92.) (Allegation N-1.)

Dr. Ruotsi said the physical examination of Patient G was inadequate because upper extremity reflexes were not evaluated. He said "It would have been adequate with – with upper extremity reflexes in addition." (Transcript, page 504.) On cross examination he testified:

> Q. … about the middle of the note where it begins to read: Neck, right trapezius muscle? At the end of that, does that indicate findings with regard to bilateral upper extremities?
>
> A. Yes.
>
> Q. And does that indicate that there was some type of testing of the upper extremities going full strength?
>
> A. Yes, there was. (Transcript, page 513.)

The Hearing Committee concluded that the Petitioner failed to prove the physical examination was not minimally adequate under the circumstances. Allegation O-1 was not sustained.

Other patient care criticisms.

Although Patient B was being treated for hypertension, the Respondent failed to renew her medications. (Allegation J-4.) Barbara Franklin was the ambulatory and community network director at Sheehan. (Transcript, page 167.) On the day of the visit, Patient B came to her complaining that the Respondent was refusing to renew her blood pressure medications unless she submitted to urine toxicology screening. (Transcript, page 189.) Dr. Thomas Small, another physician at Sheehan Memorial Hospital, was asked to review Patient B's chart. He found no valid reason to discontinue her blood pressure

medications. None of the antihypertensive medications in question had abuse potential. Dr. Small renewed them because the Respondent did not and the patient was in need. (Transcript, pages 283-84, 286; Exhibit 7, page 3.) (Allegation J-4.)

The Respondent denied that he refused to refill the blood pressure medications. He claimed "I was simply delaying writing [them]. I was not refusing. There's a big difference between those two things." (Transcript, page 1022.) Whether it was a refusal or a delay it remains the case that the patient had to complain to Ms. Franklin and another physician had to be asked to review the chart and write the prescriptions before this patient was able to get needed medication.

The Respondent's claim that it was appropriate to withhold antihypertensive medications for which there was an established, documented need until this patient submitted to a toxicology screen, was rejected by Dr. Small. He testified, and the Hearing Committee credited his opinion, that this patient record did not document any indication that a toxicology screen was necessary and that it is not standard practice to require a urine toxicology screen prior to the renewal of antihypertensive medications. (Transcript, pages 305-306.)

Dr. Ruotsi agreed that no appropriate medical reason was documented for the failure to renew the patient's blood pressure medications. (Transcript, page 389.) (Allegation J-5.) The needed medications can be given while other testing is being done. (Transcript, pages 401-405.) He characterized the Respondent's failure to renew these medications as a severe deviation from the appropriate standard of medical care. (Transcript, page 392.) The Hearing Committee credited his opinion that a position to the contrary was not simply a

matter of medical judgment within the appropriate standards of medical care. (Transcript, page 406.)

Patient C.

Patient C transferred out of the Springville practice after seeing the Respondent on May 15, 2008, angrily complaining among other things that the Respondent told him "do what I say or I will not give you medications." (Exhibit 18, page 2.) The record contains no indication that the Respondent refilled any of the patient's numerous medications on May 15. (Transcript, page 416; Exhibit 18, page 4.) As Dr. Ruotsi pointed out, such a significant change in a patient's regimen as a discontinuance of medications should be documented. (Transcript, page 391.)

The Respondent's claimed justification in curtailing prescriptions for narcotics was that this patient's medical history and use of medications and alcohol was a "red flag." (Transcript, page 959.) As he failed to enter any information in the chart on May 15, this alleged concern is neither documented nor explained as a reason to discontinue all medications. He denied refusing to refill hydrocodone but then acknowledged telling Patient C, as he did Patient B, that he would not renew prescriptions unless the patient gave him a urine specimen. (Transcript, pages 960-61.)

Dr. Ruotsi testified that there was nothing documented in this record to justify withholding medication pending a urine screen, nor was any other appropriate reason documented for a refusal to renew the patient's medications. (Transcript, pages 416, 419.) The Hearing Committee unanimously agreed that the Respondent's refusal to renew the patient's medications and failure to document an appropriate reason for doing so violated the appropriate standard of medical care. (Allegations K-4,5.)

Patient D.

Patient D had a cardiac history. She was on amiodarone, a medication used to manage an abnormal heart rhythm. An abrupt discontinuance of this medication can place a patient at risk. (Transcript, pages 443-44, 446, 449.) The Respondent did not renew Patient D's amiodarone on June 23. (Transcript, pages 974-76, 1055; Exhibit 19, page 6.) As he did not document this encounter at all, no reason was documented.

At the hearing the Respondent claimed he was concerned about amiodarone toxicity. (Transcript, page 977.) He pointed out that the PDR lists amiodarone as a "black box" medication, meaning risks should be considered. (Transcript, pages 461-62, 977.) Dr. Ruotsi, agreeing that risks should be considered, responded that the appropriate step, if amiodarone toxicity was the concern, was to test blood levels to find out if that was the case. (Transcript, pages 463-64.) No such concern was documented and no such testing was done. The medication was simply stopped without any documented explanation.

In this case, after the patient was taken off amiodarone, her atrial fibrillation recurred and she was placed back on it by her cardiologist. (Exhibit 19, pages 2, 14-15; Transcript, pages 449, 1065.) The Hearing Committee unanimously agreed that it was inappropriate to discontinue the amiodarone without any documented justification or explanation for doing so. (Allegations L-3,4.)

The Respondent said he expected the patient to see her cardiologist soon, that she had enough of the medication to last her until then, and that he was leaving it to the cardiologist to decide whether to renew the amiodarone. (Transcript, pages 1055-56, 1059-60.) He acknowledged that he probably should have communicated with the cardiologist on June 23 to discuss the matter. (Transcript, page 979-80.) The Hearing Committee concluded that the

evidence did not provide enough information to establish that the atrial fibrillation was mismanaged by the Respondent, and so did not sustain allegation L-5.

