STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Public

July 27, 2005

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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Corning Tower, Room 2509
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RE: In the Matter of Akiva Abraham, M.D.

Dear Parties:

Enclosed please find a copy of Determination and Order (No. 05-154) of the Hearing Committee in the above referenced matter. This supplants the mailing under date of July 26, 2005 which inadvertently did not include Appendix 1, and the assigned D&O number.

We regret any inconvenience this administrative error may have caused.

Sincerely,

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:djh

Enclosure

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

ORIGINAL

IN THE MATTER OF AKIVA ABRAHAM, M.D., Respondent	DETERMINATION AND ORDER BPMC NO. 05-154

A Notice of Hearing dated June 14, 2004, and a Statement of Charges dated June 24, 2004, were served upon the Respondent, AKIVA ABRAHAM, M.D., **FRED S. LEVINSON, M.D., (Chair), PETER G. KANSAS, M.D. and VIRGINIA R. MARTY** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the Committee) in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Lee A. Davis, Esq., Assistant Counsel. The Respondent appeared by Hacker & Murphy, James E. Hacker, Esq. of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Notice of Hearing	June 14, 2004
Statement of Charges:	June 24, 2004
Dates of Hearing:	June 16, 2004
	June 17, 2004
	September 9, 2004
	October 14, 2004
	December 21, 2004
	January 24, 2005
	January 25, 2005
	February 17, 2005
	February 18, 2005
	March 17, 2005
Date of Deliberations:	May 17, 2005

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated the following seven categories of professional misconduct: gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, failure to maintain accurate records, moral unfitness and having a psychiatric condition which impairs the ability to practice medicine. A copy of the Amended Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are the unanimous determination of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact.

1. Akiva Abraham, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on or about June 9, 1997 by the issuance of license number 206885 by the New York State Education Department. (Exs. 1 & 4)

PATIENT A

2. Respondent provided medical care and treatment to Patient A, a 25 year old female, from on or about January 12, 2002, through on or about September 3,

2002, at 989 Route 146, Clifton Park, New York (hereinafter his "office") and at Patient A's residence. The medical care and treatment that Respondent provided included routine gynecological care, termination of pregnancy and care for other medical conditions. (Ex. 6)

3. On or about March 8, 2002, the Respondent administered 100 mg of Methotrexate to Patient A for the purpose of terminating her pregnancy. When administering Methotrexate a contemporaneous blood analysis should be obtained to identify any potentially negative complications. The Respondent did not obtain this. (T. 198-201; Ex. 6)

4. On or about March 13, 2002, the Respondent prescribed Cytotec (misoprostol) to Patient A to assist in the termination of her pregnancy and recorded this prescription. (Ex. F)

5. On or about March 13, 2002, the Respondent delivered a prescription pain medication to Patient A at her residence but failed to record the prescribing of this medication. If a medication is prescribed it should be recorded in the medical record. (T. 89, 202-203, 1292, 1313-1314; Ex. 6)

6. On or about March 13, 2002, subsequent to delivering pain medication to Patient A at her residence and her ingestion of this medication, the Respondent initiated sexual contact with Patient A. (T. 94, 1316)

7. Between the period of March 13, 2002 and on or about August 3, 2002, the

Respondent was Patient A's gynecologist. (T. 101; Ex. J)

8. Between the period of March 13, 2002 and on or about August 3, 2002, the Respondent and Patient A had sexual relations at Patient A's apartment, the Respondent's office and St. Peter's Hospital, Albany, New York. (T. 94-98)

9. Between the period of March 13, 2002 and on or about August 3, 2002, the Respondent maintained romantic feelings for Patient A and expressed those feelings to Patient A, visited Patient A's residence on at least three occasions bringing her gifts and flowers and assisted her in obtaining a job. (T. 91-93; Exs. 27-b and J)

10. On or about May 5, 2002, Respondent compelled Patient A to have sexual intercourse with him. (T. 100-101)

11. On or about September 29, 2003, in an interview with the State Department of Health, conducted pursuant to the Public Health Law, the Respondent falsely stated that he did not have a physical or sexual relationship with Patient A. (T. 38, 1293; Ex. 27-b)

PATIENT B

12. Respondent provided medical care and treatment to Patient B on or about April 1995 at Albany Medical Center, Albany, New York. (T. 1283-1285; Ex. 9)

13. On or about April 1995 the Respondent entered information on Patient B's hospital chart from a previous physical examination conducted by someone else

without performing a contemporaneous physical examination. (T. 1284-1285; Ex. 9)

PATIENT C

14. Respondent provided medical care and treatment to Patient C, an 82 year old female, from on or about October 26, 1999 through December 16, 1999 at the Samaritan Hospital, Troy, New York and Seton Health OB/GYN, Troy, New York. On or about October 26, 1999 the Respondent performed a Dilation and Curettage on Patient C. (Ex. 10)

15. On or about December 16, 1999 the Respondent saw Patient C during a follow-up visit at Seton Hall OB/GYN. The Respondent was with Patient C for less than 15 minutes and did not physically examine the patient nor did he take the patient into an examination room. For this office visit the Respondent entered information in the Patient's chart from a physical examination which was previously conducted during the patient's hospitalization and then entered a billing code level V for the care delivered on this date. A billing code V indicates a thorough physical examination occurred during an office visit of a substantial amount of time. That did not occur in this instance. (T. 115-125; Exs. 10, 11, 11a)

PATIENT D

16. Respondent provided medical care and treatment to Patient D, a 30 year old female, from on or about March 7, 2002 through October 10, 2002, for her pregnancy, labor and delivery at his office and at St. Peter's Hospital, Albany, New York. (Exs. 12 & 13)

17. On or about October 1, 2002, the Respondent faxed an admission to St. Peter's Hospital which indicated that Patient B had complained of headaches and visual disturbances, and that she had pregnancy-induced hypertension requiring induction of labor. (Ex. 12)

18. At no time during the course of her care and treatment from March 7, 2002, to October 10, 2002 did Patient D indicate to the Respondent that she was having visual disturbances or headaches. (T. 151-153)

19. Since Patient D never complained of having visual disturbances or headaches the Respondent appropriately did not make any entry in Patient D's record of such complaints. (T. 151-153; Ex. 12)

20. On or about September 29, 2003, in an interview with the State Department of Health, conducted pursuant to the Public Health Law, the Respondent falsely stated that he did not tell Patient D he was inducing her labor to accommodate his vacation plans. (T. 147; Ex. 27-b)

21. On or about October 1, 2002, the Respondent diagnosed Patient D. with pre-eclampsia. This diagnosis was inappropriate (T. 289-290; Exs. 12 & 13).

PATIENT E

22. Respondent provided medical care and treatment to Patient E, a 26 year old female, from on or about August 28. 1997, through September 2, 1997, for her pregnancy, labor and delivery at his office and at OB/GYN Health Center Associates in Troy, New York and at Samaritan Hospital, Troy, New York. (Ex. 14)

23. Given the presentation of Patient E it was a judgment call on the part of the Respondent, who was present for the delivery, as to whether to allow Patient E to continue pushing. Therefore, it was not inappropriate to allow the patient to continue pushing for more than 2 ½ hours. (T. 448-450; Ex. 14)

24. During the course of the labor the Respondent did appropriately monitor the fetus. (T. 446-448; Ex. 14)

25. The Respondent inappropriately attempted a forceps delivery when the fetus was at zero station. (T. 308- 310; Ex. 14)

26. After two forceps assisted delivery attempts with an alternating vacuum attempt without descent of the vertex, the Respondent should have ordered a C-

section without further attempting forceps assisted delivery. He did not do this. (T. 310- 312; Ex. 14)

27. The operative note for Patient E contained inaccuracies. If an operative note contains inaccurate information, it is the responsibility of the author to correct the inaccuracies in that operative note. The Respondent failed to do this. (T. 312-314, 455; Ex. 14)

28. On or about September 29, 2003, in an interview with the State Department of Health, conducted pursuant to the Public Health Law, the Respondent falsely stated that the position of Patient E's baby was +3 when the forceps delivery was attempted. (Ex. 27-b)

PATIENT F

29. Respondent provided medical care and treatment to Patient F, a 40-year-old female, from on or about July 1, 1999, through October 25, 1999, for her pregnancy, labor and delivery at Seton Health OB/GYN, Troy, New York and at St. Mary's Hospital, Troy, New York. (Exs. 15 & 16)

30. A physician should note in a patient's chart the medical justification for discharging a patient. The Respondent failed to note in Patient F's chart the reason for her discharge on October 16, 1999, notwithstanding that she met the respondent's criteria for remaining in the hospital. (T. 336-337; Ex. 16)

31. In her October 18, 1999, admission to St. Mary's Hospital, Patient F was diagnosed with mild preeclampsia. In cases of mild preeclampsia magnesium sulfate is usually not used. The Respondent appropriately did not give the patient magnesium sulfate. (T. 479-481; Ex. 16)

32. The Respondent did not perform a C-section because he felt that delivery was imminent. Based on that belief and the time it would have taken to deliver by C-section, the Respondent appropriately chose a vaginal delivery. (T. 352, 481-482; Ex. 16)

33. If the Physician feels that the fetus is being adequately monitored by an external monitor, it is a judgment call as to whether internal monitoring is warranted. In this instance the Respondent appropriately determined it was not needed. (T. 482-483; Ex. 16)

PATIENT G

34. Respondent provided medical care and treatment to Patient G, a 45 year old female, from on or about July 21, 1999, through August 19, 1999, for heavy irregular menses at Seton Health for Women, Troy, New York and at St. Mary's Hospital, Troy, New York. (Exs. 18 & 19)

35. A physician who is going to perform a bilateral salpingo-oopherectomy should counsel the patient on the effects of such surgery. The Respondent did not do this. (T. 371-372; Ex. 18)

36. Patient G's preoperative report stated that she was scheduled for surgery which included an anterior and posterior repair. The surgery performed on Patient G did not include a cystocele and rectocele repair. When a physician states in a preoperative report that the surgery will include an anterior and posterior repair and this is not done the record should note why this repair was not done. Patient G's record did not contain such a note. (T. 373-375; Ex. 19)

37. On or about October 22, 2001, in an interview with the State Department of Health, conducted pursuant to the Public Health Law, the Respondent falsely stated that Patient G's referring physician had tried non-surgical medical treatment for her complaints. (Ex. 27-b)

PATIENT H

38. Respondent provided medical care and treatment to Patient H, a 50-year-old female, from on or about March 11, 1999, through April 15, 1999, for menometrorrhagia, bladder pressure and mild stress incontinence at Women's Healthcare Associates, Troy, New York and at St. Mary's Hospital, Troy, New York. Respondent's treatment included performing a hysterectomy and a bilateral salpingo-oophorectomy. (Exs. 21 & 22)

39. The Respondent appropriately did not perform an endometrial biopsy prior to surgery because a prior ultrasound indicated Patient H's endometrial stripe measured 1.8 millimeters. When a patient's endometrial stripe measures less than 4

millimeters it is very unlikely that there is a malignancy and therefore an endometrial biopsy is not necessary. (T. 515- 520; Ex. 18)

40. Although the hospital record did not contain a consent form, a patient is routinely not allowed to have surgery performed without such consent in the record; therefore, the consent must have been in the record. (T. 521- 522; Ex. 22)

RESPONDENT'S WEBSITE

41. When the Respondent opened up his private practice he set up an Internet website. (T. 1279)

42. From on or about February 3, 2003 through September 29, 2003, the Respondent knowingly indicated on his Internet website that he was a member of the American Association of Gynecological Laparoscopists. The Respondent was not a member of this organization. (T. 1279; Ex. 23)

43. From on or about February 3, 2003 through September 29, 2003, the Respondent knowingly indicated on his internet website that he was a member of the American Medical Association. The Respondent was not a member of this organization. (T. 1279; Exs. 23 & 24)

RESPONDENT'S IMPAIRMENT

44. Pursuant to a referral from the Committee for Physician's Health, on or about May 7 and 17, 2004, the Respondent underwent psychological testing and

evaluation at the Law and Psychiatry Service of the Massachusetts General Hospital, Boston, Massachusetts (hereinafter "the Service"). (T. 543-544; Ex. 33)

45. The Service tested and evaluated the Respondent and issued a report of its findings and conclusions to the Committee for Physicians Health. (Ex. 33)

46. As a result of its testing and evaluation the Service found that the Respondent suffers from Personality Disorder, NOS, with narcissistic and antisocial features. (T. 644- 645, 677, 700-701; Ex. 33)

47. The Service concluded that the Respondent had engaged in serious sexual boundary violations, is at a moderate to high risk to repeat these violations and currently is unable to practice medicine with reasonable skill and safety. (T. 550, 642- 644, 660, 665; Ex. 33)

48. The Service also concluded that in the Respondent's case there are no treatments which would have a likelihood of resulting in a significant personality or behavior change and that his prognosis was poor. (T. 649- 653; Ex. 33)

CONCLUSIONS

Based on the Findings of Fact noted above the Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual

Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A.: (2);

Paragraph A.1.: (3);

Paragraph A.3.: (5);

Paragraph A.4.: (5, 6);

Paragraph A.5.a.: (7, 8);

Paragraph A.5.b.: (9);

Paragraph A.5.c.: (9);

Paragraph A.6.: (10);

Paragraph A.7.: (11);

Paragraph B.: (12);

Paragraph B.1.: (13);

Paragraph C.: (14);

Paragraph C.1.: (15);

Paragraph D.: (16);

Paragraph D.1.: (17, 18);

Paragraph D.3.: **(20) as to that part of the allegation which charges that the Respondent misrepresented his conversation with Patient D during his interview of September 29, 2003;**

Paragraph D.4.: (21);

Paragraph E.: (22);

Paragraph E.3.: (25);

Paragraph E.4.: (26);

Paragraph E.5.: (26);

Paragraph E.6.: (27);

Paragraph E.7.: (28);

Paragraph G.: (34);

Paragraph G.2.: (35);

Paragraph G.3.: (36);

Paragraph G.4.: (37);

Paragraph I.1: (41,42);

Paragraph I.2: (41,43);

Paragraph J.: (44,45);

Paragraph J.1.: (46);

Paragraph J.2..: (47);

Paragraph J.3.: (48);

Paragraph J.4.: (48).

The Committee notes that Factual Allegations F.1. and G.1. were withdrawn by the Petitioner.

The Committee found that factual allegations A.2., D.2., E.1., E.2., F.2., F.3., F.4., H.1. and H.2. were not proven by a preponderance of the evidence.

Accordingly, the Committee found that the following Specifications of Misconduct as set forth in the Statement of Charges were sustained. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

ENGAGING IN CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE MEDICINE

First through Fifteenth Specifications: (Paragraphs A., A.4. - A.5.a. –c., A.6., A.7., B., B.1., C., C.1., D., D.1., D.3., E., E.6.-7., G., G.4., I., I.1. and I.2. (with the exception noted above);

FRAUDULENT PRACTICE

Sixteenth through Twenty-fifth Specifications: (Paragraphs A., A.7., B., B.1., C., C.1., D., D.1., D.3., E., E.6.-7., G., G.4., I., I.1. and I.2. (with the exception noted above);

FILING A FALSE REPORT

Twenty-seventh through Thirtieth and Thirty-second Specifications: (Paragraphs A., A.3., B., B.1., C., C.1., D., D.1. and E., E.6);

PRACTICING THE PROFESSION WITH NEGLIGENCEON MORE THAN ONE OCCASION

Thirty-third Specification: (Paragraphs A., A.1., A.3., B., B.1., D., D.4., E., E.3.-6., G. and G.1-3);

FAILURE TO MAINTAIN ACCURATE RECORDS

Thirty-sixth Specification: (Paragraphs A., A.3.,, B., B.1., C., C.1., D., D.1., E., E.3., E.6., G., and G.3);

HAVING A PSYCHIATRIC CONDITION WHICH IMPAIRS THE ABILITY TO PRACTICE

Thirty-seventh Specification: (Paragraphs J., J.1. – 2.).

The Committee found that the Twenty-sixth, Thirty-first, Thirty-fourth and Thirty-fifth Specifications were not sustained.

DISCUSSION

Respondent was charged with thirty-seven specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct that constitute professional misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for, among other conduct, gross negligence, negligence, and fraud in the practice of medicine.
The following definitions were utilized by the Committee during its deliberations:

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

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Fraudulent Practice of the Profession is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

Using the above-referenced definitions as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the first through twenty-fifth, twenty-seventh through thirtieth, thirty-second, thirty-third, thirty-sixth and thirty-seventh specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Committee found the expert witnesses for both parties credible in part, and with respect to certain patients found one more persuasive than the other, as set forth below:

PRACTICING WHILE IMPAIRED

The Committee found the testimony of both Drs. Reade and Medoff credible. They provided objective, convincing evidence of Respondent's mental health impairment. Their reports are based upon several sources of independent,

corroborating and converging data supporting the entrenched personality disorder of the Respondent. Dr. Reade's report contains her detailed clinical evaluation, contacts with several corroborative sources, and Dr. Medoff's report. Dr. Medoff's report, in turn, is comprised of two personality tests based on information obtained from Respondent in different manners and a clinical interview. Each element of this overlapping evaluation converged to yield a very convincing diagnosis of a personality disorder with antisocial and narcissistic tendencies.

Dr. Reade's evaluation describes Respondent as a self-centered, deceitful, manipulative and amoral individual who has little or no capacity to empathize with others. She found he had a history of breaking rules and that he believed he was not bound by the norms of society or his profession. Because of the longstanding, entrenched nature of the disorder, and because of Respondent's rigid personality, there is little chance for real change from cognitive psychotherapy.

Respondent admitted to serial infidelity by cheating on every relationship he has had as an adult. He has had inappropriate sexual relationships with subordinates. He has had sex with two patients. He had a simultaneous sexual relationship with Patient A and [redacted] and lied about his infidelities to OPMC.

Respondent was untruthful to the Committee regarding why he was terminated from his position of employment following the completion of his residency.

Respondent testified on cross-examination that he was fired because of a "personality conflict" after being asked if the termination resulted from an affair with a staff person. Dr. Tracey Irvin conducted the psychiatric evaluation of Respondent at BMI. Dr. Irvin testified that Respondent was fired because of the sexual affair, and so noted this in her chart of Respondent's evaluation. Respondent reported to Dr. Irvin that in addition to Patient A, he had sex with a nurse while he was a resident, and he also performed employment mandated physical examinations for this nurse during the period they were having the sexual affair yet, Respondent denied in his testimony that he was having a sexual affair with the nurse while he was her physician.

Respondent falsified the medical record of Patient B by entering a history and physical examination that he did not perform. He copied information entered by another physician at a previous time as if it were information he obtained at the recorded time and date.

Respondent also falsified the chart of Patient C. He entered history and physical information he performed as part of a consult five weeks earlier into the chart as if it represented current information. After spending five minutes with the patient and at most five minutes reviewing her chart in his office, he billed for a level V visit.

Respondent lied in the chart of Patient D. He recorded that she was experiencing visual disturbances and headaches to justify his admission of the patient for labor induction.

Respondent lied to OPMC during an investigation interview on September 29, 2003. When asked about his sexual relationship with Patient A, Respondent said he never touched Patient A. His relationship with her was only "words".

This persistent pattern of lying is but one of the obstacles that would prevent Respondent from improving through cognitive psychotherapy. As identified in Dr. Reade's report, he is rigid, oppositional, and not motivated to improve.

The Committee found the Respondent's therapy record with Dr. Peretz indicates he engages in therapy only when a crisis is looming. He initially entered therapy with Dr. Peretz in August 1995 because his first marriage was in crisis.

Respondent did not return to Dr. Peretz until August 2002, after his current mistress, Patient A learned that he was having a simultaneous affair with [redacted]

[redacted]

Respondent's treatment with Dr. Peretz is geared more toward his anxiety over the OPMC process and his marital difficulties rather than trying to achieve cognitive change. Dr. Peretz informed Respondent that he was not suitably trained to administer the cognitive therapy required to successfully address his personality disorder. In April 2004, on the eve of this hearing, Respondent enrolled in CPH

and agreed to undergo a comprehensive psychiatric evaluation for the first time. Dr. Peretz agreed that Respondent's motivation for enrolling in CPH was more about saving his license rather than achieving cognitive change. The subsequent sequence of events is consistent with the assessment of Dr. Peretz.

Respondent underwent an evaluation performed by Dr. Julia Reade in May, 2004.

Upon receiving the Reade report, CPH notified Respondent in a letter dated July 22, 2004 that he was to stop practicing until he underwent treatment and received clearance from CPH to resume practice. He was informed that his failure to comply with this directive would result in his termination from CPH, and that his confidential CPH file, including the Reade and Medoff Reports, would be provided to OPMC. Respondent was also informed that he could obtain a second opinion if he desired and received a list of CPH approved centers, including BMI in Atlanta.

Respondent did not stop practicing. He did not obtain a second opinion. He did not change his therapy to a therapist who would be better able to address his personality disorder.

Respondent is at a moderate to high risk of reporting his sexual boundary violations. Respondent has identified many additional patients with whom he has had inappropriate relationships. He has admitted to engaging in hugging patients.

He has admitted to flirting with patients. He has admitted to a blurring of the division between physician and patient.

Respondent underwent another intensive psychiatric evaluation by Tracey Irvin, M.D. at BMI. Her diagnosis was virtually identical to that reached at the Service. The only significant difference was that Dr. Irvin concluded Respondent is a candidate to return to practice, following an eight-week therapy session. Dr. Irvin testified that the only two areas she disagreed with Dr. Reade were whether Respondent was the most amoral person she had evaluated who was not behind bars and whether he would respond to treatment.

Dr. Irvin's conclusion that Respondent can respond favorably to treatment ignores every piece of the voluminous objective data to the contrary. Dr. Irvin's conclusion is not supported by the evidence. Respondent repeatedly argued that BMI somehow had more validity because they treat sex offenders, and the Service does not. The fact that the Service does not treat sex offenders does not detract from their credentials to evaluate and diagnose. Dr. Medoff testified that many psychiatric professionals are involved in performing risk assessments and evaluations, rather than treatment.

The Service's of the Massachusetts General Hospital's ability to assess Respondent's prognosis following a course of treatment is enhanced because they do not offer treatment. It provides more objectivity. The Service has no vested

interest in receiving the financial benefit associated with putting one such as Respondent through an eight-week therapy program. This could explain why Dr. Irvin concludes Respondent is a candidate to benefit from cognitive psychotherapy in the near unanimous face of objective data to the contrary.

BMI put Respondent through clinical interviews and a battery of tests, just as the Service did. BMI administered more tests and questionnaires than did the Service, although the test results were no more favorable at BMI than they were at the Service.

The report noted that: "This man is unlikely to retain motivation, even for a short-term therapeutic regimen, unless his life experiences became increasingly discouraging." This is consistent with Respondent's treatment history with Dr. Peretz.

Dr. Irvin did not directly address the negative MCMI-III interval, or the material from the Service as it relates to prognosis for successful therapy. Unlike the Service, Dr. Irvin does not describe a convergence of independent multiple sources of objective information upon which to base her conclusion. Dr. Irvin does acknowledge Respondent's deception and sexual misconduct, and that his pathology is progressing, or increasing and will continue to do so in the absence of intervention. She also acknowledges that it is very difficult to change one's personality. Without discussion or reasoning for her conclusion, Dr. Irvin

concludes Respondent is a candidate for successful treatment. The contrast between BMI's subjective conclusions and the objective conclusions of the Service is very stark.

Dr. Irvin testified that BMI does not change the personality of a patient in the course of their eight-week session, but rather provides tools or mechanisms to make behavioral changes. Many of these mechanisms would not be effective for Respondent. One simply provides educating the offender to his profession's standard of care regarding sexual misconduct. A majority of the Committee believes this would not be effective for Respondent, as ACOG adopted a very strict prohibition of physician/patient sexual relationships in 1994, a standard taught to all medical students and residents.

Dr. Irwin acknowledged that an individual must be open and honest to succeed in cognitive therapy, and the person must have motivation to succeed. The record of this care is replete with Respondent's deceit. He has not shown any ability to be truthful and it is unlikely he will change this after 39 years of experience. Respondent's history of crisis-oriented psychotherapy, and his long, tortured path to obtaining a second psychiatric opinion does not bode well for him being motivated to change.

The best evidence regarding Respondent's prognosis for successful therapy is described in the wealth of objective data generated by Dr. Reade and Dr. Medoff

at the Service. That evidence with much of the ignored data generated at BMI, conclusively states that Respondent does not have the personality to successfully change through therapy, and that he will repeat his sexually opportunistic behavior in the future.

PATIENT A

The Committee found Patient A's testimony credible. She testified in a forthright manner and responded to questions by both counsel in a direct manner. Additionally, a number of the factual allegations involving this patient were admitted by the Respondent.

Respondent's care of Patient A involved acts of negligence in addition to conduct evidencing moral unfitness.

There is no dispute that Respondent failed to order contemporaneous blood work for Patient A before administering Methotrexate. Respondent's expert on this topic argued there was no need to conduct liver function studies in an otherwise healthy young woman with no symptoms of liver disease. However he qualified this statement on direct, testifying that contemporaneous blood work was not required when there was no liver disease, kidney disease, any risk factors for these things, no history of hepatitis, or STD exposure. In fact, the expert acknowledged on cross-examination that Patient A's known history of 17 sexual partners was a risk factor for STD exposure.

The Committee found sufficient documentary evidence that the Respondent did record the prescribing of Cytotec to assist in the termination of Patient A's pregnancy.

Respondent claimed he did not recall who initiated the oral sex on March 13, 2002. Patient A testified in detail the manner in which Respondent initiated the sexual act. Her recollection is consistent with the manner in which Respondent abused his trust as Patient A's gynecologist.

Respondent subsequently returned to Patient A's apartment and engaged in sexual intercourse with his patient. The intercourse occurred eight days after she had received the Methotrexate to terminate her pregnancy. Respondent's engaging in sexual intercourse with Patient A violated his own consent form that he had Patient A sign, which provided: "I will not have intercourse (sex) or drink alcohol until 2 weeks after I receive the Methotrexate."

Respondent began a 5-month sexual relationship with his patient during which Respondent's behavior violated the accepted boundaries between patient and physician. On at least two occasions, Respondent brought Patient A to the obstetrician on-call room at St. Peter's Hospital for sexual encounters. While Respondent denied any sexual contact at St. Peter's Hospital in his Answer, he offered no rebuttal to Patient A's recollection of the events at the hospital, either on cross examination of Patient A, or on his direct testimony. Given Patient A's

credible testimony the weight of the evidence supports that Respondent engaged in sexual intercourse with Patient A in the St. Peter's Hospital on-call room.

Respondent also demonstrated abusive behavior during his sexual relationship with Patient A. In May, 2002, Respondent went to Patient A's apartment and learned that she had slept with another man. He left her apartment angry, and returned later that evening. Patient A testified that when Respondent returned he grabbed her by her hair and threw her onto her bed and then had sexual intercourse against her wishes.

Respondent denies grabbing his patient by the hair, but he corroborated every other aspect of Patient A's testimony to Tracey Irvin, M.D. at BMI. He admitted that he went to Patient A's apartment, and learned that she had slept with another man. He admitted that he left the apartment, became drunk, and returned. He then admitted that he had sex with Patient A after she said no. Respondent admitted on cross-examination that he did not stop after Patient A said "stop." Respondent's personal conduct toward Patient A was morally unfit. His medical practice on Patient A was also below the standard of care.

Respondent committed fraud when he lied to OPMC during his interview about his sexual relationship with Patient A. This lie was clearly an intent to deceive the investigator about Respondent's morally unfit conduct.

Respondent's conduct toward Patient A represent moral unfitness in the practice of medicine because he abused the position of trust he obtained by virtue of his medical license. Respondent's lies to OPMC while he was being investigated are also a violation of the moral standards of the medical community.

PATIENT B

Respondent's misconduct in this instance involved the falsification of a medical record. Respondent admitted the physical act of making a false entry in the chart of Patient B. He essentially blamed the senior resident who was part of his team, although he denied shifting blame when asked on cross-examination. This shifting of responsibility for his misconduct is consistent with the psychological profile and diagnosis of the Respondent by the Service.

The record also indicates that Respondent intentionally misrepresented information in the chart of Patient B, with an intent to deceive subsequent providers that a history and physical examination was performed. This represents a false entry into the chart, which is a fraudulent act.

PATIENT C

In this instance, approximately four years after being placed on probation while a resident at Albany Medical College for falsifying a patient record, Respondent was terminated from Seton Health for a nearly identical act. The fact that such an act constituted unprofessional behavior was either ignored or

forgotten. Despite the previous incident almost resulting in the termination of his residency, Respondent committed the same act regarding the record of Patient C.

The inappropriateness of Respondent's actions regarding Patient C is highlighted by the Seton Health Patient Service Representative's reaction to Respondent's billing. [redacted] testified that she brought the matter to the attention to her manager because she did not feel comfortable having her name attached to the level V visit. She testified further that she had handled "hundreds" of billings, and this represented the first level V visit. She understood that Respondent's brief encounter should not have been billed at the highest possible level, while Respondent excused his conduct as a mere "charting error", he should have known this was not true, based on his prior experience during residency. The fact is that Respondent intentionally misrepresented the facts in Patient C's chart, and he would not have corrected the fraudulent entries if he was not prompted to by his supervisor. Respondent clearly wanted the chart to reflect a more detailed encounter than what occurred. Respondent's conduct regarding his charting and billing of Patient C was fraudulent.

PATIENT D

In this case the Respondent was also charged with falsifying a patient's record. Patient D credibly testified that she was not complaining of headaches and visual disturbances on October 1, 2002 and that she never made such complaints to

Respondent. The noting of the alleged presence of headaches and visual disturbances would support the diagnosis for toxemia, pre-eclampsia and pregnancy-induced hypertension for Patient D. Respondent's position on this matter is equivocal. In his interview with OPMC, Respondent stated that he received a message from a nurse that Patient D had telephoned his office complaining about headaches and visual disturbances. No such telephone messages are in the office record regarding Patient D. Respondent signed the Certification for the accuracy and truthfulness of these records.

At the hearing, Respondent's testimony was inconsistent. Respondent first testified that Patient D complained about the headaches when she dropped off her 24-hour urine cup the day before, however, he admitted that there is no record of that in the patient record. When pressed on the issue, Respondent testified that he could not remember the specifics of how he learned about Patient D's complaints of headaches prior to October 1, 2002.

Patient D testified that Respondent told her on or about September 26, 2002 that she had to have her baby delivered within the next week because he was going on vacation. During his interview of September 29, 2003 with OPMC, Respondent indicated that he said this to Patient D just because she was a nervous patient and he wanted to play down the reasons for her admission. He stated that if he were inducing her because he was going on vacation, he would have placed that in her

chart. There is nothing in Patient D's chart to indicate that she was a nervous patient or that it was necessary to provide her with misrepresentations as to the reason for her induction. Similarly, the swelling that was noted in her medical record for October 1, 2002 was consistent with most women who are fully pregnant, at term. The clinical picture of this patient changes dramatically if her alleged symptoms of visual disturbances and headaches are removed. Absent the symptoms as testified by Patient D, her symptoms would have warranted observation only, and not induction. The fact that she was hospitalized for induction with only the presence of a slightly elevated blood pressure is consistent with the information Patient D provided to this committee, that Respondent was admitting her to accommodate his upcoming vacation plans.

Patient D has no motivation to lie. Respondent's credibility and his history are such that his statements are questionable. His testimony with respect to when and if he learned about the headaches and visual disturbances from Patient D are unclear and consistent with his past history and his mental health history as assessed by the Service. The need to induce Patient D for pregnancy induced hypertension is not supported absent the headaches and visual disturbances. She did not display any high blood pressure or make any complaints of visual disturbances and headaches during her hospitalization at St. Peter's Hospital.

This record supports the conclusion that Respondent intentionally misrepresented his reasons for admitting Patient D to St. Peter's Hospital on October 1, 2002. It is consistent with his desire, as stated by Patient D, that he wanted to deliver Patient D's baby to accommodate his vacation schedule. Respondent did indeed take a vacation during this period of time, further supporting the conclusion that he intentionally misrepresented the reasons for inducing his patient, and falsified her medical record to support his fraud.

Since the Committee found that the patient never complained of visual disturbances or headaches it did not sustain the charge that the Respondent deviated from accepted standards of medical care by failing to make an entry in the patient's chart of such complaints.

PATIENT E

The Committee determined that the allowing the patient to push for more than 2 ½ hours was not a deviation from accepted care but was within the judgment of the physician. Additionally, the Committee found that the Respondent did adequately perform intrapartum monitoring of the fetus. The extent of monitoring was once again a judgment call for the physician who was present for the delivery to make.

The Respondent's Operative Note was dictated ten days after the fact, and was apparently not reviewed for errors. Respondent claimed that the vertex was at

0 station prior to 2 hours and 40 minutes of pushing and the first forceps attempt. However, the record did not provide the station of vertex at the time of his first forceps attempt. This discrepancy, together with the failure to describe the vertex position as related to the Caput position leaves the record unclear. Respondent was unable to demonstrate convincingly that the vertex was in a position suitable for forceps delivery.

The Operative Note also supported the Petitioner's expert opinion that intrapartum evaluation or an earlier cesarean section was warranted. The Operative Note indicates that there was an arrest of descent, thick meconium, and prolonged late decelerations. These are all indications of fetal stress, and are supported by the information contained in the labor and delivery flow sheet. Respondent continues his trend of inaccurate statements to individuals regarding this case. During his interview of September 29, 2003, Respondent stated that the baby was at +3 station at the time of the initial forceps delivery. There is no documentation in the chart of Patient E that the vertex was lower than 0 station. This statement represents an effort to intentionally misrepresent the facts to deceive OPMC from the actual clinical presentation. Respondent argues that the baby was at +1 station at the time of full dilation, however, he agreed that this was a measurement taken by a nurse, and is a subjective measurement. Respondent's Operative Note states the location of the vertex was at 0 station.

The evidence presented in this matter reveals that Respondent allowed a fetus in stress to continue in labor for a prolonged period of time without delivery by cesarean section. Respondent also attempted a high forceps delivery and attempted too many forceps deliveries. Respondent's notation of the sequence of events is inaccurate. Respondent was untruthful and deceitful in his comments regarding the location of the vertex in his comments to the OPMC investigator. Respondent's conduct constituted a deviation from the standard of care regarding Patient E.

PATIENT F

The Committee concurred with the Respondent's expert on the care and sulfate. Furthermore, the Respondent did perform a cesarean section on this patient. Whether it was done in a timely fashion or not was not considered by the Committee because the timeliness of performing a cesarean section was not charged. The Committee agrees with the Respondent that internal monitoring was not required if he felt that the fetus was being adequately monitored externally. None of the charges relating to this patient were sustained.

PATIENT G

Respondent failed to offer appropriate counseling to Patient G. Patient G's surgery would bring on the immediate onset of menopause and counseling should have been provided. The Committee also found that the surgery anticipated

performing a cystocele and rectocele repair, and although it wasn't done, the Respondent never states why in the record. This is important information that should have been included in the record. Failure to include it in the record is a deviation from the standards of care.

Respondent's interview with OPMC on October 22, 2001 continues his disturbing trend of deceitful untruthful statements. He stated to OPMC investigator that the referring physician for Patient G, [redacted] had tried medical therapy for Patient G. The review of [redacted] record refutes this statement.

PATIENT H

In this case the Committee agrees with the Respondent's expert that an endometrial biopsy was not required. All of the corroborative evidence pointed to there not being a malignancy that was causing the patient's bleeding. The standard of care in this instance did not require a biopsy to be performed. The Committee also concurred with the Respondent's expert that there must have been a signed consent form or the patient would never have been allowed into the operating room. Therefore, the Committee concluded that the form was misplaced by the hospital. The charges relating to Patient H were not sustained.

RESPONDENT'S WEB SITE

This charge involves two inaccuracies on the Respondent's website. One relates to a statement that he was a member of the American Medical Association (AMA). During his September 29, 2003 interview with OPMC, Respondent attributed some of the blame for the inaccurate web information to his office staff, alleging that they neglected to pay his dues for membership with the AMA. However, the Respondent has not been an active member in the AMA since 1992, when he was a senior at Mt. Sinai School of Medicine. Respondent has never been a member of the AMA since he opened his private practice in 2000, and therefore it is not credible that it is the fault of his support staff that his website contained inaccurate information.

At hearing, Respondent also contended that he believed that his membership in the Medical Society of New York provided membership in the AMA. Respondent also claimed that he has never reviewed his credentialing information on his office website. The committee found these claims not credible. This same reasoning applies to the excuse provided for the inaccurate information regarding Respondent's alleged membership in the American Association of Gynecologic Laparoscopists. The Committee did not believe that this was simply an oversight.

PENALTY

The Committee feels that the Respondent has violated the public trust, which was bestowed upon him when he was granted a license to practice medicine in this State. It is the possession of a medical license and the trust and prestige associated with that license that permits patients to present themselves before that physician in the most vulnerable ways imaginable.

It was by virtue of his medical license that Respondent learned of Patient A's long history of mental health disease. It was her confidence in Respondent's position as a licensed physician that caused her to reveal to Respondent the uncertainties she was experiencing regarding her pregnancy. Respondent abused his position of trust and authority, using the intimate knowledge provided to him by Patient A for his own gain and pleasure rather than as an aid to treat and heal his patient.

The ACOG position on sexual misconduct provides that the OB/GYN has the privilege of treating women in both the happiest and saddest moments of their lives. Given the position of trust and authority of an OB/GYN, there can never be a mutual or consensual sexual relationship between physician and patient. This is particularly true when the individual is such as Patient A with her history of mental illness and the extreme vulnerability she was displaying at the time the sexual relationship began.

Respondent admitted that his boundaries with patients are "very unclear" and that he has a purpose of "self-gratification, no matter what the cost." Respondent admits that there were patients for whom he had "feelings". His level of intimacy "approached inappropriate". There was a very blurry line between doctor and patient. Respondent indicated that he would hug and smile with his patients. Respondent admitted that he would flirt with his patients. Respondent admitted that he would engage in innuendo with his patients. Respondent admitted that he "behaved very badly". This admitted conduct by Respondent represents potential victim identification. It represents an individual who is looking for a favorable response from any one of the patients with whom the professional boundary has been blurred or eliminated. Because Respondent's practice is limited to women, the potential for his future misconduct is significant. Virtually every patient he examines represents a potential victim.

Respondent underwent two comprehensive psychiatric evaluations, both of which concluded he suffers from a personality disorder with antisocial and narcissistic traits. Respondent's deceitful, self-indulgent and abusive behavior is consistent with his diagnosis. The Committee finds that this diagnosis is no defense to Respondent's conduct but rather provides only a potential understanding of that conduct. The same diagnosis is extremely resistant to change. He is likely to continue with his egregious behavior for the remainder of his life.

The Committee has a responsibility to protect the patient public of the State. The issue before this Committee is to choose a penalty that offers the best protection to the patient public of the State. Dr. Reade and Dr. Medoff concluded that the chances of Respondent committing future sexual misconduct is moderate to high, based upon his identified personality traits. A majority of the Committee finds that the Respondent has committed sufficiently egregious misconduct that is worthy of the revocation of his medical license. Whether Respondent receives sufficient treatment to enable him to return to practice is an issue to be decided by the New York State Education Department if it were to receive an application from Respondent for the restoration of his medical license after he has served the mandated 3 year period following the revocation of his license. A majority of this Committee concluded that the only way to ensure the future safety of the patient public is to revoke Respondent's medical license. Anything other than that sanction would allow Respondent to return to his predatory ways, and allow him to resume the cultivation of his next victim. Given his past record and his mental health diagnosis, the risk of re-offending is too great to allow him to return to practice.

This Committee also notes that under the Public Health Law it could not legally impose a contingency based sanction that would allow the Respondent to resume practicing if and when he successfully completed a treatment course. This

would amount to an indefinite suspension and the relevant statute, at Public Health Law § 230-a(2), requires a fixed period of suspension.

A majority of the Committee concludes that the Respondent's conduct in this matter has violated the public trust with regards to Patient A, Patient B, Patient C, Patient D, Patient G and in the information posted on his website. Respondent has committed numerous acts of dishonesty throughout his professional life. Allowing Respondent to return to the practice of medicine would send the wrong signal to both the patients and physicians of this State.

A minority of the Committee after careful consideration of the facts placed before the Committee and of the testimony of the many witnesses, recommends a penalty of a license suspension of 2 months; psychiatric therapy, initially 8 weeks as outlined by Respondent's witness, Dr. Irvin, followed by monthly sessions for 24 months; monitoring of Respondent's patient medical records for 2 years and a suspension of Respondent's obstetrical and gynecological surgery activities for 2 years.

ORDER

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

1. The **First through Twenty-fifth, Twenty-seventh through Thirtieth, Thirty-second, Thirty-third, Thirty-sixth and Thirty-seventh Specifications** of professional misconduct, as set forth in the Amended Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) are **SUSTAINED**;

2. The Respondent's license to practice medicine in New York State is **REVOKED**.

DATED: Middletown, New York
July 23, **2005**

FRED S. LEVINSON, M.D. (Chair)

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APPENDIX I

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

IN THE MATTER
OF
AKIVA ABRAHAM, M.D.

AMENDED
STATEMENT
OF
CHARGES

AKIVA ABRAHAM, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 9, 1997, by the issuance of license number 206885 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine through June 30, 2004, with a practice address of 989 Route 146, Suite 300, Clifton Park, New York 12065.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (patients are identified in Appendix A, attached hereto), a female patient 25 years old when first treated, from on or about January 12, 2002 through on or about September 3, 2002 at 989 Route 146, Suite 300, Clifton Park, New York 12209 and at Patient A's residence for routine gynecological care, termination of pregnancy and other medical conditions. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent, on or about March 8, 2002, administered 100 mg of Methotrexate to Patient A for the purpose of terminating her pregnancy. Respondent failed to obtain and/or record a contemporaneous blood analysis of Patient A to identify potentially negative complications to Methotrexate;

2. Respondent, on or about March 13, 2002, prescribed Cytotec (misoprostol) to assist in the termination of her pregnancy. Respondent failed to record the prescribing of Cytotec (misoprostol).

3. Respondent, on or about March 13, 2002, delivered a prescription pain medication to Patient A at her residence, for pain associated with her pregnancy termination. Respondent failed to record the

pain medication he delivered on or about March 13, 2002;

4. Respondent, on or about March 13, 2002, delivered a prescription pain medication to Patient A at her residence, for pain associated with her pregnancy termination. Respondent initiated sexual contact with Patient A after she ingested the pain medication;

5. Respondent, between on or about March 13, 2002 and on or about August 3, 2002 while Patient A's treating physician, engaged in the following conduct:

   a. Respondent maintained a sexual relationship with Patient A, engaging in sexual intercourse and other sexual contact with the patient at Respondent's office, Patient A's residence, and St. Peter's Hospital;

   b. Respondent maintained romantic feelings for Patient A, and expressed those feelings to Patient A; and

   c. Respondent made at least three visits to Patient A's residence, and brought gifts and flowers to Patient A assisted Patient A in obtaining a job;

6. Respondent, on or about May 5, 2002 compelled Patient A to have intercourse by grabbing her hair and pulling her to her bed ; and

7. Respondent, in an interview pursuant to Public Health Law §230 (10) (a) (iii) on or about September 29, 2003, falsely stated that he did not have a physical or sexual relationship with Patient A.

B. Respondent provided medical care and treatment to Patient B on or about April, 1995 at Albany Medical Center in Albany, New York while Respondent was a Resident at Albany Medical College. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately entered information from a physical examination of Patient B previously performed by another individual into the chart of Patient B rather than performing a contemporaneous physical examination.

C. Respondent provided medical care to Patient C, a female patient 82 years old when treated, from on or about October 26, 1999 through December 16, 1999 for heavy post-menopausal bleeding at Samaritan Hospital in Troy, New York, and

Seton Health OB/GYN in Troy, New York. Respondent was called as a consultant and performed a Dilation and Curettage on or about October 26, 1999. Respondent's care and treatment of Patient C deviated from accepted standards of medical care in the following respects:

1. During a follow-up examination on or about December 16, 1999 in his office, Respondent inappropriately entered information in the chart of Patient C reflecting a physical examination of that date which was actually derived from his hospital consult with Patient C on or about October 26, 1999, and submitted billing data falsely representing he had performed a level "V" visit.

D. Respondent provided medical care to Patient D, a female patient 30 years old when first treated, from on or about March 7, 2002 through on or about October 10, 2002 for her pregnancy, labor and delivery at Respondent's office in Clifton Park, New York and St. Peter's Hospital in Albany, New York. Respondent's care and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent falsely represented in his October 1, 2002 faxed admission to St. Peter's Hospital that Patient D complained of visual disturbances and headaches to support a diagnosis of Pregnancy Induced Hypertension (PIH), thereby requiring induction of labor;

2. Respondent failed to make any entries in Patient D's medical record that she complained of visual disturbances and headaches on or about October 1, 2002, thereby requiring her admission to St. Peter's Hospital for induction of labor;

3. Respondent, on or about October 1, 2002, misrepresented to Patient D that he was admitting her to St. Peter's Hospital for induction to accommodate his upcoming vacation plans and/or Respondent misrepresented his conversation with Patient D during his interview pursuant to Public Health Law §230 (10) (a) (iii) on or about September 29, 2003;

4. Respondent, on or about October 1, 2002 inappropriately diagnosed Patient D with toxemia and/or pre-eclampsia without sufficient clinical justification; and

E. Respondent provided medical care to Patient E, a female patient 26 years old when treated, on or about August 28, 1997 through on or about September 2, 1997 for her pregnancy, labor and delivery at OB/GYN Health Center Associates in Troy, New York and Samaritan Hospital in Troy, New York. Respondent's care and treatment of Patient E on August 29, 1997 deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately allowed Patient E to push for more than 2 ½ hours from the point of full dilation before performing a cesarean section;

2. Respondent inappropriately failed to perform some intrapartum evaluation of the fetus in the presence of the documented late decelerations, and/or failed to record the performance of an intrapartum evaluation;

3. Respondent inappropriately attempted a forceps delivery at 0 station, and/or failed to record the proper station of the vertex at the time the forceps delivery was attempted;

4. Respondent inappropriately employed 3 forceps attempts with alternating vacuum extraction;

5. Respondent inappropriately failed to perform a cesarean section following the initial failed forceps delivery when there was no demonstrated descent of the vertex;

6. Respondent failed to correct his operative note that he stated during his interview pursuant to Public Health Law §230 (10) (a) (iii) on or about September 29, 2003 contained inaccurate information regarding the procedure; and

7. Respondent, during his interview pursuant to Public Health Law §230 (10) (a) (iii) on or about September 29, 2003, falsely stated that the position of Patient E's baby was at +3 position when the initial forceps delivery was attempted, rather that the 0 station reflected in his September 8, 1997 operative note.

F. Respondent provided medical care to Patient F, a female patient 40 years old when treated at Seton Health OB/GYN and St. Mary's Hospital in Troy, New York, from on or about July 1, 1999 through on or about October 25, 1999 for her pregnancy, labor and delivery. Respondent's care and treatment of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent failed to provide an entry in Patient F's chart on October 16, 1999 providing a medical justification for her discharge from St. Mary's Hospital;

2. Respondent failed to order and/or record the ordering of magnesium sulfate for Patient F during her October 18, 1999 admission to St. Mary's Hospital;

3. Respondent failed to perform a cesarean section delivery of Patient F's baby; and

4. Respondent failed to adequately provide for internal fetal monitoring for six hours on October 20, 1999,and/or record the internal monitoring.

G. Respondent provided medical care to Patient G, a female patient 45 years old when treated at Seton Health for Women and St. Mary's Hospital in Troy, New York, from on or about July 21, 1999 through on or about August 19, 1999 for heavy irregular menses. Respondent's care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent failed to offer and/or provide alternative medical treatments to the hysterectomy which was performed on August 16, 1999, and/or failed to document medical treatments;

2. Respondent failed to counsel Patient G with regard to the bilateral salpingo-oopherectomy, and/or failed to document the counseling;

3. Respondent failed to record the reason for not performing the cystocele and rectocele repair; and

4. Respondent falsely stated during his interview pursuant to Public Health Law §230 (10) (a) (iii) on or about August 22, 2001 that Patient G's primary care physician had provided medical treatment for her heavy, irregular menses.

H. Respondent provided medical care to Patient H, a female patient 50 years old when treated at Women's Healthcare Associates and St. Mary's Hospital in Troy, New York, from on or about March 11, 1999 through on or about April 15, 1999 including a hysterectomy and bilateral salpingo-oophorectomy to treat

menometrorrhagia, bladder pressure and mild stress incontinence. Respondent's care and treatment of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent failed to obtain an endometrial biopsy of Patient H and/or document that an endometrial biopsy was obtained; and

2. Respondent failed to obtain a written surgical consent from Patient H prior to the March 29, 1999 surgery, and/or document the consent.

I. Respondent, on or about February 3, 2003 through on or about September 29, 2003, falsely represented on his office internet web site:

1. That he was a member of the American Association of Gynecologic Laparoscopists; and

2. That he was a member of the American Medical Association.

J. Respondent, on or about May 7 & 17, 2004, Respondent underwent psychological testing and evaluation at the Massachusetts General Hospital by David Medoff, Ph.D. and Julia Reade, M.D., respectively. As a result of this testing and evaluation, the following was determined:

1. That Respondent suffers from a Personality Disorder, NOS, with narcissistic and antisocial features;

2. That Respondent has engaged in serious sexual boundary violations, is at moderate to high risk for engaging in further opportunistic sexual behaviors and is currently unable to practice medicine with reasonable skill and safety;

3. That there are no treatments that would likely result in significant personality or behavior change in Respondent; and

4. That the prognosis for Respondent is poor.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTEENTH SPECIFICATIONS

MORAL UNFITNESS

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

1. Paragraph A. and A.4;
2. Paragraph A. and A.5-a;
3. Paragraph A. and A.5-b;
4. Paragraph A. and A.5-c;
5. Paragraph A. and A. 6;
6. Paragraph A. and A.7;
7. Paragraph B. and B.1.;
8. Paragraph C. and C.1;
9. Paragraph D. and D.1;
10. Paragraph D. and D.3;
11. Paragraph E. and E.6;
12. Paragraph E. and E.7;
13. Paragraph G. and G.4;
14. Paragraph I. and I.1; and
15. Paragraph I. and I.2.

SIXTEENTH THROUGH TWENTY-FIFTH SPECIFICATIONS

FRAUDULENT PRACTICE

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

16. Paragraph A. and A.7;
17. Paragraph B. and B.1;
18. Paragraph C. and C.1;
19. Paragraph D. and D.1;
20. Paragraph D. and D.3;
21. Paragraph E. and E.6;
22. Paragraph E. and E.7;
23. Paragraph G. and G.4;
24. Paragraph I. and I.1; and
25. Paragraph I. and I.2.

TWENTY-SIXTH THROUGH THIRTY-SECOND SPECIFICATIONS

FALSE REPORT

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

26. Paragraph A. and A.2;
27. Paragraph A. and A.3;
28. Paragraph B. and B.1;
29. Paragraph C. and C.1;
30. Paragraph D. and D.1;

31. Paragraph D. and D.2; and

32. Paragraph E. and E.6.

THIRTY-THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

33. Paragraphs A. and A.1, A. and A.2, A. and A.3, B. and B.1, D. and D.2, D. and D.4, E. and E.1, E. and E.2, E. and E.3, E. and E.4, E. and E.5, E. and E.6, F. and F.1, F. and F.2, F. and F.3, F. and F.4, G. and G.1, G. and G.2, G. and G. 3, H. and H. 1, and H. and H.2.

THIRTY-FOURTH THROUGH THIRTY-FIFTH SPECIFICATION

GROSS NEGLIGENCE

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

34. F. and F.2; and

35. F. and F.3.

THIRTY-SIXTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

36. Paragraphs A. and A.1, A. and A.2, A. and A.3, B. and B.1, C. and C.1, D. and D.1, D. and D.2, E. and E.2, E. and E.3, E. and E.6, F. and F.1, F. and F.2, F. and F.4, G. and G.1, G. and G.2, G. and G.3, H. and H.1, and H. and H. 2.

THIRTY-SEVENTH SPECIFICATION

HAVING A PSYCHIATRIC CONDITION WHICH IMPAIRS THE ABILITY TO PRACTICE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(8) by having a psychiatric condition which impairs the licensee's ability to practice as alleged in the facts of:

37. Paragraphs J. and J.1, and/or J. and J.2, and/or J. and J.3, and/or J. and J.4

DATED: October 5, 2004
Albany, New York

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