STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

December 27, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jeffrey Armon, Esq.
NYS Department of Health
Corning Tower - Room 2429
Empire State Plaza
Albany, New York 12237

Ronald J. Pelligra, Esq.
205 South Townsend St.
Syracuse, NY 13202

Jeffrey Wiersum, M.D.
713 East Genesee Street
Suite 311
Syracuse, New York 13210

RE: In the Matter of Jeffrey Wiersum, M.D.

Dear Mr. Armon, Mr. Pelligra and Mr. Wiersum:

Enclosed please find the Determination and Order (No. BPMC-93-207) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Very truly yours,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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In the Matter	:	DETERMINATION AND
of	:	ORDER OF THE
JEFFREY WIERSUM, M. D.	:	HEARING COMMITTEE
----------x		ORDER NO. 93-207

The undersigned Hearing Committee consisting of GEORGE C. SIMMONMS, Ed.D., Chairperson, ARSENIO G. AGOPOVICH, M. D. and TERESA S. BRIGGS, M.D., Ph.D.,was duly designated and appointed by the State Board for Professional Medical Conduct. DAVID A. SOLOMON, ESQ., Administrative Law Judge, served as the Administrative Officer.

The Hearing was conducted pursuant to the provisions of Section 230,subdivisions 10 and 12, of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive testimony and evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by JEFFREY WIERSUM, M.D., hereinafter referred to as the "Respondent." Witnesses were sworn or affirmed and examined. A stenographic record of the Hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges herein.

RECORD OF PROCEEDINGS

Commissioner's Order and Notice of Hearing:	June 11, 1993
Affidavit of Service of Order and Notice:	June 14, 1993
Respondent's Denial of the Charges: (See, T. pp.5, 6.)	July 21, 1993
Appearances:	
Bureau of Professional Medical Conduct:	Jeffrey Armon, Esq. Assistant Counsel Division of Legal Affairs, Empire State Plaza, 2429 Corning Tower Albany, NY 12237
The Respondent:	Ronald J. Pelligra,Esq. 205 S. Townsend Street Syracuse, NY 13202
Dates and Times of Pre-Hearing Conference and Two Initial Hearings at 2509 Corning Tower, Empire State Plaza,Albany,NY 12237:	Pre-Hearing Conference: July 21, 1993 9:20-10:20 a.m. Hearing Dates: July 21, 1993 10:20 a.m.-4:30 p.m. July 22, 1993 9:50 a.m.-1:10 p.m.
Dates and Times of Hearings at NYS Department of Health, 677 South Salina Street, Syracuse,NY 13202:	August 5,1993 8:30 a.m.-4:15 p.m. August 10, 1993 8:30 a.m.-4:00 p.m. August 24, 1993 8:30 a.m.-1:30 p. m.

Interim Order continuing the Summary Order of the State Commissioner of Health dated June 11, 1993 pending the final Determination of, and Order in, the matter:	September 10, 1993
Petitioner's Proposed Findings of Fact, Argument and Conclusions:	September 15, 1993
Respondent's Final Statement:	September 29, 1993
Deliberations Conference, 2509 Corning Tower, Albany,NY 12237:	October 7, 1993 10:00 a.m.-2:00 p.m.
Record Closed:	October 7, 1993

Witnesses:

The State called the following witnesses:

Jerome S. Greenholz, D. O.	Expert Witness
Richard H. Lange, M.D., FACP	Expert Witness

The Respondent called the following witnesses:

The Respondent	Fact Witness
Patient G	Fact Witness
Patient B	Fact Witness
Patient I	Fact Witness
Patient J	Fact Witness
Patient B	Fact Witness

Exhibits:

Commissioner's Order and Notice of Hearing and Statement of Charges, dtd.6/11/93:	State Ex. 1
Affidavit of Service of Order, Notice of Hearing and Statement of Charges, dtd. 6/14/93:	State Ex. 2
Stipulation and Order re Violations of Article 33 of the Public Health Law, dtd. 7/27/92:	State Ex. 3
Education Dept. Order with Regents Review Committee Report, dtd. 4/3/87:	State Ex. 4
Respondent's Stipulation and Order, dtd., 1/31/86:	State Ex. 5

License and Registration of Respondent:	State Ex. 6
Respondent's Records, Patient A:	State Ex. 7
Respondent's Records, Patient B:	State Ex. 8
Respondent's Records, Patient C:	State Ex. 9
Respondent's Records, Patient D:	State Ex. 10
Respondent's Records, Patient E:	State Ex. 11
Respondent's Records, Patient F:	State Ex. 12
Respondent's Records ,Patient G:	State Ex. 13
Respondent's Records, Patient H:	State Ex. 14
Respondent's Records, Patient I:	State Ex. 15
Respondent's Records, Patient J:	State Ex. 16
Respondent's Records, Patient K:	State Ex. 17
Respondent's Records, Patient L:	State Ex. 18
Respondent's Records, Patient M:	State Ex. 19
Respondent's Records, Patient N:	State Ex. 20
Respondent's Records, Patient O:	State Ex. 21
Prescribing Activity Chart:	State Ex. 22
Curriculum Vitae, Dr. Greenholz:	State Ex. 23
Curriculum Vitae, Dr. Lange:	State Ex. 24

Respondent's Exhibits:

Resp's. Prescription and copies, Patient G:	Resp. Ex. A
Resp's Castor Oil Stupes Information Sheet, Patient G:	Resp. Ex. B
Resp's Vitamin, Oil and Diet Program:	Resp. Ex. C
Hospital Record of Patient B, 7/20/93:	Resp. Ex. D
Copies of 5 Prescriptions, Patient A:	Resp. Ex. E
Five Prescriptions, Patient A:	Resp. Ex. F
Respondent's Curriculum Vitae:	Resp. Ex. G
Respondent's Letter to Patient N, 6/14/90:	Resp. Ex. H
Respondent's Letter to Patient N, 6/14/90:	Resp. Ex. H-1
Letters re Respondent:	Resp. Ex. I-1 through I-9*

SIGNIFICANT LEGAL RULINGS

During the course of the Hearing, the Hearing Committee had access to a memorandum dated February 5, 1992, entitled "Definitiuons of Professional Medical Conduct under the New York Education Law by Peter J. Millock, Esq., General Counsel, New York State Department of Health, containing suggested definitions for negligence and gross negligence, and incompetence and gross incompetence.

*Resp. Ex. I-9 was accepted into evidence on stipulation of the Parties with the concurrence of the Hearing Committee on 9/9/93

Negligence is defined as deviation from acceptable medical standards in the treatment of a patient, while incompetence is defined as a lack of ability to discharge a physician's required duty to a patient because of a want of skill or knowledge. Gross negligence is defined as a single act of negligence of egregious, conspicuously bad, proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Gross incompetence shows a complete lack of ability to perform an act in connection with medical practice, a flagrant lack of necessary knowledge or ability to practice. The Millock Memorandum reviews these definitions in the context of Education Law Section 6530 and the applicable case law.

The Interim Order of the Commissioner of Health is Attachment I, hereto; an Affirmation of Committee Member Dr. Briggs is Attachment II; Petitioner's Proposed Findings of Fact and Respondent's Closing Statement are Attachment III; technical transcript corrections approved by the Hearing Committee on stipulation of the parties at the Hearing on August 5, 1993 and thereafter are Attachment IV (T. 362-366).

The Respondent requested he be permitted to introduce medical journal entries over the objection of the State. The Administrative Officer, noting Morfesis v. Sobel, 172 A.D. 2d and Pahl v. Troy City Railway, 81 A.D. 308, sustained the objection over the exception of the Respondent. T. 366-370.

SUMMARY OF CHARGES

The Respondent was charged with practicing with negligence on more than one occasion, with incompetence on more than one occasion, with gross negligence on a particular occasion,and with gross incompetence. Failing to maintain accurate records, being found to violate Article 33 of the Public Health Law and violating the terms of a previous probation are charged as well. The charges relate to 15 different patients during the 1981-1993 medical practice of Respondnet. The Commissioner of Health initiated a Summary Order on the Respondent to cease practice; on September 10, 1993, a continuation order was issued pending final determination of the Hearing. Public Health Law Sec. 230, subd. 12. Two amendments to the Charges' Factual Allegations were granted to Allegations B.1 and B.1.c. They are set forth in Attachment V. T. pp. 86-88.

FINDINGS OF FACT

All findings and conclusions herein were unanimous unless noted otherwise, The findings and conclusions of the Petitioner and the Respondent's Closing Statement were each considered and rejected by the Hearing Committee unless specifically set forth herein as findings and/or conclusions of the Committee.

The following findings were made after review of the entire record. Numbers following a finding refer to page numbers of the transcript (T.___). Numbers and letters following a reference to exhibits (Ex.___) refer to exhibits in evidence. The citations represent evidence the Committee found persuasive in arriving at a particular finding. All findings were established by at least a proponderance of the evidence. Conflicting evidence was considered and rejected by the Hearing Committee; the Committee's reference to opinion in evidence given more weight than another's is demonstrated by the Committee's reference to one person's testimony rather than another's.

1. Respondent Jeffery Wiersum, M.D., was authorized to practice medicine in New York on October 28, 1953, having been issued license number 074392 by the State Education Department. The Respondent is currently registered to practice for the period January 1, 1993 through December 31, 1994 from 713 East Genesee Street, Suite 311, Syracuse, NY 13210. State Ex. 6.

2. Respondent was personally served with the Commissioner's Order and Notice of Hearing including the Specifications of Charges on June 14, 1993. The Respondent and his attorney were present at the Pre-Hearing Conference and all evidentiary hearings held on the following dates in 1993:July 21 and 22,and August 5, 10 and 24. State Ex. 2.

3. The Respondent entered into a Stipulation and Order with the Department of Health (hereinafter referred to as the State) in January, 1986 in response to a Statement of Charges alleging violations of Article 33 of the Public Health Law, wherein he admitted to violations of the Public Health Law in the Stipulation and Order, agreed to pay a civil penalty and had his rights to issue prescriptions requiring official New York State prescription forms suspended for a four year period. T. 474-477; State Ex. 5.

4. Based on the Stipulation and Order, the Respondent was charged with professional misconduct by the State Board for Professional Medical Conduct. In a March, 1987 Order the Board of Regents accepted the findings of the Regents Review Committee that the Respondent was guilty of professional misconduct and imposed a penalty of five years suspension of his medical license. Four and one-half years of the suspension was stayed during which time he was placed on probation. Terms of the probation included a requirement that the Respondent remain in compliance with legal requirements in regard to the prescribing, dispensing and administration of controlled substances. T. 475-476; State Ex. 4.

5. Respondent entered into a second Stipulation and Order with the Department in July, 1992 in response to a Statement of Charges alleging further violations of Article 33 of the Public Health Law. The Respondent admitted to violations in treating two patients and agreed to pay a civil penalty. T. 473-477; State Ex. 3.

PATIENT A

6. Respondent first treated Patient A, a 20 year old male, on February 2, 1990 for symptoms of influenza. T. 454. Either Tussionex or Hycodan was prescribed on at least seven occasions by the Respondent for Patient A between February 2 and May 11, 1990. T. 60; State Exs.7, pp. 11, 41-4; 22. The Respondent failed to record any justification for the repeated treatment with these narcotic antitussives. T. 61, 481; State Ex. 7.

7. Between May 14 and August 12, 1990, Respondent prescribed Vicodin or Vicodin ES on at least 9 occasions for Patient A in an amount which totalled at least 1040 tablets, which, if taken in accord with Respondent's directions for use, would have constituted about a 200 day supply. T. 63; State Exs. 7, 22. Such is a dangerous dose which was unnecessary for treatment with the controlled substances and perpetuated the habituation to and dependence upon the drugs. T. 63, 118.

8. Respondent noted he was advised that Patient A was being treated by another physician. Respondent's medical record entry on July 31, 1991 stated:"must get into detox and rehab...no more rx's from us." T. 466; State's Ex. 7, p.8. Despite being aware of Patient A's abuse of prescribed medications, Respondent began prescribing Lortabs 7.5 mg.,a Schedule III controlled substance, on August 19, 1991 for Patient A. T. 466-467; State Exs. 7, p. 8; 22. Between August 19 and December 16, 1991, Respondent prescribed Lortabs for Patient A on at least eight occasions. T. 65; State Ex. 7, pp. 7-8; 22. The amounts prescribed, each for 100 tablets and five refills, were excessive. T. 65. A medical record note of the Respondent on February 19, 1992 stated Patient A "can't get daily intake of Lortabs 7.5 mg. below 20 per day." State Ex. 7, p.4. This excessive dosage far exceeds the recommended dosage of one or two every four hours. T. 67. Between February 20, 1992 and May 1, 1992, Respondent prescribed Lortabs for Patient A on at least 16 occasions in the total amount of at least 3,022 tablets. Based on Patient A's medical record, there was no justification for such high or frequent doses of narcotics. T. 67; State Exs. 7, 22.

9. Respondent failed to develop and/or record treatment plans or goals for Patient A. T. 67; State Ex. 7.

10. Respondent failed to maintain adequate records for Patient A. T. 67, 119-122, 481; State Ex. 7.

PATIENT B

11. Respondent treated Patient B, a fifty-eight year old female, for back and knee pain, hypothyroidism, arthritis and hypertension between January, 1986 and February, 1993. T. 83-84, 498-499; State Ex. 8.

12. Respondent prescribed Zaroxolyn, a diuretic and known potassium depleter, as treatment for Patient B on at least five occasions between January, 1986 and September, 1988, and failed to order, perform and/or record any initial test to obtain potassium levels for Patient B during the period, except for a test result reported on June 3, 1987. T. 115, 501-503; State Ex. 8, pp. 85-85B. One and one-half years after the first treatment, the potassium level was reported as 2.8 MEq., a very low level. T. 89-90; State Ex. 8, pp. 85-85-B.

13. Respondent did not obtain another potassium level for Patient B until December 14, 1988, approximately one and one-half years later. T. 91-92, 501-503; State Ex. 8, p.60. The level was reported as 2.4 MEq. a dangerously low level. T. 91-92; State Ex. 8, p. 60. Respondent did not refer the Patient to the hospital, and reported in a note dated December 6, 1988 that the Patient should continue taking Slo-K, a potassium supplement, one a day. T. 92-93; State Ex. 8, p.52. Such treatment would have been inadequate to increase

Patient B's potassium level. T. 91, 115-116. The Patient fainted at home on the following day, and was hospitalized in a serious hypokalemic condition. State Ex. 8, pp. 55-57. The Respondent failed to advise Patient B to discontinue the use of Zaroxolyn when the Respondent received the December 14, 1988 laboratory results. T. 94.

14. Patient B was admitted to the hospital as the result of a fall after taking the first dose of Vasotec 10 mg. prescribed by the Respondent. After having been prescribed Zaroloxyn, with some depletion of water and potassium, and with an apparemt high renin activity, she was very susceptable to an ACE inhibitor. Such places a patient in danger of hypotention and fainting. Even when the ACE inhibitor is given under such conditions, it should be a small dose given under observation in the physician's office. Ten millegrams is double the usual dosage; it is not a small dose. T. 125-126; State Ex. 8, pp. 55-56.

15. Between the period March 4 to June 12, 1992, the Respondent prescribed APAP with codeine on at least six occasions, each for 120 tablets with five refills for Patient B. 3330 tablets over a three to four month period is an excessive amount. T. 99, 113; State Ex. 22.

16. Respondent failed to develop and/or record a treatment plan or goals for Patient B. T. 99-100; State Ex. 8.

17. Respondent failed to maintain adequate records for Patient B. T. 122-123; State Ex. 8.

PATIENT C

18. Respondent treated Patient C, a 39 year old female at the time of initial treatment, from May, 1990 until February, 1993 for hypothroidism, back strain and ankle and foot pain. T. 639-640, 644-645; State Ex. 9, p. 5.

19. At Patient C's initial treatment on May 4, 1990, Respondent prescribed Levothyroid 0.2 mg., a thyroid supplement, for Patient C's hypothryroid condition. Respondent failed to order, perform and/or record appropriate laboratory tests to confirm such diagnosis; and, there is no evidence in the laboratory tests to confirm such diagnosis. T. 128-130; State Ex. 9, p. 5.

20. Hyrothroidism is ordinarily diagnosed by patient history, physical examination and reliance on results from blood tests which indicate the levels of thyroid hormones and thyroid stimulating hormones. The combination of these tests is very accurate for diagnosing hypothyroidism. One may not accurately diagnose a thyroid deficiency based upon clinical observation alone. T. 129-130, 292-294.

21. Respondent prescribed Ionamin 30 mg., a Schedule IV controlled substance and appetite suppressant on several occasions during the period of May 4, 1990 through November 11, 1991. During this period, he also prescribed Levothyroid, a thyroid supplement; adverse effects are associated with use of the two together. T. 128, 132, 648-650; State Exs. 7, pp. 3-5; 22.

22. During the period of May 21, 1990 through February 21, 1991, Respondent on at least twelve occasions prescribed Empirin with Codeine, a Schedule III controlled substance, and Ionamin pursuant to telephone requests made by Patient C. The Respondent failed to personally observe or examine Patient C at any time during the period, and recorded no history or findings to provide a basis for prescribing the medications. T. 132-133, 632; State Ex. 9, p. 5. It is not an accepted medical practice to prescribe such medications without examining or observing the patient. T. 133, 139-140.

23. Respondent regularly noted that Patient C abused the controlled substances that he prescribed, yet he continued to prescribe such medications for Patient C during the period of treatment. T. 140; State Ex. 9, p.3.

24. Respondent failed to develop and/or record treatment goals or plans for Patient C. T. 144-145; State Ex. 9.

25. Respondent failed to maintain adequate records for Patient C. T. 127-128, 143-145; State Ex. 9.

PATIENT D

26. Respondent treated Patient D, a 26 year old male,for knee and back pain during the period of January, 1989 through April, 1992. T. 146, 668; State Ex. 10.

27. During the period of June 21, 1989 through July 6, 1990 Respondent prescribed Vicodin on at least seventeen occasions for treatment of Patient D's pain in an amount which totalled 4,170 dosage units. Respondent was aware of Patient D's abuse of such medication but continued to prescribe it. T. 146-149, 673-675; State Exs. 10, pp. 11-13; 22. Prescribing an average of ten or more Vicodin per day for any length of time greater than two or three days is not good medical practice. T. 147, 155.

28. Respondent noted in Patient D's medical record on July 6, 1990: "told him I would no longer be able to write for his pain meds." On that same date Respondent prescribed Vicodin for Patient D and subsequently prescribed Vicodin on at least twelve occasions until May 15,1991.

T. pp. 149-150,674-675; State Exs. 10, pp. 8-11; 22.

29. During the period June 5,1991 through April 19,1992, Respondent prescribed Lortabs 7.5 mg. on at least twelve occasions for treatment of Patient D's pain in a total amount of 4,390 dosage units. Respondent was aware of Patient D's abuse of such medication, but continued to prescribe it. State Exs. 10, pp. 4-8; 22.

30. Respondent failed to develop and/or record treatment plans for Patient D. T. 151; State Ex. 10.

31. Respondent failed to maintain adequate records for Patient D. T. 156-157; State's Ex. 10.

PATIENT E

32. Respondent treated Patient E, a 28 year old female, from the initial visit in June, 1990 through September, 1992 for hypothyroidism. Hypothyroidism is far less likely to be a diagnosis in a 28 year old; the diagnosis needs to be pursued prior to treatment. T. 129-130, 157-158, 292-294, 685-686; State Ex. 11.

33. At Patient E's initial office visit on June 20, 1990, the Respondent diagnosed Patient E as being hypothyroid, but failed to order, perform and/or record any physical finding or laboratory test results to support such diagnosis. T. 157-158; State Ex. 11, p. 5.

34. During the period of March, 1991 through September,1992 Respondent prescribed Plegine for Patient E on at least seven occasions,notwithstanding that Respondent noted in the medical record the negative effects of the medication on Patient E in several instances. T. 160-162, 687-688, 690-692; State Ex. 11 pp. 3-5. Respondent was aware of Patient E's abuse of Plegine during this period of treatment. Despite such knowledge, the Respondent continued to prescribe the medication. T. 160-162, 687-688; State Ex. 11, pp. 3-5.

35. Despite treating Patient E for obesity for an extended period , Respondent failed to obtain and/or record a weight for Patient E at any office visit after the June 20, 1990 initial visit. T. 162; State Ex. 11, p. 3-5.

36. Respondent failed to develop and/or record treatment plans for Patient E. T. 162-163; State Ex. 11.

37. Respondent failed to maintain adequate records for Patient E. T. 158, 162; State Ex. 11.

PATIENT F

38. Respondent treated Patient F, a 19 year old male, between June, 1991 and February, 1993 for a knee injury. T. 168-181, 694; State Ex. 12.

39. Respondent noted in an entry in Patient F's medical record dated June 24, 1991 that Patient F had a history of alcohol abuse. State Ex. 12, p. 5.

40. On June 24th, the Respondent prescribed APAP with Codeine #4, 60. mg., 100 tablets, with five refills. T. 169; State Ex. 12, p. 5. Prescribing such an amount of APAP with Codeine to a patient with a history of alcohol abuse was not appropriate because the patient is more easily addicted to controlled substances. T. 170.

41. Between August 16, 1991 and December 17, 1991, Respondent prescribed APAP with Codeine #4 to Patient F on at least four occasions in an amount totalling 1400 dosage units, notwithstanding Patient F's history and the Respondent's knowledge of the Patient's abuse of the medication.

State Exs. 12, pp. 4-5; 22.

42. In an entry in Patient F's medical record, Respondent noted : "again concern about prolonged used of meds." At the same date Respondent prescribed ADAP with Codeine #4,300 dosage units.State Ex.12,pp.2,5. Prescribing of such amount of a controlled substance over the time period to be used did not meet accepted standards of medical practice.
T. 179.

43. Respondent failed to develop and/or record treatment plans or goals for, or any diagnosis of, Patient F. T. 171; State Ex. 12.

44. Respondent failed to maintain adequate records for Patient F. T. 168; State Ex. 12.

PATIENT G

45. Respondent treated Patient G, a 19 year old female at the time of initial treatment in January, 1990, through December, 1993, for migraine headaches and back and leg pain. T. 182, 406; State Ex. 13..

46. Respondent failed to obtain and/or record any history, physical findings or diagnosis of Patient G's condition at the initial office visit on January 3, 1990. T. 181-183, 423-426; State Ex. 13, p. 36.

47. During the 34 day period of January 3, 1990 through February 6, 1990, Respondent prescribed Vicodin for Patient G on at least five occasions in an amount which totalled 630 dosage units and which, if taken in accordance with directions for use, constituted a 105 day supply. T. 183; State Exs. 13, p. 36; 22.

48. During the 257 day period of March 6, 1991 through November 18, 1991, Respondent prescribed Lortabs 7.5 mg. on at least 26 occasions for Patient G in an amount which totalled 4,720 dosage units and which, if taken in accordance with directions for use, constituted a 787 day supply. T. 183-184; State Exs. 13, pp. 25-33; 22.

49. During the 279 day period of May 1, 1992 through February 5, 1993, Respondent prescribed Lortabs 7.5 mg. on at least 20 occasions for Patient G in an amount which, if taken in accordance with directions for use, constituted a 616 day supply. State Exs. 13, pp. 1-18; 22. Long term treatment of Patient G with Lortabs was unwarranted on the basis of the recorded facts of her condition, and was also potentially addictive. There was no medical justification for prescribing such large amounts of a narcotic over a long period of time. T. 184- 190-191.

50. Respondent was aware of the abuse of such medications by Patient G and made note of such continued overuse, yet continued to prescribe Lortabs 7.5 mg. for Patient G. T.184-186,194-196, 434-435; State Ex. 13, pp. 23, 27.

51. Respondent failed to develop and/or record treatment plans or goals for Patient G. T. 187; State Ex. 13.

52. Respondent failed to maintain adequate records for Patient G. T. 182, 424-427; State Ex. 13.

PATIENT H

53. Respondent treated Patient H, a 37 year old male, for a back and leg injury and for a persistent cough during the period April, 1991 through February, 1993. T. 196-197, 702; State Ex. 14.

54. During the 192 day period between September 6, 1991 and March 17, 1992, Respondent prescribed Lortabs 7.5 mg., 150 tablets with five refills on at least four occasions for Patient H in an amount which totalled 3600 dosage units and which, if taken in accordance with directions for use, constituted a 300 day supply. T. 197-198; State Exs. 14, pp. 21-30; 22. Such amount of medication was clearly excessive and would have averaged a daily intake of approximately 20 tablets per day over a six month period. T. 197-198.

55. Between June, 1991 and May, 1992, Respondent prescribed Tussionex on at least seven occasions as treatment for Patient H's complaints of sore throat and cough, and failed to obtain and/or record any history or physical finding to support the repeated treatment with such narcotic antitussive. Respondent failed to take any appropriate action when the complaints did not respond to such continued treatments. T. 201-202; State Exs. 14, pp. 16-30; 22. A physician deviates from acceptable standards of medical care if he does not take some action to determine why a persistent cough does not respond to continuous treatments with narcotic antitussives over a prolonged period. There are significant adverse effects associated with long term use of Tussionex. T. 202.

56. Respondent was aware that Patient H was abusing such prescribed medications and was also aware that Patient H was being seen by other physicians and receiving duplicate prescriptions during this period. Despite such knowledge, the Respondent continued to prescribe Tussionex for Patient H. T. 198-200, 206-207, 707-710; State Ex. 14, pp. 9,11,15,31. There is a danger in continuing to prescribe medications to patients who have developed a tolerance to them; such continued prescribing should be stopped. T. 200.

57. Respondent failed to develop and/or record treatment plans or goals for Patient H. T. 202; State Ex. 14.

58. Respondent failed to maintain adequate records for Patient H. State Ex. 14.

PATIENT I

59. Patient I, a 47 year old female at the time of her initial treatment, was treated by the Respondent for obesity and arthritis during the period from September, 1980 through February, 1993. T. 209, 723; State Ex. 15.

60. Respondent failed to obtain and/or record any history, physical findings or diagnosis to support his long-term treatment of Patient I with controlled substances, including Valium, Vicodin and APAP with Codeine. Such medications were prescribed without medical justification. T. 209,215-219; State Ex. 15. Valium and Vicodin are not useful in treating arthritis. T. 217.

61. Respondent prescribed Indocin 25 mg., a non-steroidal and anti-inflammatory medication, on at least 20 occasions during this period of treatment for Patient I while failing to monitor any long-term effects of the medication on Patient I. T. 211-213; State Exs. 15; 22.

62. Respondent recorded in Patient I's medical record: "this is too much Valium... 100 a month is just too much." Respondent continued to prescribe Valium to Patient I on at least four subsequent occasions. T. 213-214, 728-729; State Exs. 15, p. 20; 22.

63. Respondent failed to develop and/or record treatment plans or goals for Patient I. T. 214; State Ex. 15.

64. Respondent failed to maintain adequate records for Patient I. T. 209, 732-733; State Ex. 15.

PATIENT J

65. Respondent treated Patient J, a 25 year old male at the time of his initial treatment, from March, 1989 until August, 1990 for back and ankle pain and migraine headaches.
T.241, 571-572; State Ex, 16, pp. 2-9.

66. Respondent prescribed APAP with codeine 30 mg., increasing the strength to 60 mg.on October 23, 1989,for Patient J at least six times between July and December, 1989. In February, 1990, Respondent changed the pain medication to Hycodan: Between February and June, 1990, Respondent prescribed Hycodan for Patient J on at least five occasions while recording several medical record entries of his concern over Patient J's abuse of such medications. T. 242-244; State Exs. 15, pp. 2-9; 22.

67. On June 18, 1990, Respondent prescribed Didrex, a Schedule III controlled substance to control Patient J's weight which was contraindicated because of hypertention. The medical record for Patient J did not provide any indication for the prescription of such medication. On May 17 and May 22, 1990, Patient J's blood pressure was recorded as elevated. T. 248-249, 605-606; State Ex. 16, pp. 2-5.

68. Respondent failed to develop and/or record treatment goals or plans for Patient J. T. 253; State Ex. 16.

69. Respondent failed to maintain adequate records for Patient J. T. 241-242; State Ex. 16.

PATIENT K

70. Respondent treated Patient K, a 31 year old female, in October, 1987 through May, 1990, for migraine headaches, carpel tunnel syndrome and hypothyroidism. T. 286-287, 734-735; State Ex. 17.

71. During the period of September, 1988 through September, 1990, the Respondent regularly prescribed anticonvulsants, including Dilantin, Mysoline and phenobarbital for Patient K to treat a condition of periodic losses of consciousness. There is no record to indicate that Patient K was ever examined by a neurologist; and, no neurological report was in the medical record to support the prescribing of anticonvulsants for

Patient K. The erratic prescribing of anticonvulsants by the Respondent over a two year period was done without establishing a confirmed diagnosis, without clinical observation, without obtaining a neurological evaluation, and without determining proper dosages. In summary, the failure to establish a definitive determination of medical need for the medication was not in accord with acceptable medical standards. T. 287-289; State Exs. 17, pp. 3-6; 22.

72. On at least six occasions during this period, the Respondent prescribed Levothyroid to treat Patient K for hypothyroidism. The Respondent failed to order, perform and/or record appropriate laboratory tests to confirm the diagnosis; and, there is no evidence to support such diagnosis in the medical record. Current accepted standards of medical practice include ordering and performing appropriate laboratory tests to confirm the diagnosis of hypothyroidism. T. 130,293-294, 296-297,303-305; State Exs. 17, pp. 3-6; 22.

73. Respondent failed to develop and/or record treatment plans or goals for Patient K. T. 298; State Ex. 17.

74. Respondent failed to maintain adequate records for Patient K. T. 288, 297-298; State Ex. 17.

PATIENT L

75. Respondent treated Patient L, a 35 year old female during the period of April 1987 through June, 1990 for migraine headaches, leg and back pain. T. 314, 751-753; State Ex. 18.

76. During this period, Respondent repeatedly prescribed APAP with Codeine 60 mg., in dosage unit amounts of 100, with five refills for Patient L. Respondent was aware of Patient L's abuse of such medication, but continued to prescribe it. T. 315-316, 754-755; State Exs. 18, pp. 2-11; 22

77. During this period, Respondent prescribed on at least six occasions Adipex-P, a Schedule IV controlled substance, which was contraindicated. T. 316-317; State Exs. 18, pp. 2-11; 22.

78. Throughout the period of treatment, Respondent regularly administered Vitamin B12 as a treatment for a diagnosed condition of anemia. Between April, 1987 and June,1990, the Respondent failed to order, perform and/or record the results of any appropriate tests to verify and/or monitor Patient L's alleged diagnosis of anemia and, in fact, the diagnosis of anemia and Vitamin B12 treatments were made without medical basis. T. 318-319, 762-763; State Ex. 18, pp. 2-11.

79. Respondent failed to develop and/or record treatment goals or plans for Patient L. T. 319; State Ex. 18.

80. Respondent failed to maintain adequate records for Patient L. T. 317-319; State Ex. 18.

PATIENT M

81. Respondent treated Patient M, a 36 year old male, from August, 1989 through June, 1990 for ankle, leg and back pain. T. 326, 773; State Ex. 19, pp. 2-9.

82. During the 189 day period of August 14, 1989 through February 19, 1990, Respondent prescribed Vicodin Tablets for Patient M on at least eight occasions in an amount which totalled 4,570 dosage units. During the 66 day period of March 27,1990 through June 1, 1990, Respondent prescribed Hycodan tablets for Patient M on at least eight occasions in an amount which totalled 1,630 dosage units. Respondent was aware of Patient M's abuse of the prescribed controlled substances, but continued to prescribe them. T. 327-329, 774; State Exs. 19, pp. 2-9; 22. Respondent prescribed controlled substances for Patient M for more than a thirty day period in violation of the Public Health Law. T. 783.

83. Respondent failed to maintain adequate records for Patient M. T. 785-786; State Ex. 19.

PATIENT N

84. Respondent treated Patient N, a 27 year old female, for obesity and hypothyroidism between February, 1990 and January, 1992. T. 338, 794-795; State Ex. 20.

85. On February 16, 1990, Resapondent prescribed Plegine 35 mg. in dosage units of 90 with five refills as treatment for Patient N's obesity. Although he was subsequently made aware of Patient N's abuse of such medication and noted in the medical record that Patient N "probably needs drug abuse clinic help", Respondent continued to prescribe Plegine for Patient N. T. 338-340, 805-806, 810; State Exs. 20, p. 3; 22.

86. On at least two occasions Respondent prescribed Levothyroid to treat Patient N's alleged hypothyroidism . The Respondent failed to order, perform and/or record appropriate laboratory tests to confirm such diagnosis and there is no evidence in the medical record to support such diagnosis. T. 338, 819-820; State Exs. 20, pp. 2-3; 22.

87. Respondent failed to maintain asdequate records for Patient N. T. 338, 820-823; State Ex. 20.

PATIENT O

88. Respondent treated Patient O, a 34 year old female, between October, 1987 and May 1990 for migraine headaches and leg pain. T. 344, 833-834; State Ex. 21.

89. Between October, 1987 and May, 1990, Respondent prescribed Fiorinal with codeine to treat Patient O's headaches on at least twenty-one occasions. T. 345; State Ex. 21, pp. 3-7. Repeated treatment with a controlled substance was excessive and was inappropriate usage for a chronic condition. T. 345. There is no record to support continuance of narcotic medication. State Ex. 21.

90. Respondent failed to develop and/or record treatment plans or goals for Patient O. T. 347; State Ex. 21.

91. Respondent failed to maintain adequate records for Patient O. T. 346-347, 835, 840; State Ex. 21.

CONCLUSIONS WITH REGARD TO PATIENTS

PATIENT A

A.1: Respondent prescribed Tussionex or Hycodan, Schedule III controlled substances, on complaints of flu by the patient on seven consecutive office visits between February and May, 1990 without noting a history or physical finding to justify the treatment. Findings 6, 9, 10.

A.2: During 90 days between May and August, Respondent prescribed Vicodin ES, a Schedule III controlled substance, on nine occasions totaling 1,040 dosage units, constituting about a 200 day supply, rather than the 1290 units and 215 day supply alleged. The medication provided was in an amount

unnecessary for treatment, perpetuating the habituation to and dependence on the drugs. Finding 7.

A.3: Respondent noted that Patient A was being treated by another physician on July 31, 1991, and that the Patient belonged in detox and rehab and should have "no more rx's"from him. On August 19, 1991, Respondent began prescribing Lortabs 7.5mg., a Schedule III controlled substance, despite his notes. Finding 8.

A.4: Between August 19 and December 16, 1991, 119 days, the Respondent prescribed Lortabs 7.5 mg. on eight occasions. The total number of dosage units prescribed was 4800 with each 100 tablet prescription directing that five refills be dispensed. With a recommended dosage of one or two tablets every four hours, the Respondent prescribed a 400 day supply. The end of the prescribing period herein was December 16, 1991, not the December 19th charged; the number of prescriptions with five refills each supplied was 8, rather than the 9 charged, with an adjusted dosage unit number of about 4,800, rather than 3,700 charged, constituting about a 400 day supply, rather than the 308 day supply charged. The amounts prescribed were excessive. Finding 8.

A.5: Respondent was aware of abuse of prescribed controlled substances,recording that Patient A "can't get daily intake of Lortabs 7.5 mg. below 20 per day" while continuing to

prescribe the medication regularly for Patient A. Finding 8.

A.6: During the 70 day period from February 20 through May 1, 1992, Respondent prescribed Lortabs 7.5 mg. on at least 16 occasions rather than the 22 alleged, in an amount of about 3,022 tablets rather than the 3,926 dosage units charged, constituting about a 250 day supply rather than the 327 days alleged. Based on Patient A's medical record, there was no justification for such high or frequent dosage of narcotics. Finding 8.

A.7: Respondent failed to develop and/or record treatment plans or goals for Patient A. Finding 9.

A.8: Respondent failed to maintain adequate records for Patient A. Finding 10.

PATIENT B

B.: Respondent treated Patient B, a fifty-eight year old female, for back and knee pain, hypothyroidisn, arthritis, and hypertention between January, 1986 and February, 1993. Finding 11.

B.1: Respondent prescribed Zaroxolyn, a diuretic and known potassium depleter, on at least five occasions between January, 1986 and September 1988, and failed to order, perform and/or record appropriate potassium level tests until June 3, 1987

when the very low level reported was 2.8 MEq. Finding 12. The next test was not done until December 14, 1988. Finding 13.

a. The potassium level on December 14, 1988 was well below the test result a year and a half before: 2.4 MEq., a dangerouisly low level. Respondent did not refer Patient B to the hospital. Medical notes state on December 6, 1988 the Patient should continue taking Slo-K, a potassium supplement, one a day. Such treatment would have been inadequate to increase the Patient's potassium level. The Patient fainted at home on the following day, and was hospitalized in a serious hypokalemic condition. Finding 13.

b. The Respondent failed to direct Patient B to discontinue the use of Zaroxolyn on receipt of the December laboratory results. Finding 13.

c. Respondent failed to order, perform and/or record an electrolyte level at the next office visit following Patient B's hospital discharge, or at any subsequent time during his treatment of Patient B. State Ex. 8.

B.2: On March 15, 1989, Respondent noted that Patient B was reported on March 10, 1989 to be confused while driving, had no idea where she was and had to be picked up by a friend. Also noted is that she was seeing "blind spots." No referral to a specialist, appropriate testing or follow-up of the complaints was made. State Ex. 8, p. 51ff.

B.3: During the 100 days from March 4 to June 12, 1992, the Respondent prescribed APAP #4 with codeine, 60.mg.,a Schedule III controlled substance, on at least six occasions for 120 tablets with five refills. The 3,330 tablets prescribed for a three to four month period were an excessive amount. Finding 15

B.4: Respondent failed to develop and/or record treatment plans or goals for Patient B. Finding 16.

B.5: Respondent failed to maintain adequate records for Patient B. Finding 17.

PATIENT C

C. Respondent treated Patient C, a 39 year old female, from May, 1990 until February, 1993 for hypothyroidism, back strain and ankle and foot pain. Finding 18.

C.1. At Patient C's initial treatment on May 4, 1990, Respondent prescribed Levothroid o.2 mg., a thyroid supplement, for Patient C's hypothyroid condition. Respondent failed to order, perform and/or record appropriate laboratory tests to confirm his diagnosis. The medical record does not support or confirm the Respondent's diagnosis. Findings 19, 20.

C.2 Respondent prescribed Ionamin 30 mg., a Schedule IV controlled substance, for Patient C's obesity on several occasions from May 4, 1990 to November 11, 1991, despite adverse effects associated with use of the drug and the thyroid

supplement, Levothyroid, prescribed by the Respondent during the same period. Finding 21.

C.3. During the period May 21, 1990 through February 21, 1991, Respondent on at least 12 occasions prescribed Emperin with Codeine and Ionamin, Schedule III and IV controlled substances, respectively, pursuant to telephone requests made by Patient C. Respondent did not personally observe or examine the Patient at any time during the period, and did not record history or findings to provide a basis for the prescriptions. It is not accepted medical practice to prescribe such medications without examining or observing the patient. Finding 22.

C.4 Respondent regularly noted that Patient C abused the controlled substances that he prescribed while continuing to prescribe them. Finding 23.

C.5 Respondent failed to develop and/or record treatment goals or plans for Patient C. Finding 24.

C.6 Respondent failed to maintain adequate records for Patient C. Finding 25.

PATIENT D

D. Respondent treated Patient D,. a 26 year old male, for knee and back pain during the period January, 1989 through April, 1992. Finding 26.

D.1 During the period of June 1, 1989 through July 6, 1990, Respondent prescribed Vicodin on at least 17 occasions for treatment of Patient D's pain in an amount which totalled 4,170 dosage units. Respondent was aware of Patient D's abuse of such medication but continued to prescribe it. Prescribing an average of ten or more Vicodin per day for greater than two or three days is not good medical practice. Finding 27.

D.2 Respondent noted in Patient D's medical record on July 6, 1990: "told him I would no longer be able to write his pain meds." On the same date, Respondent prescribed Vicodin, and continued to do so at least 12 times thereafter until May 15, 1991. Finding 28.

D.3 Between June 5, 1991 through April 19, 1992,Respondent prescribed Lortabs 7.5 mg. at least 12 times for treatment of Patient D's pain in a total amount of 4,390 dosage units. Respondent was aware of Patient D's abuse of the medication, but continued to prescribe it. Finding 29.

D.4 Respondent failed to develop and/or record treatment plans for Patient D. Finding 30.

D.5 Respondent failed to maintain adequate records for Patient D. Finding 31.

PATIENT E

E. Respondent treated Patient E numerous times for hypothyroid, obesity and other conditions during the period of June, 1990 through September, 1992. The hypothyroid diagnosis should be pursued prior to treatment. Findings 32, 35.

E.1 Respondent diagnosed Patient E on June 20, 1990 at her initial office visit as being hypothyroid. He failed to order, perform and/or record any physical finding or laboratory test results to support such diagnosis. Finding 33.

E.2 The record states that the Respondent prescribed Plegine 35 mg., 90 tablets to be taken three times per day,with five refills on June 20, 1990, a 180 day supply of the drug. Plegine is a Schedule III controlled substance, prescribed for a limited time period of a month or less; the excessive prescribing was contraindicated. T. 158-159,165; State Exs. 11, p. 15; 22.

E.3 During March, 1991 through September, 1992, Respondent continued to prescribe Plegine on at least seven occasions notwithstanding the negative effects of the drug on Patient E noted by the Respondent. Finding 34.

E.4 Respondent was aware of Patient E's abuse of Plegine during the treatment period. Despite such knowledge, the drug's use was continued. Finding 34.

E.5 Despite treating Patient A for obesity for an extended period, Respondent failed to obtain and/or record a weight for Patient E after the initial visit. Finding 35.

E.6 Respondent failed to develop and/or record treatment plans for Patient E. Finding 36.

E.7 Respondent failed to maintain adequate records for Patient E. Finding 37.

PATIENT F

F. Respondent treated Patient F, a 19 year old male, between June, 1991 and February, 1993 for a knee injury. Finding 38.

F.1 Respondent noted in an entry in Patient F's medical record dated June 24, 1991, that Patient F had a history of alcohol abuse, and prescribed ADAP with Codeine #4, 60 mg., 100 tablets, with five refills. Prescribing this amount of APAP with Codeine to a patient with a history of alcohol abuse was not appropriate because such patient is more easily addicted to controlled substances. Findings 39, 40.

F. 2 Between August 16, 1991 and December 17, 1991, the Respondent prescribed APAP with Codeine #4 to Patient F on at least four occasions in an amount totalling about 1400 dosage units notwithstanding the Patient's history of abuse of the medication. Finding 41.

F. 3. In an entry in Patient F's medical record, Respondent notes: "again concern about prolonged use of meds." At the same date Respondent prescribed APAP with Codeine #4, 300 dosage units. Prescribing such amount of a controlled substance over the time period to be used did not meet accepted standards of medical practice. Finding 42.

F.4 Respondent failed to develop and/or record treatment plans or goals, or any diagnosis of, Patient F. Finding 43.

F.5 Respondent failed to maintain adequate records for Patient F. Finding 44.

PATIENT G

G. Respondent treated Patient G, a 19 year old female at the time of initial treatment in January, 1990, through December, 1993, for migraine headaches and back and leg pain.Finding 45.

G.1 Respondent failed to obtain and/or record any history, physical findings or diagnosis of Patient G's condition at the initial office visit on January 3, 1990. Finding 46.

G.2 During the 34 day period of January 3, 1990 through February 6, 1990, Respondent prescribed Vicodin for Patient G on at least five occasions in an amount which totalled 630 dosage units and which, if taken in accordance with directions for use, constituted a 105 day supply. Finding 47.

G.3 During the 257 day period March 6, 1991 through November 18, 1991, Respondent prescribed Lortabs 7.5 mg. on at least 26 occasions for Patient G in an amount which totalled 4,720 dosage units and which, if taken in accordance with directions for use, constituted a 787 day supply. Finding 48.

G.4 During the 279 day period May 1, 1992 through February 5, 1993, Respondent prescribed Lortabs 7.5 mg. on at least 20 occasions for Patient G in an amount which, if taken in accordance with directions for use, constituted a 616 day supply. Finding 49.

G.5 Long term treatment of Patient G with Lortabs was unwarranted on the basis of the recorded facts of her condition, and was also potentially addictive. There was no medical justification for prescribing such large amounts of a narcotic controlled substance over a long period of time. Respondent was aware of the abuse of such medications by Patient G and made note of such continued overuse, while continuing to prescribe Lortabs. Findings 49, 50.

G.6 Respondent failed to develop and/or record treatment plans or goals for Patient G. Fiunding 51.

G.7 Respondent failed to maintain adequate records for Patient G. Finding 52.

PATIENT H

H. Respondent treated Patient H, a 37 year old male, for a back and leg injury and for a persistent cough during the period April, 1991 through February, 1993. Finding 53.

H.1 During the 192 day period September 6, 1991 through March, 17, 1992, Respondent prescribed Lortabs 7.5 mg., 150 tablets with five refills on at least four occasions for Patient H in an amount which totalled 3600 dosage units and which, if taken in accordance with directions for use, constituted a 300 day supply. Finding 54.

H.2 Between June, 1991 and May, 1992, Respondent prescribed Tussionex on at least seven occasions as treatment for Patient H's complaints of sore throat and cough, and failed to obtain and/or record any history or physical finding to support the repeated treatment with the narcotic antitussive. Respondent failed to take any appropriate action when the complaints did not respond to such continued treatments. Respondent deviated from acceptable standards of medical care when he did not take some action to determine why a persistent cough did not respond to continuous treatments with narcotic antitussives over a prolonged period. There are significant adverse effects associated with long term use of Tussionex. Finding 55.

H.3 Respondent was aware that Patient H was abusing such prescribed medications and that Patient H was being seen by other physicians and receiving duplicate prescriptions during the same period. Despite such knowledge, Respondent continued to prescribe Tussionex for Patient H. There is a danger in continuing to prescribe medications to patients who have developed a tolerance to them; such continued prescribing should be stopped. Finding 56.

H.4 Respondent failed to develop and/or record treatment plans or goals for Patient H. Finding 57.

H.5 Respondent failed to maintain adequate records for Patient H. Finding 58.

PATIENT I

I. Respondent treated Patient I, a 47 year old female,for obesity and arthritis from September, 1980 through February, 1993. Finding 59.

I.1 Respondent failed to obtain and/or record any history, physical findings or diagnosis to support his long-term treatment of Patient I with controlled substances,including Valium, Vicodin and APAP with Codeine. Such medications were prescribed without medical justification. Valium and Vicodin are not useful in treating arthritis. Finding 60.

I.2 Respondent prescribed Indocin 25 mg., a non-steroidal and anti-inflammatory medication, on at least 20 occasions for Patient I while failing to monitor any long-term effects of the medication on Patient I. Finding 61.

I.3 Respondent recorded in Patient I's medical record: "this is too much Valium...100 a month is just too much." He continued to prescribe Valium to Patient I on at least four subsequent occasions. Finding 62.

I.4 Respondent failed to develop and/or record treatment plans and goals for Patient I. Finding 63.

I.5 Respondent failed to maintain adequate records for Patient I. Finding 64.

PATIENT J

J. Respondent treated Patient J, a 25 year old male, from March, 1989 to August, 1990, for back and ankle pain and migraine headaches. Finding 65.

J.1 Respondent initially prescribed APAP with Codeine,30 mg., increasing the strength to 60 mg. on October 23, 1989, at least six times between July and December, 1989. In February, 1990, Respondent changed the pain medication to Hycodan, a Schedule III controlled substance. Between February and June, 1990, Respondent prescribed Hycodan on at least five occasions while recording several medical record entries of concern over Patient J's abuse of medications. Finding 66.

J.2 On June 18, 1990, Respondent prescribed Didrex, a Schedule III controlled substance to control Patient J's weight which was contraindicated because of hypertension. Finding 67.

J.3 The factual allegations set forth in the Statement of Charges in paragraph J.3 are not supported by a preponderance of the evidence.

J.4 Respondent failed to develop and/or record treatment goals or plans for Patient J. Finding 68.

J.5 Respondent failed to maintain adequate records for Patient J. Finding 69.

PATIENT K

K. Respondent treated Patient K, a 31 year old female, October, 1987 through May, 1990, for migraine headaches, carpel tunnel syndrome and hypothyroidism. Finding 70.

K.1 During September, 1988 through September,1990, the Respondent regularly prescribed anticonvulsants, including Dilantin, Mysoline and phenobarbital for Patient K to treat a condition of periodic losses of conciousness. There is no record to indicate that Patient K was ever examined by a neurologist; and no neurological report was in the medical record to support the prescribing of anticonvulsants for Patient K. Such erratic prescribing of anticonvulsants by the Respondent over a two year period was done without establishing

a confirmed diagnosis, without clinical observation, without obtaining a neurological evaluation, and without determining proper dosages. In summary, the failure to establish a definitive determination of medical need for the medication was not in accord with acceptable medical standards. Finding 71.

K.2 On at least six occasions during this period, Respondent prescribed Levothyroid to treat Patient K for hypothyroidism. The Respondent failed to order, perform and/or record appropriate tests to confirm the diagnosis; and, there is no evidence to support such diagnosis in the medical record. Current accepted standards of medical practice include ordering and performing appropriate laboratory tests to confirm the diagnosis of hypothyroidism. Finding 72.

K.3 The factual allegations set forth in the Statement of Charges in paragraphs K.3.a and K.3.b. are not supported by a preponderance of the evidence.

K.4 Respondent failed to develop and/or record treatment plans or goals for Patient K. Finding 73.

K.5 Respondent failed to maintain adequate records for Patient K. Finding 74.

PATIENT L

L. Respondent treated Patient L, a 35 year old female, during the period April, 1987 through June, 1990 for migraine headaches, leg and back pain. Finding 75.

L.1 During this period Respondent repeatedly prescribed APAP with Codeine 60mg., in 100 dose units, with five refills for Patient L. Respondent was aware of the Patient's abuse of the medication, but continued to prescribe it. Finding 76.

L.2 During this period, Respondent prescribed Adipex-P, a Schedule IV controlled substance, on at least six occasions. Such was contraindicated. Finding 77.

L.3 Throughout the period of treatment, Respondent regularly administered Vitamin B12 as a treatment for a diagnosed condition of anemia. Between April, 1987 and October, 1992, the Respondent failed to order, perform and/or record the results of any appropriate tests to verify and/or monitor Patient L's alleged diagnosis of anemia and, in fact, the diagnosis of anemia and the Vitamin B12 treatments were made without medical basis. Finding 78.

L.4 Respondent failed to develop and/or record treatment goals or plans for Patient L. Finding 79.

L.5 Respondent failed to maintain adequate records for Patient L. Finding 80.

PATIENT M

M. Respondent treated Patient M, a 36 year old male, from August, 1989 through June, 1990 for ankle, leg and back pain. Finding 81.

M.1 During the 189 day period August 14 , 1989 through February 19, 1990, Respondent prescribed Vicodin tablets for Patient M on at least eight occasions in an amount which totalled 4,570 dosage units. Such taken in accordance with directions for use were about a 381 day supply. Finding 82.

M.2 During the 66 day period March 27, 1990 through June 1, 1990, Respondent prescribed Hycodan tablets on at least eight occasions in an amount which totalled 1,630 dosage units. Such taken in accordance with directions for use were about a 136 day supply, over twice the number of tablets needed. Finding 82.

M.3 Respondent was aware of Patient M's abuse of the prescribed controlled substances, but continued to prescribe them. Finding 82.

M.4 The factual allegation set forth in the Statement of Charges in paragraph M.4 ~~are~~ not supported by a preponderance of the evidence.

M.5 Respondent failed to maintain adequate records for Patient M. Finding 83.

Patient N

N. Respondent treated Patient N, a 27 year old female, for obesity and hypothyroidism between February, 1990 and Jamuary, 1992. Finding 84.

N.1 On February 16, 1990, Respondent prescribed Plegine 35 mg. in dosage units of 90 tablets with five refills, as treatment for Patient N's obesity. Although he later was made aware of Patient N's abuse of the medication and noted in the medical record that Patient N "probably needs drug abuse clinic help", Respondent continued to prescribe Plegine for Patient N. Finding 85.

N.2 On at least two occasions Respondent prescribed Levothyroid to treat Patient N's alleged hypothyroidism. The Respondent failed to order, perform and/or record appropriate laboratory tests to confirm such diagnosis, and there is no evidence in the medical record to support the diagnosis. Finding 86.

N.3 The factual allegation set forth in the Statement of Charges in paragraph N.3 is not supported by a preponderance of the evidence.

N.4 Respondent failed to maintain adequate records for Patient N. Finding 87.

PATIENT O

O. Respondent treated Patient O, a 34 year old female, between October, 1987 and May, 1990 for migraine headaches and leg pain. Finding 88.

O.1 Between October, 1987 and May, 1990, Respondent prescribed Fiorinal with Codeine #3, 30. mg. , a Schedule III controlled substance, to treat Patient O's headaches on at least 21 occasions. Such repeated treatment was excessive and was inappropriate usage for a chronic condition. There is no record to support continuance of narcotic medication. Finding 89.

O.2 The factual allegations set forth in the Statement of Charges in paragraph O.2 are included in the allegation set forth in paragraph O.1, above.

O.3 The Respondent failed to develop and/or record treatment plans or goals for Patient O. Finding 90.

O.4 Respondent failed to maintain adequate records for Patient O. Finding 91.

CONCLUSIONS WITH REGARD TO STIPULATION

P. By Stipulation and Order, #CS-92-28, dated July 27, 1992, entered into between the New York State Department of Health and the Respondent, the Respondent admitted to, and the Commissioner of the Department of Health found, violations of the Public Health Law. State Ex. 3.

P.1 Respondent, in violation of Public Health Law Sections 3335(1) and 3335(3), issued precriptions for controlled substances on behalf of two patients in an amount which, if

used in accordance with directions for use, would have exceeded a thirty day supply. Patients A, D; State Ex. 3.

P.2 The Respondent, in violation of Public Health Law Section 3350, prescribed large amounts of controlled substances to two patients with knowledge that they were habitual over-users of the controlled substances prescribed. Patients A, D; State Ex. 3.

CONCLUSION WITH REGARD TO PROBATION

Q. On or about March 27, 1987, the New York State Board of Regents found Respondent guilty of one Specification of having been found by the Commissioner of Health to be in violation of Article Thirty-Three of the Public Health Law in violation of N.Y.Education Law Section 6509(5)(c) (McKinney 1985). Respondent's license to practice medicine was suspended for five years, four and one-half years of said suspension stayed, and Respondent was placed on probation for a four and one-half year period under specified terms of probation. Such terms of probation included a requirement that the Respondent remain in compliance with the legal requirements in regard to prescribing, dispensing and administering controlled substances. State Exs. 4, 5.

CONCLUSIONS WITH REGARD TO SPECIFICATIONS
FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

The Hearing Committee concludes that the Respondent practiced the profession with negligence on more than one occasion under N.Y. Education Law Section 6530(3) (McKinney Supp. 1993) [formerly N.Y.Education Law Section 6509(2)] in that the Respondent committed at least two, and, in fact, all of the following:

1. The Conclusions set forth above in Paragraphs A.1, A.2, A.3, A.4, A.5, A.6, A.7, and/or A.8; B and/or B.1, B.1.a, B.1.b, B.1.c., B.2, B.3, B.4, B.5; C and/or C.1, C.2, C.3, C.4 C.5, C.6; D and/or D.1, D.2, D.3, D.4, D.5; E and/or E.1, E.2, E.3, E.4, E.5, E.6, E.7; F and/or F.1, F.2, F.3, F.4, F.5; G and/or G.1, G.2, G.3, G.4, G.5, G.6, G.7; H and/or H.1, H.2, H.3, H.4, H.5; I and/or I.1, I.2, I.3, I.4, I.5; J and/or J.1, J.2, J.4, J.5; K and/or K.1, K.2, K.4, K.5; L and/or L.1, L.2, L.3, L.4, L.5; M and/or M.1, M.2, M.3,M.5; N and/or N.1, N.2, N.4; O and/or O.1, O.3, O.4.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

The Hearing Committee concludes that the Respondent practiced the profession with incompetence on more than one occasion under N.Y. Education Law Section 6530(5) (McKinney Supp. 1993) [formerly N.Y.Education Law Section 6509(2)] in that the Respondent committed at least two, and, in fact, all of the following:

2. The Conclusions set forth above in Paragraphs A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8; B and/or B.1, B.1.a, B.1.b., B.1.c, B.2, B.3, B.4, B.5; C. and/or C.1, C.2, C.3, C.4, C.5, C.6; D and/or D.1, D.2, D.3, D.4, D.5; E and/or E.1, E.2, E.3, E.4, E.5, E.6, E.7; F and /or F.1, F.2, F.3, F.4, F.5; G and/or G.1, G.2, G.3, G.4, G.5, G.6, G.7; H and/or H.1, H.2, H.3, H.4, H.5; I and/or I.1, I.2, I.3, I.4, I.5; J and/or J.1, J.2, J.4, J.5; K and/or K.1, K.2, K.4, K.5; L. and/or L.1, L.2, L.3, L.4, L.5; M and/or M.1, M.2, M.3, M.5; N and/or N.1, N.2, N.4; O and/or O.1, O.2, O.4.

THIRD THROUGH SEVENTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

The Hearing Committee concludes that the Respondent practiced the profession with gross negligence on a particular occasion within the meaning of N.Y.Education Law Section 6530(4) (McKinney Supp. 1993) [Formerly N.Y.Education Law Section 6509(2)] in that the Respondent practiced as follows:

3. The Conclusions set forth above in Paragraphs A.2, and A.3, and A.4, and A.5 and/or A.6.

4. The Conclusions set forth above in Paragraphs B and B.1, and B.1.a, and B.1.b, and B.1.c, and B.2, and/or B.3.

5. The Conclusions set forth above in Paragraphs C and C.1, and C.2, C.3, and/or C.4.

6. The Conclusions set forth above in Paragraphs D and D.1, and D.2, and/or D.3.

7. The Conclusions set forth above in Paragraphs E and E.1, and E.2, and E.3, and E.4, and/or E.5.

8. The Conclusions set forth above in Paragraphs F and F.1, and F.2, and/or F.3.

9. The Conclusions set forth above in Paragraphs G and G.2, and G.3, and G.4, and/or G.5.

10. The Conclusions set forth above in Paragraphs H and H.1, and H.2, and/or H.3.

11. The Conclusions set forth above in Paragraphs I and I.1, and I.2, and/or I.3.

12. The Conclusions set forth above in Paragraphs J and J.1 and/or J.2.

13. The Conclusions set forth above in Paragraphs K and K.1, and/or K.2.

14. The Conclusions set forth above in Paragraphs L and L.1, and L.2, and/or L.3.

15. The Conclusionms set forth above in Paragraphs M and M.1, and/or M.2.

16. The Conclusions set forth above in Paragraphs N and N.1 and/or N.2.

17. The Conclusions set forth above in Paragraphs O and O.1 and/or O.2.

EIGHTEENTH THROUGH THIRTY-SECOND SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

The Hearing Committee concludes that the Respondent practiced the profession with gross incompetence within the meaning of N.Y.Education Law Section 6530(6) (McKinney Supp. 1993) [formerly N.Y.Education Law Section 6509(2)] in that the Respondent practiced as follows:

18. The Conclusions set forth above in Paragraphs A.2, and A.3, and A.4, and A.5, and/or A.6.

19. The Conclusions set forth above in Paragraphs B. and B.1, and B.1.a, and B.1.b, and B.1.c, and B.2 and/or B.3.

20. The Conclusions set forth above in Paragraphs C. and C.1, and C.2, and C.3, and/or C.4.

21. The Conclusions set forth above in Paragraphs D. and and D.1, and D.2, and/or D.3.

22. The Conclusions set forth above in Paragraphs E. and E.1, and E.2, and E.3, and E.4, and/or E.5.

23. The Conclusions set forth above in Paragraphs F. and F.1, and F.2, and/or F.3.

24. The Conclusions set forth above in Paragraphs G. and G.2, and G.3, and G.4, and/or G.5.

25. The Conclusions set forth above in Paragraphs H. and H.1, and H.2, and/or H.3.

26. The Conclusions set forth above in Paragraphs I. and I.1, and I.2, and/or I.3.

27. The Conclusions set forth above in Paragraphs J. and J.1, and/or J.2.

28. The Conclusions set forth above in Paragraphs K. and K.1, and/or K.2.

29. The Conclusions set forth above in Paragraphs L. and L.1, and L.2, and/or L.3.

30. The Conclusions set forth above in Paragraphs M. and M.1, and M.2, and/or M.3.

31. The Conclusions set forth above in Paragraphs N. and N.1, and/or N.2.

32. The Conclusions set forth above in Paragraphs O. and/or O.1.

THIRTY-THIRD THROUGH FORTY-SEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN ACCURATE RECORDS

The Hearing Committee concludes that the Respondent failed to maintain patient records which accurately reflected the evaluation and treatment of the patients within the meaning of N.Y.Education Law Section 6530(32), (McKinney Supp. 1993) [formerly N.Y. Education Law Section 6509(9) and 8 NYCRR Section 29.2(a)(3)] as follows:

33. The Conclusions set forth above in Paragraphs A.1, A.7, and/or A.8.

34. The Conclusions set forth above in Paragraphs B. and B.1, B.1c, B.2, B.4, and/or B.5.

35. The Conclusions set forth above in Paragraphs C. and C.1, C.3, C.5 and/or C.6.

36. The Conclusions set forth above in Paragraphs D. and D.4 and/or D.5.

37. The Conclusions set forth above in Paragraphs E. and E.1 ,E.5, E.6, and/or E.7.

38. The Conclusions set forth above in Paragraphs F. and F.1, F.4, and/or F.5.

39. The Conclusions set forth above in Paragraphs G. and G.1, G.6, and/or G.7.

40. The Conclusions set forth above in Paragraaphs H. and H.2, H.4, and/or H.5.

41. The Conclusions set forth above in Paragraphs I. and I.1, I.4, and/or I.5.

42. The Conclusions set forth above in Paragraphs J. and J.4 and/or J.5.

43. The Conclusions set forth above in Paragraphs K. and K.1, K.2, K.4, and/or K.5.

44. The Conclusions set forth above in Paragraphs L. and L.4 and/or L.5.

45. The Conclusions set forth above in Paragraphs M. and M.5.

46. The Conclusions set forth above in Paragraphs N. and N.2 and/or N.4.

47. The Conclusions set forth above in Paragraphs O.and O.3, and/or O.4.

FORTY-EIGHTH SPECIFICATION

HAVING BEEN FOUND TO BE IN VIOLATION OF ARTICLE 33 OF THE PUBLIC HEALTH LAW

The Hearing Committee concludes the Respondent was found by the Commissioner of Health to be in violation of Article 33 of the Public Health Law within the meaning of N.Y. Education Law Section 6530(9)(e), (McKinney Supp. 1993) [formerly N.Y.Education Law Section 6509(5)(c)], as follows:

48. The Conclusions set forth above in Paragraphs P and P.1 and/or P.2.

FORTY-NINTH THROUGH SIXTY-FOURTH SPECIFICATIONS

VIOLATION OF TERMS OF PROBATION

The Hearing Committee concludes the Respondent engaged in professional misconduct by reason of violating a term of probation imposed pursuant to New York Public Health Law, Section 230, in violation of N.Y.Education Law Section 6530(29) (McKinney Supp. 1993) in that the Respondent failed to comply with the legal requirements in regard to prescribing dispensing and/or administering controlled substances as follows:

49. The Conclusions set forth above in Paragraphs Q and A.1,A.2,A.3,A.4,A.5, and/or A.6.

50. The Conclusions set forth above in Paragraphs Q and B and B.3.

51. The Conclusions set forth above in Paragraphs Q and C and C.2, C.3 and/or C.4.

52. The Conclusions set forth above in Paragraphs Q and D and D.1, D.2 and/or D.3.

53. The Conclusions set forth above in Paragraphs Q and E and E.2, E.3 and/or E.4.

54. The Conclusions set forth above in Paragraphs Q and F and F.1, F.2 and/or F.3.

55. The Conclusions set forth above in Paragraphs Q and G and G.2, G.3, G.4 and/or G.5.

56. The Conclusions set forth above in Paragraphs Q and H and H.1, H.2 and/or H.3.

57. The Conclusions set forth above in Paragraphs Q and I and I.1 and/or I.3.

58. The Conclusions set forth above in Paragraphs Q and J and J.1 and/or J.2.

59. The Conclusions set forth above in Paragraphs Q and K and K.3a and K3b do not support a violation of the terms of the Respondent's probation.

60. The Conclusions set forth above in Paragraphs Q and L and L.1 and/or L.2.

61. The Conclusions set forth above in Paragraphs Q and M and M.1 and/or M.2.

62. The Conclusions set forth above in Paragraphs Q and N and N.1.

63. The Conclusions set forth above in Paragraphs Q and O and O.1.

64. The Conclusions set forth above in Paragraphs Q and P and P.1 and/or P.2.

DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee unanimously determined that the Respondent's practice of the profession was as alleged in each of the 64 specified charges against each of the 15 specified patients. In every instance charged the Respondent practiced with negligence on more than one occasion, practiced with incompetence on more than one occasion, practiced the profession with gross negligence on a particular occasion, practiced the profession with gross incompetence, and failed to maintain accurate records.* And, if further danger signals were needed to characterize the Respondent's practice, he was found in violation of Article 33, Controlled Substances, of the Public Health Law, and to have violated the probation terms imposed under N.Y.Education Law Section 6530(29).

Not only are many of the cases characterized by the Respondent's penchant for overprescribing controlled substances but several are classic examples of failing to verify through standard medical methods his diagnoses and treatments. The diagnoses of hypothyroidism and of anemia are examples. As a whole, the cases reviewed reflected the Respondent's lack of knowledge in medicine. Such extends from such a basic failure as an apparent lack of effort to obtain patient's prior medical records to a failure to use standard patient examinations and testing.

NOTE: * The only factual allegations not found were set forth in subparagraphs J.3,K.3,M.4,N.3, and O.2

The Respondent's apparent empathy and compassion for his patients could not compensate for his woeful lack of contemporary medical knowledge. Such was reflected in his consistent lack of effective medical patient plans of treatment coupled with a propensity to prescribe non-indicated drugs. His naivete in the treatment of patients is repeatedly evidenced by his over-prescribing of controlled substances and his acceptance of patients' self-diagnosis in several instances. His empathy for patients was misplaced.

The Department's two professional witnesses agreed that the patient records reviewed evidenced the Respondent's lack of medical knowledge necessary to make basic medical judgements. The Committee agreed that such is so scanty and superficial as to describe his current lack of medical knowledge as exigious.

There is no question that the Respondent is a kind and generous man. But his treatment of patients dependent on controlled substances is not supported by current practice requirements and legal mandates. The Respondent's compassion cannot substitute for medical knowledge. The result has been his practice of medicine, as shown by the cases reviewed, with a failure to meet prevailing medical standards.

One of the startling examples is the Respondent's lack of recognition of the danger of prescribing Zaroxolyn for Patient B as a long term diuretic at the time of prescribing and at the time of the Hearing.

In the last 40 to 50 years, objective tests for diagnosis and treatment determinations have become an essential component of medical care. Today, diagnosis done on symptoms alone is not accepted medical practice.

The Respondent's apparent reliance on symptoms for diagnostic determinations was rivaled by his apparent reliance on his controlled substances background as a director of a successful drug abuse program in Ulster County from about 1965 to 1973. Because of an initial stipulation entered into with the State Health Department and a subsequent six month license suspension and four and one-half year probation mandating compliance with Article 33 of the Public Health Law, the Respondent had the opportunity and incentive to update his medical knowledge of current chemistry and requirements applicable to controlled substances.During such period the Respondent entered into a second stipulation relating to the failure to meet Article 33 requirements. Eight of the patients with inappropriate medical care were initially treated during the probationary period; such included Patients H through O.

It is apparent that that such penalties as censure and reprimand, limitation of the license to practice, a requirement of education and training, public service, or a second effort at probation cannot be rationalized.

The Hearing Committee concludes that the Respondent deviated from the standards of medical practive in his treatment afforded to each of the fifteen patients that were the subject of the Hearing. To meet its responsibilities to the public, to future patients and to the profession, it is concluded that revocation of the Respondent's license to practice medicine is mandated.

ORDER OF THE HEARING COMMITTEE

IT IS HEREBY ORDERED that Specification of Charges First, Second, Third through Seventeenth, Eighteenth through Thirty-Second, Thirty-Third through Forty-Seventh, Forty-Eighth, and Forty-Ninth through Sixty-Fourth are hereby SUSTAINED; and

IT IS FURTHER ORDERED that license number 074392 issued to Respondent by the New York State Education Department and the current registration issued to the Respondent for the period January 1, 1993 through December 31, 1994 be, and hereby are, REVOKED.

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

DATED: Rochester, New York
November , 1993

BY: George C. Simmons, Ed.D.
GEORGE C. SIMMONS, Ed. D.
Chairperson

ARSENIO G. AGOPOVICH, M.D.
TERESA S. BRIGGS, M.D., Ph.D.

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
JEFFERY WIERSUM, M.D.	:	CHARGES

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JEFFERY WIERSUM, M.D., the Respondent, was authorized to practice medicine in New York State on October 28, 1953 by the issuance of license number 074392 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine in New York State for the period of January 1, 1993 through December 31, 1994 from 713 East Genesee Street, Suite 311, Syracuse, N.Y. 13210.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (all patients are identified in the Appendix) numerous times for migraine headaches and other conditions between February, 1990 and May 1992 at his medical offices at 1724 James Street and, subsequently, at 1610 James Street, Syracuse, New York (these offices together with 713 East Genesee Street, Suite 311,

Syracuse, N.Y. 13210 are hereinafter designated "medical offices").

1. Respondent prescribed either Tussionex or Hycodan, Schedule III controlled substances, for Patient A's complaints of flu on seven consecutive office visits during the period of February 2, 1990, through May 11, 1990. Respondent failed to note a history or physical finding to justify the repeated treatments of these narcotic antitussives.

2. During the 90 day period between May 14, 1990 through August 12, 1990, Respondent prescribed Vicodin ES, a Schedule III controlled substance, on at least nine occasions for Patient A in an amount which totalled 1,290 dosage units and which, if taken in accordance with directions for use, constituted a 215 day supply.

3. Respondent noted that he had been advised that Patient A was being treated by another physician at that time and recorded in the medical record for Patient A in an entry dated July 31, 1991, "must get into detox and rehab... no more rx's from us". On August 19, 1991, Respondent began prescribing Lortabs 7.5 mg., a Schedule III controlled substance, for Patient A's conditions, notwithstanding his knowledge of Patient A's abuse of prescribed narcotics.

4. During the 119 day period between August 19, 1991 and December 19, 1991, Respondent prescribed Lortabs 7.5 mg., a Schedule III controlled substance, on at least nine occasions for Patient A in an amount which totalled 3,700 dosage units and which, if taken in accordance with directions for use, constituted a 308 day supply.

5. Respondent was aware of Patient A's abuse of prescribed substances and noted in Patient A's medical record that Patient A "can't get daily intake of Lortabs 7.5 mg. below 20 per day", yet continued thereafter to prescribe Lortabs 7.5 mg. regularly for Patient A.

6. During the 70 day period of February 20, 1992 through May 1, 1992, Respondent prescribed Lortabs 7.5 mg. on at least twenty-two occasions for Patient A in an amount which totalled 3,926 dosage units and which,

if taken in accordance with directions for use, constituted a 327 day supply.

7. Respondent failed to develop and/or record treatment plans or goals for Patient A.

8. Respondent failed to maintain adequate records for Patient A.

B. Respondent treated Patient B numerous times for allergies, asthma, migraine headaches and other conditions during the period of January, 1986 through February, 1993 at his medical offices.

1. Respondent prescribed Zaroxolyn, a diuretic and known depleter of potassium, for Patient B's hypertension on at least five occasions between January, 1986 and September, 1988 but failed to order, perform and/or record potassium levels for Patient B until December 14, 1988, except for one date on June 3, 1987.

   a. Patient B's potassium level was recorded on December 14, 1988 as being 2.4 mEq. Respondent failed to recognize the danger presented by this abnormally low level and did not refer Patient B to a hospital for treatment. On December 16, 1988, Respondent prescribed Slow-K 8 mg., an electrolyte replenisher, and noted "watch for potassium toxicity". On the following day, December 17, 1988, Patient B was noted by Respondent to be in serious hypokalemic condition. The patient fell at home on that day and was hospitalized through the emergency room.

   b. Respondent failed to direct Patient B to discontinue the use of Zaroxolyn when he received the results of Patient B's laboratory tests.

   c. Respondent failed to order, perform and/or record an electrolyte level at the next office visit by Patient B following the hospital discharge on December 28, 1988 and failed to obtain electrolyte levels at any subsequent time during his period of treatment of Patient B.

2. On March 15, 1989, Patient B was reported to have experienced an episode of disorientation and confusion while driving and to have been seeing blind spots. Respondent failed to refer Patient B to a specialist for consultation and failed to order, perform or record the results of appropriate tests or to otherwise investigate to establish a cause for these complaints.

3. During the 112 day period of March 4, 1992 through June 6, 1992, Respondent prescribed APAP # 4 with Codeine 60 mg., a Schedule III controlled substance on at least six occasions for Patient B in an amount which totalled 4,080 dosage units, and which, if taken in accordance with directions for use, constituted a 340 day supply.

4. Respondent failed to develop and/or record treatment plans or goals for Patient B.

5. Respondent failed to maintain adequate records for Patient B.

C. Respondent treated Patient C numerous times for hypothyroid, obesity and other conditions during the period of May, 1990 through February, 1993 at his medical offices.

1. At Patient C's initial treatment on May 4, 1990, Respondent prescribed Levothroid 0.2 mg., a thyroid supplement, for Patient C's hypothyroid condition. Respondent failed to order, perform and/or record appropriate laboratory tests to confirm such diagnosis and there is no evidence in the medical record to support such diagnosis.

2. Respondent prescribed Ionamin 30mg., a schedule IV controlled substance, as treatment for Patient C's obesity on several occasions between May 4, 1990 and November 11, 1991 which was contraindicated.

3. During the period of May 21, 1990 through February 21, 1991, Respondent on at least twelve occasions prescribed controlled substances for Patient C, including Empirin with Codeine, a Schedule III controlled substance, and Ionamin pursuant to telephone requests made by Patient C. Respondent failed to personally observe or examine Patient C at

any time during this period and recorded no history or findings to provide a basis for prescribing these medications.

4. Respondent regularly noted that Patient C abused the controlled substances that he prescribed, yet he continued to prescribe such medications for Patient C during this period of treatment.

5. Respondent failed to develop and/or record treatment goals or plans for Patient C.

6. Respondent failed to maintain adequate records for Patient C.

D. Respondent treated Patient D numerous times for leg and back pain and other conditions during the period of January, 1989 through April, 1992 at his medical offices.

1. During the period of June 21, 1989 through July 6, 1990, Respondent prescribed Viocodin on at least seventeen occasions for treatment of Patient D's pain in an amount which totalled 4,170 dosage units. Respondent was aware of Patient D's abuse of such medication but continued to prescribe it.

2. Respondent noted in Patient D's medical record in an entry dated July 6, 1990, "told him I would no longer be able to write for his pain meds". On that same date Respondent prescribed Vicodin for Patient D and subsequently prescribed Vicodin on at least twelve occasions until May 15, 1991.

3. During the period of June 5, 1991 through April 19, 1992, Respondent prescribed Lortabs 7.5 mg. on at least twelve occasions for treatment of Patient D's pain in an amount which totalled 4,390 dosage units. Respondent was aware of Patient D's abuse of such medication, but continued to prescribe it.

4. Respondent failed to develop and/or record treatment plans for Patient D.

5. Respondent failed to maintain adequate records for Patient D.

E. Respondent treated Patient E numerous times for hypothyroid, obesity and other conditions during the period of June, 1990 and September, 1992 at his medical offices.

1. At Patient E's initial office visit on June 20, 1990, Respondent diagnosed Patient E as being hypothyroid, but failed to order, perform and/or record any physical finding or laboratory test result to support such diagnosis.

2. On June 20, 1990, Respondent prescribed Plegine 35 mg., a Schedule III controlled substance for Patient E's obesity, which was contraindicated.

3. During the period of March, 1991 through September, 1992, Respondent prescribed Plegine for Patient E on at least nine occasions notwithstanding the fact that Respondent noted in the medical record the negative effects of the medication on Patient E on several instances.

4. Respondent was aware of Patient E's abuse of Plegine during his period of treatment, but continued to prescribe such medication to Patient E.

5. Despite treating Patient E for obesity for an extended period Respondent failed to obtain and/or record a weight for Patient E at any office visit subsequent to the initial visit on June 20, 1990.

6. Respondent failed to develop and/or record treatment plans for Patient E.

7. Respondent failed to maintain adequate records for Patient E.

F. Respondent treated Patient F numerous times for a knee injury and other conditions between June, 1991 and February, 1993 at his medical offices.

1. Respondent noted in an entry in Patient F's medical record dated June 24, 1991 that Patient F had a history of anti-social behavior and alcoholism. Respondent prescribed APAP with Codeine # 4 on that date with no recorded physical finding or diagnosis to support such treatment.

2. Between August 16, 1991 and December 17, 1991, Respondent prescribed APAP with Codeine # 4 to Patient F on at least four occasions in an amount totalling 1400 dosage units notwithstanding Patient F's history and the fact that Respondent was aware of the abuse of such medication by Patient F.

3. In an entry in Patient F's medical record, Respondent noted "again concern about prolonged used of meds." On that date Respondent prescribed for Patient F ADAP with Codeine # 4 in an amount totalling 300 dosage units.

4. Respondent failed to develop and/or record treatment plans or goals for Patient F.

5. Respondent failed to maintain adequate records for Patient F.

G. Respondent treated Patient G numerous times for back and leg pain, migraine headaches and other conditions between January, 1990 and February 1993 at his medical offices.

1. Respondent failed to obtain and/or record any history, physical findings or diagnosis of Patient G's condition at the initial office visit on January 3, 1990.

2. During the 34 day period of January 3, 1990 through February 6, 1990, Respondent prescribed Vicodin for Patient G on at least five occasions in an amount which totalled 630 dosage units and which, if taken in accordance with directions for use, constituted a 105 day supply.

3. During the 257 day period of March 6, 1991 through November 18, 1991, Respondent prescribed Lortabs 7.5 mg on at least twenty-six occasions for Patient G in an amount which totalled 4,720 dosage units and which, if taken in accordance with directions for use, constituted a 787 day supply.

4. During the 279 day period of May 1, 1992 through February 5, 1993, Respondent prescribed Lortabs 7.5 mg. on at least twenty occasions for Patient G in an amount which, if taken in accordance with directions for use, constituted a 616 day supply.

5. Respondent was aware of the abuse of such medications by Patient G and made note of such continued overuse, yet continued to prescribe Lortabs 7.5 mg. to Patient G.

6. Respondent failed to develop and/or record treatment plans or goals for Patient G.

7. Respondent failed to maintain adequate records for Patient G.

H. Respondent treated Patient H numerous times for back pain, sore throat and other conditions during the period of April, 1, 1991 through February, 1993 at his medical offices.

1. During the 192 day period between September 6, 1991 and March 17, 1992, Respondent prescribed Lortabs 7.5 mg. in dosage unit amounts of 150 with five refills on at least four occasions for Patient H in an amount which totalled 3600 dosage units and which, if taken in accordance with directions for use, constituted a 300 day supply.

2. Between June, 1991 and May, 1992, Respondent prescribed Tussionex on at least seven occasions as treatment for Patient H's complaints of sore throat and cough and failed to obtain and/or record any history or physical finding to support the repeated treatment of this narcotic antitussive and failed to take any appropriate action when these conditions did not respond to such continued treatments.

3. Respondent was aware that Patient H was abusing these prescribed medications and was also aware that Patient H was being seen by other physicians and receiving duplicate prescriptions during this period, yet Respondent continued to prescribe such medications for Patient H.

4. Respondent failed to develop and/or record treatment plans or goals for Patient H.

5. Respondent failed to maintain adequate records for Patient H.

I. Respondent treated Patient I numerous times for obesity, arthritis and other conditions between March, 1981 and February, 1993 at his medical offices.

1. Respondent failed to obtain and/or record any history, physical findings or diagnosis to support his long-term treatment of Patient I with controlled substances including Valium, Vicodin and APAP with Codeine and, in fact, such medications were prescribed without medical justification.

2. Respondent prescribed Indocin 25 mg., a non-steroidal anti-inflammatory medication, on at least twenty occasions during this period for Patient I and failed to monitor any long-term effects of the use of such medication on Patient I.

3. Respondent recorded in Patient I's medical record "this is too much Valium... 100 a month is just too much." Respondent continued to prescribe Valium to Patient I on at least four subsequent occasions.

4. Respondent failed to develop and/or record treatment plans or goals for Patient I.

5. Respondent failed to maintain adequate records for Patient I.

J. Respondent treated Patient J numerous times for back pain, ankle sprain, migraine headaches and other conditions between March 1989 and August, 1990 at his medical offices.

1. Respondent repeatedly prescribed APAP with Codeine, 30 mg., increased to 60 mg. on October 23, 1989, for Patient J's complaints of pain. Beginning on February 26, 1990, Respondent changed pain medications and began regularly prescribing Hycodan tablets, a Schedule III controlled substance. Respondent recorded several entries in the medical record of his concern over Patient J's abuse of such medications yet continued to prescribe them for Patient J.

2. On June 18, 1990, Respondent prescribed Didrex, a Schedule III controlled substance to control Patient J's weight which was contraindicated.

3. On June 18, 1990 Respondent prescribed Anaprox DS, an anti-inflammatory drug known to cause adverse reactions including headaches and depression, for Patient J which was contraindicated.On that same date, Respondent also prescribed Pamelor, 50mg., a tricyclic anti-depressant, for Patient J.

4. Respondent failed to develop and/or record treatment goals or plans for Patient J.

5. Respondent failed to maintain adequate records for Patient J.

K. Respondent treated Patient K numerous times for hypothyroidism, migraine headaches, carpel tunnel syndrome and other conditions during the period of October, 1987 through May, 1990 at his medical offices.

1. During the period of September, 1988 through September, 1990, the Respondent regularly prescribed anti-convulsants, including Dilantin, Mysoline and Phenobarbital for Patient K to treat a condition of periodic losses of consciousness. There is no record to indicate that Patient K was ever examined by a neurologist and no neurological report was contained in the medical record to support the prescribing of such medications for Patient K.

2. On at least six occasions during this period, Respondent prescribed Levothroid to treat Patient K for hypothyroidism. The Respondent failed to order, perform and/or record appropriate laboratory tests to confirm such diagnosis and there is no evidence to support such diagnosis in the medical record.

3. Respondent regularly prescribed APAP with Codeine 60 mg. to treat Patient K's conditions. Respondent was aware of the abuse of such medication by Patient K, but continued to prescribe it.

   a. During the 70 day period of September 12, 1988 through November 21, 1988, Respondent prescribed APAP with Codeine, 60 mg on at least four occasions for Patient K in an amount which totalled 1,830 dosage units, and which, if taken

in accordance with directions for use, constituted a 153 day supply.

b. During the 68 day period of April 21, 1989 through June 28, 1989, Respondent prescribed APAP with Codeine, 60 mg. on at least five occasions for Patient K in an amount which totalled 1,980 dosage units, and which, if taken in accordance with directions for use, constituted a 165 day supply.

4. Respondent failed to develop and/or record treatment plans or goals for Patient K.

5. Respondent failed to maintain adequate records for Patient K.

L. Respondent treated Patient L numerous times for migraine headaches, lower back, pelvic and muscular pain and other conditions during the period of April, 1987 through June, 1990 at his medical offices.

1. During this period, Respondent repeatedly prescribed APAP with Codeine 60 mg., in dosage unit amounts of 100, with five refills for Patient L's migraine, headaches and back pain. Respondent was aware of Patient L's abuse of such medication, but continued to prescribe it.

2. During this period, Respondent prescribed on at least six occasions Adipex-P, a Schedule IV controlled substance, to control Patient L's weight which was contraindicated.

3. Throughout the period of treatment, Respondent regularly administered Vitamin B12 as treatment for a diagnosed condition of anemia. Respondent failed to order, perform and/or record the results of any appropriate tests to support such a diagnosis and, in fact, the treatments of Vitamin B12 were made without medical basis.

4. Respondent failed to develop and/or record treatment goals or plans for Patient L.

5. Respondent failed to maintain adequate records for Patient L.

M. Respondent treated Patient M numerous times for foot, elbow, leg, ankle, back and abdominal pain and other conditions during the period of August 1989 through June 1990 at his medical offices.

1. During the 189 day period of August 14, 1989 through February 19, 1990, Respondent prescribed for Patient M Vicodin Tablets, on at least eight occasions in an amount which totalled 4,570 dosage units and which, if taken in accordance with directions for use, constituted a 381 day supply.

2. During the 66 day period of March 27, 1990 through June 1, 1990, Respondent prescribed Hycodan tablets on a least eight occasions in an amount which totalled 1,630 dosage units and which, if taken in accordance with directions for use, constituted a 136 day supply.

3. Respondent was aware of Patient M's abuse of the prescribed controlled substances, but continued to prescibe them for Patient M.

4. Respondent failed to develop and/or record treatment plans or goals for Patient M.

5. Respondent failed to maintain adequate records for Patient M.

N. Respondent treated Patient N at least four times between February, 1990 and January, 1992 for obesity and hypothyroidism and other conditions at his medical offices.

1. On February 16, 1990, Respondent prescribed Plegine 35mg. in dosage units of 90 with five refills, as treatment for Patient N's obesity. Although he was subsequently made aware of Patient N's abuse of such medication and noted in the medical record that Patient N "probably needs drug abuse clinic help," Respondent continued to prescribe Plegine for Patient N.

2. On at least two occasion Respondent prescribed Levothroid to treat Patient N's hypothyroidism. The Respondent failed to order, perform and/or record appropriate laboratory tests to confirm such diagnosis and there is no evidence in the medical record to support such diagnosis.

3. Respondent failed to develop and/or record treatment plans or goals for Patient N.

4. Respondent failed to maintain adequate records for Patient N.

O. Respondent treated Patient O numerous times for migraine headaches, leg pain and other conditions between October, 1987 and May, 1990 at his medical offices.

1. Respondent regularly prescribed Fiorinal with Codeine #3, 30 mg., a Schedule III controlled substance, to treat Patient O's headaches. There is no record to indicate that Patient O was examined by a neurologist or other specialist and no report of a neurological consultation was contained in the medical record to support the continued treatment of the condition with such narcotic medication.

2. During the 62 day period of September 15, 1989 through November 17, 1989, Respondent prescribed Fiorinal with Codeine #3, 30 mg. for Patient P on at least five occasions in an amount which totalled 1,250 dosage units, and which, if taken in accordance with directions for use, constituted a 104 day supply.

3. Respondent failed to develop and/or record treatment plans or goals for Patient O.

4. Respondent failed to maintain adequate records for Patient O.

P. By a Stipulation and Order, #CS-92-28, dated July 27, 1992 entered into between the New York State Department of Health and Respondent, the Respondent admitted to, and the

Commissioner of the Department of Health found, violations of the Public Health Law.

1. Respondent, in violation of Public Health Law Sections 3335(1) and 3335(3), issued prescriptions for controlled substances on behalf of two patients in an amount which, if used in accordance with directions for use, would have exceeded a thirty day supply.

2. Respondent, in violation of Public Health Law Section 3350, prescribed large amounts of controlled substances to two patients with knowledge that they were habitual over-users of the controlled substances which he prescribed.

Q. On or about March 27, 1987, the New York State Board of Regents found Respondent guilty of one Specification of having been found by the Commissioner of Health to be in violation of Article Thirty Three of the Public Health Law in violation of N.Y. Education Law Section 6509(5)(c) (McKinney 1985). Respondent's license to practice medicine was suspended for five years, four and one-half years of said suspension stayed, and Respondent was placed on probation for a four and one-half year period under specified terms of probation. Respondent's terms of probation included a requirement that he remain in compliance with the legal requirements in regard to prescribing, dispensing and administering controlled substances.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993) [formerly N.Y. Education Law Section 6509(2)] in that Petitioner charges that Respondent committed at least two of the following:

1. The facts in Paragraph A and/or A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8; B and/or B.1, B.1a, B.1b, B.1c, B.2, B.3, B.4, B.5; C and/or C.1, C.2, C.3, C.4, C.5, C.6; D and/or D.1, D.2, D.3, D.4, D.5; E and/or E.1, E.2, E.3, E.4, E.5, E.6, E.7; F and/or F.1, F.2, F.3, F.4, F.5; G and/or G.1, G.2, G.3, G.4, G.5, G.6, G.7; H and/or H.1, H.2, H.3, H.4, H.5; I and/or I.1, I.2, I.3, I.4, I.5; J and/or J.1, J.2, J.3, J.4, J.5; K and/or K.1, K.2, K.3, K.3a, K.3b, K.4, K.5; L and/or L.1, L.2, L.3, L.4, L.5; M and/or M.1, M.2, M.3, M.4, M.5; N and/or N.1, N.2, N.3, N.4; O and/or O.1, O.2, O.3, O.4.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Education Law Section 6530(5) (McKinney Supp. 1993) [formerly N.Y. Education Law Section 6509(2)], in that Petitioner charges that Respondent committed at least two of the following:

2. The facts in Paragraph A and/or A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8; B and/or B.1, B.1a, B.1b, B.1c, B.2, B.3, B.4, B.5; C and/or C.1, C.2, C.3, C.4, C.5, C.6; D and/or D.1, D.2, D.3, D.4, D.5; E and/or E.1, E.2, E.3, E.4, E.5, E.6, E.7; F and/or F.1, F.2, F.3, F.4, F.5; G and/or G.1, G.2, G.3, G.4, G.5, G.6, G.7; H and/or H.1, H.2, H.3, H.4, H.5; I and or I.1, I.2, I.3, I.4, I.5; J and/or J.1, J.2, J.3, J.4, J.5; K and/or K.1, K.2, K.3, K.3a, K.3b, K.4, K.5; L and/or L.1, L.2, L.3, L.4., L.5; M and/or M.1, M.2, M.3, M.4, M.5; N and/or N.1, N.2, N.3, N.4; O and/or O.1, O.2, O.3, O.4.

THIRD THROUGH SEVENTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH
GROSS NEGLIGENCE ON A PARTICULAR OCCASION

The Respondent is charged with practicing the profession with gross negligence on a particular occasion within the meaning of N.Y. Education Law Section 6530(4) (McKinney Supp. 1993) [formerly N.Y. Education Law Section 6509(2) of the New York Education Law], in that Petitioner charges:

3. The facts in Paragraphs A and A.2, and A.3, and A.4, and A.5 and/or A.6.

4. The facts in Paragraphs B and B.1, and B.1a, and B.1b,and B.1c, and B.2 and/or B.3.

5. The facts in Paragraphs C and C.1, and C.2, and C.3 and/or C.4.

6. The facts in Paragraphs D and D.1, and D.2, and/or D.3.

7. The facts in Paragraphs E and E.1, and E.2, and E.3, and E.4 and/or E.5.

8. The facts in Paragraphs F and F.1, and F.2, and/or F.3.

9. The facts in Paragraphs G and G.2, and G.3, and G.4 and/or G.5.

10. The facts in Paragraphs H and H.1, and H.2 and/or H.3.

11. The facts in Paragraphs I and I.1, and I.2 and/or I.3.

12. The facts in Paragraphs J and J.1, and J.2 and/or J.3.

13. The facts in Paragraphs K and K.1, and K.2, and K.3, and K.3a and/or K.3b.

14. The facts in Paragraphs L and L.1, and L.2 and/or L.3

15. The facts in Paragraphs M and M.1 and/or M.2.

16. The facts in Paragraphs N and N.1 and/or N.2.

17. The facts in Paragraphs O and O.1 and/or O.2.

EIGHTEENTH THROUGH THIRTY-SECOND SPECIFICATIONS

PRACTICING THE PROFESSION
WITH GROSS INCOMPETENCE

Respondent is charged wtih professional misconduct by reason of gross incompetence within the meaning of N.Y. Education Law Section 6530(6), (McKinney Supp. 1993) [formerly N.Y. Education Law Section 6509(2)] in that Petitioner charges:

18. The facts in Paragraphs A and A.2, and A.3, and A.4, and A.5 and/or A.6.

19. The facts in Paragraphs B and B.1, and B.1a, and B.1b, and B.1c, and B.2 and/or B.3.

20. The facts in Paragraphs C and C.1, and C.2, and C.3 and/or C.4.

21. The facts in Paragraphs D and D.1, and D.2, and/or D.3.

22. The facts in Paragraphs E and E.1, and E.2, and E.3, and E.4 and/or E.5.

23. The facts in Paragraphs F and F.1, and F.2, and/or F.3.

24. The facts in Paragraphs G and G.2, and G.3, and G.4, and/or G.5.

25. The facts in Paragraphs H and H.1, and H.2, and/or H.3.

26. The facts in Paragraphs I and I.1, and I.2, and/or I.3.

27. The facts in Paragraphs J and J.1 and J.2, and/or J.3.

28. The facts in Paragraphs K and K.1 and K.2, and K.3, and K.3a and/or K.3b.

29. The facts in Paragraphs L and L.1 and L.2, and/or L.3

30. The facts in Paragraphs M and M.1,and M.2 and/or M.3.

31. The facts in Paragraphs N and N.1 and/or N.2.

32. The facts in Paragraphs O and O.1 and/or O.2.

THIRTY-THIRD THROUGH FORTY-SEVENTH SPECFICATIONS

FAILURE TO MAINTAIN ACCURATE RECORDS

The Respondent is charged with failing to maintain a patient record which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Education Law Section 6530(32), (McKinney Supp. 1993) [formerly N.Y. Education Law Section 6509(9) and 8 NYCRR Section 29.2(a)(3)], in that Petitioner charges:

33. The facts in Paragraphs A and A.1, A.7 and/or A.8.

34. The facts in Paragraphs B and B.1, B.1c, B.2, B.4 and/or B.5.

35. The facts in Paragraphs C and C.1, C.3, C.5 and/or C.6.

36. The facts in Paragraphs D and D.4 and/or D.5.

37. The facts in Paragraphs E and E.1, E.5, E.6 and/or E.7.

38. The facts in Paragraphs F and F.1, F.4 and/or F.5.

39. The facts in Paragraphs G and G.1, G.6 and/or G.7.

40. The facts in Paragraphs H and H.2, H.4 and/or H.5.

41. The facts in Paragraphs I and I.1, I.4 and/or I.5.

42. The facts in Paragraphs J and J.4 and/or J.5

43. The facts in Paragraphs K and K.1, K.2, K.4, and/or K.5.

44. The facts in Paragraphs L and L.4 and/or L.5.

45. The facts in Paragraphs M and M.3 and/or M.4.

46. The facts in Paragraphs N and N.2, N.3 and/or N.4.

47. The facts in Paragraphs O and O.3 and/or O.4.

FORTY-EIGHTH SPECIFICATION

HAVING BEEN FOUND TO BE IN
VIOLATION OF ARTICLE THIRTY-THREE
OF THE PUBLIC HEALTH LAW

Respondent is charged with having been found by the Commissioner of Health to be in violation of Article thirty-three of the Public Health Law within the meaning of N.Y. Education Law Section 6530(9)(e), (McKinney Supp. 1993) [formerly N.Y. Education Law Section 6509(5)(c)], in that Petitioner charges:

48. The facts in Paragraph P and P.1 and/or P.2.

FORTY-NINTH THROUGH SIXTY-FOURTH SPECIFICATIONS

VIOLATION OF TERMS OF PROBATION

Respondent is charged with professional misconduct by reason of violating a term of probation imposed on him purusant to New York Public Health Law Section 230 in violation of N.Y. Education Law Section 6530(29) (McKinney Supp. 1993), in that, Petitioner charges:

49. The facts in Paragraphs Q and A and A.1, A.2, A.3, A.4, A.5 and/or A.6.

50. The facts in Paragraphs Q and B and B.3.

51. The facts in Paragraphs Q and C and C.2, C.3 and/or C.4.

52. The facts in Paragraphs Q and D and D.1, D.2 and/or D.3.

53. The facts in Paragraphs Q and E and E.2, E.3 and/or E.4.

54. The facts in Paragraphs Q and F and F.1, F.2, and/or F.3.

55. The facts in Paragraphs Q and G and G.2, G.3, and G.4 and/or G.5.

56. The facts in Paragraphs Q and H and H.1, H.2, and/or H.3.

57. The facts in Paragraphs Q and I and I.1 and/or I.3.

58. The facts in Paragraphs Q and J and J.1 and/or J.2.

59. The facts in Paragraphs Q and K and K.3, K.3a, and/or K.3b.

60. The facts in Paragraphs Q and L and L.1 and/or L.2.

61. The facts in Paragraphs Q and M and M.1 and/or M.2.

62. The facts in Paragraphs Q and N and N.1.

63. The facts in Paragraphs Q and O and O.1 and/or O.2.

64. The facts in Paragraphs Q and P and P.1 and/or P.2.

DATED: Albany, New York
June 11, 1993

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical
Conduct