Patient E.

The Petitioner alleges that the Respondent engaged in arguments with Patient E and failed to document that the patient walked out on him at one visit. (Allegations M-16,17.) The Respondent did engage in loud arguments with this patient. Ms. Szulewski witnessed one argument and the patient told her of another. (Transcript, page 211.) One reason for the arguments was the Respondent's attempts to change the patient's medication regimen and refusal to refill medications. (Transcript, page 211; Exhibit 20, page 2.) Dr. Ruotsi testified it was a deviation from the standard of care not to document that the patient walked out of the May 5 visit. (Transcript, page 479.) The Hearing Committee noted, however, that the Respondent did, two days later, record in the chart that the patient had walked out. (Exhibit 20, page 14.)

The Hearing Committee agreed with Dr. Ruotsi that it is inappropriate to engage in a loud argument with a patient. (Transcript, page 480.) However, the mere existence of a loud encounter with a patient does not establish that the physician was at fault. Dr. Ruotsi conceded that the patient might initiate an argument, and that there is no written standard of care. (Transcript, page 481.) He also testified that he "had no information whatsoever" about what actually happened in these patient encounters. (Transcript, page 489.)

The Petitioner repeatedly argued that the Respondent "deviated from the standard of care" in connection with the alleged arguments, calling it "completely inappropriate and unprofessional." (Petitioner's brief, pages 77-78.) The Petitioner then charged both negligence and incompetence without explaining just how the particular facts in this case

established either negligence or incompetence. For these reasons, the Hearing Committee did not sustain allegations M16 and M17 as violations of Ed.L 6530.

Patient F.

Patient F had been prescribed MS Contin at a strength of 60mg. (Exhibit 21, page 8; Transcript, page 1082.) On June 27 2008, the Respondent reduced the dose from 60mg to 30mg. (Exhibit 21, page 6; Transcript, page 1082.)

The Respondent claimed that he discussed this with the patient on June 23, 2008, telling her "I'll continue to be your prescriber despite my reluctance until such time as you see the pain management group for the appointment I scheduled." (Transcript, page 995.) The Hearing Committee did not credit his claim. The patient chart contains a lengthy complaint written by Patient F about her June 23 encounter with the Respondent, in which the patient plainly asserts that the Respondent did not discuss this with her. (Exhibit 21, pages 2-4.)

According to Patient F, the Respondent refused to renew her prescription when she saw him on June 23 on the grounds that it was too soon. She had to return to pick up her prescription on June 27. It was only then that she discovered the dose had been cut in half and written for only seven days, not the thirty she expected. The Respondent never told her he was cutting the dose in half, nor did he tell her that he was renewing the medication for only seven days, not thirty. (Exhibit 21, page 4.) The Hearing Committee credited the patient's written complaint.

The Respondent noted in the chart that he was uncomfortable in prescribing this narcotic medication, and so wanted to refer the patient to a pain specialist. (Exhibit 21, page 7; Transcript, page 993.) He claimed he simply reduced the dose pending that consultation,

giving the patient just enough to last from June 27 until her appointment with the pain specialist on July 3. (Transcript, pages 501, 992, 994.) The Respondent claimed he did this because he suspected she was abusing the medication. (Transcript, page 1083.) Dr. Ruotsi pointed out, however, and the Respondent conceded, that the Respondent did not document any reason to suspect abuse. (Transcript, pages 493, 1084-85.)

Furthermore, if abuse was the concern Dr. Ruotsi pointed out that the Respondent's failure to explain the matter to the patient and construct a medication reduction protocol was another failure to meet the appropriate standard of care. (Transcript, pages 495-96.) The patient saw the pain specialist on July 3, and her dose was promptly restored to 60mg. (Exhibit 21, page 14.) The Hearing Committee sustained the allegations that the Respondent's failure to document the reduction or a reason for it, or to discuss the matter with the patient, were all failures to meet the appropriate standard of care. (Allegations N-2,3,4.)

Patient G.

On March 8, the Respondent reduced the amount and frequency of Patient G's prescription for Lortab, a narcotic pain medication. (Transcript, page 511.) The Respondent acknowledged he reduced the medication, and stood by the justification recorded in the chart: that there was no reason for patient to be taking high doses of muscle relaxers and narcotics except because of abuse or diversion. (Transcript, page 936; Exhibit 22, page 3.)

Asked if abuse or diversion is an appropriate justification for reducing the medication, Dr. Ruotsi answered "It could be, based on the reason for the suspicion. But that's not documented." (Transcript, page 506.) No reason for any such suspicion was documented. (Transcript, page 507.) (Allegation O-2.) The Respondent acknowledged that

there was nothing in particular about this patient that made him suspect diversion. His explanation, which the Hearing Committee found inadequate, was that in his general experience diversion often occurred where there was no monitoring. (Transcript, pages 1002-1003.)

Dr. Ruotsi also criticized the absence of any documentation indicating that the reduction was discussed with the patient. (Transcript, page 507.) (Allegation O-3.) The Respondent acknowledged that the chart did not document a discussion or even that he informed the patient of the reduction. (Transcript, page 1011.) Indeed, this patient later returned to the clinic specifically to complain about the unexplained reduction in his Lortab regimen. (Exhibit 22, page 4.)

Allegations I-1,2,3,4; J-1,2,3,4,5; K-1,2,3,4,5; L-1,2,3,4; M-1,2,3,4,6,7,8,9,11,12,13,14; N-1,2,3,4 and O-2,3 were sustained. Allegations I-5; J-6; K-6 and M-5,10&15, that the Respondent failed to adequately document patient encounters, were deemed accurate but redundant. Allegations L-5; M-16,17 and O-1 were not sustained.

