



# 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*

September 18, 2001

## **CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

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**RE: In the Matter of Serafina Corsello, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 210) 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), 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.

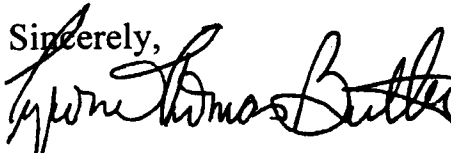
All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Administrative Law Judge  
New York State Department of Health  
Bureau of Adjudication  
Hedley Park Place  
433 River Street, Fifth Floor  
Troy, New York 12180

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

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

Sincerely,  
  
Tyrone T. Butler, Director  
Bureau of Adjudication

TTB:cah  
Enclosure

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

**IN THE MATTER  
OF  
SERAFINA CORSELLO, M.D.**

**DETERMINATION  
AND  
ORDER**

**BPMC 01 - 210**

**COPY**

**ALAN KOPMAN** (Chair), **SHARON C. H. MEAD, M.D.** and **RALPH LEVY, D.O.**, duly designated members of the State Board for Professional Medical Conduct ("SBPMC"), served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law ("P.H.L.").

**MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer ("ALJ").

The Department of Health ("Department") appeared by **TERRENCE J. SHEEHAN, ESQ.**, Associate Counsel.

**SERAFINA CORSELLO, M.D.**, ("Respondent") appeared personally and was represented by **THURM & HELLER, LLP**, by **KEVIN PORTER, ESQ.** of Counsel and by **SWANKIN & TURNER**, by **CHARLES G. BROWN, ESQ.**, of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the entire record, the Hearing Committee issues this Determination and Order in accordance with the Public Health Law and the Education Law of the State of New York.

## PROCEDURAL HISTORY

Unless otherwise noted, the following procedural history is set forth by the ALJ.

Date of Notice of Hearing:	August 23, 2000
Date of Statement of Charges:	August 23, 2000
Date of Answer to Charges:	None (see discussion)
Pre-Hearing Conference Held:	November 29, 2000 <sup>1</sup>
Service of Notice of Hearing and Statement of Charges:	November 22, 2000 [11/29/2001 - P.H.T-14-22] <sup>2</sup> .

On October 25, 2000, the ALJ scheduled a Pre-Hearing Conference for November 2, 2000.

The Pre-Hearing was held on that date but the Department did not properly serve Respondent and the ALJ ruled that the matter be closed due to lack of jurisdiction [11/2/2000 - P.H.T-1-36].

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<sup>1</sup> The first day of the Hearing had previously been scheduled for November 29, 2000 but was rescheduled for December 12, 2000. The November 29<sup>th</sup> date was kept as a Pre-Hearing date by the ALJ.

<sup>2</sup> Numbers in brackets refer to Hearing transcript page numbers [T- ]; to Pre-Hearing transcript page numbers [P.H.T- ] or to Intra-Hearing transcript page numbers [I.H.T- ]. The Hearing Committee did not review the Pre-Hearing transcripts, the Intra-Hearing transcripts or the ALJ Exhibits. The ALJ Exhibits are not evidence for the Hearing Committee to review but are made part of the record of the proceedings for purposes of complete review by the Courts if such review is necessary. Due to the substantial number of procedural correspondences, Pre-Hearing Conferences and Intra-Hearing Conferences held in this proceeding, the ALJ will also sign this Determination and Order. It is noted that both Mr. Brown and Mr. Porter have made numerous, substantial misrepresentations, inaccurate and misleading statements and false accusations to the Hearing Committee and to the ALJ in their arguments and submissions, including the proposed Findings of Fact and Conclusions of Law. In addition, Respondent's attorney, Mr. Porter, inappropriately submitted to the Hearing Committee documents which were specifically excluded from evidence by the ALJ. These documents were annexed to Respondent's proposed Findings of Fact and Conclusions of Law and were given to the Hearing Committee by the ALJ despite their inappropriateness. The Hearing Committee considered all submissions when it made its Determination and Order. The actions of the attorneys were not a factor held against Respondent when the Hearing Committee made its Determination and Order.

On November 24, 2000, the ALJ scheduled a Pre-Hearing Conference for November 29, 2000. At that Pre-Hearing, the ALJ ruled that Respondent was properly served, on November 22, 2000, and that the Board for Professional Medical Conduct had obtained jurisdiction over Respondent [P.H.T-14-21]. Respondent made numerous (at least 16) motions, in oral format at the Pre-Hearing and in written format subsequently, which were addressed by the ALJ in a decision dated December 8, 2000 (ALJ Exhibit # 11). One of the motions made by Respondent was a request to adjourn the scheduled Hearing date of December 12, 2000 to some date in January 2001. This request was denied by the Hearing Committee for failure to provide good cause for the granting of an adjournment. The ALJ also noted that the first two Hearing dates (November 29 and December 12, 2000) had previously been set by agreement between the prosecutor, one of Respondent's previous attorneys' and the Hearing Committee members who agreed to be available to serve on those two particular days (ALJ Exhibit # 11).

Kevin D. Porter of the firm of Thurm & Heller, LLP, submitted an affirmation supporting the motion of Charles G. Brown to be admitted *Pro hac vice* to represent Respondent at the New York State Health Department Administrative Hearing before the SBPMC. The ALJ granted said motion (ALJ Exhibits # 10 and 11); [11/29/2000 - P.H.T-13, 31-36].

At the Pre-Hearing of November 29, 2000, the ALJ requested that Respondent submit an answer to the Statement of Charges [P.H.T-121-125]. Respondent (through Mr. Brown) indicated that the answer would be submitted as requested by December 5, 2000 [P.H.T-122, 123]<sup>3</sup>. Respondent changed attorneys from Mr. Friedman to Mr. Brown (with Mr. Porter as New York advisor) on or about November 6, 2000 (ALJ Exhibit # 10); [11/2/2001 - P.H.T-21, 32-33]; [I.H.T-4].

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<sup>3</sup> At the November 2, 2001 Pre-Hearing Conference, where Respondent's counsels Mr. Wilfred T. Friedman and Mr. Charles G. Brown were present, Mr. Friedman indicated "Once she's served, the rules provide that she has to put an answer in within a certain period of time." [11/2/2001 - P.H.T-20-21].

On December 12, 2000 the Hearing Committee appeared for the scheduled Hearing and was informed by the ALJ that New York Supreme Court Justice Martin Shulman had issued an Order precluding the Hearing from going forward [T-1-4].

On March 22, 2001, the ALJ was informed that Justice Shulman had vacated the stay of the Hearing (ALJ Exhibit # 14). On March 27, 2001, the ALJ contacted the representatives of the parties and requested scheduling availability. Respondent refused to cooperate. The ALJ discussed scheduling dates with the Hearing Committee and on March 30, 2001 the ALJ informed the representatives of the parties that the first Hearing day was scheduled for April 16, 2001 and gave the dates for four additional scheduled Hearing days (ALJ Exhibit # 15).

Respondent made additional written motions which were addressed by the ALJ in a decision dated April 4, 2001 (ALJ Exhibit # 16). On April 10, 2001 Respondent made an "emergency motion to delay commencement of Hearing due to Respondent's medical condition"<sup>4</sup>. This motion was denied by the Hearing Committee on April 13, 2001 (ALJ Exhibit # 18).

On the April 16, 2001 Hearing day (the first actual Hearing day), Respondent did not personally appear but, through her representatives, Mr. Porter and Mr. Brown, renewed her request for an adjournment. The Hearing Committee heard Respondent's request and reviewed the documents submitted (Respondent's Exhibit # A)<sup>5</sup>.

Respondent's request was denied as indicated in the transcript [T-12-31]. The Hearing Committee, comprised of two physicians, was surprised that Dr. Fratellone, Respondent's alleged treating cardiologist, would not recommend immediate hospitalization for an individual who is

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<sup>4</sup> Respondent's alleged medical problems were known to Respondent and Respondent's counsel for a substantial period of time prior to April 10, 2001 (ALJ Exhibit # 18); [I.H.T-98-101].

<sup>5</sup> Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Serafina Corsello (Respondent's Exhibit #).

being treated for angina, diabetes, has increased blood pressure of 150/90, and is experiencing pain radiating to her left arm, especially given "the crescendo and the frequency of at rest angina" that the individual was experiencing. The Hearing Committee found Dr. Fratellone's conclusions simply not credible.

On April 16, 2001, after opening statements of the parties, the ALJ scheduled an Intra-Hearing Conference. During that Intra-Hearing, the ALJ ruled that Respondent had received ample notice and opportunity to submit an answer. The Notice of Hearing (Department's Exhibit # 1) at page 2 states:

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 and allegation not so answered shall be deemed admitted. (Underline in original)

The Public Health Law to which Respondent's counsel was repeatedly referred by the ALJ, clearly indicates that the failure to file a written answer will result in the charges and allegations being deemed admitted. Respondent's counsel was also reminded on November 29, 2000 to submit an answer [P.H.T-121-125]. The ALJ ruled that the law requiring an answer was enacted by the New York State Legislature in 1996<sup>6</sup>. The ALJ indicated that the only way he believed he could disregard the "shall" language of the law would be to rule that the law was unconstitutional, a power the ALJ does not possess [I.H.T-10-11, 41, 43, 72]. The ALJ ruled that he did not have the power to not abide by the law and had no discretion except to follow the language of P.H.L. §230(10)(c).

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<sup>6</sup> Chapter 627 of the Laws of 1996, §3, required the notice of hearing to state that the licensee shall, rather than may, file a written and verified, rather than written, answer to each of the charges and allegations in the statement of charges; and required such notice to also state that any charge and allegation not so answered shall be deemed admitted.

Therefore, due to the Respondent's failure to submit a written answer, the ALJ ruled that the factual allegations and charges of misconduct contained in the Statement of Charges (Department's Exhibit # 1) were deemed admitted by Respondent [4/16/2001 - I.H.T-1-75].

On April 16, 2001 at approximately 4:00 PM, Respondent obtained, from New York County Supreme Court, a stay of the scheduled April 16, 2001 Administrative Hearing (which had concluded at approximately 1:03 PM [T-62] and the subsequent intra-Hearing which had concluded at approximately 1:20 PM) [4/16/2001 - I.H.T-75]; (ALJ Exhibit # 24 - tab C) . On April 17, 2001 the Court-Ordered stay was vacated.

The next scheduled Hearing date of May 14, 2001 (the second scheduled Hearing day) was adjourned to May 30, 2001 by the ALJ, pursuant to a request by Respondent, due to a death in the family of Respondent's Counsel.

Respondent made additional motions requesting the ALJ to reconsider his ruling that P.H.L. §230(10)(c) controls the Respondent's failure to submit an answer (ALJ Exhibits # 24-28). These motions were denied by the ALJ because the ALJ does not have the discretion to disregard a statute which is specific, unambiguous, clear and controlling [I.H.T-121-123]. On May 30, 2001 the ALJ had an approximately one hour telephonic discussion with Justice Shulman regarding the administrative proceeding and an Order to Show Cause that was being presented to him by Respondent (ALJ Exhibit # 29); [I.H.T-78-133].

Justice Shulman did not sign the Order to Show Cause (ALJ Exhibit # 30); [I.H.T-111]. The May 30, 2001 Hearing (second actual Hearing day) proceeded [T-66-182].

Hearings Held: - (First Hearing day):

April 16, 2001;  
May 30, 2001;  
June 22, 2001;  
June 29, 2001



Intra-Hearing Conferences Held:

April 16, 2001  
May 30, 2001;  
June 22, 2001;  
June 29, 2001

Department's Proposed Findings of Fact,  
Proposed Conclusions of Law and  
Proposed Sanction:

None submitted [T-480]

Respondent's Proposed Findings of Fact,  
and Conclusions of Law

Received August 10, 2001 <sup>7</sup>

Department Exhibits admitted in evidence:  
(all of the Department's exhibits were admitted  
in evidence without objection from Respondent  
[11/29/2000 - P.H.T-21, 108-116, 120-121, 130-131].

1, 2, 2A, and 3 through 12

Respondent Exhibits admitted in evidence:  
(Respondent's exhibits E, F, G, H and I were  
admitted in evidence without objection from the  
Department [T-395, 421-424].

A, E, F, G, H, I

Witnesses called by the Department of Health:

NONE [T-55-60].

Witnesses called by Respondent, Serafina Corsello, M.D.:  
Serafina Corsello, M.D., Patient K.Y.,  
Patient L.B., Patient P.M.M. <sup>8</sup>

Deliberations Held:

August 16, 2001

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<sup>7</sup> Even though Respondent's submission contains numerous documents which were not admitted in evidence and are outside of the Hearing Committee record, the ALJ provided the entire document to the Hearing Committee.

<sup>8</sup> The full names of the witnesses are contained in an appendix to the June 29, 2001 Hearing transcript.

## STATEMENT OF CASE

This case was brought by the Department pursuant to §230 of the P.H.L.

SERAFINA CORSELLO, M.D., ("**Respondent**" or "**Dr. Corsello**") is charged with sixty nine (69) specifications of professional misconduct within the meaning of §§6530 (2), (3), (4), (5), (6), (11), (20), (21), (25), (30), (32), (33) and (35) of the Education Law of the State of New York ("**Education Law**") <sup>9</sup> including: (1) Gross Negligence; (2) Gross Incompetence; (3) Negligence on more than one occasion; (4) Incompetence on more than one occasion; (5) Fraudulent practice; (6) Unwarranted tests or treatment; (7) False report; (8) Improper delegation of professional responsibilities; (9) Failure to exercise appropriate supervision; (10) Abetting the unlicensed practice of medicine; (11) Abandoning a patient; (12) Moral unfitness; and (13) Failure to maintain records. The Charges involve Respondent's treatment of Patients A through H for a period of time between 1987 and 1999.

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct in the care and treatment of eight (8) patients <sup>10</sup>.

## FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing

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<sup>9</sup> A copy of the Notice of Hearing and the Statement of Charges is contained in Appendix 1. Starting at paragraph 52 of the Specifications (page 22 of the Statement of Charges), the paragraph numbers are incorrect. The last specification should read "Sixty-Second through Sixty-Ninth Specifications".

<sup>10</sup> All patients are identified in the Appendix annexed to the Statement of Charges (Department's Exhibit # 1).

Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was licensed to practice medicine in New York State on August 29, 1966 by the issuance of license number 096113 by the New York State Education Department (Department's Exhibit # 1); (admitted pursuant to P.H.L. §230{10}{c}).

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ); (Department's Exhibit # 1); [11/29/2000 - P.H.T-14-22].

3. In or about 1999, Respondent treated Patient A for asthma at Respondent's medical office. Respondent's treatment of Patient A deviated from accepted standards of medical practice in the following respects (paragraphs 3 through 11 inclusive): Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following: (a) Stress management profile; (b) Darkfield examination of blood; (c) RBC magnesium; (d) Estradiol; (e) Progesterone; (f) Testosterone; (g) Thyroid panel; (h) DHEA, DHEA sulfate; (i) Estrone; (j) ESR; (k) North East Rast Panel; (l) Allergy panel to Cockelbury, elm English Pantin, June, Maple leaf sycamore, oak, ragweed, timothy grass, ragweed, meadow fescue, rye, Alternaria, cat epithelium, and dog epithelium; (m) Candida antibody titers; (n) Antithyroid microsomal antibody; (o) Antithyroglobulin antibody; (p) Somatomedin; (q) Stool analysis; (r) Triglycerides; (s) Chymotrypsin; (t) LCEAs; (u) Cholesterol; (v) Total fecal fat; (w) Bacteria; (x) Candida; (y) G-

glucuronidase; (z) pH; (aa) Fecal immunoglobulin A; (bb) Glucose tolerance test; (cc) Insulin tolerance test (Department's Exhibits # 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

4. Respondent inappropriately and without legitimate medical purpose treated Patient A with intravenous infusion of unknown substances for unknown reasons (Department's Exhibits # 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

5. Respondent inappropriately and without legitimate medical purpose ordered the administration to Patient A of a behavior modification test or therapy (Department's Exhibits # 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

6. Respondent notified Patient A that Patient A would not be permitted to make any appointments to see Respondent unless and until Patient A took the behavior modification test or therapy. Respondent thereby conditionally abandoned Patient A (Department's Exhibits # 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

7. Respondent made the following diagnoses which were not medically justified: (a) mitral valve prolapse; (b) severe environmental allergies (Department's Exhibits # 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

8. The diagnoses listed in paragraph 7, supra, were not made in good faith or for a legitimate medical purpose (Department's Exhibits # 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

9. Patient A presented for treatment of asthma and a precipitous decline in respiratory function. Respondent improperly failed to attempt to contact Patient A's previous providers regarding their findings, therapies and the Patient's responses thereto. Respondent also improperly failed to adequately evaluate, treat and monitor Patient A's pulmonary status (Department's Exhibits

# 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

10. Respondent inappropriately permitted unqualified employee(s) to order tests, evaluate the Patient's history and symptoms and make diagnoses (Department's Exhibits # 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

11. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records (Department's Exhibits # 1, 2, 2A and 12); (admitted pursuant to P.H.L. §230{10}{c}).

12. In or about 1997 and 1998, Respondent treated Patient B at Respondent's private office. Respondent's care of Patient B departed from accepted standards of medical practice in the following respects (paragraphs 12 through 20 inclusive): Respondent failed to perform and note an adequate physical examination (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

13. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following: (a) two testosterone tests; (b) dehydrotestosterone; (c) two DHEA tests; (d) two DHEA-sulfate tests; (e) lymphocyte panel; (f) viral tests; (g) Candida tests; (h) RBC magnesium; (i) immunoglobulin levels; (j) Candida and pollen RAST profile; (k) ACTH stimulation test; (l) antithyroglobulin antibodies; (m) Darkfield examination of blood (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

14. Respondent made the following diagnoses which were not medically justified: (a) intestinal dysbiosis; (b) adrenal and thyroid insufficiency; (c) viral load; (d) multiple delayed food sensitivities; (e) hypersomnia; (f) sluggish immune system (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

15. The diagnoses listed in paragraph 14, supra, were not made in good faith or for a legitimate medical purpose (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

16. Respondent inappropriately and without legitimate medical purpose administered or ordered the administration of approximately 12 sessions of parenteral treatments containing "AOD with DC4" (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

17. Respondent inappropriately ordered the following treatments: (a) Synthroid; (b) BioPro; (c) Probiotics (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

18. Respondent failed to adequately follow-up the following complaints or findings: (a) Patient B's complaint of five bowel movements a day and weight loss of 20 pounds; (b) Patient B's complaint of "raging penile problems" and history of gonorrhea and a penile discharge. A urethral smear was indicated but not ordered by Respondent; (c) a finding of E-Coli being cultured from the Patient's throat (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

19. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

20. Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records (Department's Exhibits # 1, 3 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

21. In or about 1996, Respondent treated Patient C at her office. Patient C had been diagnosed elsewhere with breast cancer with one positive axillary node. Respondent's care of Patient C deviated from accepted standards of medical practice in the following respects (paragraphs

21 through 27 inclusive) (Department's Exhibits # 1, 4 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

22. Respondent inappropriately failed to recommend or even discuss with Patient C chemotherapy and/or radiation, the standard treatments for this condition (Department's Exhibits # 1, 4 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

23. Respondent improperly failed to coordinate her care of Patient C with the Patient's surgeon or oncologist (Department's Exhibits # 1, 4 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

24. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following: (a) Darkfield examination of blood; (b) Heidelberg gastrogram; (c) chemistry panel; (d) lipid fractionation; (e) RBC magnesium; (f) progesterone, testosterone and Estradiol levels; (g) thyroid function panel; (h) hepatitis antibody panel; (i) viral titers to: Epstein-Barr, cytomegalo virus, herpes simplex and herpes virus 6; (j) anti-Candida titers; (k) antinuclear antibody; (l) immunoglobulin levels; (m) hair analysis; (n) serum levels of various vitamins (Department's Exhibits # 1, 4 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

25. Respondent inappropriately and without legitimate medical purpose treated Patient C's breast cancer with nutritional supplements, antioxidants and/or Costrosyn (Department's Exhibits # 1, 4 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

26. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses (Department's Exhibits # 1, 4 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

27. Respondent failed to maintain a record for Patient C which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan,

rationales for tests, accurate interpretation of tests and insurance and billing records (Department's Exhibits # 1, 4 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

28. In or about 1995, Respondent treated Patient D for hypercholesterolemia. Respondent's treatment of Patient D deviated from accepted standards of medical practice in the following aspects (paragraphs 28 through 36 inclusive) (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

29. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following: (a) two hair analysis tests; (b) gastric acid analysis; (c) immunoglobulin level to foods; (d) oral glucose tolerance test with insulin levels; (e) two Darkfield examinations of blood; (f) RBC magnesium and total T3/TSH; (g) ACTH stimulation test, hepatitis antibody profile, DHEA/DHEA Sulfate; (h) vital titers to Epstein-Barr virus, cytomegalo virus and herpes simplex virus 1, 2, & 6; (i) anti-Candida titers; (j) Total IgE; (k) creatinine and creatinine tolerance; (l) Electrocardiogram without interpretation dated 6/13/95 (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

30. Patient D was taking Questran and niacin for his hypercholesterolemia-induced atherosclerosis. Respondent inappropriately caused Patient D to discontinue Questran (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

31. Respondent inappropriately and without legitimate medical purpose treated Patient D's premature coronary heart disease and hypercholesterolemia with IV infusions of vitamins and other substances (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

32. Respondent inappropriately and without legitimate purpose treated Patient D's premature coronary heart disease and hypercholesterolemia with Chelation with "MgIVP and M/C" (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).



33. While under Respondent's care, Patient D's lipid levels increased dramatically. At that time Respondent should have referred Patient D to a consultant with expertise in managing lipid disorders. Respondent improperly failed to do so (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

34. Respondent improperly billed Patient D for a "electromyogram" which she knew had not been performed or interpreted (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

35. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

36. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records (Department's Exhibits # 1, 5 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

37. In or about 1994, Respondent treated Patient E for epilepsy. Respondent's care of Patient E deviated from accepted standards of medical practice in the following respects (paragraphs 37 through 44 inclusive): Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following: (a) Betacarotene, RBC zinc, vitamin A, RBC vitamin B1, B2 & B6, serum vitamin B12, C, E & D fractions; (b) lipid fractionation; (c) ANA; (d) Candida antibodies; (e) RBC magnesium; (f) progesterone; (g) testosterone; (h) Estradiol; (i) T3, T4, TSH & total T3; (j) RBC Mg; (k) food IgG sensitivity; (l) 10 CBC, chem 24 panel and valproic acid level tests; (m) 4 CBC, SMA24 panel, valproic acid level tests; (n) stool culture, ova & parasites; (o) Cortrosyn stimulation test; (p) antiadrenal antibody; (q) DHEA; (r) DHEA Sulfate;

(s) Interluken 2 (Department's Exhibits # 1, 6, 10 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

38. Respondent inappropriately and without legitimate medical purpose treated Patient E's epilepsy with a "therapeutic cocktail" containing: Micel-E, Aqua Tene-A, AALzinc, Balmix, magnesium, chloride, Milk Thistle, Liver, Liquesence, Bioflavonoid liquified, Ester C Max and Yeast relief (Department's Exhibits # 1, 6, 10 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

39. Respondent inappropriately failed to consider and prevent the "therapeutic cocktail" from interfering with the absorption and elimination of the drugs Patient E was taking for her epilepsy. In fact, the cocktail did disturb the proper levels of those epilepsy drugs (Department's Exhibits # 1, 6, 10 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

40. Respondent improperly failed to coordinate, in a timely fashion, her treatment of the patient's epilepsy with the patient's neurologist, Linda Lewis, M.D. (Department's Exhibits # 1, 6, 10 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

41. Patient E complained of rectal bleeding, low appetite and change in weight. Respondent improperly failed to follow-up these complaints. A rectal exam and GI evaluation were indicated but not undertaken by Respondent (Department's Exhibits # 1, 6, 10 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

42. The complaints of headache and depression were also improperly overlooked by the Respondent. The headaches may have been related to the epilepsy or other central nervous system pathology and required investigation (Department's Exhibits # 1, 6, 10 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

43. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses (Department's Exhibits # 1, 6, 10 and 12);

(admitted pursuant to P.H.L. §230{10}{c}).

44. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records (Department's Exhibits # 1, 6, 10 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

45. In or about 1987 and 1988 Respondent treated Patient F for ASHD and CABG. Respondent's care of Patient F deviated from accepted standards of medical practice in the following respects (paragraphs 45 through 52 inclusive): Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following: (a) MMPI Inventory; (b) gastric pH measurement; (b) two Hb A/c and glucose tests; (c) four urine and serum Creatinine tests; (d) Anti-Candida and EBV titers; (e) lymphocyte fractionation; (f) immunoglobulin level and autoantibody panel; (g) Thyroid panel and RBC magnesium; (h) two 24-hour urine for lead tests; (i) three cortisol levels; (j) 24-hour urine for calcium, chloride, protein, sodium and potassium; (k) 24-hour urine for Creatinine (Department's Exhibits # 1, 7 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

46. Respondent inappropriately and without legitimate medical reason ordered numerous sessions of intravenous chelation as treatment of Patient F's heart disease (Department's Exhibits # 1, 7 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

47. Respondent made a diagnosis of lead toxicity which was not indicated (Department's Exhibits # 1, 7 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

48. Respondent falsely, and with intent to deceive, notified Patient F's insurance carrier that the patient suffered from lead toxicity (Department's Exhibits # 1, 7 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

49. Respondent's diagnosis of lead toxicity was made not in good faith and without legitimate medical purpose (Department's Exhibits # 1, 7 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

50. Respondent falsely, and with intent to deceive, represented to Patient F's insurance carrier that the patient manifested chronic fatigue and weakness (Department's Exhibits # 1, 7 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

51. Respondent inappropriately permitted unqualified employees to order tests, evaluate the patient's history and symptoms and make diagnoses (Department's Exhibits # 1, 7 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

52. Respondent failed to maintain a record for Patient F which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests accurate interpretation of tests and insurance and billing records (Department's Exhibits # 1, 7 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

53. In or about 1987, 1988 and 1989, Respondent treated Patient G for various conditions. Respondent's care of Patient G deviated from accepted standards of medical practice in the following respects (paragraphs 53 through 59 inclusive): Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following: (a) MMPI; (b) Anti-Candida antibody; (c) Antithyroglobulin and antimicrosomal antibody; (d) 24-hour urine for lead; (e) Lymphocyte fractionation; (f) Immunoglobulin level and antibody level to: mitochondria, smooth muscle, parietal cell, reticular, ribosomal, Bruch border, canalicular and basement membrane and Epstein-Barr virus; (g) Cortrosyn stimulation and DHEA; (h) three Anti-Candida antibodies tests; (i) DHEA, antioxoplasma antibody, LYM ELISA, SMA, ferritin and DHEA sulfate; (j) Cortrosyn stimulation test; (k) Urine for cadmium, aluminum, copper, mercury,

and nickel; (l) ANA; (m) Antimicrobial and antithyroglobulin antibody, thyroid profile and DHEA/DHEA sulfate; (n) two presumed stool for O&P, crypto and giardia fluorescence, and yeast stain; (o) two hair analysis tests; (p) Heidelberg pH gastrogram; (q) numerous creatinine clearance tests; (r) numerous thyroid profiles (Department's Exhibits # 1, 8 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

54. Respondent inappropriately and without legitimate medical purpose ordered numerous sessions of intravenous chelation (Department's Exhibits # 1, 8 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

55. Respondent made the following diagnoses which were not medically justified: (a) lead toxicity; (b) electrolyte imbalance; (c) candidiasis; (d) hypomagnesemia (Department's Exhibits # 1, 8 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

56. The diagnoses listed in paragraph 55, supra, were not made in good faith or for a legitimate medical purpose (Department's Exhibits # 1, 8 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

57. Respondent inappropriately ordered the following treatments: (a) Synthroid; (b) Cytomel (Department's Exhibits # 1, 8 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

58. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses (Department's Exhibits # 1, 8 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

59. Respondent failed to maintain a record for Patient G which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records (Department's Exhibits # 1, 8 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

60. On of about 7/27/95 and 10/2/95, Respondent saw Patient H for management of secondary amenorrhea. Respondent's care of Patient H deviated from accepted standards of medical practice in the following respects (paragraphs 60 through 62 inclusive): Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following: (a) Darkfield examination of blood; (b) Heidelberg gastrogram; (c) cholesterol fractionation; (d) thyroid function tests; (e) Candida antibody titers; (f) immunoglobulin levels; (g) RBC magnesium level; (h) antinuclear antibody; (i) ANA (Department's Exhibits # 1, 9 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

61. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses (Department's Exhibits # 1, 9 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

62. Respondent failed to maintain a record for Patient H which accurately reflects the evaluation and treatment she provided including patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records (Department's Exhibits # 1, 9 and 12); (admitted pursuant to P.H.L. §230{10}{c}).

### **CONCLUSIONS OF LAW**

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions as to the allegations contained in the Statement of Charges were by a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that all of the following Factual Allegations, in the August 23, 2000 Statement of Charges are **SUSTAINED**.

Based on the entire record, the Findings of Fact, and the Discussion that follows, the Hearing Committee unanimously concludes that all of the sixty-nine (69) Specifications of Charges of misconduct contained in the Statement of Charges are **SUSTAINED**.

The rationale for the Hearing Committee's conclusions is set forth below.

### **DISCUSSION**

Respondent, by virtue of P.H.L. §230(10)(c), admitted the allegations and charges filed against her by the Department. The Hearing Committee then heard evidence from Respondent regarding the appropriate penalty, if any, which should be assessed on Respondent's license to practice medicine in the State of New York. The Hearing Committee even allowed Respondent to present substantial details as to Patient A and substantial testimony which was irrelevant to the issue of penalty.

The undeniable fact is that Respondent admitted her guilt by virtue of failing to submit an answer as required by the Public Health Law and the Hearing Committee's sole responsibility became one of determining the appropriate penalty, if any, to assess.

With the above understanding, The Hearing Committee concludes by a unanimous vote that Respondent committed significant professional misconduct under the laws of New York State (Department's Exhibits # 1 through 10 and #12 and Respondent's admission of the allegations and charges by operation of P.H.L. §230{10}{c}).

Respondent is guilty of: (a) committing professional misconduct by practicing the profession of medicine with gross negligence in the care and treatment of eight (8) patients; and (b) committing professional misconduct by practicing the profession of medicine with gross

incompetence in the care and treatment of eight (8) patients; and (c) committing professional misconduct by practicing the profession of medicine with negligence on more than one occasion in the care and treatment of eight (8) patients; and (d) committing professional misconduct by practicing the profession of medicine with incompetence on more than one occasion in the care and treatment of eight (8) patients; and (e) committing professional misconduct by practicing the profession of medicine fraudulently in the care and treatment of eight (8) patients; and (f) committing professional misconduct in the practice of the profession of medicine by ordering excessive tests or treatment not warranted by the condition of eight (8) patients; and (g) committing professional misconduct in the practice of the profession of medicine by wilfully making or filing a false report in the care and treatment of one (1) patient (Patient F); and (h) committing professional misconduct in the practice of the profession of medicine by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure to perform them in the care and treatment that Respondent provided to eight (8) patients; and (i) committing professional misconduct in the practice of the profession of medicine by failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensee in the care and treatment of eight (8) patients; and (j) committing professional misconduct in the practicing of the profession of medicine by permitting, aiding or abetting an unlicensed person to perform activities requiring a license in the care and treatment of eight (8) patients; and (k) committing professional misconduct in the practicing of the profession by abandoning a patient (Patient A) under and in need of immediate professional care without making reasonable arrangements for the continuance of such care; and (l) committing professional misconduct in the practicing of the profession of medicine by engaging in conduct that evidences moral unfitness to practice the profession in the care and treatment of eight (8) patients.



## **DETERMINATION AS TO PENALTY**

The Hearing Committee unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

The numerous acts of misconduct committed by Respondent are of such magnitude and severity that no penalty other than revocation would be appropriate.

The Hearing Committee was disappointed that Respondent's counsel failed to submit an answer as required by the Public Health Law. We would have preferred to hear from witnesses for both sides', however we understand, and are bound by the Public Health Law and the ALJ's ruling. We must admit that the testimony that we did hear from Respondent was extremely troubling, especially from a medical quality of care standpoint. Respondent's testimony was more harmful to her case than helpful. Had Respondent not failed to submit an answer, the Department needed no other witness but Respondent and the report of the Department's expert to prove its case (Department's Exhibit # 12 [admitted in evidence without objection]). As much as Respondent claimed not to be a primary care physician, that is not the perspective apparent to her patients or to the Hearing Committee.

Once the allegations and the charges were deemed admitted by the ALJ in accordance with the Public Health Law, our function became one of determining the appropriate penalty, if any, to be assessed against Respondent. The ALJ gave Respondent considerable latitude in explaining

her philosophy and approach to care and treatment of patients. Although Respondent was requested to present general examples in presenting to the Hearing Committee the way Respondent practices, she insisted on attempting to re-litigate each patient. Respondent explained which tests she considered necessary and why and her philosophy as to the care she and her office staff rendered to patients. After a thorough explanation by Respondent of the care and treatment of Patient A, the Hearing Committee and the ALJ insisted that Respondent give only general information or address the issue of penalty.

There are certain basic principles and fundamentals in the practice of medicine. Each licensed New York State physician must meet certain minimum standards. Each licensed New York State physician who undertakes the care and treatment of an individual must provide safe treatment in compliance with minimally accepted standards of medical practice. These minimum standards must be followed regardless of the licensed physician's specialty or calling. For Respondent to argue that as an alternative <sup>11</sup> care physician she is not subject to the minimum standards of other physicians is unacceptable. Respondent's representation that she is a medical doctor, licensed and registered in New York State, obligates her to practice medicine within the appropriate medical standard of care which apply to all physicians.

Respondent's argument that an alternative care physician should be on the Hearing Committee or should have provided a report to the Hearing Committee shows a failure to understand that all physicians must meet certain minimum standards of care; it was not necessary to have an alternative care physician review Respondent's conduct to understand the fact that Respondent failed to meet those minimum standards in the care and treatment that she provided to Patients A through H. Respondent also failed to understand that non-alternative care physicians ("orthodox physicians") need to be aware of the effects of alternative medicine particularly in the peri-operative period of a patient. That awareness requires orthodox physicians to take a thorough history of

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<sup>11</sup> The Hearing Committee will use the words "alternative medicine" with the understanding that the term includes "complementary medicine" and/or "non-conventional medicine".

alternative medical products being used by the patient.

On occasions, Respondent appeared to argue that some of the treatment and tests that she used were in the nature of research and evaluation of the efficacy of the treatment or tests. If that was Respondent's plan, then Respondent was obligated to maintain records to that effect and document her plan for each patient. It is also questionable whether Respondent can charge the patient for her research. Respondent's statements on this issue were simply not supported by the medical records that she maintained for these eight (8) patients.

Given the serious nature of the professional misconduct committed by Respondent, censure and reprimand and performing community service is inadequate. Although Respondent was found guilty of fraud, insufficient evidence is present to assess a monetary fine and the Hearing Committee determines that the revocation of her license is a sufficiently severe financial penalty. The nature and the severity of the misconduct were of such magnitude and occurrences that a suspension of Respondent's license would not serve to protect the public. The potential to return Respondent to active practice of medicine by retraining or rehabilitation of Respondent is unrealistic. Respondent acknowledged that she has been practicing this way for twenty (20) years. Respondent further indicated that she sees nothing wrong with her practice. Respondent's lack of insight and understanding of her acts and omissions rules out rehabilitation. We perceived no possibility of rehabilitation or successful retraining.

The Hearing Committee listened to and entertained the mitigating circumstances and evidence presented by Respondent, but the misconduct committed by Respondent was of such magnitude that anything short of revocation was unrealistic.

Although the above factors were considered as possible mitigation in arriving at an appropriate penalty determination, the aggravating circumstances present in the sustained charges greatly surpass the mitigation presented.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines the above to be the appropriate sanction under the circumstances. The Hearing Committee concludes that the sanction imposed strikes the appropriate balance between the need to punish Respondent, deter future misconduct, and protect the public.

The Hearing Committee considers Respondent's misconduct to be very serious. No other available sanction is deemed sufficient to address Respondent's gross negligence, gross incompetence, negligence on numerous occasions, incompetence on more than one occasion, fraudulent practice, ordering excessive tests and providing unnecessary treatment, filing a false report, improper delegation of professional responsibilities, failures to exercise appropriate supervision, abetting the unlicensed practice of medicine, abandoning a patient, lack of moral fitness and lack of medical record keeping.

Given the fact that Respondent, by virtue of P.H.L. §230(10)(c), admitted the allegations and charges filed against her by the Department. The Hearing Committee's assessment of the evidence presented by Respondent can only lead to the above conclusion that revocation is the appropriate penalty which should be assessed on Respondent's license to practice medicine in the State of New York.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, by the Chair, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding and are unanimous in their Determination.

## ORDER


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

1. The FIRST through SIXTY-NINTH Specifications of professional misconduct from the Statement of Charges (Department's Exhibit # 1) are **SUSTAINED**, and;
2. Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and
3. This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: New York, New York  
September 17, 2001



**MARC P. ZYLBERBERG, ESQ.**  
Administrative Law Judge



**ALAN KOPMAN (Chair),**  
**SHARON C. H. MEAD, M.D.**  
**RALPH LEVY, D.O.**

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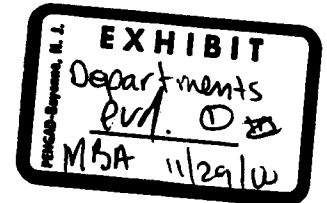
# APPENDIX I

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

IN THE MATTER  
OF  
SERAFINA CORSELLO, M.D.

NOTICE  
OF  
HEARING

TO: SERAFINA CORSELLO, M.D.  
200 West 57<sup>th</sup> Street  
New York, New York 10019



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 2000) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 2000). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on December 12, 2000, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the 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.

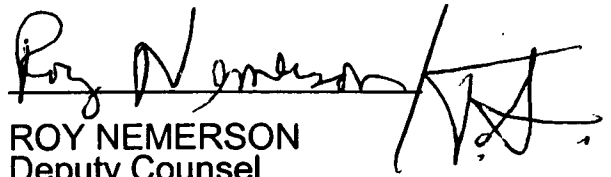
Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to 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 (McKinney Supp. 2000) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A

DETERMINATION THAT YOUR LICENSE TO PRACTICE  
MEDICINE IN NEW YORK STATE BE REVOKED OR  
SUSPENDED, AND/OR THAT YOU BE FINED OR  
SUBJECT TO OTHER SANCTIONS SET OUT IN NEW  
YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp.  
2000). YOU ARE URGED TO OBTAIN AN ATTORNEY TO  
REPRESENT YOU IN THIS MATTER.

DATED: New York, New York  
August 23, 2000

  
ROY NEMERSON  
Deputy Counsel  
Bureau of Professional  
Medical Conduct

Inquiries should be directed to: TERRENCE J. SHEEHAN  
Associate Counsel  
Bureau of Professional  
Medical Conduct  
5 Penn Plaza, Suite 601  
New York, New York 10001  
(212) 268-6816

## SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

---

Licensee's Name \_\_\_\_\_ Date of Proceeding \_\_\_\_\_

Name of person to be admitted \_\_\_\_\_

Status of person to be admitted \_\_\_\_\_  
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

Signature (of licensee or licensee's attorney) \_\_\_\_\_

---

This written notice must be sent to either:

New York State Health Department  
Bureau of Adjudication  
Hedley Park Place  
433 River Street, Fifth Floor South  
Troy, NY 12180  
Fax: 518-402-0751

New York State Health Department  
Bureau of Professional Medical Conduct  
5 Penn Plaza  
New York, NY 10001  
Fax: 212-613-2611

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

**IN THE MATTER  
OF  
SERAFINA CORSELLO, M.D.**

**STATEMENT  
OF  
CHARGES**

SERAFINA CORSELLO, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 29, 1966, by the issuance of license number 096113 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. In or about 1999, Respondent treated Patient A for asthma at Respondent's medical office. (The names of the patients are contained in the attached Appendix). Respondent's treatment of Patient A deviated from accepted standards of medical practice in the following respects:
1. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following:
    - a. Stress management profile
    - b. Darkfield examination of blood
    - c. RBC magnesium
    - d. Estradiol
    - e. Progesterone
    - f. Testosterone
    - g. Thyroid panel
    - h. DHEA, DHEA sulfate
    - i. Estrone

- j. ESR
- k. North East Rast Panel
- l. Allergy panel to Cockelbury, elm English Pantin, June,  
Maple leaf sycamore, oak, ragweed, timothy grass,  
ragweed, meadow fescue, rye, Alternaria, cat  
epithelium, and dog epithelium
- m. Candida antibody titer
- n. Antithyroid microsomal antibody
- o. Antithyroglobulin antibody
- p. Somatomedin
- q. Stool analysis
- r. Triglycerides
- s. Chymotrypsin
- t. LCEAs
- u. Cholesterol
- v. Total fecal fat
- w. Bacteria
- x. Candida
- y. G-glucuronidase
- z. pH
- aa. Fecal immunoglobulin A
- bb. Glucose tolerance test
- cc. Insulin tolerance test

- 2. Respondent inappropriately and without legitimate medical purpose  
treated Patient A with intravenous infusion of unknown substances for  
unknown reasons.

3. Respondent inappropriately and without legitimate medical purpose ordered the administration to Patient A of a behavior modification test or therapy.
4. Respondent notified Patient A that Patient A would not be permitted to make any appointments to see Respondent unless and until Patient A took the behavior modification test or therapy. Respondent thereby conditionally abandoned Patient A.
5. Respondent made the following diagnoses which were not medically justified:
  - a. mitral valve prolapse
  - b. severe environmental allergies
6. The diagnoses listed in paragraph A(5), supra, were not made in good faith or for a legitimate medical purpose.
7. Patient A presented for treatment of asthma and a precipitous decline in respiratory function. Respondent improperly failed to attempt to contact Patient A's previous providers regarding their findings, therapies and the Patient's responses thereto. Respondent also improperly failed to adequately evaluate, treat and monitor Patient A's pulmonary status.
8. Respondent inappropriately permitted unqualified employee(s) to

order tests, evaluate the Patient's history and symptoms and make diagnoses.

9. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records.

B. In or about 1997 and 1998, Respondent treated Patient B at Respondent's private office. Respondent's care of Patient B departed from accepted standards of medical practice in the following respects:

1. Respondent failed to perform and note an adequate physical examination.
2. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following:
  - a. two testosterone tests
  - b. dehydrotestosterone
  - c. two DHEA tests
  - d. two DHEA-sulphate tests
  - e. lymphocyte panel
  - f. viral tests
  - g. candida tests
  - h. rbc magnesium
  - i. immunoglobulin levels

- j. candida and pollen RAST profile
- k. ACTH stimulation test
- l. antithyroglobulin antibodies
- m. Darkfield examination of blood

3. Respondent made the following diagnoses which were not medically justified:

- a. intestinal dysbiosis
- b. adrenal and thyroid insufficiency
- c. viral load
- d. multiple delayed food sensitivities
- e. hypersomnia
- f. sluggish immune system

4. The diagnoses listed in paragraph B(3), supra, were not made in good faith or for a legitimate medical purpose.

5. Respondent inappropriately and without legitimate medical purpose administered or ordered the administration of approximately 12 sessions of parenteral treatments containing "AOD with DC4".

6. Respondent inappropriately ordered the following treatments:

- a. Synthroid
- b. BioPro
- c. Probiotics



7. Respondent failed to adequately follow-up the following complaints or findings:
    - a. Patient B's complaint of five bowel movements a day and weight loss of 20 pounds.
    - b. Patient B's complaint of "raging penile problems" and history of gonorrhea and a penile discharge. A urethral smear was indicated but not ordered by Respondent.
    - c. A finding of E-Coli being cultured from the Patient's throat.
  8. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses.
  9. Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records.
- C. In or about 1996, Respondent treated Patient C at her office. Patient C had been diagnosed elsewhere with breast cancer with one positive axillary node. Respondent's care of Patient C deviated from accepted standards of medical practice in the following respects:

1. Respondent inappropriately failed to recommend or even discuss with Patient C chemotherapy and/or radiation, the standard treatments for this condition.
2. Respondent improperly failed to coordinate her care of Patient C with the Patient's surgeon or oncologist.
3. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following:
  - a. Darkfield examination of blood
  - b. Heidelberg gastrogram
  - c. chemistry panel
  - d. lipid fractionation
  - e. rbc magnesium
  - f. progesterone, testosterone and estradiol levels
  - g. thyroid function panel
  - h. hepatitis antibody panel
  - i. viral titers to: Epstein-Barr, cytomegalo virus, herpes simplex and herpes virus 6
  - j. anticandida titers
  - k. antinuclear antibody
  - l. immunoglobulin levels
  - m. hair analysis
  - n. serum levels of various vitamins

4. Respondent inappropriately and without legitimate medical purpose treated Patient C's breast cancer with nutritional supplements, antioxidants and/or costrosyn.
5. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses.
6. Respondent failed to maintain a record for Patient C which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records.

D. In or about 1995, Respondent treated Patient D for hypercholesterolemia. Respondent's treatment of Patient D deviated from accepted standards of medical practice in the following respects:

1. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following:
  - a. two hair analysis tests
  - b. gastric acid analysis
  - c. immunoglobulin level to foods
  - d. oral glucose tolerance test with insulin levels
  - e. two Darkfield examinations of blood
  - f. Rbc magnesium and total T3/TSH
  - g. ACTH stimulation test, hepatitis antibody profile,

### DHEA/DHEA Sulfate

- h. vital titers to Epstein-Barr virus, cytomegalo virus and herpes simplex virus 1, 2, & 6
  - i. anticandida tier
  - j. Total IgE
  - k. creatinine and creatinine tolerance
  - l. Electrocardiogram without interpretation dated 6/13/95.
- 
- 2. Patient D was taking Questran and niacin for his hypercholesterolemia-induced atherosclerosis. Respondent inappropriately caused Patient D to discontinue Questran.
  - 3. Respondent inappropriately and without legitimate medical purpose treated Patient D's premature coronary heart disease and hypercholesterolemia with IV infusions of vitamins and other substances.
  - 4. Respondent inappropriately and without legitimate purpose treated Patient D's premature coronary heart disease and hypercholesterolemia with chelation with "MgIVP and M/C".
  - 5. While under Respondent's care, Patient D's lipid levels increased dramatically. At that time Respondent should have referred Patient D to a consultant with expertise in managing lipid disorders. Respondent improperly failed to do so.
  - 6. Respondent improperly billed Patient D for a "electromyogram"

which she knew had not been performed or interpreted.

7. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses.
8. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records.

E. In or about 1994, Respondent treated Patient E for epilepsy. Respondent's care of Patient E deviated from accepted standards of medical practice in the following respects:

1. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following:
  - a. Betacarotene, rbc zinc, vitamin A, rbc vitamin B1, B2 & B6, serum vitamin B12, C, E & D fractions.
  - b. lipid fractionation
  - c. ANA
  - d. candida antibodies
  - e. rbc magnesium
  - f. progesterone
  - g. testosterone
  - h. estradiol

- i. T3, T4, TSH & total T3
  - j. rbc Mg
  - k. food IgG sensitivity
  - l. 10 cbc, chem 24 panel and valproic acid level tests
  - m. 4 cbc, sma24 panel, valproic acid level tests
  - n. stool culture, ova & parasites
  - o. Cortrosyn stimulation test
  - p. antiadrenal antibody
  - q. DHEA
  - r. DHEA sulfate
  - s. Interluken 2
2. Respondent inappropriately and without legitimate medical purpose treated Patient E's epilepsy with a "therapeutic cocktail" containing: Micel-E, Aqua Tene-A, AALzinc, Balmix, magnesium, chloride, Milk Thistle, Liver, Liquescence, Bioflavonoid liquified, Ester C Max and Yeast relief.
3. Respondent inappropriately failed to consider and prevent the "therapeutic cocktail" from interfering with the absorption and elimination of the drugs Patient E was taking for her epilepsy. In fact, the cocktail did disturb the proper levels of those epilepsy drugs.
4. Respondent improperly failed to coordinate, in a timely fashion, her treatment of the patient's epilepsy with the patient's neurologist, Linda Lewis, M.D.

5. Patient E complained of rectal bleeding, low appetite and change in weight. Respondent improperly failed to follow-up these complaints. A rectal exam and GI evaluation were indicated but not undertaken by Respondent.
  6. The complaints of headache and depression were also improperly overlooked by Respondent. The headaches may have been related to the epilepsy or other central nervous system pathology and required investigation.
  7. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses.
  8. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records
- F. In or about 1987 and 1988 Respondent treated Patient F for ASHD and CABG. Respondent's care of Patient F deviated from accepted standards of medical practice in the following respects:
1. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following:
    - a. MMPI Inventory

- b. gastric pH measurement
  - c. two Hb A/c and glucose tests
  - d. four urine and serum Creatinine tests
  - e. Anticandida anti and EBV titers
  - f. lymphocyte fractionation
  - g. immunoglobulin level and autoantibody panel
  - h. Thyroid panel and rbc magnesium
  - i. two 24-hour urine for lead tests
  - j. three cortisol levels
  - k. 24-hour urine for calcium, chloride, protein, sodium and potassium
  - l. 24-hour urine for creatinine
- 2. Respondent inappropriately and without legitimate medical reason ordered numerous sessions of intravenous chelation as treatment of Patient F's heart disease.
  - 3. Respondent made a diagnosis of lead toxicity which was not indicated.
  - 4. Respondent falsely, and with intent to deceive, notified Patient F's insurance carrier that the patient suffered from lead toxicity.
  - 5. Respondent's diagnosis of lead toxicity was made not in good faith and without legitimate medical purpose.
  - 6. Respondent falsely, and with intent to deceive, represented to Patient



F's insurance carrier that the patient manifested chronic fatigue and weakness.

7. Respondent inappropriately permitted unqualified employees to order tests, evaluate the patient's history and symptoms and make diagnoses.
8. Respondent failed to maintain a record for Patient F which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records.

G. In or about 1987, 1988 and 1989, Respondent treated Patient G for various conditions. Respondent's care of Patient G deviated from accepted standards of medical practice in the following respects:

1. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following:
  - a. MMPI
  - b. Anticandida antibody
  - c. Antithyroglobulin and antimicrosomal antibody
  - d. 24-hour urine for lead
  - e. Lymphocyte fractionation
  - f. Immunoglobulin level and antibody level to:  
mitochondria, smooth muscle, parietal cell, reticular,  
ribosomal, brush border, canalicular and basement

- membrane and Epstein-Barr virus
  - g. Cortrosyn stimulation and DHEA on
  - h. three Anticandida antibodies tests
  - i. DHEA, antioxoplasma antibody, LYM ELISA, SMA, ferritin and DHEA sulfate
  - j. Cortrosyn stimulation test
  - k. Urine for cadmium, aluminum, copper, mercury, and nickel
  - l. ANA
  - m. Antimicrobial and antithyroglobulin antibody, thyroid profile and DHEA/DHEA sulfate
  - n. two presumed stool for O&P, crypto and giardia fluorescence, and yeast stain
  - o. two hair analysis tests
  - p. Heidelberg pH gastrogram
  - q. numerous creatinine clearance tests
  - r. numerous thyroid profiles.
2. Respondent inappropriately and without legitimate medical purpose ordered numerous sessions of intravenous chelation.
3. Respondent made the following diagnoses which were not medically justified:
- a. Lead toxicity
  - b. electrolyte imbalance
  - c. candidiasis
  - d. hypomagnesemia

4. The diagnoses listed in paragraph G(3), supra, were not made in good faith or for a legitimate medical purpose.
  5. Respondent inappropriately ordered the following treatments:
    - a. Synthroid
    - b. cytomel
  6. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses.
  7. Respondent failed to maintain a record for Patient G which accurately reflects the evaluation and treatment she provided including Patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records.
- H. On or about 7/27/95 and 10/2/95, Respondent saw Patient H for management of secondary amenorrhea. Respondent's care of Patient H deviated from accepted standards of medical practice in the following respects:
1. Respondent inappropriately and without legitimate medical purpose ordered numerous tests and studies including the following:
    - a. Darkfield examination of blood
    - b. Heidelberg gastrogram
    - c. cholesterol fractionation
    - d. thyroid function tests

- e. candida antibody titer
  - f. immunoglobulin levels
  - g. rbc magnesium level
  - h. antinuclear antibody
  - i. ANA
- 
- 2. Respondent inappropriately permitted unqualified employees to order tests, evaluate the Patient's history and symptoms and make diagnoses.
  
  - 3. Respondent failed to maintain a record for Patient H which accurately reflects the evaluation and treatment she provided including patient history, valid diagnoses, treatment plan, rationales for tests, accurate interpretation of tests and insurance and billing records.

## **SPECIFICATION OF CHARGES**

### **FIRST THROUGH EIGHTH SPECIFICATIONS**

#### **GROSS NEGLIGENCE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2000) by practicing the profession of medicine with gross negligence as alleged in the facts of the following paragraphs:

1. A and A(2), A(5) and A(8).
2. B and B(3), B(5), B(6), B(7) and B(8).
3. C and C(1), C(4) and C(5).
4. D and D(2), D(3), D(4), D(5) and D(7).
5. E and E(2), E(3), E(4), E(5) and E(7).
6. F and F(2), F(3) and F(7).
7. G and G(2), G(3), G(5) and G(6).
8. H and H(2).

### **NINTH THROUGH SIXTEENTH SPECIFICATIONS**

#### **GROSS INCOMPETENCE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2000) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following paragraphs:

9. A and A(2), A(5) and A(8).
10. B and B(3), B(5), B(6), B(7) and B(8).
11. C and C(1), C(4) and C(5).
12. D and D(2), D(3), D(4), D(5) and D(7).
13. E and E(2), E(3), E(4), E(5) and E(7).

14. F and F(2), F(3) and F(7).
15. G and G(2), G(3), G(5) and G(6).
16. H and H(2).

### **SEVENTEENTH SPECIFICATION**

#### **NEGLIGENCE ON MORE THAN ONE OCCASION**

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

17. A and A(1) through A(9); B and B(1) through B(9); C and C(1) through C(6); D and D(1) through D(5), D(7), D(8); E and E(1) through E(8); F and F(1), F(2), F(3), F(7), F(8); G and G(1), G(2), G(4) through G(7); H and H(1) through H(3).

### **EIGHTEENTH SPECIFICATION**

#### **INCOMPETENCE ON MORE THAN ONE OCCASION**

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

18. A and A(1) through A(9); B and B(1) through B(9); C and C(1) through C(6); D and D(1) through D(5), D(7), D(8); E and E(1) through E(8); F and F(1), F(2), F(3), F(7), F(8); G and G(1), G(2), G(4) through G(7); H and H(1) through H(3).

## **NINETEENTH THROUGH TWENTY-SIXTH SPECIFICATIONS**

### **FRAUDULENT PRACTICE**

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

19. A and A(1), A(2), A(3), A(6).
20. B and B(2), B(4), B(5).
21. C and C(3), C(4).
22. D and D(1), D(3), D(4), D(6).
23. E and E(1), E(2).
24. F and F(1), F(2), F(4), F(5), F(6).
25. G and G(1), G(2), G(4).
26. H and H(1).

## **TWENTY-SEVENTH THROUGH THIRTY-FOURTH SPECIFICATIONS**

### **UNWARRANTED TESTS/TREATMENT**

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

27. A and A(1), A(2), A(3).
28. B and B(2), B(5).
29. C and C(3), C(4).
30. D and D(1), D(3), D(4).
31. E and E(1), E(2).
32. F and F(1), F(2).
33. G and G(1), G(2).

34. H and H(1).

### **THIRTY-FIFTH SPECIFICATION**

#### **FALSE REPORT**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 2000) 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 following paragraph:

35. F and F(4) and F(6).

### **THIRTY-SIXTH THROUGH FORTY-THIRD SPECIFICATIONS**

#### **IMPROPER DELEGATION OF PROFESSIONAL RESPONSIBILITIES**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(25)(McKinney supp. 2000) by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure to perform them, as alleged in the following paragraphs:

- 36. A and A(8).
- 37. B and B(8).
- 38. C and C(5).
- 39. D and D(7).
- 40. E and E(7).
- 41. F and F(7).
- 42. G and G(6).
- 43. H and H(2).



## **FORTY-FOURTH THROUGH FIFTY-FIRST SPECIFICATIONS**

### **FAILURE TO EXERCISE APPROPRIATE SUPERVISION**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(33)(McKinney Supp. 2000) by failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensee, as alleged in the following paragraphs:

- 44. A and A(8).
- 45. B and B(8).
- 46. C and C(5).
- 47. D and D(7).
- 48. E and E(7).
- 49. F and F(7).
- 50. G and G(6).
- 51. H and H(2).

## **FIFTY-SECOND THROUGH FIFTY-NINTH SPECIFICATIONS**

### **ABETTING THE UNLICENCED PRACTICE OF MEDICINE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(11)(McKinney Supp. 2000) by permitting, aiding or abetting an unlicensed person to perform activities requiring a license, as alleged in the following paragraphs:

- 52. A and A(8).B and B(8).
- 53. C and C(5).
- 54. D and D(7).
- 55. E and E(7).
- 56. F and F(7).
- 57. G and G(6).

58. H and H(2).

### **SIXTIETH SPECIFICATION**

#### **ABANDONING A PATIENT**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(30)(McKinney Supp. 2000) by abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuance of such care, as alleged in the following paragraph:

59. A and A(4).

### **SIXTY-FIRST SPECIFICATIONS**

#### **MORAL UNFITNESS**

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

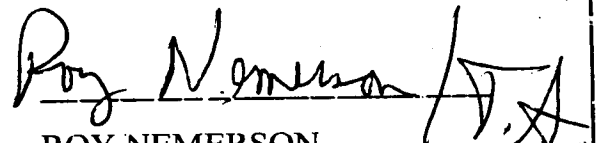
60. A and A(1), A(2), A(3), A(6); B and B(2), B(4), B(5); C and C(3), C(4); D and D(1), D(3), D(4), D(6); E and E(1), E(2); F and F(1), F(2), F(4), F(5), F(6); G and G(1), G(2), G(4); H and H(1).

**SIXTY-SECOND THROUGH SEVENTY-FOURTH SPECIFICATIONS**  
**FAILURE TO MAINTAIN RECORDS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2000) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the following paragraphs:

- 61. A and A(9).
- 62. B and B(9).
- 63. C and C(6).
- 64. D and D(8).
- 65. E and E(8).
- 66. F and F(8).
- 67. G and G(7).
- 68. H and H(3).

**DATED:** August 23, 2000  
New York, New York

  
ROY NEMERSON  
Deputy Counsel  
Bureau of Professional  
Medical Conduct