NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 2, 2017

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Paul Tsui
New York State Department of Health
Bureau of Professional Medical Center
Corning Tower- Room 2512
Empire State Plaza
Albany, New York 12237

Jeanine Santiago M.D.
Physician Who Makes House Calls
PWMHC
[redacted]

RE: In the Matter of Jeanine Santiago M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 17-281) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Riverview Center
150 Broadway – Suite 355
Albany, New York 12204

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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: ISM
Enclosure

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

In the Matter of Jeanine Santiago, M.D. (Respondent) A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)	Administrative Review Board (ARB) Determination and Order No. 17-281

Before ARB Members D'Anna, Koenig, Grabiec, Wilson and Milone
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Paul Tsui, Esq.
For the Respondent: *Pro Se*

After a hearing below, a BPMC Committee found that the Respondent committed professional misconduct in providing and supervising medical treatment for seven persons and that the Respondent engaged in conduct that resulted in felony convictions under New York Law. The Committee voted to place a permanent limitation on the Respondent's license to practice medicine in New York State (License), to suspend the Respondent's License pending an evaluation and treatment and to place the Respondent on probation, with a practice monitor for five years following the suspension. In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2017), both parties ask the ARB to modify the Committee's Determination. After reviewing the hearing record and the parties' review submissions, the ARB sustains the Committee's Determination on the charges, but we overturn the Committee's Determination on penalty. The ARB votes 5-0 to revoke the Respondent's License.

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent violated New York Education Law (EL) §§ 6530(2-5), 6530(9)(a)(i), 6530(11), 6530(16), 6530(25), 6530(29), 6530(31-33) and 6530(47) (McKinney Supp. 2017) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently;
- practicing medicine with negligence on more than one occasion;
- practicing medicine with gross negligence;
- practicing medicine with incompetence;
- engaging in conduct that results in a conviction under New York Law;
- permitting, aiding or abetting an unlicensed person perform activities requiring a license;
- failing to comply, willfully or with gross negligence, with substantial provisions of federal, state or local laws, rules or regulations governing the practice of medicine;
- delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, by experience or by licensure to perform them;
- violating any condition or limitation imposed on the licensee under PHL § 230;
- harassing, abusing or intimidating a patient willfully, either physically or verbally;
- failing to maintain accurate patient records;
- failing to exercise appropriate supervision over persons who are authorized to practice only under supervision by a licensee; and,
- failing to use scientifically accepted barrier precautions and infection control practices as established by the Department of Health.

The charges involved the Respondent's medical care for seven persons (Patients A to G), unsanitary conditions at the Respondent's home office and the Respondent's criminal conviction, which involved delegating professional responsibilities and signing blank prescription forms for

a nurse to complete. The case began with a February 24, 2016 Order by the Commissioner of Health of the State of New York suspending the Respondent's License summarily.

The Committee sustained the charges that the Respondent engaged in conduct that resulted in her conviction under New York Law, delegated professional duties improperly, failed to maintain accurate records, failed to use infection control practices, practiced with negligence on more than one occasion, practiced with gross negligence and practiced with incompetence on more than one occasion. In making their findings the Committee credited the testimony by the Department's medical expert, Gary Dunkerly, M.D. The Committee found that the Respondent lacked credibility in certain of her testimony [Committee Determination page 28] and found disturbing the Respondent's lack of accountability and her rationalization for every wrong decision in her life [Committee Determination page 33].

The Committee found that, from January 2006 until February 2016, the Respondent operated a practice that involved seeing patients at their homes and in the Respondent's private home. The Respondent employed Wendy Potter, R.N. to go to the homes of Patients A-G to provide the Patients with medical care and prescriptions for medications, which the Respondent pre-signed. The Committee found such conduct a severe deviation from the standards of care. The Committee noted that physicians are obligated to manage prescription pads responsibly to make certain that they are protected from abuse or fraud, which could result in substantial harm to patients. The Committee found further that, between March 2013 and July 2014, the Respondent deviated from the standard of care by providing medical care to Patients B, F and G in an unsanitary environment at the Respondent's home, where a strong odor of cat urine was detected and multiple animals and feces were observed.

The Respondent's prescription and billing practices resulted in her November 16, 2015 felony convictions in Dutchess County Supreme and County Court on three counts of Unauthorized Practice, a Crime, Medicine, in violation of EL § 6512(1) and one count of Offering a False Instrument for Filing, in violation of New York Penal Law § 175.35 (McKinney Supp. 2015). The Court sentenced the Respondent to a conditional discharge, 200 hours

community service, a $4000.00 fine and fees and surcharges totaling $750.00. The Commissioner's February 2016 Summary Suspension Order followed the criminal convictions.