DETERMINATION ON SPECIFICATIONS OF CHARGES

The Hearing Committee did not sustain factual allegations A-7, B-4, C-6, D-8, E-3, F-2, L-5, M-16,17 and O-1. The Committee sustained but deemed redundant allegations A-3, A-4, C-3, D-3,4,5, I-5, J-6, K-6 and M-5,10,15 and so did not consider them as contributing to the penalty determination. All other factual allegations were sustained. The charges of misconduct are:

1. **Fraudulent practice. First through eighth specifications.** The Petitioner charges that the Respondent violated Ed.L 6530(2) by reason of having practiced medicine fraudulently.

This specification involves representations made on all six applications (allegations A-F) and the two license applications (allegations G, H.)

The Respondent repeatedly made very serious misrepresentations about his employment history in applications to numerous employers and licensing authorities. There is no question that he had every reason to know that disclosure of the accurate facts about these matters would be likely to seriously and negatively affect his prospects of success in those applications. The number, consistency and nature of the misrepresentations and the Respondent's complete failure to offer any credible or acceptable explanation for them left no question, in the Hearing Committee's view, that they were knowingly false and intended to deceive. The Committee unanimously and without hesitation inferred, on the basis of this evidence, that fraudulent practice was established.

The Hearing Committee unanimously sustained the charge.

2. **Filing a false report. Ninth through sixteenth specifications.** The Petitioner charges that the Respondent violated Ed.L 6530(21) by reason of having made a false report.

This specification involves representations made on all six applications (allegations A-F) and the two license applications (allegations G, H.)

The Respondent's perpetuation of misinformation on applications, knowing it to be misinformation, demonstrated a willful intent to mislead and deceive employers and licensing authorities and so constitutes a willful filing of false reports.

The Hearing Committee unanimously sustained the charge.

3. **Violation of Ed.L 2805-k(1), failure to disclose. Seventeenth through twentieth specifications.** The Petitioner charges that the Respondent violated Ed.L

6530(14) by failing to disclose on applications for employment the discontinuance and reasons for discontinuance of his association with other facilities.

Pursuant to Education Law 2805-k, before hiring or granting privileges, hospitals and other facilities are required to request, and physicians are required to provide, the name of any hospital or facility with or at which the physician had or has any association, employment, privileges or practice. Where such association, employment, privilege or practice was discontinued, the physician is also required to disclose the reasons for its discontinuation.

This specification involves four applications (allegations A, C, D, E) in which the Respondent failed to disclose his employment at Sheehan and failed to disclose his termination from E.J. Noble.

The Hearing Committee unanimously sustained the charge.

4. **Gross negligence. Twenty-first though twenty-fifth specifications.** The Petitioner charges that the Respondent violated Ed.L 6530(4) by practicing with gross negligence.

This specification involves treatment of Patients A, B, C, D and E. (Allegations I, J, K, L, M.)

The Hearing Committee did not single out any one of these charts that clearly shows gross negligence, but the cumulative record of the charts reviewed, together with Ms. Mayerat's testimony that the Respondent failed to in any way document 200 of 980 patient encounters during his brief time at Springville, persuaded the Committee that the Respondent practiced with gross negligence because these multiple acts of negligence cumulatively amount to egregious conduct.

The Hearing Committee unanimously sustained the charge.

5. **Gross incompetence. Twenty-sixth through thirtieth specifications.** The Petitioner charges that the Respondent violated Ed.L 6530(6) by practicing with gross incompetence.

This specification involves treatment of Patients A, B, C, D and E. (Allegations I, J, K, L, M.)

The Hearing Committee unanimously concluded that the evidence failed to establish gross incompetence. The charge was not sustained.

6. **Negligence on more than one occasion. Thirty-first specification.** The Petitioner charges that the Respondent violated Ed.L 6530(3) by practicing with negligence on more than one occasion.

This specification involves treatment of Patients A, B, C, D, E, F and G. (Allegations I, J, K, L, M, N, O.)

The Hearing Committee unanimously sustained the charge.

7. **Incompetence on more than one occasion. Thirty-second specification.** The Petitioner charges that the Respondent violated Ed.L 6530(5) by practicing with incompetence on more than one occasion.

This specification involves treatment of Patients A, B, C, D, E, F and G. (Allegations I, J, K, L, M, N, O.)

The Hearing Committee unanimously sustained the charge.

8. **Failure to maintain records. Thirty-third through thirty-ninth specifications.** The Petitioner charges that the Respondent violated Ed.L 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.

This specification involves treatment of Patients A, B, C, D, E, F and G. (Allegations I, J, K, L, M, N, O.)

The Hearing Committee unanimously sustained the charge.

PENALTY DETERMINATION

The Respondent suggested that his misrepresentations about his employment history should not be taken very seriously because he had an even bigger stain on his record to worry about:

> In the sum total of things, the biggest thing negative on my entire resume is five years out of practice due to a license suspension. A six week activity at a struggling urban hospital is a minor blemish compared to a huge scar hardly even worth considering. (Transcript, page 772.)

The Hearing Committee was not persuaded by the view that these matters are "hardly even worth considering" simply because he also had a medical license suspension in his history. To the contrary, the experience of having his license suspended should, if he were truly willing and able to correct his behavior, have caused him to be especially conscientious and scrupulous about his conduct in professional matters.

There is abundant evidence that the Respondent was a disaster in his dealings with both patients and colleagues wherever he worked. His behavior with both staff and patients was unacceptable, and yet there appeared to be little sense in which the Respondent considered himself responsible for any of it. He did apparently represent himself to Dr. Canavan as suffering from some form of attention deficit disorder. (Exhibit 10, page 125.) In the Hearing Committee's view, however, there is a significant distinction between a disability and a character flaw. The Committee concluded that in this case the Respondent's record demonstrates flaws well beyond what is excusable on account of a disability, and well beyond remediation.

