

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

X

IN THE MATTER : DETERMINATION
OF : AND
PETER CHRISTOPHER SCHOOLER, M.D. : ORDER

BPMC-94-240

X

Thea Graves Pellman , Chairperson, **Michael R. Golding, M.D.**, and **Jack Schnee, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **Michael P. McDermott, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this DETERMINATION AND ORDER.

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with violation of Article 33 of the Public Health Law; with practicing the profession fraudulently; with practicing with negligence on more than one occasion; with practicing with gross negligence and with failure to maintain record.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this DETERMINATION AND ORDER.

SUMMARY OF PROCEEDINGS

Notice of Hearing and
Statement of Charges:

June 14, 1994

Pre-Hearing Conference:

July 21, 1994

Hearing Dates:

July 28, 1994
August 30, 1994
August 31, 1994

Place of Hearing:

NYS Department of Health
5 Penn Plaza
New York, New York

Date of Deliberations:

October 11, 1994

Petitioner Appeared By:

Peter J. Millock, Esq.
General Counsel
NYS Department of Health
By: David W. Smith, Esq.
Associate Counsel

Respondent Appeared By:

John Lawrence Kase, Esq.
Kase & Drucker
1325 Franklin Ave., Suite 225
Garden City, New York 11530

WITNESSES

For the Petitioner:

Herbert Gershberg, M.D.

Peter Benjamin Berkey, M.D.

Fred Baitaglia

For the Respondent:

Peter Christopher Schooler, M.D., the Respondent

Patient D

Patient X

Patient Y

Patient Z

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Dr. Christopher Schooler was duly licensed to practice medicine in New York State on January 30, 1981, under license number 145015 (Pets. Exs. 1 and 2).

2. Dr. Schooler is a graduate of the University of Brussels, where he received his medical degree in June, 1979. (Pet's Ex. 2; Tr. 260).

3. Dr. Schooler was an intern at St. Clare's Hospital and St. Elizabeth's Hospital in New York City (Tr. 259-260, 339).

4. Thereafter, he began working with Dr. Benjamin Shalette, a single practitioner in his 80's in 1981. Six months later Dr. Shalette retired, and Dr. Schooler continued the practice. (Tr. 260, 343).

5. Dr. Schooler remains in practice as a general practitioner in the West Side, at 425 West 23rd Street, New York, New York.

6. Dr. Schooler devotes a significant portion of his practice to problems of the local community. Approximately 60% of his patients are HIV infected, or have active AIDs (TR 267, 279). Such patients typically lose their jobs and therefore, both their health insurance and their ability to earn a living are affected. Dr. Schooler claims to treat these patients free of charge when they cease to have resources. Approximately 10-15% of his practice consists of these pro bono patients. (Tr. 260, 343).

7. There is also a large portion of his practice which is transsexual (Tr. 267).

FINDINGS AS TO ARTICLE 33 VIOLATIONS

8. By Stipulation and Order, dated July 26, 1994, the Respondent entered into a Stipulation with the New York State Department of Health, Bureau of Controlled Substances, whereby the Respondent admitted to, and the Commissioner of Health found, violations of Article 33 of the N.Y. Public Health Law, in that the Respondent prescribed and dispensed controlled substances not in good faith, nor in the course of his professional practice, nor for legitimate medical purposes and willfully made false statements on prescriptions for controlled substances. The Respondent was fined \$30,000.00, payment of \$15,000.00 of which was suspended pending lawful conduct by the Respondent for three years from the date of the Order, and his right to issue prescriptions on official New York State prescription forms was suspended for one year. (Pet's Ex. 3).

FINDINGS AS TO PATIENT "FRANK BARONE"

(Frank Barone was a fictitious name used by an undercover narcotic agent (Tr. 184-185)).

9. The Respondent first saw Patient Barone on November 7, 1988. He saw the Patient five times between November 7, 1988 and January 23, 1989 (Pet's Ex. 4; Tr. 184-193).

10. No adequate physical examination was ever performed nor was an adequate medical history ever taken (Pet's Ex. 4; Tr. 17, 184-193).

11. Patient Barone continually received prescriptions for Valium, although he never gave the Respondent a valid medical reason for such prescriptions (Pet's Ex. 4; Tr. 196).

12. On the fourth and fifth visits, June 4, 1989 and July 23, 1989, the dosage of Valium was increased without medical justification (Pet's Ex. 4; Tr. 17-18, 188-192).

13. The Respondent has admitted that he gave the Valium prescriptions to Patient Barone fraudulently, and not in the good faith practice of medicine (Pet's Ex. 3).

14. The care rendered to Patient Barone by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Ex. 4; Tr. 18-19, 263).

CONCLUSIONS AS TO PATIENT "FRANK BARONE"

1. The care rendered to Patient Barone by the Respondent did not meet the minimum acceptable standards of medical care.

2. The Respondent's medical records for Patient Barone do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT A

15. The Respondent first saw Patient A in June 8, 1988. The patient's second visit was on July 14, 1990. No adequate physical examination was ever performed, nor was an adequate medical history ever taken (Pet's Ex. 5, 5A; Tr. 35-37).

16. Patient A's next visit was on February 12, 1991. He had a rash, which the Respondent diagnosed as a fungal infection (Pet's Exs. 5, 5A; Tr. 36). The patient's next visit was on April 18, 1991, and the same diagnosis was made (Pet's Exs. 5, 5A; Tr. 35-36; 162-164).

17. On the last visit, May 18, 1991, Patient A weighed 185 pounds which was 33 pounds less than he had weighed 11 months prior, but the Respondent did not determine the etiology of the weight loss. The Respondent also diagnosed Patient A's cough as bronchitis (Pet's Ex. 5, 5A; Tr. 36-39).

18. The Respondent knew that Patient A. was gay and at risk for HIV infection. Nevertheless, he never did any diagnostic laboratory tests to identify the patient's HIV status (Pet's Ex. 5, 5A; Tr. 275, 345-346).

19. On May 28, 1991, ten days after his last visit to the Respondent, Patient A saw Dr. Peter Berkey whom he knew was an infectious disease specialist, for treatment (Pet's Ex. 5, 5A; 159-161, 166-174). When Dr. Berkey first saw Patient A he was aware of the possibility that the patient could have AIDS (Tr. 161-166).

20. Dr. Berkey noted that Patient A had Kaposi's sarcoma, a frequent indicator of AIDs in a patient, as well as a thrush infection in his mouth. However, the patient was not malnourished. Dr. Berkey formed an opinion the patient had active AIDs and confirmed this opinion with a blood test. The patient consented to this testing (Tr. 161-163).

21. The Respondent thought that Patient A had stopped his visits because he had cured him of bronchitis (Tr. 411-412).

22. Patient A died of complications of AIDs in 1993 (Tr. 165).

23. The care rendered to Patient A by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Exs. 5, 5A; Tr. 38-39, 47-65, 263, 347-350).

CONCLUSIONS AS TO PATIENT A

1. The care rendered to Patient A by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent's medical records for Patient A do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT B

24. Patient B was first seen on July 11, 1988, and for almost the next three years the Respondent simultaneously prescribed Dalmane and Valium or similar acting substitutes for the patient (Pet's. Ex. 6; Tr. 66, 71, 95-96).

25. Taking Dalmane and Valium together could be dangerous, but the Respondent was unaware of this fact (Pet's Ex. 6; Tr. 95-96, 412-416). The Respondent did not monitor Patient B in the taking of these drugs (Pet's Ex. 6; Tr. 76-77, 92, 94).

26. The Respondent attempted to convince Patient B to decrease and eventually give up taking the Valium (Tr. 353). There were many psychiatric referrals during the course of the treatment in an attempt to find a psychiatrist with whom the patient would be comfortable (Tr. 69, 74, 87, 352). At one point, February 24, 1990, there appears a notation in the file that the patient signed an agreement to cease taking Valium and Dalmane by a date certain (Pet's Ex. 6, P.6; Tr. 80).

27. On March 8, 1990, the patient complained of palpitations and the Respondent ordered an EKG which was appropriate (Pet's Ex. 6; Tr. 99-100).

28. The Respondent also diagnosed Patient B with hyperventilation but never recorded a respiratory rate (Pet's Ex. 6; Tr. 99-100).

29. The Respondent never performed an adequate physical examination on Patient B, nor did he ever take an adequate medical history of the patient (Pet's Ex. 6; Tr. 76-77, 99-100, 107-108).

30. The care rendered to Patient B by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Ex. 6; Tr. 76-108, 263).

CONCLUSIONS AS TO PATIENT B

1. The care rendered to Patient B by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent's medical records for Patient B do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT C

31. The Respondent first saw Patient C on January 11, 1983. Patient C was overweight and hypertensive (Pets Ex. 7; Tr. 248-249).

32. The Respondent prescribed anti-hypertensive medication to lower the patient's blood pressure, and he also prescribed Didrex for weight reduction. He continued to prescribe Didrex for the next eight years (Pet's Ex. 7; Tr. 248-249).

33. Patient C never lost weight, and at the end of eight years he weighed 46 pounds more than he did when he first started seeing the Respondent (Pet's Ex. 7; Tr. 252-253).

34. The Respondent was not aware that Didrex could be harmful. However, he was aware that it would not be effective after a period of time, but he continued to prescribe it as a placebo (Pet's Ex. 7; Tr. 382-383, 394-395).

35. During the eight years that he treated Patient C, the Respondent never performed an adequate physical examination of the patient, nor did he ever obtain an adequate medical history (Pet's Ex. 7; Tr. 252-253).

36. Dr. Schooler engaged in counseling Patient C in an attempt to have him lose weight; stop taking Didrex, to stop smoking and to control his blood pressure (Tr. 261-262).

37. Dr. Schooler has acknowledged that the Didrex prescriptions represented a misguided effort to assist Patient C, and that he would not treat this patient again in the same manner (Tr. 383).

38. The care rendered to Patient C by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's. Ex. 7; Tr. 263).

CONCLUSIONS AS TO PATIENT C

1. The care rendered to Patient C by the Respondent did not meet minimum acceptable standards of medical care.
2. The Respondent's medical records for Patient C do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT D

39. The Respondent first saw Patient D on September 3, 1987. From February 22, 1992 to November 20, 1993, the Respondent continually prescribed Darvocet and Meprobamate for the patient and added Procardia on May 27, 1992 and Placidyl on October 22, 1992. There is nothing in the patient's medical record to justify the prescribing of these drugs (Pet's Exs. 8, 8A; Tr. 115-121, 302-303).

40. Patient D was being treated by a psychiatrist, a gynecologist and a gastro-enterologist at the same time she was being treated by the Respondent (Tr. 302, 308-310).

41. The Respondent did not secure the records of patient D's other treating physicians to have as part of his own medical record on this patient (Tr. 354, 357-358).

42. Patient D testified on behalf of the Respondent. She stated that his office was neat and clean, his practice well run, and that a nurse took her history when she came in (Tr. 305).

43. The Respondent never recorded an adequate physical examination on Patient D and he failed to record an adequate medical history of the patient (Pet's Ex. 8 & 8A).

44. The care rendered to Patient D by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Ex. 8; Tr. 120, 263, 378).

CONCLUSIONS AS TO PATIENT D

1. The care rendered to Patient D by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent's medical records for Patient D do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT E

45. The Respondent treated Patient E from May 2, 1990 through March 14, 1994. He diagnosed hypertension and continually prescribed Inderal and Meprobamate during the course of treatment (Pet's Ex. 9, 9A; Tr. 127-130, 243).

46. Patient E's medical record does not reflect that the patient actually suffered from hypertension (Pet's Ex. 9, 9A).

47. The Respondent's prescribing of Inderal was not justified since none of the blood pressure readings recorded for Patient E indicated hypertension. Likewise, the prescribing of Meprobamate for "anxiety", without further elaboration, was also unjustified (Pet's Ex. 9, 9A; Tr. 129-134).

48. Patient E was being treated by other physicians while seeing the Respondent, but the Respondent did not obtain any records from the other treating physicians to have as part of his own records on this patient (Pet's Exs. 9, 9A; Tr. 130)

49. The care rendered to Patient E by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Ex. 9; Tr. 131-132, 263).

CONCLUSIONS AS TO PATIENT E

1. The care rendered to Patient E by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent's medical records for patient E do not accurately reflect the evaluation and treatment of the patient.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise indicated)

FIRST SPECIFICATION: (VIOLATION OF ARTICLE 33 OF THE PUBLIC HEALTH LAW)

SUSTAINED

SECOND SPECIFICATION: (PRACTICING THE PROFESSION FRAUDULENTLY)

SUSTAINED

THIRD SPECIFICATION: (PRACTICING WITH NEGLIGENCE ON MORE THAN ONE
OCCASION)

SUSTAINED

FOURTH AND FIFTH SPECIFICATIONS: (PRACTICING WITH GROSS NEGLIGENCE)

SUSTAINED

SIXTH THROUGH ELEVENTH SPECIFICATION: (FAILURE TO MAINTAIN RECORDS)

SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee has reviewed the entire record in this case. The record reveals that the Respondent's treatment of "Patient Barone" and patients A, B, C, D and E, in each and every case, did not meet minimum acceptable standards of medical care.

In addition, the record reveals that the Respondent prescribed and dispensed controlled substances, not in good faith, nor in the course of his professional practice, nor for legitimate medical purposes and wilfully made false statements on prescriptions for controlled substances.

The Hearing Committee has unanimously (3-0) **SUSTAINED** all of the charges against the Respondent.

The Hearing Committee determines unanimously (3-0) that the Respondent's license to practice medicine in the State of New York should be **REVOKED**.

The Hearing Committee recommends to the licensing authority that should the Respondent apply in the future for reinstatement of his license to practice medicine, no action be taken on said application unless it is accompanied by documentation showing that the Respondent has successfully completed appropriate retraining courses in medical practice and ethics.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondents license to practice medicine in the State of New York is **REVOKED.**
2. This ORDER shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

Dated: *W. Hempstead*, New York
Nov 9, 1994


THEA GRAVES PELLMAN (Chairperson)

**MICHAEL R. GOLDING, M.D.
JACK SCHNEE, M.D.**

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

-----X
: IN THE MATTER :
: OF : NOTICE
: CHRISTIAN SCHOOLER, M.D. : OF
: HEARING
-----X

TO: CHRISTIAN SCHOOLER, M.D.
425 West 23rd Street
New York, New York 10011

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 28th day of July, 1994, at 10:00 in the forenoon of that day at 5 Penn Plaza, Sixth Floor, New York, New York 10001 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce

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

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

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the

Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A
DETERMINATION THAT YOUR LICENSE TO PRACTICE
MEDICINE IN NEW YORK STATE BE REVOKED OR
SUSPENDED, AND/OR THAT YOU BE FINED OR
SUBJECT TO THE OTHER SANCTIONS SET OUT IN
NEW YORK PUBLIC HEALTH LAW SECTION 230-a
(McKinney Supp. 1994). YOU ARE URGED TO
OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS
MATTER.

DATED: New York, New York

June 14, 1994


CHRIS STERN HYMAN,
Counsel

Inquiries should be directed to: DAVID W. SMITH
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001
Telephone No.: 212-613-2617



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

-----X
IN THE MATTER : STATEMENT
OF : OF
CHRISTOPHER SCHOOLER, M.D. : CHARGES
-----X

CHRISTOPHER SCHOOLER, M.D., the Respondent, was authorized to practice medicine in New York State on January 30, 1981 by the issuance of license number 145015 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994.

FACTUAL ALLEGATIONS

- A. By Stipulation and Order dated on or about July 26, 1991, Respondent entered into a Stipulation with the New York State Department of Health, Bureau of Controlled Substances, whereby Respondent admitted to, and the Commissioner of Health found, violations of Article 33 of the N.Y. Public Health Law, in that Respondent dispensed controlled substances not in the good faith practice of medicine and willfully and knowingly made false statements on prescriptions for controlled substances. Respondent was

fined \$30,000.00, payment of \$15,000.00 of which was suspended pending lawful conduct by Respondent for three years from the date of the Order, and his right to issue prescriptions on official New York State prescription forms was suspended for one year.

- B. On or about November 14, 1988, January 4, 1989, and January 23, 1989, Respondent willfully and knowingly issued prescriptions not in the good faith practice of medicine and without an adequate medical history or an adequate physical examination to an investigator posing as patient Frank Barone.

- C. Between in or about July, 1988 and May, 1991, Respondent treated Patient A for anxiety and other medical conditions approximately five (5) times at his office at 425 West 23rd Street, New York City.
 - 1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.
 - 2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.

3. Despite the fact that Patient A presented to Respondent with skin rash, chest congestion and sudden weight loss, Respondent failed to order or perform indicated laboratory tests, or note such tests, if any, failed to prescribe indicated medicines, or note such prescriptions, if any, and failed to diagnose Patient A as HIV Positive and having AIDS or note such diagnosis, if any.

D. Between in or about July, 1988, and February, 1991, Respondent treated Patient B for anxiety and other medical conditions at his office at 425 West 23rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.
2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.
3. Throughout the period, Respondent inappropriately prescribed controlled substances including Valium and Dalmane.

4. Respondent failed to warn Patient B about the possible addictive effects of Valium and Dalmane taken together, or note such warnings, if any, and failed to monitor possible adverse side effects of the controlled substances he was prescribing, or note such monitoring, if any.
- E. From in or about January, 1983 through January, 1989, Respondent treated Patient C for hypertension and other medical conditions at his medical office at 425 West 23rd Street, New York City.
1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.
 2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.
 3. Throughout the period, Respondent inappropriately prescribed Didrex, which, among other things, was contra-indicated, and other controlled substances, including Dalmane.

F. From in or about August, 1992, through in or about May, 1993, Respondent treated Patient D for anxiety and other medical conditions at his medical office at 425 West 23rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.

3. Throughout the period, Respondent inappropriately prescribed controlled substances including Meprobamate and Darvocet.

G. From in or about September, 1991 through June, 1993, Respondent treated Patient E for hypertension and other medical conditions at his medical offices at 425 West 23rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.
3. Throughout the period, Respondent inappropriately prescribed Inderal and Meproamate.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

VIOLATION OF ARTICLE 33 OF THE PUBLIC HEALTH LAW

Respondent is charged with having been found by the Commissioner of Health to be in violation of Article 33 of the Public Health Law within the meaning of N.Y. Educ. Law Section 6530(9)(e) (McKinney Supp. 1994). Specifically, Petitioner charges:

1. The facts in Paragraph A.

SECOND SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1994). Specifically, Petitioner charges:

2. The facts in Paragraph B.

THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE ON

MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1994).

Specifically, Petitioner charges two or more of the following:

3. The facts in Paragraph B; C and C1-3; D and D1-3; E and E1-3; F and F1-3 and/or G and G1-3.

FOURTH AND FIFTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing with gross negligence on a particular occasion within the meaning of N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1994). Specifically, Petitioner charges:

4. The facts in Paragraph C and C1-3.

5. The facts in paragraph E and E1-3.

SIXTH THROUGH ELEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1994). Specifically, Petitioner charges:

6. The facts in Paragraph B.

7. The facts in Paragraph C and C1-3.

8. The facts in Paragraph D and D1, 2 and 4.

9. The facts in Paragraph E and E1-2.

10. The facts in Paragraph F and F1-2.

11. The facts in Paragraph G and G1-2.

DATED: New York, New York

June 14, 1994



CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct

