These charges are only allegations which may be contested by the licensee in an administrative hearing.

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

IN THE MATTER

OF

BERNARD RAXLEN, M.D.

STATEMENT

OF

CHARGES

Bernard Raxlen, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 3, 1987, by the issuance of license number 170256 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, from on or about 8/28/08 through on or about 12/29/10. Patient A presented to Respondent complaining of a variety of symptoms including but not limited to freezing, burning, air hunger, weakness, fatigue, neck pain and intestinal pain. Patient A reported prior treatment by multiple doctors including prolonged courses of antibiotics and other treatments. (Patient names are identified in the Appendix.) Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history, including psychiatric history, appropriate physical examinations, neuropsychological testing and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.
3. Inappropriately prescribed medications without appropriate medical indications.
4. Failed to present and/or note potential risks, benefits, side effects and safe use of prescribed medications.

5. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
6. Failed to appropriately identify, address and/or follow-up on potential side effects.
7. Failed to appropriately identify, address and/or follow up on a potentially life threatening circumstance when the patient was severely dehydrated.
8. Failed to maintain a record that accurately reflects the care and treatment of the patient.

B. Respondent treated Patient B, from on or about 1/20/10 through on or about 5/25/11. Prior to the initial visit with Respondent, Patient B, a 14-year-old, had experienced depression and suicidal ideation and was hospitalized after he developed a severe headache and left-sided Bell's Palsy. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history, including psychiatric history, appropriate physical examinations, neuropsychological testing and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.
3. Inappropriately prescribed medications without appropriate medical indications and/or without considering potential drug interactions.
4. Failed to present and/or note potential risks, benefits, side effects and safe use of prescribed medications.
5. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnosis and/or treatment.
6. Failed to appropriately identify, address and/or follow-up on potential side effects.

7. Failed to maintain a record that accurately reflects the care and treatment of the patient.

C. Respondent treated Patient C, from on or about 5/25/11 through on or about 1/13/12. Patient C presented with a history of lobular carcinoma in situ (LCIS) and symptoms that included breast pain, rib pain and visual issues. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history, including psychiatric history, appropriate physical examinations, neuropsychological testing and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.
3. Inappropriately prescribed medications without appropriate medical indications including but not limited to inappropriately prescribing Rifampin while the patient was on Tamoxifen.
4. Failed to present and/or note potential risks, benefits, side effects and safe use of prescribed medications.
5. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnosis and/or treatment.
6. Failed to appropriately identify, address and/or follow-up on potential side effects.
7. Failed to maintain a record that accurately reflects the care and treatment of the patient.

D. Respondent treated Patient D, from on or about 12/4/98 through in or about May 2011. Patient D presented to Respondent reporting a history of hypothyroidism, depression and anxiety. Respondent continued to treat Patient D even after she moved from Connecticut to Myrtle Beach in or around December 2005. Respondent's

care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history including a psychiatric history, appropriate physical examinations and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation.
3. Inappropriately prescribed medications without appropriate medical indications and/or without appropriate patient assessment.
4. Failed to appropriately identify, address and/or follow-up on potential side effects.
5. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
6. Failed to present and/or note potential risks, benefits and side effects for prescribed medications including a controlled substance.
7. Failed to maintain a record that accurately reflects the care and treatment of the patient.

E. Respondent treated Patient E, from on or about 5/25/11 through on or about 7/27/12. Patient E presented to Respondent complaining of an increase in symptoms that included but were not limited to fatigue, migraines, neck pain, joint pain, numbness and tingling, irritability, sound, light and temperature sensitivity and, nonrestorative sleep. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history, including psychiatric history, appropriate physical examinations and/or mental status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.

3. Inappropriately prescribed medications without appropriate medical indications and/or at inappropriate doses.
4. Inappropriately treated the patient with Xanax before arriving at a diagnosis of anxiety disorder and/or considering non-addictive therapeutic treatment first.
5. Failed to present and/or note potential risks, benefits and side effects and safe use of prescribed medications.
6. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
7. Failed to appropriately identify, address and/or follow-up on potential side effects.
8. Failed to maintain a record that accurately reflects the care and treatment of the patient.

F. Respondent treated Patient F, from on or about 9/7/07 through on or about 9/24/12. Patient F presented to Respondent reporting a tick bite one month prior and complaining of symptoms that included but were not limited to headaches, burning, tingling, mood swings, anxiety and, an eating disorder. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to treating the patient, despite her initial presentation and prior treatment.
2. Repeatedly failed to perform and/or note a comprehensive history including a psychiatric history, appropriate physical examinations and/or mental health status examinations.
3. Inappropriately prescribed medications without appropriate medical indications and/or at inappropriate doses.
4. Inappropriately treated the patient with anti-depressants and anti-anxiety medications, including controlled substances, before arriving at a diagnosis and/or considering non-addictive therapeutic treatment first.

5. Failed to present and/or note potential risks, benefits and side effects of prescribed medications.
6. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
7. Failed to appropriately identify, address and/or follow-up on potential side effects.
8. Failed to maintain a record that accurately reflects the care and treatment of the patient.

G. Respondent treated Patient G, from in or about 7/24/00 through in or about 10/2/12. Patient G presented to Respondent reporting a variety of symptoms including but not limited to back pain, abdominal pain, feet pain, extremity weakness, anxiety, depression and mood swings. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history including a psychiatric history, appropriate physical examinations and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.
3. Inappropriately prescribed monthly narcotic analgesics for the patient.
4. Inappropriately prescribed medications including but not limited to benzodiazepines and opiates, without appropriate medical indications.
5. Failed to present and/or note potential risks, benefits and side effects of prescribed medications.
6. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
7. Failed to appropriately identify, address and/or follow-up on potential side effects.

8. Failed to maintain a record that accurately reflects the care and treatment of the patient.

H. Respondent treated Patient H, who was referred by her dentist, from on or about 4/25/14 through in or about 8/14. Patient H presented with a 8-year history of incapacitating mouth, teeth and jaw pain as well as a variety of symptoms including but not limited to confusion, forgetfulness, irritability and mood swings. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history including a psychiatric history, appropriate physical examinations and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis or treatment plan.
3. Inappropriately relied upon Applied Kinesiology to formulate a diagnosis.
4. Inappropriately prescribed medications, without appropriate medical indications.
5. Failed to present and/or note potential risks, benefits and side effects of prescribed medications.
6. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
7. Inappropriately ordered the placement of a Hickman catheter, without medical necessity.
8. Inappropriately administered antibiotics, including but not limited to intravenous Invanz, Clindamycin and Flagyl and, Rifampin, Minocycline, Mepron, Plaquenil and Bactrim, without medical indication.
9. Failed to appropriately identify, address and/or follow-up on potential side effects.
10. Failed to maintain a record that accurately reflects the care and treatment of the patient.

SPECIFICATION OF CHARGES

FIRST 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:

1. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs and/or Paragraph H and its subparagraphs.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its

subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs and/or Paragraph H and its subparagraphs.

THIRD-TENTH SPECIFICATIONS

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:

3. Paragraph A and its subparagraphs.
4. Paragraph B and its subparagraphs.
5. Paragraph C and its subparagraphs.
6. Paragraph D and its subparagraphs.
7. Paragraph E and its subparagraphs.
8. Paragraph F and its subparagraphs.
9. Paragraph G and its subparagraphs.
10. Paragraph H and its subparagraphs.

ELEVENTH SPECIFICATION

GROSS INCOMPETENCE

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

11. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs and/or Paragraph H and its subparagraphs.

TWELFTH-NINETEENTH SPECIFICATIONS

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

12. Paragraph A and its subparagraphs.

13. Paragraph B and its subparagraphs.

14. Paragraph C and its subparagraphs.

15. Paragraph D and its subparagraphs.

16. Paragraph E and its subparagraphs.

17. Paragraph F and its subparagraphs.

18. Paragraph G and its subparagraphs.

19. Paragraph H and its subparagraphs.

DATE: September 5, 2017
New York, New York

[redacted]

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct