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

COMMISSIONER'S ORDER

TO: NIELS HELTH LAUERSEN, M.D.

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr. P.H., Commissioner of Health, after an investigation, upon the attached recommendation of a Hearing Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached thereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by NIELS HELTH LAUERSEN, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12), that effective immediately NIELS HELTH LAUERSEN, M.D. Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12).

DATED: Albany, New York
August, 9, 2000

REDACTED

ANTONIA C. NOVELLO, M.D., M.P.H., Dr. P.H.
Commissioner
New York State Health Department

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

IN THE MATTER

OF

NIELS HELTH LAUERSEN, M.D.

HEARING COMMITTEE'S RECOMMENDATION TO THE COMMISSIONER

MICHAEL R. GOLDING, M.D. (Chair), **REVEREND THOMAS KORNMEYER** , and **FRED LEVINSON, MD.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARY NOE, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health appeared by **PAUL STEIN, ESQ.**, Associate Counsel.

Respondent, **NIELS HELTH LAUERSEN, M.D.**, appeared personally and was represented by **ROBERT S. DEUTSCH, ESQ., AARONSON RAPPAPORT FEINSTEIN & DEUTSCH, LLP.** for the hearing of **DR. NIELS HELTH LAUERSEN.**

Hearings were held on May 18th, June 5th, July 17th, July 18th, July 19th, July 20th, July 21st, July 24th, July 25th, July 26th, July 27th, July 28, 2000. Evidence was received and examined. Transcripts of the proceeding were made. The Hearing Committee after hearing the testimony to date and reviewing the evidence issues this Hearing Committee's Recommendation to the Commissioner of the New York State Department of Health.

NIELS HELTH LAUERSEN, M.D., ("Respondent") is charged with professional misconduct within the meaning of §§6530(3), (4), (5), (6), (19), and (32) of the Education Law of the State of New York.

A copy of the Statement of Charges is attached to this Hearing Committee Recommendation to the Commissioner as Appendix I.

The Hearing Committee has heard the testimony of the Department's twelve witnesses and Respondent's six witnesses. In addition, the Respondent testified on: July 21st, July 25th, July 26th, and July 28th. The Respondent has not concluded his testimony as to one Patient, (out of a total of 8 patients) and has not addressed the fraud charges.

Based on the evidence presented in this proceeding, it is the opinion of the Hearing Committee that Respondent's continued practice of medicine represents an imminent danger to the health of the public. The Respondent's medical care is fraught with dangerous, inappropriate techniques repeatedly used in the hospital and at his office. The Respondent's credibility is questionable due to his testimony which directly contradicts facts in evidence as well as his pattern of practice whereby his operative reports repeatedly conflict with the diagnosis on the pathological reports submitted in evidence. Finally, the Committee is concerned about the Respondent's behavior exhibited during the hearing whereby the Respondent's testimony became increasingly more confused and incoherent, this was especially worrisome because the Respondent was intending on returning to his office immediately after the hearing to care for patients. The Committee reviewed letters from the Respondent to patients, which were admitted into evidence, containing disjointed facts and his request of a patient to not cooperate with the New York State Office of Professional Medical Conduct's investigations. The Hearing Committee strongly believes that it would be dangerous and prejudicial to the interest and health of the People of New York to permit Respondent

to continue to practice medicine. The Hearing Committee believes that Respondent's license should be immediately suspended pending the issuance of the final Determination and Order in this matter.

Therefore, the Hearing Committee makes this unusual request and recommendation to the Commissioner of the Department of Health. The Hearing Committee recommends that NIELS HELTH LAUERSEN's license to practice medicine in the State of New York be immediately suspended.

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

DATED: ~~New York, New York~~ Flims-Waldhaus Switzerland
August 04, **2000**

REDACTED

MICHAEL R. GOLDING, M.D. (Chair)
REVEREND THOMAS KORNMEYER
FRED LEVINSON, MD

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
New York State Department of Health
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NIELS HELTH LAUERSEN, M.D.
REDACTED

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

IN THE MATTER

OF

NIELS HELTH LAUERSEN, M.D.

