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

August 31, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Robert Binenfeld, M.D.
4 Woodland Road
Monroe, New York 10950-4408

Michael Sussman, Esq.
Scott Thornton, Esq.
Flat Iron building
25 Main Street
Goshen, New York 10924

Frederick Zimmer, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2438
Albany, New York 12237

RE: In the Matter of Robert Binenfeld, M.D.

Dear Dr. Binenfeld, Mr. Sussman, Mr. Thornton and Mr. Zimmer :

Enclosed please find the Determination and Order (No. 94-168) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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 then 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
Empire State Plaza
Corning Tower, Room 2503
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.

Sincerely,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER
-OF-
ROBERT BINENFELD, M.D.

DECISION AND ORDER OF THE HEARING COMMITTEE

ORDER NO. BPMC-94-168

The undersigned Hearing Committee consisting of **JOSEPH G. CHANATRY, M.D., Chairperson, F. MICHAEL JACOBIUS, M.D.,** and **MS. TRENA DeFRANCO,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, Esq.,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 230(10) of the New York State Public Health Law and sections 301-307 and 401 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **ROBERT BINENFELD, M.D.** (hereinafter referred to as "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 New York State Board for Professional Medical Conduct (hereinafter referred to as "Petitioner") appeared by **Peter J. Millock, General Counsel**, by **Frederick J. Zimmer, Esq.**, of counsel. Respondent appeared in person and by **The Law offices of Michael Sussman, Esq., Michael Sussman, Esq.** and **Scott Thornton, Esq.**, of Counsel.

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

RECORD OF PROCEEDING

Original Notice of Hearing and Statement of Charges:	January 25, 1994
Amended Statement of Charges Dated:	March 25, 1994
Notice of Hearing returnable:	March 4, 1994
Location of Hearing:	Albany, New York
Respondent's answer dated:	February 7, 1994
The State Board for Professional Medical Conduct appeared by:	**Frederick Zimmer, Esq.** Assistant Counsel Bureau of Professional Medical Conduct Corning Tower Albany, New York
Respondent appeared in person and was represented by:	**The Law offices of Michael Sussman, Esq.,** **Michael Sussman, Esq.** **Scott Thornton, Esq.** Flat Iron Building 25 Main St. Goshen, New York 10924
Respondent's present address	4 Woodland Road Monroe, N.Y. 10950-4408
Hearings held on:	March 4, May 4, May 5, and May 10 1994
Conferences held on:	March 4 May 4, 10, 1994
Closing briefs received:	
State	June 13, 1994
Respondent	June 14, 1994
Record closed:	June 22, 1994
Deliberations held:	June 22, 1994

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges Respondent has committed gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion,

violating a term of probation and failing to maintain appropriate patient records. The allegations arise from the treatment of nine patients from 1988 through 1992. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Attachment I.

Respondent denied each of the charges. Respondent submitted an answer to the charges which is attached hereto as Attachment II.

The State called these witnesses:

David N. Mesches, M.D.	Expert Witness

Respondent testified in his own behalf and called no other witnesses.

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Committee that negligence is the failure to use that level of care and diligence expected of a prudent physician under the circumstances. The standard to be applied is consistency with accepted standards of medical practice in this state. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious meant a conspicuously bad act or an extreme, extreme or flagrant deviation from standards.

Incompetence was defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice. Gross incompetence was defined as a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

The Committee was instructed that ordinary English usage would be a sufficient definition of the phrase "violation of a term of probation". The Committee was instructed that with regard to the guilt or innocence of Respondent in this proceeding, they were to disregard the underlying conviction in the former proceeding. The Committee was reminded that the charges in this

proceeding were dependant upon the evidence adduced at this hearing only.

With regard to the keeping of medical records, the Committee was instructed that state regulations require a physician to maintain an accurate record of the evaluation and treatment of each patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given chart or record and be able to understand a practitioner's course of treatment and the basis for same.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

The Committee was further under instructions that with regard to a finding of medical misconduct, The Committee must first assess Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any. Under any circumstances, the Committee was instructed that patient harm need never be shown to establish negligence in a proceeding before the State Board For Professional Medical Conduct.

The following findings of fact were made after review of the entire record. Numbers in parentheses (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. The State was required to meet the burden of proof by a preponderance of the evidence. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

FINDINGS OF FACT
RELEVANT TO
ALL CHARGES HEREIN

1. Respondent was authorized to practice medicine in New York state on June 22, 1967 by the issuance of license number 098887 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 4 Woodland Drive, Monroe, N.Y. 10950

2. After graduation from medical school, Respondent underwent a surgical internship for one year and a three year surgical residency specializing in plastic surgery and trauma surgery. Respondent did not complete the residency (Resp., T. 314-315).

3. In 1968, Respondent opened an office in Monroe, New York, where he has been a general practitioner since that time (Resp., T. 315-316, 403).

4. Respondent is not board certified in any area of medicine. Respondent is not a residency trained family physician (Resp., T. 315, 385).

5. Respondent resigned from the staffs of Arden Hill and Tuxedo Hospitals and has not been affiliated with any hospitals for the last 10 to 15 years (Resp., T. 388, 404-406).

8. Respondent's office is located at the basement level of his house and is open approximately fourteen hours weekly (Resp., T. 388-390).

FINDINGS OF FACT WITH REGARD TO FORMER PROCEEDINGS

FP.1. On May 17, 1988, Respondent signed an Application for Consent Order admitting nine specifications of professional misconduct

FP.2 An Order adopting Respondent's Application for Consent Order was signed by the Commissioner of Education on September 22, 1988 and served by mail upon Respondent on October 21, 1988.

FP.3 Respondent's medical license was suspended for 2 1/2 years. The suspension was stayed and he was placed on probation for 2 1/2 years beginning October 26, 1988.

FP.4 Term 1 of his probation terms required him to, among other things, conform fully to the professional standards of conduct imposed by law and his profession (Pet.'s Ex. 2).

FINDINGS OF FACT WITH REGARD TO PATIENT A

A.1. Respondent provided medical care to Patient A, a 24 year old female who first presented at his office beginning on November 12, 1982. Respondent continued to treat her through at least December of 1992 (Mesches, T. 19; Pet.'s Ex. 4 and 5, see last prescription in Ex. 5 dated December 17, 1992).

A.2. A complete medical history consists of a chief complaint, the history of the patient's present illness, the patient's past medical history, a review of systems and a family history. A systems review refers to a review of symptomatology covering the various parts of the entire body. A complete history should be taken on the first visit or very soon thereafter. (Mesches, T. 21 - 23).

A.3. A complete initial physical examination consists of the taking of vital signs such as height, weight, blood pressure, temperature and respiratory rate and includes an examination of the eyes, ears, nose, throat, head, neck, lungs, heart, abdomen, genitalia, skin and extremities. The initial physical examination would generally be performed at the time a medical history is taken (Mesches, T. 23).

A.4. Respondent did not elicit a complete history from or perform a complete physical examination on Patient A at any time during his treatment of her. (Mesches, T. 22-24, 128, Pet.'s Ex. 4).

A.5. The first visit by Patient A to respondent took place on November 12, 1982. Patient A complained of headaches, reporting pain behind her right eye. Patient A continued to complain of headaches at various times throughout the course of her treatment by Respondent (Mesches, T.19; Pet.'s Ex.4; Resp., T. 317, 319).

A.6. Respondent treated Patient A's headaches during the period of November 1982 through June 1989. Respondent prescribed Cafergot and beta blockers such as Inderal and Corgard and a narcotic, Empirin with Codeine (Mesches, T. 21, 58-80; Pet.'s Ex. 4, pgs. 1-12).

A.7. Beta blockers are anti-hypertensive drugs which can reduce blood pressure. They can have beneficial effects in some patients with migraine headaches. (Mesches, T. 40, 64).

A.8. Patient A's blood pressure was recorded as 125/80 on January 28, 1983 (Pet.'s Ex. 4, pg. 1).

A.9. On May 9, 1983, Respondent prescribed Inderal. Patient A's blood pressure was recorded as 94/66 on this date (Pet.'s Ex.4, pg. 1).

A.10. On March 26, 1984, Respondent prescribed Inderal. Patient A's blood pressure was recorded as 90/60 (Pet.'s Ex.4, pg.2).

A.11. 90/60 is a fairly low blood pressure (Mesches, T. 64).

A.12. On November 22, 1988, Respondent noted Patient A's blood pressure as 84/70 and increased Patient A's dosage from 1/2 a dose of Corgard 120 mg. to Corgard 120 mg. twice daily (Pet.'s Ex.4, pg. 9).

A.13. Patient A was noted to have complained of back pain beginning on April 25, 1985 (Pet.'s Ex. 4, pg. 5).

A.14. Respondent prescribed controlled substances to Patient A as is set forth in Attachment III to this decision.[1] (ALJ's 101).

A.15. Vicodin is a narcotic prescriptive drug and controlled substance. It combines Acetaminophen with five milligrams of Codeine. Vicodin is used for the control of pain. Vicodin can cause central nervous system symptoms such as drowsiness and impaired memory. Vicodin can also impair the patient's ability to stay alert as well as the reflex responses of a patient. (Mesches, T. 24-26, 31, 198-201).

A.16. Vicodin ES (extra strength) contains 7.5 milligrams of codeine and is fifty percent stronger than regular Vicodin (Mesches, T. 25-26).

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[1]There were a number of ALJ exhibits received in this proceeding. They were not received as evidence, but rather as tools for illustration for the Committee. After reviewing ALJ exhibit 101 and comparing it with the original prescriptions in evidence and the testimony of Respondent, the committee adopts ALJ exhibit 101 as a finding of fact which sets forth an accurate list of prescriptions issued by Respondent. A copy of this exhibit is attached hereto as attachment III.

A.17. Patient A was still complaining of headaches nearly seven years after the start of her treatment on November 12, 1982. Respondent noted a referral to and appointments at the Montefiore headache clinic during August and November 1989 (Pet.'s Ex. 4, pgs. 1-15).

A.18. Respondent referred Patient A to the headache clinic because she was coming in more frequently than every seven days to receive Vicodin (Resp., T. 427).

A.19. Respondent did not note the results of Patient A's treatment at the clinic or obtain a consultation report (Mesches, T. 27-28; Pet.'s Ex. 4, pgs. 14-15, et seq.).

A.20. On March 5, 1988, Respondent began prescribing Vicodin for Patient A and continued to prescribe Vicodin through October 19, 1990 as shown in the attachment IV. (Pet.'s Ex. 4, pgs. 7-25 and Ex. 5, see prescriptions through 10/19/90; Attachment IV).

A.21. By February of 1990, Patient A was being prescribed Vicodin on an approximately weekly basis (Mesches, T. 111; Pet.'s Ex. 4, pg. 17 et seq.; Pet.'s Ex. 5, Appendix. A).

A.22. On October 5, Respondent began to treat Patient A with Vicodin ES (extra strength) and continued this treatment through December of 1992 as set forth in Appendix A (Pet.'s Ex. 4, pg. 26, et. seq. and Ex. 5; Appendix A).

A.23. Respondent did not obtain a consultation with a specialist, neurologist or neurosurgeon regarding Patient A's back pain (Dept's Ex. 4; Mesches, T.136-137; Resp. T. 333).

A.24 An x-ray of Patient A's dorsal spine, dated December 5, 1989 demonstrated no abnormality. Likewise, a February 23, 1990 CT scan of Patient A's cervical spine was normal. An MRI of the lumbar spine, dated July 20, 1990 indicated mild bilateral facet hypertrophy and minimal

idline disc bulge. These findings are not consistent with the need for chronic narcotic treatment (Mesches, T. 28-30, Pet.'s Ex. 4, pg. 67,69-70).

A.25. On July 28, 1992, Respondent noted the need for Patient A to cut down on pain medications. On September 21, 1992, Patient A and Respondent discussed her prolonged Vicodin use. Up to those dates, Respondent had been prescribing Vicodin #[2]20 on an approximately weekly basis (Pet.'s Ex. 4, pgs. 48, 51).

A.26. Respondent did not change his prescribing pattern to Patient A. Subsequent to his notes on July 28 and September 21. Respondent prescribed Vicodin ES #20 on July 28, August 3, August 12 (2 prescriptions), August 17 and August 21, Vicodin ES, #10 on August 24, Vicodin ES #20 on August 31, September 7, September 14, September 21, October 2, October 20 and November 2, Vicodin ES #10 on November 9, and Vicodin ES #20 on November 13 and December 17 of 1992. (Mesches, T. 32-34, Pet.'s Ex. 4, pgs. 48-52, Pet.'s Ex. 5; Appendix. A).

A.27. Xanax, a benzodiazepine and controlled substance, is a tranquilizer. It is indicated for patients who demonstrate symptoms of anxiety. Accepted standards of medicine require that Tranquilizers be started at a low dose and titrated to the individual need of the patient. This is because tranquilizers can have significant central nervous system effects. z Long term risks of benzodiazepines include addiction and serious withdrawal symptoms. (Mesches, T. 35-36,44).

A.28. Respondent prescribed Xanax on October 3, 1988 and prescribed Xanax and Vicodin in combination on May 12, 1989 and July 18, 1990 (Pet.'s Ex. 4, pgs. 8, 12, 24).

A.29. There is no justification documented for these prescriptions. The patient record makes no reference to Patient A's symptoms, history or physical findings nor is there any indication

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[2]This symbol refers to the number of tablets prescribed. In this particular instance, 20 Vicodin were prescribed.

of a physical examination having been performed other than a note of frequent headaches and a pulse of 100 on October 3, 1988 (Mesches, T. 36-44; Pet.'s Ex. 4, pgs. 8, 12, 24).

A.30. Talwin, a controlled substance, is a synthetic pain killer. Talwin can be addictive (Mesches, T. 44, 191, 210-211).

A.31. Valium, a benzodiazepine, is used for the treatment of anxiety. Valium has significant central nervous system effects. Long term risks include addiction and serious withdrawal symptoms (Mesches at T. 44-45 referring back to T. 36).

A.32 Valium 5 mg., Feldene, Flexeril and Vicodin were simultaneously prescribed on June 18, 1990 (Pet.'s Ex. 4, pg. 22).

A.33. The treatment undertaken by Respondent did not resolve Patient A's complaints as she continued to complain of back or headache pain. (Pet.'s Ex. 4).

A.34 On December 7, 1988, Respondent noted that he was tapering Corgard, continuing Xanax and also prescribing Decadron, 4 mg., and 30 tablets of Vicodin. He recorded that Patient A was having "bad headaches - 2 x/week - tachycardia" (Pet.'s Ex.4, pg. 9; Mesches, T. 47).

A.35. Decadron is a steroid. Steroids have multiple uses and can be used as an anti-inflammatory medication (Mesches, T. 48).

A.36. The patient record provides no medical justification for the prescription of Decadron for headaches. (Mesches, T. 47-48).

ONCLUSIONS WITH REGARD TO PATIENT A

The Committee now turns its attention to the factual allegations leveled by the State. The first two allegations A.1 and A.2 are that Respondent failed to document or elicit adequate initial and interval histories (Allegation A.1) or adequate initial and interval physical examinations (Allegation A.2). The fact is that Respondent neither elicited nor recorded any histories or physical examinations. Respondent testified that such information was of little value. The Committee disagrees with such a proposition particularly in this instance where the patient complained of chronic headache and backache and where Respondent was treating her over a long period of time with potentially addicting controlled substances. Absent an initial physical and history, Respondent has no basis upon which to ascertain the possible cause of the ailment. Absent interval objective information, there is no way to monitor progress or lack thereof.

Of particular note is Respondent's failure to document the results of Patient A's referral to the headache clinic. Given that Patient A had suffered from headaches for a period of approximately seven years, it is a serious deviation of standards to fail to integrate the information from the headache clinic into the record and resultant treatment. This lack of documentation continued even as Patient A became increasingly dependent on Vicodin in the early 1990's.

Therefore:

Factual Allegation A.1 **IS SUSTAINED**
Factual Allegation A.2 **IS SUSTAINED**

In Factual Allegations A.3 the State takes issue with Respondent's prescribing of controlled substances. Respondent's prescription of the controlled substances Vicodin, Vicodin ES, Valium, Talwin and Xanax was certainly repeated throughout the period. Continuous prescribing of controlled substances for chronic pain is not, in and of itself, inappropriate. Here however, Respondent did prescribe inappropriately. Respondent continuously prescribed controlled substances to this patient. Yet he performed no diagnostic studies to ascertain the reason for the pain. Absent any empiric data, Respondent was unable to objectively assess the progress or lack thereof of the patient. Simply treating a patient with analgesics over a period of years is not in the

best interest of a patient since the underlying cause of the pain is never investigated. Respondent had no way of knowing if the pain could be permanently alleviated through other modalities of treatment or whether the pain was indicative of some more serious condition which warranted direct treatment. Finally, with regard to controlled substances, the possibility of addiction or dependance must be addressed. Respondent showed no appropriate attention to this important consideration.

Therefore:
Factual Allegation A.3 **IS SUSTAINED**

In Allegation A.4, Respondent is charged with prescribing Vicodin, Xanax and Decadron. The essence of the charge is that the prescribing of these substances in concert is, in and of itself, a violation of accepted standards of medicine. The Committee cannot sustain the charge on the basis presented. This patient complained of pain. Vicodin is an analgesic. Xanax is an anti-depressant and Decadron is a steroid. The prescription of an analgesic, anti-depressant and a steroid (which can reduce inflammation) is not, absent more, a violation of accepted standards of medicine. While the Committee does not endorse Respondent's treatment of this patient, the Committee cannot find, based upon the evidence presented that the prescribing was inappropriate.

Therefore:
Factual Allegation A.4 **IS NOT SUSTAINED**

In Allegation A.5, Respondent is charged with prescribing Beta blockers Inderal and Corgard in the presence of low blood pressure. The Committee does not sustain this allegation. Clearly, Respondent prescribed Inderal and Corgard to this patient and often in combination with the controlled substances set forth above. However, these anti-hypertensive substances were given to treat this patient's migraine headaches. The State acknowledged that the use of Beta blockers in the treatment of migraines is well recognized. However, the State asserted that the use of Beta-blockers, which can lower blood pressure, was contraindicated because this patient's blood pressures were too low. The blood pressures which were recorded speak for themselves, but are not necessarily indicative of hypotension. The Committee takes notice that blood pressure is physiologic and therefore, within certain broad parameters, individualized to each patient. For the State to prove that the Beta blockers were inappropriate for this patient, the State would have to

establish that the blood pressures reported were too low for this individual patient. Since there was no evidence that the patient reported feeling light -headed, dizzy, confused etc., the numbers reported, in and of themselves, do not establish hypotension. The simple fact is that the State presented no evidence that the blood pressures reported were not acceptable for this particular patient.

Therefore, based on the above conclusions:
Allegation A.5 is NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT B

B.1. Respondent provided medical care to Patient B. Patient B was 21 when his first visit occurred on June 20, 1980. Respondent continued to treat Patient B through approximately January 4, 1993. (Pet.'s Ex. 11 and 12).

B.2. There is no record of a complete history from Patient B at any time during the entire period of his treatment by Respondent (Mesches, T. 155; Pet.'s Ex. 11).

B.3. There is no record of a complete physical examination at any time during the treatment of Patient B by Respondent. (Mesches, T. 155).

B.4. Respondent prescribed controlled substances to Patient B as is set forth in Attachment V to this decision (ALJ Ex. 102).[3]

B.5. Librium, a benzodiazepine and controlled substance, is a tranquilizer (Mesches, T. 151).

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[3]After reviewing ALJ exhibit 102 and comparing it with the original prescriptions in evidence and the testimony of Respondent, the committee adopts t ALJ exhibit 102 as a finding of fact which sets forth an accurate list of prescriptions issued by Respondent. A copy of this exhibit is attached hereto as Attachment V.

B.6. On Patient B's initial visit to Respondent of June 20, 1980, Respondent prescribed Librium, 25 mg. # 100 (Pet.'s Ex. 11, pg. 1; Mesches, T. 151).

B.7. There is no medical justification present in the patient record for the prescription of Librium (Pet.'s Ex. 11, pg. 1; Mesches, T. 151).

B.8. Patient B was an alcoholic when he began treatment with Respondent (Resp., T. 497).

B.9. Patient B returned to Respondent's office on April 2, 1987 after sustaining a fracture of two vertebrae during an auto accident and having undergone a spinal fusion (Pet.'s Ex. 11, pg. 1, Mesches, T. 152).

B.10. On April 15, 1987, Respondent noted that Patient B was "on Methadone program". Patient B was a Heroin addict and had been on the Methadone program for over a year (Resp., T. 499; Pet.'s Ex. 11, pg. 1).

B.11. The goal of Methadone treatment is to gradually terminate the use of Methadone while attempting to keep the patient from returning to the use of Heroin.

B.12 It is dangerous to prescribe narcotic medication to a patient who is a narcotics addict. A physician should exercise extreme caution in the prescription of any pain medication to such a patient. Where such treatment is necessary, it should be coordinated with the Methadone program. Detailed and careful follow-up histories should be recorded. These histories should document the dosage of Methadone which the patient is taking, the progress of his Methadone treatment (Mesches, T. 154-155, 216-219).

B.13. Respondent documented no information regarding Patient B's drug use prior to April

15, 1987. There was also no documentation regarding the Methadone treatment for this patient beyond the April 15, 1987 note (Pet.'s Ex. 11).

B.14. Patient B left the Methadone program shortly after April 1987. He also failed to continue his Alcoholics Anonymous program (Resp. T. 501).

B.15. Treatment of a patient with chronic back pain employing long term narcotic medication is not justified (Mesches, T. 201).

B.16. On June 26, 1987, Respondent prescribed Xanax 1 mg. three times daily for Patient B. He continued to prescribe Xanax 1 mg. until March of 1988, at times on an approximately weekly basis (Pet.'s Ex. 11, pgs. 3-6; Appendix B).

B.17. On July 27, 1987, Respondent instructed Patient B to call his surgeon regarding Patient B's complaints of pain. There is no record of any results arising from this instruction (Pet.'s Ex. 11, pg. 4, et. seq.; Resp., T. 537).

B.18. Darvon and Darvocet are pain medications with addicting potential (Mesches, T. 153-154, 170).

B.19. On July 27, 1987, Respondent prescribed Xanax, 1 mg, #20 and Darvon 65 mg. (Pet.'s Ex. 11, pg. 4).

B.20. On August 3, 1987, Respondent prescribed Xanax, 1 mg. #20 (Pet.'s Ex. 11, pg. 4).

B.21. On July 30, 1987, Respondent prescribed Restoril 30 mg. # 30 and Atarax (Pet.'s Ex. 11, pg. 4).

B.22. Restoril, a controlled substance and hypnotic, is a benzodiazepine derivative in a class of drugs similar to Xanax. It has effects upon the central nervous system similar to a benzodiazapine and is a potentially addicting drug. Restoril is used as a sleeping pill (Mesches, T, 157, 184-185).

B.23. On July 30, 1987, Respondent did not record any medical justification for the prescription of Restoril. (Pet.'s Ex. 11, pg. 4; Mesches, T. 157-158).

B.24. An x-ray consultation of February 6, 1989 indicates good repair of Patient B's fractures, normal spine alignment and disc spaces being well preserved. This report does not provide objective evidence of pain and is therefore not supportive of chronic pain treatment with narcotic analgesics (Pet.'s Ex. 11, pg. 39; Mesches, T. 172-173).

B.25. Atarax is an anti-histamine. As such, it can affect the central nervous system. (Mesches, T. 158-159).

B.26. On July 5, 1989, Respondent prescribed Vicodin and Talwin in combination (Pet.'s Ex. 11, pg. 7).

B.27. On February 7, 1989, Respondent cautioned Patient B regarding addictive behavior because Patient B was asking for too many Vicodin. Respondent prescribed 60 Vicodin for Patient B on this date. Respondent thereafter continued to prescribe Vicodin (Pet.'s Ex. 11 and 12; Resp., T. 512-513; Attachment V)

B.28. Respondent never obtained a consultation from a neurologist or neurosurgeon for this patient (Pet.'s Ex. 11; Resp., T. 531).

B.29. On September 14, 1989, Respondent noted that he had referred Patient B to a pain

clinic. This occurred approximately two years and six months after Respondent began to treat Patient B (Pet.'s Ex. 11, pg. 8).

B.30. A pain clinic is a specialized center for the treatment of pain with specially trained physicians on staff (Mesches, T. 193).

B.31. Patient B did not attend the pain clinic (Mesches, T. 162; Pet.'s Ex. 11, pg. 8-10 - entry of 11/16/89 and 2/16/90).

B.32. Patient B terminated physical therapy on August 17, 1989, after three to four months of treatment. Respondent documented no follow-up with the physical therapist. Respondent continued to prescribe controlled substances for Patient B (Resp., T. 543; Pet.'s Ex. 11, pg. 8 - entry of 8/17/89).

B.33. Demerol, a controlled substance, is a powerful narcotic medication used for the treatment of pain. It has central nervous system side effects, is highly addictive and is generally used in a hospital setting (Mesches, T. 163, 194).

B.34. Respondent administered intramuscular injections of Demerol to Patient B in the following doses on the following thirty occasions; October 20 (100 mg) and December 4, 1989 (100 mg); January 24 (150 mg) February 16(?), March 16 (150 mg), May 4(150 mg), June 15(150 mg), July 12 (150 mg), August 6(150 mg), August 20(150 mg), October 11 (150 mg), November 9 (150 mg), November 23 (150 mg), and December 7, 1990 (150 mg); January 14 (150 mg), January 28 (150 mg), March 1 (150 mg), April 12 (150 mg), June 17 (150 mg), September 20 (150 mg), and December 13, 1991 ; January 10 (150 mg), February 5 (150 mg), April 17 (150 mg), May 7 (150 mg), May 28 (150 mg), June 15 (150 mg), July 3 (150), July 23 (150) and August 27 1992 (150 mg) (Pet.'s Ex. 11, pgs. 8-32; Resp., T.507-509, 521; Attachment V).

B.35. 150 mg. is a large dose of Demerol (Mesches, T. 165).

B.36. On October 20, 1989, Respondent simultaneously prescribed Talwin and Vicodin. During the same visit, Respondent treated Patient B with an intra-muscular injection of Demerol 100 mg (Pet.'s Ex. 11, pg. 8).

B.37. On May 9, Respondent prescribed Xanax 1 mg.,to be taken three times daily. The number of tablets prescribed was 90. Respondent also prescribed Vicodin #20. On May 20, 1991, Respondent prescribed Vicodin #20. Vicodin # 20 was also prescribed on May 27, June 4 and June 10, 1991. On June 17 1991 Vicodin #20 and Xanax 1 mg. TID #30 were prescribed. Vicodin #20 was also prescribed on June 24, 1991 (Pet.'s Ex. 11, pgs. 19-20; Pet.'s Ex. 12; Attachment V).

B.38. Prescriptions for Vicodin written by Respondent on May 17, 1990, April 23, 1991, and August 21, 1991 were not noted in Patient B's medical record. There is no patient visit documented in the medical record for the May 17, 1990 and August 21, 1991 prescriptions (Pet.'s Ex. 11, pgs. 11, 18 and 21-22; Pet.'s Ex. 12).

B.39. On July 23, 1992, Respondent treated Patient B with an intra-muscular injection of Demerol 150 mg. At the same visit, Respondent prescribed Vicodin #40 and Percodan (Pet.'s Ex. 11, pg. 31).

B.40. There was no qualitative improvement in Patient B's condition from the onset to the conclusion of his treatment by Respondent (Pet.'s Ex. 11; Mesches, T. 207; Resp., T. 525, 540).

B.41 On March 6, 1992, Respondent noted a discussion of this patient's chronic pain. Respondent noted, "try to reduce amount of meds" (Pet.'s Ex. 11, page 26).

B.42. Respondent continued to treat Patient B with controlled substances including

Demerol following the March 6, 1992 note (Pet.'s Ex. 11 and 12; Attachment V).

CONCLUSIONS WITH REGARD TO PATIENT B

Allegations B.1 and B.2 again allege that Respondent failed to take adequate initial or interval histories or physical examinations of this patient. Respondent showed a pattern throughout this proceeding of virtually non-existent histories and physical examinations. There was no mitigation offered by Respondent for this deviation from accepted standards. In fact, Respondent was of the opinion that such information was of little value.

Therefore:

Factual Allegation B.1 **IS SUSTAINED**
Factual Allegation B.2 **IS SUSTAINED**

In Factual Allegation B.3, B.4 and B.5 Respondent is charged with inappropriately prescribing controlled substances and administering intra-muscular injections for pain (Allegation B.3), failure to refer the patient to a pain clinic (Allegation B.4) and continuing to prescribe controlled substances to a patient he knew was participating in a Methadone program (Allegation B.5). The Committee considers these charges to be intertwined and hence will consider them together.

As was stated in reference to Allegations A.3 and A.4, the Committee begins with the proposition that it is contrary to accepted standards of medicine to prescribe controlled substances over lengthy periods of time for pain, in the absence of a diagnostic workup to ascertain or substantiate the cause of the pain. This is because analgesics can mask symptoms of serious conditions. Ultimately, if the cause of the pain can be ascertained and eliminated, there will be no further need for potentially dangerous controlled substances. As in the case of Patient A, Respondent simply continued to prescribe potent analgesics to this patient and made no substantial effort to ascertain the cause of the pain. This pattern of practice is outside the bounds of accepted standards of medicine.

In this case the deviation from accepted standards is more glaring since Respondent knew this patient was a narcotics addict who was receiving treatment for his addiction. Treating a narcotics addict with any addictive substances, particularly narcotics or synthetic narcotic substitutes, constitutes contradictory treatment. The prescriptions by Respondent negated the work of the addiction control treatments and added to the patient's substance abuse problems.

In addition to the glaring deviations from accepted standards just cited, the repeated injections of Demerol were also gross departures from accepted standards of medicine. In so finding the Committee cites the following considerations: First, Demerol is extremely addictive, especially when administered intra-muscularly. Second, the doses administered were too large to be given safely on an outpatient basis in a physician's office. Doses of the quantity administered by Respondent should not be given on an outpatient basis since it is highly likely that the patient may be impaired from the effects of the drug. The Committee finds that if Respondent was convinced that 100 to 150 mg of Demerol was needed to treat this patient he should have referred the patient to a controlled setting such as a hospital emergency room. However, Respondent had no basis to be convinced that Demerol was warranted since he made no effort to obtain objective data through examination or diagnostic work-up. Consequently, both in the administration itself and the particular aspects of the administration, Respondent grossly deviated from accepted standards of medicine.

Therefore:

Factual Allegation B.3 **IS SUSTAINED**

FINDINGS OF FACT WITH REGARD TO PATIENT D

D.1. Respondent provided medical care to Patient D, who was 29 years old on the date of his first office visit, November 12, 1974. Respondent continued to provide treatment through April 8, 1993. (Pet.'s Ex. 16 and 17, see prescription of 4/8/93).

D.2. In November of 1974 Patient D wanted to lose weight. Respondent prescribed

amphetamine medication which resulted in weight loss (Mesches, T. 232; Pet.'s Ex. 16, pgs. 1-9).

D.3. Patient D's medical record includes a form entitled Annual History and Physical. This form primarily consists of a category entitled medical history. The medical history portion of the form provides checklists of various physical problems. The document lists 1985 as the date when Patient D had an illness or operation and July 9, 1992 as the date of Patient D's last menstrual cycle. The document is otherwise undated (Pet.'s Ex. 16, pg. 36).

D.4. The check-off list is, in and of itself, insufficient as a medical history. The form does not provide an opportunity to measure degree or intensity of a particular ailment. Nor does it provide an adequate review of systems nor provide an adequate family history. The form, as it appears, includes the date of July 9, 1992 and was therefore completed late in the course of Patient D's treatment.

D.5. There is no record of Respondent ever having elicited a complete history of Patient D during the entire period he treated her (Pet. Ex. 16; Mesches, T. 230-231, 281-282).

124. There is no record of Respondent ever having performed a complete physical examination for Patient D. The form entitled Annual History and Physical contains no documentation of a physical examination (Pet.'s Ex. 16, pg. 36; Mesches, T. 232, 256, 282).

D.6. Respondent prescribed controlled substances for Patient D as listed in Attachment VI[4] (Pet.'s Ex. 16, 17 and Attachment VI (ALJ's Ex. 104)).

D.7. Ionamin, Tenuate and Fastin are amphetamine derivatives which can be used for weight control (Mesches, T. 233-234, 236-240).

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[4]After reviewing ALJ exhibit 104 and comparing it with the original prescriptions in evidence and the testimony of Respondent, the committee adopts t ALJ exhibit 104 as a finding of fact which sets forth an accurate list of prescriptions issued by Respondent. A copy of this exhibit is attached hereto as Attachment VI.

D.8.. On April 25, 1986 Respondent recorded a blood pressure of 150/100. Respondent also prescribed Tenuate for weight reduction (Pet.'s Ex. 16, pg. 10).

D.9. On January 15, 1987, Respondent recorded that Patient D had a headache at the top of her head, no aura, a blood pressure of 170/114 and weighed 180 1/2. He gave her an intramuscular injection of Demerol 75 mg. (Pet.'s Ex. 16, pg. 10; Resp. T. 560-561).

D.10. On April 3, 1987 and December 3, 1990, Respondent prescribed Vicodin (Pet.'s Ex. 16, pg. 11, 17; Mesches, T. 246-247, 251).

D.11. There is no justification in the patient record for Vicodin.

D.12. Halcion is a benzodiazepine derivative commonly used as a sleeping tablet. Halcion can produce side effects to the central nervous system. Halcion has addictive potential. (Mesches, T. 248).

D.13. On July 20, 1989, Respondent prescribed Halcion at the maximum dose, .25 mg, for Patient D (Pet.'s Ex. 16, pg. 12).

D.14. There is no medical justification indicated in the patient record for the prescription of Halcion (Mesches, T. 249).

D.15. On January 25, 1987 Respondent prescribed Fastin 1 mg. #30. Respondent also prescribed Maxzide. The blood pressure recorded on that date is 180/110 (Pet.'s Ex. 16, pg. 10).

D.16. Maxzide is a diuretic which decreases blood pressure and is used to treat hypertension (Resp. T. 562; Mesches, T. 237, 244).

D.17. Respondent prescribed Ionamin on April 3, May 8, and November 13 of 1987 and June 5, and October 23 of 1989 in the presence of blood pressures of 150/94 on April 3, 140/110 on May 8, 142/92 on November 13 of 1987, 150/100 on June 5 and 140/94 on October 23 of 1989 (Pet.'s Ex. 16, pg. 11-13).

D.18. On October 23, 1989, Respondent recorded that Patient D had been having palpitations. Respondent prescribed Ionamin on that occasion and continued to prescribe it on November 20, 1989 and January 29, 1990 (Pet.'s Ex. 16, pgs. 13-14).

D.19.. Ionamin can stimulate palpitations. (Mesches, T. 249-250).

D.20. Lasix is a diuretic which can be used to reduce fluid retention in the body and has anti-hypertensive qualities (Mesches, T. 240, 262).

D.21. Calan and Verapamil are calcium channel blockers and anti-hypertensive drugs (Mesches, T.240-241).

D.22. Respondent prescribed Fastin and Maxzide in combination on January 25, 1987; Lasix, and Ionamin in combination on May 8 and November 13, 1987. Lasix, Calan, and Ionamin were prescribed in combination on June 5 June 30, October 23 and November 20 of 1989 (Pet.'s Ex. 16, pgs. 10-14).

D.23 On August 16, 1990, Respondent prescribed Xanax 1 mg. #90. (Pet.'s Ex. 16, pg. 16).

D.24. There was no medical justification indicated in the patient record for the prescription of Xanax on August 16, 1990. (Mesches, T. 251).

D.25. On December 20, 1990, Respondent prescribed Valium 10 mg. #90 (Pet.'s Ex. 16, pg. 17).

D.26. There was no medical justification indicated in the patient record for the prescription of Valium 10 mg. on December 20, 1990 (Mesches, T. 251-252, 274-275).

D.27. Respondent, on numerous occasions, failed to note that he had prescribed controlled substances such as Valium, Xanax and Vicodin in Patient D's medical record (see Pet.'s Ex. 16 and 17, prescriptions for 2/16/91, 3/18/91, 6/28/91, 7/9/91, 9/3/91, 2/3/92, 4/27/92 and 6/12/92 and Pet.'s Ex. 16; Resp. T.575-576).

D.28. Accepted standards of medical care dictate that a practitioner obtain a baseline electrocardiogram-cardiogram and chest x-ray to determine heart size given Patient D's hypertension. A baseline blood count prior to beginning treatment is also warranted because anti-hypertensive drugs can cause side effects to bone marrow (Mesches, T. 245-246, 270, 279; Resp. T. 607).

D.29. Respondent does not routinely obtain laboratory work-ups, such as a complete blood count for each patient (Resp., T. 406-407).

D.30. Respondent failed to do any medical testing beyond a March 20, 1991 serum Potassium test (Pet.'s Ex. 16, pg. 33) and a blood test of September 26, 1989 (Pet.'s Ex. 16, pgs. 31-33). No blood count or electrocardiogram-cardiogram was done (Mesches, T. 244-246; Resp. T. 606-607).

CONCLUSIONS WITH REGARD TO PATIENT D

Allegations D.1 and D.2 again allege that Respondent failed to take adequate initial or interval histories or physical examinations of this patient. Respondent showed a pattern throughout this proceeding of virtually non-existent histories and physical examinations. There was no mitigation offered by Respondent for this deviation from accepted standards. In fact, Respondent was of the opinion that such information was of little value.

Therefore:
Factual Allegation D.1 **IS SUSTAINED**
Factual Allegation D.2 **IS SUSTAINED**

In Allegation D.3, Respondent is charged with failing to have adequate medical testing done for this patient who was receiving anti-hypertensive medication. The Committee sustains this charge. Clearly, except for blood pressure measurements, Respondent made no effort to monitor the condition of this patient. Accepted standards of medical care dictate that a practitioner obtain a baseline electrocardiogram-cardiogram and chest x-ray. The former is important to ascertain the patient's cardiac condition. The latter is used to determine heart size. Both are important guides in the treatment of a hypertensive patient. A baseline blood count and serum assay prior to beginning treatment is also important because anti-hypertensive drugs can cause side effects to bone marrow and other body chemistries. Respondent failed to do any medical testing beyond a March 20, 1991 serum Potassium test and a blood test of September 26, 19893). No blood count or electrocardiogram-cardiogram was done. Respondent testified that he does not routinely obtain laboratory work-ups, such as a complete blood count for any of his patients. This admission demonstrates another significant departure from accepted standards of medicine.

Therefore:
Factual Allegation D.3 **IS SUSTAINED**

In Allegation D.4, Respondent is charged with prescribing analgesics and anorectics

inappropriately. Once again, the facts show Respondent prescribing potent controlled substances for headaches over a significant period with no effort to ascertain the cause of the pain. Of particular note is the prescription of Demerol. Absent a documented history of intractable pain of known origin, it is a serious violation of accepted principles of medicine to prescribe Demerol, especially in an out-patient, office setting.

In addition to the analgesics which were prescribed inappropriately, Respondent also prescribed Tenuate, Ionamin and Fastin. These are anorectics and are closely related to amphetamines. It is a clear violation of accepted standards of medicine to prescribe substances from this family of medication to a patient with a history of palpitations and headache. These drugs are stimulants by nature and can effectuate headaches and palpitations. Hence, to provide them to a patient who already suffers these symptoms is inconsistent with appropriate medical care.

Therefore:
Factual Allegation D.4 **IS SUSTAINED**

In Factual Allegation D.5, Respondent is charged with misconduct on the basis that he prescribed the anorectics, which are amphetamine like drugs to a patient who was also taking anti-hypertensive medications. The Committee finds that Respondent did indeed prescribe anorectics and anti-hypertensive drugs at the same time. However, the Committee also finds that the use of anorectics and anti-hypertensive medications, in and of itself, does not constitute a deviation from accepted standards. While it is true that anorectics may increase blood pressure, the benefits obtained from the anorectics may outweigh the hypertensive result. Furthermore, there is no provision of accepted medical standards which makes the use of one drug to compensate for the side-effects of another drug inherently inappropriate. While the Committee certainly does not agree with the management of this particular patient, as set forth above, in fairness, the Committee cannot sustain this charge on the basis upon which it was brought.

Therefore:
Factual Allegation D.5 is **NOT SUSTAINED**

FINDINGS OF FACT WITH REGARD TO PATIENT G

G.1. Respondent provided medical care to Patient G, a thirty year old female from March 5, 1992 G through at least October 14, 1992 (Pet.'s Ex. 22).

G.2. An undated form entitled Annual History and Physical is included in Patient G's medical record. The only date on the form is August 10, 1992 which appears under the section entitled "synopsis" (Pet.'s Ex. 22, pg. 3).

G.3. The form in and of itself does not constitute a patient history. There is no record of Respondent ever having a elicited a complete history for Patient G throughout the entire period of his treatment of her (Pet.'s Ex. 22; Mesches, T.288-292, see also 230-232, 281-282).

G.3. There is no record of Respondent ever having performed a complete physical examination of Patient G during his treatment of her. Respondent only recorded one blood pressure on August 26, 1992 and examined Patient G for sinusitis on that occasion (Pet.'s Ex. 22; Mesches, T. 288-292).

G.4. On her initial visit of March 5, 1992, Patient G initially reported she was "very nervous," that she was caring for her grandmother and that she was taking Xanax 1 mg. three times daily. Respondent prescribed Xanax, 1 mg. (Pet.'s Ex. 22, pg. 1).

G.5. On April 8, 1992, Respondent prescribed Valium 10 mg. #90 stating that the patient wants Valium as she has no Medicaid coverage (Pet.'s Ex. 22, pg. 1; Mesches, T. 293).

G.6. There is no medical justification present for the prescription of Valium. The

statement that Patient G wants Valium is not a sufficient medical reason for its prescription (Mesches, T. 293).

G.7. Xanax 1 mg. was prescribed on May 7, 1992. Respondent noted Patient G wanted a refill of Xanax the recorded basis is that Valium did not work well. Respondent continued to prescribe Xanax on June 8 and July 8 of 1992. The notations regarding the prescriptions on the June and July visits read: "she needs med renewal" (Pet.'s Ex. 22, pg. 1).

G.8. There is no medical justification for the prescription of Xanax based on Patient G's statements that she wanted Xanax or needed a med renewal. There is no examination or diagnosis present for these dates (Mesches, T. 293-295).

G.9. On August 10, 1992, Respondent prescribed Xanax 1 mg. and Talwin 50 mg. Respondent's notes state that Patient G complained of frequent headaches over a three month period and that she was very tense (Pet.'s Ex. 22, pg. 2).

G.10. Respondent documented no physical examination, blood pressure or diagnosis as to the cause of the headaches (Mesches, T. 295-297).

G.11. On September 10, 1992, Respondent prescribed Xanax 1 mg. #90 and Zoloft 50 mg. Respondent noted that Patient G complained of occasional episodes of depression and that she was always nervous. (Pet.'s Ex. 22, pg. 2; Resp. T. 453-454).

G.12. Zoloft is an anti-depressant medication (Mesches, T. 297).

G.13. On October 14, 1992, Xanax 1 mg #90, Zoloft 50 mg. and Tylenol with Codeine were prescribed (Pet.'s Ex. 22, pg. 2, Resp., T. 453-454).

CONCLUSIONS WITH REGARD TO PATIENT G

Allegations G.1 and G.2 again allege that Respondent failed to take adequate initial or interval histories or physical examinations of this patient. Respondent showed a pattern throughout this proceeding of virtually non-existent histories and physical examinations. There was no mitigation offered by Respondent for this deviation from accepted standards. In fact, Respondent was of the opinion that such information was of little value.

Therefore:

Factual Allegation G.1 **IS SUSTAINED**
Factual Allegation G.2 **IS SUSTAINED**

In Factual Allegation G.3, Respondent is again charged with providing analgesics in the absence of any effort to ascertain the precise nature and cause of the pain. For the reasons set forth above, the Committee finds this activity to violate accepted standards of care. In addition to analgesics, Respondent also prescribed anxiety medication for this patient. The Committee has found no justification whatsoever in the record. In so finding the Committee finds neither diagnostic examinations nor any sort of written explanation for the prescriptions. The Committee finds that prescribing substances in the absence of any meaningful justification whatsoever is a clear and significant violation of accepted standards of medicine.

Therefore:

Factual Allegation G.3 **IS SUSTAINED**

FINDINGS OF FACT WITH REGARD TO PATIENT H

H.1. Respondent provided medical care to Patient H, a 33 year old male from February 27, 1992 through at least October 8, 1992 (Pet.'s Ex. 23).

H.2. Patient H is the husband of Patient G (Resp., T. 474).

H.3. A form entitled Annual History and Physical similar to that described for Patients D and G above is part of Patient H's medical record. The form is dated August 3, 1992 (Pet.'s Ex. 23, pg. 1; Resp., T. 479).

H.4.. There is no record of a complete history for Patient H having been elicited or recorded by Respondent over the entire period Respondent treated him. The form entitled Annual History and Physical Examination, dated August 3, 1992, doe not constitute a complete history. This form was was not completed until August 3, 1992, some five months after Patient H began treatment by Respondent (Mesches, T. 303-304; Pet.'s Ex. 23).

H.5.. The form entitled Annual History and Physical Examination contains no physical examination. There is no record of Respondent ever having performed a complete physical examination of Patient B during his treatment of him. (Mesches, T.303; Pet.'s Ex. 23).

H.6. On March 26, 1992, Respondent noted that Patient H had furunculosis. Respondent prescribed Tetracycline on March 26 and April 29, 1992 and thereafter prescribed Minocin on May 29 and June 29, 1992 (Pet.'s Ex. 23, pgs. 2-3).

H.7. Respondent did not have Patient H undergo any laboratory testing of the blood and urine (Pet.'s Ex. 23; Mesches, T. 310).

H.8. On February 29, 1992, Respondent noted that Patient H was very tense, that his wife had left him, that Patient H had taken Xanax 1 mg. three times daily and had not taken this medication for four days. Patient H complained of nausea and vomiting. Respondent prescribed Xanax 1 mg #90 and indicated that the patient should start at three times daily and begin to taper (Pet.'s Ex. 23, pg. 2; Mesches, T. 304).

H.9. Respondent continued to prescribe Xanax on March 26, April 29 and May 29, 1992.

On August 3 and September 3, 1992, he prescribed Valium 10 mg (#90 were prescribed on September 3). Respondent instructed Patient H that he should taper the Valium to 1/2 tablet QD[5].

H.10. Xanax was prescribed on October 8, 1992. A notation by Respondent indicates that Valium was not sufficiently effective and that the Xanax should last 45 days. The note indicated that Patient H should take 1/2 tablet in the morning, 1/2 during the day and a full tablet at night (Pet.'s Ex. 23, pgs. 2-3; Mesches, T. 304-309).

H.11. There is no diagnosis present in the medical record which would provide medical justification for the prescription of these controlled substances. There is a statement in the note of February 29, 1992 that Patient H is very tense and that his wife has left him. Respondent did not explain why he switched Patient H to Valium.(Mesches, T. 304-309).

H.12. Respondent continues to see Patient H as of the time of this proceeding. Respondent provides Xanax to Patient H as needed.

H.13. Patient H no longer requires Xanax in the same quantities as before however, Respondent acknowledges that by some definitions, he is an addict (Resp., T. 472-473).

CONCLUSIONS WITH REGARD TO PATIENT H

Allegations H.1 and H.2 again allege that Respondent failed to take adequate initial or interval histories or physical examinations of this patient. Respondent showed a pattern throughout this proceeding of virtually non-existent histories and physical examinations. There was no mitigation offered by Respondent for this deviation from accepted standards. In fact, Respondent

[5]QD is an abbreviation for once daily.

was of the opinion that such information was of little value.

Therefore:
Factual Allegation H.1 **IS SUSTAINED**
Factual Allegation H.2 **IS SUSTAINED**

In Factual Allegation H.3, Respondent is charged with a failure to obtain an electrocardiogram-cardiogram and laboratory testing for this patient. The Committee sustains this charge. Clearly, neither an electrocardiogram nor blood tests were performed for this patient. The failure to obtain the procedures constitutes a deviation from accepted standards of medicine because one needs the results of such tests to provide a baseline from which care can be assessed. Absent these most basic diagnostic findings, a physician cannot know the progress or lack thereof of the patient. Respondent chose to treat this patient with potentially dangerous drugs yet had no measure of the patient's objective condition. This is a serious departure from accepted standards.

Therefore:
Factual Allegation H.3 **IS SUSTAINED**

In Factual Allegation H.4, Respondent is charged with prescribing Xanax and Valium inappropriately. The Committee sustains this charge. There is no meaningful justification in the record for prescribing these potentially addictive controlled substances. Simple phrases referring to patient anxiety or familial break-up are insufficient bases upon which to issue these prescriptions. The lack of justification is exacerbated in this case since Respondent not only lacked justification, he made no effort to assess the overall health of his patient to see if the complaints were legitimate and if so whether the underlying cause could be ascertained and cured. Providing Xanax and Valium for the period herein and absent the fundamental data referred to is both irresponsible and a clear violation of accepted medical standards.

Therefore:
Factual Allegation H.4 **IS SUSTAINED**

FINDINGS OF FACT WITH REGARD TO PATIENT I

I.1. There is no record of Respondent ever having performed a complete physical examination of Patient I or of eliciting a complete history from him (Pet.'s Ex. 24)

I.2. Patient I was a 14 year old male who received treatment from Respondent on June 8, October 26, 1988 and January 23, 1989 (Pet.'s Ex. 24).

I.3. Patient I was noted to be allergic to Penicillin (Pet.'s Ex. 24).

I.4. On January 23, 1989, Respondent prescribed Amoxicillin to Patient I (Pet.'s Ex. 24; Resp. T. 485).

I.4. The prescription of Amoxicillin to a Penicillin allergic patient is contraindicated (see Stipulation, T. 301-302).

I.5. Respondent did not perform any tests to determine if Patient I was allergic to Penicillin (Resp. T. 488-489)

I.6. Respondent does not recall his rationale for prescribing Amoxicillin to a penicillin allergic patient (Resp., T. 485-487).

I.7. Respondent did not chart Patient I's reaction to the Amoxicillin and does not know how this patient reacted (Resp., T. 485-488).

CONCLUSIONS WITH REGARD TO PATIENT I

Allegations I.1 and I.2 again allege that Respondent failed to take adequate initial or interval

histories or physical examinations of this patient. Respondent showed a pattern throughout this proceeding of virtually non-existent histories and physical examinations. There was no mitigation offered by Respondent for this deviation from accepted standards. In fact, Respondent was of the opinion that such information was of little value.

Therefore:
Factual Allegation I.1 **IS SUSTAINED**
Factual Allegation I.2 **IS SUSTAINED**

In Factual Allegation I.3, Respondent is charged with prescribing Amoxicillin to this patient. Amoxicillin is related chemically to Penicillin and Respondent admitted both that he prescribed the Amoxicillin and that it was inappropriate medically to do so to one who is known to be allergic to Penicillin.

Therefore:

Factual Allegation I.3 **IS SUSTAINED**

CONCLUSIONS WITH REGARD TO THE FIRST THROUGH NINTH SPECIFICATIONS (GROSS NEGLIGENCE)

The Committee has sustained each of the charges except Factual Allegation A.4 and Factual Allegation A.5. Therefore, Factual Allegations A.4 and A.5 will not form the basis for any finding of misconduct. The Committee further finds that Allegations H.3, H.4 and I.3 do not rise to the level of gross negligence. As set forth above, the Committee sustained the facts that Respondent did not have patient undergo an electrocardiogram or laboratory testing (Allegation H.3) and that he inappropriately prescribed Xanax and Valium to this patient (Allegation H.4). Nevertheless, the Committee finds that while an EKG and laboratory tests would have been desirable, the failure to perform them is not an egregious departure from standards. In reference to the prescriptions of Xanax and Valium, the Committee cites Respondent's note to wean the patient from the drugs. Consequently, the Committee cannot find a flagrant departure from

standards. Finally, the Committee finds that under all the facts and circumstances, the provision of Amoxicillin to a patient who is Penicillin allergic, while not appropriate management, does not constitute a gross departure from standards.

With regard to the remaining charges, the Committee finds that each of the allegations which were sustained form the basis of a separate act of misconduct. Beginning with an analysis of the charges under the definition of gross negligence cited in the beginning of this decision, the Committee finds that each charge, with the exception of Factual Allegations H.3, H.4 and I.3 constitutes a separate act of gross negligence.

In so finding, the Committee sees several patterns which constitute egregious deviations from accepted standards. First, Respondent asserted that basic histories and physical examinations were of little value. Consequently, he did not perform them. The Committee finds such a position preposterous. As set forth earlier, only by examination can the root causes of pain and anxiety be diagnosed. Once the cause of the pain or anxiety is established, it can be ascertained whether the condition which is causing the problem can be corrected. If the condition cannot be alleviated and the discomfort of the patient is sufficient, there is justification for the prescription of medication. However, even where examination establishes that medication is appropriate, continued monitoring of the patient through repeat physical examinations and objective testing is required to ascertain the progress of the patient. Absent a detailed examination and history, and absent an emergency, there is simply no basis to prescribe analgesics or anti-depressants to any patient. Respondent made not the slightest effort to explore either the legitimacy or the basis of his patient's complaints. He apparently relied solely upon the subjective reports of his patients and their requests for specific drugs. Such conduct is a clear and glaring deviation from accepted standards of practice.

The second troubling pattern exhibited by Respondent was the long term provision of potent narcotic and synthetic narcotics to patients who complained of pain. Due to the significant dependency and addictive issues associated with narcotics and narcotic like substances, their long term use must not be routinely undertaken. The substances prescribed by Respondent are appropriate as short term tools to treat acute episodes. The long term use of such drugs can only

be justified after all other modalities have been assessed. Since Respondent made no such meaningful assessments, he had no medical justification to provide the analgesics and anti-depressants over such long periods of time. The provision of significantly dependance and addiction producing drugs, over considerable periods of time (in some cases years), in the absence of any meaningful examination of alternatives is a flagrant deviation from accepted standards of care and diligence.

Another serious departure from due diligence which Respondent exhibited by was conspicuous irresponsibility in his use of the most potent of analgesics. On two occasions, he prescribed narcotics and narcotic-like substances to patients he knew to be addicts. Moreover, Respondent showed a cavalier disregard to the practical consequences of the use of potent analgesics by administering large dose Demerol injections in his office. Hence, Respondent allowed patients to receive large doses of a substance with a high potential for impairment. These patients were then allowed to leave the office unassisted. Clearly, by any reasonable definition of due diligence and care, Respondent's acts must be seen as glaring deviations.

Therefore, based upon Factual Allegations A.1, A.2, A.3, B.1, B.2, B.3, B.4, B.5, D.1, D.2, D.3, D.4, D.5, G.1, G.2, G.3, H.1, H.2, I.1 and I.2:[6]

The First Specifications **IS SUSTAINED**
The Second Specifications **IS SUSTAINED**
The Fourth Specifications **IS SUSTAINED**
The Seventh Specifications **IS SUSTAINED**
The Eighth Specifications **IS SUSTAINED**
The Ninth Specifications **IS SUSTAINED**

CONCLUSIONS WITH REGARD TO THE TENTH THROUGH EIGHTEENTH SPECIFICATIONS (GROSS INCOMPETENCE)

In the First through Ninth Specifications, the issue of negligence was addressed. The of assessment of negligence addresses the care and diligence exhibited by a physician. In the

[6]Patients C, E, and F were not considered by the Committee. Therefore none of the allegations set forth under these patients may form the basis for a finding of misconduct.

present specifications, the issue of incompetence is addressed. Here, the Committee is asked to assess the skill and expertise exhibited by a physician within the facts established by the State. As in the first set of specifications, the Committee must consider whether any deviations found are egregious in nature and hence gross departures from accepted standards.

As noted above, Factual Allegations A.4 and A.5 will not form the basis for any finding of misconduct. The Committee further finds that Allegations H.3, H.4 and I.3 do not rise to the level of gross incompetence. The Committee sustained the facts that Respondent did not have Patient H undergo an electrocardiogram or laboratory testing (Allegation H.3) and that he inappropriately prescribed Xanax and Valium to this patient (Allegation H.4). Nevertheless, the Committee finds that while an EKG and laboratory tests would have been desirable, the failure to perform them is not an egregious departure from standards. In reference to the prescriptions of Xanax and Valium, the Committee cites Respondent's note to wean the patient from the drugs. Consequently, the Committee cannot find a flagrant departure from standards. The Committee was split on the question of whether the substances provided to Patient G in the quantities provided rose to the level of gross incompetence. The majority was of the opinion that it did constitute a flagrant violation of accepted standards, while the minority view was that under all the facts and circumstances the prescribing pattern in this particular example was not a gross deviation from standards. Finally, as set forth above in reference to the issue of negligence, the Committee finds that under all the facts and circumstances, the provision of Amoxicillin to this particular patient who was known to be Penicillin allergic (Allegation I.3), while not appropriate management, does not constitute a gross departure from standards.

Moving to the other allegations, the Committee finds that Respondent's position with regard to histories and physical examinations represents both an egregious lack of care and diligence as well as an egregious violation of accepted standards of knowledge and expertise. The Committee finds that any physician practicing in this state must know the importance of initial and serial physical examinations and histories. To say, as Respondent did, that such information is unimportant demonstrates a lapse of the most fundamental and basic nature. Therefore, with regard to the first and second allegations under each patient, the Committee finds each allegation

to constitute a separate pattern of gross incompetence.

Likewise, with reference to Patients A, B, and D, the Committee finds that Respondent's management evidenced a clear failure of the skill and knowledge expected of a practitioner in this state. In so finding, the Committee cites the reasons set forth under the First through Ninth Specifications. A physician exhibiting appropriate levels of skill and expertise would not have treated these patients primarily with analgesics and anti-depressants. A physician exhibiting appropriate levels of skill and expertise would have fully explored other modalities for pain relief such as pain clinics and physical therapy. A physician exhibiting appropriate levels of skill and expertise would have recognized the potential for addiction, habituation and resultant manipulative activity of patients receiving analgesics on a long term basis. Respondent's failure to exhibit any of these qualities makes his behavior an extreme and flagrant deviation from accepted standards of skill and expertise, and hence gross incompetence.

Therefore, based upon Factual Allegations A.1, A.2, A.3, B.1, B.2, B.3, B.4, B.5, D.1, D.2, D.3, D.4, D.5, G.1, G.2, G.3, H.1, H.2, I.1 and I.2:

The Tenth Specifications **IS SUSTAINED**
The Eleventh Specifications **IS SUSTAINED**
The Thirteenth Specifications **IS SUSTAINED**
The Sixteenth Specifications **IS SUSTAINED**
The Seventeenth Specifications **IS SUSTAINED**
The Eighteenth Specifications **IS SUSTAINED**

CONCLUSIONS WITH REGARD TO THE NINETEENTH SPECIFICATION (NEGLIGENCE ON MORE THAN ONE OCCASION)

For the reasons set forth above, the lesser included offense of ordinary negligence is sustained for all charges except A.4 and A.5, which were not sustained. The Committee was unanimous in its conclusion that while Allegations G.3, H.3, H.4 and I.3 did not rise to the level of a gross departure from standards, the pattern in each allegation showed a clear failure of care and diligence. Hence negligence is established.

Therefore, based upon Factual Allegations A.1, A.2, A.3, B.1, B.2, B.3, B.4, B.5, D.1, D.2, D.3, D.4, D.5, G.1, G.2, G.3, H.1, H.2, H.3 H.4, I.1 I.2 and I.3:

The Nineteenth Specification **IS SUSTAINED**

CONCLUSIONS
WITH REGARD TO
THE TWENTIETH SPECIFICATION
(INCOMPETENCE ON MORE THAN ONE OCCASION)

For the reasons set forth above, the lesser included offense of ordinary incompetence is sustained for all charges except Allegations A.4 and A.5, which were not sustained. The Committee was unanimous in its conclusion that while Allegations G.3, H.3, H.4 and I.3 did not rise to the level of a gross departure from standards, the pattern in each allegation showed a clear failure of care and diligence. Hence negligence is established.

Therefore, based upon Factual Allegations A.1, A.2, A.3, B.1, B.2, B.3, B.4, B.5, D.1, D.2, D.3, D.4, D.5, G.1, G.2, G.3, H.1, H.2, H.3 H.4, I.1 I.2 and I.3:

The Twentieth Specification **IS SUSTAINED**

CONCLUSIONS
WITH REGARD TO
THE TWENTY FIRST SPECIFICATION
(VIOLATION OF PROBATION)

The Twenty-first Specification refers to the uncontroverted fact that Respondent was on probation for a period of thirty months. Violation of probation, is in and of itself, an act of professional misconduct. Since one of the provisions of the probation was that Respondent would commit no misconduct while he was on probation, the fact that he has been found to have committed misconduct constitutes a violation of probation. In other words, misconduct committed while a physician is on probation comprises a separate act of misconduct. Since many of the findings of misconduct in this proceeding, occurred during a time when Respondent was on probation, the Committee has no choice but to sustain this specification.

Therefore, based upon Factual Allegations A.1, A.2, A.3, B.1, B.2, B.3, B.4, B.5, D.1, D.2, D.3, D.4, D.5, G.1, G.2, G.3, H.1, H.2, H.3 H.4, I.1 I.2 and I.3:

The Twenty first Specification **IS SUSTAINED**

CONCLUSIONS
WITH REGARD TO
THE TWENTY SECOND THROUGH THIRTIETH SPECIFICATION
(FAILURE TO MAINTAIN PATIENT RECORDS)

This practitioner had virtually no records for these patients. Those that he had were entirely inadequate in that they did not include vital information necessary for Respondent or any successor in treatment to ascertain what Respondent did for a given patient and why. Based upon the standard set forth under the instructions in this proceeding, the Committee finds that each of the records was a violation of the established standards.

Therefore, based upon Factual Allegations A.1, A.2, A.3, B.1, B.2, B.3, B.4, B.5, D.1, D.2, D.3, D.4, D.5, G.1, G.2, G.3, H.1, H.2, I.1 and I.2:

The Twenty-Second Specifications **IS SUSTAINED**
The Twenty-Third Specifications **IS SUSTAINED**
The Twenty-Fifth Specifications **IS SUSTAINED**
The Twenty-Eighth Specifications **IS SUSTAINED**
The Twenty-Ninth Specifications **IS SUSTAINED**
The Thirtieth Specifications **IS SUSTAINED**

CONCLUSIONS
WITH REGARD TO
PENALTY

The Committee has sustained each of the Specifications, finding six acts of gross negligence and six acts of gross incompetence. In addition, numerous acts of negligence and incompetence on more than one occasion were sustained. Respondent in this case is a practitioner devoid of skill, knowledge and judgment. His initial training was less than complete, and he has obviously done nothing to improve that condition.

Respondent shows not the slightest inkling of his gross departures from accepted standards. He considers his practice to be mainstream and, with the exception of the necessity for improved records, Respondent will continue to practice in the manner set forth herein until he is stopped.

This case is particularly troubling since Respondent is using his ignorance about accepted standards to contribute to the ongoing drug problems which this society is trying to cope with. While there is certainly a need for long term analgesic treatment of some patients, this practitioner

was engaged in little more than a clearinghouse for the wants of known addicts and habitués. This Committee cannot allow a physician to use the authority of his license in this manner.

ORDER

Wherefore it is hereby **ORDERED;**

That the license to practice medicine in the State of New York of **ROBERT BINENFELD** be and is hereby **REVOKED**

Dated: Utica, New York

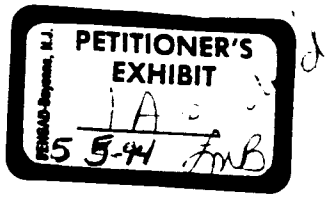
August 26, **1994**

Joseph G. Chanatry

JOSEPH G. CHANATRY, M.D., Chairperson

F. MICHAEL JACOBIUS, M.D.
MS. TRENA DeFRANCO

APPENDIX I



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

----------X

: AMENDED

IN THE MATTER : STATEMENT

OF : OF

ROBERT BINENFELD, M.D., : CHARGES

Respondent :

----------X

ROBERT BINENFELD, M.D., the Respondent, was authorized to practice medicine in New York State on June 22, 1967 by the issuance of license number 098887 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period of January 1, 1993 through December 31, 1994 with a current registration address of 4 Woodland Road, Monroe, New York 10950-4408.

FACTUAL ALLEGATIONS

A. Respondent, during a period beginning on approximately November 12, 1982 and continuing through at least approximately December 30, 1992, provided medical care to patient A (all patients are identified in Appendix A) at his office at 4

Woodland Road, Monroe, New York (hereinafter "Respondent's office") for tachycardia and complaints of headaches and other conditions. Respondent's care was deficient in the following respects:

1. Respondent failed to document and/or elicit adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent, during the above period, repeatedly and/or inappropriately prescribed controlled substances, including Vicodin, Vicodin ES, Valium, Talwin and Xanax. For example, Respondent prescribed approximately 530 tablets of Vicodin (Hydrocodone/APAP 5/500 mg.) between February 5, 1990 through October 1990 and approximately 1800 tablets of Vicodin ES between approximately October 5, 1990 and approximately December 30, 1992.

4. Respondent, on or about December 7, 1988, inappropriately prescribed Vicodin, Xanax and Decadron.

5. Respondent, on various occasions, treated Patient A with beta blockers such as Inderal and Corgard in the face of low blood pressure.

B. Respondent, during a period beginning on approximately June 20, 1980 and continuing through at least approximately January 4, 1993, provided medical care at Respondent's office to patient B who had a history of drug abuse for complaints of back pain and other conditions. Respondent's care was deficient in the following respects.

1. Respondent failed to document and/or elicit adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent, during the above period, repeatedly and/or inappropriately prescribed controlled substances, including Darvon, Percodan, Darvocet, Vicodin, Librium, Restoril, Xanax, and Talwin, and administered frequent Demerol 100-150 mg. intra-muscular injections.

4. Respondent failed to refer Patient B to pain management specialists and/or other appropriate medical specialists in a timely manner.

5. Respondent continued to prescribe controlled substances following an April 15, 1987 note that patient B was in a Methodone program, including but not limited to approximately 1,950 Vicodin tablets between approximately February 7, 1990 and approximately January 4, 1993 and approximately 550 Darvocet tablets between approximately May 27, 1991 and approximately September 3, 1992.

C. Respondent, during a period beginning on approximately January 30, 1989 and continuing through at least approximately April 12, 1993, provided medical care to patient C at Respondent's office for complaints of back pain and other conditions. Respondent's care was deficient in the following respects.

1. Respondent failed to elicit and/or document adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent, during the above period, repeatedly and/or inappropriately prescribed controlled substances such as Vicodin and Meprobamate. For example, Respondent prescribed approximately 2370 tablets of Vicodin during the period of approximately February 22, 1990 through approximately April 12, 1993.

D. Respondent, during a period beginning on approximately November 12, 1974 and continuing through at least approximately

April 8, 1993, provided medical care to patient D at Respondent's office, for weight loss, hypertension and other conditions. Respondent's care was deficient in the following respects.

1. Respondent failed to elicit and/or document adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent failed to have adequate medical testing done for patient D who was on anti-hypertensive medication from approximately May 1989 through approximately August 27, 1992.

4. Respondent, during the period of approximately April 25, 1986 and continuing through approximately April 8, 1993, repeatedly and/or inappropriately prescribed controlled substances for patient D including Vicodin, Demerol, Xanax, Valium, Halcion, Restoril, Fiorinal with Codeine, Tenuate, Ionamin and Fastin.

5. Respondent, during a period of January 25, 1987 through approximately November 20, 1989, at various times inappropriately prescribed amphetamine and/or amphetamine derivatives in combination with anti-hypertensive drugs.

E. Respondent, during a period beginning on approximately January 24, 1991 and continuing through at least approximately October 2, 1992, provided medical care to patient E at Respondent's office, for complaints of anxiety, difficulty in swallowing and other conditions. Respondent's care was deficient in the following respects.

1. Respondent failed to document and/or elicit adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent, during the period of approximately August 9, 1991 through approximately October 2, 1992, repeatedly prescribed Xanax and Halcion in combination.

F. Respondent, during a period beginning on approximately May 16, 1977 and continuing throughout at least approximately October 19, 1992, provided medical care to patient F at Respondent's office, for hypertension and other conditions. Respondent's care was deficient in the following respects.

1. Respondent failed to elicit and/or document adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent repeatedly and/or inappropriately prescribed controlled substances for patient F such as Tenuate, Fastin, Meprobamate, Valium, Xanax and Halcion.

4. Respondent, on or about October 21, 1988, prescribed ninety tablets of Valium 5 mg., three times daily. On approximately November 10, 1988, Respondent inappropriately prescribed Xanax 1 mg., three times daily.

G. Respondent, during a period beginning on approximately March 5, 1992 and continuing through at least approximately October 14, 1992, provided medical care to patient G at Respondent's office, for complaints of headaches, anxiety and other conditions. Respondent's care was deficient in the following respects:

1. Respondent failed to document and/or elicit adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent repeatedly and/or inappropriately prescribed controlled substances including Xanax, Valium, Talwin and Tylenol No. 3.

H. Respondent, during a period beginning on approximately February 27, 1992 and continuing through at least approximately October 8, 1992, provided medical care to patient H at Respondent's office, for complaints of palpitations, chronic fatigue, diarrhea, anxiety and other conditions. Respondent's care was deficient in the following respects:

1. Respondent failed to document and/or elicit adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent failed to have patient H undergo an electro-cardiogram or laboratory testing.

4. Respondent repeatedly and/or inappropriately prescribed the controlled substances Xanax and/or Valium.

I. Respondent, during a period beginning on approximately June 8, 1988 and continuing through at least September 18, 1988, provided pediatric care to patient I at Respondent's office. Respondent's care was deficient in the following respects:

1. Respondent failed to document and/or elicit adequate initial and interval histories.

2. Respondent failed to obtain and/or document adequate initial and interval physical examinations.

3. Respondent treated patient I with Amoxicillin despite the fact that patient I was allergic to Penicillin.

J. Respondent, on or about May 17, 1988, signed an Application for Consent Order which was duly executed by the Commissioner of Education on September 22, 1988, which contained probation terms (attached hereto as Appendix B) effective for 2 1/2 years beginning on approximately October 26, 1988, requiring Respondent to, among other things, conform fully to the professional standards of conduct imposed by law and his profession. Respondent violated these terms of probation in that the Petitioner alleges:

1. The facts in Factual Allegations "A" through "J", insofar as those Factual Allegations relate to the period of probation.

SPECIFICATION OF CHARGES

FIRST THROUGH NINTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(4) (McKinney Supp. 1993) by reason of his having practiced the profession with gross negligence on a particular occasion, in that Petitioner charges:

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

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

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

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

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

6. The facts in Paragraphs F and F.1, F.2, F.3, and/or F.4.

7. The facts in Paragraphs G and G.1, G.2, and/or G.3.

8. The facts in Paragraphs H and H.1, H.2, H.3 and/or H.4.

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

TENTH THROUGH EIGHTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION
WITH GROSS INCOMPETENCE

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(6) (McKinney Supp. 1993) by reason of his having practiced the profession with gross incompetence, in that Petitioner charges:

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

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

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

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

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

15. The facts in Paragraphs F and F.1, F.2, F.3, and/or F.4.

16. The facts in Paragraphs G and G.1, G.2, and/or G.3.

17. The facts in Paragraphs H and H.1, H.2, H.3 and/or H.4.

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

NINETEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(3) (McKinney Supp. 1993) by reason of his having practiced the profession with negligence on more than one occasion, in that the Petitioner charges that the Respondent committed at least two of the following:

19. The facts contained in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3, H and H.1, H and H.2, H and H.3, H and H.4, I and I.1, I and I.2 and/or I and I.3.

TWENTIETH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(5) (McKinney Supp. 1993) by reason of his having practiced the profession with incompetence on more than one occasion, in that the Petitioner

charges that the Respondent committed at least two of the following:

20. The facts contained in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3, H and H.1, H and H.2, H and H.3, H and H.4, I and I.1, I and I.2 and/or I and I.3.

TWENTY-FIRST SPECIFICATION

VIOLATING ANY TERM OF PROBATION IMPOSED PURSUANT TO §230 OF THE PUBLIC HEALTH LAW

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(29) (McKinney Supp. 1993) by reason of his having violated a term of probation imposed upon him pursuant to Section 230 of the Public Health Law, in that Petitioner charges:

21. The facts in Paragraphs J and J.1.

TWENTY-SECOND THROUGH THIRTIETH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD FOR EACH PATIENT WHICH ACCURATELY REFLECTS THE EVALUATION AND TREATMENT OF THE PATIENT

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1993) by reason of his having failed to maintain a record for each

patient which accurately reflects his evaluation and treatment of the patient, in that Petitioner charges:

22. The facts in Paragraphs A and A.1 and/or A.2.
23. The facts in Paragraphs B and B.1 and/or B.2.
24. The facts in Paragraphs C and C.1 and/or C.2.
25. The facts in Paragraphs D and D.1 and/or D.2.
26. The facts in Paragraphs E and E.1 and/or E.2.
27. The facts in Paragraphs F and F.1 and/or F.2.
28. The facts in Paragraphs G and G.1 and/or G.2.
29. The facts in Paragraphs H and H.1 and/or H.2.
30. The facts in Paragraphs I and I.I and/or I.2.

DATED: Albany, New York
March 25, 1994

Peter D. Van Buren

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

APPENDIX II

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

IN THE MATTER

OF

ROBERT BINENFELD, M.D.

RESPONDENT.

ANSWER TO CHARGES

By and through his attorney, Michael H. Sussman, Esq., respondent hereby denies each and every charge against him as contained in the Statement of Charges dated January 25, 1994 and specifically denies that he provided deficient care to any patient listed in Attachment A to said charges; that he engaged in the practice of medicine in a grossly negligent manner; that he practiced professionally in a grossly negligent manner; that he engaged in negligent or grossly negligent practice on more than one occasion; that he practiced incompetently on more than one occasion; that he violated **any term** of his probation or that he failed to maintain records showing the course of treatment for each of his patients.

Respectfully submitted,

MICHAEL H. SUSSMAN

SUSSMAN LAW OFFICES
25 Main Street
Goshen, New York 10924
(914)-294-3991
Counsel for Respondent

Dated: February 7, 1994