



STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

August 19, 2008

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Elliott S. Cohen, M.D.

Redacted Address

Samuel C. Young, Esq.
Costello, Cooney, et al
205 South Salina Street
Syracuse, New York 13202

Richard J. Zahnleuter, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2509
Empire State Plaza
New York, New York 12237

RE: In the Matter of Elliott S. Cohen, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 08-154) 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure

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

COPY

IN THE MATTER
OF
ELLIOTT S. COHEN, M.D.

DETERMINATION
AND
ORDER

BPMC 08-154

WILLIAM P. DILLON, M.D., Chairperson, **EDMUND A. EGAN, M.D.** and **IRVING S. CAPLAN**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **THOMAS G. CONWAY**, General Counsel, **RICHARD J. ZAHNLEUTER, ESQ.**, Associate Counsel, of Counsel. The Respondent, **ELLIOTT S. COHEN, M.D.** personally appeared and by **COSTELLO COONEY & FEARON, P.L.L.C.**, **SAMUEL C. YOUNG, ESQ.** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Notice of Hearing:	January 14, 2008
Date of Pre-hearing:	February 20, 2008
Dates of Hearing:	February 29, 2008

Date of Deliberation:

April 29, 2008

May 30, 2008

July 9, 2008

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged seventy-eight (78) specifications of professional misconduct for allegations of gross negligence, negligence on more than one occasion, failure to comply with substantial provisions of state laws and regulations, failure to maintain records, failure to make requested documents available to the Department of Health, and practicing the profession beyond the medically underserved geographic area authorized in Respondent's limited New York State license. The charges are more specifically set forth in the Statement of Charges dated January 14, 2008, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

WITNESSES

For the Petitioner:
(Department of Health)

Thomas E. Avery
Allan LaFlore
Debra M. Hotaling
Alfredo Lopez, M.D.

For the Respondent:

Spencer Falcon, M.D.
David Towle, M.D.
Elliott S. Cohen, M.D.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Citations in parentheses refer to transcript page numbers or exhibits. These citations

represent evidence found persuasive in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Respondent, Elliott S. Cohen, M.D., is a physician licensed to practice medicine in the State of New York, pursuant to the issuance of a 3-year limited license number 002063 issued by the New York State Department of Education on December 17, 2003. This limited license expired on December 31, 2006, but a new 6-year limited license number 002775 was issued on January 3, 2007. (Pet. Ex.4)
2. The "limitation" imposed by the Education Department was that the Respondent was authorized to practice medicine only in the medically under served area of Watertown, New York, as an obstetrician/gynecologist having privileges at Samaritan Medical Center. (Pet. Exs. 4 and 5)
3. Respondent graduated Medical School from the University of Ottawa in 1972. (T. 318)
4. Respondent next completed an internship and residency program in OB-GYN at the University of Alberta in Edmonton, Alberta, followed by additional medical education in ambulatory care, surgery and outpatient care at the University of Ottawa. (T. 319)
5. Respondent then practiced OB-GYN at Salvation Army Hospital in Ottawa from approximately 1981 until 2004, including serving as chief of OB-GYN from 1983-1992. (T. 319-321)
6. Respondent is a Fellow of the Society of Obstetrics and Gynecology of Canada, a Fellow of the Royal College of Physicians and Surgeons of Canada, and a Diplomate of the American College of Obstetrics and Gynecology. (T. 320; Resp. Ex. "B-11")
7. In addition to his license in New York State, Respondent is licensed to practice in the

Provinces of Ontario, Saskatchewan, and Alberta, and the State of Tennessee. (T. 320)

