



# 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*

# PUBLIC

October 30, 2003

## CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Milton M. Smith, M.D.  
1000 Park Avenue  
New York, New York 10028

Alexander G. Bateman, Esq.  
Ruskin, Moscou, Faltischek, P.C.  
East Tower, 15<sup>th</sup> Floor  
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Leslie Eisenberg, Esq.  
Associate Counsel  
NYS Department of Health  
Bureau of Professional  
Medical Conduct  
5 Penn Plaza – 6<sup>th</sup> Floor  
New York, New York 10001

**RE: In the Matter of Milton M. Smith, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 03-286) 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.

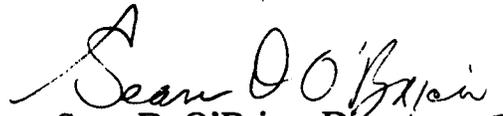
The notice of review served on the Administrative Review Board should be forwarded to:

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,

  
Sean D. O'Brien, Director  
Bureau of Adjudication

SDO:djh  
Enclosure

IN THE MATTER : HEARING COMMITTEE  
OF : DETERMINATION  
MILTON M. SMITH, M.D. : AND ORDER

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X BPMC NO. 03-286

**MICHAEL R. GOLDING, M.D., CHAIRPERSON, WOODSON MERRELL M.D. AND CONSTANCE DIAMOND, D.A.**, duly designated members of the State Board of 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) and 230 (12) of the Public Health Law. **STEPHEN BERMAS, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

Dr. Golding was not present at a portion of the hearing sessions conducted on March 13, 2003 and May 12, 2003. Dr. Golding duly affirmed that he had read and considered the transcript of proceedings and the evidence received at such hearing sessions prior to the deliberations in this matter on September 15, 2003. See Appendix A.

Dr. Merrell was not present at a portion of the hearing sessions conducted on April 28, 2003, May 5, 2003, May 12, 2003, May 15, 2003 and May 29, 2003. Dr. Merrell duly affirmed that he had read and considered the transcript of proceedings and the evidence received at such hearing sessions prior to the deliberations in this matter on September 15, 2003. See Appendix B.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

## **SUMMARY OF THE PROCEEDINGS**

Notice of Hearing dated: December 2, 2003  
Amended Statement of Charges dated: January 14, 2003  
Hearing Dates: February 11, 2003, March 13, 2003, April 28, 2003,  
April 29, 2003, May 5, 2003, May 12, 2003, May 15,  
2003, May 29, 2003 and July 21, 2003  
Deliberation Date: September 15, 2003  
Place of Hearing: NYS Department of Health  
5 Penn Plaza  
New York, New York  
Petitioner Appeared By: Leslie Fisenberg, Esq.  
Associate Counsel  
Bureau of Professional Medical Conduct  
NYS Department of Health  
Respondent Appeared By: Ruskin Moscou Falteschek, P.C.  
by Alexander G. Batemen, Jr., Esq.  
and Nili S. Yolin, Esq.

## **STATEMENT OF CHARGES**

The Amended Statement of Charges has been marked as Petitioner's Exhibit 1 and attached hereto as Appendix C.

## **FINDINGS OF FACT**

Numbers in parentheses refer to transcript page numbers 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 cited evidence. All findings are unanimous.

1. Milton M. Smith, Respondent, was authorized to practice medicine in New York State on or about July 1, 1972, by the issuance of license number 112612 by the New York State Education Department (Pet. Ex. 2).
2. Respondent is engaged in the private practice of orthopedic surgery, but he is not board certified in orthopedics or surgery (T. 982-3, 1048).
3. A substantial portion of Respondent's practice has been performing Independent Medical Examinations (IME's) (T. 863, 1070, 1072, 1390).

#### PATIENT A

4. On May 14, 2001, Patient A fell and broke her wrist and injured her right ankle and lower back. Patient A went by ambulance to Elmhurst Hospital where x-rays were taken of her wrist, ankle and back. (T26-28, 1491-1492).
5. Patient A underwent surgery for her left wrist at Elmhurst Hospital on June 5, 2003. (T28; Pet. Ex. 4)
6. Patient A sought medical treatment at QB Medical in Queens, New York, on June 12, 2003. On that date, Patient A met with an internist who took a history and examined her arm. Patient A was told that she would have to see an orthopedist for authorization to receive physical therapy. (T28-30, 51, 95; Pet. Ex. 3).
7. Patient A speaks Spanish; she does not speak any English. As a result, Patient A communicated with personnel at QB Medical through staff members who spoke Spanish. (T26, 29-30, 64).
8. On June 20, 2003, Patient A saw Respondent at QB Medical. Respondent called Patient A into an examination room and the door was closed with no one else in the room. Patient A informed Respondent that she did not speak any English. Respondent told her that he spoke a

little Spanish. Initially, Patient A sat in a chair near the desk and Respondent sat at the desk, asking Patient A, in Spanish, her name and where she was hurt. Patient A extended her left hand, which was swollen due to her recent surgery, and Patient A told Respondent that she felt pain in her lower back and ankle but that she came to him because of her hand. Respondent took some notes and then asked Patient A to stand in the middle of the office. (T30-31, 35, 69, 92-93).

9. Patient A stood in the middle of the examination room and Respondent stood behind her. Respondent squeezed Patient A's breasts first through Patient A's blouse and then underneath her shirt. (T31-32, 64).

10. Patient A previously had her breasts examined and testified that Respondent's touching was not a breast exam. (T36-37, 71).

11. While Patient A was standing in the middle of the examination room, Respondent placed his hands inside of Patient A's pants and panties and touched her vagina. Respondent had the palm of his hand on the pubic bone of Patient A's vagina and his fingers touched the inside of her vagina. Respondent was not performing a proper hip examination of Patient A, in that he improperly touched her vagina. (T32, 70-71).

12. Respondent moved Patient A's bra above her chest and he again grabbed her breasts. Respondent leaned against Patient A's right side and she felt his erect penis against her body. (T32-33, 38, 71-72, 75, 79-80).

13. Patient A went home and immediately told her husband what happened. (T41).

14. Patient A had not provided Respondent with any medical records. If Respondent had medical records pertaining to Patient A, Respondent did not ask her any questions based on those records. (T39).

15. Respondent failed to perform an appropriate physical examination of Patient A as detailed by expert witness, Dr. Ramesh Gidumal. During the course of the encounter, Respondent never examined Patient A's back. Respondent did not touch or examine Patient A's rib cage. Respondent did not perform any range of motion tests on Patient A's neck, torso arms or legs. Respondent did not have Patient A walk on her heels and toes. Respondent did not check Patient A's reflexes in her arms or legs. Respondent did not examine the movements of Patient A's elbows, wrists, knees or ankles. Respondent did not have Patient A do leg raises or extensions. Patient A did not sit or lie down during the entire exam. Respondent did not use any tool or equipment during the course of the exam. (T39-41, 76, 81-82).

16. Respondent failed to perform and document an appropriate orthopedic examination of Patient A's wrist, which was one of her current complaints, as detailed by expert witness, Dr. Ramesh Gidumal. Respondent failed to examine and document range-of-motion for all joints. Respondent failed to clearly document comparisons of the right and left wrist. Respondent failed to indicate which bone was injured and what type of injury occurred. Although Respondent indicated the presence of a scar, Respondent failed to specify where the scar is and failed to specify the type of scar. Similarly, Respondent noted tenderness and swelling without any specificity. In fact, Respondent failed to note any detail regarding the fact that Patient A had surgery on her wrist a few weeks prior to his examination. (T592-598, 626-628, 630-631, 636-637, 655, 1485-1486; Pet. Ex. 3).

17. Respondent could not have examined Patient A's wrists to determine that Tinel's sign was negative, as documented in his report, since Respondent did not touch Patient A's wrist with his fingers, a pin, pen or tool. (T598-600; Pet. Ex. 3).

18. Respondent did not perform an appropriate hip examination on Patient A as detailed by expert witness, Dr. Ramesh Gidumal. Although Patient A complained about back pain radiating to her left lower extremity at the time of her initial evaluation at QB Medical, Respondent failed to note whether this complaint continued or changed. Patient A did not lie down during the examination, which would have made a complete evaluation possible. Respondent failed to

document that he performed a hip examination as well as any pertinent findings of such an examination. (T624-625, 1492, 1620-1621; Pet. Ex. 3)

19. Respondent failed to perform and document an appropriate orthopedic examination of Patient A's right ankle, which was one of her current complaints, as detailed by expert witness, Dr. Ramesh Gidumal. Respondent failed to examine and note range-of-motion, instability and strength. He did not indicate where the tenderness or swelling was, i.e. foot, ankle, top, side, middle, front or Achilles tendon. Respondent could not have examined Patient A's walk, as documented by Respondent, since Patient A did not walk on heels or toes. It is not possible for someone to walk well on heels and toes with the limitations in range-of-motion that Respondent documented. (T600-604, 630-631, 650-652; Pet. Ex. 3).

20. Patient A attempted to file a report with the police the day following the office visit, but when she went to the police precinct, she felt embarrassed and left because there were only men there. Patient A returned to the police precinct a few days later and reported Respondent's conduct. (T41, 78, 94-95).

21. Although Respondent admits that he performed an examination on Patient A on June 20, 2001, Respondent has no independent recall of this examination and testified based on his examination of report. (T1421, 1429, 1619).

22. Respondent submitted a bill for his examination of Patient A at the highest possible level although his records do not support that level of a comprehensive examination. (T622, 657; Pet. Ex. 3).

23. Respondent submitted a report of examination regarding Patient A to QB Medical that does not reflect the evaluation he performed on June 20, 2001. (Pet. Ex. 3).

## **PATIENT B**

24. On July 1, 2001, Patient B was a passenger in a car that was struck in the rear by another vehicle. Patient B injured her neck, back and shoulder and was taken by ambulance to a hospital in Marlboro County, South Carolina. Patient B was still in pain when she returned to New York about one week later, and went to Long Island College Hospital. Approximately one week later, Patient B was in a great deal of pain so she went to NYU Hospital. At each hospital, x-rays were taken and Patient B was given prescriptions for pain medication including Flexeril, Vicodin and Motrin. (T177, 211; Pet. Ex. 6a, 6b, 6c).

25. In the middle of July, 2001, Patient B sought medical treatment at QB Medical in Queens. At her initial visit, Patient B completed medical forms and was evaluated by a physician who recommended physical therapy. Patient B continued receiving physical therapy at QB Medical two or three times a week for several months. (T180-181, 216-617, 232; Pet. Ex. 5)

26. Patient B saw Respondent at QB Medical on September 24, 2001. Patient B believed that Respondent was to determine if she needed surgery. Respondent called Patient B into the examination room, the door was closed and there was no one else in the room despite Respondent's testimony that there was always a chaperon present during that time period. Respondent sat at a desk and Patient B sat on the other side. Patient B was not asked to put on a gown. Respondent then asked Patient B to stand and touch her toes. At this point, Respondent stood at Patient B's side and touched her back. (T181-182, 184-185, 247-248).

27. Respondent asked Patient B to sit on the examination table and to open and close her hands. Respondent stood in front of Patient B. As Patient B opened and closed her hands, she felt Respondent's clothed penis in her hand. Patient B initially thought that her hands were too close to the edge of the table so she moved her hands and continued to open and close her hands, as Respondent instructed. Respondent moved closer to Patient B and again Patient B felt Respondent's penis in her hand. Respondent asked Patient B to lie down on the table and to

continue opening and closing her hands. Patient B did so and again felt Respondent's penis in her hand. (T182-183, 186, 265, 268-269).

28. Respondent told Patient B that when you have neck pain, it can be accompanied by pain in the ribs. Respondent then touched Patient B's left breast through her shirt and then under her shirt, moving her bra. Respondent touched Patient B's nipple. Patient B described the touching as a caress; not like a breast exam where breasts are examined in a circular motion. Respondent did not examine Patient B's ribs. Respondent did not document a legitimate medical reason for his touching of Patient B's left breast. (T183, 186-187, 246, 273).

29. Respondent then told Patient B that when you have pain in your back, you have pain in your hips. However, Respondent did not perform an appropriate hip examination. He did not palpate the hip areas. Respondent placed his hands through Patient B's pants on her pelvis, down the crease in her groin, touching her vagina. As Patient B was leaving she saw that Respondent's penis was erect. (T183-184, 187-188, 250, 270-272).

30. Respondent failed to perform an appropriate physical examination of Patient B as detailed by expert witness, Dr. Ramesh Gidumal. Respondent did not test Patient B's range-of-motion of her torso, arms or legs, or have her perform leg raises or extensions. Respondent did not have Patient B walk on heels and toes. Respondent did not touch Patient B's toes or have her move her toes. Respondent did not check Patient B's reflexes or pulses. Respondent did not utilize any tool or equipment such as a pin, feather or hammer. Respondent did not percuss Patient B's funny bone. (T188-190).

31. On the day following the incident, Patient B told her employer about Respondent's conduct and reported Respondent's conduct to the police. (T190-191).

32. Respondent has no independent recall of the examination of Patient B on September 24, 2001 and based his testimony on his records. (T1633-1634).

33. Respondent could not have examined Patient B's elbow and made a finding regarding the ulnar nerve and Tinel's sign as documented in his report, since Respondent did not press on Patient B's elbow or percuss Patient B's funny bone and ask if she had pain or tingling. (T188-189, 666-667; Pet. Ex. 5).

34. Respondent failed to perform an appropriate examination of Patient B's shoulders, as detailed by expert witness, Dr. Ramesh Gidumal. Respondent's report does not indicate which of the three joints in the shoulder were examined nor does it reflect whether the findings are for one shoulder or both. (T188-189, 663-665; Pet. Ex.5)

35. Respondent could not have examined Patient B's knees and made findings that McMurray test is negative, as documented in his report, since Respondent did not have Patient B bend her knee so that her ankle touched her thigh and Respondent did not rotate her leg to determine if there was a torn meniscuses. Respondent could not have examined Patient B's knees and made findings regarding patella tracking since Patient B did not do leg raises. Respondent did not push Patient B's patella and Patient B had pants on during the examination so Respondent could not observe the patella. Moreover, since Patient B had her pants on and she did not lie on the examination table face down, Respondent could not have examined Patient B's knee and made findings regarding Baker's and popliteal cysts, as documented in his report. (T182-189, 669-671; Pet. Ex. 5)

36. Respondent could not have examined Patient B's lower extremities including reflexes, as documented in his report, since Respondent did not check any of Patient B's reflexes and Respondent did not use any tool or equipment during the examination. Respondent could not have made findings regarding Patient B's range-of-motion in her lower extremities since Respondent did not have Patient B do active or passive leg raises or any range-of-motion. (T188-189, 672-674; Pet. Ex. 5).

37. Respondent could not have examined Patient B's extensor hallos longus, as documented in his report, since Respondent did not have Patient B move her toes and Respondent did not touch her toes. (T184, 189, 673; Pet. Ex. 5).

38. Even though it would have been appropriate, based on Patient B's complaints, for Respondent to have Patient B open and close her hands, it was inappropriate for Respondent to position himself, on several occasions, such that his clothed penis rested in Patient B's hand while she opened and closed her hands. (T182-183, 186, 674-675, 681-682; Pet. Ex. 5).

39. Respondent submitted a report of examination regarding Patient B to QB Medical that does not reflect the evaluation he performed on September 24, 2001. (Pet. Ex. 5).

### **PATIENT C**

40. On October 13, 2000, Patient C's automobile was struck in the rear while he was driving to work, and he injured his back, neck, left shoulder, groin and right wrist. Patient C was taken to NYU Downtown Hospital where he was evaluated and released. Patient C filed a worker's compensation claim. (T287-289).

41. Shortly after his accident, Patient C sought medical treatment at Queens Medical Rehabilitation, where he received physical therapy, two or three times a week, for almost a year. (T289; Pet. Ex.8).

42. On February 12, 2001, Patient C saw Respondent in Respondent's office as directed by his insurance company. A woman dressed like a nurse asked Patient C questions about his medical background. Patient C was called into an examination room. Patient C, Respondent and a woman wearing white, were all in the room. The door remained open. Patient C remained clothed. Respondent had some medical records from Patient C's prior treatment. Respondent asked Patient C about his complaints but did not ask Patient C anything based on his medical records. (T290-296).

43. Respondent instructed Patient C to lift his head and raise his hands to the side. Patient C lifted his right hand but was moving his left hand slowly, due to pain in his shoulder. Respondent yanked Patient C's arm all the way up and Patient C told him to take it easy.

Respondent asked Patient C to walk on his toes and heels. Patient C told Respondent that he could not do so because he was weak on his left side, had painful sciatica and would lose his balance. Respondent asked Patient C to lift his shirt so Respondent could look at his back. Patient C pulled his shirt from inside his pants with his right hand. Respondent was facing Patient C and never looked at his back. (T292-293, 295, 354-355).

44. Respondent failed to perform an appropriate examination of Patient C as detailed by expert witness, Dr. Ramesh Gidumal. During the entire encounter, Respondent did not touch or palpate Patient C's neck or body. Respondent did not examine Patient C's back, chest, rib cage or wrists. Respondent did not check Patient C's range-of-motion of his torso, arms or legs. Respondent did not check Patient C's reflexes. Respondent did not touch Patient C's toes or have him move his toes. Patient C's shoes and socks were never removed. Respondent did not have Patient C perform leg raises or extensions. Patient C stood the entire time. Respondent did not utilize any tool or equipment such as a pen, feather or hammer. (T297-299, 349-350, 358).

45. In May 2001, Patient C was sent to another physician for another IME. Patient C testified that his examination was thorough and professional. Every part of his body was examined, touched and measured with special tools. Although that physician concluded that no additional therapy was required, Patient C did not complain about this physician because his exam was thorough and professional. (T300-302, 333).

46. A few weeks after seeing Respondent, Patient C was notified that his insurance would no longer cover his therapy, based on Respondent's report. Patient C complained to OPMC about Respondent's examination because he felt Respondent did not evaluate him independently for the insurance company and because Respondent wrote a report indicating he did tests that he never did. (T302-304).

47. Although Respondent admits that he performed an IME on Patient C on February 12, 2001, Respondent has no independent recall of this examination and testified based on his examination of report. (T1350-1351).

48. Respondent could not have examined Patient C's neck and made the findings documented in his report since Respondent did not touch or palpate Patient C's neck. (T292, 297, 718-719, 905-906, 921, 1362; Pet. Ex. 7).

49. Respondent could not have examined Patient C's upper extremities and made the findings documented in his report since Patient C did not do any range-of-motion testing and other than yanking his arm up, Respondent did not touch Patient C. (T292, 297, 719; Pet. Ex. 7).

50. Respondent could not have examined Patient C and made the findings regarding reflexes and knee/ankle jerks documented in his report since Respondent did not check Patient C's reflexes, Patient C did not sit or lie on the examination table and Respondent did not use any tools or equipment during the examination. (T297-299, 719; Pet. Ex. 7).

51. Respondent could not have examined Patient C's lower extremities including extensor hallos longus and made the findings documented in his report since Patient C did not do leg raises. Patient C stood the entire time and Patient C had his shirt, pants, shoes and socks on the entire time. (T297-299, 709-720; Pet. Ex. 7).

52. Respondent submitted a report of examination regarding Patient C to Med-Val, Inc. that does not reflect the evaluation he performed on February 12, 2001. (Pet. Ex. 7).

#### **PATIENT D**

53. On February 9, 1997, Patient D, a licensed practical nurse, slipped on the ice as she was leaving her job at Nassau County Medial Center. As a result, Patient D injured her back, left shoulder and right wrist. Patient D filed a worker's compensation claim for her injuries. (T452-453).

54. Patient D sought medical treatment from Dr. Sunil Butani. Dr. Butani ordered x-rays, examined Patient D and, recommended physical therapy. Patient D received physical therapy

including ultrasound and massage, three times a week, then two, then one, until worker's compensation concluded her treatment in January 2001. (T455-456; Pet. Ex. 10).

55. On June 27, 1997, Patient D saw Respondent in his office as directed by the Worker's Compensation Board. A female staff employee named Ms. Smith took Patient D's history, brought Patient D into an examination room and closed the door. Ms. Smith stayed in the room with Respondent and Patient D. Respondent asked Patient D what part of her body she injured. Patient D told Respondent she injured her back, left shoulder and right wrist. (T459-461, 476).

56. Patient D sat on the examination table as instructed. Respondent yanked her left arm up; Patient D told Respondent he should not be so rough. Respondent told Patient D to get off the table and walk two steps forward and two steps back. Respondent asked Patient D to walk on her heels and toes. Patient D was not able to walk on her heels and toes. (T460-482).

57. Respondent failed to perform an appropriate examination of Patient C as detailed by expert witness, Dr. Ramesh Gidumal. During the encounter, other than yanking her arm, Respondent did not touch or palpate Patient D's neck, extremities or any other part of her body. Respondent did not examine or touch her rib cage or chest wall. Respondent did not have Patient D perform any range-of-motion exercises. Respondent did not check Patient D's reflexes and did not measure her extremities. Respondent did not use any tools or equipment during the exam. Respondent did not have Patient D do leg raises or extensions and Respondent did not check Patient D's toes or have her move her toes. Patient D did not lay down on the examination table and she did not take her shoes off. (T461-463)

58. Over the course of Patient D's medical treatment, Patient D had other IME's. Although the results of the other IMEs were similar to Respondent's findings, Patient D has not complained about those physicians because their examinations were thorough and complete. (T464-470, 478, 491)

59. In October 1997, Patient D complained to OPMC about Respondent's exam and the fact that he reported an exam that he didn't perform. (T464, 484, 486-487)

60. Although Respondent admits that he performed an IME on Patient D on June 27, 1997, Respondent has no independent recall of this examination and testified based on his examination of report. (T1118-1119, 1121, 1147-11478).

61. Respondent could not have examined Patient D's neck or upper extremities including shoulders and wrists, as documented in his report, since Respondent did not have Patient D do active or passive range-of-motion exercises. Respondent did not push on or pull Patient D's arm to see if there was instability in the shoulder joints and, other than yanking her arm up, Respondent did not touch or palpate Patient D. (T460-463, 731-734, 738, 932; Pet. Ex. 9).

62. Respondent could not have examined Patient D's lower extremities including extensor hallos longus and reflexes and Respondent could not have made the findings documented in his report since Patient D did not do leg raises or extensions, Patient D stood the entire time, Patient D's shoes were on the entire time and, Respondent did not use any tool or equipment during the examination. (T462-463, 738-740, 933-935, 942; Pet. Ex. 9).

63. Respondent failed to perform and note appropriate measurements of arm and leg circumference. Patient D testified that Respondent did not measure her arms and legs. Even if Patient D is incorrect and Respondent did take these measurements, Respondent failed to indicate a reference point to indicate where the measurements were taken. (T746-747, 939; Pet. Ex. 9).

64. Although it would have been appropriate for Respondent to perform a hip examination on Patient D, based on her complaint of back pain, Respondent did not perform a hip exam on Patient D. There is no notation in his worksheet or report indicating that he did a hip exam. In addition, in order for Respondent to perform an appropriate hip exam, Respondent would have had to palpate Patient D's hip area while she was lying face-up on the exam table, or Respondent would have had to examine Patient D's hips while she sat on the table and did leg raises. However, Patient D did not lie or sit on the exam table nor did she do leg raises and Respondent did not palpate Patient D. (T459-460, 463, 1146-1147; Pet. Ex. 9).

65. Respondent failed to perform and note an appropriate orthopedic examination in that he failed to document any specifics regarding his findings. For instance, Respondent's report indicates that Patient D has no instability in the wrist. Even though one of Patient D's current complaints was right wrist, Respondent failed to note where the instability is or whether he is talking about the ulnar collateral ligaments on the thumb or the scaphoid lunate area. (T733-734; Pet. Ex. 9)

66. Respondent submitted a report of examination regarding Patient D to Crossland Medical Services that does not reflect the evaluation he performed on June 27, 1997. (Pet. Ex. 9)

### **PATIENT E**

67. Patient E had a stroke earlier this year. As a result, he was unavailable to testify. However, Senior Medical Conduct Investigator John Flynn, the investigator responsible for investigating complaints regarding Respondent, testified regarding Patient E. John Flynn conducted a telephone interview with Patient E on or about November 30, 2001. (T498-500)

68. Patient E was in a car accident on June 4, 1999 and suffered injuries to his neck and lower back. He sought medical treatment from Dr. Ku, Dr. Broadbeck and Dr. Hammershlag. Patient E filed a Worker's Compensation claim for his injuries. (T500-501; Pet., Ex. 12, 13.)

69. Although Respondent admitted he performed an IME for Patient E on September 30, 1999, he has no independent recall of the examination and testified based on his report of examination. (T1296-1298).

70. Respondent submitted a report of examination regarding Patient E to First Rehabilitation Insurance Company of America. (Pet. Ex. 11)

## PATIENT F

71. On October 2, 1997, Patient F's automobile was struck in the rear while she was driving to work. She developed stiffness and pain in her neck and lower back and went to North Shore University in Plainview, New York. X-rays were taken and Patient F was given prescriptions for medication and a cervical collar. (T107-109, 119; Pet. Ex. 15).

72. On October 7, 1997, Patient F sought medical treatment with Barry Fisher, M.D. Dr. Fisher diagnosed Patient F with cervical radiculitis, low back derangement and bulging discs and recommended physical therapy treatment. Patient F received physical therapy at North Shore Sports Institute from October 8, 1997 thorough February 11, 1998. (T109, 119, 130; Pet. Ex. 17).

73. On January 22, 1998, Patient F saw Respondent in his office as directed by her insurance company. Patient F entered an examination room and put on a gown. Respondent entered the room accompanied by a woman who stood in the doorway throughout the course of the examination. Although Patient F does not recall much detail of the examination, she does recall that it was a short exercise that included standing, walking on her heels and toes and flexing at the waist. (T110-114, 133-138).

74. Respondent failed to perform an appropriate physical examination of Patient F as detailed by expert witness, Dr. Ramesh Gidumal. Patient F testified that the entire examination lasted less than five minutes, that Respondent never touched her during the examination, that Respondent did not tell her what he was doing as he was doing it and did not inquire about how she felt when doing the things he instructed her to do. (T110-114, 133-138).

75. Patient F did not provide Respondent with any medical records and did not ask her any questions regarding any medical records he may have had. (T154, 158, 165).

76. On February 13, 1998, Patient F had another IME performed by Alan Wolf, M.D. The results of Dr. Wolf's examination were similar to Respondent's in that they both concluded that Patient F was capable of returning to work. However, Patient F testified that Dr. Wolf's examination was much more thorough than Respondent's. (T115-117, 152-153).

77. Some time after Respondent's examination, Patient F was notified that her insurance company denied any further treatment based on Respondent's report of examination. On April 1, 1998, Patient F complained to the New York State Insurance Department about Respondent's conduct. Patient F complained because she believed Respondent's examination was inadequate and that he could not have prepared an apparently complete report based on the limited examination he conducted. (T115, 117, 141, 144-145, 149).

78. Respondent admits that he performed an IME on Patient F on January 22, 1998, but Respondent has no independent recollection of this exam and testified based on his report of examination. (T1168).

79. Respondent could not have examined Patient F's neck, measured her arms and legs and made findings regarding reflexes or warmth, tenderness and strength, all as documented in his report, since Respondent did not touch Patient F. (T135, 1174; Pet. Ex. 14).

80. Respondent submitted a report of examination regarding Patient F to Allstate that does not reflect the evaluation he performed on January 22, 1998. (Pet. Ex. 14).

### **PATIENT G**

81. On December 13, 1989, Patient G was injured. Patient G experienced pain in her neck and left shoulder, shooting pain down her left arm and a creak in her hips. Patient G filed a worker's compensation claim for her injuries. Patient G received medical treatment for several months. (T362-364).

82. In May 1991, Patient G sought additional medical treatment for her injuries since she was experiencing recurrent symptoms. Patient G needed authorization from a physician before she could receive physical therapy. (T364-366, 415-416).

83. On Tuesday, May 21, 1991, Patient G went to see Respondent at his office. Patient G complained of pain down her left arm, soreness in her left shoulder and lower back and creaky hips. Patient G was called into an examination room and a medical history was taken. Respondent instructed Patient G to take off her clothing and put on a gown. Patient G removed her bra and clothing and put the gown on. Patient G sat on the examination table. Respondent re-entered the room. The door was closed and there was no one else present in the room. (T366-368, 372-373).

84. Respondent had Patient G move her head in different directions and he asked her if it hurt. Respondent continued examining Patient G's range-of-motion of her shoulders, head and arm. Respondent had Patient G stand and Respondent stood behind her. Respondent held Patient G's left hip with his left hand, and with his right hand Respondent went down from the top of her back to her lower back, including the buttocks, spending a lot of time at the crease between her buttocks and thigh, continually asking if it hurt. Respondent touched Patient G on the right side, between the buttocks and thigh and on the left side as well. Respondent touched the lips of Patient G's vagina, several times. Respondent touched Patient G's labia major and labia minor. Respondent did not put his hand in Patient G's vaginal canal. Patient G tried to move away but Respondent followed her as she moved. (T368-369, 395-397, 420, 426, 439-440).

85. Respondent felt Patient G's rib cage and sternum and cupped her left breast. Respondent did not perform a breast examination. When Respondent cupped her breast, Patient G snapped and asked Respondent if he was done. Respondent said yes and told Patient G to get dressed and go for x-rays. (T369-370, 374-375, 403-404).

86. During the course of this encounter, Patient G was unsure about the legitimacy of the examination. (T369-370, 389, 397, 400-401).

87. When Patient G left the room she warned women in the waiting room that something weird just happened. Patient G went for x-rays. Patient G started to cry and told the x-ray technician, Delores Taylor, what Respondent had done. Although Patient G wanted to leave, she returned to Respondent's office because she needed a referral for physical therapy. Respondent gave Patient G a referral and she left. (T370-371, 399-400).

88. Respondent failed to perform an appropriate physical examination of Patient G as detailed by expert witness, Dr. Ramesh Gidumal. During this encounter, Respondent did not touch Patient G's feet and ankles. Respondent did not have Patient G move her toes. Respondent did not use tools or equipment such as a pin. Respondent did not have Patient G perform leg raises or extensions. Other than when Respondent initially entered the room and examined Patient G's range-of-motion in her neck, Patient G did not sit or lie down on the exam table. (T372-373, 376-377, 427).

89. After leaving Respondent's office, Patient G went back to work and told a co-worker and several friends what Respondent had done. Patient G called a rape crisis hotline and filed a complaint with the police. Respondent was arrested within three days of the examination. (T378-381, 1116).

90. Approximately one week later, Patient G complained about Respondent's conduct to the Office of Professional Medical Conduct. Patient G was interviewed and then notified that the case would be closed. In 2001, Patient G was re-contacted and notified that the case had been re-opened. (T383-384, 422-424).

91. Respondent admits to performing an examination on Patient G on May 21, 1991, but Respondent has no independent recall of this examination and testified based on his medical records. (T1018).

92. There is no evidence that Respondent performed a hip exam. Patient G would have had to lie on the exam table, face-up, which she did not do. By touching Patient G's vaginal lips and

crease between her thigh and buttocks, Respondent inappropriately touched Patient G's vaginal area and buttocks. (T367-370, 1026-1027, 1043, 1091).

93. Although it would have been appropriate for Respondent to examine Patient G's chest wall based on complaints of shoulder pain radiating down her arm, there is no evidence that Respondent performed such an examination. Respondent simply cupped Patient G's left breast, which was inappropriate. (T367-370, 1026-1027, 1043, 1091).

### **DISCUSSION**

The Hearing Committee found Patients A, B, C, D, F and G to be credible witnesses. The fact that some of them had instituted civil actions against Respondent was considered, but did not in the Committee's opinion lessen their credibility. Furthermore, the institution of a civil action does not in any way have any probative value as to the adequacy of the physical examinations or the appropriateness of the physical touchings. Similarly, the fact of Respondent's acquittal in certain prior criminal proceedings in which some of these patients testified did not lessen their credibility. The Committee is aware of the different standards of proof in criminal proceedings and in this pending proceeding.

The Committee did not find Respondent to be a credible witness. By his own admission he had no present recollection of any of these patients. His responses to his own counsel (T. 1397-1400) as well as to opposing counsel (T. 1058-1059, 1069, 1078-1080) and Committee members, (T. 1158-1164, 1336-1343) were evasive and unresponsive to the questions asked. The answers were directed at establishing Respondent's general medical competence rather than at providing the information sought.

The Committee did not find John Flynn's testimony convincing because of the number of information gaps in his investigation of Patient E's complaint. (T. 503, l. 16-18, T. 506, l. 17-19, T. 518, l. 16, T. 519, l. 2).

The Committee found Dr. Ramesh Gibumal a credible expert witness who addressed the issues directly and informatively. By contrast, Dr. Joel Teicher appeared to be unduly based in Respondent's behalf and trying too hard to defend the Respondent against any claim of wrong doing. See pages 1538-1539 of the transcript. In several instances he testified that although good medical practice required a particular examination procedure, he could imagine a situation where the procedure followed by Respondent was adequate. See pages 1267-1271 of the transcript. Dr. Michael Pierre Rafiy appeared confused by many of the questions and his answers were too vague to be informative. For example, on pages 909-910 of the transcript, he first said something was consistent and then said it was inconsistent. At pages 918-919 he first testified that he had previously testified in his own defense and then said he had not.

### **CONCLUSIONS OF LAW**

**FIRST:** Respondent is found to have engaged in professional misconduct by reason of practicing the profession of medicine fraudulently within the meaning of N.Y. Education Law Section 6530 (2) as charged in the **FIRST, SECOND, THIRD, FOURTH, SIXTH and SEVENTH** Specifications of Charges, and as set forth in Findings of Fact 4 through 66 and 71 through 93, *supra*.

**SECOND:** Respondent is found to have engaged in professional misconduct by reason of willfully harassing, abusing or intimidating a patient, either physically or verbally within the meaning of N.Y. Education Law Section 6530 (31) as charged in the **EIGHTH, NINTH and TENTH** Specifications of Charges, and as set forth in Findings of Fact 4 through 13, 24 through 29, 31, 38, 81 through 87, 90 and 92, *supra*.

**THIRD:** Respondent is found to have engaged in professional misconduct by reason of engaging in conduct in the practice of medicine that evidences moral unfitness to practice within the meaning of N.Y. Education Law Section 6530 (20) as charged in the **ELEVENTH, TWELFTH, THIRTEENTH, FOURTEENTH, SIXTHEENTH and SEVENTEENTH** Specifications of Charges, and as set forth in Findings of Fact 4 through 66 and 71 through 93, *supra*.

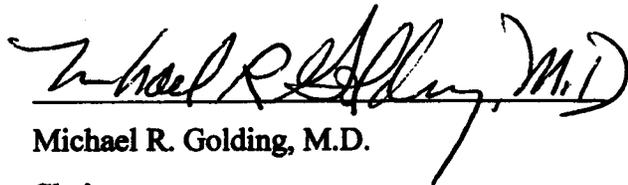
**FOURTH:** Respondent is found to have engaged in professional misconduct by reason of willfully making or filing a false report within the meaning of N.Y. Education Law Section 6530 (21) as charged in the EIGHTEENTH, NINETEENTH, TWENTH, TWENTY-FIRST and TWENTY-THIRD Specifications of Charges, and as set forth in Findings of Fact 16 through 19, 23, 33 through 39, 48 through 52, 61 through 66, 79 and 80, supra.

**FIFTH:** Respondent is found to have engaged in professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Education Law Section 6530 (3) as charged in the TWENTY-FOURTH Specification of Charges, and as set forth in Findings of Fact 4 through 14 and 71 through 93, supra.

**SIXTH:** Respondent is not found to have engaged in professional misconduct as charged in the FIFTH, FIFTEENTH and TWENTY-SECOND Specifications of Charges, relating to Patient E because of the lack of sufficient evidence presented to support said charges.

**ORDER**

The Hearing Committee determines and orders that Respondent's license to practice medicine in New York State be revoked.



Michael R. Golding, M.D.

Chairperson

Woodson Merrell, M.D.

Constance Diamond, D.A.

Dated: New York, NY  
October 28, 2003

# APPENDIX 1

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

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**IN THE MATTER : AFFIRMATION  
OF : OF MEMBER OF THE  
MILTON M. SMITH, M.D. : HEARING COMMITTEE**

---

**MICHAEL R. GOLDING, M.D.**, a duly designated member of the State Board for Professional Medical Conduct and of the Hearing Committee thereof designated to hear the **MATTER OF MILTON M. SMITH, M.D.**, hereby affirms that he was not present at a portion of the hearing sessions conducted on March 13, 2003 and May 12, 2003. He further affirms that he has read and considered the transcript of proceedings and the evidence received at such hearing sessions prior to deliberations of the Hearing Committee on the 15<sup>th</sup> day of September, 2003.

DATED: October 6, 2003

  
Michael R. Golding, M.D.

APPENDIX A

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

---

IN THE MATTER : AFFIRMATION  
OF : OF MEMBER OF THE  
MILTON M. SMITH, M.D. : HEARING COMMITTEE

---

WOODSON MERRELL, M.D., a duly designated member of the State Board for Professional Medical Conduct and of the Hearing Committee thereof designated to hear the **MATTER OF MILTON M. SMITH, M.D.**, hereby affirms that he was not present at a portion of the hearing sessions conducted on April 28, 2003 and May 5, 12, 15 and 29, 2003. He further affirms that he has read and considered the transcript of proceedings and the evidence received at such hearing sessions prior to deliberations of the Hearing Committee on the 15<sup>th</sup> day of September, 2003.

DATED: October 6, 2003

  
Woodson Merrell, M.D.

APPENDIX B

Relitigated / In Good  
DATE 2-6-03

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

IN THE MATTER  
OF  
MILTON M. SMITH, M.D.

AMENDED  
STATEMENT  
OF  
CHARGES

Milton M. Smith, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1, 1972, by the issuance of license number 112612 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. Patient A was seen by Respondent at 34-09 Queens Boulevard, Queens, New York, for evaluation, on June 20, 2001, in connection with injuries to her left wrist, sustained in a fall, on May 14, 2001. Respondent thereafter wrote a report of examination for QB Medical. (The names of patients are contained in the attached Appendix.)
  - 1. In the course of a purported physical examination but not for a legitimate medical purpose, Respondent inappropriately touched Patient A as follows:
    - a. Respondent inappropriately touched Patient A's breasts;
    - b. Respondent inappropriately touched Patient A's vaginal area, and;
    - c. Respondent inappropriately rubbed his clothed penis against Patient A's body.
  - 2. Respondent failed to perform an appropriate physical examination.
  - 3. Respondent knowingly and intentionally prepared and submitted to QB

APPENDIX C

Medical a report of his examination of Patient A, which he knew to be false in that it did not accurately report the actual nature and scope of his evaluation of Patient A.

- a. Respondent intended to mislead the recipient(s) of the report.

B. Patient B was seen by Respondent at 34-09 Queens Boulevard, Queens, New York, for evaluation, on September 24, 2001, in connection with neck and back injuries sustained in a car accident, on July 1, 2001. Respondent thereafter wrote a report of examination for QB Medical.

1. In the course of a purported physical examination but not for a legitimate medical purpose, Respondent inappropriately touched Patient B as follows:
  - a. Respondent inappropriately rubbed his clothed penis against Patient B's hand;
  - b. Respondent inappropriately touched Patient B's breasts, and;
  - c. Respondent inappropriately touched Patient B's vaginal area.
2. Respondent failed to perform an appropriate physical examination.
3. Respondent knowingly and intentionally prepared and submitted to QB Medical a report of his examination of Patient B, which he knew to be false in that it did not accurately report the actual nature and scope of his evaluation of Patient B.
  - a. Respondent intended to mislead the recipient(s) of the report.

- C. Patient C was seen by Respondent at 112-47 Queens Boulevard, Forest Hills, New York, for evaluation, on February 12, 2001, in connection with neck, back and shoulder injuries sustained in a work-related car accident, on October 13, 2000. Respondent thereafter wrote a report of examination for MED-VAL Inc..
1. Respondent failed to perform an appropriate physical examination.
  2. Respondent knowingly and intentionally prepared and submitted to MED-Val Inc. a report of his examination of Patient C, which he knew to be false in that it did not accurately report the actual nature and scope of his evaluation of Patient C.
    - a. Respondent intended to mislead the recipient(s) of the report.
- D. Patient D was seen by Respondent at 1670 Old Country Road, Plainview, New York, for evaluation, on June 27, 1997, in connection with back, shoulder and wrist injuries sustained in a work-related fall, on February 9, 1997. Respondent thereafter wrote a report of examination for Crossland Medical Services, P.C..
1. Respondent failed to perform an appropriate physical examination.
  2. Respondent knowingly and intentionally prepared and submitted to Crossland Medical Services, P.C., a report of his examination of Patient D, which he knew to be false in that it did not accurately report the actual nature and scope of his evaluation of Patient D.
    - a. Respondent intended to mislead the recipient(s) of the report.
- E. Patient E was seen by Respondent at 1719 North Ocean Avenue, Medford, New York, for evaluation, on September 30, 1999, in connection with neck and back injuries sustained in a motor vehicle accident, on June 4, 1999. Respondent thereafter wrote a report of examination for the First Rehabilitation Insurance Company of America.

1. Respondent failed to perform an appropriate physical examination.
  2. Respondent knowingly and intentionally prepared and submitted to the First Rehabilitation Insurance Company of America a report of his examination of Patient E, which he knew to be false in that it did not accurately report the nature and scope of his evaluation of Patient E.
    - a. Respondent intended to mislead the recipient(s) of the report.
- F. Patient F was seen by Respondent at 1670 Old Country Road, Plainview, New York, for evaluation, on January 22, 1998, in connection with back injuries sustained in a motor vehicle accident, on October 2, 1997. Respondent thereafter wrote a report of examination for Allstate.
1. Respondent failed to perform an appropriate physical examination.
  2. Respondent knowingly and intentionally prepared and submitted to Allstate a report of his examination of Patient F, which he knew to be false in that it did not accurately report the nature and scope of his evaluation of Patient F.
    - a. Respondent intended to mislead the recipient(s) of the report.
- G. Patient G was seen by Respondent at 749 Union Street, Brooklyn, New York, for evaluation, on May 21, 1991, in connection with injuries to her back, sustained in a work-related accident, on December 13, 1989.
1. In the course of a purported physical examination but not for a legitimate medical purpose, Respondent inappropriately touched Patient G as follows:
    - a. Respondent inappropriately touched Patient G's vaginal area and buttock, and;
    - b. Respondent inappropriately touched Patient G's

breast;

2. Respondent failed to perform an appropriate physical examination.

## **SPECIFICATION OF CHARGES**

### **FIRST THROUGH SEVENTH SPECIFICATIONS**

#### **FRAUDULENT PRACTICE**

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

1. Paragraph A and its respective sub-paragraphs.
2. Paragraph B and its respective sub-paragraphs.
3. Paragraph C and its respective sub-paragraphs.
4. Paragraph D and its respective sub-paragraphs.
5. Paragraph E and its respective sub-paragraphs.
6. Paragraph F and its respective sub-paragraphs.
7. Paragraph G and its respective sub-paragraphs.

### **EIGHTH THROUGH TENTH SPECIFICATIONS**

#### **WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT**

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(31) by willfully harassing, abusing or intimidating a patient either physically or verbally, as alleged in the facts of the following:

8. Paragraph A and A1 and its respective sub-paragraphs.
9. Paragraph B and B1 and its respective sub-paragraphs.
10. Paragraph G and G1 and its respective sub-paragraphs.

## **ELEVENTH THROUGH SEVENTEENTH SPECIFICATIONS**

### **MORAL UNFITNESS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) 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:

11. Paragraph A and its respective sub-paragraphs.
12. Paragraph B and its respective sub-paragraphs.
13. Paragraph C and its respective sub-paragraphs.
14. Paragraph D and its respective sub-paragraphs.
15. Paragraph E and its respective sub-paragraphs.
16. Paragraph F and its respective sub-paragraphs.
17. Paragraph G and its respective sub-paragraphs.

## **EIGHTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS**

### **WILLFULLY MAKING OR FILING A FALSE REPORT**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

18. Paragraph A and A3.
19. Paragraph B and B3.
20. Paragraph C and C2.
21. Paragraph D and D2.
22. Paragraph E and E2.

23. Paragraph F and F2.

**TWENTY-FOURTH SPECIFICATION**  
**NEGLIGENCE ON MORE THAN ONE OCCASION**

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

24. Paragraph A and A2 and/or, Paragraph B and B2 and/or, Paragraph C and C1 and/or, Paragraph D and D1 and/or, Paragraph E and E1 and/or, Paragraph F and F1 and/or, Paragraph G and G2.

DATED: January 14, 2003  
New York, New York



Roy Nemerson  
Deputy Counsel  
Bureau of Professional  
Medical Conduct

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

IN THE MATTER

OF

Milton Smith, M.D.

NOTICE  
OF  
HEARING

TO: Milton Smith, M.D.  
c/o Jankoff & Gabe, P.C.  
575 Lexington Avenue  
New York, NY 10022

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on January 16, 2003, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, 6<sup>th</sup> Floor, NYC 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 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(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy 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 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. 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. YOU  
ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU  
IN THIS MATTER.

DATED: New York, New York  
December 2, 2002

A handwritten signature in black ink, appearing to read "Roy Nemerson", is written over a horizontal line.

Roy Nemerson  
Deputy Counsel  
Bureau of Professional  
Medical Conduct

Inquiries should be directed to: Leslie Eisenberg  
Associate Counsel  
Bureau of Professional Medical Conduct  
5 Penn Plaza, 6<sup>th</sup> Floor  
NYC 10001  
212-268-6806

IN THE MATTER OF MILTON SMITH M. D.,

- against -

Plaintiff(s)

Defendant(s)

Index No.

COURT DATE 01/16/03

AFFIDAVIT OF SERVICE

NOTICE OF HEARING, STATEMENT OF CHARGES, REGULATIONS

STATE OF NEW YORK: COUNTY OF NEW YORK

ss:

ANDRE ADAMSON

BEING DULY SWORN DEPOSES AND SAYS DEPONENT IS NOT A PARTY TO THIS ACTION AND IS OVER THE AGE OF EIGHTEEN YEARS AND RESIDES IN THE STATE OF NEW YORK.

That on 12/17/02 at 1053AM Hours at 189 MONTAGUE STREET # 801 A BROOKLYN, NEW YORK 11201

deponent served the within NOTICE OF HEARING, STATEMENT OF CHARGES, REGULATIONS therein named, MILTON SMITH M. D.

on

INDIVIDUAL

by delivering a true copy of each to said personally; deponent knew the person so served to be the person described as said person therein.  (S) He identified (her) himself as such.

A

CORPORATION

a (domestic) (foreign) corporation by delivering therest a true copy of each to personally, deponent knew said corporation so served to be the corporation described in legal papers and knew said individual to be thereof

B

SUITABLE AGE PERSON

by delivering therest a true copy of each to a person of suitable age and discretion. Said premises is recipient's (actual place of business) (dwelling house) (usual place of abode) within the state.  (S) He identified (her) himself as of recipient

C

AFFIXING TO DOOR, ETC.

by affixing a true copy of each to the door of said premises, which is recipient's (actual place of business) (dwelling house) (usual place of abode) within the state. Deponent was unable, with due diligence to find recipient or a person of suitable age and discretion, therest, having called there on the dates below:

D

MAILING USE WITH C or D

Deponent also enclosed a copy of same in a postpaid sealed wrapper properly addressed to the above recipient and deposited at

said wrapper in (a post office) official depository under exclusive care and custody of the United States Postal Service within New York State.

Deponent further states that he describes the person actually served as follows

Sex	Skin Color	Hair Color	Age (Approx.)	Height (Approx.)	Weight (Approx.)
MALE	WHITE	BROWN	40	5' 6	160

GLASSES

MILITARY SERVICE

Above person has asked, whether the recipient (s) was (were) in the military service of the State of New York or the United States and received a negative reply. Upon information and belief based upon the conversation and observation as aforesaid deponent avers that the recipient (s) is (are) not in the military service of the State of New York or the United States as that term is defined in the statutes of the State of New York or the Federal Soldiers and Sailors Civil Relief Act.

That at the time of such service deponent knew the person (s) so served as aforesaid to be the same person (s) mentioned and described as the defendant(s) in this action.

USE IN NYC CIVIL CT.

The language required by NYCRR 2900.2(e), (f) & (h) was set forth on the face of said summons (es).

Sworn to before me on the 12/17/02

SANDRA FARRON  
Notary Public, State of New York  
No. 01FA4784241  
Qualified in Nassau County  
Commission Expires September 2005

ANDRE ADAMSON  
LICENSE No.  
103 8789

IN THE MATTER OF MILTON SMITH M. D.,

- against -

Plaintiff(s)

Defendant(s)

Index No.

COURT DATE 01/16/03

AFFIDAVIT OF SERVICE

NOTICE OF HEARING, STATEMENT OF CHARGES, REGULATIONS

STATE OF NEW YORK: COUNTY OF NEW YORK

ss:

ANDRE ADAMSON

BEING DULY SWORN DEPOSES AND SAYS DEPONENT IS NOT A PARTY

TO THIS ACTION AND IS OVER THE AGE OF EIGHTEEN YEARS AND RESIDES IN THE STATE OF NEW YORK.

That on 12/17/02 at 1053AM Hours at 189 MONTAGUE STREET # 801 A BROOKLYN, NEW YORK 11201

deponent served the within NOTICE OF HEARING, STATEMENT OF CHARGES, REGULATIONS on MILTON SMITH M. D. therein named,

INDIVIDUAL

A

by delivering a true copy of each to said personally; deponent knew the person so served to be the person described as said person therein.  (S) He identified (her) himself as such.

CORPORATION

B

a (domestic) (foreign) corporation by delivering thereto a true copy of each to personally, deponent knew said corporation so served to be the corporation described in legal papers and knew said individual to be thereof

SUITABLE AGE PERSON

C

by delivering thereto a true copy of each to a person of suitable age and discretion. Said premises is recipient's (actual place of business) (dwelling house) (usual place of abode) within the state.  (S) He identified (her) himself as of recipient

AFFIXING TO DOOR, ETC.

D

by affixing a true copy of each to the door of said premises, which is recipient's (actual place of business) (dwelling house) (usual place of abode) within the state. Deponent was unable, with due diligence to find recipient or a person of suitable age and discretion, thereto, having called there on the dates below:

MAILING USE WITH C or D

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Deponent further states that he describes the person actually served as follows

Sex	Skin Color	Hair Color	Age (Approx.)	Height (Approx.)	Weight (Approx.)
MALE	WHITE	BROWN	40	5'6	160

GLASSES

MILITARY SERVICE

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That at the time of such service deponent knew the person (s) so served as aforesaid to be the same person (s) mentioned and described as the defendant(s) in this action.

USE IN NYC CIVIL CT.

The language required by NYCRR 2900.2(e), (f) & (h) was set forth on the face of said summons (es).

SANDRA FARRON  
Notary Public, State of New York  
No. 01PA4784241  
Qualified in Nassau County  
Commission Expires Sept. 30, 2005

Sworn to before me on the

12/17/02

ANDRE ADAMSON

LICENSE No.

103 8789