Concerning the medical care the Respondent rendered to Patients A-G, the Committee made findings that the Respondent deviated from the standard of care by failing to:

- perform physical examinations;
- obtain medical, social and family histories;
- monitor the Patients for drug abuse or diversion by performing urine testing;
- maintain an ongoing list of medications as part of each Patient's medical records;
- document clinical justifications for prescribing controlled substances and other drugs; and
- assess the Patients' functional levels and pain levels, in prescribing controlled substances.

As to the specific medications the Respondent prescribed for each Patient, the Committee made findings that the Respondent deviated from the standard of care by prescribing:

- Valium and Ambien at such excessive dosages that placed Patient A at significant risk for amnesia, injury or falls;
- combinations of extended release Morphine, short acting Morphine or Percocet and Fentanyl for Patient B that posed the potential for significant harm, including overdose;
- Oxycodone in increasing dosages for Patient C without documenting medical rationales for the prescriptions and dosage amounts;
- Oxycodone for Patient D without documenting the prescription in the medical records or documenting whether the Patient was taking other drugs in combinations;
- Opioids and Benzodiazepines for Patient E in dosages and combinations without rationales, evaluation for adverse side effects or clinical contact;
- Oxycodone for Patient F in increasing dosages without documenting the reasons for the prescriptions and without evaluating the Patient for memory loss; and

- Oxycodone and Restoril, the sleep medication, for Patient G in combination, which pose the risk for memory impairment, falls and amnesia, without documentation to support medical necessity and without documenting clinical contact.

The Committee found that the Respondent deviated severely from the standard of care by prescribing Valium for Patient A in dosages that placed the Patient at increased risks for falls, depression and central nervous system dysfunction.

The record before the Committee also showed that the Respondent was convicted of Driving While Intoxicated (DWI), a misdemeanor, in the Town of Wappinger Justice Court in May 2014. The Court sentenced the Respondent to three years on probation, fines, surcharges and a six-month suspension of her driver's license. The Respondent entered into a Consent Agreement that resulted in an April 28, 2015 BPMC Board Order relating to the DWI conviction, in which the Respondent admitted to professional misconduct and agreed to a Censure and Reprimand and a $1,500.00 fine. In connection with that 2015 Board Order, the Office of Professional Medical Conduct (OPMC) requested a psychiatric evaluation of the Respondent. In April 2015, Benjamin Cheney, M.D. completed the evaluation and questioned whether alcohol abuse and depression or a "Psychotic illness" were responsible for the Respondent's poor judgement. Dr. Cheney recommended that the Respondent not work until she complete neuropsychiatric testing and further evaluation by the Committee for Physician Health. Dr. Cheney recommended further that the Respondent be seen by a psychiatrist periodically to assess if she needed psychiatric medication.

The Committee found particularly troubling the Respondent's willingness to direct Ms. Potter to issue prescriptions and provide care to persons over a period of months and even years without the Respondent having clinical contact with the Patients. Dr. Dunkerly testified that the Respondent's practices placed the Patients, who were prescribed large dosages of dangerous and addictive drugs, at risk for significant damage. The Committee found the Respondent's inadequate record keeping suggested the Respondent's disregard for follow-up or contemporaneous care for the Patients by other providers. The Committee called the

Respondent's opioid practices extremely dangerous, which resulted in addiction for at least one patient.

The Committee did find mitigating factors in the record. The Committee noted that the Respondent's misconduct occurred during a period of personal hardship and tragedy, including the loss of her partner and then her mother. The Committee cited evidence that the Respondent had cleaned her home. The Respondent also demonstrated support from patients and staff at two of the Respondent's former employers.

The Committee voted to limit the Respondent's License permanently to prohibit the Respondent from prescribing controlled substances. The Committee concluded that, if provided with the opportunity to participate in and complete an intensive therapy program, the Respondent would be capable of providing safe and proper medical care to patients. The Committee voted to suspend the Respondent's License until the Respondent submits to and completes a psychiatric evaluation and then completes a course of therapy. The Committee placed the Respondent on probation for five years following the suspension, under terms that appear as Appendix B to the Committee's Determination. The probation terms include a practice monitor.

Review History and Issues

The Committee rendered their Determination on April 24, 2017. This proceeding commenced on May 1, 2017, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and reply brief and the Respondent's brief and reply brief. The record closed when the ARB received the Respondent's reply brief on or about July 11, 2017.

The Respondent accused the Petitioner of bias due to the Respondent's sexual orientation. The Respondent accused the Petitioner's counsel of unprofessional conduct and collusion with the State Attorney General's Office. The Respondent noted that an appellate court has overturned her 2015 DWI conviction. The Respondent sought to relitigate her criminal

conviction for unlicensed practice and offering a false instrument for filing. The Respondent also argued that she did nothing improper in caring for Patients A to G. The Respondent requested that the ARB reinstate her License without restriction.

