



STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 13, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David W. Smith, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza – Sixth Floor
New York, New York 10001

Manuel L. Saint Martin, J.D.
115-10 Queens Boulevard
Forest Hills, New York 11372

Luther C. Williams, Jr., Esq.
25 Court Street, Suite 1001
Brooklyn, New York 11242

Raphael Bazin, M.D.
19 Gilcrest Road
Great Neck, New York 11021

RE: In the Matter of Raphael Bazin, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-64) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

Request for review of the Committee's determination by the Administrative Review Board stays 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., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

COPY

IN THE MATTER

OF

RAPHAEL BAZIN, M.D.

RESPONDENT

DECISION
AND
ORDER
OF THE
HEARING
COMMITTEE

ORDER NO.

BPMC 01-64

The undersigned Hearing Committee consisting of **DAVID HARRIS, M.D., M.P.H.**, Chairperson, **ADEL R. ABADIR, M.D.** and **MICHAEL A. GONZALEZ, RPA** was duly designated and appointed by the State Board for Professional Medical Conduct.

JONATHAN M. BRANDES, ESQ., Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Section 230 (10) of the New York Public Health Law and Sections 301-307 and 401 of the New York State Administrative Procedure act. The purpose of the hearing was to receive evidence concerning alleged violations of Section 6530 of the New York State Education Law by **RAPHAEL BAZIN, M.D.** (hereinafter referred to as Respondent).

The New York State Board For Professional Medical Conduct (hereinafter referred to as the State or Petitioner) appeared by **HANK GREENBERG, ESQ.**, General Counsel, New York State Department of Health (hereinafter referred to as DOH). **DAVID W. SMITH, ESQ.**, Associate Counsel, Bureau of Professional Medical Conduct of counsel. Respondent appeared in person and by **MANUEL SAINT MARTIN, ESQ.**, and **LUTHER C. WILLIAMS, ESQ.** Mr. Saint Martin was lead counsel for the proceeding.

Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record. There were motions and briefs which are all part of the record herein whether submitted to the Trier of Fact or not.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision.

RECORD OF PROCEEDING

Notice of Hearing and Statement of Charges dated / served:	July 9, 2000 / July 12, 2000	
Summary Order Signed / Served:	NA	
Notice of Hearing returnable:	September 2, 2000	
First Amended Statement of Charges Dated:	NA	
Respondent's Answer Dated / Served:	August 29 / August 31, 2000	
Pre-Hearing Conference held:	August 31, 2000 (Phone)	
90/120 days ends:	Dec 2, 2000/Jan 2, 2001(Waived by Respondent)	
License Registration Number:	103564	
Original License Registration Date:	June 13, 1969	
Probation / Consent Order Number / Dated:	97-243 / September 30, 1997	
State Board for Professional Medical Conduct appeared by:	David W. Smith, Esq. → Associate Counsel Division of Legal Affairs 5 Penn Plaza New York, New York 10001	
Respondent represented by:	Manuel L. Saint Martin, J.D. 115-10 Queens Blvd. Forest Hills NY 11372	Luther C. Williams, Jr, Esq. 25 Court Street, Suite 1001 Brooklyn, NY 11242
Respondent's Present Address:	19 Gilchrest Road, Great Neck NY 11021	
Conferences Held	September 6,	
Location of Hearing	5 Penn Plaza, NY, NY	
Hearing Dates	September 6, and October 23, 2000	
State Rests	September 6, 2000	
Respondent Rests	October 23, 2000 ¹	
Closing Briefs Due (Respondent / State):	November 23 / December 13, 2000	
Closing Brief From State Received :	December 15, 2000	
Closing Brief From Resp. Dated:	November 28,2000	
Record Closed:	December 15, 2000	
Deliberations Scheduled:	January 23, 2001	
Deliberations Held:	January 23, 2001	

¹ Respondent appeared with counsel on September 6, 2000. The State's sole witness was examined and cross-examined. On October 23, Respondent appeared without counsel. He was found in default. However, he was also given an opportunity to contact counsel with the intention of re-opening and completing the case. Counsel contacted the Administrative Law Judge. After a conference with the parties, it was agreed that Respondent would waive his right to testify and finish the proceeding by submitting a written summation. The State also submitted a closing brief.

SUMMARY OF PROCEEDINGS

The Statement of Charges in this proceeding alleges seven grounds of misconduct arising from substandard medical care and violations of probation. Respondent is charged with violations of Consent Order 97-243. This is the Consent Order under which Respondent agreed to be placed on probation in September 1997.

The substandard medicine allegations arise from the from the treatment of five patients during the period 1996 through 1999. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One.

1. In the First through Fifth Specifications, Respondent is alleged to have committed fraud as set forth in N.Y. Education Law Section 6530 (2);
2. In the Sixth through Tenth Specifications, Respondent is alleged to have committed gross negligence as set forth in N.Y. Education Law Section 6530 (35);
3. In the Eleventh through Fifteenth Specifications, Respondent is alleged to have exercised undue influence on the patient, including the promotion of the sale of services, goods, appliances, or drugs in such manner as to exploit the patient for the financial gain of the licensee or of a third party as set forth in N.Y. Education Law Section 6530 (17);
4. In the Sixteenth Specification Respondent is alleged to have committed negligence on more than one occasion as set forth in N.Y. Education Law Section 6530 (3);
5. In the Seventeenth Specification, Respondent is alleged to have committed incompetence on more than one occasion as set forth in N.Y. Education Law Section 6530 (5);
6. In the Eighteenth through Twenty-Second Specifications, Respondent is alleged to have committed moral unfitness as set forth in N.Y. Education Law Section 6530 (20);
7. In the Twenty-Third through Twenty Seventh Specifications, Respondent is alleged to have given excessive treatment as set forth in N.Y. Education Law Section 6530 (35);

The Board called one witness: Louis J. Benton, M.D.

Respondent did not testify and did not call any witnesses.

SIGNIFICANT LEGAL DECISIONS

Instructions to the Trier of Fact

The Administrative Law Judge delivered the following instructions to the Committee:

1. Negligence is the failure to demonstrate that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state.
2. Incompetence is defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice in this state.
3. Incompetence can arise where a practitioner does not have the knowledge necessary to appropriately provide a given course of care and treatment. It may also arise where a practitioner has the requisite training and knowledge for a course of treatment but acts as if he or she does not have the appropriate level of training and knowledge.
4. There is one standard of medical care in this state. A prudent, competent physician is expected to consider the same medical issues regardless of where he practices. Whether a physician practices in a major teaching hospital, with all the most modern facilities and staff or in a rural or inner city clinic with less facilities and assistance available, the prudent, competent physician must consider all relevant medical issues.
5. There are some issues which reasonable minds may consider to be non-medical in nature. Such issues include, but are not limited to, patient cost, patient inconvenience, patient discomfort, anticipated patient compliance and other relevant issues. The prudent, competent physician is expected to consider these questions as they relate to the individual episode of medical care.
6. The prudent , competent physician may weigh the necessity and patient benefit of a given test, procedure or other treatment issue against the cost of the test or procedure, convenience and discomfort to the patient and anticipated compliance of the patient. Individual patients may raise other

pertinent issues as well. The prudent, competent physician is expected to make a well reasoned decision and record his reasons for same.

7. The customs and practices of the medical community in which the physician practices may be considered either as mitigation of a penalty or as one of the factors to be weighed in the physician's thought process as he deliberates the advisability of a given medical procedure. However, the practices of a given medical community cannot insulate a physician from a finding of incompetence, negligence or other misconduct.
8. With regard to a finding of medical misconduct, the Committee must first review Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response.
9. Where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any.
10. Patient harm need never be shown to establish negligence or incompetence in a proceeding before the Board For Professional Medical Conduct.
11. With regard to the expert testimony herein, including Respondent's, if any, each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.
12. The term "excessive" in the phrase "excessive tests and treatments" can be defined according to the ordinary meaning of the of the word.
13. In assessing whether a given activity or set of activities constitutes "excessive tests and treatments," the standard to be followed is whether the activity in question is reasonably related to the signs and symptoms of the patient and whether the reasonably anticipated results of the activities in issue are likely to provide the practitioner with relevant information. The elements set forth above constitute justification for a test or treatment or course of tests and treatments. The justification for a given test or treatment or course of tests and treatments must appear in the patient record to support the test or treatment or course of tests and treatments.

14. To sustain an allegation of moral unfitness, the State must show Respondent committed acts which "evidence moral unfitness." There is a distinction between a finding that an act "evidences moral unfitness" and a finding that a particular person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Committee is asked to decide if certain alleged conduct is suggestive of, or would tend to prove, moral unfitness. The Committee is not called upon to make an overall judgement regarding the moral character of any Respondent. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgement or other temporary aberration.
15. The standard for moral unfitness in the practice of medicine is twofold: First, there may be a finding that the accused has violated the public trust which is bestowed upon one solely by virtue of his earning a license to practice medicine in this state. Physicians have privileges that are available solely due to the fact that one is a physician. The public places great trust in physicians solely based upon the fact that they are physicians. For instance, physicians have access to controlled substances and billing privileges that are available to them solely because they are physicians. Patients are asked to place themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment. Hence, it is expected that a physician will not violate the trust the public has bestowed upon him by virtue of his professional status. This leads to the second aspect of the standard: Moral unfitness can be seen as a violation of the moral standards of the medical community which the Committee, as delegated members of that community, represent.
16. The fraudulent practice of medicine can be sustained when it is proven that Respondent made an intentional misrepresentation or concealment of a known fact, in connection with the practice of medicine. The fraudulent practice of medicine is present when:
 - a.) In the practice of medicine, a false representation is made by Respondent, whether by words, conduct or concealment of that which should have been disclosed accurately;
 - b.) Respondent knew the representation was false;
 - and
 - c.) Respondent intended to mislead through the false representation.
1. Where fraud is alleged, Respondent's knowledge and intent may properly be inferred from facts found by the hearing committee. However, the committee must specifically state the inferences and the basis for the inference or inferences.

2. The exercise of undue influence on the patient, includes the following elements:
 - a. The promotion of the sale of services (including but not limited to examinations, treatments or office visits), goods, appliances, or drugs;
 - b. In such manner as to exploit the patient financially or otherwise as opposed to in such a manner as to cure or ameliorate a condition;
 - c. For the financial gain of the licensee or of a third party
3. The Committee was instructed that to establish undue influence, the State must show that Respondent coerced or persuaded a patient to receive services, goods, appliances or drugs that were unnecessary. Unnecessary services, goods, appliances or drugs includes both services, goods, appliances or drugs which are excessive in duration or frequency or are simply unwarranted given the condition of the patient.
4. To establish undue influence, the State must further show that but for the persuasion of Respondent, as a physician, the patient would not have acted in the manner alleged. Undue influence includes both the receipt of services, goods, appliances or drugs which the patient does not want as well as services, goods, appliances or drugs the patient accepts willingly because the clinician convinced the patient the services, goods, appliances or drugs were necessary. The key element is the unwarranted or inappropriate persuasion of the practitioner and the reliance of the patient upon the instructions or persuasion of the practitioner.
5. The findings of fact in this decision were made after review of the entire record. Numbers in parentheses (T._) refer to transcript pages or numbers of exhibits (Ex._) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony may have been rejected as irrelevant.
6. The standard of proof in this proceeding is "preponderance of the evidence." This means that the State must prove the elements of the charges to a level wherein the trier of fact finds that a given event is more likely than not to have occurred. All findings of fact made herein by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

7. The Committee was instructed that in deciding this case, the members may consider only the exhibits which have been admitted in evidence and the testimony of the witnesses as it was heard in this hearing.
8. The Committee was instructed that remarks of the attorneys or the Administrative Law Judge are not evidence.
9. The Committee was instructed that if it is found that any witness has willfully testified falsely as to any material fact, that is as to an important matter, the law permits the trier of fact to disregard completely the entire testimony of that witness upon the principle that one who testifies falsely about one material fact is likely to testify falsely about everything. The Committee was told that they are not required, however, to consider such a witness as totally unworthy of belief. The trier of fact may accept so much of his or her testimony as is deemed true and disregard what you find is false. The Trier of Fact was told that it is by the processes which was described, they, as the sole judges of the facts, decide which of the witnesses they will believe, what portion of their testimony will be accepted and what weight it will be given.
10. The Committee was further instructed that occasionally, the weight to be given evidence is a matter of Law. The Committee was instructed that in such a case, the Administrative Law Judge would issue specific instructions to them.

FINDINGS OF FACT

The findings of fact in this decision were made after review of the entire record. Numbers in parentheses (T. _) refer to transcript pages. Exhibits received in evidence are identified by number and the party who introduced it (Pet. Or Resp. Ex. __;). These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony may have been rejected as irrelevant or redundant.

This matter includes charges that Respondent violated probation as set forth in Consent Order #97-243. In so far as the charges herein are proven, they constitute a violation of that probation.

General Findings of Fact

1. Respondent is a physician currently licensed to practice medicine in the State of New York. (Pet. Ex. 2)
2. In 1997, Respondent was charged with professional misconduct. Respondent was cited for making incorrect diagnoses and providing unnecessary or excessive treatment, as well as fraud and conduct evidencing moral unfitness.
3. Upon advice of counsel he ultimately plead "no contest" to charges of excessive treatment.
4. In October, 1997, a Consent Order was issued in which Respondent received a two-year stayed suspension and a two-year probation. (Pet. Ex. 3)
5. Paragraph 1 of the Terms of Probation required Respondent to conduct himself in a proper and professional manner and to "conform fully to the moral and professional standards of conduct and obligations imposed by law and his profession". (Pet. Ex. 3)
6. The acts cited herein occurred within the two-year limit of his probation. (Pet. Ex. 3; Paras 6 - 32, Infra)

Findings of Fact
Arising From
the Care and Treatment
of
PATIENT A

7. Respondent first saw Patient A on January 23, 1996 for injuries sustained to his back when he slipped on ice. (Tr. 26-27; Pet. Ex. 4)
8. Respondent diagnosed cervical spine derangement, and possible herniated lumbar disc with bilateral sciatica.
9. In addition, according to Respondent, X-rays of the cervical spine apparently showed, narrowing of the C4-5 and 5-6 spaces; A lumbosacral spine film showed narrowing of the L4-5 and S1 disc spaces (Tr. 27; Pet. Ex. 5)

10. Such diagnoses and findings are not supported by the office and other records of this patient. The disc spaces of the lumbar spine appeared to be essentially normal and the AP film of the lumbar spine appeared to be normal for a man this age (Tr. 27-31, 38-39)
11. Respondent treated² Patient A 135 times between March 7, 1997 and June 22, 1999. The patient showed no improvement during this period. (Tr. 27-29, 59-61; Pet. Ex. 4)
12. In January, 1996 and August, 1997, Patient A had two independent medical evaluations. Neither of the independent medical evaluations found the disability or other problems noted by Respondent. (Tr. 29; Pet. Ex. 4)
13. Respondent billed the insurance carrier of Patient A for all the treatments. (Pet. Ex. 4, pp 607-706)

Conclusions
With Regard to
Factual Allegations
Arising From
the Care and Treatment
of
Patient A

Under Factual Allegations A., A.1 through A.4, Respondent is alleged to have:

- A.1. Inappropriately diagnosed Patient A with narrowing of the spine;
- A.2. Inappropriately diagnosed Patient A with cervical spine derangement and lumbosacral spine derangement;
- A.3. inappropriately treated Patient A 135 times;
- A.4. Falsely billed Patient A's insurance carrier (the issue of intent to deceive, which also appears in Factual Allegation A.4 will be considered later).

The Committee sustains each of the Factual Allegations.

In so finding, the Committee relies upon the expert testimony of Louis J. Benton, M.D. Dr. Benton was presented as the State's expert. He is a Board Certified Orthopedic surgeon and is currently Chairman of the Orthopedic Department at the Veterans Hospital in Albany, New York. Dr. Benton's testimony was clear and

² For the purposes of this decision, the words "treat or treatment" refers to all office visits including those for examinations as well as those for therapeutic or other activity.

unequivocal during both direct and cross-examination. There appeared to be no hidden agenda against Respondent. There appeared to be no bias or other elements of thought that would cloud Dr. Benton's judgment. The Committee found Dr. Benton's judgments to be fairly presented and devoid of drama or other artifice. In sum, the Committee found Dr. Benton's testimony to be entirely credible and well supported by the records and x-rays supplied by Respondent and the various institutions.

Respondent does not dispute that between December 1996 and June 1999 Respondent saw this patient 135 times to treat a narrowing of the cervical spine at C4-5, C5-6, L4-5 and L 5-1. Respondent also does not dispute that he billed the insurance carrier of Patient A for each visit.

The fact is however, the patient did not suffer from these conditions. Dr. Benton stated that the spine of Patient A was essentially normal for a man his age. Furthermore, while Dr. Benton found the conditions cited by Respondent to be meaningless, the fact is the patient had no abnormal condition to describe. The findings of Dr. Benton were supported by x-ray films and the opinions of two independent medical reviewers who did not find the conditions asserted by Respondent.

Finally, the fact that there was essentially no change in this patient over 135 visits supports the State's assertions. Where a physician treats a patient so many times over such a period, the prudent, honest physician would expect to see some improvement or would explore the reasons for a lack of improvement. Of course, where, as here, the treatments are for conditions that do not exist, one cannot expect improvement.

For the purposes of the analysis herein, the Committee points out that the term "patient treatment" refers not just to the frequency of treatment. It also includes the duration of the care provided. The duration of care is not measured in terms of time in the office but rather the time from the beginning of treatment to the release of the patient. Therefore, the frequency of the visits times the duration of the care equals the patient treatment for the purposes of this analysis.

Utilizing the above definition, according to any reasonable standards of care, the patient treatment given Patient A by Respondent was excessive. As set forth earlier, they were also unwarranted.

Therefore,

Factual Allegation A and A. 1. ARE SUSTAINED;

Factual Allegation A and A. 2. ARE SUSTAINED;

Factual Allegation A and A. 3. ARE SUSTAINED;

Factual Allegation A and A. 4. ARE SUSTAINED;³

**Findings of Fact
Arising From
the Care and Treatment
of
PATIENT B**

13. Respondent first saw Patient B on November 16, 1998. She sought treatment for injuries suffered in a traffic accident.
14. Respondent described her chief complaint as posterior cervical pain radiating to both shoulders and low back pain radiating to both buttocks and back. (Tr. 65-67; Pet. Ex. 6)
15. Respondent diagnosed cervical spine and lumbosacral spine derangement. He also found that the odontoid process was closer to the first vertebral body on the right than on the left. (Tr. 67-68; Pet. Ex. 6, 7)
16. The treatment plan proposed by Dr. Bazin included Vicodin and Daypro for pain. He also planned for physical therapy.
17. The physical therapy consisted of 787 application #13 with four modalities for about twelve minutes. These were to be applied to the cervical spine at 3MA.
18. Similar treatment was to be applied to the lumbosacral spine.
19. Respondent concluded from an x-ray of the cervical spine that there was flattening of the cervical lordosis and narrowing at C4-5 and 5-6. (Tr. 67-68; Pet. Ex. 6, 7)
20. The x-rays of this patient's cervical spine, particularly on the lateral , showed no trauma or injuries from trauma.

³ Intent will be considered later.

21. The odontoid open mouth view was normal. (Tr. 67-68; Pet. Ex. 6)
22. The lumbosacral spine films similarly displayed normal limits for a patient of this age. (Tr. 67-68; Pet. Ex. 6)
23. Between November, 1998 and May, 1999, Respondent treated Patient B 59 times. (Tr. 67-68; Pet. Ex. 6)
24. Respondent billed Patient B's insurance carrier for all the treatments. (Pet. Ex. 6, pp 315-327)

Conclusions
With Regard to
Factual Allegations
Arising From
the Care and Treatment
of
Patient B

Under Factual Allegations B.1 through B.3, Respondent is alleged to have:

- B.1 inappropriately diagnosed Patient B with cervical spine and lumbosacral spine derangement;
- B.2 Throughout the period, Respondent inappropriately gave or caused to be given treatment including physical therapy to Patient B 59 times;
- B.3 deliberately and with intent to deceive⁴ falsely billed the insurance carrier of Patient B for unwarranted treatment and/or physical therapy given to Patient B.

The Committee sustains each of the Factual Allegations.

The Factual allegations regarding Patient B are sustained for the same reasons set forth in the analysis stated for Patient A.

The Committee relied upon the expert testimony of Louis J. Benton, M.D. The Committee found Dr. Benton's testimony to be entirely credible and well supported by the records and x-rays supplied by Respondent and the various institutions.

⁴ Intent to deceive will be dealt with later in this decision.

Respondent does not dispute that the time period set forth nor the number of visits. Respondent also does not dispute that he billed the insurance carrier of Patient A for each visit.

Again, as with Patient A, Patient B did not suffer from the conditions set forth by Respondent. Dr. Benton stated that the spine of Patient B was essentially normal for a woman her age.

Again, the fact that the patient had 59 visits Between November, 1998 and May, 1999, and there was no change in this patient over the period supports the State's assertions. Where a physician treats a patient so many times over such a period, the prudent, competent and honest physician would expect to see some improvement or would explore the reasons for a lack of improvement. Of course, where, as here, the treatments are for conditions that do not exist, one cannot expect improvement.

According to any reasonable standards of care, the treatment received by Patient B from Respondent was excessive. As set forth earlier, the treatments were also unwarranted since the patient did not suffer from the maladies Respondent was allegedly treating.

Therefore,

Factual Allegation B and B. 1. ARE SUSTAINED;

Factual Allegation B and B. 2. ARE SUSTAINED;

Factual Allegation B and B. 3. ARE SUSTAINED;

Findings of Fact
Arising From
the Care and Treatment
of
PATIENT C:

17. In August, 1998 Respondent began treating Patient C, a 76 year old man. Two Years earlier, in July, 1996, Patient C had slipped on a wet floor and hurt his right knee. (Tr. 78-79; Pet. Ex. 8, 9)
18. Respondent diagnosed Patient C with traumatic synovitis. Traumatic synovitis is an acute condition. (Tr. 80-83, 91-92; Pet. Ex. 8)
19. Patient C suffered from an arthritic effusion which is characterized by additional fluid on the joint. Arthritis is a chronic condition. Fluid from arthritis is a malady suffered by a significant number of 76 year old patients. (Tr. 80-83, 91-92; Pet. Ex. 8)

20. In a 76 year old patient with the signs and symptoms of Patient C, accepted standards of medicine would limit treatment to Non-steroidal anti-inflammatories, a cane, exercise and, perhaps a short term of physical therapy.
21. This patient had no recent history which would warrant the diagnosis of traumatic synovitis. His fall had taken place two years prior to meeting Respondent.
22. Respondent diagnosed a chronic condition as an acute condition for other than medial reasons. (Tr. 80-83, 91-92; Pet. Ex. 8)
23. Respondent treated Patient C 66 times between August, 1998 and June, 1999. He performed physical therapy on the patient. (Tr. 79; Pet. Ex. 8)
24. Respondent billed Patient C's insurance carrier for the treatments. (Pet. Ex. 8, pp 361-401)

Conclusions
With Regard to
Factual Allegations
Arising From
the Care and Treatment
of
Patient C

Under Factual Allegations C.1 through C.3, Respondent is alleged to have:

- C.1 Inappropriately diagnosed Patient C with traumatic synovitis of the right knee.
- C.2 Inappropriately treated Patient C 66 times.
- C.3 Deliberately and with intent to deceive⁵ falsely billed the insurance carrier of Patient C for unwarranted treatment and/or physical therapy given to Patient C.

The Committee sustains each of the Factual Allegations.

⁵ The issue of intent will be discussed later.

The Factual allegations regarding Patient C fall into the same pattern as those alleged under Patient A and Patient B. Therefore, the Factual Allegations regarding Patient C are sustained for the same reasons set forth in the analysis stated for Patient A.

The Committee relied upon the expert testimony of Louis J. Benton, M.D. The Committee found Dr. Benton's testimony to be entirely credible and well supported by the records and x-rays supplied by Respondent and the various institutions.

Respondent does not dispute that the time period set forth nor the number of visits. Respondent also does not dispute that he billed the insurance carrier of Patient A for each visit.

Again, as with prior patients, Patient C did not suffer from the conditions set forth by Respondent. While Dr. Benton did agree this patient could have had swelling from fluid on his knee, there was no basis for diagnosing acute synovitis as opposed to the very much more likely condition of arthritis.

Again, the fact that the patient had 66 visits between August, 1998 and June, 1999, and there was no change in this patient over the period supports the State's assertions.

According to any reasonable standards of care, the treatment received by Patient C from Respondent was excessive. As set forth earlier, the treatments were also entirely unnecessary.

Therefore,

Factual Allegation C and C. 1. ARE SUSTAINED;

Factual Allegation C and C. 2. ARE SUSTAINED;

Factual Allegation C and C. 3. ARE SUSTAINED;

Findings of Fact
Arising From
the Care and Treatment
of PATIENT D

25. Respondent first saw Patient D on November 23, 1998. Patient D suffered from low back pain and knee problems resulting from an auto accident. (Tr. 99-100; Pet. Ex. 10, 11)
26. The Initial office note, indicates Patient D was a 47-year-old man. He complained of posterior cervical pain radiating to both buttocks; low back pain radiating to both lower extremities; pain and swelling

over the knees, and his history indicated that he was injured in an automobile accident. (Tr. 99-104; Pet. Ex. 10, 11).

27. Respondent's diagnosis indicated: cervical spine derangement; lumbosacral spine derangement; traumatic synovitis of the right knee; and traumatic synovitis to the left knee. (Tr. 99-104; Pet. Ex. 10, 11)
28. X-rays taken and read by Respondent indicated cervical spine narrowing at the C3-4 disc space. Respondent further notes the L5/S1 disc appears to be bulging into L5. Some joint effusion is noted on the right knee which is similar to the left knee. (Tr. 99-104; Pet. Ex. 10, 11)
29. In order to make the finding that the L5/S1 disc appears to be bulging into L5, one must examine the patient with more than a flat x-ray study. An MRI or other 3 dimensional view is required. Respondent's records do not include any such study or reference to one. (Tr. 99-104; Pet. Ex. 10, 11)
30. Treatment for the patient started on 12/4/98 and continued until 3/31/99. There were 44 office visits spaced approximately every two to three days. (Tr. 99-104; Pet. Ex. 10, 11)
31. The treatment provided by Respondent consisted 787 applications of phyaction, and #13 with four modalities for twelve minutes to the lumbosacral spine and to the knees. The treatments were given approximately, two to three times a week. (Tr. 99-104; Pet. Ex. 10, 11)
32. The x-rays taken by Respondent at the initial visit indicate no significant effusion of either knee. The x-rays also do not support a diagnosis, of L5/S1 disc bulging into L5. (Tr. 99-104; Pet. Ex. 10, 11)
33. Accepted standards of medicine would have indicated the conclusion of treatment after approximately ten visits for physical therapy and perhaps two to four evaluations by Respondent. Respondent billed Patient D's insurance company for both physical therapy and an examination and appraisal each time Patient D came to the office. (Tr. 99-104; Pet. Ex. 10, 11)
34. Respondent treated Patient D 44 times between December, 1998 and March, 1999. (Tr. 99-104; Pet. Ex. 10)
35. Respondent billed Patient D's insurance carrier for all the treatments. (Tr. 10, pp 4-53)

**Conclusions
With Regard to
Factual Allegations
Arising From
the Care and Treatment
of
Patient D**

Under the Factual Allegations arising from Patient D, Respondent is charged with having:

- D.1 Inappropriately diagnosed Patient D with the L5-S1 disc bulging into L-5;
- D.2 Inappropriately given treatment to Patient D 44 times.
- D.3 falsely billed the insurance carrier of Patient D for unwarranted treatment and physical therapy.

The Committee sustains each of the Factual Allegations.

The Factual allegations regarding Patient D fall into the same pattern as those alleged under the previous patients. Therefore, the Factual Allegations regarding Patient D are sustained according to the same theories and standards set forth in the analysis stated for the earlier patients.

Once again, the Committee relied upon the expert testimony of Louis J. Benton, M.D. The Committee found Dr. Benton's testimony to be entirely credible and well supported by the records and x-rays supplied by Respondent.

Respondent does not dispute that the time period set forth nor the number of visits. Respondent also does not dispute that he billed the insurance carrier of Patient D for each visit.

Again, as with the prior patients, Patient D did not suffer from the conditions set forth by Respondent.

Again, the fact that the patient had 44 visits between December, 1998 and March, 1999., and there was no change in this patient over the period supports the State's assertions.

According to any reasonable standards of care, the treatment received by Patient D from Respondent was excessive.

Therefore,

**Factual Allegation D and D. 1. ARE SUSTAINED;
Factual Allegation D and D. 2. ARE SUSTAINED;
Factual Allegation D and D. 3. ARE SUSTAINED;**

Findings of Fact
Arising From
the Care and Treatment
of
PATIENT E

36. Respondent first saw Patient E on December 5, 1998. Patient E suffered from foot injuries sustained when Patient E had been struck by a small loading vehicle. (Tr: 107; Pet. Ex. 12)
37. Respondent diagnosed lumbosacral spine derangement, a fracture at the back of the fifth metatarsal bone of the left foot and Lisfranc subluxation of the left foot. (Tr. 107; Pet. Ex. 12)
38. Patient E did not have a Lisfranc subluxation of the right foot. (Tr. 108-110; Pet. Ex. 13)
39. Respondent treated Patient E 49 times between December, 1998 and June, 1999. (Tr. 108, 112; Pet. Ex. 12)
40. Under accepted standards of medicine, the frequency and number of treatments given by Respondent were unnecessary and excessive. (Tr. 112-113)
41. Respondent billed Patient E's insurance carrier for all treatments. (Pet. Ex. 12, pp 281-302)

Conclusions
With Regard to
Factual Allegations
Arising From
the Care and Treatment
of
Patient E

In the Factual Allegations against Respondent arising from Patient E, he is cited for having:

- E.1 Inappropriately diagnosed Patient E with a Lisfranc subluxation of the left foot;
- E.2 Inappropriately gave Patient E treatment and/or physical therapy 39 times;

E.3 deliberately and with intent to deceive falsely billed the insurance carrier of Patient E for unwarranted treatment and/or physical therapy given.

The Committee sustains each of the Factual Allegations.

The Factual allegations regarding Patient E fall into the same pattern as those alleged under the previous patients with one notable exception: The Committee finds Respondent treated the fracture of the fifth metatarsal bone within accepted standards of medicine. However, the charges do not mention any violation regarding that fracture. Therefore, the Factual Allegations regarding Patient E are sustained according to the same theories and standards set forth in the analysis stated for the earlier patients.

Once again, the Committee relied upon the expert testimony of Louis J. Benton, M.D. The Committee found Dr. Benton's testimony to be entirely credible and well supported by the records and x-rays supplied by Respondent.

Respondent does not dispute that the time period set forth nor the number of visits. Respondent also does not dispute that he billed the insurance carrier of Patient E for each visit. Again, as with the prior patients, Patient E did not suffer from the conditions set forth by Respondent. Again, the fact that the patient had 49 visits between December, 1998 and June, 1999, and there was no change in the condition of this patient over the period supports the State's assertions.

According to any reasonable standards of care, the treatment received by Patient E from Respondent was excessive.

Therefore,

Factual Allegation E and E. 1. ARE SUSTAINED;

Factual Allegation E and E. 2. ARE SUSTAINED;

Factual Allegation E and E. 3. ARE SUSTAINED;

CONCLUSIONS
WITH REGARD TO THE
FIRST THROUGH FIFTH SPECIFICATIONS

(PRACTICING THE PROFESSION FRAUDULENTLY)

As set forth earlier, the definition of fraud has three elements:

- a.) In the practice of medicine, a false representation is made by Respondent, whether by words, conduct or concealment of that which should have been disclosed accurately;
- b.) Respondent knew the representation was false;
and
- c.) Respondent intended to mislead through the false representation.

In addition, where fraud is alleged, Respondent's knowledge and intent may properly be inferred from facts found by the hearing committee. However, the committee must specifically state the inferences and the basis for the inference or inferences.

The facts proven for each of the patients fall into an identical pattern: Respondent treats the patient for non-existent maladies over many visits and bills the patient's insurance carrier for each visit. In many cases Respondent charges for evaluations and examinations that are too close in time to the previous examination and evaluation (see Patient D, Finding of Fact 33).

In each patient presented, Respondent would provide services over multiple visits. However, none of the patients showed any improvement. The prudent, honest physician would have either ended treatment and told the patient the condition was incurable and chronic or sent the patient to a specialist for an additional evaluation and a different form of treatment.

For instance, Patient C, who suffered from chronic arthritis was treated 66 times for an acute condition. Not only did Patient C not have the condition for which Respondent rendered care, the number of visits was excessive even if Patient C had the condition cited by Respondent.

In each of the five cases presented, Respondent saw the patients for non-existent conditions on too many occasions and over too much time. From the fact patterns presented, the Committee finds the requisite elements of fraud: Respondent knew he was billing for non-existent conditions and he did so with the sole intent of defrauding the insurance carriers to pay him for services which were not warranted. The Committee infers Respondent knew he was committing fraud because, other than absolute incompetence, there is no other rational basis for Respondent to have committed the acts proven.

Furthermore, in the fact patterns proven, Respondent committed three separate and distinct acts of fraud: He represented to his patients that they suffered from maladies which did not exist and he told them to appear for needless treatments and services and performed these needless treatments and services. He then obtained payments from insurance carriers for services that, in the majority of instances, were not necessary. Thus, the patients and their insurance carriers were harmed. The third act of fraud was perpetrated

upon the entire public. This is because the costs of needless treatments are eventually passed on to consumers and tax payers in higher insurance premiums or additional costs to government sponsored aid programs. The only person who benefitted from these schemes was Respondent.

Therefore:

The First	Specification	<u>is SUSTAINED;</u>
The Second	Specification	<u>is SUSTAINED;</u>
The Third	Specification	<u>is SUSTAINED;</u>
The Fourth	Specification	<u>is SUSTAINED;</u>
The Fifth	Specification	<u>is SUSTAINED.</u>

CONCLUSIONS
WITH REGARD TO THE
SIXTH THROUGH TENTH SPECIFICATIONS
(EXCESSIVE TREATMENT)

Based upon the reasoning set forth above, the Hearing Committee sustains the Sixth through Tenth Specifications. A preponderance of the evidence shows that Respondent provided services for non-existent maladies. Respondent also performed procedures that were not warranted had the maladies existed. In addition, Respondent saw the patients an inordinate number of times. Any treatment which is unwarranted for any reason is, by its very nature, excessive. By any reasonable definition of the word "excessive", Respondent must be found guilty of providing excessive treatments, as charged.

Therefore:

The SIXTH	Specification	<u>is SUSTAINED;</u>
The SEVENTH	Specification	<u>is SUSTAINED;</u>
The EIGHTH	Specification	<u>is SUSTAINED;</u>
The NINTH	Specification	<u>is SUSTAINED;</u>
The TENTH	Specification	<u>is SUSTAINED.</u>

CONCLUSIONS
WITH REGARD TO THE
ELEVENTH THROUGH FIFTEENTH SPECIFICATIONS
(EXERCISING UNDUE INFLUENCE)

Turning to the question of undue influence, the Committee was instructed that to establish undue influence, the State must show that Respondent convinced, coerced or persuaded a patient to receive services, goods, appliances or drugs that were unnecessary. The State must further show that but for the persuasion of Respondent, in his capacity as a physician, the patient would not have accepted the services, goods,

appliances or drugs in the manner alleged. **The key element is the unwarranted or inappropriate persuasion by the practitioner** and the reliance of the patient upon the instructions or persuasion of the practitioner.

In assessing the question presented, the Committee could not say it was more likely than not that Respondent had persuaded the five patients to receive the care rendered. There was no evidence regarding the state of mind of the patients. Therefore it can be said that it was just as likely that the patients sought the care and services provided for their own non-medical needs such as in order to pursue civil damages, worker's compensation or for other reasons. The Committee does not insinuate any negative motivation upon any of the patients. However, to sustain this charge, the State must prove by a preponderance of the evidence, that Respondent was the sole or primary motivator for the services provided. Since there was no evidence regarding the state of mind of the patients, the Committee cannot sustain these specifications.

Therefore:

The ELEVENTH	Specification	<u>is NOT SUSTAINED;</u>
The TWELFTH	Specification	<u>is NOT SUSTAINED;</u>
The THIRTEENTH	Specification	<u>is NOT SUSTAINED;</u>
The FOURTEENTH	Specification	<u>is NOT SUSTAINED;</u>
The FIFTEENTH	Specification	<u>is NOT SUSTAINED.</u>

CONCLUSIONS
WITH REGARD TO THE
SIXTEENTH SPECIFICATION
(NEGLIGENCE ON MORE THAN ONE OCCASION)

The Committee now turns its attention to whether or not Respondent demonstrated the level of attention and diligence expected of a physician acting within accepted standards of medical treatment.

Under this analysis, the fact patterns established clearly demonstrate negligence on more than one occasion. A physician exhibiting appropriate standards of medical care and diligence would not have seen these patients as often and for as long as Respondent saw them. Hence, Respondent's actions are consistent with a physician who is not paying sufficient attention to how and whether his patient is progressing under the treatment plan established. A physician demonstrating an acceptable level of care and attention would have realized well prior to the full number of treatments given, that the patient was not improving and therefore a different care plan or specialty should be considered.

In each of the patients presented, Respondent did not exhibit the level of care and diligence expected of a physician practicing within accepted medical standards in this State.

Therefore:

The SIXTEENTH Specification is SUSTAINED;

CONCLUSIONS
WITH REGARD TO THE
SEVENTEENTH SPECIFICATION
(INCOMPETENCE ON MORE THAN ONE OCCASION)

To sustain a finding of incompetence, the State must show, by a preponderance of the evidence that Respondent did not demonstrate the level of knowledge and expertise consistent with accepted standards of medicine.

Two of the many ways a physician demonstrates an acceptable level of competence is to make the appropriate diagnosis and provide treatments designed to cure the patient. In each of the cases presented, Respondent treated these patients for non-existent or the wrong malady. Furthermore, he provided treatments which were excessive in number or entirely unwarranted by the condition of the patient.

One could argue that when, as herein, Respondent knew the maladies did not exist but set them down in his records and provided treatment he knew was unwarranted or excessive, he was competent. In other words, where one knows one is being a thief, it implies he knows the proper medicine but does not practice it.

Such an argument would not change the findings herein. Even if Respondent knew these patients did not suffer from the maladies for which he treated them and even if Respondent knew the correct diagnosis and what would have been the appropriate treatment, for the purposes of a proceeding before the Board, such knowledge would be irrelevant. In assessing the competence of a physician before the Board, the trier of fact is not required to look inside the mind of the practitioner any further than what the outward acts indicate. Therefore, if Respondent recorded false diagnoses and provided unwarranted care, he acts in a manner consistent with a physician who actually knows no better. Having acted in the manner of an incompetent physician, Respondent is guilty of incompetence as defined part 6530 of the Education Law. Hence Respondent is found to have committed incompetence on more than one occasion.

Therefore:

The SEVENTEENTH Specification is SUSTAINED;

CONCLUSIONS
WITH REGARD TO THE
EIGHTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS
(MORAL UNFITNESS)

The Hearing Committee hereby sustains the Eighteenth through Twenty-Second Specifications. The evidence clearly proves that Respondent engaged in pervasive fraud. While there are forms of moral unfitnes which do not involve fraud, all fraud is consistent with moral unfitnes in the practice of medicine.

Furthermore, Respondent violated the two tenets of appropriate moral fitness in the practice of medicine. When Respondent performed and billed for services he knew were unwarranted and caused patients to visit his office unnecessarily, he violated the trust bestowed upon him by virtue of his licensure. But for his license to practice medicine, Respondent could not have billed for unnecessary services. But for his license to practice medicine, Respondent could not have subjected these patients to unnecessary visits and unwarranted treatments.

The second tenet of moral fitness in the practice of medicine is the standards of the community of physicians. Respondent also violated this standard. The members of the medical profession do not countenance thievery at the price of patients. Providing unnecessary services and causing patients to undergo treatment they did not require, violates the standards of the medical community in this state.

Therefore:

The EIGHTEENTH	Specification	<u>is SUSTAINED;</u>
The NINETEENTH	Specification	<u>is SUSTAINED;</u>
The TWENTIETH	Specification	<u>is SUSTAINED;</u>
The TWENTY-FIRST	Specification	<u>is SUSTAINED;</u>
The TWENTY SECOND	Specification	<u>is SUSTAINED.</u>

CONCLUSIONS
WITH REGARD TO THE
TWENTY-THIRD THROUGH TWENTY-EIGHTH SPECIFICATIONS
(VIOLATION OF PROBATION)

The final Specification herein alleges that the facts established constitute violations of Consent Order #97-243. The Hearing Committee hereby sustains the Twenty-Third through Twenty-Eighth Specifications. The State has established by clear and convincing evidence⁶ that Respondent violated the terms of his probation.

⁶ A greater level of proof than is required.

The evidence in this proceeding clearly shows that Respondent deliberately failed to meet these conditions:

1. The State has conclusively proven that Respondent provided excessive, unwarranted treatment for Patients A through E. (Tr. 29-31, 51-53, 57-58, 69-70, 82-86, 101-103, 113-114; Pet. Ex. 4-13 inclusive)
2. The State has conclusively proven that Respondent continually made incorrect diagnoses for Patients A through E. (Tr. 27, 31, 38-39, 68, 80-83, 91-92, 101-103, 108-110)
3. Respondent knew he was billing for non-existent conditions and he did so with the sole intent of defrauding the insurance carriers to pay him for services which were not warranted. The Committee infers Respondent knew he was committing fraud because, other than absolute incompetence, there is no other rational basis for Respondent to have committed the acts proven.
4. The State has conclusively proven that Respondent billed for all these unnecessary treatments. (Pet. Ex. 4, pp 607-706; 6, pp 315-327; 8, pp 361-401; 10, pp 4-53; and 12, pp 281-302)

Paragraph 1 of the Terms of Probation required Respondent to conduct himself in a proper and professional manner and to "conform fully to the moral and professional standards of conduct and obligations imposed by law and his profession." There can be no dispute that Respondent unequivocally violated these tenets.

Therefore:

The TWENTY-THIRD	Specification	<u>is SUSTAINED;</u>
The TWENTY FOURTH	Specification	<u>is SUSTAINED;</u>
The TWENTY-FIFTH	Specification	<u>is SUSTAINED;</u>
The TWENTY-SIXTH	Specification	<u>is SUSTAINED;</u>
The TWENTY SEVENTH	Specification	<u>is SUSTAINED.</u>
The TWENTY EIGHTH	Specification	<u>is SUSTAINED.</u>

CONCLUSIONS **WITH REGARD TO PENALTY**

In 1997, Respondent was charged with violations of Professional Medical Conduct which were virtually identical to those in this proceeding. He was given a chance to plead to only one of the charges and return to the practice of medicine. He was placed on probation. All he had to do was practice medicine in accordance with generally accepted medical standards. Instead, Respondent chose to squander his second chance by committing virtually identical acts of misconduct. This alone would be sufficient to warrant revocation.

Nevertheless, the Committee makes these further observations: Respondent has proven virtually beyond any reasonable doubt that he considers his license to practice medicine as a tool to cheat the

government and insurance carriers. He has shown indifference to his patients by using them as tools to further his own wealth. Unwilling to be satisfied with just a few unwarranted patient visits, Respondent defrauded his patients into attending his office dozens of times. Hence in assessing the penalty herein, the Committee finds not just a few instances of monetary fraud and patient manipulation, but rather a multitude.

The acts proven herein show a dangerous level of arrogance on the part of Respondent. Apparently Respondent believes that the rules are made for others but not for him. He has grossly deviated from all accepted standards of practice both in the clinical sense and in the business honest sense. The committee finds this physician to exhibit no possibility of remediation. His actions cannot be tolerated. Therefore his license to practice medicine in this state must be revoked.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

1. It is hereby **ORDERED** that the Factual Allegations in the Statement of Charges (attached to this Decision and Order as Appendix One) are disposed of as follows:

Factual Allegation A and A. 1. ARE SUSTAINED;
Factual Allegation A and A. 2. ARE SUSTAINED;
Factual Allegation A and A. 3. ARE SUSTAINED;
Factual Allegation A and A. 4. ARE SUSTAINED;
Factual Allegation B and B. 1. ARE SUSTAINED;
Factual Allegation B and B. 2. ARE SUSTAINED;
Factual Allegation B and B. 3. ARE SUSTAINED;
Factual Allegation C and C. 1. ARE SUSTAINED;
Factual Allegation C and C. 2. ARE SUSTAINED;
Factual Allegation C and C. 3. ARE SUSTAINED;
Factual Allegation D and D. 1. ARE SUSTAINED;
Factual Allegation D and D. 2. ARE SUSTAINED;
Factual Allegation D and D. 3. ARE SUSTAINED;
Factual Allegation E and E. 1. ARE SUSTAINED;
Factual Allegation E and E. 2. ARE SUSTAINED;
Factual Allegation E and E. 3. ARE SUSTAINED;

Furthermore, it is hereby **ORDERED** that;

2. The Specifications in the Statement of Charges (attached to this Decision and Order as Appendix One) are disposed of as follows:

The First	Specification <u>is SUSTAINED;</u>
The Second	Specification <u>is SUSTAINED;</u>
The Third	Specification <u>is SUSTAINED;</u>
The Fourth	Specification <u>is SUSTAINED;</u>
The Fifth	Specification <u>is SUSTAINED;</u>
The SIXTH	Specification <u>is SUSTAINED;</u>
The SEVENTH	Specification <u>is SUSTAINED;</u>
The EIGHTH	Specification <u>is SUSTAINED;</u>
The NINTH	Specification <u>is SUSTAINED;</u>
The TENTH	Specification <u>is SUSTAINED;</u>
The SIXTEENTH	Specification <u>is SUSTAINED;</u>
The SEVENTEENTH	Specification <u>is SUSTAINED;</u>
The EIGHTEENTH	Specification <u>is SUSTAINED;</u>
The NINETEENTH	Specification <u>is SUSTAINED;</u>
The TWENTIETH	Specification <u>is SUSTAINED;</u>
The TWENTY-FIRST	Specification <u>is SUSTAINED;</u>
The TWENTY SECOND	Specification <u>is SUSTAINED;</u>
The TWENTY-THIRD	Specification <u>is SUSTAINED;</u>
The TWENTY-FOURTH	Specification <u>is SUSTAINED;</u>

The TWENTY-FIFTH Specification is SUSTAINED;
The TWENTY-SIXTH Specification is SUSTAINED;
The TWENTY SEVENTH Specification is SUSTAINED;

Furthermore, it is hereby **ORDERED** that;

The ELEVENTH Specification is NOT SUSTAINED;
The TWELFTH Specification is NOT SUSTAINED;
The THIRTEENTH Specification is NOT SUSTAINED;
The FOURTEENTH Specification is NOT SUSTAINED;
The FIFTEENTH Specification is NOT SUSTAINED;

Furthermore, it is hereby **ORDERED** that;

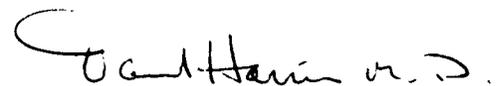
3. The license of Respondent to practice medicine in the State of New York is **REVOKED;**

Furthermore, it is hereby **ORDERED** that;

4. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail.

DATED: New York, New York

March 6, 2001



David Harris, M.D., M.P.H.
Chairperson

Michael A. Gonzalez, RPA.
Adel R. Abadir, M.D.

To: DAVID W. SMITH, ESQ.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza
New York, New York 10001

LUTHER C. WILLIAMS, JR, ESQ.
25 Court Street, Suite 1001
Brooklyn, NY 11242

MANUEL L. SAINT MARTIN, J.D.
115-10 Queens Blvd.
Forest Hills NY 11372

RAPHAEL BAZIN, M.D.
19 Gilcrest Road
Great Neck NY 11021

APPENDIX ONE

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

IN THE MATTER
OF
RAPHAEL BAZIN, M.D.

NOTICE
OF
VIOLATION OF
PROBATION
PROCEEDING

TO: Raphael Bazin, M.D.
16 Gilcrest Road
Great Neck, New York 11021

PLEASE TAKE NOTICE:

In response to your request for a hearing pursuant to the provisions of New York Public Health Law §230(19), a Violation of Probation Proceeding will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp 2000) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 2000). The proceeding will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on September 2, 2000, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the dispute of any facts forming the basis of the alleged violation of probation set forth in the attached Statement of Charges. 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

New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), 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 §230 (McKinney 1990 and Supp. 2000), you may file an Answer 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, §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 §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. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 2000) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

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, based, inter alia, upon any violation found and upon the misconduct resulting in the imposition of the terms of probation. 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 OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 2000). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
~~June~~ 9 2000
July



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: DAVID W. SMITH
Associate Counsel
NYS Department of Health
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 266-6816

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

IN THE MATTER
OF
RAPHAEL BAZIN, M.D.

STATEMENT
OF
CHARGES

RAPHAEL BAZIN, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 13, 1969, by the issuance of license number 103564 by the New York State Education Department.

In or about October, 1997, Consent Order #97-243 suspended Respondent's license to practice medicine for a period of two years, stayed the suspension and placed him on probation for a period of two-years. The Charges set forth below, if proven, reflect both probation violations and professional misconduct as indicated by the Specifications.

FACTUAL ALLEGATIONS

- A. Between in or about December, 1996 and June, 1999 Respondent treated Patient A for injuries of the spine at his office located at 2215 Hendrickson Street, Brooklyn, New York ("Office").
1. Respondent inappropriately diagnosed Patient A with narrowing of the cervical spine at C4-5 and 5-6 and L4-5 and 5-1 disc spaces.

2. Respondent inappropriately diagnosed Patient A with cervical spine derangement and lumbosacral spine derangement.
3. Throughout the period, Respondent inappropriately gave or caused to be given treatment and/or physical therapy to Patient A approximately 135 times.
4. Respondent deliberately and with intent to deceive falsely billed the insurance carrier of Patient A for unwarranted treatment and/or physical therapy given to Patient A.

B. Between in or about November, 1998 and May, 1999, Respondent treated Patient B for cervical pain at his Office.

1. Respondent inappropriately diagnosed Patient B with cervical spine and lumbosacral spine derangement.
2. Throughout the period, Respondent inappropriately gave or caused to be given treatment and/or physical therapy to Patient B 59 times.
3. Respondent deliberately and with intent to deceive falsely billed the insurance carrier of Patient B for unwarranted treatment and/or physical therapy given to Patient B.

C. Between in or about August, 1998 and June, 1999, Respondent treated Patient C, a 76-year old man, at his Office for knee problems.

1. Respondent inappropriately diagnosed Patient C with traumatic synovitis of the right knee.
2. Throughout the period, Respondent inappropriately gave or caused to be given treatment and/or physical therapy to Patient C 66 times.
3. Respondent deliberately and with intent to deceive falsely billed the insurance carrier of Patient C for unwarranted treatment and/or physical therapy given to Patient C.

D. Between in or about November, 1998 and March, 1999, Respondent treated Patient D at his Office for lower back pain.

1. Respondent inappropriately diagnosed Patient D with the L5-S1 disc bulging into L-5.
2. Throughout the period, Respondent inappropriately gave or caused to be given treatment and/or physical therapy to Patient D 44 times.

3. Respondent deliberately and with intent to deceive falsely billed the insurance carrier of Patient D for unwarranted treatment and/or physical therapy given to Patient D.

E. Between in or about December, 1998 and June, 1999, Respondent treated Patient E at his Office for an injured left foot.

1. Respondent inappropriately diagnosed Patient E with a Lisfranc subluxation of the left foot.
2. During this period, Respondent inappropriately gave or caused to be given Patient E treatment and/or physical therapy 39 times.
3. Respondent deliberately and with intent to deceive falsely billed the insurance carrier of Patient E for unwarranted treatment and/or physical therapy given to Patient E.

SPECIFICATION OF CHARGES
FIRST THROUGH FIFTH SPECIFICATIONS
PRACTICING FRAUDULENTLY

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 2000) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. Paragraphs A and A3-4.
2. Paragraphs B and B2-3
3. Paragraphs C and C2-3.
4. Paragraphs D and D2-3.
5. Paragraphs E and E2-3.

SIXTH THROUGH TENTH SPECIFICATIONS
EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 2000) by the giving of excessive tests/treatment not warranted by the condition of the patient as alleged in the facts of the following:

6. Paragraphs A and A3.
7. Paragraphs B and B2.
8. Paragraphs C and C2.

9. Paragraphs D and D2.
10. Paragraphs E and E2.

ELEVENTH THROUGH FIFTEENTH SPECIFICATIONS
EXERCISING UNDUE INFLUENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(17)(McKinney Supp. 2000) by exercising undue influence on patients for his financial gain as alleged in the facts of the following:

11. Paragraphs A and A1-4.
12. Paragraphs B and B1-3.
13. Paragraphs C and C1-3.
14. Paragraphs D and D1-3.
15. Paragraphs E and E1-3.

SIXTEENTH SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2000) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

16. Paragraphs A and A1-3; B and B1-2; C and C1-2; D and D1-2; and/or E and E1-2.

SEVENTEENTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2000) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

17. Paragraphs A and A1-3; B and B1-2; C and C1-2; D and D1-2; and/or E and E1-2.

EIGHTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS
MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 2000) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

18. Paragraphs A and A3-4.
19. Paragraphs B and B2-3.
20. Paragraphs C and C2-3.
21. Paragraphs D and D2-3.
22. Paragraphs E and E2-3.

TWENTY-THIRD THROUGH TWENTY-SEVENTH SPECIFICATIONS
VIOLATION OF PROBATION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. §6530(29)(McKinney Supp. 2000) by violating the terms of his probation as alleged in the facts of the following:

- 23. Paragraphs A and A1-4.
- 24. Paragraphs B and B1-3.
- 25. Paragraphs C and C1-3.
- 26. Paragraphs D and D1-3.
- 27. Paragraphs E and E1-3.

DATED:

JUN 9
JUN 9 2000
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct