



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

June 27, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Nicholas Gonzalez, M.D.
737 Park Avenue
New York, New York 10021

Ralph J. Bavaro, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Norton L. Travis, Esq.
Garfunkel, Wild & Travis, P.C.
175 Great Neck Road
Great Neck, New York 11021

RE: In the Matter of Nicholas Gonzalez, M.D.

Dear Dr. Gonzalez, Mr. Travis and Mr. Bavaro :

Enclosed please find the Determination and Order (No. 94-96) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the

Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

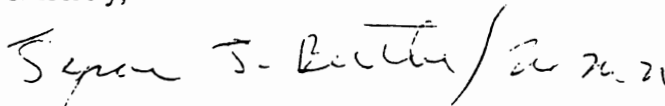
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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,

A handwritten signature in dark ink, appearing to read "Tyrone T. Butler / a.m.", is written over the printed name and title.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

-----X

IN THE MATTER

:

DETERMINATION

OF

:

AND

NICHOLAS GONZALEZ, M.D.

:

ORDER

-----X

NO. BPMC-94-96

Sharon C.H. Mead, M.D., Chairperson, Edward C. Zaino, M.D., and Ms. Eugenia Herbst 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 Sections 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10) of the Public Health Law. Nancy M. Lederman, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Notice of hearing and

Statement of Charges dated: August 24, 1993

Place of hearing:

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

Petitioner appeared by:

Ralph J. Bavaro, Esq.
Associate Counsel
NYS Department of Health

Respondent appeared in person
and was represented by:

Norton L. Travis, Esq.
Garfunkel, Wild & Travis, P.C.
175 Great Neck Road
Great Neck, New York 11021
Judith A. Eisen, Esq., Of Counsel

Note: Respondent was initially represented by Richard A. Jaffe, Esq., of 1710 Summit Tower, 11 Greenway Plaza, Houston, Texas 77046, who appeared at the first hearing date. He was replaced by Norton L. Travis, Esq., who appeared at all subsequent dates.

Hearing dates: October 7, 1993
 December 8, 1993
 December 17, 1993
 February 2, 1994
 February 18, 1994
 March 16, 1994
 March 21, 1994

Conferences: February 2, 1994
 February 16, 1994

Deliberation dates: April 22, 1994
 May 2, 1994

Note: The 120-day hearing period set forth in Public Health Law Section 230(10)(f) was waived upon request of the Respondent, who changed attorneys during the hearing. (T. 363-364)

WITNESSES

For the petitioner:

1. Hal Teitelbaum, M.D.

For the respondent:

1. Nicholas Gonzalez, M.D.
2. Jonas Goldstone, M.D.
3. George Blackburn, M.D.

STATEMENT OF CHARGES

Respondent was authorized to practice medicine in New York State on August 11, 1987 by the issuance of license number 171787 and is currently licensed to practice medicine with the New York State Department of Education. On August 27, 1993, Respondent was served with a Notice of Hearing and Statement of Charges. Respondent was charged with misconduct under New York Education Law Section 6530.

The Statement of Charges essentially charges the Respondent

with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion, practicing with incompetence on more than one occasion, practicing with gross negligence, practicing with gross incompetence, and failure to maintain adequate records.

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

FINDINGS OF FACT

Having heard testimony and considered evidence presented by the Department of Health and the Respondent, respectively, the Hearing Committee hereby makes the following findings. Citations refer to evidence found persuasive by the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

The Hearing Committee noted two errors in the transcript. At pp. 751-774, the heading reads, "Gonzalez - direct - Bavaro," and it should read, "Gonzalez - direct - Travis." At pp. 970-1006, the heading reads, "Gonzalez - direct - Travis," and it should read, "Goldstone - direct - Travis."

PRELIMINARY

Respondent is charged with 15 specifications of professional misconduct as set forth in the Statement of Charges. The specifications, and the factual allegations upon which they are

based, relate to Respondent's care of six patients identified as Patients A through F.

Respondent's office records for Patients A through F and Respondent's testimony reveal that Patients A through F were treated by Respondent with a particular treatment protocol which consisted of three basic components: various diets, large doses of supplements, and detoxification, i.e. multiple daily coffee enemas. (T. 660-662, 725, 1180)

The scope of the Hearing Committee's review was strictly limited to and guided by the specific factual allegations and specifications of misconduct contained in the Statement of Charges. The Hearing Committee did not attempt to evaluate or make judgments regarding the merits of Respondent's alternative therapeutic protocol. However, the Hearing Committee did conclude that the Respondent's alternative protocol did not entitle him to an alternative standard of review insofar as the charges were concerned. Further, according to Respondent's testimony, the vast majority of his practice were cancer patients, and Patients A through F were terminally ill with cancer at the outset of treatment by Respondent. The Hearing Committee concluded that the medical conditions of Patients A through F did not alter Respondent's responsibilities with respect to fundamental medical care and management of patients. Respondent had an obligation to act reasonably under the circumstances and to demonstrate the skill and knowledge necessary to practice the medical profession.

FINDINGS OF FACT AS TO PATIENT A

1. Patient A was a patient of Respondent from December 1988 through December 1991.
2. In 1984, at age 33, Patient A was found after biopsy to have intraductal comedocarcinoma of the left breast. She refused conventional therapy of surgery and radiation, choosing instead a program of diet therapy. In November 1986, a mammogram revealed progressive disease with microcalcifications in the left breast. Upon biopsy, an enlarged lymph node in the left axillary proved to be poorly differentiated adenocarcinoma. Subsequently, Patient A agreed to a chemotherapy/surgery program, completing five cycles of neoadjuvant chemotherapy. She then refused the surgery, and was treated again with alternative therapy. In June 1988, the disease was found to have progressed further. Surgery was recommended, but the patient refused. (T. 37-40; Ex. 3, pp. 56-59; T. 752-54)
3. Patient A saw Respondent on December 8, 1988. At that initial visit, Respondent took Patient A's history and performed a physical examination. Respondent recommended surgery which Patient A refused. Respondent's plan was to design a nutritional protocol for the patient. (Ex. 3, p. 59; T. 41-42)
4. Respondent did not stage Patient A at the time of her initial visit. The most recent studies had been performed six months before, in May of 1988, when Patient A underwent a liver/spleen scan, bone scan, chest x-ray, and mammogram. Patient A also had a mammogram on November 30, 1988, one week prior to her first

visit with Respondent. (Ex. 3, pp. 6-9)

5. In the three-year period from December 1988 to December 1991, Patient A made a total of six visits to Respondent. These office visits took place on December 8, 1988, May 22, 1989, January 12, 1990, May 25, 1990, September 18, 1991, and December 19, 1991.

(Ex. 3, p. 62, p. 87, T. 761)

6. A mammogram performed on December 1, 1989, at the request of Patient A's gynecologist, Dr. Jill Ladd, showed a worsening of the disease. (T. 42)

7. In an office visit on January 12, 1990, Respondent attributed Patient A's worsening condition to stress and partial noncompliance with the nutritional protocol. A new diet was prescribed. (Ex. 3, pp. 87-88, 74-77; T. 42-43)

8. Patient A returned in September 1991, after an absence of more than one year. The tumor had increased in size and severity. No staging was performed at that time, and a new program of dietary therapy was initiated. Respondent's assessment was, "Despite noncompliance patient stable." (Ex. 3, pp. 24-26, T. 47-49, 64-68)

9. On October 11, 1991, Patient A complained by telephone of her breast looking worse. (Ex. 3, p. 44)

10. On October 30, 1991, Patient A complained by telephone of blurry vision. Respondent advised her to contact an ophthalmologist. (Ex. 3, p. 41)

11. By telephone on December 9, 1991, Respondent reassured Patient A that her breast will look worse on the program. On

December 13, 1991, Patient A again called to complain of an inflamed breast. (Ex. 3, p. 37, T. 48-50)

12. Respondent did not schedule a visit with Patient A until December 19, 1991, with no explanation for the delay. At the December 19, 1991 visit, Patient A presented with a tender, red, oozing left breast, and shortness of breath. Respondent found no lesions in the right breast, and noted that "perhaps her breast is simply overloaded with waste," although he recommended surgery, which Patient A resisted. No further restaging was performed. No lab work was done at that time. Respondent performed a chest x-ray. At the December 19 visit, Respondent did not mention Patient A's blurry vision. Respondent attributed Patient A's shortness of breath to a cold, and recommended that she return in two months. (Ex. 3, pp. 33-34)

13. Respondent referred Patient A to Dr. Avram Cooperman for surgery. Dr. Cooperman instead recommended chemotherapy. (Ex. 3, pp. 5, 29, 33; T. 52-53)

14. On January 9, 1992, Patient A was found by Dr. Michael Sarg, a physician at St. Vincent's Hospital, to have large pleural infusion, accounting for the patient's shortness of breath. Dr. Sarg found the left breast destroyed and denuded, and, contrary to Respondent's finding of December 19, 1991, found inflammatory carcinoma in the right breast.

15. On January 17, 1992, Dr. Rosenblum, in the patient's home state of Maryland, found liver and bone metastases. The patient subsequently received chemotherapy and hormonal therapy and

achieved a partial response. (Ex. 5; T. 54-55)

CONCLUSIONS AS TO PATIENT A

1. **Allegation A-1 is SUSTAINED.** Respondent did not perform appropriate staging on Patient A. Respondent did not stage Patient A at the time of her initial visit on December 8, 1988. Respondent thus did not have adequate information upon which to base his recommendation for surgery. The mammogram performed the week before, offering only local information, did not constitute an assessment of Patient A's cancer sufficient to support a chosen mode of therapy or to provide a baseline for future evaluation. (Ex. 3, pp. 6-9) When Patient A returned in September 1991, after a one-year absence, Respondent again did not stage her, despite the fact that the tumor had increased in size and severity. (Ex. 3, pp. 24-26, T. 47-49, 64-68) In December 1991, Respondent recommended surgery, without further restaging. (Ex. 3, pp. 33-34)

2. **Allegation A-2 is NOT SUSTAINED.** In the period Patient A was under Respondent's care, she had sufficient laboratory and radiological evaluations, including blood tests, performed by other doctors. There was no evidence of any bone scan. One chest x-ray was performed by Respondent, in December 1991.

3. **Allegation A-3 is SUSTAINED.** Respondent failed to perform sufficiently frequent follow-up evaluations. Patient A made a total of six visits to Respondent in the period from December 1988 to December 1991. She saw Respondent on average every six

months, except for the single interval of one year. Despite testimony by Respondent, there was no documentation of a care plan which included a schedule of visits, at either three or six months. To the contrary, Respondent's office notes referred to her "yearly visit." (Ex. 3, p. 62, p. 87, T. 761) Patient A complained of blurry vision on October 30, 1991, but Respondent did not schedule a visit until December 19, 1991, with no explanation for the delay and failed to evaluate Patient A's complaint of blurry vision at that December 19 visit. Despite the deteriorating condition of her left breast and shortness of breath on December 19, 1991, Respondent recommended that she return in two months.

4. **Allegation A-4 is SUSTAINED.** Respondent failed to correctly interpret signs and symptoms of disease progression, including but not limited to the patient's complaint of blurry vision and shortness of breath, which he attributed to a cough, and the marked deterioration of her left breast. At the December 19, 1991 visit, Respondent incorrectly interpreted the tumor's increased mass as increased waste (although he referred Patient A to a surgeon) and failed to recognize any abnormality of the right breast.

5. **Allegation A-5 is SUSTAINED.** Respondent's failure to correctly interpret signs and symptoms of disease progression resulted in inaccurate documentation of Patient A's evaluation and treatment. When Patient A's tumor was changing, Respondent noted "stable." On December 19, 1991, Respondent noted "breast

is simply overloaded with waste," although he recommended surgery. Although Respondent documented physical examination of the patient's breast, there were no specifics regarding liver flushes and clean sweeps. There was no documentation of hormone receptors or menopausal status prior to therapy. (T. 88-95)

FINDINGS OF FACT AS TO PATIENT B

1. Patient B was a patient of Respondent from July 1989 through June 1990.
2. In 1967, at age 16, Patient B was diagnosed with osteogenic carcinoma and underwent a hemipelvectomy. In 1968 and 1969, she developed pulmonary metastases and underwent thoracotomies. She did well until 1988, when she developed a mass in her right breast. Biopsy showed this to be a poorly differentiated adenocarcinoma. Patient B was treated with three courses of chemotherapy, followed by a right modified radical mastectomy, which revealed 17 involved lymph nodes. She was treated with further chemotherapy and radiation therapy to the right breast and superclavicular area, followed by further chemotherapy. In April 1989, Patient B began various courses of alternative care. Subsequently the disease was found to be progressive to the right lung and right chest wall, and she refused further chemotherapy. (Ex. 6, pp. 54-58)
3. Patient B started with Respondent on July 18, 1989. On her initial visit, Respondent took her history. She returned on August 1, 1989, having decided to proceed with Respondent's

treatment, at which time Respondent performed a physical examination. Routine laboratory work and blood chemistries were obtained. A CEA tumor marker study could not be performed because the specimen hemolyzed. (It was never repeated.) After this, Patient B had no further blood chemistries performed.

4. Patient B had been staged a few weeks prior to her first visit with Respondent, in June 1989, when she underwent a CT scan of the head, a CT scan of the chest and abdomen, bone scan, and chest x-ray. (Ex. 6, pp. 60-64, 69-71, 74)

5. Respondent's records include her hormone receptor status as well as the fact that she was 38 years old, with two very young children, and pre-menopausal. (Ex. 6, p. 76, p. 97; T. 786)

6. Patient B visited Respondent on July 1, 1989, August 1, 1989, September 28, 1989, October 23, 1989, November 10, 1989, December 14, 1989, January 8, 1990, February 12, 1990, February 27, 1990, and March 19, 1990, and April 15, 1990. For the most part, Respondent's examinations of Patient B were problem-oriented rather than full physical examinations.

7. In an office visit on September 28, 1989, changes in the chest wall were reported, including new erythematous lesions larger than 1 cm. on Patient B's right chest wall. Respondent characterized these as an inflammatory reaction, although he also noted that it might be disease progression. No biopsy, x-ray, bone scan, or tumor marker tests were ordered or performed. Respondent assessed Patient B as doing fine and requested that she return in six weeks. (Ex. 6, p. 53, T. 245)

8. In an office visit on October 23, 1989, Patient B reported an episode of arm lymphangitis two weeks earlier which had been treated by another physician. Physical examination was limited to the chest wall which revealed erythematous nodules and her arm, which was better. Respondent's assessment was stable, and the patient to return in six weeks. (Ex. 6, p. 52; T.214)

9. Patient B returned on November 10, 1989, and expressed concern about right chest wall inflammation. Respondent advised her that that was part of the rebuilding process. Physical examination noted a new 3 cm. left axillary lymph node enlargement, and erythematous raised pustular regions of the chest wall. No effort was made to further assess the progressive abnormalities on the chest wall with biopsy or laboratory study or x-ray as indicated. (Ex. 6, p. 51; T.214-215, 245)

10. In an office visit on December 14, 1989, Patient B had continued inflammation and crusting of the right chest wall, and new right cervical lymph nodes. She complained of fatigue, depression, oozing from the right chest wall, enlarged lymph nodes, and muscle aches and pains. Respondent did not perform a musculoskeletal or neurological examination as indicated. No x-ray or bone scan or any other laboratory or radiology tests was ordered. Again, the patient was assessed as doing fine and instructed to return in six weeks. (Ex. 6, p. 48; T. 217-218, 233-234)

11. By telephone on February 1, 1990, Patient B complained of pain and an inability to perform her job. In a telephone

conversation on February 7, 1990, she complained of rash, fever, and being cold and shaky. (Ex. 6, pp. 45-46)

12. In an office visit on February 12, 1990, Patient B presented with redness and swelling of the right hand. She reported that the left axillary mass was much better. There was no documentation of physical examination of the area or the chest. (Ex. 6, pp. 43-44; T. 219-220)

13. In an office visit of February 27, 1990, Patient B complained of chest pain. Physical examination revealed a necrotizing right chest tumor. No laboratory or radiology was performed.

14. On March 19, 1990, Patient B visited Respondent's office very concerned about her chest wall and pain. Respondent observed that "wound actually looks better." Respondent noted further that "there is really nothing more that can be done other than wait and allow the program to do what it can do." (Ex. 6, p. 20; T. 221)

15. In an office visit on April 15, 1990, Patient B complained of worsening severe chest wall pain and daily fevers. Physical examination revealed a "large fungating chest tumor unchanged." Respondent's assessment was that Patient B needed pain control, and he prescribed MS Contin. This was the last time Respondent saw Patient B. (Ex. 6, p. 17)

16. On May 10, 1990, Patient B was admitted to Doctors Hospital under the care of Dr. Lewis for pain control. She underwent intravenous antibiotics and a blood transfusion. A chest x-ray

performed at the hospital revealed metastatic disease in the lungs. (Ex. 6, pp. 9-11)

17. On May 21, 1990, Patient B's husband telephoned Respondent and reported that Patient B had been incoherent for the preceding 12 hours. No further history nor evaluation was sought by Respondent. Respondent instructed that all nutrients be stopped. No neurological examination was obtained. (Ex. 6, pp. 4, 7; T. 225-226, 228-239, 252-253)

18. On June 14, 1990, Patient B was admitted to St. Vincent's Hospital. Tests revealed metastatic carcinoma of the brain, lungs, and bone. Patient B expired on June 18, 1990. (Ex. 8)

CONCLUSIONS AS TO PATIENT B

1. **Allegation B-1 is SUSTAINED.** Respondent did not perform appropriate staging on Patient B. The CT scan and other tests done three weeks before Patient B's initial visit to Respondent were adequate. However, Respondent failed to stage Patient B subsequently, particularly when she developed muscle aches and pains on December 14, 1989 and later when she became incoherent on May 14, 1990.

2. **Allegation B-2 is NOT SUSTAINED.** Respondent's records include Patient B's hormone receptor status as well as the fact that she was 38 years old, with two very young children, and premenopausal. (Ex. 6, p. 76, p. 97; T. 786)

3. **Allegation B-3 is NOT SUSTAINED.** Respondent's examinations, although mostly problem-oriented rather than full physical

examinations, were adequate and constituted sufficiently frequent follow-up evaluations.

4. **Allegation B-4 is SUSTAINED.** Respondent failed to perform sufficient laboratory and radiological evaluations, such as blood tests, tumor markers, CAT scan, chest x-ray and/or bone scan. Periodic blood tests were indicated, e.g. CEA, alkaline phosphatase or other tests to assess bone metastases. Either biopsy, x-ray, bone scan, or tumor marker should have been performed to assess change in chest wall in September 1989 (T. 245). Similarly, an x-ray or bone scan was indicated to assess for bone metastases when Patient B complained of muscle aches and pains in December 1989. When Patient B complained of incoherence in May 1990, an emergent calcium level test was indicated. (T. 249) Objective tests were necessary to assess the progress of Patient B's disease and to determine how treatment should proceed, as well as to assess the possible need for palliative treatment or pain relief.

5. **Allegation B-5 is SUSTAINED.** Patient B required neurological evaluations at regular intervals. However, Respondent failed to perform, or seek consultation for, adequate neurological evaluation after the initial visit. Most significantly, Respondent failed to obtain a neurological evaluation on May 21, 1990, after Patient B complained of being incoherent for 12 hours. Respondent's claim that it was not his responsibility, but the responsibility of the doctor who was monitoring Patient B's pain medications, is unfounded and without merit.

6. **Allegation B-6 is SUSTAINED.** Respondent failed to correctly interpret signs and symptoms of disease progression. Throughout Patient B's course of treatment with Respondent, Patient B's chest wall got larger, began ulcerating and necrotizing; a new erythematous pustular lesion appeared on the chest wall; lymphadenopathy developed; fatigue, depression, and anxiety developed; aches and pains began; performance status decreased; and incoherence began. However, Respondent continued to characterize Patient B as "stable" or "doing fine." (T. 253-257)
7. **Allegation B-7 is NOT SUSTAINED.** Although Respondent continued to characterize Patient B as "stable" or "doing fine," his records accurately reported the worsening of the chest wall. Diets were referenced in Respondent's charts.

FINDINGS OF FACT AS TO PATIENT C

1. Patient C was a patient of Respondent from October 1989 through October 1990.
2. In August 1989, bilateral breast masses were discovered. Bilateral lumpectomies and axillary node dissections were performed in August and September of 1989. The available pathology revealed poorly differentiated infiltrating duct carcinoma of both breasts. Bilaterally lymph nodes were positive. Estrogen receptors were positive bilaterally, progesterone receptors were positive on only one side. Bone scan, abdominal CAT scan, and chest x-ray were all normal. Post-operatively radiation and chemotherapy or hormone therapy were

recommended. (Ex. 9, pp. 7-11, 17-23)

3. Patient C was first seen by Respondent on October 1, 1989. She had refused orthodox therapy as recommended, and elected his form of therapy. (Ex. 9, pp. 1-3)

4. Patient C was next seen on November 1, 1989 and again on January 2, 1990. A diagnosis of metastatic breast cancer was noted on her chart. (Ex. 9, p. 26)

5. Patient C was next seen on January 22, 1990, after an episode of streaking of her right arm during the previous weekend. She had been treated for phlebitis with antibiotics at a local emergency room. Respondent examined her arm and advised her to return in six weeks. (Ex. 9, p. 25)

6. By telephone on March 2, 1990, Patient C complained of "muscular" problems with her legs. Respondent advised her to soak her feet in mustard and cayenne soaks, and to come in the next week. (Ex. 9, p. 27)

7. In an office visit on March 12, 1990, Respondent noted a diagnosis of bilateral breast cancer metastatic to multiple nodes and suspicion of metastases to bone. Patient reported migratory aches and pains, particularly in the hips. Respondent's assessment was that the patient was stable, and that she was generally doing well. "The program is doing its job." Respondent did not perform a musculoskeletal or neurological examination, as indicated. (Ex. 9, p. 28)

8. A telephone message on March 28, 1990, recorded the patient was doing well after chiropractic adjustment. (Ex. 9, p. 29)

9. At the next office visit on May 14, 1990, the Respondent noted that the patient was reporting left rib and back pain, occasional fevers, and weight loss. A physical examination performed on that date revealed probable local metastatic lesion. Neither a musculoskeletal nor a neurological evaluation was performed. Respondent's assessment was that Patient C was going through an aggressive repair and rebuilding process, and he expressed concern about the left rib pain. Subsequently, CBC chemistries were obtained and a chest x-ray performed, which showed that she now had metastatic disease to bone. Respondent noted, "Multiple rib lesions." (Ex. 9, pp. 30-34)

10. Respondent's evaluation of Patient C's deteriorating condition was that she was being non-compliant. On May 15, 1990, he wrote a note saying, "I wonder about compliance - could she be lying?" A note dated May 16, 1990, records, "As it turns out, [Patient C] has not been compliant." (Ex. 9, pp. 34-35)

11. In telephone conversations on May 23, June 6, June 14, and June 21, 1990, Patient C indicated further complaints of increasing low back pain, and muscle spasm. The patient was not seen until June 26. There is no indication that she was asked to come in and refused. (Ex. 9, pp. 37, 39, 40, 41)

12. In an office visit on June 26, 1990, the patient's low back pain was reported as "excruciating." Respondent noted that she was unable to work, that there was now a 3 cm. lesion on the right breast and a 2 cm. draining lesion on the left breast, and that she had a rash on both arms. The evaluation was that the

patient is "stable - I think she is going through aggressive repair and rebuilding cycle." No change in therapy was ordered. Respondent ordered blood chemistries and the patient was to return in eight weeks. (Ex. 9, pp. 42-44)

13. By telephone on July 13, 1990, Patient C complained of inflamed rash and pain in the hip. Respondent prescribed Cataplex F, phosfood, and calcium citrate. Laboratory work was done on June 26, 1990 and again on July 31, 1990. Results reported calcium at 10.2 (upper limit of normal). Although patient was at risk for hypercalcemia, Respondent did not discontinue calcium prescription. (Ex. 9, pp. 44-45, 55, 65-66)

14. Patient C was next seen on August 8, 1990. Respondent noted that Patient was now compliant with the nutritional protocol. Respondent believed that she had improved, based on lessening of her rib pain. Respondent noted her neck pain, which he attributed to motor vehicle accident, and her need for a walker for support. Again, she was described as being stable, "somewhat improved clinically." A new diet was prescribed, and she was to return in three months. (Ex. 9, p. 62)

15. Respondent did not see Patient C after her visit of August 8, 1990. Several telephone calls are reported from June 1990 through October 1990. These telephone contacts with Patient C indicated fever, weakness, pain, nausea, vomiting, inability to perform enemas, flu-like symptoms, anorexia, constipation, the need for home health aide, and other indications that she was deteriorating rapidly. On August 16, 1990, it was noted that

Patient C's pain pills weren't working and she was unable to get on the floor to do enemas. Respondent advised her to go to the hospital, but she refused. On August 23, 1990, it was noted that Patient C had gotten someone to help at night, and installed a pole to help her get up. She was doing the enemas okay, but reported fever and vomiting. Respondent's assessment was, "Sounds toxic. She's doing OK." On September 7, 1990, Patient C reported vomiting anything she ate, dry heaves, and that she was too sick to do enemas. Respondent's impression was "sounds like flu." He prescribed bentonite 1-1/2 cup TID. On September 11, 1990, vomiting had ceased and on September 12, 1990, Patient C noted some improvement of appetite and that she was once again taking her supplements. On September 17, 1990, she reported vomiting, and Respondent instructed her to take peppermint tea and bentonite. Subsequent phone calls reflected that Patient C was constipated for three days, and Respondent told her to take herbal laxative. (Ex. 9, pp. 67-76, 78)

16. On October 7, 1990, Patient C was admitted to Brunswick Hospital in Amityville, complaining of rectal bleeding. History included constipation for two weeks, inability to move right leg, increasing neck pain. Significant findings at the hospital included multiple pathological fractures including fifth cervical vertebrae, right femur and right acetabular roof and right humerus. Massive rectal bleeding was thought to be secondary to rectal ulceration. Laboratory tests revealed calcium at a life-threatening 17.6 level. Patient C was treated with steroids,

hydration, didronel, and transfusion. She died of advanced metastatic cancer, with hypercalcemia and congestive heart failure and/or pneumonia. (Ex. 11; T-290)

17. Respondent's final entry, dated October 17, 1990, noted "[Patient C] passed away last night, She was completely non compliant first 4-6 months in the program." (emphasis in original) (Ex. 9, p.77)

CONCLUSIONS AS TO PATIENT C

1. **Allegation C-1 is NOT SUSTAINED.** Patient C was appropriately staged. By August 1989 information was available as to chest x-ray, lab work, mammography. Respondent had possession of all appropriate records. Respondent performed a chest x-ray on May 14, 1990 which gave him information about the progress of her disease.
2. **Allegation C-2 is NOT SUSTAINED.** Respondent's records included Patient C's hormone receptors, from just prior to the patient's first visit. Relevant history was included in her chart.
3. **Allegation C-3 is NOT SUSTAINED.** A complete physical was performed on the patient's first visit. Although there is no documentation of breast examination on each visit, Respondent did examine her breasts on most of her visits. Given the patient's infrequent visits, this was sufficient.
4. **Allegation C-4 is SUSTAINED.** There is no documentation of an adequate neurological evaluation at any time, or that Respondent

sought one. Multiple complaints by Patient C on numerous occasions suggestive of neurological problems, i.e. leg weakness, leg pain, difficulty in walking and use of a walker, neck pain, rib and bone pain, "muscle pain" indicated urgent need for neurological evaluation, which Respondent ignored or attributed to benign disease, without neurological reevaluation. (T. 297-298, 30)-301)

5. Allegation C-5 is SUSTAINED. The first laboratory work Respondent ordered was seven months after Patient C's initial visit. CBC, CEA and SMA12 in May 1990 did not show any abnormality. The chest x-ray done on May 14, 1990 showed metastatic disease. These were sufficient laboratory tests. However, Respondent should have performed or ordered a bone scan, which was indicated by Patient C's progressive complaints of hip pain, back pain, and neck pain from May 23, 1990 forward. A bone scan would have revealed other sites of metastases and allowed palliative therapy, such as radiation and/or hormonal therapy, to be offered to the patient, to prevent unnecessary pain and pathologic fractures to improve the quality of her life. By his failure to perform radiological testing, Respondent foreclosed these possible options for Patient C. (T. 301-305)

6. Allegation C-6 is NOT SUSTAINED. After January 22, 1990, Respondent saw Patient C in March, May, June, and August - approximately every six to eight weeks. According to Respondent's testimony, she refused more frequent visits (not noted in chart). Considering the distance and the severity and

progression of her disease, these visits were of sufficient frequency.

7. **Allegation C-7 is SUSTAINED.** Respondent failed to interpret signs and symptoms of disease progression in Patient C. The patient was not only suffering increasing pain in many areas of her body, including ribs, hips, and lower back pain, but she was losing weight, becoming less functional, suffering from increased breast lesions, weakness, inability to walk, suffering from nausea, vomiting, anorexia, and constipation. These things should have been interpreted as evidence of marked progression of her disease, despite which Respondent continued to describe Patient C variously as stable, doing fine, or in a rebuilding process.

8. **Allegation C-8 is NOT SUSTAINED.** Respondent's initial documentation of Patient C's evaluation and treatment was adequate.

FINDINGS OF FACT AS TO PATIENT D

1. Patient D was seen from August 1989 to August 1990.
2. Patient D was born in July 1943. In January 1987, the patient developed abdominal distension, found to be due to ascites. Paracentesis was done at North Shore University Hospital, revealing malignant cells in the ascitic fluid. In February 1987, she had an abdominal total hysterectomy, bilateral salpingo-oophorectomy, and debulking omentectomy for stage III-C papillary adenocarcinoma of the ovary. From March to April 1987,

she had chemotherapy. After this she was advised to have a second-look laparotomy, which she refused. In 1988, the CA 125 increased, and CAT scan revealed a pelvic mass. A laparotomy was performed at Memorial Sloan Kettering Hospital with debulking of recurrent carcinoma. Patient D had metastases to the transverse colon, jejunum, cul-de-sac, and bladder, and multiple tumor nodules remained. She received further chemotherapy through an intra-peritoneal catheter for six months. In November 1988, she underwent a third laparotomy. No gross tumor was found, however, biopsies revealed metastatic carcinoma. The patient refused a third series of chemotherapy. She saw Dr. Revici, for alternative therapy in December 1988. Patient D had been on anti-depressants under the care of a psychiatrist, and had a history of sciatica and colitis. (Ex. 13, p. 62; Ex 15)

3. On August 3, 1989, Patient D saw Respondent and complained of lethargy, constipation, and depression. A physical exam performed at that time was unremarkable, except for obesity. A pelvic and rectal exam was not performed. Patient D was placed on a nutritional regime. In July 1989, a CA 125 ordered by Dr. Janoff was markedly elevated. An MRI of September 8, 1989, ordered by Respondent, showed abnormalities of liver and spleen, suggestive of metastatic disease. (Ex. 13, pp. 62-65, 71, 78)

4. During the course of the next several months, Patient D appeared to remain clinically stable. Patient D saw Respondent on October 3, 1989, November 3, 1989, January 5, 1990. On January 5, 1990, Patient D complained of some dysuria. By

February 28, 1990, she began complaining by telephone of hair falling out, nausea, difficulty swallowing pills, indigestion, and cramps. (Ex. 13, pp. 51, 66-67, 71-73, 76)

5. In an office visit on March 5, 1990, Patient D reported chronic digestive problems of gas and bloating, one episode of emesis, and continued hair loss. Examination revealed distended abdomen. CBC and blood chemistries were essentially normal. Respondent's assessment was that Patient D was stable and should return in six weeks. A CA 125 was done on March 6, 1990, revealing elevated levels indicative of a progression of ovarian cancer. No further CA 125 tests were ordered. (Ex. 13, pp. 54-55)

6. A series of telephone conversations took place between March and May 1990, as follows. By telephone on March 29, 1990, Patient D complained of low energy level on raw food and raw liver diet; leg pain was better. On April 9, 1990, she complained of worsening hair loss, which Respondent attributed to the body releasing stored chemotherapy. On April 11, 1990, she reported decreased diarrhea, but aggravated by raw food and juices. On May 2, 1990, she reported being on clean sweep and soreness in abdomen, and respondent suggested peppermint caps. On May 3, 1990, she complained of cramps and weakness. Respondent discontinued clean sweeps. On May 4, 1990, Patient D complained of raw foods irritating her, and Respondent ordered her back on the original diet. On May 10, 1990, she called hysterically crying, and reported doing better on diet but in

pain and nauseous. Respondent suggested castor oil pack and to call back in one hour. On May 14, 1990, she complained of cramps and tremendous stomach upset. (Ex. 13, p. 36)

7. In an office visit on May 15, 1990, Respondent noted that Patient D was doing better after a rough two weeks. Examination revealed tenderness around surgical scar. Respondent felt this was due to exacerbation of her colitis. The diet was changed and Patient D was to return in eight weeks. (Ex. 13, p. 35)

8. On May 27, 1990, Patient D patient reported inability to keep much food down, and Respondent insisted she see Dr. Schmerin, a gastrointestinal specialist, which patient did. Dr. Schmerin felt her problems were due to surgical scar tissue. Respondent prescribed herbal laxative, continued enemas, and enzymes.

9. The patient's symptoms persisted, as reflected in subsequent phone calls. By telephone on June 4, 1990, she reported constipation. On June 8, 1990, she reported pain. Respondent referred her to the Hoffman Center for procaine injections. Subsequently, she complained of burning in gut and difficulty eating. Respondent noted possible duodenitis, and Dr. Schmerin's diagnosis of adhesions/cancer. On June 18, 1990, Patient D's husband requested stronger pain medication and tranquilizer, and Respondent prescribed Chronoset for sleep. On June 19, 1990, Patient D and her husband made an emergency call to Respondent at 6 a.m. Respondent noted that they were becoming abusive with constant calls. He referred her to Dr. Goessel for full gastrointestinal workup. Patient D was admitted to St. Francis

Hospital by Dr. Goessel for a gastrointestinal work-up. (Ex. 13, pp. 22-29, 31-34)

10. On June 21, 1990, CAT scan showed lesions of the spleen and liver, intestinal obstruction, and a pelvic mass compressing the rectosigmoid. (Ex. 13, p. 11)

11. In an office visit on June 25, 1990, Respondent noted that flat and upright films showed extensive impaction. Patient D complained of difficulty eating, nausea, and abdominal pain. She was noted to be depressed and negative. Laboratory tests were within normal limits. Physical examination revealed decreased bowel sounds and diffuse abdominal tenderness. A pelvic and rectal exam was not performed. Respondent referred patient to Ms. Heather Stanley for disimpaction. (Ex. 13, pp. 12, 20-21)

12. Patient D continued to complain of constipation and cramping. On July 14, 1990, Dr. Rule, covering for Respondent, noted four or five telephone calls regarding abdominal pain and instructed her to go to the emergency room, which she refused.

13. Patient D eventually was admitted to North Shore University Hospital, where she was from July 14 to 18, 1990. Sigmoidoscopy and biopsy were positive for adenocarcinoma. Renal sonogram revealed bilateral hydronephrosis. IVP revealed minimum collecting system dilation. Patient D was given intravenous hydration. (Ex. 14, p. 6)

14. Patient D was transferred to Memorial Sloan Kettering, where she was treated for pain from July 19 to July 23, 1990 and readmitted on July 30. A laparotomy was performed, which

revealed a large fixed pelvic mass. She had massive retroperitoneal carcinoma, with metastases to the rectum, bladder, liver, and spleen. (Ex. 15)

15. Respondent's last office entry, on August 11, 1990, noted, "I learned that [Patient D] had not given up smoking, but continued to smoke, though small amounts while on program. My protocol won't work if patient smokes." (Ex. 13, p. 1; T. 344)

CONCLUSIONS AS TO PATIENT D

1. **Allegation D-1 is NOT SUSTAINED.** The staging on Patient D was appropriate, taken into consideration all the tests done before, including a CA 125 in July 1989 noted in Respondent's records. An MRI of September 8, 1989, ordered by Respondent, showed abnormalities of liver and spleen, suggestive of metastatic disease. CA 125 was done in March 1990. Patient had three laparotomies before (one in 1987, in February of 1988, and again in November 1988) and one during her treatment with Respondent. The MRI ordered by Respondent was adequate. (Ex. 13, pp. 54, 64, 78)

2. **Allegation D-2 is SUSTAINED.** Respondent failed to perform adequate physical examinations of Patient D. Respondent never performed a rectal nor a pelvic exam, offering as explanation that the patient refused to have these done. However, there is no evidence of any repeated request for performance of rectal and pelvic exam. Rectal and pelvic examinations were indicated because of gastrointestinal symptoms, abdominal pelvic disease,

and frequency of enema treatments. For example, on June 25, 1990, physical examination revealed decreased bowel sounds and diffuse abdominal tenderness, but rectal and pelvic examination was neither performed nor sought by Respondent. (T. 852)

3. Allegation D-3 is SUSTAINED. Respondent failed to perform sufficient laboratory and radiological evaluations. Between September 1989 and March 1990, only a single CBC and urinalysis were performed (in January of 1990), despite the fact that Patient D had extensive metastatic carcinoma to the intestinal tract and was on numerous nutritional supplements and enemas. At a minimum, tumor marker tests and/or CBC's were indicated.

4. Allegation D-4 is NOT SUSTAINED. Respondent's referrals of Patient D to two gastroenterologists, Drs. Schmerin and Goessel, constituted sufficient and timely consultation for a gastroenterologic workup.

5. Allegation D-5 is NOT SUSTAINED. Patient D saw Respondent in at least seven visits in a one-year period, constituting sufficiently frequent follow-up evaluations. (Ex. 13, pp. 20, 35, 55, 62, 71, 73, 76)

6. Allegation D-6 is SUSTAINED. Respondent did not recognize signs and symptoms and evidence of disease progression. From September 1989, when an MRI showed probable disease in the spleen and liver, to June 1990, when a CAT scan showed a large pelvic mass and intestinal obstruction, Patient D's disease increased markedly. In addition, during that period of time, Patient D developed nausea, alternating diarrhea and constipation,

abdominal pain and worsening abdominal distension and tenderness. Respondent failed to recognize these to be the results of progressing disease. For example, on May 15, 1990, his assessment of Patient D's pain and symptoms was exacerbation of spastic colitis, although in actuality it was extension of cancer. In a patient with underlying cancer it is first indicated to rule out other oncologic causes for those symptoms. Even up to July 1990, despite all the evidence of disease progression, it is never documented and there is no evidence that Respondent recognized disease progression. (T. 353-357)

7. **Allegation D-7 is SUSTAINED.** Respondent failed to adequately document evaluation and treatment. Despite all the evidence of disease progression, it is never documented and there is no evidence that Respondent recognized disease progression.

FINDINGS OF FACT AS TO PATIENT E

1. Patient E was a patient of Respondent from July 1988 through September 1990.

2. Patient E, born in 1927, was 58 at the time his tumor was diagnosed. He had a resection of a sigmoid carcinoma Dukes C of the colon and received radiation. His CEA, an indicator of disease presence, began to rise. In December 1986, most of the right lobe of the liver was removed.

3. Patient E began seeing Respondent on July 26, 1988. During the period that Patient E saw Respondent, he was also followed by both a surgeon, Dr. Jerome DeCosse, and an oncologist, Dr. Mark

Brower. However, neither Dr. DeCosse nor Dr. Brower administered any therapy from July 1988 through September 1990. (Ex. 16, pp. 192-194; Ex. 17, pp. 75-94; T. 393-397)

4. At Patient E's initial visit on July 26, 1988, Respondent performed a physical examination and took a history.

Respondent's assessment was recurrent colon cancer.

5. A CT scan in October 1988 ordered by Dr. DeCosse revealed metastases in the lung. However, on November 9, 1988, Respondent noted that the CAT scan was within normal limits. Respondent's assessment was "doing fine." (Ex. 16, p. 181; Ex. 18, p. 40)

6. An entry by Respondent in Patient E's office record dated October 6, 1988 indicated, "At present [Patient E] is receiving a program of adjunctive immune stimulation therapy in the hope of preventing further recurrence." (Ex. 16, p. 191)

7. The CT scan along with a chest x-ray was repeated on November 18, 1988, revealing pulmonary disease. On November 18, 1988, Respondent recorded the evidence of tumor on the CAT scan and noted, "I am not surprised, our tests already revealed that. I assured [Patient E] I am treating him for such disease and he is relieved." (Ex. 16, p. 181)

8. On December 20, 1988, Patient E began complaining of a sore throat and coughing up slight amounts of blood. Respondent noted, "I think he has an old fashion sore throat." (Ex. 16, p. 180)

9. On January 11, 1989, the CEA was elevated at 5.3. A January 24, 1989 CAT scan of the chest and abdomen order by Dr. DeCosse

showed multiple pulmonary nodules scattered throughout both lung fields varying in size from a few millimeters to 3.5 cm.

Respondent's notation of a February 9, 1989 office visit stated, "CT scan of the chest showed no change in pulmonary nodules."

(Ex. 16, pp. 167, 170, 173)

10. In the February 9, 1989 office visit, Patient E complained of coughing up whitish mucous tinged with blood. His CEA was up to 8.3. (Ex. 16, p. 167)

11. A CAT scan from May 3, 1989 showed pulmonary masses. A chest x-ray performed in July 1989 showed multiple pulmonary metastases. Another in January 1990 showed multiple metastases nodules. Numerous tests were included as part of record.

12. Dr. Brower, in his office notes of May 1989 and by letter to Dr. DeCosse of June 8, 1989, stated that Patient E's disease is worsening - rising CEA, increasing tumors. (Ex. 17, pp. 85-86, 116)

13. In an office visit of August 9, 1989, Patient E reported symptoms of wheezing, cough, and some chills, but said he was doing better on antibiotics. CEA was up to 13.5. Respondent felt that a strep infection was responsible for Patient E's symptoms: "I don't think tumor enlargement is significant in view of his recent infection." (Ex. 16, pp. 109, 125)

14. A CAT scan of November 3, 1989 ordered by Dr. Brower showed tumors enlarging. On November 8, 1989, Respondent noted Patient E's "cough and wheezing are less," and attributed it to toxic fumes from house paint. (Ex. 16, pp. 94-95, 99)

15. By letter dated November 21, 1989, Patient E reported to Respondent that his wheezing and dry cough were somewhat better, but he was now experiencing shortness of breath. In an office visit of December 21, 1989, Respondent noted a coughing spasm of December 13, where Patient E coughed up a piece of tissue that looked like a tumor, and wheezing stopped. Despite rising CEA, and progressively abnormal CAT scans, and pulmonary symptoms, Respondent's assessments was, "Doing fine - I think he is going to turn the corner." (Ex. 16, pp. 89, 92, 93)

16. By telephone on March 9, 1990, Patient E reported that he had passed out for two minutes the day before. Respondent said it was a reaction to codeine, and told Patient E to cut back on cough medication. Respondent did not request Patient E to come in for an evaluation nor did he mention this episode on Patient E's next visit. (Ex. 16, p. 71)

17. In an office visit on March 30, 1990, Respondent's assessment was that Patient E was "improving," and was to return in six months. Dr. DeCosse, who saw Patient E eight days earlier, noted shortness of breath, coughing, and presence of pleural effusion, and described Patient E's condition as "deteriorating." Dr. DeCosse also noted that proctosigmoidoscopy revealed distal rectum to be red and erythematous which could be related to daily coffee enemas. (Ex. 16, p. 65; Ex. 18, 7.2)

18. On April 5, 1990, Patient E telephoned Respondent and complained of night sweats, shortness of breath, and weakness. Elevated CEA of 100.7 taken on March 30 was discussed. A CAT

scan of the chest, abdomen, and pelvis on April 9, 1990 revealed bilateral pulmonary masses, the largest of which was 6.5 cm., clearly showing progression of disease in the chest, as compared to prior CAT scans and chest x-rays. (Ex. 16, pp. 57-58, 61, 64; T. 403, 405)

19. In an office visit on May 14, 1990, Patient E reported some shortness of breath, with mild wheezing and improved cough. Respondent's assessment was "stable." Respondent's plan was for Patient E to return in two months and to perform CBC, CEA, and chemistries. (Ex. 16, p. 56)

20. By telephone on May 30, 1990, Patient E complained of earache and weakness. On June 1, 1990, a telephone complaint reported a bad cough. On June 4, 1990, Patient E complained of bronchitis/cough and was told to come to the office. In the office that same day, Patient E complained of worsening cough, mucous production, sweats without fever, and diminished appetite. Respondent noted, "Mild recurrent bronchitis." On June 6, 1990, Patient E complained of black mucous. Respondent noted, "I think he is rejecting his tumor." On June 19, 1990, cough was worse after ten days on antibiotics and Patient E was not sleeping. On June 20, 1990, he complained of fever blisters on lip and weakness. (Ex. 16, pp. 45-46, 48-49, 51, 54-55)

21. In an office visit July 6, 1990, Respondent noted that patient was "doing well ..." and advised a new diet and protocol and to return in eight weeks. In contrast, Dr. DeCosse, five days earlier, noted shortness of breath, dyspnea on exertion,

hemoptysis, decreased weight and weakness. Dr. DeCosse's assessment was that "the patient is rapidly deteriorating," and he urged studies and chemotherapy. (Ex. 16, p. 37-38; Ex. 18, p. 1)

22. On July 11, 1990, Patient E telephoned Respondent and complained of a boil in his anus for two to three days, and was told by Respondent over the phone to try a Castor oil pack. No further evaluation of that complaint was performed as indicated. On July 18, 1990, Patient E telephoned and complained of pain in the lower abdomen and nausea. On August 2, 1990, a telephone message from Patient E stated, "Please call - disorientated, shortness of breath." Return call from Respondent noted pleural effusion shown on chest x-ray and that Patient E would see Dr. Brower on Monday (four days hence) for thoracentesis. There was no attempt to evaluate the patient's disorientation. (Ex. 16, pp. 26, 29, 31; T. 406-408)

23. On August 6, 1990, Patient E saw Dr. Brower and complained of weakness, inability to write straight, frontal headache, and increased cough, now productive. A CAT scan of the brain on August 7, 1990, ordered by Dr. Brower, revealed brain metastases. (Ex. 16, p. 21; Ex. 17, p. 78)

24. Patient E presented to Respondent on August 8, 1990. Respondent noted "I believe lesions are not new. I believe the problem is he has not been compliant with detox [enemas]." Respondent did not examine or question Patient E with regard to peri-rectal discomfort despite the July 11, 1990 complaint of a

boil. Respondent's plan was to increase the frequency of clean sweeps, flush and purge. Respondent further noted: "We discussed the options - chemo, Dr. Falk, Dr. Atkins, etc. - [Patient E and spouse] know chemo won't work and are against it - I argued that the only chance for long term survival is this nutritional protocol." (Ex. 16, pp. 23-24; T. 407-408)

25. Dr. Brower recommended radiation therapy to the brain, which Patient E refused. Respondent noted on August 22, 1990 that Patient E decided to see Dr. Falk in Canada. A last office entry by Respondent on September 15, 1990 noted Patient E's death. Ex. 16, p. 4, 7; Ex. 17, p. 75

CONCLUSIONS AS TO PATIENT E

1. **Allegation E-1 is NOT SUSTAINED.** Sufficient staging was done on Patient E, and more by Respondent was not required. Patient E had metastatic disease, which was well evaluated and documented. Numerous CAT scans and tumor marker studies were performed and included as part of Patient E's record.

2. **Allegation E-2 is SUSTAINED.** Respondent failed to perform sufficiently thorough follow-up monitoring, particularly with respect to progressive dyspnea, disorientation, weight gain/loss, and syncope. After Patient E's episode of syncope on March 9, 1990, Respondent did not request Patient E to come in for an evaluation nor did he mention this episode on Patient E's next visit.

3. **Allegation E-3 is SUSTAINED.** Respondent failed to correctly

interpret signs and symptoms of Patient E's disease progression. Despite Patient E's rising CEA and progressively abnormal CAT scans, and pulmonary symptoms, Respondent's assessments were that Patient E was "doing fine - I think he is going to turn the corner." During the two years Patient E treated with Respondent, Patient E developed progressive cough with hemoptysis and dyspnea, lost weight, had a CEA rising from 2.4 to over 200, and developed increasingly numerous lesions ranging from 8 cm. early on to 6.5 cm. with pleural effusion later. Nevertheless, Respondent's conclusions were variously that Patient E was suffering from toxicity due to tumor breakdown and/or inflammation, and other non-malignant causes such as bronchitis, strep infection, toxic paint fumes, old fashioned sore throat, reaction to codeine. Even Patient E's brain metastases in 1990 were interpreted as a sign of toxicity.

4. Allegation E-4 is NOT SUSTAINED. Respondent's documentation for Patient E was adequate.

FINDINGS OF FACT AS TO PATIENT F

1. Patient F saw Respondent from February 1990 through July 1990.
2. In May 1989, at the age of 39, Patient F noticed a lump in her right breast. In July 1989, the lump was biopsied and a 3x4 segment of the right lower right lower quadrant was removed. Pathology revealed poorly differentiated infiltrating duct carcinoma. Two weeks later, a re-excision of the biopsy site and

axillary dissection revealed no lymph node involvement. A chest x-ray, bone scan, and liver sonogram at that time were all within normal limits. The patient was started on Nolvadez. She also began alternative therapy with Dr. Atkins and autogenous vaccine therapy with Dr. Speckhart. These therapies continued until 1990. Patient had refused radiation and chemotherapy, although she did take Nolvadex. In September 1989, when Patient F had a recurrence, she agreed to start chemotherapy and radiation. She received six cycles of chemotherapy, followed by radiation to the chest wall. The treatment was planned to continue until February or March 1990, but Patient F elected to discontinue in December 1989. (Ex. 20, pp. 54-58)

3. Patient F first met with Respondent on February 1, 1990. He noted Patient F's history and physical exam revealed no breast lesion. Respondent's assessment was cancer with no evidence of active disease at present. His plan was to place Patient F on his nutritional protocol. Routine laboratory tests (blood chemistries and CBC) were done. Blood chemistry revealed elevated alkaline phosphatase and lactic dehydrogenase. (Ex. 20, pp. 50, 54-58)

4. By telephone on February 9, 1990, Patient F reported a rash on her face. In telephone calls of February 21 and March 21, 1990, she reported doing well. In a telephone call of April 12, 1990, Patient F complained of diarrhea and smoke coming from her mouth after taking supplements. On April 23, 1990, Patient F's husband telephoned and reported that Patient F had a rash on her

radiated breast, which was oozing and had little sores.

Respondent noted that she was doing OK, other than inflammation of the chest wall. On May 2, 1990, another phone call from Patient F's husband reported that the skin on her breast was opening up and weeping. Respondent directed that she stop hot baths. On May 7, 1990, a telephone message reported that Patient F had "lumps in her neck, painful loss of sensation, right arm and hand." (Ex. 20, pp. 36, 44-47, 52-53; T. 422-423)

5. In an office visit of May 9, 1990, Respondent recorded that Patient F's diagnosis was recurrent metastatic breast cancer. At that point, there was no documentation regarding the disease being metastatic. Respondent noted an MRI of May 8, 1990 of the cervical spine, which was clear. Respondent noted neck and right arm pain and attributed the right arm pain to repair and rebuilding. Physical examination revealed large left and right cervical nodes which were very tender and up to 3 cm. in size on the left. Examination of the chest revealed scabbing and erythremia. Other than the MRI, no further neurological examination was performed. Respondent's assessment noted a CT test result and that the patient was doing fine and was toxic. (Ex. 20, p. 38; T. 423-424, 432)

6. Following a telephone call from Patient F on May 21, 1990, Respondent noted, "She sounds toxic - told to stop pills." On May 23, 1990, Patient F called complaining of worsening pain to the back of the neck, feeling like a head cold. (Ex. 20, pp. 34-35; T. 425-426)

7. In an office visit on May 31, 1990, Patient F expressed concern about pain and adenopathy in her neck and generalized malaise. Respondent explained that those were predictable signs of toxicity, usually from tumor breakdown. Physical examination revealed large left cervical nodes which were hard and tender, as well as a single mid-scalp 2 cm. nodule. Her right chest was inflamed. Respondent's assessment was, "toxic, probably secondary to tumor breakdown." Respondent ordered blood chemistries. (Ex. 20, pp. 31, 32; T. 426, 432)

8. Patient F was admitted to Community Medical Center, Toms River, New Jersey, on June 12, 1990. The hospital evaluation revealed large right pleural effusion. Thoracentesis and pleural biopsy showed metastatic cancer of the breast. CAT scan revealed hepatic metastases. The right breast was noted to be enlarged, erythematous, and irregular with crusting. (Ex. 20, p. 30; Ex. 24; T. 426-427)

9. In June 18, 1990, Patient F's husband telephoned to report that Patient F had been off diet and pills since June 12 and May 9, 1990, respectively, and that he wanted her out of the hospital. Respondent noted that it was dangerous to be off diet and pills for so long. Patient F's husband telephoned again on June 21, 1990, and reported that Patient F was home, her pain appeared controlled and her jaw shut tight. He called again on June 22 to report that Patient F could not swallow her pills. Respondent noted that, "if she doesn't do the program she is going to die." (Ex. 20, pp. 10-11, 28; T. 427)

10. At an office visit on June 25, 1990, Respondent noted that Patient F had been off protocol and options were discussed. Respondent referred Patient F to Dr. Falk in Toronto. No examination was performed. (Ex. 20, p. 9; T. 427-428)

11. By letter dated June 26, 1990, Dr. Falk wrote Respondent that Patient F had a mass in her left cheek, a scalp nodule and enlarged lymph nodes, all felt to be the result of cancer, as well as known pleural effusion. It also stated that Patient F would be treated by Dr. Falk. (Ex. 20, pp. 3-4)

12. Respondent's last office entry of July 9, 1990 stated that Patient F was significantly improved since seeing Dr. Falk. (Ex. 20, p. 5)

13. Patient F was readmitted to Community Medical Center in Toms River on June 23 and July 11, 1990, and underwent repeat thoracentesis each time. She expired on July 20, 1990. (Ex. 20, p. 2; Ex. 24)

CONCLUSIONS AS TO PATIENT F

1. **Allegation F-1 is SUSTAINED.** Respondent failed to perform appropriate staging of Patient F's disease. He did not order a baseline chest x-ray when Patient F first came to see him in February 1990 nor did he order a bone scan, which was also indicated to assess dissemination of disease. Blood tests and tumor markers in February 1990 were sufficient. Subsequently, as Patient F developed progressive lymphadenopathy, and crusting and weeping of the chest wall, Respondent did not perform a biopsy of

the chest wall, additional blood tests (other than CBC on May 31, 1990), tumor markers, chest x-ray or bone scan, to assess whether symptoms were due to recurring disease and whether other evidence of progressive or metastatic disease was present.

2. **Allegation F-2 is NOT SUSTAINED.** Follow up monitoring, particularly with respect to neurological symptoms, was adequate.

3. **Allegation F-3 is SUSTAINED.** Respondent failed to correctly interpret signs and symptoms of Patient F's disease. Tests taken during Patient F's June 12, 1990 hospitalization showed that her symptoms - progressive inflammation, crusting and weeping of breast, increased pain in neck and arms, progressive lymphadenopathy and malaise - were the result of metastatic disease. However, Respondent attributed those symptoms to toxicity and to a repair and rebuilding process.

4. **Allegation F-4 is SUSTAINED.** Respondent failed to correctly document evaluation and treatment of Patient F. Respondent never documented that Patient F was in fact experiencing progressive disease.

DISPOSITION OF ALLEGATIONS

Allegation A is sustained.

Allegation A-1 is SUSTAINED. (appropriate staging of disease)

Allegation A-2 is NOT SUSTAINED. (sufficient laboratory and radiological evaluations)

Allegation A-3 is SUSTAINED. (sufficiently frequent follow-up evaluations)

Allegation A-4 is SUSTAINED. (interpretation of signs and symptoms of disease progression)

Allegation A-5 is SUSTAINED. (documentation of evaluation and treatment)

Allegation B is sustained.

Allegation B-1 is SUSTAINED. (appropriate staging)

Allegation B-2 is NOT SUSTAINED. (adequate history)

Allegation B-3 is NOT SUSTAINED. (adequate and/or sufficiently frequent follow-up evaluations)

Allegation B-4 is SUSTAINED. (sufficient laboratory and radiological evaluations)

Allegation B-5 is SUSTAINED. (adequate neurological evaluation)

Allegation B-6 is SUSTAINED. (interpretation of signs and symptoms of disease progression)

Allegation B-7 is NOT SUSTAINED. (documentation of evaluation and treatment)

Allegation C is sustained.

Allegation C-1 is NOT SUSTAINED. (appropriate staging)

Allegation C-2 is NOT SUSTAINED. (adequate history)

Allegation C-3 is NOT SUSTAINED. (adequate physical examinations)

Allegation C-4 is SUSTAINED. (adequate neurological evaluation)

Allegation C-5 is SUSTAINED. (sufficient laboratory and radiological evaluations)

Allegation C-6 is NOT SUSTAINED. (sufficiently frequent follow-up evaluations)

Allegation C-7 is SUSTAINED. (interpretation of signs and

symptoms of disease progression)

Allegation C-8 is NOT SUSTAINED. (documentation of evaluation and treatment)

Allegation D is sustained.

Allegation D-1 is NOT SUSTAINED. (appropriate staging)

Allegation D-2 is SUSTAINED. (adequate physical examinations)

Allegation D-3 is SUSTAINED. (sufficient laboratory and radiological evaluations)

Allegation D-4 is NOT SUSTAINED. (adequate gastroenterologic workup)

Allegation D-5 is NOT SUSTAINED. (sufficiently frequent follow-up evaluations)

Allegation D-6 is SUSTAINED. (interpretation of signs and symptoms of disease progression.

Allegation D-7 is SUSTAINED. (documentation of evaluation and treatment)

Allegation E is sustained.

Allegation E-1 is NOT SUSTAINED. (appropriate staging)

Allegation E-2 is SUSTAINED. (sufficiently thorough follow-up monitoring)

Allegation E-3 is SUSTAINED. (interpretation of signs and symptoms of disease progression)

Allegation E-4 is NOT SUSTAINED. (documentation of evaluation and treatment)

Allegation F is sustained.

Allegation F-1 is SUSTAINED. (sufficient laboratory and

radiological evaluations)

Allegation F-2 is NOT SUSTAINED. (sufficiently thorough follow-up monitoring)

Allegation F-3 is SUSTAINED. (interpretation of signs and symptoms of disease progression)

Allegation F-4 is SUSTAINED. (documentation of evaluation and treatment)

CONCLUSIONS

Based upon the foregoing Findings of Fact, the Hearing Committee makes the following Conclusions with regard to the Specifications. In so doing, the Hearing Committee notes its conclusion that Respondent's practice as an alternative specialist did not entitle him to an alternative standard of review insofar as the charges were concerned. For all patients A through F, the Hearing Committee found that Respondent failed to correctly interpret signs and symptoms of disease progression (allegations A-4, B-6, C-7, D-6, E-3, F-3), in some cases attributing symptoms of cancer progression to non-compliance with his protocol. For each of the patients A through F, this failure was compounded by Respondent's failure to otherwise meet specified minimum standards as evidenced by the factual allegations sustained by the Hearing Committee. However, this pattern was not consistent, as evidenced by those allegations not sustained by the Committee, in reference to Respondent's staging of disease (C-1, D-1, E-1), history (B-2, C-2), laboratory and

radiological evaluations (A-2), follow-up evaluations (B-3, C-6, D-5, F-2), and documentation (B-7, C-8, E-4).

All votes of the Hearing Committee were unanimous.

1. The First Specification charges Respondent with practicing with negligence on more than once occasion based upon factual allegations A through F of the Statement of Charges. The Hearing Committee sustains this specification and finds that Respondent's treatment of Patients A through F was negligent within the meaning of New York State Education Law Section 6530(3) in that it did not conform to the standard of care of a reasonably prudent physician under the same circumstances. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The First Specification is SUSTAINED.

2. The Second Specification charges that Respondent with practicing with incompetence on more than one occasion, based upon factual allegations A through F of the Statement of Charges. The Hearing Committee sustains this specification and finds that Respondent's treatment of Patients A through F was incompetent within the meaning of New York State Education Law Section 6530(5) in that it demonstrated a lack of requisite skill and knowledge. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Second Specification is SUSTAINED.

3. The Third through Eighth Specifications charge Respondent with gross negligence in the treatment of Patients A through F, as set forth in factual allegations A through F of the Statement of Charges. The Hearing Committee does not sustain these specifications, finding that Respondent's treatment was not grossly negligent within the meaning of New York State Education Law Section 6530(4) in that although not conforming to the requisite standard of care, it was not characterized by conduct which was egregious and conspicuously bad.

The Third through Eighth Specifications are NOT SUSTAINED.

4. The Ninth through Fourteenth Specifications charge Respondent with gross incompetence in the treatment of Patients A through F, as set forth in factual allegations A through F of the Statement of Charges. The Hearing Committee does not sustain these specifications, finding that Respondent's treatment was not grossly incompetent within the meaning of New York State Education Law Section 6530(6) in that it did not demonstrate an unmitigated lack of requisite skill and knowledge.

The Ninth through Fourteenth Specifications are NOT SUSTAINED.

5. The Fifteenth Specification charges Respondent with failure to maintain records which accurately reflected the evaluation and treatment of Patients A through F, based upon factual allegations A and A-5, B and B-7, C and C-8, D and D-7, E and E-4, F and F-4,

as set forth in the Statement of Charges. The Hearing Committee has sustained specifications A and A-5, D and D-7, and F and F-4, and finds that Respondent failed to maintain records which accurately reflected the evaluation and treatment of Patients A, D, and F, within the meaning of New York State Education Law Section 6530(32).

The Fifteenth Specification is SUSTAINED.

ORDER AND PENALTY

In determining a penalty, the Hearing Committee was motivated by its belief that the serious nature of the findings warranted supervised probation of the Respondent, and appropriate training in regard to the deficiencies he had exhibited, as evidenced by the factual allegations sustained.

To that end, the Hearing Committee sought both training appropriate for Respondent's practice, the vast majority of whose patients have some form of cancer, and experience in a setting that would acquaint Respondent with the broader aspects of practice, including the entire cycle of death and available palliative aspects of treatment of the terminally ill. In addition, the Hearing Committee concluded that a stringent monetary penalty should be assessed, both as a penalty to Respondent and a deterrent to others.

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

1. The license to practice medicine of Respondent **NICHOLAS**

GONZALEZ shall be suspended for three years, and that

2. The suspension shall be stayed with probation, subject to the following conditions:

(a) Respondent will be supervised by the Office of Professional Medical Conduct (OPMC). OPMC will have the responsibility for monitoring and determining Respondent's compliance with the conditions of his probation.

(b) Respondent will find, enroll in, and satisfactorily complete a qualified certified oncology program or internship, subject to approval by OPMC.

(c) Respondent will locate and complete 200 hours of community service in a hospice setting, subject to approval by OPMC.


3. Respondent shall pay a fine in the amount of \$15,000, \$5,000 for each sustained specification of professional misconduct.

This Order shall take effect thirty (30) days from the date of service upon Respondent's counsel by personal service or certified or registered mail.

Dated: New York, New York

June 8 1994

BY:


Sharon C.H. Mead, M.D.
Chairperson

Edward C. Zaino, M.D.
Eugenia Herbst

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

-----X
:
IN THE MATTER
:
OF
:
NICHOLAS GONZALEZ, M.D.
:
HEARING
-----X

TO: NICHOLAS GONZALEZ, M.D.
737 Park Avenue
New York, New York 10021

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1993). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 7th and 8th days of October, 1993, at 10:00 in the forenoon of those days at 5 Penn Plaza, Sixth Floor, New York, New York 10001 and at such other adjourned dates, times and places as the committee may direct.

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

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

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

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the

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

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

THESE PROCEEDINGS MAY RESULT IN A
DETERMINATION THAT YOUR LICENSE TO PRACTICE
MEDICINE IN NEW YORK STATE BE REVOKED OR
SUSPENDED, AND/OR THAT YOU BE FINED OR
SUBJECT TO THE OTHER SANCTIONS SET OUT IN
NEW YORK PUBLIC HEALTH LAW SECTION 230-a
(McKinney Supp. 1993). YOU ARE URGED TO
OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS
MATTER.

DATED: New York, New York

Aug 27, 1993

Chris Stern Hyman for:

CHRIS STERN HYMAN,
Counsel

Inquiries should be directed to: Ralph J. Bavaro
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001
Telephone No.: 212-613-2615

DLS

DEMOVSKY LAWYER SERVICE

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

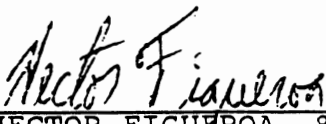
-----X
IN THE MATTER
OF NICHOLAS GONZALEZ, M.D.,
AFFIDAVIT OF SERVICE

-----X
STATE OF NEW YORK)
 S.S.:
COUNTY OF NEW YORK)

HECTOR FIGUEROA, being duly sworn, deposes and says
that he is over the age of eighteen years, is employed by the
attorney service, DLS, INC., and is not a party to this action.

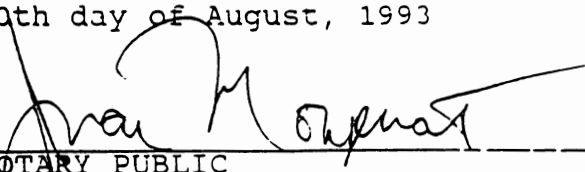
That on the 27th day of August, 1993, at approximately
1:25P.M., deponent served a true copy of the NOTICE OF HEARING
upon Nicholas Gonzalez, M.D. at 737 Park Avenue, New York, New
York 10021, by personally delivering and leaving the same with
Nicholas Gonzalez, M.D. at that address. At the time of
service, deponent asked Nicholas Gonzalez whether he is in
active military service for the United States of America or for
any state in the United States in any capacity whatever and
received a negative reply.

Dr. Gonzales is a white male, approximately 35 years of
age, stands approximately 5 feet 11 inches tall, weighs
approximately 190 pounds with dark hair and blue eyes.



HECTOR FIGUEROA 870141

Sworn to before me this
30th day of August, 1993



NOTARY PUBLIC

JUAN MONSERATE
NOTARY PUBLIC, State of New York
No. 24-4962482
Qualified in Kings County 94
Commission Expires Feb. 20, 1994

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

-----X
IN THE MATTER : STATEMENT
OF : OF
NICHOLAS GONZALEZ, M.D. : CHARGES
-----X

NICHOLAS GONZALEZ, M.D., the Respondent, was authorized to practice medicine in New York State on August 11, 1987 by the issuance of license number 171787 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 737 Park Avenue, New York, N.Y. 10021.

FACTUAL ALLEGATIONS

- A. Respondent treated Patient A (Patient A and all patients heretofore mentioned are more fully identified in Appendix A) for breast cancer at Respondent's private office located at 737 Park Avenue, New York, N.Y., from approximately December 1988 through December 1991. With respect to Patient A, Respondent:

1. Failed to perform appropriate staging of disease.

2. Failed to perform sufficient laboratory and radiological evaluations such as blood tests, chest x-ray and bone scan.
3. Failed to perform sufficiently frequent follow-up evaluations.
4. Failed to correctly interpret signs and symptoms of disease progression.
5. Failed to accurately document evaluation and treatment.

B. Respondent treated Patient B for breast cancer at Respondent's private office, from approximately July 1989 through June 1990. With respect to Patient B, Respondent:

1. Failed to perform appropriate staging of disease.
2. Failed to obtain adequate history.
3. Failed to perform adequate and/or sufficiently frequent physical examinations.
4. Failed to perform sufficient laboratory and radiological evaluations, such as blood tests, tumor markers, CAT scan, chest x-ray and/or bone scan.

5. Failed to perform, or seek consultation for, adequate neurological evaluation.
6. Failed to correctly interpret signs and symptoms of disease progression.
7. Failed to accurately document evaluation and treatment.

C. Respondent treated Patient C for breast cancer at Respondent's private office, from approximately October 1989 through October 1990. With respect to Patient C, Respondent:

1. Failed to perform appropriate staging of disease.
2. Failed to obtain adequate history.
3. Failed to perform adequate physical examinations.
4. Failed to perform, or seek consultation for, adequate neurological evaluation.
5. Failed to perform sufficient laboratory and radiological evaluations such as blood tests, chest x-ray and bone scan.

6. Failed to perform sufficiently frequent follow-up evaluations.
7. Failed to correctly interpret signs and symptoms of disease progression.
8. Failed to accurately document evaluation and treatment.

D. Respondent treated Patient D for ovarian cancer at Respondent's private office, from approximately August 1989 through August 1990. With respect to Patient D, Respondent:

1. Failed to perform appropriate staging of disease.
2. Failed to perform adequate physical examinations.
3. Failed to perform sufficient laboratory and radiological evaluations such as tumor markers, and CAT scan or magnetic resonance imaging.
4. Failed to perform, or seek consultation for, adequate gastroenterologic workup in a timely manner.
5. Failed to perform sufficiently frequent follow-up evaluations.

6. Failed to correctly interpret signs and symptoms of disease progression.

7. Failed to adequately document evaluation and treatment.

E. Respondent treated Patient E for colonic cancer at Respondent's private office, from approximately July 1988 through August 1990. With respect to Patient E, Respondent:

1. Failed to perform appropriate staging of disease.

2. Failed to perform sufficiently thorough follow-up monitoring, particularly with respect to progressive dyspnea, disorientation, weight gain/loss, and syncope.

3. Failed to correctly interpret signs and symptoms of disease progression.

4. Failed to accurately document evaluation and treatment.

F. Respondent treated Patient F for breast cancer at Respondent's private office, from approximately February 1990 through July 1990. With respect to Patient F, Respondent:

1. Failed to perform sufficient laboratory and radiological evaluations such as chest x-ray, bone scan, tumor markers and blood tests.
2. Failed to perform sufficiently thorough follow-up monitoring, particularly with respect to neurological symptoms.
3. Failed to correctly interpret signs and symptoms of disease progression.
4. Failed to accurately document evaluation and treatment.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993) in that Petitioner charges the Respondent with having committed at least two of the following:

1. The facts contained in Paragraphs A and A1-A5, B and B1-B7, C and C1-C8, D and D1-D7, E and E1-E4, and/or F and F1-F4.

SECOND SPECIFICATION
PRACTICING WITH INCOMPETENCE
ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1993), in that Petitioner charges the Respondent with having committed at least two of the following:

2. The facts contained in Paragraphs A through A1-A5, B and B1-B7, C and C1-C8, D and D1-D7, E and E1-E4, and/or F and F1-F4.

THIRD THROUGH EIGHTH SPECIFICATIONS
PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1993), in that Petitioner charges:

3. The facts contained in Paragraph A and A1-A5.

4. The facts contained in Paragraph B and B1-B7.
5. The facts contained in Paragraph C and C1-C8.
6. The facts contained in Paragraph D and D1-D7.
7. The facts contained in Paragraph E and E1-E4.
8. The facts contained in Paragraph F and F1-F4.

NINTH THROUGH FOURTEENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence on more than one occasion under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1993), in that Petitioner charges:

9. The facts contained in Paragraph A and A1-A5.
10. The facts contained in Paragraph B and B1-B7.
11. The facts contained in Paragraph C and C1-C8.
12. The facts contained in Paragraph D and D1-D7.

13. The facts contained in Paragraph E and E1-E4.

14. The facts contained in Paragraph F and F1-F4.

FIFTEENTH SPECIFICATION

FAILURE TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1993), in that he failed to maintain records for patients which accurately reflected the evaluation and treatment of the patients.

Petitioner charges:

15. The facts contained in Paragraphs A and A5, B and B7, C and C8, D and D7, E and E4, and/or F and F4.

DATED: New York, New York

8/24/93

Chris Stern Hyman for:

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct