STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

October 10, 2008

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237-0032

George J. Szary, Esq.
David Kunz, Esq.
DeGraff, Foy & Kunz, LLP
90 State Street
Albany, New York 12207

David A. Rigle, M.D.
Redacted Address

RE: In the Matter of David A. Rigle, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 08-192) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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

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

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

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

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

Sincerely
Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER **OF** **DAVID A. RIGLE, M.D.**	**DETERMINATION** **AND** **ORDER** **BPMC # 08-192**

ANDREW J. MERRITT, M.D., Chairperson, **STEPHEN H. COHEN, M.D.** and **WILLIAM W. WALENCE, Ph.D.**, duly designated members of the State Board for Professional Medical Conduct ("Board") appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ESQ.**, served as Administrative Officer for the Hearing Committee. After consideration of the entire record, the Hearing Committee submits this Determination.

SUMMARY OF PROCEEDINGS

Notice of Hearing/Statement of Charges:	January 25, 2008
Dates of Hearing:	February 29, April 23, May 15, 20, 21, 2008
Department of Health appeared by:	**Thomas G. Conway, Esq.** General Counsel, NYS Department of Health **BY: TIMOTHY J. MAHAR, ESQ.** NYS Department of Health Corning Tower, Room 2519 Albany, New York 12237
Representative for Respondent :	**DeGraff, Foy & Kunz, LLP** **BY: DAVID F. KUNZ &** **GEORGE J. SZARY, ESQs.** 90 State Street Albany, New York 12207
Witness for the Department of Health:	Stafford Henry, M.D. Linda M. Sobotka, R.N. Annette Palk Teresa Clonan Karen Vendetti

Witnesses for the Respondent:	Erica Lambert-Zukher, M.D. Christopher J. DePerno David A. Engelhart, Ph.D. Martin Schaeffer, M.D. David A. Rigle, M.D. (Respondent)
Receipt of Submissions (close of record)	July 1, 2008
Deliberations held:	July 16, 2008

STATEMENT OF THE CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law (PHL) of the State of New York.

This matter was brought by the New York State Department of Health ("Petitioner" or "Department"), Office of Professional Medical Conduct ("OPMC") pursuant to §230 of the P.H.L. David A. Rigle, M.D. ("Respondent") was charged with six specifications of professional misconduct, as defined in §6350 of the Education Law of the State of New York ("Education Law"). These charges included allegations that Respondent committed professional misconduct by reason of his being a habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, or having a psychiatric condition which impairs his ability to practice; by reason of his having violated a term of probation or condition or limitation imposed on him by an order of a Hearing Committee of the State Board for Professional Misconduct; and by reason of his having failed to file a report required by the Department of Health.

A copy of the Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix II.

NOTE: The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. In accordance with Public Health Law §230(10)(f), conclusions were based on a preponderance of the evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript

page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Hearing Committee hereby makes the following findings of fact:

GENERAL FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on or about July 24, 1990 by the issuance of license number 183181 by the New York State Education Department. (Ex. 2)

2. On or about July 19, 1991, Respondent entered into an agreement with the Board in which he stated he was presently incapacitated for the active practice of medicine due to alcohol abuse and by which he voluntarily agreed to temporarily surrender his license to practice medicine in New York state and his registration certificate. Respondent entered a residential treatment program for approximately 30 days and thereafter had his New York medical license restored by the Board, effective September 26, 1991, following a determination that he was no longer incapacitated for the active practice of medicine. Respondent was placed on a two year period of probation, which he successfully completed, during which he was monitored to ensure that he remained drug and alcohol free. (Ex. 13, E)

3. On November 9, 1998, Respondent entered into a Voluntary Agreement with the OPMC in which the OPMC agreed not to go forward with a proceeding to review Respondent's use of alcohol and pain medications during the period from February 24, 1995 to October 14, 1996 and in which Respondent agreed to and represented in the Voluntary Agreement the following:

> I do not at this time practice as a forensic pathologist, except as a private consulting medical expert who provides opinions and/or testimony in civil and criminal litigation. I do not treat patients. I do not practice medicine except as a private consulting medical expert in civil and criminal litigations as described above. The terms "practice medicine" and "practice of

> medicine" shall be defined throughout this Agreement as the diagnosing, treating, operating, or prescribing for any human disease, pain, injury, deformity or physical condition (see, Education Law §6521).

Respondent further agreed in the Voluntary Agreement to provide 30 days written notice to OPMC if he practiced medicine other than as a private consulting medical expert under the following terms:

> I shall provide 30 days written notification to the Office of Professional Medical Conduct prior to my resumption of the practice of forensic pathology, other than as a private consulting medical expert who provides opinions and/or testimony in civil or criminal litigation; the treatment of patients; or the practice of medicine, except as a private consulting medical consultant in civil and criminal litigation as described above. The notification shall be governed by the provisions of Education Law §6530(21).

(Ex. 12, paragraph #4 [a][c])

4. On or before February 10, 2007, Respondent was served with the Determination and Order (BPMC # 07-29) of a Hearing Committee of the State Board for Professional Medical Conduct. The Hearing Committee sustained charges finding that Respondent had violated an order of the State Board for Professional Medical Conduct requiring that he attend an evaluation within 14 days The Order required, among other things, that Respondent pay to the Department of Health a civil penalty in the sum of $2,500.00 within 30 days of the effective date of the order, i.e., the date of service. Respondent failed to pay the civil penalty (fine) within 30 days of the effective date of the Hearing Committee order. Respondent was sent letters from the Health Department's Bureau of Accounts Management on April 17, 2007 and again on June 13, 2007 advising him that the fine had not been received .Respondent did not send the fine payment until August 3, 2007, more than four months after it was due. (Ex. 10, 11)

5. Respondent is a forensic pathologist. He is not engaged in the clinical practice of medicine and has not done so since 1989. His professional activities are limited to providing medical expert consulting services in civil and criminal litigation. Respondent does not have a DEA registration. (T. 396; 447-48, 756)

FINDINGS OF FACT RELATED TO RESPONDENT'S ALLEGED USE OF COCAINE

6. Respondent underwent a three day evaluation at Rush Behavioral Health (renamed Resurrection subsequent to Respondent's evaluation) in Chicago, Illinois from December 4, 2006 to December 6, 2006 to determine his general psychiatric status, to screen for the presence of chemical dependencies, to determine his fitness for duty, and to provide treatment recommendations if indicated. (T. 57, 62- 63)

7. At the conclusion of the evaluation, Respondent was diagnosed with cocaine dependence, alcohol dependence in sustained partial remission, and major depressive disorder. (Ex.4, p.36)

8. Respondent's estranged wife had reported to OPMC that she had observed Respondent use cocaine on April 16, 2003 and October 30, 2005. During the course of his evaluation at Rush Behavioral Health, Respondent's wife stated that she had never observed him using cocaine. (T. 92-94, 167-171)

9. Respondent's sister, Dr. Deborah McMenamin, gave his medical history to the staff of the Wilkes-Barre Hospital Emergency Department on January 24, 2006 and reported that Respondent had a problem with crack cocaine. Dr. McMenamin gave a similiar history of Respondent's cocaine use to the staff at First Hospital of Wyoming Valley on January 25, 2006. (Ex. 7, p. 10, Ex. K, pp. 53, 68; T. 92)

10. Dr. Stafford C. Henry, the Medical Director of the Multidisciplinary Assessment Program at Rush Behavioral Health, testified as to Respondent's evaluation. In his capacity as Medical Director of such Program, he oversaw Respondent's assessment. Dr. Henry holds Board certifications in general, forensic and addiction psychiatry. (Ex. 3, T. 56-59)

11. Dr. Henry relied on results of hair sample testing performed at NMS Laboratory in arriving at an opinion that Respondent was dependent on cocaine. (Ex. 4; T. 97-98; 103-104)

12. The federally recommended reporting limit for hair sample testing for cocaine is 500 ng/g. (R. 807-08). The NMS Laboratory report contained in the Rush University Medical Center evaluation of Respondent used a reporting limit of 380 ng/g. The NMS Laboratory report did not document the level of cocaine allegedly found in the hair sample relative to the reporting limit. (Ex.4; T. 807-808)

13. A hair sample test which does not report the presence both of cocaine and cocaine metabolites cannot be relied on to establish that the test subject ingested cocaine. The NMS Laboratory report was positive for the presence of cocaine and negative for the presence of cocaine metabolites. (Ex.4; T. 808-809)

14. The laboratory report did not contain a proof of chain of custody relative to the testing of Respondent's hair sample. (Ex. 4)

CONCLUSIONS OF LAW RELATED TO RESPONDENT'S ALLEGED USE OF COCAINE

The Department presented no evidence to support the allegation that Respondent abused cocaine other than the test results obtained during Respondent's evaluation at Rush Behavioral Center. Respondent's wife and sister did not appear to testify about their reports made to OPMC about his alleged use of cocaine. Dr. Henry's testimony as to the basis for diagnosing Respondent as being cocaine dependent was weak, defensive and confused. He could not clearly explain why greater weight was given to the statements made by Respondent's wife that she observed Respondent abusing cocaine than to her other contradictory statements that Respondent did not use cocaine. Dr. Henry was unfamiliar with the protocols utilized to obtain and test Respondent's hair sample and could not verify procedures taken to protect such sample from contamination. He was not the person who obtained the

sample and no proof of maintenance of a chain of custody was provided in support of the test's validity. Dr. Henry also testified that Rush Behavioral Health made no contact with Respondent's family physician and did not obtain Respondent's medical chart from the family physician. Dr. Henry did not present himself as being objective and appeared to be biased in favor of the Department.

The laboratory director for a hair drug testing laboratory testified on behalf of Respondent as to the appropriate standards for both collecting hair samples for testing and for reporting laboratory test results. He stated that the NMS Laboratory report, relied on by Rush Behavioral Health, was unreliable because the negative finding for cocaine metabolites could not rule out the possibility of external contamination. The NMS Laboratory report also failed to indicate the amount of cocaine found relative to the reporting limit, thereby preventing a determination of the amount of drug usage. The Department offered no evidence to rebut the testimony related to standards for hair sample testing.

The Committee concluded that the hair sample test results obtained during Respondent's evaluation at Rush Behavioral Health were unreliable and could not support the allegation that Respondent was dependent on and/or a habitual user of cocaine. Dr. Henry provided little credible evidence as to how the test was conducted and could not adequately justify the conclusion that Respondent was dependent on cocaine. Respondent consistently denied ever having used that substance and no evidence was presented to demonstrate that any test of his blood or urine had ever indicated the presence of cocaine. **Factual Allegation A. was NOT SUSTAINED.**

FINDINGS OF FACT RELATED TO RESPONDENT'S ALLEGED ABUSE OF ALCOHOL

15. Respondent was evaluated by Stephen Price, M.D. on March 11, 1996 at the request of the OPMC following the receipt of a report from Respondent's wife that he was intoxicated. Dr. Price found that Respondent "exhibited no signs of any impairment during [his] examination", and concluded "I found that Dr. Rigle is not currently impaired by alcohol, drugs or mental disability." (Ex. E)

16. Respondent was evaluated by Richard B. Freeman, M.D. in late 1996 at the request of OPMC following Respondent's arrest on October 14, 1996 for driving while intoxicated. Dr. Freeman noted Respondent's "sobriety is now not as rigid as it once was while he complied with the Committee on Physician's Health program". His report concluded, "[a]t the time of this examination, Dr. Rigle exhibited no signs of impairment of mental or physical abilities, except those related to his lumbar disc problem". Dr. Freeman added that "In view of the allegations and possible false pretenses, it would be reasonable to ask [Respondent] to submit to random drug screens for a period of time to more firmly establish his credibility." (Ex. E)

17. On January 24, 2006, Respondent was involuntarily admitted to the Wilkes-Barre Hospital Emergency Department on the application of his sister, Deborah McMenamin, M.D. Dr. McMenamin reported finding Respondent in his hotel room with empty bottles of alcohol and drugs, with a knife placed at his throat and threatening to kill himself. Respondent's blood alcohol level was reported as .187, representing a high level of alcohol intake. (Ex. 7, p. 10; T. 80-81)

18. Respondent was transferred on the following day to First Hospital Wyoming Valley in Kingston, Pennsylvania. He was diagnosed with a major depression, single episode, and was started on 10 mg/daily of the antidepressant Lexapro. Respondent acknowledged drinking alcohol twice a week; two to three glasses of wine at a time. Dr. Steven Kafrissen of First Hospital noted Respondent "refused to admit a drug and alcohol problem even though he was in a rehab in 1991" and recommended Respondent attend outpatient drug and alcohol treatment following his discharge. Respondent agreed to arrange for treatment with a psychiatrist in Syracuse following his discharge; however, he never made such an appointment and also failed to obtain outpatient drug and alcohol treatment. (Ex. K, pp. 6-7; T. 598-599)

19. Among the treatment recommendations at the time of Respondent's discharge from First Hospital Wyoming Valley was that he not use alcohol. Respondent repeatedly reported occasional alcohol use to his treating physician after his discharge from First Hospital. (Ex. C, pp. 26, 39, 43, 45, Ex. K, p. 7)

20. Respondent admitted to having used alcohol subsequent to the two year period of probation he completed in 1993. (Ex. 4, p. 33, Ex. C, pp. 26, 39, 43, 45, Ex. E, p. 3; T. 536, 552, 568-569)

CONCLUSIONS OF LAW RELATED TO RESPONDENT'S ALLEGED ABUSE OF ALCOHOL

Substantial credible evidence in the record demonstrated that Respondent had habitually abused alcohol at times prior to his evaluation at Rush Behavioral Health Center in December 2006. In October 1996, it was reported that Respondent was found slumped over in his car with the faint odor of alcohol on his breath. A subsequent breathalyzer test was positive for alcohol at .05%. During the period of approximately December 2005 through January 2006, Respondent admitted drinking to excess on more than one occasion. Respondent testified that the cause of the excessive consumption of alcohol during that period was marital distress. He explained that his hospitalization in January 2006 was the result of his sister bringing him to a hotel near her home in Pennsylvania and then taking his shoes and wallet while he slept. He remained in the hotel for at least a day and a half during which time he consumed enough alcohol from the hotel room's courtesy bar to have his blood alcohol level be recorded as .187% when he was received in the hospital's Emergency Department. The evaluation report prepared by staff at Rush Behavioral Health recorded Respondent as stating that his alcohol consumption in the summer of 2005 through January 2006 was "excessive".

Respondent admitted consuming alcohol "occasionally" following his inpatient treatment in 1991 and the two year period of probation thereafter. He testified that he believed he could resume his use of alcohol after his completion of his outpatient program notwithstanding that he was not told by any counselor that he could safely do so. It was noted that he admitted discontinuing his participation in Alcohol Anonymous meetings and that he failed to comply with recommendations for continued treatment and abstinence from alcohol. The Committee concluded that clear evidence had been presented to demonstrate Respondent habitually abused alcohol prior to December, 2006. **Factual Allegation B was SUSTAINED**

FINDINGS OF FACT RELATED TO RESPONDENT'S ALLEGED ABUSE OF HYDROCODONE

21. Respondent sustained a serious back injury in the course of his employment in or about 1991. (T. 407-08)

22. Respondent was treated by Dr. John J. Cambareri, an orthopedic surgeon, from 1998 through 2005 for chronic pain associated with the back injury. He prescribed hydrocodone-acetaminophen, 10-325 mg. with refills providing six, 10 mg. hydrocodone tablets a day or 60mg. of hydrocodone per day as treatment. The dosage of acetaminophen in the hydrocodone tablets varied from 325 mg to 500mg. (Ex. 5)

23. Respondent was also treated by Dr. Martin Schaeffer, a physiatrist, from 2003 through May 14, 2008 for his back pain. He also prescribed hydrocodone-acetaminophen, 10-325 mg on a therapeutic basis as treatment. (Ex. 6, 6A, 6B; T. 830, 838)

24. On January 27, 2005, Respondent filled a prescription for 40 hydrocodone tablets written by Dr. Schaeffer due to the unavailability of Dr. Cambareri at a pharmacy on Gifford Street in Syracuse. The prescription provided sufficient hydrocodone for five days. The following day, January 28, 2005, Respondent filled a prescription written by Dr. Cambareri for another 40 hydrocodone tablets at a different pharmacy on James Street in Syracuse. Three days later, on January 31, 2005, Dr. Cambareri wrote Respondent a prescription for 180 hydrocodone tablets which was filled at the Gifford Street pharmacy. (Ex. 8, p.4 , Ex. 9, p. 3; T. 869-871)

25. Respondent filled or refilled prescriptions from Dr. Cambareri for 180 hydrocodone tablets on both May 12, 2005 and June 11, 2005 at the Gifford Street pharmacy. On May 27, 2005, Respondent filled a prescription for 40 hydrocodone tablets and on June 1, 2005, Respondent filled a prescription for 240 hydrocodone tablets each of which was written by Dr. Schaeffer. Respondent filled both of Dr. Schaeffer's prescriptions at the James Street pharmacy. Dr. Schaeffer was unaware that Dr. Cambareri

had written hydrocodone prescriptions for Respondent during the same time period (Ex. 8, p. 4, Ex. 9, pp.3-4; T. 875-876)

26. On September 2, 2005, Dr. Cambareri issued Respondent a prescription for 180 hydrocodone tablets with five refills. The prescription was filled on September 2, 2005, and five refills (180 hydrocodone tablets each) were all obtained over the next four months, including on September 28, 2005 and October 24, 2005, at the Gifford Street pharmacy. On September 16, 2005, and again October 10, 2005, Respondent filled prescriptions, each for 240 hydrocodone tablets written by Dr.Schaeffer at the James Street pharmacy. (Ex. 8, pp. 4-6, Ex. 9, p.4; T. 876-879)

27. On March 6, 2006, Respondent filled a prescription written by Dr.Cambareri for 180 hydrocodone tablets. The prescription was filled at the Gifford Street pharmacy. On March 24, 2006, Erika Lambert, M.D., who became Respondent's primary care physician on that day, wrote a prescription for 90 hydrocodone tablets which Respondent filled at the James Street pharmacy. Dr. Lambert was unaware that Respondent had filled a month's prescription for hydrocodone 18 days earlier. (Ex. 8, p. 2, Ex. 9, p. 4; T. 701)

CONCLUSIONS OF LAW RELATED TO RESPONDENT'S ALLEGED ABUSE OF HYDROCODONE

There was no disagreement that Respondent has a serious back injury that necessitates the use of hydrocodone as treatment for chronic pain. His recommended treatment dosage was six to eight 10 mg. tablets per day as needed. Pharmacy records in evidence demonstrated that on several occasions Respondent obtained hydrocodone well in excess of his recommended treatment regimen. These periods included January 2005, May through June 2005,September through November 2005 and March 2006. The fact that Respondent obtained prescriptions during those limited periods of time from more than one physician and filled them at two different pharmacies was considered by the Committee to reflect Respondent's drug seeking behavior. Dr. Lambert and Dr. Schaeffer each testified that he or she was unaware that Respondent was obtaining prescriptions for hydrocodone from another physician concurrently with their prescriptions.

Their collective testimony revealed that Respondent had not provided them with a complete and accurate medical history. The fact that the prescriptions were filled at two pharmacies demonstrated Respondent's intent to conceal his activities.

The Committee found Respondent's assertions that his sister stole prescriptions from him and diverted the drugs for her personal use to not be credible. His contention that he used two pharmacies to fill the prescriptions only for his own convenience was also not believed by the Committee. Calculations by Respondent that the amount of hydrocodone obtained over the two year period of 2005 through 2006 was consistent with the therapeutic amount prescribed by his treating physicians did not conceal the fact that at times during those two years he obtained numbers of the drug greatly in excess of the therapeutic amount. The fact that his physicians did not express concerns about Respondent's possible abuse of hydrocone was negated by his concealment from them of the true nature of his receipt of treatment from multiple providers. **Factual Allegation C was SUSTAINED**.

FINDINGS OF FACT RELATED TO RESPONDENT'S ALLEGED PSYCHIATRIC CONDITION

28. Respondent exhibited signs and symptoms of clinical depression in 2005. He acknowledged that he was unable to function as he had prior to the Summer of 2005 and that he was severely depressed. (T. 427-428, 469, 474-476)

29. Clinical depression causes sleep disturbances, loss of interest in pleasurable activities, lack of energy, difficulty concentrating, appetite disturbances, helplessness, and physical slowing. (T. 657-658)

30. Respondent is being treated for clinical depression with the use of psychotropic medications and the condition is in remission. (Ex. C, K; T. 686-687)

31. The Rush Behavioral Health Center evaluation concluded that alcohol and opioids have adversely affected Respondent's cognition which is necessary to the safe and effective practice of medicine. These substances affect mood, reality testing, and logical thought processing, all of which are needed for the safe and competent practice of medicine. (Ex. 4, pp. 36-39; T. 131-132)

CONCLUSIONS OF LAW RELATED TO RESPONDENT'S ALLEGED PSYCHIATRIC CONDITION

The Committee considered Factual Allegation D. to be an accurate statement of fact. The abuse of alcohol and hydrocodone was evidence of psychiatric conditions that could impair Respondent's ability to practice. It was noted that Respondent's clinical depression was in remission so long as he was compliant with treatment recommendations. **Factual Allegation D. was SUSTAINED**; however, no additional penalty was imposed.

FINDINGS OF FACT RELATED TO RESPONDENT'S VIOLATION OF THE BOARD'S ORDER

32. A Determination and Order (BPMC # 07-29) of a Hearing Committee of the State Board for Professional Medical Conduct was sent by certified mail to Respondent on or about February 7, 2007. The Hearing Committee Order required, among other things, that Respondent pay to the Department of Health a civil penalty in the sum of $2,500.00 within 30 days of the effective date of the order, i.e., the date of service. (Ex. 10)

33. The Order was received by Respondent's wife on February 10, 2007. The effective date of the Determination and Order established by OPMC was February 15, 2007. In accordance with the terms of the Order, payment by Respondent was due between March 10 and March 15, 2007. (T. 293-294)

34. Respondent was sent letters from the Health Department's Bureau of Accounts Management on April 17 and June 13, 2007 advising him that the fine had not been received. (Ex. 11, pp. 3, 5)

35. Respondent's payment of the civil penalty was received by the Department on August 7, 2007. (Ex. 11, p.11)

CONCLUSIONS OF LAW RELATED TO RESPONDENT'S VIOLATION OF THE BOARD'S ORDER

The Committee concluded that Factual Allegation E was an accurate statement of fact, in that he failed to pay the civil penalty imposed by the Board within 30 days of the effective date of the Order. **Factual Allegation E. was SUSTAINED**. No additional penalty was imposed.

FINDINGS OF FACT RELATED TO RESPONDENT'S VIOLATION OF THE 1998 VOLUNTARY AGREEMENT

36. Respondent made numerous orders to pharmacies for erectile dysfunction medications for his personal use during the years 2004 and 2005. Each medication required a physician's order. (Ex. 8, 9; T. 554 - 555)

37. Respondent's order or prescriptions for these medications was in the treatment of a human disease or physical condition and constituted the practice of medicine. He failed to provide notice to the OPMC prior to ordering these medications, in violation of Paragraph 4.c. of the Voluntary Agreement he entered into in 1998. (Ex. 12; T. 554)

CONCLUSIONS OF LAW RELATED TO RESPONDENT'S VIOLATION OF THE 1998 VOLUNTARY AGREEMENT

Respondent did not dispute the fact that he obtained quantities of erectile disfunction medications for his own use. He contended that such acts were not the practice of medicine in that the medications were not for the use of anyone other than himself. The members of the Hearing Committee strongly disagreed with that position. The medication was not an over-the-counter item; it required a prescription issued by a licensed physician. The basis for requiring a prescription is that erectile disfunction medications have potential side effects that necessitate their being issued by licensed providers with knowledge of those possible complications. A layperson cannot legally gain access to those medications without a determination by a licensed provider that their use would be appropriate. Respondent used his status as a physician to obtain a medication he otherwise would have been unable to access and the Committee believed his having done so constituted the practice of medicine, even if the medication was solely intended for his own use.

The issue of whether Respondent's obtaining those medications constituted his practice of medicine and thereby a violation of the Voluntary Agreement, was not presented to the Hearing Committee in Respondent's 2007 proceeding before the Board, and no determination was made by that Committee as to whether he was, in fact, practicing medicine by obtaining erectile disfunction medications for himself. A review of the 2007 Determination and Order (BPMC #07-29; Ex. 10) by this Committee demonstrated that the 2007 Hearing Committee made no determination as to whether Respondent was in violation of the 1998 Voluntary Agreement; it determined only that Respondent was in violation of a Board order issued pursuant to Public Health Law §230(7). **Factual Allegation F. was SUSTAINED**. The violation of the Voluntary Agreement was considered to be technical in nature and no additional penalty was imposed. The Terms of Probation imposed by the Committee (Appendix I) clarifies that the conditions of the Voluntary Agreement shall include a prohibition against his obtaining for his personal use, or for the use of any family member, any medication requiring a prescription without obtaining such a prescription from another licensed practitioner.

DISCUSSION

Assessment of Respondent's credibility was critical to the Committee's consideration of the allegations of his impairment. Respondent offered a detailed description of his personal and professional experiences which could only be characterized as unsettled. He has had frequent interactions with the Board, the Committee on Physician's Health (CPH) and the OPMC since 1991. While he indicated he considered he was being "harassed" by these monitoring bodies, most of the contacts were initiated by the receipt of reports from others that he was seen to be using illicit drugs or that he was intoxicated. Those reports both justified and required subsequent investigations. In 1995, CPH received a report from Respondent's wife that he had been intoxicated. In 1996, he was arrested on suspicion of driving while intoxicated. As a result of that arrest, he was evaluated in December, 1997 and admitted he occasionally used alcohol "one to two times a year.' He was found to show no signs of impairment "at the present time". Respondent admitted to drinking excessively during the period of mid-2005 through January 2006. Two of his employees testified as to his appearing intoxicated during that period. While their testimony was considered credible, the Committee made no inferences from their reports. In January 2006, Respondent was involuntarily admitted to a Pennsylvania hospital with a reported blood alcohol level of .187. He testified that thereafter he continued to occasionally have a drink.

Respondent offered a wide assortment of rationales for the instances of excessive drinking, including his undiagnosed clinical depression, his sister, work related stress, his wife, hypothyroidism, marital stresses and hypotestosterone. He attempted to excuse repeated instances of automobile mishaps, family disputes and observations by other objective persons of unusual exhibitions of behavior by shifting blame to others and offering unreasonable explanations of events. Respondent refused to accept any personal responsibility for his aberrant actions which stretched over a period of many years. In sum, the Hearing Committee found Respondent to be a completely incredible and unbelievable witness.

Respondent was found to be in full denial of his alcoholism and exhibited no insight into his condition. He was not involved in any continuing support group and disregarded several recommendations that he participate in an outpatient treatment program. Significantly, his two treating physicians each testified that they were unaware of Respondent's history of alcohol dependency or that he had participated in a residential treatment program in 1991. The Committee believed Respondent

intentionally withheld such fact which would be clearly relevant for his continued treatment for depression. Respondent was consistently vague about his continued use of alcohol in his testimony and obviously has failed to accept the fact that the struggle against the disease of alcohol abuse requires a lifetime commitment.

The Committee also found Respondent not credible in the explanation of his use of opiates to manage his back pain. His justification for the use of multiple physicians and pharmacies to obtain his medications was not believable and was considered to represent drug seeking behavior. Between May 12 and June 11, 2005, Respondent filled four prescriptions from two physicians at two different pharmacies for a total of 640 hydrocodone tablets. Between September 2, 2005 and November 22, 2005, Respondent filled prescriptions for 840 hydrocodone tablets which he obtained from two different physicians and filled at two different pharmacies. In addition, the volumn of medications prescribed for Respondent has been considerable. The record of Respondent's office visit of November 5, 2007 with his primary care physician reflected his current medications as including Testosterone Cypionate 200 mg/ml, Phentermine HCL 37.5 mg., Xanax 0.5mg, Provigil 200 mg., Ambien CR 12.5 mg., Lexapro 20 mg., Nicotrol Inhaler 10 mg., and Viagra 100 mg. The fact that Respondent did not fully inform his treating physicians as to the extent of his medical history and treatment reinforced the Committee's concern of a demonstrated pattern of drug seeking behavior.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in New York be suspended for a two year period, with such suspension stayed. During the period of the stayed suspension, Respondent shall be placed on probation and made subject to all conditions set forth in Appendix I of this Determination and Order. Such conditions include requirements that he remain drug and alcohol free and comply with all components of his treatment regimen including initiation of treatment with an approved therapist and compliance with sobriety monitoring directives. This determination was made following due consideration of the full spectrum of penalties available pursuant to statute, including license revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee unanimously determined that Respondent has been dependent on, or habitually abused alcohol and hydrocodone during periods before his evaluation at Rush Behavioral Health Center in December, 2006. Subsequent to that date, Respondent's life has appeared to have somewhat stabilized. His clinical depression has been in remission with medication and stressors derived from his personal life appeared to have been reduced. This increase in Respondent's stability was a significant factor in causing the Committee to reject the Department's request that his medical license be revoked.

However, in developing an appropriate penalty the Committee could not disregard Respondent's history of appearances before the Board. He agreed to temporarily surrender his license in 1991 based on his impairment, voluntarily agreed to restrict his practice of medicine in 1998 and was sanctioned for having failed to comply with a Board Order to participate in a medical examination in 2007. Respondent's attempts at rehabilitation have clearly been both unsuccessful and inadequate and his testimony at this proceeding made it very apparent that he does not accept his condition. He has consistently ignored recommendations that he participate in a treatment program. The Committee believed it necessary to impose conditions of probation requiring, in part, abstinence from alcohol and

unauthorized substances in order to educate Respondent about approaches to address stress and depression. The Committee also determined that Respondent's failure to fully inform his physicians of the care he was in receipt of justified requiring submission of reports of all diagnoses and treatments from each provider to his primary care physician.

In imposing this penalty, the Committee considered the fact that Respondent has agreed to treat no patients and does not presently constitute a threat to the public's health. Respondent's activities as a medical practitioner are limited to providing medical expert consulting services in civil and criminal litigation. His medical opinions are given greater weight as a result of his status of being licensed to practice medicine in New York. The license is the imprimatur for offering those opinions and lends credibility to them. The Committee considered that Respondent receives a significant benefit in possessing a New York medical license and that it was not unreasonable to expect him to conduct himself at all times in a manner reflecting his professional status.

ORDER

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

1. The following Specification of Charges as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED:**

Second through and including Sixth Specification; and

2. All other Specification of Charges are **NOT SUSTAINED** and are **DISMISSED**; and

3. The license of Respondent to practice medicine in New York State be hereby **SUSPENDED** for a period of two (2) years, said suspension to be **STAYED**; and

4. Respondent shall be placed on **PROBATION** during the period of the stayed suspension of his license, and he shall comply with all Terms of Probation as set forth in Appendix I, attached hereto and made a part of this Determination and Order; and

5. This Order shall be effective upon service on the Respondent or his attorney by personal service or by certified or registered mail.

DATED: Troy, New York
9/26, **2008**

Redacted Signature

ANDREW J. MERRITT, M.D., Chairperson

STEPHEN H. COHEN, M.D.

WILLIAM W. WALENCE, Ph.D.

TO:

Timothy J. Mahar, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2512
Empire State Plaza
Albany, New York 12237-0032

George J. Szary, Esq.
David Kunz, Esq.
DeGraff, Foy & Kunz, LLP
90 State Street
Albany, New York 12207

David A. Rigle, M.D.
Redacted Address

APPENDIX I

TERMS OF PROBATION

1. Respondent shall conduct himself at all times in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit written notification to the Board addressed to the Director, Office of Professional Medical Conduct ("OPMC"), Hedley Park Place, 433 River Street, 4th Floor, Troy, New York 12180, regarding any change in employment, practice, addresses, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. Within 30 days of the effective date of this Order, Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department.

6. Respondent shall remain free from alcohol and all other mood altering substances other than those prescribed for Respondent's treatment by a licensed medical practitioner aware of Respondent's history.

7. Respondent shall comply with all terms and conditions set forth in the Voluntary Agreement he entered into on or about October 22, 1998 and shall continue to limit his practice as a forensic pathologist to that as a private consulting medical expert who provides opinions and/or testimony in civil and criminal litigation.

8. Respondent shall not obtain for himself or any family member any medication that requires a prescription without obtaining such a prescription from another licensed practitioner.

9. Respondent shall conduct his consulting medical expert practice only when monitored by qualified health care professional monitors proposed by him and approved, in writing, by the Director of OPMC. Monitors shall not be family members or personal friends, or be in professional relationships which would pose a conflict with monitoring responsibilities. Respondent shall ensure that the monitors are familiar with Respondent's chemical dependency and with the terms of this Order. Respondent shall cause the monitors to report any deviation from compliance with the terms of this Order to OPMC and to submit required reports on a timely basis.

a. Within ninety (90) days of the effective date of this Order, Respondent shall engage and continue in therapy with a qualified health care professional (**Therapist**) and shall continue treatment with said Therapist for the duration of the period of probation. Respondent shall submit the name of a proposed successor within seven (7) days of becoming aware that his approved Therapist is no longer able or willing to serve in that capacity.

i. The Therapist shall submit a proposed treatment plan and quarterly reports to the OPMC certifying Respondent's compliance with the treatment plan and describing in detail any failure to comply.

ii. Respondent shall identify his primary care physician to the Therapist and shall promptly advise the Therapist in any change of his primary care physician. The Therapist shall submit a copy of Respondent's proposed treatment plan and quarterly report to the OPMC to the primary care physician.

ii. The Therapist shall report within 24 hours to the OPMC if Respondent displays any significant pattern of absences or discontinuation of recommended treatment or any symptoms of suspected or actual relapse.

b. The Respondent will be monitored for sobriety by a qualified health care professional (**Sobriety Monitor**) and shall comply with the sobriety monitoring requirements set forth in this Paragraph. The Sobriety Monitor's responsibilities shall

include assessment of self-help group attendance and 12 step progress, evaluation of compliance with the terms or conditions in the Order and ordering urines for drug/alcohol assay. Respondent shall cause the Sobriety Monitor to report to the Office of Professional Medical Conduct within 24 hours if a test is refused or delayed by Respondent or a test is positive for any unauthorized substance.

i. Respondent shall submit the name of a proposed successor within seven (7) days of learning that the approved Sobriety Monitor is no longer willing or able to serve.

ii. The Respondent will meet with the Sobriety Monitor on a regular basis and will submit to random, unannounced observed screens of blood, breath and/or urine for the presence of drugs/alcohol at the direction of the Sobriety Monitor. This monitoring will be on a random, seven-day a week, twenty-four hour a day basis. The Respondent will report for a urine drug screen, blood and/or breathalyzer test within four (4) hours of being contacted by the Monitor.

iii. The Respondent will authorize the Sobriety Monitor to submit to the Office of Professional Medical Conduct quarterly reports certifying Respondent's compliance with the Terms of Probation. Respondent's failure to comply with any of the terms must be reported within 24 hours to the Office of Professional Medical Conduct. The reports will include forensically valid results of all drug/alcohol monitoring tests to be performed at a frequency of no less than six (6) screens per month for the first twelve (12) months of the period of probation, then at a frequency of no less than two (2) screens per month for the remainder of the period of probation, in a schedule proposed by the Sobriety Monitor and approved by the OPMC. The report shall also include an assessment of self-help group attendance and 12 step progress.

10. Respondent shall ensure that all treating medical practitioners are familiar with Respondent's chemical dependency and with the terms of this Order.