STATEMENT

OF

CHARGES

NIELS HELTH LAUERSEN, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 16, 1969 by the issuance of license number 104954 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about April 1, 1998 through on or about December 2, 1998, Respondent provided obstetrical care for Patient A (Patient A and all other patients are identified in Appendix A), in his New York City offices and at Lenox Hill Hospital, New York City. Patient A's prenatal course was essentially uneventful. On or about November 28, 1998, Respondent admitted Patient A to Lenox Hill Hospital. She was managed with analgesics and epidural anesthesia for pain relief, and given oxytocin to augment her labor. The fetus developed signs of distress late in the course of the labor. Respondent attempted forceps delivery twice, but failed, and the infant was delivered on November 28, 1998 by emergency cesarean section. The infant required aggressive cardiopulmonary resuscitation and was treated in the neonatal intensive care

unit, where he was found to have suffered severe brain damage. He recovered sufficiently to be discharged home.

1. On November 27, 1998, Respondent scheduled Patient A for induction of labor on November 29, 1998 without adequate medical indication.

2. Respondent failed to timely recognize and respond to the development of a nonreassuring electronic fetal heart rate monitoring tracing pattern of Patient A's fetus, indicative of compression of the fetal umbilical cord.

3. Respondent failed to timely effect delivery of Patient A's baby upon recognizing signs of fetal compromise.

4. Respondent failed to timely recognize the signs of cephalopelvic disproportion in Patient A.

5. Respondent failed to timely evaluate Patient A for the presence of cephalopelvic disproportion.

6. Respondent inappropriately applied fundal pressure to Patient A in the presence of cephalopelvic disproportion.

7. Respondent inappropriately attempted a vaginal delivery with midforceps on Patient A.

8. Respondent failed to timely perform a cesarean section on Patient A.

9. Respondent improperly positioned the forceps on Patient A's fetus.

10. Respondent employed excessive force to deliver Patient A's fetus with forceps.

11. Respondent failed to keep an adequate record for Patient A, including but not limited to, failing to periodically record fetal station, not identifying the type of forceps used, not identifying the fetal position at application of forceps, not identifying fetal station at time of application of forceps, not describing the degree of molding, and not characterizing the pelvic architecture and capacity.

12. Respondent, intentionally, with intent to deceive, asked the delivery room nurse (identified in Appendix A) to falsify the times listed in Patient A's record for Respondent's application of forceps.

B. From in or about 1984 through on or about May 22, 1998, Respondent treated Patient B, in his New York City offices and at Lenox Hill Hospital, New York City, for a long history of

pelvic pain. During the course of this treatment, before May 9, 1997, Respondent performed approximately 11 laparoscopies on Patient B for pain, all without more than temporary relief. On or about May 9, 1997, Respondent performed a laparoscopy and other procedures on Patient B, in his New York City offices. On or about May 11, 1998, Respondent performed a laparoscopy and other procedures on Patient B, at Lenox Hill Hospital.

1. Respondent incorrectly recorded in the operative reports for the May 9, 1997 and May 11, 1998 procedures that Patient B suffered from menometrorrhagia and from heavy menstrual and intermenstrual bleeding.

2. Respondent incorrectly recorded in the operative report for Patient B's May 9, 1997 laparoscopy a 5 by 5 cm. ovarian cyst with a large endometrioma.

3. Respondent incorrectly recorded in the operative report for Patient B's May 11, 1998 procedures an approximately 5 cm. cyst.

4. Respondent failed to refer Patient B for a psychiatric consultation.

5. Respondent failed to refer Patient B for a pain management consultation.

6. Respondent performed surgery on Patient B on May 11, 1998 without adequate medical indication.

7. Respondent failed to keep an adequate record for Patient B.

8. On several occasions in or about 1999, Respondent, by telephone, intentionally, with intent to deceive, attempted to discourage Patient B's husband (identified in Appendix A) from cooperating with any New York State Department of Health investigation of Respondent.

9. In or about April of 1999, Respondent, intentionally, with intent to deceive, instructed Patient B to write an inaccurate and misleading patient history of herself for his inclusion in his office medical record for Patient B.

C. From on or about March 10, 1987 through on or about October 22, 1992, Respondent provided obstetrical and gynecological care for Patient C, in his New York City offices and at Lenox Hill Hospital, New York City. On or about January 18, 1989, Respondent operated on Patient C for worsening pelvic pain, in his New York City offices. Patient C was admitted to Lenox Hill Hospital on or about March 22, 1992 in labor at 37-38 weeks' gestational age. The

delivery, on March 22, 1992, was complicated by shoulder dystocia. The infant, who weighed 4717 grams at birth, was diagnosed with Erb's palsy of the left arm.

1. Respondent failed to determine whether or not Patient C was pregnant before initiating treatment for endometriosis on or about ~~January 18, 1989~~ March 10, 1987 in what was at least the seventh week of her pregnancy.

2. Respondent performed surgery on Patient C on January 18, 1989 without adequate medical indication.

3. Respondent failed to properly screen Patient C for gestational diabetes during the pregnancy that culminated in the March 22, 1992 birth.

4. Respondent failed to appropriately manage Patient C's gestational diabetes during the pregnancy that culminated in the March 22, 1992 birth.

5. Respondent failed to timely anticipate and prepare for the complicated delivery of Patient C of March 22, 1992.

6. Respondent failed to timely diagnose Patient C's fetus' developing fetal macrosomia.

7. Respondent failed to properly employ appropriate procedures to deliver the Patient C's baby once the diagnosis of shoulder dystocia was made at delivery, including, but not limited to a use of excessive force when pulling on the fetal head, and the inappropriate use of fundal pressure.

8. Respondent failed to keep an adequate record for Patient C, including but not limited to, failing to accurately record Patient C's symptoms, response to therapy, and surgical findings for the procedure of January 18, 1989, and failing to adequately record estimated fetal weight for the pregnancy that culminated in the March 22, 1992 birth.

D. From on or about May 1, 1997 through on or about March 25, 1999, Respondent treated Patient D, in his New York City offices and at Lenox Hill Hospital, New York City, for a long history of endometriosis with chronic pelvic pain and heavy periods. On or about October 8, 1997, in his New York City offices, Respondent performed laparoscopic surgery on Patient D, which included an ovarian cystectomy. On or about January 26, 1998, Respondent performed a hysterectomy, right ovarian cyst resection, and other procedures on Patient D, at Lenox Hill Hospital.

1. Respondent failed to take an appropriate history of Patient D.

2. Respondent incorrectly recorded in his operative report for the laparoscopy of October 8, 1997 that Patient D had extensive endometriosis, an ovarian cyst, and a large uterus.

3. Respondent inconsistently recorded in his office records the size of Patient D's uterine fibroid.

4. Respondent incorrectly recorded Patient D's anatomical condition at the time of the January 26, 1998 surgery on Patient D.

5. Respondent performed a hysterectomy on Patient D without adequate medical indication.

6. Respondent incorrectly recorded that he performed a total abdominal hysterectomy on Patient D on January 26, 1998.

7. Respondent failed to appropriately diagnose and treat Patient D.

8. Respondent failed to keep an adequate record for Patient D.

E. From on or about February 25, 1997 through on or about February 27, 1998, Respondent treated Patient E, in his New York City offices and at Lenox Hill Hospital, New York City, for a long history of increasingly severe pelvic pain and menometrorrhagia. On or about March 12, 1997, Respondent performed a laparoscopy on Patient E, in his New York City offices. On or about February 2, 1998, Respondent performed a total abdominal hysterectomy and removal of left ovarian cyst on Patient E, at Lenox Hill Hospital.

1. Respondent failed to objectively corroborate Patient E's complaints of heavy menstrual and intermenstrual bleeding.

2. Respondent failed to refer Patient E for a psychiatric consultation.

3. Respondent failed to refer Patient E for a pain management consultation.

4. On or about February 2, 1998, Respondent performed a total abdominal hysterectomy on Patient E without adequate medical indication.

5. On or about March 12, 1997, Respondent performed a removal of a normal follicular cyst on Patient E without adequate medical indication.

6. On or about March 12, 1997, Respondent incorrectly recorded a normal follicular cyst removed from Patient E as an ovarian cyst and misdescribed its size.

7. Respondent incorrectly recorded Patient E's symptoms in the hospital record for her admission of February 2-6, 1998.

8. Respondent incorrectly recorded Patient E's anatomical condition in his preoperative office record notes and in the operative record of February 2, 1998.

9. Respondent incorrectly recorded having performed a pelvic floor reconstruction on Patient E on February 2, 1998.

10. Respondent failed to keep an adequate record for Patient E.

F. From on or about January 30, 1998 through on or about May 7, 1999 Respondent treated Patient F, in his New York City offices and at Lenox Hill Hospital, New York City, for a long history of pelvic pain. On or about March 9, 1998, Respondent

performed a dilatation and curettage, examination under anesthesia, exploratory laparotomy, lysis of adhesions, removal of a right ovarian cyst, vaporization of endometriosis, removal of staples from the bowel, a uterine suspension procedure, and a repair of the left incisional hernia on Patient F, at Lenox Hill Hospital.

1. Respondent inappropriately attributed Patient F's pain to endometriosis and adhesions.

2. Respondent failed to refer Patient F for psychiatric consultation.

3. Respondent failed to refer Patient F for pain treatment consultation.

4. Respondent failed to include irritable bowel syndrome in Patient F's differential diagnosis.

5. Respondent undertook surgery on Patient F without adequate medical indication.

6. Respondent inappropriately attributed Patient F's urinary and fecal incontinence, loss of colonic motility, and loss of feeling below the waist to her previous presacral neurectomy.

7. Respondent removed a normal 2.4 cm. hemorrhagic corpus luteum cyst from Patient F without adequate medical indication.

8. Respondent failed to keep an adequate record for Patient F.

G. From on or about March 10, 1998 through on or about May 13, 1998, Respondent treated Patient G, in his New York City offices and at Lenox Hill Hospital, New York City, for symptoms of progressively heavy bleeding and pain due to fibroids. On or about March 30, 1998, Respondent performed a multiple myomectomy, uterine suspension and other procedures on Patient G, at Lenox Hill Hospital.

1. Respondent incorrectly recorded Patient G as suffering from a history of menometrorrhagia.

2. Respondent incorrectly recorded the tissue he removed from Patient G in surgery as a 4 cm. ovarian cyst.

3. Respondent removed a normal corpus luteum cyst from Patient G without adequate medical indication.

4. Respondent incorrectly recorded the size of Patient G's uterus in the operative record and in his office record.

5. Respondent failed to keep an adequate record for Patient G.

H. On or about October 21, 1996, Respondent executed, certified the truth of, and submitted a Confidential Information form for recertification to Aetna/US Healthcare, P.O. Box 150428, Hartford, Connecticut 06115.

1. In this application, Respondent, intentionally, with intent to deceive, answered "No" to question, "8. Are you presently under investigation by any state licensing board or federal agency?", although Respondent knew this statement to be false.

2. In this application, Respondent, intentionally, with intent to deceive, answered "No" to question, "9. Have you been investigated by any state licensing board or federal agency during the past five years?", although Respondent knew this statement to be false.

3. In this application, Respondent, intentionally, with intent to deceive, answered "No" and provided no further information to question, "11. Are you presently a defendant in a malpractice, discrimination or professional liability lawsuit or proceeding or have you been placed on notice of such a potential lawsuit or

proceeding yet to be filed which has not been reported to US Healthcare? If yes, provide full details (including the plaintiff and court caption of any pending lawsuit.", although Respondent knew this statement to be false.

I. On or about April 24, 1998, Respondent executed, affirmed the truth of, and submitted a Recredentialing Addendum to Oxford Health Plans, Westchester One, 44 South Broadway, White Plains, New York 10601.

1. In this application, Respondent, intentionally, with intent to deceive, initialed the statement, "There are no professional medical misconduct proceedings or peer review-type proceedings pending wherein I am a party in this state or any other state or country.", although Respondent knew this statement to be false.

2. In this application, Respondent, intentionally, with intent to deceive, initialed the statement, "I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payer, Medicare, or Medicaid, or governmental licensing or other authority.", although Respondent knew this statement to be false.

J. On or about December 10, 1998, Respondent executed, affirmed

the truth of, and submitted an Application for Medical Staff Appointments of Continuum Health Partners, Inc. for appointment to Beth Israel Medical Center and to St. Luke's-Roosevelt Hospital Center, both in New York City.

1. In this application, Respondent, intentionally, with intent to deceive, answered "No" to question, "9. 3. Are any professional misconduct proceedings pending against you in any state or other jurisdiction?", although Respondent knew this statement to be false.

2. In this application, Respondent, intentionally, with intent to deceive, answered "No" to question, "9. 7. Have your medical/dental staff appointment/employment status or clinical privileges in any hospital or health care facility every been denied, revoked, suspended, restricted, reduced, limited, placed on probation, not renewed, voluntarily relinquished, discontinued or otherwise changed, including any leaves of absence?", although Respondent knew this statement to be false.

K. On or about December 21, 1998, Respondent executed, verified the truth of, and submitted an Application for Appointment to the Medical/ Dental/Ancillary Staff at Saint Vincent's Hospital and Medical Center, 153 West 11th Street, New York, NY 10011.

1. In this application, Respondent, after listing Lenox Hill Hospital under the section "ALL HOSPITAL APPOINTMENTS", intentionally, with intent to deceive, answered "No" to question, "V. Was any employment, privilege or practice related to ANY Hospital and Faculty Appointments discontinued, *or have your clinical privileges at any listed facilities been limited, reduced or lost*?" [italics and underlining in original], although Respondent knew this statement to be false.

2. In this application, under "Professional Conduct History", Respondent, intentionally, with intent to deceive, answered "No" to question, "IX. A. Have you ever, during your professional career, been the subject of a disciplinary proceeding in this state or any other state?", although Respondent knew this statement to be false.

L. On or about March 16, 1999, Respondent executed and submitted a Membership Application for participation in Saint Vincent's PHO, 130 West 12th Street, New York, NY 10011. On or about April 13, 1999, the Assistant Director of the PHO (identified in Appendix A) had a telephone conversation with Respondent regarding his Membership Application. On or about April 14, 1999 Respondent signed a letter that was sent to the Saint Vincent's PHO.

1. On page "9" of this application, Respondent, after listing Lenox Hill Hospital under the section "Discontinued Hospital Affiliations", intentionally, with intent to deceive, wrote under the heading "Reason for Terminating Privileges" the words "Patients Requests", although Respondent knew this statement to be false and/or misleading.

2. In the telephone conversation with the Assistant Director of the PHO, on or about April 13, 1999, Respondent, intentionally, with intent to deceive, told the Assistant Director of the PHO that by "Patients Requests" he meant that patients had requested that he affiliate himself with St. Vincent's Medical Center. Respondent further stated that he "left" Lenox Hill Hospital, and the Assistant Director of the PHO requested that Respondent provide a letter clarifying why he left Lenox Hill Hospital.

3. In the letter signed by Respondent on or about April 14, 1999 and sent to the Saint Vincent's PHO, Respondent, intentionally, with intent to deceive, stated

> This is to state that I, Niels H. Lauersen, MD as well as other physicians, have left Lenox Hill Hospital because of disagreements with the direction the department was taking after a new Chairman was appointed.

although Respondent knew this statement to be false and/or misleading.

M. On or about April 7, 1999, a nurse reviewer (identified in Appendix A) for Oxford Health Plans, Westchester One, 44 South Broadway, White Plains, New York 10601, spoke with Respondent by telephone as part of her investigation of Respondent's care and treatment of Patient A.

1. During this telephone call, Respondent, intentionally, with intent to deceive, stated that as far as his privileges at Lenox Hill Hospital, he resigned from the hospital, although Respondent knew this statement to be false and/or misleading.

N. On or about July 26, 1999, Respondent was interviewed by Office of Professional Medical Conduct (OPMC) Medical Coordinator Michael Tepedino, M.D. and OPMC Senior Medical Conduct Investigator Thomas Hotz at the OPMC offices at 5 Penn Plaza, 6th floor, New York, New York.

1. During this July 26, 1999 interview, Respondent, intentionally, with intent deceive, stated that Patient B had been a patient of his since January of 1997, he had seen Patient B once before then more than 10 years earlier, he did not maintain Patient B's early records as he did not believe she would return as a private patient, and of the 10 to 12 prior laparoscopies performed on Patient B before 1998, he had performed one, although he knew these statements to be false and/or misleading.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

PRACTICING WITH 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:

1. Paragraphs A and A1-11.
2. Paragraphs B and B1-7.
3. Paragraphs C and C1-8.
4. Paragraphs D and D1-8.
5. Paragraphs E and E1-10.

SIXTH THROUGH TENTH SPECIFICATIONS

PRACTICING WITH 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:

6. Paragraphs A and A1-11.
7. Paragraphs B and B1-7.

8. Paragraphs C and C1-8.

9. Paragraphs D and D1-8.

10. Paragraphs E and E1-10.

ELEVENTH SPECIFICATION

PRACTICING WITH 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:

11. Paragraphs A and A1-11; B and B1-7; C and C1-8; D and D1-8; E and E1-10; F and F1-8; and/or G and G1-5.

TWELFTH SPECIFICATION

PRACTICING WITH 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:

12. Paragraphs A and A1-11; B and B1-7; C and C1-8; D and D1-8; E and E1-10; F and F1-8; and/or G and G1-5.

THIRTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

EXCESSIVE TREATMENT

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

13. Paragraphs B and B6.
14. Paragraphs C and C2.
15. Paragraphs D and D5.
16. Paragraphs E and E4-5.
17. Paragraphs F and F5, 7.
18. Paragraphs G and G3.

NINETEENTH THROUGH TWENTY-SEVENTH 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 fraudulently as alleged in the facts of the following:

19. Paragraphs A and A12.
20. Paragraphs B and B8-9.
21. Paragraphs H and H1-3.

22. Paragraphs I and I1-2.

23. Paragraphs J and J1-2.

24. Paragraphs K and K1-2.

25. Paragraphs L and L1-3.

26. Paragraphs M and M1.

27. Paragraphs N and N1.

TWENTY-EIGHTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6630(20)(McKinney Supp. 2000) by conduct in the practice of medicine which evidences moral unfitness to practice medicine as alleged in the facts of the following:

28. Paragraphs A and A12; B and B8-9; H and H1-3; I and I1-2; J and J1-2; K and K1-2; L and L1-3; M and M1; and/or N and N1.

TWENTY-NINTH THROUGH THIRTY-FIFTH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

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 evaluation and treatment of the patient as alleged in the facts of the following:

29. Paragraphs A and 11.

30. Paragraphs B and B1-3, 7.

31. Paragraphs C and C8.

32. Paragraphs D and D2-4, 6, 8.

33. Paragraphs E and E6-10.

34. Paragraphs F and F8.

35. Paragraphs G and G1-2, 4-5.

DATED: New York, New York
April 24, 2000

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct