Department of Health

ANDREW M. CUOMO
Governor

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

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

April 24, 2017

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Paul Tsui, Esq.
NYS Department of Health
Corning Tower Room 2512
Empire State Plaza
Albany, New York 12237

William J. McDonald, Esq.
Campolo, Middleton & McCormick, LLP
4175 Veterans Memorial Highway
Suite 400
Ronkonkoma, New York 11779

Jeanine Santiago, M.D.

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

Dear Parties:

Enclosed please find the Determination and Order (No. 17- 120) 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
Office of Professional Medical Conduct
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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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.

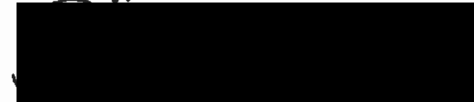
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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,



James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: nm
Enclosure

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

COPY

IN THE MATTER OF JEANINE SANTIAGO, M.D.	DETERMINATION AND ORDER

BPMC-17-120

A Notice of Hearing and Statement of Charges, both dated April 25, 2016, were served upon **JEANINE SANTIAGO, M.D.** ("Respondent"). Pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("PHL"), **WILLIAM A. TEDESCO, M.D.**, Chairperson, **GAIL S. HOMICK HERRLING** and **MARY E. RAPPAZZO, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **DAWN MacKILLOP-SOLLER**, served as the Administrative Law Judge.

The Department of Health, Office of Professional Medical Conduct ("Department") appeared by RICHARD J. ZAHNLEUTER, General Counsel, by **PAUL TSUI, Associate Counsel**. The Respondent was represented by **WILLIAM J. McDONALD, ESQ**. Evidence was received, witnesses were sworn and heard, and transcripts of the proceedings were made. After consideration of the entire record, the Hearing Committee issues this Determination and Order, sustaining eight Specifications of Misconduct and dismissing six others, such that the Respondent's license to practice medicine is subject to suspension and probation, with conditions.

PROCEDURAL HISTORY

Pre-Hearing Conference:	July 1, 2016
Hearing Dates:	July 15, 2016 August 23, 2016 August 24, 2016 September 12, 2016 September 13, 2016 October 14, 2016 November 10, 2016 November 14, 2016 November 28, 2016
Witnesses for Petitioner:	Gary Dunkerley, M.D. Wendy Potter Frank DiChiaro Peter Olsen Laura Boris Eve Rufino Lavonne Cooper Meghan Johnson Shannon Tanksley, R.N. Karen Lehan, L.P.N.
Witnesses for Respondent:	Jeanine Santiago, M.D. Raymond McDermott Patricia Medina Cruz Tabatha Fuoco John Santiago Renee Santiago
Written Submissions Received:	February 3, 2017
Deliberations Held:	February 15, 2017 and February 23, 2017

STATEMENT OF CASE

In a Statement of Charges dated April 25, 2016, the Department charged the Respondent with thirteen specifications of professional misconduct, as defined in § 6530 of the Education Law of the State of

New York ("Educ. Law"). In an Amended Statement of Charges dated October 13, 2016, the Department added a Fourteenth Specification of professional misconduct, as defined in § 6530(29) of the Educ. Law. The Respondent admitted the first two factual allegations and specifications of professional misconduct, but denied the remaining charges. A copy of the Amended Statement of Charges is attached to this Determination and Order as Appendix A.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Numbers below in parentheses refer to exhibits ("Ex.") or transcript page numbers ("T."). The Hearing Committee hereby makes the following findings of fact:

1. The Respondent was authorized to practice medicine in New York State on December 15, 1989, by the issuance of license number 181053. (Ex. 4A).

2. From approximately January of 2006 until February of 2016, the Respondent was the sole owner and operator of "Physicians Who Make House Calls!" The Respondent's practice involved seeing patients at their homes and at her private home, located in Fishkill, New York. (T. 820).

3. Between approximately January of 2008 and March of 2013, the Respondent hired Wendy Potter, a registered nurse, to go to the homes of patients A, B, C, D, E and G to provide them with medical care and prescriptions for medications, which the Respondent pre-signed. This conduct was a severe deviation from the standard of care. 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. (T. 200, 305, 334, 625).

4. Ms. Potter's prescription practices resulted in her plea of guilty to the felony crime of Unlicensed Practice, a Crime, Medicine. She was placed on probation and surrendered her nursing license. (T. 196-197).

5. Within the period of approximately March of 2013 through July of 2014, the Respondent deviated from the standard of care by providing medical care to patients G, F and B in an unsanitary environment at her home, where a strong odor of cat urine was detected and multiple animals and feces were observed, as testified to by Laura Boris, probation officer with the Dutchess County Office of Probation, and Peter Olsen and Frank DiChiaro, investigators from the New York State Attorney General's office. (Ex. 11, 15, 16, 17, 26; T. 47, 75, 91-92).

6. In approximately July of 2014, after the death of her partner and her mother, the Respondent admitted that she was "able to put her house back in order." (T. 893, 895).

7. On May 15, 2014, in the Town of Wappinger Justice Court, County of Dutchess, New York, the Respondent was convicted of Driving While Intoxicated, a misdemeanor, and sentenced to three years of probation, fines and surcharges and suspension of her driver's license for a period of six months. (Ex. 8).

8. In a Board Order dated April 28, 2015, which incorporated a Consent Agreement signed by the Respondent on April 23, 2015, and was based on the Driving While Intoxicated conviction, the Respondent admitted to professional misconduct and agreed to the penalties of Censure and Reprimand and payment of a $1,500.00 fine. (Ex. 8).

9. In April of 2015, at the request of the Office of Professional Medical Conduct ("OPMC") for the prior Board case, Benjamin B. Cheney, M.D., completed a psychiatric evaluation of the Respondent. Dr. Cheney questioned whether alcohol abuse and depression or "a psychotic illness" were responsible for the Respondent's "poor judgment." Dr. Cheney recommended that the Respondent not work until she complete neuropsychiatric testing and further evaluation by the Committee for Physician Health ("CPH"). He also recommended that the Respondent "be seen by a psychiatrist periodically to assess if she needs psychiatric medication." (Ex. 40).

10. On November 16, 2015, in Dutchess County Supreme and County Court, the Respondent's prescription and billing practices involving Ms. Potter led to her felony convictions for three counts of Unauthorized Practice, a Crime, Medicine, in violation of Educ. Law §

6512(1), and one count of Offering a False Instrument for Filing in the First Degree, in violation of Penal Law § 175.35. On May 12, 2016, the Respondent was sentenced to a conditional discharge, 200 hours of community service, a $4,500.00 fine, and fees and surcharges totaling $750.00. (Ex. 9, 10).

11. Based on these criminal convictions, on February 24, 2016, a Commissioner's Order of Summary Action was issued pursuant to PHL § 230(12)(b), which resulted in the suspension of the Respondent's license to practice medicine. (Ex. 5).

12. In the medical care rendered to Patients A through G, the Respondent deviated from the standard of care by failing to perform physical examinations and obtain medical, social and family histories. The Respondent failed to provide treatment plans and diagnoses that followed logically from the "history and physical" of these patients. (Ex. 27; T. 247-249, 336-337, 379, 640).

13. The Respondent deviated from the standard of care in the medical care she provided to Patients A through G by failing to monitor them for abuse or diversion of drugs by performing urine drug testing. (T. 424).

14. The Respondent deviated from the standard of care in her failure to maintain an ongoing list of medications as part of the medical records for Patients A through G and her failure to document clinical justifications for prescribing controlled substances and other drugs. In prescribing controlled substances, the Respondent was

obligated to assess patients' functional capacities and pain levels, which she failed to do. (Ex. 27; T. 336-338, 603).

Patient A

15. Patient A was a 77-year-old female when she was seen in her home as part of the Respondent's medical practice between January of 2007 and August of 2014, for hip and right leg pain, sciatica, depression, anxiety and arthritis. (Ex. 19, 19A).

16. Ms. Potter wrote prescriptions for Valium, Ultram, Haldol, Prozac, Ambien, Celexa, Paxil, Doxepin, Norvasc and Plavix. (T. 246, 300, 310, 823, 959).

17. The Respondent severely deviated from the standard of care by prescribing Patient A Valium at 10 mg, or two tablets at 5 mg each, every six hours, dispense 240. Diazepam or Valium is an anxiolytic used to treat anxiety, and it has a long half-life of up to 60 hours, which means that the older the person and the longer the patient is prescribed it, the longer the body takes to metabolize it. This prescription placed Patient A at an increased risk for harm from falls, depression and central nervous system dysfunction. (Ex. 27; T. 347-350).

18. The Respondent deviated from the standard of care in prescribing Patient A combinations of high dosages of Valium and Ambien, at a strength of 10 mg. The combination of these drugs at such excessive dosages placed this patient at significant risk for amnesia, injury and falls. (T. 362-363, 367).

19. The Respondent failed to document in Patient A's medical record reasons for prescribing drugs, such as Haldol, a drug used to treat psychotic disorders in patients who are a "harm to themselves or others." She also failed to document reasons for discontinuing medications, such as Ativan, a drug with a shorter half-life than Valium. (T. 343, 354-356).

20. The Respondent deviated from the standard of care by continuing the Valium prescription for Patient A without evaluating her depression, dizziness and ambulating difficulties, which are known side effects of the drug. The Respondent failed to consider whether this drug was contributing to the conditions. (T. 369-370).

21. The Respondent deviated from the standard of care by failing to evaluate Patient A's depression by providing a treatment plan that included assessment of her suicide risk. (T. 370).

22. Between February and May of 2012, Patient A complained of an irregular heartbeat and palpitations, yet the Respondent failed to evaluate this, which was a deviation from the standard of care. (Ex. 27; T. 363-364).

23. At the time of multiple home visits, Patient A was noted to suffer from depression, chronic dizziness, feet numbness, ataxic gait, tinnitus, severe dizziness and fatigue, yet there were no treatment plans documented to address any of these conditions. (T. 338, 357, 370).

Patient B

24. Patient B was in his 50's when he was seen as part of the Respondent's medical practice between February of 2007 and January of 2015, for sciatica and chronic back and leg pain. The patient had a history of multiple prior motor vehicle and motor cycle accidents. (Ex. 20, 20A).

25. Ms. Potter wrote prescriptions for Patient B that included Morphine and Fentanyl. (T. 235-237, 291-292).

26. The Respondent deviated from the standard of care by prescribing Patient B combinations of extended release ("ER") Morphine, short acting ("IR") Morphine or Percocet and Fentanyl. The Respondent initially prescribed Fentanyl at 25 mcg, dispense 15, ER Morphine at 30 mg, dispense 90 and IR Morphine or Percocet at 5 mg, dispense 70. In September of 2011, the Respondent increased the IR Morphine dispense amount to 180 and in July of 2012, she raised it again to 240. In November of 2012, the IR Morphine was decreased to dispense 180, but it was increased again in January of 2013 to 240. These drugs in combination have the potential for significant harm, including overdose. (Ex. 20, 20A, 27, 29, 30; T. 403, 411).

27. The Respondent continued to prescribe this combination of drugs despite Patient B's "altered" gait, which the Respondent failed to describe in the medical record. (Ex. 27A; T. 413).

28. Although Patient B's pain levels were recorded using pain scales that showed minimal or no pain, the Respondent continued to prescribe these drugs. (T. 406).

29. On multiple occasions between January of 2007 and July of 2014, the Respondent deviated from the standard of care by prescribing Patient B controlled substances without documenting clinical contact. (Ex. 27; T. 340, 415).

Patient C

30. Patient C was in his 40's and markedly obese when he was seen as part of the Respondent's medical practice between July of 2010 and February of 2015 for left calf and hip pain. (Ex. 21, 21A).

31. Ms. Potter wrote prescriptions for Patient C for Percocet and Oxycodone. (T. 291-292).

32. The Respondent deviated from the standard of care by doubling Patient C's Oxycodone prescription between January and June of 2012 from 30 mg, dispense 60, to 30 mg, dispense 120, and from dispense 120 to 240 and then to 360, without documenting medical rationales for the prescriptions and dosage amounts. (Ex. 21, 21A, 27; T. 427-431).

33. On multiple occasions between November of 2012 and September of 2014, the Respondent deviated from the standard of care by issuing Patient C prescriptions for Oxycodone without documenting clinical contact. (Ex. 27; T. 427).

Patient D

34. Patient D, son of Patient E, was in his 20's when he was seen as part of the Respondent's medical practice between September of 2011 and December of 2012, for anxiety, migraines, leg pain, bipolar disorder

and dental pain. The patient presented to the Respondent taking Xanax, Endocet, Trileptal and Vistaril. (Ex. 22, 22A; T. 434).

35. Within that period, at the direction of the Respondent, Ms. Potter prescribed Patient D Percocet. (T. 291-292, 263-268).

36. There was inadequate history documented in Patient D's medical record to support the ongoing diagnosis of bipolar disorder. (T. 436).

37. The Respondent deviated from the standard of care by issuing Patient D a prescription for Oxycodone on September 22, 2011, without documenting this prescription in the medical record. (Ex. 22, 27; T. 435).

38. The Respondent deviated from the standard of care by failing to document in Patient D's medical record whether the patient was taking ongoing combinations of Trileptal, Vistaril, Xanax and Endocet from other providers. (T. 433-434).

39. Between November of 2011 and July of 2014, the Respondent deviated from the standard of care by prescribing Percocet at 7.5 mg, dispense 90, and increasing it to 10 mg, dispense 240, without documenting the reasons for the prescriptions. (Ex. 27; T. 435-437).

40. On at least two occasions between October of 2011 and September of 2012, the Respondent also prescribed Patient D Endocet at 7.5 mg, dispense 90, which, in combination with the other prescribed drugs, has the potential to cause central nervous system dysfunction, depression and metabolic syndrome. (Ex. 27; T. 433-435).

41. The Respondent deviated from the standard of care by failing to monitor Patient D, who had a history of mental illness, for abuse associated with taking such drugs. (T. 424, 533-534, 554).

Patient E

42. Patient E, mother of Patient D, was in her 50's when she was seen as part of the Respondent's medical practice between May of 2011 and February of 2015, for anxiety, leg pain, gastroesophageal reflux disease, herniated disc, fatty liver and sub cystic kidney disease. An intake history indicates that Patient E was taking Xanax, Percocet and Seroquel, a drug used for psychotic disorders. (Ex. 23, 23A, 27; T. 439, 443).

43. Ms. Potter prescribed Patient E opioids and benzodiazepines. (Ex. 23, 23A; T. 291-292).

44. The Respondent deviated from the standard of care by simultaneously prescribing Patient E, who had a history of a fatty liver, Oxycontin, a long-acting narcotic containing acetaminophen, and Oxycodone, a short-acting narcotic. The Respondent's prescriptions included Oxycodone at 10 mg, dispense 240, in combination with Oxycontin at 60 mg, dispense 90. (T. 440).

45. The Respondent deviated from the standard of care by also prescribing Patient E Percocet at 10 mg, dispense 180, Xanax at 1 mg, dispense 120, and Endocet at 10 mg, dispense 240, without documenting medical rationales for the drugs. (Ex. 23, 23A, 27; T. 440).

46. The Respondent failed to evaluate Patient E for adverse side effects caused by taking excessive combinations of drugs, such as overdose, drug diversion, falls, amnesia and central nervous system depression. (T. 440, 443, 445, 559).

47. Between May of 2011 and approximately June of 2013, the Respondent deviated from the standard of care by issuing Patient E prescriptions without clinical contact. (Ex. 27; T. 339-440, 442-443).

Patient F

48. Patient F was twenty-seven years old when he was seen as part of the Respondent's practice between August of 2013 and February of 2015 for inflammatory bowel disease, chronic pain, memory loss and rheumatoid arthritis. (Ex. 24, 24A).

49. It was a deviation from the standard of care for the Respondent to increase the Oxycodone prescription for Patient F between September of 2013 and April of 2014 from 30 mg, dispense 90, to dispense 240, without documenting the reasons for the prescriptions. (Ex. 24, 24A, 27; T. 382, 386-392, 395).

50. The Respondent deviated from the standard of care by failing to evaluate Patient F's memory loss. (T. 379, 382).

Patient G

51. Patient G was in her 50's when she was seen as part of the Respondent's medical practice between April of 2008 and February of 2015 for diabetes, back pain, sciatica, peripheral neuropathy and chronic kidney disease. (Ex. 25, 25A).

52. Ms. Potter issued prescriptions for Patient G for opioids and benzodiazepines. (T. 291-292).

53. The Respondent deviated from the standard of care by prescribing Patient G high dosages of Oxycodone and Restoril, a sleep medication, without documentation to support the medical necessity for prescribing these drugs, which in combination have the risk of impaired memory, falls and amnesia. (Ex. 25, 25A, 27; T. 454).

54. The Respondent deviated from the standard of care by also prescribing Patient G Percocet, which increased from 7.5 mg, dispense 90, to 10 mg, dispense 240, and Xanax, without documenting medical rationales for the prescriptions. (Ex. 25, 25A, 27; T. 454, 458).

55. It was a deviation from the standard of care for the Respondent to switch Patient G from Xanax, a short acting benzodiazepine, to Valium, a long acting benzodiazepine, without documenting the reasons for the drug changes. (Ex. 27; T. 457).

56. On multiple occasions between approximately June of 2009 and October of 2009, the Respondent deviated from the standard of care by issuing Patient G prescriptions without documenting clinical contact. (T. 452-453).

CONCLUSIONS OF LAW

The charges of professional misconduct as defined in § 6530 of the Educ. Law include the following:

- § 6530(9)(a)(i) - Convicted of committing an act constituting a crime under New York state law.

- § 6530(3) - Practicing medicine with negligence on more than one occasion. This involves the "failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances." Bogdan v. State Bd. For Prof'l Med. Conduct, 195 A.D.2d 86, 88 (3rd Dept. 1993). It may also be found when a physician fails to document in a medical record "objectively meaningful medical information concerning the patient treated." Youssef v. State Bd. For Prof'l Med. Conduct, 89 A.D.3d 824, 825 (3rd Dept. 2004).
- § 6530(4) - Practicing medicine with gross negligence on a particular occasion. This involves a significant deviation from acceptable medical standards that creates the risk of grave consequence to the patient. Post v. NYS Dept. of Health, 245 A.D.2d 985, 986 (3rd Dept. 1997).
- § 6530(5) - Practicing medicine with incompetence on more than one occasion or with a lack of knowledge necessary to practice the profession.
- § 6530(25)- Delegating professional responsibilities.
- § 6530(32)- Failing to maintain an adequate medical record.
- § 6530(47)- Failing to use accepted barrier precautions and infection control practices pursuant to PHL § 230-a.

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department. (*See* Prince, Richardson on Evidence § 3-206). The Hearing Committee made these

conclusions of law pursuant to the factual findings and definitions listed above, and all conclusions resulted from a unanimous vote.

The Department's expert witness, Gary Dunkerley, M.D., has over 30 years of experience as a board certified specialist in family medicine and geriatrics, and his practice includes house calls for approximately 40 patients. He received his medical school education from Hahnemann Medical College and Hospital in Philadelphia, P.A., where he also performed his training. Dr. Dunkerley's experience includes Chair, Department of Family Practice and Director, residency program at Ellis Medicine. Currently, he is a clinician at Ellis Medicine. Dr. Dunkerley's experience also includes working as a hospice medical director for ten years. The Hearing Committee found Dr. Dunkerley's testimony credible and consistent with the medical records in evidence.

Felony convictions

The Respondent's decision to delegate her professional responsibilities in the care and treatment of patients to Ms. Potter, a nurse, to render medical care to patients and complete prescriptions for drugs resulted in four felony convictions for Unauthorized Practice, a Crime, Medicine, in violation of Educ. Law § 6512(1) and Offering a False Instrument for Filing in the First Degree, in violation of Penal Law § 175.35. These convictions, which are not in dispute, constituted crimes under New York state law and amount to professional misconduct as defined in Educ. Law § 6530(9)(a)(i).

Directing a Registered Nurse to Write Prescriptions

Dr. Dunkerley testified to the Respondent's improper prescription practices, which involved directing Wendy Potter, who she knew was a licensed registered nurse, to provide unsupervised medical care to Patients A, B, C, D, E and G. The Respondent admitted to this practice, which included providing Ms. Potter with pre-signed prescriptions to complete and issue to patients. Dr. Dunkerley explained that under New York State law, nurses are not authorized to write prescriptions within their scope of practice, which Ms. Potter acknowledged. (T. 300, 335, 589, 623, 822, 947, 1345, 1465; *See also* Educ. Law §§ 6902 and 6810).

The Respondent should have known about this requirement. While the Respondent argued that the patients Ms. Potter treated were stable and she limited Ms. Potter to only writing prescriptions for chronic or ongoing drugs, as opposed to drugs that were new to a patient, this practice did not excuse the improper arrangement. The Hearing Committee noted that the Respondent failed to supervise prescriptions that Ms. Potter administered. While Ms. Potter testified that she "took orders and directions" from the Respondent to write these prescriptions, it is undisputed that this was done outside of the Respondent's presence. (T. 209, 312; Respondent's brief, p. 8).

The Hearing Committee found particularly concerning the Respondent's willingness to direct Ms. Potter to issue such prescriptions and provide care to these patients over a period of months - even years - without having clinical contact with them personally. Even more troubling to the Hearing Committee was the

ongoing and continuous nature of this prescription practice, which involved Ms. Potter writing prescriptions for combinations of controlled substances. This conduct, per Dr. Dunkerley, included "handing a signed prescription that's not completed," and placed these patients, who were prescribed large dosages of dangerous and addictive drugs, at risk for "significant damage." (T. 271, 311, 355).

The Department charges that in directing Ms. Potter to provide care to patients, the Respondent inappropriately submitted billing for services "as if (she) had provided the services as a physician at a higher rate." The evidence failed to establish this. While the Respondent was convicted of a felony related to her billing practices, the Hearing Committee found no correlation between the criminal case, which involved patients not at issue here, and billing for Patients A through G. In a statement to the Medicaid Fraud Unit, the Respondent did not identify billing details for these patients, and the Department did not offer any into evidence. The Hearing Committee agreed with Dr. Dunkerley, who testified that he found this allegation unsubstantiated because without "access to billing," it was impossible to review data "to support it." (Ex. 1A, 9, 10, 13; T. 581-584).

As such, the Hearing Committee concluded that the Respondent's conduct involving Ms. Potter's unauthorized practice of medicine constituted professional misconduct pursuant to §§ 6530(3), 6530(4), 6530(5) and 6530(25), but not § 6530(2), fraudulent practice. To sustain a charge of fraudulent practice, the Department must show that

the Respondent made a false representation that she knew was false and was made with the intent to mislead. Adler v. Bureau of Prof'l. Med. Conduct, 211 A.D.2d 990, 992 (3rd Dept. 1995). The Hearing Committee determined that the evidence did not support that the Respondent's arrangement with Ms. Potter was the result of an intentional scheme to mislead. They believed the Respondent when she testified that she thought it was permissible. (T. 1511-1512).

Having concluded that the Respondent's conduct constituted an improper delegation of professional duties pursuant to Educ. Law § 6530(25), the Hearing Committee dismissed as cumulative the related specifications pursuant to Educ. Law §§ 6530(11), aiding, abetting an unlicensed person, 6530(33), failure to supervise and 6530(16), failure to comply.

Medical care

Prescription Practices

Dr. Dunkerley discussed the Respondent's prescription practices and determined that the Respondent improperly prescribed controlled substances to Patients A through G, at excessive dosages, which placed these patients at an increased risk for overdose, toxicity and drug diversion. (T. 336, 394-395).

The Respondent argues that Dr. Dunkerley "did not testify that her care deviated from the appropriate standard of care" in her prescribing practices of Valium for Patient A. On the contrary, Dr. Dunkerley emphasized that the Respondent's conduct in prescribing this

elderly patient Valium at two tablets, 10 mg, every six hours, dispense 240, was a deviation from the standard of care. In fact, he emphasized that the Respondent's prescription of this drug at such excessive dosages and frequencies "far exceeds any accepted standard of care." (Respondent's brief, p. 11; T. 348).

In prescribing Patients G and D excessive amounts of Oxycodone and Percocet, Endocet and other drugs, respectively, the Respondent placed these patients at risk for central nervous system dysfunction, falls, depression, metabolic syndrome and amnesia. Instead of decreasing or discontinuing the ongoing Oxycodone prescriptions for Patient F, who was in his 20's, the Respondent increased his monthly dispense quantity from 30 to 240, which the record established could have worsened his memory loss. In prescribing large dosages and combinations of Oxycontin, Oxycodone and Endocet for Patient E, who had a fatty liver, and Morphine and Fentanyl for Patient B, the Respondent placed them at risk for toxicity and "narcotic overdose." (T. 379, 403-404, 435, 440, 454, 381-382).

In defense of her prescribing practices, the Respondent points to Dr. Dunkerley's testimony that "there is no maximum dose" in prescribing narcotics. This takes Dr. Dunkerley's opinion on opioid prescribing out of context. The Hearing Committee agreed with Dr. Dunkerley that in determining opioid dosage amounts for patients, it is "general wisdom" for physicians to consider functional capacity, pain levels and their abilities to perform activities of daily living,

items that the record established the Respondent failed to evaluate. While the Respondent correctly argues that "(r)easonable doctors are free to disagree on modes of treatment," the Hearing Committee considered the overdose rate for such prescriptions in this country and found the Respondent's judgment defective in issuing them in the combinations and dosages prescribed. (T. 533; Respondent's brief, p. 11, 13).

The Respondent does not dispute that in prescribing these drugs to Patients A through G, she did not have in place a monitoring program. The Respondent testified that in assessing patients for abuse of drugs, she observes physical signs, such as pupils, speech, thought processes and sweating. The Hearing Committee rejected these forms of monitoring and noted Dr. Dunkerley's testimony that pursuant to the American Society of Addiction Medicine, the standard of care for patients prescribed chronic opioid and benzodiazepine drugs is to administer urine drug testing and screening, which the Respondent failed to perform. The Hearing Committee considered as critical the purpose in this requirement, which is to reduce narcotic deaths and regulate prescriptions by monitoring patients for drug diversion and abuse. (T. 424, 533-534, 546, 575, 1445, 1461).

The Hearing Committee considered it especially egregious that the Respondent issued patients ongoing prescriptions for controlled substances over extended periods of time without any contact with them. In the case of Patient E, this included a period of approximately two

and one-half years, for Patient G, the period was five months, and for Patient C, the period was four months. In the case of Patient B, the Respondent increased the dosages of his prescriptions during a period when she did not see him, which was approximately ten months. Dr. Dunkerley testified that these prescription practices, which included issuing "complex narcotic" prescriptions to patients, posed a severe danger to these patients. (Ex. 27; T. 414, 427, 442, 452).

Physical assessments

Physicians are prohibited from continuously prescribing controlled substances to patients without "obtaining medical histories or performing appropriate physical examinations or evaluations necessary for proper diagnosis and treatment" of patients. Conteh v. Daines, 52 A.D.3d 994, 996 (3rd Dept. 2008). Physicians are also required to take the necessary steps to evaluate whether such drugs are medically necessary at the dosages provided. Roumi v. State Bd. for Prof'l Med. Conduct, 89 A.D.3d 1170, 1172 (3rd Dept. 2011).

In issuing ongoing prescriptions for controlled substances to Patients A through G, Dr. Dunkerley found that the Respondent failed to perform adequate physical examinations and obtain and record medical, surgical or social histories "to support (a) diagnosis." Although intake histories were noted at the time of initial visits, there were no histories recorded as part of the medical record for subsequent or follow-up visits. (T. 336-337, 352-353, 386, 408, 644).

In the case of Patient C, who had "a diagnosis of morbid obesity," the Respondent failed to obtain "an estimated weight of the patient" or evaluate "weight bearing joint pain." In the cases of Patients E, D, F and G, who presented with histories of fatty liver and sub cystic kidney, memory loss, generalized pain or edema, and chronic kidney disease respectively, the evidence established that the Respondent failed to evaluate these conditions. (T. 379, 381-382, 426-427, 440, 450).

Dr. Dunkerley testified to the purpose in the checklists that the Respondent used for physical examinations, which is to review patients' cardiovascular, gastrointestinal, neurological, spine, psychiatric, range of motion, musculature and genitourinary systems and place a check for normal findings. While the use of checklists for physical examinations is acceptable, they must be complete and accurate. Even if proper histories had been documented, the evidence showed that these checklists were not reliable. Ms. Potter acknowledged that a check for "w/o rebound" and "w/o guarding" for a patient's gastrointestinal system does not mean that the patient's abdomen was palpated as part of an exam. Similarly, the record showed that musculature checked for Patient F, who had a history of lumbosacral in the low back and leg pain, does not mean that a musculoskeletal exam was performed. Likewise, cardiovascular system checked for Patient A, who complained of an irregular heartbeat, does not mean that the heart rate was checked. While checks for "w/o suicidal ideations" and "w/o homicidal

ideations" are noted for Patient A, who complained of depression, the record failed to establish that her suicide risk was assessed. (T. 247, 363-364, 370, 386, 407-409).

Dr. Dunkerley was particularly critical of the Respondent's ongoing prescriptions for controlled substances for Patients A through G while simultaneously failing to evaluate pain, specifically the quality and timing of it and whether it radiated. Patient A complained of sciatica pain, yet the Respondent failed to assess it by testing reflexes and motor strike, and continued prescriptions for benzodiazepines. While Patient B had a "0" recorded for his pain level using a pain scale of 0 out of 10, which rose to a "5" a few months later, the Respondent failed to evaluate his pain and continued prescriptions for Morphine and Fentanyl. (T. 326, 397, 406, 408, 409).

Dr. Dunkerley explained that the "(v)ast majority of the assessments done were symptoms." This resulted in the lack of documented treatment plans that followed logically from patients' histories and physical examinations. Instead of considering treatment plans for patients that included therapies other than pain medications, such as exercise for a patient diagnosed with anxiety or diet changes for a patient with diabetes, the Respondent's treatments consisted of long-term and ongoing dosages of narcotics. (T. 337, 453).

Specialists

The Hearing Committee concluded that, contrary to Dr. Dunkerley's testimony, the record established that the Respondent made referrals,

when appropriate, to subspecialists for Patients A through F. Patient A's medical record reflects that on July 2, 2008, and July 1, 2014, the Respondent made mental health referrals. The Hearing Committee also found the Respondent's testimony credible that she discussed with this patient referrals to other specialists, such as a gastroenterologist, urologist, neurologist and ophthalmologist. Similarly, the Hearing Committee determined that referrals were made to bariatric and orthopedic specialists for Patient C and to a memory loss specialist for Patient F. (T. 355, 371, 851-854, 872, 1220, 1227).

In some instances, referrals were not warranted, such as for psychological care for Patient F, as well as Patient D, who was already under the care of a psychiatrist. They also found that a referral for Patient B for a neuropsychometric evaluation was unnecessary, and a referral for Patient D to an orthopedic provider had been made through this patient's mother. In the care provided to Patients A through G, the Hearing Committee agreed with Dr. Dunkerley that the underlying problem was not with the absence of referrals, but with the Respondent's failure to adequately document follow-up on the referrals or efforts in coordinating care with other providers in the medical records. (T. 355, 379, 404, 437, 452, 1443, 1453, 1477).

The Hearing Committee unanimously voted that the Respondent's prescribing practices involving Patient A constituted professional misconduct as gross negligence pursuant to Educ. Law § 6530(4). They also found that the Respondent's medical care of Patients A through G

constituted professional misconduct as negligence on more than one occasion under Educ. Law § 6530(3).

Documentation

Physicians are required to maintain records for each patient that "accurately reflect the evaluation and treatment of the patient." The purpose behind this rule, is to record "meaningful information" for other physicians. Mucciolo v. Fernandez, 195 A.D.2d 623, 624 (3rd Dept. 1993). Dr. Dunkerley confirmed this when he testified that the purpose in medical records "is to communicate." (T. 457).

Dr. Dunkerley testified that the Respondent was obligated to record patients' pain quality and functional capacities prior to prescribing controlled substances. Also, he testified that "it is incumbent upon" physicians "to document" a justification for escalating dosages of controlled substances and administration frequencies for such drugs. The record established that the Respondent failed to document these important items while routinely prescribing large dosages of Valium to Patient A, Morphine, Percocet and Fentanyl for Patient B, Oxycodone for Patients F and C, combinations of Oxycontin, Oxycodone and Percocet for Patient E and Percocet for Patients D and G. (T. 388, 391, 397, 404, 435, 439, 454, 606).

While the Respondent suggests that Dr. Dunkerley's opinion on her recordkeeping is "hypercritical," she acknowledged as important that the "the next person" responsible for treating these patients "has an understanding" of why drugs are prescribed at specific dosages. The

problem here, according to Dr. Dunkerley, was that in reviewing the medical records for Patients A through G, there was no way to tell "what knowledge the doctor had about her patients." (Respondent's brief, p. 11; T. 392, 600, 1043).

In defense of her medical record keeping, the Respondent testified that she is the "only physician who takes care of these patients," and the medical records are "thorough" and reflect her "ongoing care." The Hearing Committee disagreed and considered that the Respondent's deficient record keeping deprived other physicians of even the most basic patient information, including histories, physical exam findings and an "ongoing list of medications" that patients were "taking from visit to visit." The Respondent testified that she maintained a "flow chart" to record medications, but the Hearing Committee found it inadequate because it lacked complete details for drugs, such as prescription dates and dosage amounts. (T. 383, 374, 384-385, 412, 438, 453-454, 603, 879-880, 1041).

The Respondent's inadequate record keeping for her patients suggested to the Hearing Committee her disregard for follow-up or contemporaneous care of them by other providers. Accordingly, the Hearing Committee unanimously voted that the Respondent's deficient medical record keeping involving Patients A through G constituted professional misconduct as negligence on more than one occasion pursuant to Educ. Law § 6530(3) and as failing to maintain an adequate medical record pursuant to Educ. Law § 6530(32).

Infection Control

The record established that in 2013 and 2014, while her home was unsanitary with animal feces and multiple cats, the Respondent provided medical care to patients B, G and F at her home. Physicians are required under 10 NYCRR 92.1(a) to use infection control practices in medical office environments that avoid "transmission of disease pathogens" and include adherence to scientifically accepted standards to prevent "bi-directional contact with blood and body fluids." (Ex. 15, 16, 17, 26).

Dr. Dunkerley testified that the Respondent provided medical care to these patients in a "non-hygienic" environment that "exposed" them to "potential animal transmitted infections" through "cat and dog bodily fluids." This includes Patient B who was required to "walk through animal feces to get a prescription" at the front door of the Respondent's home. This also includes Patients G and F because the Respondent saw them inside her home in 2013 and 2014, which was prior to the period when she admits to cleaning the home to conform to infection control requirements. (Ex. 15, 16, 17; T. 522, 541, 593-594, 628, 631, 893-895).

The Hearing Committee did not find credible the Respondent's testimony that she only provided medical care to patients at her home between July of 2014 and January of 2015, the period of her license suspension related to the Driving While Intoxicated conviction, when her home was in clean and orderly condition. Although the Hearing Committee determined that the record established this to be accurate

for Patients D and E, the Department's evidence showed that Patients B, F and G were seen by the Respondent at her home for medical care at a time when the home was in dirty, "poor" and "bad" condition. Based on this, the Hearing Committee unanimously voted that regarding Patients B, F and G, the Respondent's conduct constituted professional misconduct pursuant to Educ. Law § 6530(47), a failure to use infection control practices. (Ex. 15, 16; T. 91, 92, 630, 816, 891, 926-927, 929-930, 1288, 1290, 1466).

Inappropriate Conduct

The Department charges that based on a report of interview to an OPMC investigator made by Patient B, the Respondent engaged in an inappropriate relationship with Patient B by scratching him and asking him to purchase alcohol. The Hearing Committee determined that the evidence failed to establish this interaction. The Respondent denied this conduct, which was consistent with Ms. Potter's inability to confirm it. The Hearing Committee considered that Patient B did not testify, and the credibility of his statement to the investigator was diminished by his bipolar disorder, which Dr. Dunkerley explained could distort his reality. The Hearing Committee agreed with Dr. Dunkerley that based on this, the record was devoid of reliable evidence to support this allegation and unanimously voted that the Respondent's conduct did not constitute professional misconduct pursuant to Educ. Law § 6530(31). (Ex. 17; T. 233, 417, 537, 1327-1328).

Commissioner's Order

The Department charged that on October 8, 2016, the Respondent violated a condition or limitation of the Commissioner's Order of Summary Suspension by practicing medicine in identifying herself to staff at the Thompson House, where Patient A was a resident, as Patient A's doctor, and stating requirements for Patient A's Valium prescriptions, in violation of Educ. Law § 6530(29). The Hearing Committee determined that this charge by the Department was superfluous in this case - a case that already involves 13 other Specifications of Misconduct.

Even if they had chosen to consider this charge, the Hearing Committee found that the Respondent's conduct in visiting Patient A did not constitute the practice of medicine in violation of the Commissioner's Order. Shannon Tanksley, Registered Nurse, testified that medication discussions between the Respondent and staff involving Patient A were not interpreted as medical directives from the Respondent and constituted, at most, the Respondent's recommendations. Consistent with this was the testimony of Ms. Tanksley's colleague, Karen Lehan, Licensed Practical Nurse, who stated that the Respondent did not visit Patient A with the intent to "evaluate" or "examine" her or even to prescribe medications. Ms. Tanksley even confirmed that the Respondent never identified herself as Patient's A's doctor. (Ex. 44, 45; T. 1366-1367, 1374, 1383, 1408-1409).

Although the Hearing Committee found credible the testimony from the Thompson House employees, they attributed their recollection of the Respondent suggesting Valium for Patient A at "ten times (the patient's) normal dose," to be the result of a misunderstanding on the part of the staff. At a dosage amount of 25 mg, four times per day, which exceeds even the Respondent's highest dosages of the drug, the Hearing Committee found this scenario unlikely. As such, the Hearing Committee unanimously voted that the Respondent's conduct did not constitute professional misconduct pursuant to Educ. Law § 6530(29). (T. 1365-1366, 1403).

Factual Allegations

The vote of the Hearing Committee on the factual allegations contained in the Statement of Charges is as follows:

Paragraph A -	Sustained
Paragraph B -	Sustained
Paragraph C - C.1	Sustained
Paragraph C - C.2	Sustained
Paragraph C - C.3	Not Sustained
Paragraph C - C.4	Sustained
Paragraph C - C.5	Sustained
Paragraph C - C.6	Sustained
Paragraph C - C.7	Sustained
Paragraph C - C.8	Not Sustained
Paragraph C - C.9	Not Sustained
Paragraph D - D.1	Sustained
Paragraph D - D.2	Sustained
Paragraph D - D.3	Not Sustained
Paragraph D - D.4	Sustained
Paragraph D - D.5	Sustained
Paragraph D - D.6	Sustained
Paragraph D - D.7	Sustained
Paragraph D - D.8	Sustained
Paragraph D - D.9	Not Sustained

Paragraph D - D.10	Not Sustained
Paragraph D - D.11	Sustained
Paragraph E - E.1	Sustained
Paragraph E - E.2	Sustained
Paragraph E - E.3	Not Sustained
Paragraph E - E.4	Sustained
Paragraph E - E.5	Sustained
Paragraph E - E.6	Sustained
Paragraph E - E.7	Sustained
Paragraph E - E.8	Not Sustained
Paragraph F - F.1	Sustained
Paragraph F - F.2	Sustained
Paragraph F - F.3	Not Sustained
Paragraph F - F.4	Sustained
Paragraph F - F.5	Sustained
Paragraph F - F.6	Sustained
Paragraph F - F.7	Sustained
Paragraph F - F.8	Not Sustained
Paragraph F - F.9	Not Sustained
Paragraph G - G.1	Sustained
Paragraph G - G.2	Sustained
Paragraph G - G.3	Not Sustained
Paragraph G - G.4	Sustained
Paragraph G - G.5	Sustained
Paragraph G - G.6	Sustained
Paragraph G - G.7	Sustained
Paragraph G - G.8	Not Sustained
Paragraph G - G.9	Not Sustained
Paragraph H - H.1	Sustained
Paragraph H - H.2	Sustained
Paragraph H - H.3	Sustained
Paragraph H - H.4	Not Sustained
Paragraph H - H.5	Sustained
Paragraph H - H.6	Sustained
Paragraph H - H.7	Withdrawn
Paragraph H - H.8	Withdrawn
Paragraph H - H.9	Sustained
Paragraph I - I.1	Sustained
Paragraph I - I.2	Sustained
Paragraph I - I.3	Sustained
Paragraph I - I.4	Sustained
Paragraph I - I.5	Sustained

Paragraph I - I.6	Sustained
Paragraph I - I.7	Sustained
Paragraph I - I.8	Not Sustained
Paragraph I - I.9	Sustained
Paragraph J -	Not Sustained
Paragraph K -	Not Sustained

DETERMINATION AS TO PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to statute, including revocation, suspension, probation, censure, and the imposition of civil penalties and gave extremely strong consideration to revoking the Respondent's medical license. Despite prior disciplinary action by the Board, the Respondent has failed to make any meaningful changes to her medical practices. They noted the Respondent's repeated instances of issuing prescriptions for dangerous combinations of opioids and benzodiazepines to her patients and her poor judgment in allowing a nurse to do the same, without oversight.

The Hearing Committee was disturbed by the Respondent's lack of accountability and rationalization for every wrong decision in her life. For instance, she blamed her unclean home on her partner's illness, charged "the government" with permitting the unauthorized arrangement she had with the nurse and attributed the Driving While Intoxicated conviction to her partner's alcoholism and a sick pet. The Hearing Committee noted Dr. Cheney's summary, which described the Respondent as having "a form of magical thinking, where if she believes something to

be true, then it is true." They also considered his assessment of the Respondent that alcohol abuse, "endogenous depression, or even a psychotic illness" may be the basis for her irrational decisions. (Ex. 40; T. 884-885, 1512-1514).

While the Hearing Committee deliberated at length on revocation as the only sanction to protect the public, they ultimately decided that mitigating circumstances exist here that warrant a lesser sanction. The Respondent's professional misconduct occurred during a period of intense personal hardship and tragedy, including the ongoing illness and death of her partner, which was followed by the death of her mother. The evidence also showed the current condition of the Respondent's home as clean, and the Respondent demonstrated support from patients and staff from two of her former employers, Moran's Rest Home and McClelland's Home for Adults. (Ex. I).

At the same time, the Hearing Committee considered extremely dangerous the Respondent's opioid prescription practices, which resulted in addiction for at least one of her patients, who described the difficult "withdrawal" process after no longer having access to prescribed drugs. To this end, the Hearing Committee concluded that the Respondent's medical license must be permanently limited to prohibit prescribing controlled substances. (Ex. L; T. 884, 1254-1255).

The Hearing Committee believes that if provided with the opportunity to participate in - and complete - an intensive therapy program, the Respondent will be capable of providing safe and proper

medical care to patients. Accordingly, the Hearing Committee determined that the Respondent's medical license should be subject to suspension and that she only be able to practice medicine after she completes a course of therapy, including completion of any conditions and terms. A practice monitor must also be put in place, during a five-year probationary period, to review the medical care that the Respondent provides to make certain that the treatment she renders to patients conforms to the standard of care.

ORDER

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

1. The First, Second, Third, Fourth, Fifth, Eighth, Eleventh and Twelfth Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED**.

2. The Sixth, Seventh, Ninth, Tenth, Thirteenth and Fourteenth Specifications of professional misconduct, as set forth in the Statement of Charges are **NOT SUSTAINED**.

3. The Respondent's license to practice medicine in the State of New York is subject to a permanent limitation of license under PHL 230-a(3) to prohibit prescriptions in any form for controlled substances.

4. The Respondent's license to practice medicine in the State of New York is hereby wholly **SUSPENDED** under PHL § 230-a(2)(c) and (e), until such time as the Respondent completes the following:

(a) submits to and cooperates with a psychiatric evaluation by a physician, physicians or facility proposed by the

Respondent, but subject to the prior written approval by the Director of the OPMC; and

(b) causes the evaluator to report in writing to the Director of the OPMC regarding the Respondent's fitness to practice medicine.

5. The period of whole suspension ends only after the completion of steps (a) and (b) in (4) above, at which time the Respondent is immediately placed on **PROBATION FOR A PERIOD OF FIVE YEARS**. The Respondent must comply with the **TERMS OF PROBATION** annexed hereto as Appendix B.

6. The probation period shall toll whenever the Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more.

7. During the period of probation, the Respondent shall practice medicine only when monitored by a licensed physician as detailed in paragraph seven of Appendix B; and

8. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail or upon the Respondent at her last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Albany, New York
April , 2017

WILLIAM A. TEDESCO, M.D. (CHAIR)

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APPENDIX A

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

IN THE MATTER OF JEANINE SANTIAGO, M.D.	AMENDED STATEMENT OF CHARGES

JEANINE SANTIAGO, M.D., Respondent, was authorized to practice medicine in New York State on December 15, 1989, by the issuance of license number 181053 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about November 16, 2015 in the County Court, County of Dutchess, State of New York, Respondent was found guilty, based on a jury verdict of guilty, of three (3) counts of Unauthorized Practice a Crime – Medicine, a class E felony, in violation of New York State Education Law §6512(1). At various times between 2008 and 2013, Respondent being a licensed physician, furnished to Registered Nurse W.P., a person not licensed to practice medicine, with pre-signed blank prescripticns printed in Respondent's name, which Registered Nurse W.P. completed to prescribe medications, of her selection, to three (3) patients, persons Respondent did not examine and treat at that time.

B. On or about November 16, 2015 in the County Court, County of Dutchess, State of New York, Respondent was found guilty, based on a jury verdict of guilty, of one (1) count of Offering a False Instrument for Filing in the First Degree, a class E felony, in violation of New York State Penal Law §175.35(1). Respondent being a licensed physician enrolled as a provider in the New York State Medical Assistance Program, commonly known as Medicaid, was found to have knowingly submitted and caused to be submitted a claim for payment, to a fiscal agent for the State of New York, which falsely stated that Respondent had provided a home visit for the evaluation and management of an established patient, who was a Medicaid recipient.

1A

C. Respondent provided medical care to Patient A (patients are identified in Appendix A), an 86 year old female, at Patient A's residence, and/or at Respondent's residence/office at 124 Smithtown Road, Fishkill, New York, at various times from on or about January 31, 2007, to, at least, on or about August 28, 2014. Respondent treated Patient A for anxiety, depression, hip and back pain, among other conditions. Respondent's medical care of Patient A deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate medical history for Patient A.

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

3. Respondent failed to refer Patient A to a psychiatrist or an appropriate subspecialty provider despite medical indications and/or failed to document any such referrals.

4. Respondent inappropriately prescribed opioids and benzodiazepines (valium) to Patient A on one or more occasions including on or about January 9, 2007; January 31, 2007; March 7, 2007; March 21, 2007; March 28, 2007; October 3, 2007; October 10, 2007; December 5, 2007; January 16, 2008; January 30, 2008; March 7, 2008; May 28, 2008; June 25, 2008; April 8, 2009; January 4, 2010; February 15, 2011; May 22, 2011; June 16, 2011; September 27, 2011; October 18, 2011; February 21, 2012; March 13, 2012; April 10, 2012; April 24, 2012; May 22, 2012; August 6, 2012; August 13, 2012; August 20, 2012; September 4, 2012; August 24, 2014; and/or August 28, 2014.

5. Respondent failed to adequately test Patient A for abuse of the drugs prescribed and/or failed to order such tests.

6. Respondent inappropriately provided pre-signed blank prescriptions printed in Respondent's name to Registered Nurse W.P., which Registered Nurse W.P. completed to prescribe medications to Patient A knowing that Respondent had not provided the medication to prescribe and that it was to be completed by Registered Nurse W.P. with the intent

to deceive or mislead pharmacies, the Bureau of Narcotics Enforcement, and/or Department of Health.

7. Respondent failed to adequately monitor Patient A's progress and/or document an assessment/treatment plan including diagnostic tests for Patient A.

8. Respondent, on various dates between January 31, 2007,and 2013, sent Nurse W.P. to treat Patient A, at Patient A's residence and billed for services as if Respondent had provided the services as a physician at a higher rate. Respondent knowingly reported that she provided services with the intent to deceive or mislead the insurance companies.

9. Respondent, on various dates between January 31, 2007, and August 28, 2014, treated Patient A at Respondent's residence/office located at 124 Smithtown Road, Fishkill, New York, where there was dirt, garbage, animal feces, and medical waste about the house and/or several cats roamed the house. Patient files were left unsecured and/or were covered and stained by dirt and/or animal waste.

D. Respondent provided medical care to Patient B, a 62 year old male, at Patient B's residence and/or at Respondent's residence/office, at various times from on or about February 8, 2007, to, at least, on or about December 8, 2014. Respondent treated Patient B for chronic pain, among other conditions. Respondent's medical care of Patient B deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate medical history for Patient B.

2. Respondent failed to obtain and/or document an adequate physical examination for Patient B.

3. Respondent failed to refer Patient B to an appropriate subspecialty provider(s) for monitoring of Patient B's traumatic brain injury, among other conditions and/or failed to document any such referrals.

4. Respondent inappropriately prescribed opioids (morphine, percocet and fentanyl), to Patient B on one or more occasions including on or about February 8, 2007; November 21, 2007; March 20, 2008; February 7, 2009; April 23, 2009; July 2, 2009; January 20, 2010; May 4, 2010; July 19, 2010; August 6, 2010; August 24, 2010; October 29, 2010; December 30, 2010; February 9, 2011; March 21, 2011; April 27, 2011; June 1, 2011; July 8, 2011; July 20, 2011; August 10, 2011; September 22, 2011; November 1, 2011; December 6, 2011; January 6, 2012; February 10, 2012; April 9, 2012; May 8, 2012; June 25, 2012; July 27, 2012; August 28, 2012; September 28, 2012; November 16, 2012; January 11, 2013; February 19, 2013; April 29, 2013; and/or November 11, 2013.

5. Respondent failed to adequately monitor Patient B's renal function and/or document that Respondent monitored it properly.

6. Respondent failed to adequately test Patient B for abuse of the drugs prescribed and/or failed to order such tests.

7. Respondent inappropriately provided pre-signed blank prescriptions printed in Respondent's name to Registered Nurse W.P., which Registered Nurse W.P. completed to prescribe medications to Patient B knowing that Respondent had not provided the medication to prescribe and that it was to be completed by Registered Nurse W.P. with the intent to deceive or mislead pharmacies, the Bureau of Narcotics Enforcement, and/or Department of Health.

8. Respondent failed to appropriately monitor Patient B's progress and/or document an assessment/treatment plan including diagnostic tests for Patient B.

9. Respondent engaged in an inappropriate relationship and/or contact with Patient B by having Patient B purchase alcohol for her when she was prohibited from purchasing alcohol and/or possessing alcohol; and on or about December 8, 2014, Respondent grabbed Patient B by the neck and scratched him.

10. Respondent, on various dates between February 8, 2007 and 2013, sent Registered Nurse W.P. to treat Patient B, at Patient B's residence and billed for services as if Respondent had provided the services as a physician at a higher rate. Respondent knowingly reported that she provided services with the intent to deceive or mislead the insurance companies

11. Respondent, on various dates between February 8, 2007 and December 8, 2015, treated Patient B at Respondent's residence/office located at 124 Smithtown Road, Fishkill, New York, where there was dirt, garbage, animal feces, and medical waste about the house and/or several cats roamed the house. Patient files were left unsecured and/or were covered and stained by dirt and/or animal waste.

E. Respondent provided medical care to Patient C, a 56 year old male, at Patient C's residence, at various times from on or about July 30, 2010, to, at least on or about October 7, 2013. Respondent treated Patient C for knee and hip pain, among other conditions. Respondent's medical care of Patient C deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate medical history for Patient C.

2. Respondent failed to obtain and/or document an adequate physical examination for Patient C.

3. Respondent failed to refer Patient C to an orthopedic surgeon and/or bariatric subspecialty provider despite medical indications and/or failed to document such referrals.

4. Respondent inappropriately prescribed opioids (oxycodone) to Patient C on one or more occasions including on or about July 30, 2010; January 21, 2011; May 2, 2011; May 9, 2011; July 12, 2011; September 21, 2011; January 10, 2012; January 18, 2012; March 30, 2012; May 19, 2012; June 26, 2012; July 27, 2012; August 20, 2012; September 28, 2012; November 1, 2012; November 30, 2012; February 4, 2013; March 5,

2013; April 10, 2013; May 15, 2013; June 12, 2013; August 20, 2013; and/or November 25, 2013.

5. Respondent failed to adequately test Patient C for abuse of the drugs prescribed and/or failed to order such tests.

6. Respondent failed to appropriately monitor Patient C's progress and/or document an assessment/treatment plan including diagnostic tests for Patient C.

7. Respondent inappropriately provided pre-signed blank prescriptions printed in Respondent's name to Registered Nurse W.P., which Registered Nurse W.P. completed to prescribe medications to Patient C knowing that Respondent had not provided the medication to prescribe and that it was to be completed by Registered Nurse W.P. with the intent to deceive or mislead pharmacies, the Bureau of Narcotics Enforcement, and/or Department of Health.

8. Respondent, on various dates between July 30, 2010 and 2013, sent Registered Nurse W.P. to treat Patient C at Patient C's residence and billed for services as if Respondent had provided the services as a physician at a higher rate. Respondent knowingly reported that she provided services with the intent to deceive or mislead the insurance companies

F. Respondent provided medical care to Patient D, a 28 year old male, at Patient D's residence and/or at Respondent's residence/office, at various times from on or about September 22, 2011, to, at least, on or about July 19, 2013. Respondent treated Patient D for anxiety, migraines, bipolar disorder and dental pain, among other conditions. Respondent's medical care of Patient D deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate medical history for Patient D.

2. Respondent failed to obtain and/or document an adequate physical examination for Patient D.

3. Respondent failed to refer Patient D for a psychiatric and/or orthopedic evaluation despite medical indications and/or failed to document such referrals.

4. Respondent inappropriately prescribed opioids (Percocet) to Patient D on one or more occasions, including on or about September 22, 2011; November 14, 2011; January 16, 2012; February 13, 2012; February 27, 2012; March 12, 2012; April 30, 2012; May 29, 2012; June 25, 2012; August 27, 2012; October 25, 2012; December 14, 2012; and/or February 27, 2013.

5. Respondent failed to adequately test Patient D for abuse of the drugs prescribed and/or failed to order such tests.

6. Respondent failed to appropriately monitor Patient D's progress and/or document an assessment/treatment plan including diagnostic tests for Patient D.

7. Respondent inappropriately provided pre-signed blank prescriptions printed in Respondent's name to Registered Nurse W.P., which Registered Nurse W.P. completed to prescribe medications to Patient D knowing that Respondent had not provided the medication to prescribe and that it was to be completed by Registered Nurse W.P. with the intent to deceive or mislead pharmacies, the Bureau of Narcotics Enforcement, and/or Department of Health.

8. Respondent, on various dates between September 22, 2011 and 2013, sent Registered Nurse W.P. to treat Patient D at his residence and billed for services as if Respondent had provided the services as a physician at a higher rate. Respondent knowingly reported that she provided services with the intent to deceive or mislead the insurance companies

9. Respondent, on various dates between September 22, 2011 and July 19, 2013, treated Patient D at Respondent's residence/office located at 124 Smithtown Road, Fishkill, New York, where there was dirt, garbage, animal feces, and medical waste about the house and/or several cats roamed the house. Patient files were left unsecured and/or were covered and stained by dirt and/or animal waste.

G. Respondent provided medical care to Patient E, a 50 year old female, at Patient E's residence and/or at Respondent's residence/office, at various times from on or about May 2, 2011, to, at least, on or about November 4, 2013. Respondent treated Patient E for anxiety, leg pain, GERD, and hypertension, among other conditions. Respondent's medical care of Patient E deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate medical history for Patient E.

2. Respondent failed to obtain and/or document an adequate physical exam of Patient E.

3. Respondent failed to refer Patient E to a psychiatrist and/or other appropriate subspecialty provider despite medical indications and/or failed to document such referrals.

4. Respondent inappropriately prescribed opioids (Percocet, oxycontin, oxycodone) and/or benzodiazepines to Patient E on one or more occasions including on or about May 31, 2011; June 27, 2011; July 23, 2011; August 22, 2011; September 19, 2011; October 17, 2011; November 12, 2011; January 23, 2012; February 20, 2012; March 12, 2012; April 9, 2012; May 7, 2012; May 29, 2012; June 25, 2012; July 16, 2012; August 13, 2012; September 10, 2012; September 30, 2012; October 25, 2012; November 17, 2012; December 14, 2012; January 8, 2013; January 29, 2013; and/or February 27, 2013

5. Respondent failed to adequately test Patient E for abuse of the drugs prescribed and/or failed to order such tests.

6. Respondent failed to monitor Patient E's progress and/or document an assessment/treatment plan including diagnostic tests for Patient E.

7. Respondent inappropriately provided pre-signed blank prescriptions printed in Respondent's name to Registered Nurse W.P., which Registered Nurse W.P. completed to prescribe medications to Patient E knowing that Respondent had not provided the medication to prescribe and that it was to be completed by Registered Nurse W.P. with the intent to deceive or mislead pharmacies, the Bureau of Narcotics Enforcement, and/or Department of Health.

8. Respondent, on various dates between May 2, 2011, to on or about 2013 sent Registered Nurse W.P. to treat Patient E at Patient E's residence and billed for services as if Respondent had provided the services as a physician at a higher rate. Respondent knowingly reported that she provided services with the intent to deceive or mislead the insurance companies

9. Respondent, on various dates between May 2, 2011, and November 4, 2013, treated Patient E at Respondent's residence/office located at 124 Smithtown Road, Fishkill, New York, where there was dirt, garbage, animal feces, and medical waste about the house and/or several cats roamed the house. Patient files were left unsecured and/or were covered and stained by dirt and/or animal waste.

H. Respondent provided medical care to Patient F, a 30 year old male, at Patient F's residence and/or Respondent's residence/office at various times from on or about August 14, 2013, to, at least, on or about March 2, 2015. Respondent treated Patient F for generalized pain. Patient F had been treated previously by other providers for a brachial DVT, inflammatory bowel disease and a lumbosacral radiculopathy/radiculitis, among other conditions. Respondent's medical care of Patient F deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate medical history for Patient F.

2. Respondent failed to obtain and/or document an adequate physical exam of Patient F.

3. Respondent inappropriately prescribed opioids (oxycodone) to Patient F on one or more occasions, including on or about November 25, 2013.

4. Respondent failed to refer Patient F to an appropriate subspecialty provider for treatment of pain and/or a mental health provider to address Patient F's memory loss and depressive symptoms and/or failed to document such referrals.

5. Respondent failed to adequately test Patient F for abuse of the drugs prescribed and/or failed to order such tests.

6. Respondent failed to appropriately monitor Patient F's progress and/or document an assessment/treatment plan including diagnostic tests for Patient F.

(7 and 8 withdrawn)

9. Respondent, on various dates between August 14, 2013, and March 2, 2015, treated Patient F at Respondent's residence/office located at 124 Smithtown Road, Fishkill, New York, where there was dirt, garbage, animal feces, and medical waste about the house and/or several cats roamed the house. Patient files were left unsecured and/or were covered and stained by dirt and/or animal waste.

I. Respondent provided medical care to Patient G, a 53 year old female, at Patient G's residence and/or at Respondent's residence/office at various times in 2008 and from on or about March, 2011, to, at least, on or about June 18, 2014. Respondent treated Patient G for asthma and pain, among other conditions. Respondent's medical care of Patient G deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate medical history for Patient G.

2. ~~Respondent failed to obtain and/or document an adequate physical exam~~ of Patient G.

3. Respondent inappropriately prescribed Patient G opioids (oxycodone) and/or benzodiazepines (Xanax) to Patient G on one or more occasions including on or about November 23, 2011; January 10, 2012; February 19, 2013; March 19, 2013; and/or April 24, 2013;

4. Respondent inappropriately prescribed analgesics and/or benzodiazepines to Patient G after May 2014 on one or more occasions.

5. Respondent failed to adequately test Patient G for abuse of the drugs prescribed and/or failed to order such tests.

6. Respondent failed to appropriately monitor Patient G's progress and/or document an assessment/treatment plan including diagnostic tests for Patient G.

7. Respondent inappropriately provided pre-signed blank prescriptions printed in Respondent's name to Registered Nurse W.P., which Registered Nurse W.P. completed to prescribe medications to Patient G knowing that Respondent had not provided the medication to prescribe and that it was to be completed by Registered Nurse W.P. with the intent to deceive or mislead pharmacies, the Bureau of Narcotics Enforcement, and/or Department of Health.

8. Respondent, on various dates between 2008 and 2013, sent Registered Nurse W.P. to treat Patient G at Patient G's residence and billed for services as if Respondent had provided the services as a physician at a higher rate. Respondent knowingly reported that she provided services with the intent to deceive or mislead the insurance companies

9. Respondent, on various dates between 2008 and June 18, 2014, treated Patient G at Respondent's residence/office located at 124 Smithtown Road, Fishkill, New York, where there was dirt, garbage, animal feces,

and medical waste about the house and/or several cats roamed the house. Patient files were left unsecured and/or were covered and stained by dirt and/or animal waste.

J. Respondent, on or about February 24, 2016, by a Commissioner's Order of Summary Suspension was ordered, pursuant to Public Health Law §230(12)(b), that effective immediately, that Respondent shall not practice medicine in the State of New York, or practice in any setting under the authority of Respondent's New York license.

K. Respondent, on or about October 8, 2016, at the Thompson House nursing home facility of Northern Dutchess Hospital, Rhinebeck, New York, where Patient A is a current patient/resident, identified herself as "Dr. Santiago" and that she was Patient A's doctor in the community. Respondent asked the nurses on duty to verify Patient A's medications. The nurses declined to do so because Respondent was not on Patient A's contact list. Respondent stated to the nurses that Patient A needed to be on valium four times a day when she is ambulatory for anxiety and that Patient A needs 25 mg of valium as well. A nurse informed Respondent that Patient A was being followed by the physicians at the facility and that it would be the physician's decision on changing Patient A's medications. After visiting with Patient A, Respondent gave the nurses a note with Respondent's name and telephone numbers to add to Patient A's chart in case the nurses needed anything or if Patient A wanted to speak to Respondent.

SPECIFICATIONS

FIRST THROUGH SECOND SPECIFICATIONS

CONVICTED OF A CRIME

Respondent violated New York Education Law §6530(9)(a)(i) by being convicted of committing an act constituting a crime under New York State law, in that Petitioner charges:

3.

1. The facts in Paragraph A.

2. The facts in Paragraph B.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent violated New York Education Law §6530(3) by practicing the profession with negligence on more than one occasion, in that Petitioner charges:

3. The facts in Paragraphs C and C1, C and C2, C and C3, C and C4, C and C5, C and C6, C and C7, C and C8, C and C9, D and D1, D and D2, D and D3, D and D4, D and D5, D and D6, D and D7, D and D8, D and D9, D and D10, D and D11, E and E1, E and E2, E and E3, E and E4, E and E5, E and E6, E and E7, E and E8, F and F1, F and F2, F and F3, F and F4, F and F5, F and F6, F and F7, F and F8, F and F9, G and G1, G and G2, G and G3, G and G4, G and G5, G and G6, G and G7, G and G8, G and G9, H and H1, H and H2, H and H3, H and H4, H and H5, H and H6, H and H9, I and I1, I and I2, I and I3, I and I4, I and I5, I and I6, I and I7, I and I8, and/or I and I9.

FOURTH SPECIFICATION

GROSS NEGLIGENCE

Respondent violated New York Education Law §6530(4) by practicing the profession with gross negligence on a particular occasion, in that Petitioner charges:

4. The facts in Paragraphs C and C4, C and C6, D and D7, E and E7, F and F7, G and G7, and/or I and I7.

FIFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent violated New York Education Law §6530(5) by practicing the profession with incompetence on more than one occasion, in that Petitioner charges:

5. The facts in Paragraphs C and C1, C and C2, C and C3, C and C4, C and C5, C and C6, C and C7, C and C8, C and C9, D and D1, D and D2, D and D3, D and D4, D and D5, D and D6, D and D7, D and D8, D and D9, D and D10, D and D11, E and E1, E and E2, E and E3, E and E4, E and E5, E and E6, E and E7, E and E8, F and F1, F and F2, F and F3, F and F4, F and F5, F and F6, F and F7, F and F8, F and F9, G and G1, G and G2, G and G3, G and G4, G and G5, G and G6, G and G7, G and G8, G and G9, H and H1, H and H2, H and H3, H and H4, H and H5, H and H6, H and H9, I and I1, I and I2, I and I3, I and I4, I and I5, I and I6, I and I7, I and I8, and/or I and I9.

SIXTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent violated New York Education Law §6530(1) by practicing the profession fraudulently or beyond its authorized scope, in that Petitioner charges:

6. The facts in Paragraphs C and C6, C and C8, D and D7, D and D10, E and E7, E and E8, F and F7, F and F8, G and G7, G and G8, I and I7, and/or I and I8.

SEVENTH SPECIFICATION

PERMITTING, AIDING, ABETTING AN UNLICENSED PERSON

Respondent violated New York Education Law §6530(11) by permitting, aiding or abetting an unlicensed person to perform activities requiring a license, in that Petitioner charges:

7. The facts in Paragraphs A, C and C6, C and C8, D and D7, D and D10, E and E7, E and E8, F and F7, F and F8, G and G7, G and G8, I and I7, and/or I and I8.

EIGHTH SPECIFICATION

DELEGATING PROFESSIONAL RESPONSIBILITIES

Respondent violated New York Education Law §6530(25) by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them, in that Petitioner charges:

8. The facts in Paragraphs A, C and C6, C and C8, D and D7, D and D10, E and E7, E and E8, F and F7, F and F8, G and G7, G and G8, I and I7, and/or I and I8.

NINTH SPECIFICATION

FAILING TO EXERCISE APPROPRIATE SUPERVISION

Respondent violated New York Education Law §6530(33) by failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensee, in that Petitioner charges:

9. The facts in Paragraphs A, C and C6, C and C8, D and D7, D and D10, E and E7, E and E8, F and F7, F and F8, G and G7, G and G8, I and I7, and/or I and I8.

TENTH SPECIFICATION

FAILURE TO COMPLY

Respondent violated New York Education Law §6530(16) by a willful or grossly negligent failure to comply with substantial provisions of federal, state, or local laws, rules or regulations governing the practice of practice of medicine, in that Petitioner charges:

10. The facts in Paragraphs A, C and C6, D and D7, E and E7, F and F7, G and G7, and/or I and I7.

ELEVENTH SPECIFICATION

FAILING TO MAINTAIN A RECORD

Respondent violated New York Education Law §6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

11. The facts in Paragraphs C and C1, C and C2, C and C3, C and C7, D and D1, D and D2, D and D5, D and D8, E and E1, E and E2, E and E3, E and E6, F and F1, F and F2, F and F3, F and F6, G and G1, G and G2, G and G3, G and G6, H and H1, H and H2, H and H4, H and H6, I and I1, I and I2, and/or I and I6.

TWELFTH SPECIFICATION

FAILING TO USE BARRIER PRECAUTIONS

Respondent violated New York Education Law §6530(47) by failing to use scientifically accepted barrier precautions and infection control practices as established by the department of health pursuant to §230-a of the Public Health Law, in that Petitioner charges:

12. The facts in Paragraph C and C9, D and D11, F and F9, G and G9, H and H9, and/or I and I9.

THIRTEENTH SPECIFICATION

HARASSING, ABUSING, INTIMIDATING A PATIENT

Respondent violated New York Education Law §6530(31) by willfully harassing, abusing, or intimidating a patient either physically or verbally, in that Petitioner charges:

13. The facts in Paragraph D9.

FOURTEENTH SPECIFICATION

VIOLATION OF ANY CONDITION OR LIMITATION IMPOSED ON A LICENSEE PURSUANT TO PUBLIC HEALTH LAW §230

Respondent violated New York Education Law §6530(29) by violating any condition or limitation imposed on the licensee pursuant to section two hundred thirty of the public health law, in that Petitioner charges:

14. The facts in Paragraphs J and K.

DATED: Oct. 13, , 2016
Albany, New York

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX B

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to PHL § 230(19).

2. Respondent shall maintain active registration of her license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3. Respondent shall provide the Director, OPMC, Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204 with the following information, in writing, and ensure that this information is kept current: a full description of her employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.

4. Respondent shall cooperate fully with and respond in a timely manner to OPMC requests to provide written periodic verification of her compliance with these terms. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. The probation period is for five years and shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if she is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in the Determination and Order or as are necessary to protect the public health.

6. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or

electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

7. During the probationary period, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with PHL § 230(18)(b). Proof of coverage shall be submitted to the Director of OPMC within 30 days after the effective date of this Order.

8. Respondent shall comply with these probationary terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.