The Petitioner requested that the ARB sustain additional charges against the Respondent. In relation to the arrangement with Ms. Potter, the Committee sustained the misconduct specification charging improper delegation of professional responsibilities, but dismissed as cumulative the specifications charging failure to supervise, failure to comply and aiding and abetting an unlicensed person. The Petitioner requested that the ARB overturn the Committee and sustain those three overturned specifications. Further, the Petitioner requested that the ARB overrule the Committee and revoke the Respondent's License. The Petitioner argues that the Respondent poses a risk to public safety, that she has demonstrated a clear lack of insight into her actions and that she will not be restrained by any restriction the Committee placed upon the Respondent's License. In reply to the Respondent's Brief, the Petitioner argued that the Respondent submitted material to the ARB from outside the hearing record.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on

the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent committed professional misconduct and engaged in conduct that resulted in felony convictions under New York Law. The ARB overturns the Committee's

Determination on the sanction for the Respondent's misconduct and we vote 5-0 to revoke the Respondent's License. In rendering this Determination, the ARB disregarded any material from outside the hearing record.

The Respondent accused the Petitioner's counsel of unprofessional conduct and indicated that she would file a formal complaint with the professional ethics committee for lawyers. That ethic committees constitutes the appropriate forum for such a complaint, so the ARB will not address the accusation. The Respondent indicated further that she would appeal her felony convictions. The appellate courts constitute the proper forum for the Respondent to challenge the convictions and the Respondent may not re-litigate the convictions in this proceeding. Such convictions are in force at this point and they bind the Respondent in the proceeding before the Committee and now before the ARB. The Respondent also alleged bias against her by the Department of Health and by the Petitioner's counsel. The Respondent made no allegation of bias against the Committee and made no showing that bias affected the Committee's Determination.

The Respondent did challenge the Committee's findings. The Committee based their findings on the testimony by Dr. Dunkerly, which the Committee found credible. The Committee found the Respondent lacked credulity in her testimony that contradicted Dr. Dunkerly. The ARB defers to the Committee as the fact finder in their decision to credit Dr. Dunkerly's testimony. That testimony and the felony convictions demonstrated that the Respondent engaged in criminal conduct that related directly to her medical practice. The Respondent placed the Patients at risk of addiction and harm, the Respondent failed to follow up with the Patients or test the Patients for addiction and the Respondent practiced in filthy conditions. The evidence the

Committee found credible shows that the Respondent committed professional misconduct and that she placed her patients at risk.

The Committee voted to limit the Respondent's License and to allow the Respondent to return to practice after completing a psychiatric evaluation and a course of treatment. The ARB finds this penalty inconsistent with the Committee's findings and conclusions. The Respondent has shown no insight into nor remorse for her misconduct and the Committee found disturbing the Respondent's lack of accountability and rationalization for every wrong decision in her life. The Respondent has given no indication that she is willing to correct the deficiencies in her practice. She defended her practice in her brief. Further, the Respondent gave no indication that she was willing to undergo an evaluation and treatment, but rather she has requested that the ARB return her license without restrictions.

The facts in this case demonstrate the Respondent's unfitness to practice medicine and the likelihood that the Respondent would continue her dangerous practice habits if she were to return to practice. The ARB concludes that revocation constitutes the only sanction in this case that will protect the public.

ORDER

NOW, with this Determination as our basis, the ARB renders the following ORDER:

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB overturns the Committee's Determination to limit the Respondent's License permanently, to suspend the Respondent's License pending an evaluation and to place the Respondent on probation for five years with a practice monitor.
3. The ARB votes 5-0 to revoke the Respondent's License.

Peter S. Koenig, Sr.
Steven Grabiec, M.D.
Linda Prescott Wilson
John A. D'Anna, M.D.
Richard D. Milone, M.D.

In the Matter of Jeanine Santiago, M.D.

Linda Prescott Wilson, an ARB Member concurs in the Determination and Order in the Matter of Dr. Santiago.

Dated: 20 July, 2017

[redacted]

Linda Prescott Wilson

In the Matter of Jeanine Santiago, M.D.

Peter S. Koenig, Sr., an ARB Member concurs in the Determination and Order in the Matter of Dr. Santiago.

Dated: September 26, 2017

Peter S. Koenig, Sr.

In the Matter of Jeanine Santiago, M.D.

Steven Grabiec, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Santiago.

Dated: 9/26, 2017

[redacted]

Steven Grabiec, M.D.

In the Matter of Jeanine Santiago, M.D.

Richard D. Milone, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Santiago.

Dated: September 27, 2017

[redacted]

Richard D. Milone, M.D.

In the Matter of Jeanine Santiago, M.D.

John A. D'Anna, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Santiago.

Dated: Sept 26, 2017

[redacted]

John A. D'Anna, M.D.