In spite of his extensive experience of failure, numerous attempts of employers to address his deficiencies, and previous discipline imposed by the Petitioner, the Respondent has showed no improvement in his work or his approach to it. He shows no real insight and fails to acknowledge his severe difficulties or his own part in them. He has demonstrated an intention to mislead, misrepresent and conceal as necessary, in order to continue to practice in the same way as he always has. He clearly cannot be trusted to be honest about his background, nor is there good reason to believe that he is willing to learn from others, accept guidance, and correct his deficiencies in order to provide an acceptable level of patient care.

The Hearing Committee reviewed the penalties available to it under PHL 230-a. The Committee struggled to find some way to view this situation as correctible or remediable but could not find one. The fraud on the applications alone was viewed by the Committee as sufficient reason to revoke. Particularly clear examples showing the Respondent is incapable of remediation are his attempts at this hearing to suggest he could reasonably believe he was not really terminated by E.J.Noble and so did not have to disclose the termination, his insistence that "absolutely it was appropriate" to describe Mid-State as a *locum tenens* position, and his coming before this Hearing Committee to vouch for the authenticity of a fabricated letter he submitted to the North Dakota Board.

The Hearing Committee is convinced that it would be unconscionable to allow the Respondent to continue to hold a medical license. The abysmal professional performance reflected in the Respondent's treatment of Patients A-G shows good reason to conclude that the many terminations for cause were justified and appropriate because this physician is unable or unwilling to provide responsible and competent patient care. The clear impression given by the Respondent at the hearing was that he does not see that there was much if

anything wrong in his patient care and does not think that his misrepresentations to potential employers and licensing authorities were of any real significance. Given his demonstrated propensity to lie about his history and qualifications, the Hearing Committee can see no possible way to leave him in possession of a medical license with which to continue to foist himself on employers and patients. The possession of a medical license is a privilege that he has abused, and revocation is the only responsible way to address that abuse.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following charges of misconduct under Ed.L 6530 are sustained:

   Ed.L 6530(2). Practicing fraudulently.
   Ed.L 6530(21). Filing a false report.
   Ed.L 6530(14). Violation of Ed.L 2805-k.
   Ed.L 6530(4). Practicing with gross negligence.
   Ed.L 6530(3). Practicing with negligence on more than one occasion.
   Ed.L 6530(5). Practicing with incompetence on more than one occasion.
   Ed.L 6530(32). Failing to maintain accurate patient records.

   The charge of misconduct under Ed.L 6530(6), practicing with gross incompetence, is not sustained.

2. The Respondent's license to practice medicine is revoked.

3. This order shall be effective upon service on the Respondent by personal service or by registered or certified mail as required under PHL 230(10)(h).

Dated: Albany, New York

By: REDACTED SIGNATURE

Richard P. Kasulke, M.D., Chair

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Heidi B. Miller, M.P.H.

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REDACTED ADDRESS

APPENDIX I

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

IN THE MATTER

OF

ROBERT NICAISE, M.D.

STATEMENT

OF

CHARGES

Robert Nicalse, M.D., Respondent, was authorized to practice medicine in New York State on or about August 22, 1983, by the issuance of license number 155535 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, on or about July 28, 2007, submitted an application for Medical Staff Membership at Kenmore Mercy Hospital, Kenmore (Buffalo), New York. On or about August 8, 2007, Respondent submitted/completed a two page "Explanation Addendum" to his Kenmore Mercy application.

1. Respondent, on his Kenmore Mercy application, falsely represented his past medical staff memberships, employments, or professional affiliations, in that Respondent omitted his employment/affiliation with Sheehan Health, Buffalo, New York from February 2007 through March 22, 2007. Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

2. Respondent, on his Kenmore Mercy application, falsely represented that he had resigned his affiliation with E.J. Noble Hospital, Gouverneur, New York due to "personal financial reasons". In fact, Respondent was terminated by E.J. Noble. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

3. Respondent, on his Kenmore Mercy application, failed to identify his termination by E.J. Noble in 2004 as an example of his membership or affiliation with a health care facility staff having been "voluntarily or involuntarily denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation, not renewed, or relinquished to avoid possible disciplinary action". Respondent's

response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

4. Respondent, in the curriculum vitae he submitted with his application to Kenmore Mercy, misrepresented his "Professional Experience" from January 1, 2007, through March 26, 2007, by omitting any reference to his employment with Sheehan Health from February 2007 to March 22, 2007.

5. Respondent, in the curriculum vitae he submitted with his application to Kenmore Mercy, misrepresented his "Professional Experience" from January 1, 2007, through March 26, 2007, by representing that his work as a Staff Physician [in] Walden, New York was from January 2007 to present. In fact, Respondent did not commence employment at Hudson River Healthcare's Wallkill Health Center in Walden, New York until approximately March 26, 2007. Respondent's responses/omissions were made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

6. Respondent, in the curriculum vitae he submitted as part of his application process to Kenmore Mercy, misrepresented that his employment as a Staff Physician at Mid-State Correctional Facility from October 2002 - March 2003 was a "Locums" employment. In fact, Respondent had been hired as a New York State employee, and his employment at Mid-State Correctional Facility ended when Respondent was terminated by Mid-State Correctional Facility in about March 2003, prior to the end of Respondent's probationary period as an employee. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

7. Respondent, in the curriculum vitae he submitted as part of his application process to Kenmore Mercy, misrepresented that he had been employed as a "Staff Physician" at the Community Health Center of Buffalo, Buffalo, New York. In fact, Respondent was not credentialed to provide patient care while at CHCB, and did not provide any patient care during his employment at CHCB. Respondent's representation of his employment at CHCB was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

B. Respondent applied for a position at Springville Pediatrics and Adult Care, Springville, New York, where he was hired and was employed from on or about March 10, 2008 until he was terminated on or about July 28, 2008.

1. Respondent, in the curriculum vitae he submitted as part of his application process to Springville Pediatrics and Adult Care, misrepresented his employment history by omitting any mention of his employment by Sheehan Health from February 2007 through March 22, 2007. Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

2. Respondent, in the curriculum vitae he submitted with his application to Springville Pediatrics and Adult Care, misrepresented his "Professional Experience" from "01/07 – 06/07", by omitting any reference to his employment with Sheehan Health from February 2007 to March 22, 2007, and by representing that his work as a "Staff Physician [in] Walden, New York" was from January 2007 - June 2007. In fact, Respondent did not commence employment at Hudson River Healthcare's Wallkill Health Center in Walden, New York until approximately March 26, 2007. Respondent's responses/omissions were made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

3. Respondent, in the curriculum vitae he submitted as part of his application process to Springville Pediatrics and Adult Care, misrepresented that his employment as a Staff Physician at Mid-State Correctional Facility from October 2002 - March 2003 was a "Locums" employment. In fact Respondent had been hired as a New York State employee, and his employment at Mid-State Correctional Facility ended when Respondent was terminated by Mid-State Correctional Facility in about March 2003, prior to the end of Respondent's probationary period as an employee. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

4. Respondent, in the curriculum vitae he submitted as part of his application to Springville Pediatrics and Adult Care, misrepresented that he had been employed as a "Staff Physician" at the Community Health Center of Buffalo, Buffalo, New York. In fact, Respondent was not credentialed to provide patient care while at CHCB, and did not provide any patient care during his employment at CHCB. Respondent's representation of his employment at CHCB was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

C. Respondent, on or about January 23, 2009, completed an application for Medical Staff Membership at TLC Health Network, Irving, New York.

1. Respondent, in his TLC Health Network application, when asked to list "all present and previous affiliations in chronological order, most recent first", falsely represented his past affiliations, in that Respondent omitted his employment/affiliation with Sheehan Health, Buffalo, New York from February 2007 through March 22, 2007. Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

2. Respondent, in his TLC Health Network application, failed to include his termination by EJ Noble in 2004 as an example of a membership or affiliation with a healthcare facility staff that had been "denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation, not renewed or voluntarily relinquished to avoid possibly disciplinary action." Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

3. Respondent, in the curriculum vitae he submitted as part of his application to TLC Health, omitted any mention of his employment by Sheehan Health in Buffalo, including under the heading for his employments in "Urban Community Medicine." Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

4. Respondent, in the curriculum vitae he submitted as part of his application to TLC Health, misrepresented that his employment as a Staff Physician at Mid-State Correctional Facility from October 2002 - March 2003 was a "Locums" employment. In fact Respondent had been hired as a New York State employee, and his employment at Mid-State Correctional Facility ended when Respondent was terminated by Mid-State Correctional Facility in about March 2003, prior to the end of Respondent's probationary period as an employee. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

5. Respondent, in the curriculum vitae he submitted as part of his application to TLC Health, misrepresented that his employment at Springville Pediatrics and Adult Care from March 2008 until July 2008 was "locums [at] ambulatory private practice group", when in fact Respondent had been hired as a full time physician for said practice, and/or his employment was not a "locums" employment. Respondent's employment by Springville Pediatrics and Adult Care ended when said practice terminated Respondent for cause. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

6. Respondent, in the curriculum vitae he submitted as part of his application to TLC Health, misrepresented that he had been employed as a "Staff Physician" at the Community Health Center of Buffalo, Buffalo, New York. In fact, Respondent was not credentialed to provide patient care while at CHCB, and did not provide any patient care during his employment at CHCB. Respondent's representation of his employment at CHCB was made with intent to deceive or with

reckless disregard as to the truthfulness of his statement.

D. Respondent, on or about March 2009, submitted an application for Medical Staff Membership at Kaleida Health, Buffalo, New York.

1. Respondent, in the section of the Kaleida application for listing hospital and healthcare affiliations, omitted his employment/affiliation with Sheehan Health, Buffalo, New York from February 2007 through March 22, 2007. Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

2. Respondent, in his Kaleida application and/or addendum, failed to include his termination by EJ Noble in 2004 as an example of a membership or affiliation with a healthcare facility staff that had been "denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation, not renewed or voluntarily relinquished to avoid possibly disciplinary action." Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

3. Respondent, in his Kaleida application which asked him to "provide a chronological list of all activities since graduation from professional school to the present", omitted any mention of his employment/affiliation with Sheehan Health from February 2007 through March 22, 2007. Respondent's response/omission was made with intent to deceive or with reckless disregard to the truthfulness of his statement.

4. Respondent, in the section of the Kaleida application which asked him to "provide a chronological list of all activities since graduation from professional school to the present", misrepresented that from "09/06 to 02/07" he had engaged in the following: "continuing medical education, search for clinical employment, consulting, technical writing, medical device development, medical record reviews", when in fact Respondent was employed by Sheehan Health in February 2007. Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

5. Respondent, in the curriculum vitae he submitted as a part of his application to Kaleida Health, omitted any mention of his employment by Sheehan Health from February 2007 - March 22, 2007, including under the heading for his employments in "Urban Community Medicine". Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

6. Respondent, in the curriculum vitae he submitted as a part of his application to Kaleida Health, misrepresented that his employment as a Staff Physician at Mid-State Correctional Facility from October 2002

- March 2003 was a "Locums" employment. In fact, Respondent had been hired as a New York State employee, and his employment at Mid-State Correctional Facility ended when Respondent was terminated by Mid-State Correctional Facility in about March 2003, prior to the end of Respondent's probationary period as an employee. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

7. Respondent, in the curriculum vitae he submitted as a part of his application to Kaleida Health, misrepresented that his employment at Springville Pediatrics and Adult Care from March 2008 until July 2008 was "locums [at] ambulatory private practice group", when in fact Respondent had been hired as a full time physician for said practice and/or his employment was not a "locums" employment. Respondent's employment at Springville Pediatrics and Adult Care ended when said practice terminated Respondent for cause. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

8. Respondent, in the curriculum vitae he submitted as part of his application to Kaleida Health, misrepresented that he had been employed as a "Staff Physician" at the Community Health Center of Buffalo, Buffalo, New York. In fact, Respondent was not credentialed to provide patient care while at CHCB, and did not provide any patient care during his employment at CHCB. Respondent's representation of his employment at CHCB was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

E. Respondent was employed by Hudson River Health Care in its clinic in Walden, New York from approximately March 26, 2007 through approximately May 25, 2007. Respondent, on or about March 16, 2007, had submitted an application and other information to Hudson River Health Care.

1. Respondent, in the curriculum vitae he submitted as a part of his application to Hudson River Health Care, omitted his employment by Sheehan Health from February 2007 - March 22, 2007, including under the heading for his employments in "Urban Community Medicine". Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

2. Respondent, in the curriculum vitae he submitted as a part of his application to Hudson River Health Care, misrepresented that his employment as a Staff Physician at Mid-State Correctional Facility from October 2002 - March 2003 was a "Locums" employment. In fact, Respondent had been hired as a New York State employee, and his employment at Mid-State Correctional Facility ended when

Respondent was terminated by Mid-State Correctional Facility in about March 2003, prior to the end of Respondent's probationary period as an employee. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

3. Respondent, in the curriculum vitae he submitted as part of his application to Hudson River Health Care, misrepresented that he had been employed as a "Staff Physician" at the Community Health Center of Buffalo, Buffalo, New York. In fact, Respondent was not credentialed to provide patient care while at CHCB, and did not provide any patient care during his employment at CHCB. Respondent's representation of his employment at CHCB was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

F. Respondent was employed by Clifton-Fine Hospital in Star Lake, New York from approximately September 2005 through approximately June 22, 2006. Respondent, on or about September 7, 2005, submitted an application for appointment to the Medical Staff and other information to Clifton-Fine Hospital.

1. Respondent, in the curriculum vitae he submitted as a part of his application to Clifton-Fine Hospital, misrepresented that his employment as a Staff Physician at Mid-State Correctional Facility from October 2002 - March 2003 was a "Locums" employment. In fact, Respondent had been hired as a New York State employee, and his employment at Mid-State Correctional Facility ended when Respondent was terminated by Mid-State Correctional Facillty in about March 2003, prior to the end of Respondent's probationary period as an employee. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

2. Respondent, in the curriculum vitae he submitted as part of his application to Clifton-Fine Hospital, misrepresented that he had been employed as a "Staff Physician" at the Community Health Center of Buffalo, Buffalo, New York. In fact, Respondent was not credentialed to provide patient care while at CHCB, and did not provide any patient care during his employment at CHCB. Respondent's representation of his employment at CHCB was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

G. Respondent, on about May 2, 2009, completed an application to the North Dakota State Board of Medical Examiners for a North Dakota medical license. Respondent, on or about July 29, 2009, was issued a six-month conditional license.

1. Respondent, in the "Professional Training and Experience Addendum" he submitted as part of his application process to the North Dakota Board, omitted any mention of his employment by Sheehan Health from February 2007 - March 22, 2007. Respondent, in said addendum, misrepresented that he was engaged in "Various non-clinical activities [in] Hamburg, NY [from] 09/06 - 02/07", when in fact Respondent commenced his employment at Sheehan Health in February 2007. Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

2. Respondent, in the "Professional Training and Experience Addendum" he submitted as part of his application process to the North Dakota Board, omitted any mention of his employment at Mid-State Correctional Facility from October 2002 - March 2003, when he was terminated prior to the end of his probationary period as an employee. Respondent, in said Addendum, misrepresented that he was engaged in various activities from 3/00 - 10/03, including employment search job interviews, when in fact from October 2002 - March 2003, Respondent was employed at Mid-State Correctional Facility. Respondent's response/omission was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

3. Respondent, in said Addendum, listed that he was employed by E.J. Noble Hospital, Governeur, New York as a "Locums Attending Physician" when in fact, the employment position which Respondent held at E.J. Noble was not a "locums" position, and Respondent knew such fact. Respondent's employment at E.J. Noble ended when Respondent was terminated for cause. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

4. Respondent, in the materials he submitted to the North Dakota Board, submitted a statement regarding the termination of his employment with Springville Pediatrics and Adult Care in July 2008. Respondent misrepresented that he "drafted a resignation letter" which gave 90 days notice, and that "[his] resignation intent was immediately countered with an immediate termination." Respondent attached a resignation letter dated July 26, 2008, and Springville Pediatrics' letter dated July 28, 2008, terminating Respondent's employment. Respondent's response/statement was made with intent to deceive or with reckless disregard as to the truthfulness of his statement, in that Respondent never submitted a resignation letter to Springville Pediatrics, nor did Respondent offer to resign, prior to Springville

Pediatrics' termination of Respondent's employment on July 28, 2008.

H. Respondent, on or about July 7, 2004, submitted a Registration Renewal to the New York State Education Department, Division of Professional Licensing Services, for renewal of his registration of his New York State medical license for the period from July 1, 2004 through June 30, 2006.

1. Respondent, in response to the question "Since your last registration application, [h]as any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, ...?", answered "No", when in fact Respondent was terminated by E.J. Noble Hospital on or about February 2004 and Respondent knew such fact. Respondent's response was made with intent to deceive or with reckless disregard as to the truthfulness of his statement.

I. Respondent provided medical care to Patient A (patient names appear in Appendix), a then 53 year old female, on or about March 31, 2008 at Springville Pediatrics and Adult Care (SPAC) in Springville, New York. Respondent failed to meet the standard of care in that:

1. Respondent failed to adequately evaluate or address Patient A's primary complaint and/or concerns and/or failed to document any evaluation he performed to address same.

2. Respondent failed to perform an adequate physical exam of Patient A and/or failed to document any exam performed.

3. Respondent failed to obtain an adequate history from Patient A and/or failed to document any history he obtained.

4. Respondent failed to formulate an appropriate treatment plan for Patient A and/or failed to document a treatment plan.

5. Respondent failed to adequately document in Patient A's medical record his March 31, 2008 encounter with Patient A.

J. Respondent provided medical care to Patient B, a then 48 year old female, on or about March 22, 2007 at Sheehan Memorial Hospital (SMH). Respondent failed to meet the standard of care, in that:

1. Respondent failed to adequately evaluate or address Patient B's primary complaint and/or concerns and/or failed to document any

information regarding any action he took to address same.

2. Respondent failed to perform an adequate physical exam of Patient B and/or failed to document any exam performed.

3. Respondent failed to obtain an adequate history from Patient B and/or failed to document any history he obtained.

4. Respondent refused or failed to provide prescriptions for refills of Patient B's blood pressure medications without an appropriate medical justification.

5. Respondent failed to document an appropriate medical reason for his refusal or failure to provide prescriptions for refills for Patient B's blood pressure medications.

6. Respondent failed to adequately document in Patient B's medical record his March 22, 2007 encounter with Patient B.

K. Respondent provided medical care to Patient C, a then 65 year old male, on or about May 15, 2008 at SPAC. Respondent failed to meet the standard of care, in that:

1. Respondent failed to adequately address Patient C's primary complaint and/or concerns and/or failed to document any information regarding any action he took to address same.

2. Respondent failed to perform an adequate physical exam of Patient C and/or failed to document any exam performed.

3. Respondent failed to obtain an adequate history from Patient C and/or failed to document any history he obtained.

4. Respondent refused or failed to provide prescriptions for refills of Patient C's medications without an appropriate medical justification.

5. Respondent failed to document an appropriate medical reason for his refusal or failure to provide prescriptions for refills of Patient C's medications.

6. Respondent failed to adequately document in Patient C's medical record his May 15, 2008 encounter with Patient C.

L. Respondent provided medical care to Patient D, a then 79 year old female, on or about May 23, 2008 and on or about June 23, 2008 at SPAC. Respondent failed to meet the standard of care, in that:

1. Respondent failed to perform an adequate physical examination of Patient D during the May 23, 2008 visit and/or failed to adequately document any exam performed.

2. Respondent failed to perform an adequate physical examination of Patient D during the June 23, 2008 visit and/or failed to adequately document any exam performed.

3. Respondent failed to adequately evaluate or treat Patient D, including providing a refill of Amiodarone and/or failed to adequately document his intention or plan with regard to said medication.

4. Respondent decided not to or failed to refill Patient D's Amiodarone, and/or failed to adequately document an appropriate medical reason or rationale for not refilling said medication.

5. Respondent failed to adequately manage Patient D's atrial fibrillation and/or placed Patient D at risk due to his actions with regard to her medication.

M. Respondent provided medical care to Patient E, a then 53 year old male, on or about April 7, 2008; on or about May 5, 2008; and on or about May 22, 2008 at SPAC. Respondent failed to meet the standard of care, in that:

1. Respondent failed to address Patient E's primary complaint and/or concerns on the April 7, 2008 visit, and/or failed to document any information regarding any action he took to address same for the April 7, 2008 visit.

2. Respondent failed to perform an adequate physical exam of Patient E on the April 7, 2008 visit, and/or failed to document any exam performed.

3. Respondent failed to obtain an adequate history from Patient E on the April 7, 2008 visit, and/or failed to document any history he obtained.

4. Respondent failed to formulate an appropriate treatment plan for Patient E on the April 7, 2008 visit, and/or failed to document a treatment plan.

5. Respondent failed to adequately document in Patient E's medical record his April 7, 2008 encounter with Patient E.

6. Respondent failed to address Patient E's primary complaint and/or concerns on the May 5, 2008 visit, and/or failed to document any information regarding any action he took to address same.

7. Respondent failed to perform an adequate physical exam of Patient E on the May 5, 2008 visit, and/or failed to document any exam performed.

8. Respondent failed to obtain an adequate history from Patient E on the May 5, 2008 visit, and/or failed to document any history he obtained.

9. Respondent failed to formulate an appropriate treatment plan for Patient E on the May 5, 2008 visit, and/or failed to document a treatment plan.

10. Respondent failed to adequately document in Patient E's medical record his May 5, 2008 encounter with Patient E.

11. Respondent failed to address Patient E's primary complaint and/or concerns on the May 22, 2008 visit, and/or failed to document any information regarding any action he took to address same.

12. Respondent failed to perform an adequate physical exam of Patient E on the May 22, 2008 visit, and/or failed to document any exam performed.

13. Respondent failed to obtain an adequate history from Patient E on the May 22, 2008 visit, and/or failed to document any history he obtained.

14. Respondent failed to formulate an appropriate treatment plan for Patient E on the May 22, 2008 visit, and/or failed to document a treatment plan.

15. Respondent failed to adequately document in Patient E's medical record his May 22, 2008 encounter with Patient E.

16. Respondent, during one or more of Patient E's appointments for medical care, engaged in a loud, lengthy argument with Patient E and/or yelled loudly at Patient E.

17. Respondent failed to adequately document the content of Patient E's office visits, including that during the May 5, 2008 visit, Patient E walked out of his appointment with Respondent.

N. Respondent provided medical care to Patient F, a then 58 year old female, on or about May 27, 2008 and on or about June 23, 2008 at SPAC.

Respondent failed to meet the standard of care, in that:

1. Respondent failed to perform an adequate physical exam on the June 23, 2008 visit, and/or failed to document any exam performed.

2. Respondent failed to adequately document for the June 23, 2008 visit his intention to reduce Patient F's narcotic pain medication.

3. Respondent failed to adequately document for the June 23, 2008 visit an appropriate medical justification for reducing Patient F's narcotic pain medication.

4. Respondent failed to adequately inform Patient F in the June 23, 2008 visit that he was reducing Patient F's narcotic pain medication and failed to document any discussion with or counseling of Patient F with regard to Respondent's reduction of said medication.

O. Respondent provided medical care to Patient G, a then 51 year old male, on or about March 8, 2007, at SMH. Respondent failed to meet the standard of care, in that:

1. Respondent failed to perform an adequate physical examination of Patient G and/or failed to adequately document the exam performed.
2. Respondent failed to adequately document an appropriate medical justification for reducing Patient G's medications (muscle relaxers and narcotic pain medication).
3. Respondent failed to adequately discuss with Patient G and/or counsel Patient G regarding Respondent's intention to reduce Patient G's medications and/or failed to adequately document any discussion with or counseling of Patient G with regard to Respondent's reduction of said medications.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with professional misconduct under New York Education Law §6530 (2) by reason of his having practiced medicine fraudulently, in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6 and/or A.7.
2. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4.
3. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6.
4. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3 and/or D.4

and/or D.5 and/or D.6 and/or D.7 and/or D.8.

5. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3.
6. The facts in Paragraphs F and F.1 and/or F.2.
7. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3 and/or G.4.
8. The facts in Paragraphs H and H.1.

NINTH THROUGH SIXTEENTH SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with professional misconduct under New York Education Law §6530 (21) by reason of his having made or filed a false report, in that Petitioner charges:

9. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6 and/or A.7.
10. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4.
11. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6.
12. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3 and/or D.4 and/or D.5 and/or D.6 and/or D.7 and/or D.8.
13. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3.
14. The facts in Paragraphs F and F.1 and/or F.2.
15. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3 and/or G.4.
16. The facts in Paragraphs H and H.1.

SEVENTEENTH THROUGH TWENTIETH SPECIFICATIONS

VIOLATION OF EDUCATION LAW §2805-k(1)(a) AND/OR (b)

Respondent is charged with having violated New York Education Law § 6530 (14) in that Respondent failed to disclose on applications for employment at

a hospital or facility, and/or the granting of hospital privileges or association, the discontinuance and/or the reason for discontinuance of his association, employment or privileges; and/or the name of any hospital or facility with or at which Respondent had an association, employment, privileges, or practice; in that Petitioner charges:

17. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5.
18. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3.
19. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3 and/or D.4 and/or D.5.
20. The facts in Paragraphs E and E.1.

TWENTY-FIRST THROUGH TWENTY-FIFTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges:

21. The facts of Paragraph I and any or all of the following subparagraphs: I.1, I.2, I.3, I.4 and/or I.5.
22. The facts of Paragraph J and any or all of the following subparagraphs: J.1, J.2, J.3, J.4, J.5 and/ or J.6.
23. The facts of Paragraph K and any or all of the following subparagraphs: K.1, K.2, K.3, K.4, K.5 and/or K.6.
24. The facts of Paragraph L and any or all of the following subparagraphs: L.1, L.2, L.3, L.4 and/or L.5.
25. The facts of Paragraph M and any or all of the following subparagraphs: M.1, M.2, M.3, M.4, M.5, M.6, M.7, M.8, M.9, M.10,

M.11, M.12, M.13, M.14, M.15, M.16 and/or M.17.

TWENTY-SIXTH THROUGH THIRTIETH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(6) by practicing the profession of medicine with gross incompetence, in that Petitioner charges:

26. The facts of Paragraph I and any or all of the following subparagraphs: I.1, I.2, I.3, I.4 and/or I.5.

27. The facts of Paragraph J and any or all of the following subparagraphs: J.1, J.2, J.3, J.4, J.5 and/ or J.6.

28. The facts of Paragraph K and any or all of the following subparagraphs: K.1, K.2, K.3, K.4, K.5 and/or K.6.

29. The facts of Paragraph L and any or all of the following subparagraphs: L.1, L.2, L.3, L.4 and/or L.5.

30. The facts of Paragraph M and any or all of the following subparagraphs: M.1, M.2, M.3, M.4, M.5, M.6, M.7, M.8, M.9, M.10, M.11, M.12, M.13, M.14, M.15, M.16 and/or M.17.

THIRTY-FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

31. The facts of Paragraphs I, J, K, L M, N, and/or O, and any or all subparagraphs.

THIRTY-SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

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

32. The facts of Paragraphs I, J, K, L, M, N, and/or O, and any or all subparagraphs.

THIRTY-THIRD THROUGH THIRTY NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

33. The facts of Paragraph I and any or all of the following subparagraphs: I.1, I.2, I.3, I.4 and/or G.5.
34. The facts of Paragraph J and any or all of the following subparagraphs: J.1, J.2, J.3, J.5 and/ or J.6.
35. The facts of Paragraph I and any or all of the following subparagraphs: K.1, K.2, K.3, K.5 and/or K.6.
36. The facts of Paragraph L and any or all of the following subparagraphs: L.1, L.2, L.3, and/or L.4.
37. The facts of Paragraph M and any or all of the following subparagraphs: M.1, M.2, M.3, M.4, M.5, M.6, M.7, M.8, M.9, M.10, M.11, M.12, M.13, M.14, M.15 and/or M.17.
38. The facts of Paragraph N and any or all of the following

subparagraphs: N.1, N.2, N.3, and/or N.4.

39. The facts of Paragraph O and any or all of the following subparagraphs: O.1, O.2, and/or O.3

DATE: June 24, 2011
Albany, New York

REDACTED SIGNATURE

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