8. In 2003, Respondent was recruited to work in Watertown, New York and the Samaritan Medical Center. At the time that Samaritan Medical Center began recruiting Respondent, the entire community had only two practicing OB-GYNs. At that time, none of the OB-GYNs were performing advanced surgical procedures, and women were frequently forced to leave the community to seek competent medical care. Presently Respondent offers a full spectrum of advanced gynecological and surgical procedures, and is just one of four obstetricians practicing in the community. (T. 330, 559-560, Resp. Ex. "I")
9. Currently there are approximately 900 civilian and 900 military deliveries each year at Samaritan Medical Center. Respondent is just one of three civilian obstetricians actively delivering babies in the Watertown area, and he performs between 250 and 300 deliveries each year. (T. 333-34, 487-89, 557; Resp. Ex. "I") Of his deliveries, his percentage of cesarean sections is approximately 9 to 10 percent, which is below average for his area.
10. In addition to delivering babies, Respondent performs advanced gynecological procedures at Samaritan Medical Center. He performs approximately ninety percent of the gynecological procedures at that hospital. (T. 332) Respondent's gynecology practice includes pelvic floor reconstruction, laparoscopic surgeries, hysterectomies, and treatment for infertility and urogynecological and stress incontinence, among others. (T. 332)
11. Thomas Avery is a pharmacy board investigator in Maine. (T. 22) Mr. Avery's office was contacted by a physician in Maine named Dr. Myron Cohen, regarding concerns

about a pharmacy in Presque Isle, Maine. (T. 30-31) Dr. Myron Cohen had been contacted by a patient, Mr. E. E. (Patient "A" in the Specification of Charges), who apparently purchased a prescription over the internet from the Presque Isle pharmacy.

12. Based on Dr. Myron Cohen's call, Mr. Avery traveled to City Drug in Presque Isle, Maine, and spoke with Mr. Talbot, the pharmacist in charge at City Drug. (T. 35)
13. A pharmacy technician who worked at City Drug produced a copy of what the pharmacy considered prescriptions regarding Patient A. When they printed out the information, the records contained the name of Respondent, Dr. Elliott Cohen. (T. 35-36)
14. After speaking with Mr. Talbot, Mr. Avery learned that the drug store had entered into an agreement with an internet company to fill drug orders sent over the internet, based upon customer questionnaires. (T. 36) The Drug store was being paid a premium for dispensing these orders from the internet company. (T. 37) City Drug was dispensing between 50 and 100 prescriptions per day, based upon orders from the internet company. (T. 36-38)
15. After further investigations, Mr. Avery determined that the internet company that was dealing with both City Drug and another nearby pharmacy in Maine was called Business Services, Inc., of Raleigh, North Carolina. (T. 81; Resp. Ex. "C") Business Services, Inc. is owned by Joe Monahan. (T. 81; Pet. Ex.21, Resp. Ex. "C")
16. Subsequently, at the request of OPMC, Mr. Avery asked City Drug to produce additional examples of the customer questionnaires and prescription order forms. According to Mr. Avery's testimony, Mr. Talbot's staff printed out the documents, and Mr. Talbot sent them to Mr. Avery, who in turn transmitted them to OPMC. (Pet. Exs. 6A, 7 and 8;

T. 42-44)

17. From approximately February 2005 through March 2007, Respondent prescribed certain non-controlled prescription drugs to customers of Business Services Inc. for a fee. (Pet. Ex. 21)
18. Paragraph 1.1 of the contract that Respondent signed with Business Services II provides that the Respondent "will provide the service of reviewing patient profiles and issuing a prescription for those individuals whom [the Respondent] is of the opinion require the prescription drugs as requested by the patient. (Pet. Ex. 21)
19. Respondent reviewed online requests from approximately 400 members of the general nationwide public who submitted the questionnaires listed in Exhibit 8, as well as the 18 patients coded as A-R, whose questionnaires are contained in Petitioners' Exhibits 6A and 7.
20. The drugs prescribed included Tramadol, Viagra, Floricet, Soma, Cialis, Levitra, Amoxicillin, Ultracet and Flexiril. (Pet. Exs. 6A, 7 and 8)
21. These drugs are not controlled substances. (T. 182)
22. Respondent admitted that he reviewed approximately 50,000 questionnaires in a two year period for which he earned \$100,000. (T.364)
23. Respondent acknowledged that he reviewed the questionnaires in the Watertown area when he was experiencing lag time in the hospital or office. (T. 438)
24. Respondent admitted that the billing and shipping addresses of the patients who submitted the questionnaires were not in the Watertown, New York area. (T. 447-448)
25. After several interviews with OPMC, Respondent resigned from his participation with

- the internet pharmacy as of March 20, 2007. (Resp.'s Ex. B-10, T. 360)
26. Respondent's issuance of prescriptions to online patients deviated from minimally accepted standard of care because Respondent failed to have a sufficient physician-patient relationship with the patients, take a history and perform examinations, formulate a reasonable diagnosis, give alternatives to different modalities of treatment or no treatment, and follow up, all with no documentation. (T. 228, 235-236)
 27. §21 of the Public Health Law requires that all prescriptions written in New York State must adhere to New York State requirements as to form. (Pet. Ex. 18)
 28. The internet documents reviewed by Respondent did not conform to New York State's requirements as to form because the Respondent's license number and telephone number were missing, a "DAW" box was missing, and billing and shipping addresses of the patients were insufficient because there were no residential addresses as required. (Pet. Exs. 6A and 7; T. 176-178)
 29. 10 NYCRR §910.2(a) requires that all prescriptions written in New York State must be written "in good faith." (Pet. Ex. 19)
 30. The internet documents reviewed by Respondent did not conform to New York State's "good faith" requirements because the patients diagnosed themselves and Respondent failed to perform history and physical and failed to provide a diagnosis with treatment options. (T. 254-255)
 31. Respondent failed to maintain adequate medical records for all patients listed in the Statement of Charges. (T. 255)

CONCLUSIONS OF LAW

The Hearing Committee makes the unanimous conclusion, pursuant to the Findings of Fact listed above, the following Factual Allegations are sustained:

Factual Allegations A, B, C, D and F : SUSTAINED

Factual Allegations E : NOT SUSTAINED

DISCUSSION

Respondent is charged with seventy-eight (78) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross negligence is failure to exercise the care that would be exercised by a

reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that fifty-eight (58) of the seventy-eight (78) specifications of professional misconduct should be sustained. The rationale for the Hearing Committee's conclusions regarding the specifications of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of the witnesses presented. The Department offered the testimony of Thomas Avery, a pharmacy board investigator from the State of Maine. The Hearing Committee found Mr. Avery to be an honest witness who did his best to explain the origination of the internet documents that were traced back to the Respondent. Alan LaFlore, an investigator from the Office of Professional Medical Conduct also testified. The Hearing Committee found Mr. Lafore to be an unbiased witness who answered questions in a forthcoming manner. The Department also offered the testimony of Deborah Hotaling who is a pharmacist employed in the Department's Bureau of Narcotics Enforcement. While credible, the Hearing Committee found that Ms. Hotaling's testimony was more helpful to Respondent because she re-emphasized that the drugs involved were not controlled substances. She further acknowledged that patients can experience harmful effects from non-prescribed over the counter drugs if they are abused or mixed with other drugs. (T. 168, 201)

The Department offered Dr. Alfredo Lopez as its expert witness. Dr. Lopez is board certified in obstetrics and gynecology. He works in a specially designated medically under

served area of inner city Syracuse and has privileges at St. Joseph's Hospital. (Pet. Ex. 14; T. 212-218) The Hearing Committee found Dr. Lopez to be a credible but weak witness. He had difficulty articulating what the standard of care was in this instance. The Hearing Committee agrees with the basic premise stated by Dr. Lopez regarding the standard of care but they did not find other parts of his testimony to be helpful. As a result, Dr. Lopez's testimony was given moderate weight.

Respondent took the stand on his own behalf. The Hearing Committee found Respondent to be a well trained physician who tried to be honest but strained his credibility in explaining his actions. The Hearing Committee finds it hard to believe that Respondent did not have an understanding of what he was doing when viewing the internet documentation. Even if Respondent was naive in getting involved with the internet company, they believe he should have known better.

Respondent also offered the testimony of Falcon Spencer, M.D., the Medical Director of Samaritan Medical Center regarding quality assurance and review. The Hearing Committee found that Dr. Spencer did not answer questions directly and did not speak to the issues covered in the Statement of Charges. As a result, the Hearing Committee did not find Dr. Spencer's testimony to be helpful. David Towle, D.O., Director of Medical Education at Samaritan Hospital also testified. His testimony was that of a character witness who provided insight into the nature of Respondent's practice at the hospital. The Hearing Committee found that Dr. Towle's testimony was not helpful with respect to the allegations in the Statement of Charges.

FIRST THROUGH NINETEENTH SPECIFICATIONS

(GROSS NEGLIGENCE)

The Hearing Committee finds that Respondent's misconduct does not rise to the level of gross negligence. The Hearing Committee notes that the drugs involved were non scheduled drugs which are not drugs with high abuse potential. Their safety profiles are similar to many over the counter drugs. As a result, the First through Nineteenth Specifications are not sustained.

TWENTIETH SPECIFICATION

(NEGLIGENCE ON MORE THAN ONE OCCASION)

The Hearing Committee agrees with Dr. Lopez, that Respondent did not follow good clinical practice for issuing prescriptions over the internet. They were not persuaded by Respondent's explanation that he was not writing new prescriptions but was reviewing the appropriateness of prescriptions written by the customer's physician's. The Hearing Committee agrees with the Department that quality assurance of this nature is generally performed by pharmacists and it is unlikely that Respondent would be paid to second guess the initial physician. As a result, the Hearing Committee finds that Respondent acted with negligence on more than one occasion and they sustain the Twentieth Specification.

TWENTY FIRST THROUGH THIRTY NINTH SPECIFICATIONS

**(FAILURE TO COMPLY WITH SUBSTANTIAL PROVISIONS OF STATE LAWS
AND REGULATIONS)**

The Hearing Committee finds that the record establishes that Respondent failed to

issue the prescriptions that are the subject of the Statement of Charges on official New York State prescription forms and "in good faith" as required by public Health Law § 21 and 10 NYCRR §910.2 (a). As a result, the Hearing Committee sustains the aforementioned Specifications.

FORTIETH THROUGH FIFTY-EIGHTH SPECIFICATIONS

(FAILING TO MAINTAIN RECORDS)

The Hearing Committee finds that Respondent's patient records in all instances were inadequate.

FIFTY-NINTH SPECIFICATION

(FAILING TO MAKE REQUESTED DOCUMENTS AVAILABLE TO THE DEPARTMENT OF HEALTH)

The Hearing Committee notes that Respondent did not ignore the Department's requests for information and that he responded at various intervals through correspondence from his attorney. They believe that the medical records that were requested by the Department resided with the internet company and that Respondent had no access to them particularly after he resigned from doing business with them. With respect to financial information, the Hearing Committee finds that the evidence is insufficient to sustain this aspect of the charge and note that the Department did not specifically request copies of Respondent's 1040 tax forms. As a result, the Hearing Committee does not sustain the Fifty-Ninth Specification.

SIXTIETH THROUGH SEVENTY-EIGHTH SPECIFICATIONS
(PRACTICING THE PROFESSION BEYOND WATERTOWN SAMARITAN
MEDICAL CENTER)

By a vote of 2 to 1, a majority of the Hearing Committee finds that Respondent violated the spirit of his limited license by writing prescriptions for patients who resided outside of the geographic area to which his limited license was restricted. The Hearing Committee notes that Respondent's New York license was in full effect when he initiated the internet practice. They find no evidence that he ever used his Tennessee license to practice medicine at any point and unanimously reject his argument that he conducted the internet practice only under the authority of his Tennessee license. As a result, the above Specifications are sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent shall be censured and reprimanded for his misconduct. In addition, a civil penalty of TEN THOUSAND DOLLARS (\$10,000) shall be assessed against Respondent. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee did not revoke Respondent's license because they specifically found that his misconduct did not rise to the level of gross negligence. They further note that there was no evidence of patient harm and no evidence of prior misconduct

in Respondent's 36 year career. The Hearing Committee concludes that the penalty should be the same regardless if the physician's license was restricted or unrestricted.

The Hearing Committee notes that Respondent promptly ceased his internet practice once he was informed by OPMC that he was in violation of his limited license. At the hearing, Respondent expressed his regret for getting involved in this activity and stated that he would never return to it. (T. 360, 363) Based upon Respondent's demeanor at the hearing the Hearing Committee believes Respondent has been changed for the better by this experience. The Hearing Committee also believes that probation is not necessary due to the already limited nature of Respondent's license.

The Hearing Committee believes that Respondent is an otherwise good physician whose service to the Watertown area is of the highest quality. They believe it would be a disservice to this under served region of New York State if Respondent's license were revoked. The Hearing Committee concludes that a censure and reprimand and a civil penalty of \$10,000 is the appropriate penalty in this instance.

ORDER

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

1. The Twentieth through Fifty-Eighth Specifications and the Sixtieth through Seventy-Eighth Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED;** and
2. The First through Nineteenth Specifications and the Fifty-Ninth Specification of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;** and
3. Respondent is **CENSURED AND REPRIMANDED;**
4. A fine in the amount of **TEN THOUSAND DOLLARS (\$10,000)** is imposed against Respondent. Payment of the aforesaid penalty shall be made to the Bureau of Accounts Management, New York State Department of Health, Corning Tower Building, Room 1717, Empire State Plaza, Albany, New York 12237 within thirty (30) days of the effective date of this Order.
5. Any civil penalty not paid by the date prescribed herein shall be subject to all

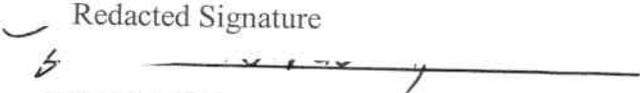
provisions of laws relating to debt collection by the state of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; and non-renewal of permits or licenses (Tax Law, section 171(27); state Finance Law, section 18; CPLR, section 5001; Executive Law, section 32)

6. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Buffalo, New York

8/15 2008

Redacted Signature


WILLIAM P. DILLON, M.D.

(Chairperson)

EDMUND A. EGAN, M.D.

IRVING S. CAPLAN

To: Richard J. Zahnleuter, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower - Rm. 2509
Albany, New York 12237-0032

Samuel C. Young, Esq.
Costello, Cooney & Fearon, P.L.L.C.
205 South Salina Street
Syracuse, N.Y. 13202

Elliott S. Cohen, M.D.

Redacted Address

APPENDIX I



IN THE MATTER
OF
ELLIOTT S. COHEN, M.D.

STATEMENT
OF
CHARGES

FACTUAL ALLEGATIONS

**THE RESPONDENT'S PRACTICE LIMITATION TO
SAMARITAN MEDICAL CENTER IN WATERTOWN**

- A. Elliott S. Cohen, M.D., (the "Respondent"), was authorized to practice medicine by the issuance of a 3-year "limited license," number 002063, on December 17, 2003 by the N.Y. Education Department. This "limited license" expired on December 31, 2006, but a new 6-year "limited license," number 002775, was issued on January 3, 2007.
- B. The "limitation" imposed by the Education Department was that the Respondent was authorized to practice medicine only in the medically underserved area of Watertown, New York, as an obstetrician/gynecologist having privileges at Samaritan Medical Center.

**THE RESPONDENT'S WORLD WIDE WEB
INTERNET PRESCRIBING PRACTICE**

- C. At times during 2005 and/or 2006 and/or 2007, for a fee paid by an Internet company, the Respondent prescribed on numerous occasions certain non-controlled prescription drugs to customers of the Internet company.
- D. The Respondent prescribed the drugs based on the Respondent's review of questionnaires submitted on-line by members of the general

nationwide public who were not part of the medically underserved population of Watertown, New York, needing obstetrician/gynecologist services at Samaritan Medical Center.

- E. The Respondent failed to make available within 30 days of the N.Y. Health Department's request relevant documents itemized in a letter dated June 12, 2007 (item 1 and/or item 3 as clarified on August 28, 2007).
- F. Individually and/or collectively, with respect to the patients identified as Patients A through R in corresponding paragraphs G through Y in the chart below, the Respondent did not meet acceptable standards of medical care in that the Respondent prescribed the drugs:
 - a. Without having performed an in-person medical evaluation and/or otherwise having a sufficient physician-patient relationship; and/or
 - b. Without having formulated an adequate or appropriate diagnosis or treatment plan; and/or
 - c. Without having complied with the "form" and "in good faith" prescription requirements set forth in Public Health Law § 21 and/or 10 NYCRR § 910.2(a) and/or (f); and/or
 - d. Without having maintained an adequate medical record that reflects the evaluation and treatment of the patient.

Paragraph	Patient Name ¹	Patient Sex	Shipping Address (City, State)	Prescription Drug
G	A	Male	Newburyport, Massachusetts	Tramadol
H	A	Male	Newburyport, Massachusetts	Viagra
I	B	Male	Cypress, Texas	Fioricet
J	C	Male	Lockhart, Texas	Tramadol
K	D	Male	Poughkeepsie, New York	Soma
L	E	Male	Livermore, California	Soma
M	F	Male	Chapel Hill, North Carolina	Cialis
N	G	Male	Bulard, Texas	Levitra
O	H	Male	Louisa, Virginia	Cialis
P	I	Male	East Northport, New York	Viagra
Q	J	Female	Clark, New Jersey	Tramadol
R	K	Male	Santa Rosa, California	Cialis
S	L	Male	Erie, Pennsylvania	Amoxicillin
T	M	Female	Stafford, Virginia	Ultracet
U	N	Male	Port Washington, New York	Fioricet
V	O	Male	Chesterfield, Michigan	Tramadol

¹To preserve privacy throughout this document, patients are referred to by letter designation. An Appendix of Patient Names, Appendix A, is attached hereto for appropriate recipients.

Paragraph	Patient Name	Patient Sex	Shipping Address (City, State)	Prescription Drug
W	P	Female	Gahanna, Ohio	Soma
X	Q	Male	Wilmington, North Carolina	Flexeril
Y	R	Male	Springfield, Louisiana	Soma

SPECIFICATIONS OF MISCONDUCT

FIRST THROUGH NINETEENTH SPECIFICATIONS (GROSS NEGLIGENCE)

Respondent is charged with committing professional misconduct as defined in Education Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the following:

1. The facts set forth in paragraphs F(a, b, c, and/or d) and/or G.
2. The facts set forth in paragraphs F(a, b, c, and/or d) and/or H.
3. The facts set forth in paragraphs F(a, b, c, and/or d) and/or I.
4. The facts set forth in paragraphs F(a, b, c, and/or d) and/or J.
5. The facts set forth in paragraphs F(a, b, c, and/or d) and/or K.
6. The facts set forth in paragraphs F(a, b, c, and/or d) and/or L.
7. The facts set forth in paragraphs F(a, b, c, and/or d) and/or M.
8. The facts set forth in paragraphs F(a, b, c, and/or d) and/or N.
9. The facts set forth in paragraphs F(a, b, c, and/or d) and/or O.
10. The facts set forth in paragraphs F(a, b, c, and/or d) and/or P.
11. The facts set forth in paragraphs F(a, b, c, and/or d) and/or Q.
12. The facts set forth in paragraphs F(a, b, c, and/or d) and/or R.
13. The facts set forth in paragraphs F(a, b, c, and/or d) and/or S.
14. The facts set forth in paragraphs F(a, b, c, and/or d) and/or T.
15. The facts set forth in paragraphs F(a, b, c, and/or d) and/or U.
16. The facts set forth in paragraphs F(a, b, c, and/or d) and/or V.
17. The facts set forth in paragraphs F(a, b, c, and/or d) and/or W.
18. The facts set forth in paragraphs F(a, b, c, and/or d) and/or X.
19. The facts set forth in paragraphs F(a, b, c, and/or d) and/or Y.

TWENTIETH SPECIFICATION
(NEGLIGENCE ON MORE THAN ONE OCCASION)

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

20. The facts set forth in paragraphs F(a, b, c, and/or d) and/or G and/or H and/or I and/or J and/or K and/or L and/or M and/or N and/or O and/or P and/or Q and/or R and/or S and/or T and or U and/or V and/or W and/or X and/or Y.

TWENTY-FIRST THIRTY-NINTH SPECIFICATIONS
(FAILURE TO COMPLY WITH SUBSTANTIAL PROVISIONS
OF STATE LAWS AND REGULATIONS)

Respondent is charged with committing professional misconduct as defined in Education Law §6530(16) by willfully or with gross negligence failing to comply with substantial provisions of State laws and regulations, namely Public Health Law § 21 and/or 10 NYCRR § 910.2(a) and/or(f), which relate to prescribing only on official New York State prescription forms and "in good faith," as alleged in the following:

21. The facts set forth in paragraphs F(c) and/or G.
22. The facts set forth in paragraphs F(c) and/or H.
23. The facts set forth in paragraphs F(c) and/or I.
24. The facts set forth in paragraphs F(c) and/or J.
25. The facts set forth in paragraphs F(c) and/or K.
26. The facts set forth in paragraphs F(c) and/or L.
27. The facts set forth in paragraphs F(c) and/or M.

28. The facts set forth in paragraphs F(c) and/or N.
29. The facts set forth in paragraphs F(c) and/or O.
30. The facts set forth in paragraphs F(c) and/or P.
31. The facts set forth in paragraphs F(c) and/or Q.
32. The facts set forth in paragraphs F(c) and/or R.
33. The facts set forth in paragraphs F(c) and/or S.
34. The facts set forth in paragraphs F(c) and/or T.
35. The facts set forth in paragraphs F(c) and/or U.
36. The facts set forth in paragraphs F(c) and/or V.
37. The facts set forth in paragraphs F(c) and/or W.
38. The facts set forth in paragraphs F(c) and/or X.
39. The facts set forth in paragraphs F(c) and/or Y.

**FORTIETH THROUGH FIFTY-EIGHTH SPECIFICATIONS
(FAILING TO MAINTAIN RECORDS)**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient that accurately reflects the evaluation and treatment of the patient, and/or by failing to maintain such a record for 6 years, as alleged in the following:

40. The facts set forth in paragraphs F(d) and/or G.
41. The facts set forth in paragraphs F(d) and/or H.
42. The facts set forth in paragraphs F(d) and/or I.
43. The facts set forth in paragraphs F(d) and/or J.
44. The facts set forth in paragraphs F(d) and/or K.
45. The facts set forth in paragraphs F(d) and/or L.
46. The facts set forth in paragraphs F(d) and/or M.
47. The facts set forth in paragraphs F(d) and/or N.

48. The facts set forth in paragraphs F(d) and/or O.
49. The facts set forth in paragraphs F(d) and/or P.
50. The facts set forth in paragraphs F(d) and/or Q.
51. The facts set forth in paragraphs F(d) and/or R.
52. The facts set forth in paragraphs F(d) and/or S.
53. The facts set forth in paragraphs F(d) and/or T.
54. The facts set forth in paragraphs F(d) and/or U.
55. The facts set forth in paragraphs F(d) and/or V.
56. The facts set forth in paragraphs F(d) and/or W.
57. The facts set forth in paragraphs F(d) and/or X.
58. The facts set forth in paragraphs F(d) and/or Y.

FIFTY-NINTH SPECIFICATION

(FAILING TO MAKE REQUESTED DOCUMENTS AVAILABLE TO THE DEPARTMENT OF HEALTH)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(28) by failing to respond within 30 days to written communications from the Department of Health and to make available any relevant records with respect to an inquiry or complaint about the licensee's professional misconduct, as alleged in the following:

59. The facts set forth in paragraph E.

SIXTIETH THROUGH SEVENTY-EIGHTH SPECIFICATIONS

(PRACTICING THE PROFESSION BEYOND WATERTOWN SAMARITAN MEDICAL CENTER)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(2) by practicing the profession beyond its authorized scope, as alleged in the following:

60. The facts set forth in paragraphs A and/or B and/or C and/or D and/or G.
61. The facts set forth in paragraphs A and/or B and/or C and/or D and/or H.
62. The facts set forth in paragraphs A and/or B and/or C and/or D and/or I.
63. The facts set forth in paragraphs A and/or B and/or C and/or D and/or J.
64. The facts set forth in paragraphs A and/or B and/or C and/or D and/or K.
65. The facts set forth in paragraphs A and/or B and/or C and/or D and/or L.
66. The facts set forth in paragraphs A and/or B and/or C and/or D and/or M.
67. The facts set forth in paragraphs A and/or B and/or C and/or D and/or N.
68. The facts set forth in paragraphs A and/or B and/or C and/or D and/or O.
69. The facts set forth in paragraphs A and/or B and/or C and/or D and/or P.
70. The facts set forth in paragraphs A and/or B and/or C and/or D and/or Q.
71. The facts set forth in paragraphs A and/or B and/or C and/or D and/or R.
72. The facts set forth in paragraphs A and/or B and/or C and/or D and/or S.
73. The facts set forth in paragraphs A and/or B and/or C and/or D

- and/or T.
74. The facts set forth in paragraphs A and/or B and/or C and/or D and/or U.
 75. The facts set forth in paragraphs A and/or B and/or C and/or D and/or V.
 76. The facts set forth in paragraphs A and/or B and/or C and/or D and/or W.
 77. The facts set forth in paragraphs A and/or B and/or C and/or D and/or X.
 78. The facts set forth in paragraphs A and/or B and/or C and/or D and/or Y.

DATE:

January 14, 2008
Albany, New York

Redacted Signature

Peter D. Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct