STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Dennis P. Whalen
Executive Deputy Commissioner

November 20, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ronal M. Levy, M.D.
1331 N. Forest
Suite 120
Williamsville, NY 14221

Michael Hiser, Esq.
NYS Department of Health
ESP Corning Tower - Room 2509
Albany, NY 12237

Jeffrey A. Lazroe, Esq.
135 Delaware Avenue
Suite 101
Buffalo, NY 14202

RE: In the Matter of Ronald M. Levy, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-279) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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), "the 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 penalties **other than suspension or revocation** 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be

sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

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

Sincerely,

Tyrone Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

COPY

IN THE MATTER

OF

RONALD M. LEVY, M.D.

DETERMINATION

AND

ORDER

BPMC #98-279

MS. TRENA DeFRANCO, Chairperson, ROBERT KLUGMAN, M.D., and **MARGARET McALOON, M.D.,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **TIMOTHY J. TROST, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	March 31, 1998
Answer:	April 3, 1998
Pre-Hearing Conference:	April 14, 1998
Hearing Dates:	May 6, 1998 May 7, 1998 June 17, 1998 July 22, 1998 August 19, 1998 August 26, 1998

Committee member Margaret McAloon, M.D. was absent on June 17, 1998 and Committee member Ms. Trena DeFranco was absent on August 26, 1998. The Affirmation of each is attached hereto.

Place of Hearing: Quality Inn at the airport
Buffalo, New York and

Radisson at the airport
Buffalo, New York

Date of Deliberation: September 23, 1998

Petitioner appeared by: Henry M. Greenberg, General Counsel
NYS Department of Health
BY: Michael A. Hiser, Esq., of Counsel
NYS Department of Health
Corning Tower Room 2509
Empire State Plaza
Albany, New York 12237

Respondent appeared by: Jeffrey A. Lazroe, Esq.
135 Delaware Avenue
Suite 101
Buffalo, New York 14202

WITNESSES

For the Petitioner:
Deborah Diggins
V.C.'s mother
Neil J. McKinnon, Esq.
Patient B
Patient C
Patient D
Melvin Pisetzner, M.D.
Ronald M. Levy, Respondent
Patient A

For the Respondent:
Jessie A. Levy
Ronald M. Levy, Respondent
G.P.
A.L.
Patient E

STATEMENT OF CHARGES

The Department of Health, Office of Professional Medical Conduct (Petitioner) has charged Respondent, Ronald M. Levy, M.D., (Respondent), a psychiatrist, with 26 specifications of professional misconduct, including fraudulent practice, moral unfitness, exercising undue influence on patients for his own financial gain, wilfully making and filing a false report, gross negligence and gross incompetence, negligence and incompetence on more than one occasion, wilful or grossly negligent failure to comply with state laws and regulations regarding the practice of medicine, failure to provide records on demand, failure to maintain accurate records, and violating a condition imposed on him pursuant to Section 230 of the Public Health Law.

A copy of the Statement of Charges is attached to this Determination and Order.

FINDINGS OF FACT - RESPONDENT

1. Ronald M. Levy, the Respondent, was licensed as a physician in New York State on June 23, 1969 by the issuance of license number 103809 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice as a physician for the period January 1, 1997 through October 1, 1999 with an address of 1331 N. Forest, Suite 120, Williamsville, New York 14221. (Pet. Ex. 1, by stipulation)

2. Respondent received his medical degree from the State University of New York at Buffalo in 1967.

   He performed psychiatric residency at Manhattan VA Hospital, Harvard General (UCLA), became board certified in Adult Psychiatry in 1978 and board certified in Child Psychiatry in 1980. Respondent started his private practice in Psychiatry in the Buffalo, New York area in 1978 and has been in continuous private practice since.

FINDINGS OF FACT - CREDIBILITY

3. Petitioner produced Melvin Pisetzner, M.D. to testify both as to the accepted standard of care and how Respondent's medical care fell below the generally accepted standard. Dr. Pisetzner is a well trained and experienced practitioner with appropriate Board certification. (Ex. 31) He testified directly, completely, and in an informed fashion regarding the Respondent's improper prescribing practices for Patients A, B, D and E, and as to the multiple breaches of proper therapeutic boundaries that Respondent engaged in with his patients and staff (though often times, patients and staff were one and the same in the Respondent's office). And he testified regarding the poor--in some instances, non-existent--documentation practices used by Respondent.

4. No one appeared to give objective corroboration to the Respondent's assertions that his care was appropriate. To the extent that there is a credibility question between Dr. Pisetzner and the Respondent, Dr. Pisetzner's testimony was viewed as more credible, and was given greater weight. This is particularly so given the lack of credibility that permeated Respondent's testimony on the medical and factual issues.

Credibility of Respondent's Main Witnesses

5. Respondent's main witnesses -- (himself and Mrs. Levy) testified evasively, in a manner that was at the same time contradictory and devoid of corroboration. Both were viewed as having less credibility, and their testimony was given less weight, than any other witnesses' competing testimony. Repeatedly, each sought to evade questions, or simply told increasingly incredible stories to explain the Respondent's conduct. Several examples are cited as to both Respondent and his wife:

Respondent's lack of credibility

6. Dr. Levy's refusal to testify forthrightly was demonstrated when he was asked about his loss of privileges at Bry-Lin Hospital. Respondent first denied, then admitted that he had been informed of his suspension by Bry-Lin Hospital in April and May of 1993. (T. 401-404) He next denied that he knew "where he stood with" Bry-Lin regarding his privileges as of January 1, 1995 (T. 405); as to "actually what had taken place and what my relationship was with them I had no idea") (T. 406). He then admitted that, as of July 6, 1994 -- the day he stood before a panel at the hospital and resigned -- the status of his privileges was no longer in question. (T. 408)

7. Respondent confirmed that he was the only licensed physician in his office. Despite being asked three times, however, he refused to provide an answer as to whether he was ultimately responsible for the financial transactions in his office.[1] (FN-1)

8. Dr. Levy testified that there was a clear policy against socialization between staff and patients at his office, and that he and his wife were considered staff. When asked how his clear office policy could be squared with Patient A's visits to his home to watch television, have snacks, eat dinner, and his taking car rides with the patient, Respondent changed his story and said the problem "was really with romantic involvement and dates". (T. 726-27)

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[1]FN-1 Q. Don't you agree that you have ultimate responsibility for the funds coming into your office and the way they are paid out?
A. Well, I would earn the money, but --
Q. That's a yes or no answer, Doctor. Yes or no, do you have ultimate responsibility for the financial transactions that your office participated in?
A. I delegated that responsibility to Jessie.
Q. Doctor yes or no, do you have ultimate responsibility for the financial transactions that your office participated in?
A. How do you mean that Mr. Hiser?
Q. In the usual sense of the English language, Doctor.
A. Well, you mean am I responsible ultimately if something goes wrong or am I the person who okayed the things as they went out?
(Respondent, T. 735-736)

9. Respondent attempted to evade the contradiction suggesting that it was appropriate to have group therapy sessions at the psychiatrist's home, although Patient A's visits were not of that nature. (T. 728-29)

10. Respondent testified at length about the "confession" that Patient A supposedly made to him shortly after Respondent left the hospital in May 1994. This "confession" was of illegal drug purchases and drug use by Patient A in the company of Patient B, who was Respondent's secretary. The "confession" also reported on Patient A's "infatuation" with Patient B. By the testimony of both Respondent (and his wife) this was deemed to be a serious, highly significant event in the ten year course of treatment of Patient A, as it not only provided an admission of illegal drug purchasing and use, but also a breach of the policy against dating/socializing between staff and patients. Respondent testified that this was such a serious mater that it lead, within two or three visits with Patient A, to the termination of his ten years of treatment. Yet Respondent could offer no real explanation why he documented nothing of the "confession", the drug purchase, the drug use, the infatuation...nothing.

11. Respondent also clearly sought to tie in the "confession" with an incident about Patient A's guns; he later admitted that they must have occurred at different times, since the "gun incident" was during Respondent's hospitalization. (T. 722-725)

12. Respondent admitted that he called former Patient VC from Patient A's house and that it was "a long phone call", "possibly" four hours. (T. 747) He said that he did this to tell her that he was recovering from his injuries. (T. 747) It was not until questioning from the panel, however, that Respondent embellished the story to say that he had only been on the phone a short time with VC, and that Patient A had taken up most of the time with a poetry discussion with VC. (T. 786) (In his rebuttal testimony, Patient A credibly denied any great interest in poetry). (T. 949)

13. In attempting to describe his rationale for prescribing Xanax and Valium to Patient D, Dr. Levy first indicated that "I don't prescribe two benzodiazepines at the same time". (T. 777) He then said that there may be occasions when two are given at the same time, but the patients are given instructions to take one in lieu of the other. (T. 777)

When confronted with his own records that showed prescriptions for Xanax and Valium both at four times a day, he speculated that maybe a patient took one for a week, then another for a week. (T. 781) Again, he said that "we may have prescribed more medicine for him", expecting that he would stop taking one of the medicines, and the other would have to last him the whole month. None of this is at all documented in Dr. Levy's records. The Respondent again contradicted himself by giving as yet another reason why Patient D was receiving prescriptions for both Xanax and Valium at the same time, the fact that Patient D had strained muscles. (T. 891-93)

14. The Respondent appeared generally less credible throughout the proceedings. His answers were vague, he did not recall recent events or his wife's recent testimony, yet he gave very specific details about other things (old office address and layout). His testimony that Patient A and V.C. discussed poetry for four hours on the telephone while all he did was talk for a few minutes was completely unbelievable. He minimized the importance of many seemingly inappropriate things that he did. He took no responsibility for his own actions or for the running of his office. His demeanor was sad and depressed (perhaps disoriented) but he demonstrated no remorse or sense that he did anything wrong. Everything was rationalized and poor judgment was indicated. Other credible witnesses gave testimony supporting the view that the Respondent was not truthful.

Jesse Levy's lack of credibility

15. Mrs. Levy's testimony consisted of uncorroborated allegations neatly tailored to respond to the many questions raised of her husband's conduct in the case. Her testimony was directly contradicted by other witnesses -- often those called on behalf of Dr. Levy. In several instances she went so far to offer self-serving details in support of the Respondent, however, clear inconsistencies were revealed. These demonstrate that she lacks credibility.

16. She testified that Patient B stole checks from her son's "educational" checking account, forged his name, and stole money.[2] (FN-2) Her story unraveled when she tried to explain how this all could have occurred. She tried to have the Committee believe that the checks were in her purse, blank, but pre-signed by her son, and that there was nothing at all unusual about this. (T. 595-96, 602) Mrs. Levy also absolutely denied that the "educational" account was ever used for business purposes prior to May 1994, when she did use it to pay Patient B for payroll. In seeking to label Patient B as a thief who would stoop so low as to steal from an "educational" account, she "remembered" a conversation with her son wherein she told him, in December of 1993, that "Josh, I know it's Christmas but you overdid it a little on the checking account. Christmas you go haywire but there is a limit." (T. 592)

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[2]This issue became relevant after Patient B had testified about the strange methods by which she was paid by Respondent -- first personal checks, then a payroll service, then a combination of checks being given over to her by Respondent/Mrs. Levy together with checks drawn on a checking account in the name of Joshua Levy (T. 148-150). Jesse Levy tried to rebut Patient B's testimony by alleging theft, forgery, and deceit by Patient B.

17. The evidence submitted by the Petitioner in Exhibits 39, 40, and 41 conclusively showed that Mrs. Levy's statements were not true. The "education" account was used by Mrs. Levy for business purposes from August of 1993 onward, just as Patient B said, including to pay employee/Patient B, and employee/Patient GP, and office rental, among others. Mrs. Levy's "remembered" conversation with her son could not have occurred in the way she said. That she offered such demonstrably false detail shows the lengths she was willing to go in attacking Patient B.

18. Mrs. Levy testified that she talked to Patient B when she was in Bry-Lin Hospital, and that she offered her support as follows: "Well, I said, Patient B, you have to do what people at Bry-Lin tell you to do and you'll recover and you'll be able to go home." (T. 479) Mrs. Levy also denied that Respondent talked to Patient B at that time; the reason was that "Dr. Levy was no longer her treating physician." (T. 479) Both Respondent and his current secretary, Amy Levy, contradicted Mrs. Levy's testimony -- and both corroborated portions of Patient B's testimony that (1) the patient spoke to both Respondent and his wife, and that (2) she was urged to sign herself out against medical advice. (T. 172-4)[3] (FN-3)

19. Mrs. Levy testified that Patient B was the one who wanted to find an attorney to prepare an affidavit or other document regarding her experience at Bry-Lin. (T. 518-21) According to Patient B, she was intimidated and coerced by both Dr. Levy and his wife to sign the affidavit. That it was Mrs. Levy's idea that Patient B see Mr. Lazroe was corroborated by Amy Levy, who said of that conversation: "Jesse said, 'I would like you to tell my lawyer this' and I guess they went down to your office." (T. 842)

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[3]Amy Levy said that Mrs. Levy told Patient B, "If you don't want to be there, sign yourself out" (T. 840); Dr. Levy said that he did speak to Patient B. (T. 691-692)

20. Mrs. Levy testified that Patient A "was not a patient in formal therapy" when Dr. Levy went into the hospital (T. 556) -- yet the record clearly shows that Patient A had been continuously receiving therapy up until ten days before the hospitalization, and he was continued on medication by the Respondent during and afterwards. (Ex. 12, p. 315)

21. Like the Respondent, Mrs. Levy went into great detail about the so-called "confession" of Patient A regarding his alleged drug use with Patient B, his inappropriate relationship with Patient B, etc. (T. 509-517) Despite the final entry of June 21 (Ex. 12, p. 322) being made by her, Mrs. Levy could offer no real explanation of why this highly significant event would not be documented. (T. 556-62)

22. Finally, Mrs. Levy described having seen former Patient VC on only two occasions in passing for the past few years -- but on cross examination she suddenly recalled a late night telephone call from VC, who sounded "drugged" and was in "acute distress", which led Mrs. Levy to drive to VC's apartment in Lewiston, NY, and: "I knocked on her door, she wasn't there, I left." (T. 552-553) (Respondent testified to having never been apprised of this contact). (T. 749)

23. By Mrs. Levy's testimony, she apparently has better recollection of seeing someone in passing at a peach festival than responding to a telephone call out of the blue from the same person who was in "acute distress", sounding "drugged" and which lead Mrs. Levy to make an abortive visit to the person's house.

24. Generally, Jessie Levy's answers were evasive and tangential. Her demeanor seemed untruthful, manipulative and vindictive. Too many relevant questions were answered with "I don't know".

25. These examples highlight that, where testimony conflicts with the versions of both Respondent and his wife were not credible.

PATIENT A AND PATIENT B CREDIBILITY

26. Patient A answered questions fully, but did not volunteer extra information. He was measured in his response, correcting information to the extent he felt it was required, without exaggeration. (Confirming part of the information but denying the part which he felt was not true). His reaction to Dr. Levy's conduct rings true.

27. Patient B testified in a straight forward fashion, readily admitted her crimes and addictions and,. thus, had no reason to lie about the Dilaudid prescription. She was sincere in describing her motivation; i.e. threat of losing her daughter. She exhibited a tendency to exaggerate but not to fabricate.

28. Patients A and B were forthright about giving Dr. Levy credit for past help, and both described a declining pattern of professionalism. Both offered telling details -- Patient A, for example, explained that he would never consider moving to Colorado since that would mean leaving his son who was conceived only after much difficulty. Patient B testified of Dr. Levy's pain when he asked her to fill a prescription for Dilaudid -- which came on the same day (6/21/94) he underwent additional surgery. Importantly, Patient B admitted to having forged Dr. Levy's name on certain prescriptions for Dexedrine -- but not for Dilaudid. She also testified precisely about the office finances. Her accuracy on that point is to be contrasted with what can only be called Mrs. Levy's misrepresentations.

29. However fragile, dependent or vulnerable Patients A and B were in the past, their testimony was much more credible than either Respondent or Mrs. Levy.

CREDIBILITY OF PATIENTS C, D, E

30. Patient C seemed credible, straight forward, measured in response and not inflammatory. She contradicted the testimony of Respondent and Jessie Levy about telephone calls to Patient B and Jessie Levy's involvement in the release of records and the affidavit regarding Dr. Levy.

31. Patient D seemed credible and straight forward.

32. Patient E was probably credible but appeared judgmental. She had little to offer except that Patient B was drunk one day.

FINDINGS OF FACT - PATIENT A

33. Respondent provided medical care to Patient A, a male born 4/9/52, from on or about May 7, 1984, through on or about July 1, 1994. Patient A was treated at Respondent's office at 6325 Sheridan Drive, Williamsville, New York 14221-4801 (hereafter "the office"), and at other health care facilities, including Bry-Lin Hospital, Inc., 1263 Delaware Avenue, Buffalo, New York 14209 (hereafter, "Bry-Lin Hospital"). Patient A was 32 years old when first treated by Respondent. (Pet. Exs. 12, p. 15; Ex. 14)

Allegations A.1 and A.2 -- Prescribing of Xanax

34. Respondent, beginning in or about July 1984, and continuing through approximately June 1994, prescribed Xanax to Patient A. The amount of Xanax prescribed varied from 3 to 6 mg. per day. (Ex. 12) Xanax is a benzodiazepine. It is used for the primary treatment of anxiety and panic disorder. It has two primary side effects -- sedation and addiction. When someone uses Xanax over a period of time, the patient develops a physical dependence. (Pisetzner, T. 281-82) Contraindications for use of Xanax include use by patients who have a history of substance abuse or addiction. (Pisetzner, T. 283)

35. Between 1984 and June of 1991, Patient A used alcohol on a fairly routine basis, including at work, after work, and on the weekends. Patient A stopped drinking in June 1991 after drinking to excess and attending a concert at which he injured himself due to excessive drinking of alcohol. (Ex. 12, pp. 21, 25 (drinking during holidays), 86 (AA discussion with patient), 163, 173; Patient A, T. 31, 88-89)

36. During the times he was treated by Respondent, Patient A developed a tolerance for Xanax. He consistently took daily amounts between 3 and 6 mgs/day. In March, 1993, Patient A was admitted as an inpatient to Bry-Lin Hospital to be weaned off Xanax. He was not fully successful in this. (Ex. 12, pp. 60, 61, 71, 78-93, 103-104, 111, 146-47, 224-25; Ex. 14, pp. 29-32)

Allegation A.4 --Violation of therapeutic boundaries

37. In May of 1994, Respondent was injured when he fell at home. He remained in the hospital from May 16 through 26, 1994. (Stipulation of July 22, 1998, T. 421-422)

a. Requesting that Patient A provide transportation for Respondent on multiple occasions

38. Patient A visited Respondent in the hospital on several occasions. Immediately after Respondent's discharge from the hospital, Respondent was not able to drive. During this time, Respondent allowed Patient A to give him rides in the patient's car so that Respondent could run errands. This was done on more than one occasion. (Patient A, T. 38-39, 43-44, Respondent, T. 701-02, 760)

b. Allowing Patient A to stay overnight at Respondent's home

39. During the time immediately after Respondent's discharge from the hospital, Patient A also came to the Respondent's house. This happened on more than one occasion. These visits were social in nature, not a forum for therapy to occur, and no therapy occurred. Instead, Patient A watched movies and tapes with the Respondent and his family, ate snacks, etc. Patient A spent one entire night at Respondent's house. (Patient A, T. 44-47; Jessie Levy, T. 505-07)

c. Divulging extensive information to Patient A relating to Respondent's personal life

40. During the time that Respondent was with Patient A in his car and in the Respondent's house, Respondent shared confidences with the patient about the Respondent's personal life including Respondent's own marital difficulties. In Patient A's view, these were "friendship kinds of things, just guy things." These conversations included references by Respondent to "VC", a person identified by Respondent as his girlfriend, and also to his wife. (Patient A, T. 39-48)

d. Staying overnight at Patient A's house on or about May 30, 1994

41. On or about May 30, 1994, Respondent telephoned Patient A. He asked Patient A to come to Respondent's house, pick him up, and take him to Patient A's house. The reason this was done is that Respondent wanted to use Patient A's phone to call VC. (Patient A, T. 48-49)

42. Respondent spent that evening at Patient A's house. He was observed there the next morning by Patient A's ex-wife, "DD", sitting on the couch, and looking disheveled and "out of it". DD was upset that Respondent was there and complained to Patient A about it. (DD, T. 97-98)

e. Using Patient A's telephone on May 29 and 30 to conduct lengthy telephone calls with Respondent's former patient/girlfriend in the presence of Patient A

43. During the time that Respondent stayed at Patient A's house, Respondent made a number of telephone calls to a former patient named VC. VC, a young woman then approximately 18 years old, had been a patient of Respondent's several years earlier. Respondent had maintained contact with VC after she ceased being a patient of his. Respondent described VC to Patient A as Respondent's girlfriend. (Patient A, T. 40-42, 49-54; "JC" T. 102)

44. In May of 1994, VC was living in Boulder, Colorado. When she learned that Respondent had been hospitalized, she came to Buffalo from Boulder to visit him in the hospital. A few days after his discharge, Respondent called VC from Patient A's house for personal reasons. The telephone calls were conducted in Patient A's presence on a speaker phone, and were of great length -- one in excess of four hours. During the telephone calls, Respondent spoke to VC about personal matters. (Patient A, T. 47-54; "JC", T. 106-107, 109-110; Ex. 15)

f. Repeatedly requesting and/or allowing Patient A to act as a contact person to arrange telephone calls between the Respondent and the Respondent's former patient/girlfriend

45. After these initial contacts by telephone were made by the Respondent with VC, there were many other occasions when Respondent sought to involve Patient A in his relationship with VC. This was done by Respondent using Patient A as a go-between to contact VC and tell her if it was "safe" to call Respondent, i.e., that she could call without being detected by, among others, Respondent's wife. Patient A thus contacted VC on numerous occasions usually of very short length, to leave a message that was essentially, "Hi, this is Patient A; call Ron". (Patient A, T. 54-55; Ex. 15)

g. Failing to reimburse Patient A for the numerous and lengthy personal long-distance phone calls made by Respondent to his girlfriend from Patient A's house, despite Patient A's request for reimbursement

46. The numerous long distance phone calls made by Respondent from Patient A's house caused Patient A to incur substantial long distance tolls. Patient A was assured by Respondent that these charges would be reimbursed. Respondent failed to make that reimbursement. (Patient A, T. 55; Ex. 15)

h. Suggesting that Patient A become romantically involved with Respondent's then secretary/patient, further identified below as "Patient B".

47. During the latter part of Patient A's treatment, Respondent suggested to Patient A that he should date a secretary/receptionist in their office. The secretary/receptionist was also a current or former patient of Respondent. Patient A did seek to do so, and eventually developed a friendship with the secretary/receptionist. Patient A also had discussions with Respondent about different aspects of the personal life of the secretary/receptionist, who is further identified in this matter as "Patient B". (Patient A, T. 57)

Allegation A.5 -- Documentation of the circumstances under which Patient A ceased being a patient of Respondent on or about June 20, 1994

48. Patient A became concerned with his continued treatment by Respondent in mid-June, 1994. One reason for this was that Patient A was informed by Patient B that Respondent had billed Workers Compensation for therapy that had not in fact been tendered. Patient A was told by his attorney, Neil McKinnon, that Patient A would be responsible to pay those amounts back to Workers Compensation should he receive a settlement in his pending (and unrelated) personal injury litigation. A second reason was that Respondent informed Patient A that their relationship would need to change -- that Patient A could no longer call Respondent "Ron", for example. This distressed and confused Patient A since he had become (he thought) good friends with Respondent, had been invited over to his house for dinner, etc. (Patient A, T. 58-63, 953-55, Neil McKinnon, T. 118, 125-6)

49. Given these concerns, Patient A decided to not return to Respondent for treatment. He did this despite receiving phone calls from Respondent's wife and Patient B asking him to comeback. (Patient A, T. 63-64)

50. Respondent's medical record for Patient A states only that Respondent had twice sent Patient A for a drug screen, that Patient A refused, and that because of this, Respondent would no longer treat Patient A. (Ex. 12, p. 322)

Allegation A.6 -- Documentation of rationale for "discharging" Patient A from treatment

51. Respondent's medical record for Patient A does not document the information required by accepted standards of practice, including what brought the patient in to treatment, what the problems were during treatment, what the treatment was, and whether the recommendations for either ongoing treatment or not were made. (Pisetzner, T. 303)

FINDINGS OF FACT - PATIENT B

52. Respondent treated Patient B, a female patient born 7/11/64, from on or about February 16, 1988 through on or about April, 1993 at Respondent's office and at other health care facilities, including Bry-Lin Hospital. Patient B was 23 years old when first seen by Respondent. (Exs. 16, 17, 19, 20)

Allegations B.1 and B.2 -- Prescribing of Benzodiazepines

53. Patient B began in treatment with Respondent in February 1988. At her first visit, she identified a past history of hospitalizations for alcohol abuse (1984, 1986, 1987), that she had a previous history of alcohol abuse, and that she was going to Alcoholics Anonymous meetings to avoid alcohol. (Ex. 16, pp. 2, 6, 15)

54. Respondent, beginning in or about February 1988, and continuing through at least April 1993, prescribed Xanax to Patient B. Xanax is a benzodiazepine. The amount of Xanax prescribed varied. It is used for treatment of anxiety and panic disorder. Xanax should not be used by patients who have a history of substance abuse or indications of ongoing problems with substance abuse. (Pisetzner, T. 283)

55. Respondent also prescribed Valium to Patient B, often at the same time as Xanax was prescribed. (Ex. 16, pp. 79, 84, 113, 115, 122; also Ex. 18 (prescriptions in patients possession when admitted to Bry-Lin Hospital in April 1993). For example, in 1992, she was on 50 mg of Valium a day, and 6 mg of Xanax. These are "super substantial" amounts. (Pisetzner, T. 311)

56. During the course of her therapy, Patient B used alcohol on a recurring basis, including in September of 1990 when she was admitted to Bry-Lin Hospital for detoxification. (Ex. 16, pp. 55-59)

57. During the time she was treated by Respondent, Patient B was also admitted to Bry-Lin Hospital in April 1993 after taking an overdose of Valium. (Ex. 17)

Allegation B.4 -- Therapeutic Boundaries (Inappropriate Employment)

58. In early 1992 through the middle part of 1992, Patient B was certified as being disabled to perform her work at her then employment, People Incorporated, due to psychiatric problems. The certifications were submitted by Respondent. Between May and July, 1992, the certifications were put in on a routine basis by Respondent. Patient B was deemed by Respondent to be totally disabled from her ability to perform her work at People Incorporated. (Ex. 16, pp. 102-105)

59. Nonetheless, In July, 1992, Patient B was hired by Respondent to work in his office. At the time, she was still receiving psychiatric treatment from him in the form of therapy and medication. (Patient B, T. 141-44; Respondent, T. 683-84; Ex. 16, p. 107)

Allegation B.4(b) -- Suggesting that Patient B become involved with Patient A and other male patients

60. During the course of her employment, Respondent discussed with Patient B on several occasions that she should become involved with certain patients. Patient A was one patient that Respondent urged Patient B to go out with. Another patient that Respondent urged Patient B to date was Patient R.N. The reason given by Respondent was that it would be good for the self-esteem or the confidence of these patients. (Patient B, T. 151-154)

Allegation B(4)(c) -- repeatedly contacting Patient B at her home

61. During the time that Patient B worked for Respondent, Respondent repeatedly contacted Patient B at her home at other than usual and customary office hours. The reason he did this was to discuss problems with his marriage, and other personal matters. On one occasion, Respondent called at least fifteen times on one day for Patient B. Mrs. Levy also called often. (Patient B, 7, 155-158; Patient B's mother, a.k.a., "Patient C", T. 248-251)

Allegation B.5 -- Writing prescriptions for controlled substances in names of Patients B and/or C

62. Patient C, Patient B's mother, was never a patient of Respondent. ("Patient C", T. 249)

63. On several occasions between July 1, 1992 and July 1, 1994, Respondent wrote triplicate prescriptions for controlled substances in the names of Patient B and Patient C. (Patient B, T. 159-165; Exs. 22, 25)

64. On or about January 3, 1994, Respondent signed a prescription for Valium in the name of Patient C. He instructed Patient B to fill the prescription for Valium and to bring at least part of the medication to him for his use. (Patient B, T. 162-5)

65. On or about June 21, 1994, Respondent was still suffering the effects of his injuries for which he was hospitalized in May 1994, and, in fact, underwent an additional surgical procedure on or about June 21, 1994. He was receiving pain medications during that time from his own physicians. He had received Dilaudid as a prescription for pain relief while he was hospitalized. (Respondent, T. 750-751; Stipulation of July 22, 1998)

66. On or about June 21, 1994, Respondent requested or ordered Patient B to write a prescription for Dilaudid and to sign the prescription in Respondent's name for that medication. Respondent requested that Patient B bring that medication back to him for his use. (Patient B, T. 160-162; Ex. 22)

67. This was not the first time that Respondent had written a prescription in the name of a patient who was not physically present and then asked another patient to fill the prescription and bring the medication back to him. He did this in the Spring of 1990 when he wrote a prescription in the name of "S.S." for Synthroid and then gave the medication to Patient "A.A." and asked that she fill the prescription for him and then return and bring the medication to him. (Respondent, T. 756-60)

Allegation B.6 -- Contacting Patient B during Patient B's hospitalization at Bry-Lin Hospital in April 1993

68. Patient B was hospitalized at Bry-Lin Hospital from on or about April 12, 1993 through April 20, 1993. She was admitted under the care of Respondent. On April 15, 1993, Respondent's care was transferred to another psychiatrist. (Ex. 17)

69. Thereafter, Respondent personally and through agents spoke to Patient B during Patient B's hospitalization. Respondent personally and through his wife suggested that Patient B sign herself out of the hospital, i.e., against medical advice. Respondent, at that time, was no longer the patient's treating psychiatrist. (Patient B, T. 172-173; A.L., T. 864-65)

70. Patient B reported this at the time to a Bry-Lin Hospital representative, who noted this in her record. (Ex. 17, pp. 34-36)

Allegation B.7 -- Continued employment after Patient's discharge from Bry-Lin

71. Patient B's psychiatric condition was serious enough as of April 12, 1993, that she was deemed suicidal and had taken an overdose of Valium. In her possession were two prescriptions, signed by Respondent, for benzodiazepines. She was recommended for outpatient treatment following her discharge on or about April 22, 1993. (Ex. 17, pp. 1-6)

72. Despite the patient's psychiatric condition which required the hospitalizations and recommended outpatient treatment noted above, Respondent continued to employ her in his office after her discharge, beginning as early as May, 1993. (Patient B, T. 176; Jesse Levy, T. 486-7)

Allegation B.8 -- Intimidating and coercing Patient B into signing an affidavit

73. During Patient B's admission at Bry-Lin, she provided great detail regarding the Respondent's prescribing practice, i.e., that the patient was allowed to fill out signed prescriptions, and also that the Respondent was concerned about the patient having information about his relationship with V.C. These assertions by Patient B resulted in the Respondent losing his privileges at Bry-Lin Hospital. (Ex. 17, pp. 34-36)

74. Thereafter, Respondent personally and through his wife, intimidated and coerced Patient B into signing an affidavit that retracted the patient's assertions made regarding Respondent during her hospitalization. Pressure was brought to bear on Patient B in the form of threatening her ability to retain custody of her daughter if she would not sign such a statement. The recommendation that the patient go to the office of Respondent's lawyer, Jeffrey Lazroe, was made by Mrs. Levy. Mrs. Levy was the person who was very interested

in having Patient B sign such a statement. She made a number of phone calls to Patient B's mother about this matter, and eventually came to Patient B's house to pick her up and physically transport her to Mr. Lazroe's office for this purpose. (Patient B, T. 176-180; "Patient C", T. 253-254; A.L., T. 842; Ex. 34)

75. The language of the affidavit, including reference to "utter fabrication", was not Patient B's language (Patient B, T. 181-182), Patient B signed the affidavit because she was afraid that Dr. Levy could have her daughter taken away.

Allegation B.9 -- Continued providing of treatment and/or medications after purported cessation of treatment

76. Respondent, between approximately May 1993 and July 1994, continued to provide medications to Patient B. Respondent maintained no medical records of such treatments and/or medications. (Patient B, T. 176)

Allegation B.10 -- Intimidating and coercing Patient B into signing a statement which indicated Patient B did not want her medical records released

77. In early 1994, the New York State Department of Health requested that Respondent provide a copy of Patient B's medical records. In response, Respondent personally or through agents, including his wife, intimidated and coerced Patient B into signing a statement which indicated the patient did not want her medical records released. (Patient B, T. 182-185; Ex. 23)

78. The language of the statute indicating that "doctor-patient confidentiality is a vital part of therapy" is not language that it is likely Patient B would have created on her own without any assistance from Respondent, Respondent's wife, or Respondent's attorney.

79. The purported letter from Patient B was dated "January 1992," though it did not appear in Respondent's record for Patient B at that time. Neither were there any reference in Respondent's record for Patient B at that time regarding any questions about release of records. The "January 1992" date was a misrepresentation, added to deceive the persons who had requested the records. (Patient B; T. 185)

FINDINGS OF FACT - PATIENT C

80. Respondent, on or about January 3, 1994, signed a triplicate prescription for a 30 day supply of Valium for a person identified as "Patient C", which was the name of Patient B's mother. (Ex. 25, Patient B, T. 162-65; Stipulation, T. 385)

81. "Patient C" (Patient B's mother) was never a patient of Dr. Levy's. (Ex. 27; "Patient C", T. 249)

82. The prescription was fraudulent, as "Patient C" was never a patient of the Respondent, and Respondent knew this. (Patient B, T. 162-165)

83. Respondent asked Patient B to fill the prescription, and to then give the medication to the Respondent. (Patient B, T. 112-65)

FINDINGS OF FACT - PATIENT D

84. Respondent provided medical care to Patient D, a male patient born 4/15/47, from on or about November 1, 1987, through on or about July 1, 1994. Patient D was treated at Respondent's office and at other health care facilities including Bry-Lin Hospital. Patient D was 40 years old when first seen by Respondent. (Exs. 27, 28)

85. Respondent, beginning in or about November 1987, and continuing through approximately April 1994, prescribed Xanax to Patient D. The amount of Xanax prescribed ranged up to 8 mg. per day. Patient D also was prescribed Valium, Klonopin and Halcion. All three are benzodiazepines. (Ex. 27, pp. 70-71, 369-371, 439-440) Xanax is used for the primary treatment of anxiety and panic disorder. It has two primary side effects -- sedation and addiction. When someone uses Xanax over a period of time, the patient develops a physical dependence. (Pisetzner, T. 281-82)

86. Contraindications for use of Xanax include use by patients who have a history of substance abuse or addiction. (Pisetzner, T. 283)

87. Receiving these medications concurrently, as Patient D apparently was in December 1987 (Ex. 27, pp. 70-71) was contrary to accepted practice. (Pisetzner, T. 324)

88. Respondent prescribed Xanax and Valium concurrently to Patient D, for example, in the amounts of 40 mg. of Valium and up to 6 mg. of Xanax daily. (Ex. 27, pp. 369-371, 439-440) This was contrary to accepted standards of practice. (Pisetzner, T. 326-328)

89. During the time he was treated by Respondent, Patient D showed substance abuse. This was shown by the amount of addictive medications he was prescribed by Respondent, and his taking increasing doses of those addictive medications. Eventually, Patient D was admitted as in inpatient to Bry-Lin Hospital to be weaned off Xanax. (Ex. 28, pp. 26-29; Pisetzner, T. 329-330)

90. Patient D made the decision to be weaned off these medications. He had reached the point where the medications were profoundly affecting him physically. (Patient D, T. 262-263)

FINDINGS OF FACT - PATIENT E

91. Respondent provided medical care to Patient E, a female patient born 5/23/55, from on or about September 10, 1990, through on or about July, 1995. Patient E was treated at Respondent's office and at other health care facilities including Bry-Lin Hospital. Patient E was 35 years old when treatment began. (Exs. 29, 30)

92. Respondent, beginning in or about September 1990, and continuing through approximately July 1995, prescribed several Benzodiazepines including Xanax and Valium to Patient E. The amount of Xanax prescribed ranged up to 16 mg. per day. (Ex. 29, pp. 113-114)

93. Taking up to 16 mg/day of Xanax indicated the patient had a problem of dependence on Xanax. (Pisetzner, T. 333)

94. Patient E had a history of abuse of alcohol. Dr. Levy also made that diagnosis. (Ex. 29, p. 102)

95. When that diagnosis was made, the alcohol abuse and substance abuse (Xanax) should have been addressed before the panic disorder could be adequately treated. (Pisetzner, T. 333-4)

FINDINGS OF FACT - PARAGRAPH F

Failure to disclose restriction of Bry-Lin privileges/termination of Bry-Lin privileges

96. Respondent, on or about January 1, 1995, completed his registration application to the New York Education Department to be licensed as a physician for the period January 1, 1995 through October 31, 1997. (Ex. 5)

97. Respondent's privileges at Bry-Lin Hospital had been summarily suspended beginning April 21, 1993 and continuing through July 6, 1994, all of which was after Respondent's previous registration, and Respondent clearly knew such facts. (Stipulation, T. 420; Exs. 6-11)

98. Respondent knowingly and intentionally failed to provide details regarding the restriction of his hospital privileges, as required by that application, in response to Question 1(c), which read as follows:

> Since you last registered, has any hospital or licensed facility restricted or terminated your professional . . . privileges . . .?

99. Respondent resigned from Bry-Lin Hospital on July 6, 1994 after having been charged by the hospital on May 19, 1994 with acts constituting professional misconduct, unprofessional conduct, incompetence, and/or negligence, all of which was after Respondent's previous registration, and Respondent knew such facts. (Stipulation, T. 420; Exs. 6-11)

100. Respondent knowingly and intentionally failed to provide details regarding the resignation of his privileges, as required by that application, in response to Question 1(c), which read as follows:

> Since you last registered, has any hospital or licensed facility restricted or terminated your professional . . . privileges . . ., or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence, or negligence?

FINDINGS OF FACT - PARAGRAPH G

Failure to provide medical records as requested by Department of Health in February 1998

101. On or about February 13, 1998, the Buffalo Area Office of the New York State Department of Health, Office of Professional Medical Conduct, personally served a letter to the Respondent in accordance with §230 of the Public Health Law, requesting transmission of original medical records of Patients A, B, C, D and E. (Ex. 3, with affidavit of service)

102. Respondent was advised in the letter that failure to transmit the records could be held to be punishable as professional misconduct under the New York Education law.

103. Respondent failed to transmit a copy of such record within thirty days, the time set forth in §230 of the Public Health Law.

FINDINGS OF FACT - PARAGRAPH H

Failure to pay fine levied January 10, 1994

104. By Administrative Review Board Determination and Order No. 93-161, issued on or about January 10, 1994, there was a prior discipline of the Respondent by the Administrative Review Board of the Bureau of Professional Medical Conduct, Department of Health, State of New York, ("ARB"). (Respondent, T. 409-411)

105. That decision sustained a Hearing Committee Determination of October 8, 1993, that Respondent was guilty of professional misconduct, including fraud, wilfully making a false report, and inadequate record keeping. The ARB confirmed that Respondent should receive a censure and reprimand, and that he should be fined $30,000 as a penalty. More than $27,000 of this fine remains due and owing. (Respondent, T. 409-411; Stipulation, T. 420)

106. Respondent testified that he had filed bankruptcy, and was therefore unable to pay the fine. Although Respondent failed to produce any documentary evidence of the date of his bankruptcy filing, a possible date of July 1995 was referred to. (Jesse Levy, T. 543-45)

107. Assuming a filing date of July 1995, Respondent had nearly 18 months to pay the fine from the date of the January 1995 imposition. Respondent failed to provide any documentary evidence regarding his ability to pay the fine before the filing of bankruptcy.

108. Respondent failed to produce any documentary evidence as to the current status of the bankruptcy.

CONCLUSIONS OF LAW - PATIENT A

109. Patient A's history in treatment with the Respondent supports the conclusion that Patient A had a history of substance abuse, and also that the patient had ongoing problems with substance abuse. The substances that the patient abused were alcohol and Xanax. A person can become a substance abuser during the course of therapy. (Pisetzner, T. 289-90)

110. Given the patient's history of substance abuse and indications of ongoing problems, Respondent's continued treatment of Patient A with Xanax was below the accepted standard of care. (Pisetzner, T. 289-290) Allegation A1 is **SUSTAINED.**

111. Respondent knew or should have known of the indications of ongoing substance abuse problems by Patient A.

112. Respondent failed to appropriately respond to indications of substance abuse by Patient A. (Pisetzner, T. 292) Allegation A2 is **SUSTAINED.**

Respondent's records apparently accurately reflect his response to the indications of substance abuse by Patient A in that he took no specific steps, and still continued to prescribe Xanax to the patient. Allegation A3 is **NOT SUSTAINED.**

113. It is below accepted standards of medical practice for a psychiatrist to solicit or accept rides from a patient for the convenience of the physician. This is a violation of appropriate therapeutic boundaries. It appears that Dr. Levy was using the Patient for his own gain. (Pisetzner, T. 297) Allegation A4(a) is **SUSTAINED.**

114. It is below accepted standards of medical practice for a psychiatrist to solicit or allow a patient to socially visit the psychiatrist, and to entertain that patient as a guest, especially overnight. This is a violation of appropriate therapeutic boundaries. (Pisetzner, T. 297-298) Allegation A4(b) is **SUSTAINED.**

115. It is below accepted standards of medical practice for a psychiatrist to share personal confidences as described by Patient A with a patient. This is a violation of appropriate therapeutic boundaries. (Pisetzner, T. 298-299) Allegation A4(c) is **SUSTAINED.**

116. It is below accepted standards of medical practice for a psychiatrist to spend the evening at his patient's house in order to escape his own personal troubles, as did Respondent. This is a violation of appropriate therapeutic boundaries. (Pisetzner, T. 299-300) Allegation A4(d) is **SUSTAINED.**

117. It is below accepted standards of medical practice for a psychiatrist to make lengthy personal telephone calls with a person described as Respondent's former patient and current girlfriend, in the presence of a current patient. This is a violation of appropriate therapeutic boundaries. Dr. Levy was again using Patient A for his own needs. (Pisetzner, T. 300) Allegation A4(e) is **SUSTAINED.**

118. It is below accepted standards of medical practice for a psychiatrist to request and/or allow his current patient to act as a contact person to arrange telephone calls between the psychiatrist and his former patient and current girlfriend. This is a violation of appropriate therapeutic boundaries. (Pisetzner, T. 300-01) Allegation A4(f) is **SUSTAINED.**

119. It is below accepted standards of medical practice for a psychiatrist to fail to reimburse a patient for numerous lengthy and personal long distance phone calls made by the psychiatrist to his girlfriend from the patient's house. This is a violation of appropriate therapeutic boundaries. (Pisetzner, T. 300) Allegation A4(g) is **SUSTAINED.**

120. It is below accepted standards of medical practice for a psychiatrist to suggest that a patient become romantically involved with the psychiatrist's secretary/patient. There are numerous risks to the patient. This is a violation of appropriate therapeutic boundaries. (Pisetzner, T. 301-02) Allegation A4(h) is **SUSTAINED.**

121. Respondent's medical record for Patient A fails to properly record or intentionally misrepresents the circumstances under which Patient A ceased being a patient of Respondent on or about June 20, 1994. Allegation A5 is **SUSTAINED.** Allegation A6 is **SUSTAINED.**

CONCLUSIONS OF LAW - PATIENT B

122. Patient B's history in treatment with the Respondent supports the conclusion that Patient B had a history of substance abuse, and also that the patient had ongoing problems with substance abuse. The substances that the patient abused were alcohol and benzodiazepines.

123. Given the patient's past history, and indications of ongoing problems with substance abuse, Respondent's continued treatment of Patient B with Xanax, Valium and a third benzodiazepine, Halcion, was below the accepted standard of care. (Pisetzner, T. 312) Allegation B1 is **SUSTAINED.**

124. Respondent knew or should have known of the indications of ongoing substance abuse problems by Patient B.

125. Respondent failed to appropriately respond to indications of substance abuse by Patient B. (Pisetzner, T. 313) Allegation B2 is **SUSTAINED.**

126. Respondent's records apparently accurately reflect his response to the indications of substance abuse by Patient B in that he took no specific steps, and still prescribed Xanax, Valium and Halcion to the patient. Allegation B3 is **NOT SUSTAINED.**

127. It is unethical for a psychiatrist to employ a current patient in his psychiatric office. Such employment of a current patient blurs the role of the therapist and employer. A patient is deprived of the objectivity the psychiatrist needs to conduct the appropriate psychiatric treatment. It is an exploitation of the patient. (Pisetzner, T. 313-14; Exhibit F)

There are no special circumstances here that justified the hiring of Patient B. In fact, this was part of a pattern used by Respondent of hiring his patients to work in his office. At least six patients were identified by Respondent as having been hired by him at one time or another. (Patient B, VC, GP, WJ, AL, and DS; Respondent, T. 395-6, 400)

128. It was contrary to accepted standards of practice for a Respondent to have hired Patient B to work in his office. (Pisetzner, T. 314-15) Allegation B4(a) is **SUSTAINED.**

129. It was contrary to accepted standards of practice for Respondent to suggest that Patient B become involved with Patient A and other male patients. (Pisetzner, T. 315-16) Allegation B4(b) is **SUSTAINED.**

130. By repeatedly contacting Patient B at her home at other than usual customary office hours, Respondent again blurred the line between employer and therapist. This was below accepted standards of medical practice. (Pisetzner, T. 316) Allegation B4(c) is **SUSTAINED.**

131. It was unethical and inappropriate for Respondent to write prescriptions for controlled substances in the name of Patients B and/or C and then request that Patient B fill the prescriptions and provide the medications to him. (Pisetzner, T. 316-317) Allegation B5 is **SUSTAINED.**

132. It was contrary to accepted standards of practice for Respondent personally or through agents to have contacted the patient after she was no longer in his care and suggested she sign herself out of the hospital. (Pisetzner, T. 317-319) Allegation B6 is **SUSTAINED.**

133. This was inappropriate, contrary to accepted standards of practice. (Pisetzner, T. 320-21) Allegation B7 is **SUSTAINED.**

134. It was unethical and inappropriate conduct for Respondent, as a licensed physician, to have engaged in behavior that intimidated and coerced Patient B in this manner. Allegation B8 is **SUSTAINED.**

135. It was contrary to accepted standards of practice for Respondent to have engaged in the conduct described in paragraph 76 above. (Pisetzner, T. 321) Allegation B9 is **SUSTAINED.**

136. It was unethical and inappropriate to coerce a patient to sign a false statement to benefit the Respondent and which inhibited an official investigation of the Respondent. Allegation B10 is **SUSTAINED.**

CONCLUSIONS OF LAW - PATIENT C

137. Respondent committed fraud. Allegations C1 and C2 are **SUSTAINED.**

CONCLUSIONS OF LAW - PATIENT D

138. Patient D's history in treatment with the Respondent supports the conclusion that Patient D had a history of substance abuse, and also that the patient had ongoing problems with substance abuse. The substances that the patient abused were prescription medications. (Pisetzner, T. 329-330)

139. Given the patient's history of substance abuse and indications of ongoing problems Respondent's continued treatment of Patient D with addictive medications was below the accepted standard of care. (Pisetzner, T. 330-331)

140. Respondent knew or should have known of the indications of ongoing substance abuse problems by Patient D. Allegation D1 is **SUSTAINED.**

141. Respondent failed to appropriately respond to indications of substance abuse by Patient D prior to 1993. (Pisetzner, T. 331) Allegation D2 is **SUSTAINED.**

142. Respondent's records apparently accurately reflect his response to the indications of substance abuse by Patient D, i.e., that he took no specific steps, and still continued to prescribe benzodiazepines to the patient up until 1993. Allegation D3 is **NOT SUSTAINED.**

CONCLUSIONS OF LAW - PATIENT E

143. Patient E's history in treatment with the Respondent supports the conclusion that Patient E had a history of substance abuse, and also that the patient had ongoing problems with substance abuse. The substances that the patient abused were alcohol and Xanax. (Ex. 29, p. 102)

144. Given the patient's history of, and indications of ongoing problems with, substance abuse, Respondent's ongoing treatment of Patient E with Xanax was below the accepted standard of care. (Pisetzner, T. 334-335) Allegation E1 is **SUSTAINED.**

145. Respondent knew or should have known of the indications of ongoing substance abuse problems by Patient E.

146. Respondent failed to appropriately respond to indications of substance abuse by Patient E. (Pisetzner, T. 336) Allegation E2 is **SUSTAINED.**

147. Respondent's records apparently accurately reflect his response to the indications of substance abuse by Patient E, i.e., that he took no specific steps, and still continued to prescribe Xanax and Valium to the patient. Allegation E3 is **NOT SUSTAINED.**

CONCLUSIONS OF LAW - PARAGRAPH F

148. Respondent had ample notice of the action taken against his privileges by Bry-Lin Hospital. He engaged an attorney to defend himself, requested a hearing and resigned from the staff before the hearing. The answers provided on the state registration application were knowingly false. Allegations F1 and F2 are **SUSTAINED.**

CONCLUSIONS OF LAW - PARAGRAPH G

149. Respondent was aware of the subpoena and failed to heed its terms. He is guilty of professional misconduct according to the Public Health Law. Allegation G is **SUSTAINED.**

CONCLUSIONS OF LAW - PARAGRAPH H

150. Respondent deliberately failed to pay the fine leveled by the Administrative Review Board of the Bureau of Professional Medical Conduct. His explanation was not credible. He is guilty of professional misconduct as charged. Allegation H is **SUSTAINED.**

DETERMINATION - PATIENT A

In his relationship with Patient A, Respondent engaged in substandard practice in three ways -- poor prescribing, poor maintenance of therapeutic boundaries which eventually became exploitation and fraud.

Prescriptions: Patient A was prescribed Xanax for the entire ten years he was treated by Respondent. During that time there were repeated references in Patient A's chart to the patient's use of alcohol. Patient A was heavily dependent on, if not addicted to alcohol; he was certainly addicted to Xanax.

Xanax and alcohol can potentiate each other in addiction, i.e., since they deal with the same pathways, a person taking one can become more sensitive to the other, and vice versa. By prescribing as he did to Patient A, Respondent was creating a potential for Xanax dependence while at the same time potentiating the patient's problems with alcohol -- and the patient was not being treated for either.

Respondent could have used other non-addictive medications, such as Mellaril, referred the patient for behavior modification, insisted on a referral to AA, or to a drug rehabilitation program.

Years went by and Respondent did none of this. In all, his prescription of Xanax to Patient A, given the patient's history of substance abuse, showed a failure to exercise the care required of a reasonably prudent physician, despite a knowledge of risk and thus negligence. It did not indicate a lack of skill or knowledge necessary to practice the profession and thus was not incompetence. Accordingly, Specification Nineteen (Negligence on More Than One Occasion) is **UPHELD.** Specification 20 is **NOT UPHELD.**

Therapeutic Boundary Violations: Patient A testified credibly and completely about his course of treatment by Respondent. Significantly, he gave ample credit to Dr. Levy for helping him, particularly in the early years of treatment. His candor in favor of Dr. Levy regarding early treatment makes his testimony about the last few years of contact with Respondent even more telling.

Much of what Patient A revealed about the last six months of contact with Respondent was confirmed in one way or another by other witnesses, including the Respondent and Mrs. Levy:

* Dr. Levy confirmed getting car rides from him to run Respondent's personal errands;
* Jesse Levy confirmed that the patient came to their house for a "social" visit and was entertained in that fashion while he was a patient;
* Dr. Levy confirmed going to the patient's house, staying "a long time" and making phone calls to VC; and
* Dr. Levy confirmed not paying for the long distance calls.

The telephone records (Ex. 15) showed just how many phone calls were made to VC, that the ones made when Respondent was there were exceedingly long, and that most of the others were like Patient A said -- short enough for him to say, "Hi, VC, this is [Patient A], call Ron."

Patient A's testimony demonstrated the extent to which Respondent used this patient to serve his own needs -- for companionship, for a sounding board for personal problems, for rides, for a place to lay his head, and for someone to help him maintain an ongoing romantic entanglement with another former patient.

Respondent was not a reasonable and competent professional to Patient A, but rather a dependent, needy, and nearly desperate person who sought help from Patient A. The loss to Patient A in this role reversal was twofold: he was deprived of competent care from Respondent; and, because he was being used by Respondent, he was prevented from receiving competent care from another therapist.

Respondent's care of Patient A in this regard constituted gross negligence, negligence on more than one occasion, and exercising undue influence on a patient to exploit the patient for the personal gain of the Respondent. Accordingly, Specification Eleven, Fifteen, and Nineteen, are **UPHELD.** Specification Seventeen and Twenty are **NOT UPHELD.**

Fraud: Respondent (and Mrs. Levy) testified that Patient A had come to him shortly after Respondent's discharge from the hospital and "confessed" to purchasing and using cocaine with Patient B, and having been infatuated with Patient B. According to Respondent, this was a very serious event, as it showed not only illegal drug use and criminal activity by Patient A; it also showed a clear breach by Patient A of what Respondent said was a "clear policy" in Respondent's office that there should be no social relationships or dating between patients and employees.

Respondent did not react to this "confession". According to Respondent, he sent Patient A for two drug screens, recommended that Patient A be admitted for inpatient drug abuse treatment, and then terminated treatment of Patient A when the Patient allegedly refused to implement any of Respondent's suggestions. Dr. Levy said these events occurred over several visits and meetings with Patient A. Patient A denied these allegations. Save for a fleeting reference to a drug screen, Respondent's medical record for Patient A contains no mention of these wild assertions.

For all the reasons already cited above, Patient A's testimony is credited, and Respondent's rejected. It is not credible that these events occurred as Respondent testified. Patient A told why he left -- Respondent's behavior became increasingly strange; Patient A checked in with his attorney; and Patient A "checked out" of care by Dr. Levy. Respondent's medical record, whenever prepared [4] (FN-4) seeks to mislead.

This is fraud. Specification One (Fraud) is **UPHELD.**

Respondent's fraudulent behavior and taking advantage of a patient for personal gain [A4(g)] constitutes moral unfitness. Specification Six is **SUSTAINED.**

To the extent that Respondent's medical record did not seek to intentionally mislead, it fails to accurately reflect the evaluation and treatment of Patient A relating to the circumstances of termination (as testified to by Respondent). Respondent's record fails to properly record the circumstances under which Patient A ceased being a patient of Respondent on or about June 20, 1994. Respondent was thus negligent in his documentation of treatment decisions regarding Patient A, and he failed to maintain accurate records. Accordingly, Specifications Nineteen (Negligence) and Twenty-Five (Failure to Maintain Adequate records) are **UPHELD.**

DETERMINATION - PATIENT B

In his relationship with Patient B, Respondent engaged in substandard practice again in three ways - over prescribing, the complete destruction of therapeutic boundaries by, among others, the hiring of his patient as his employee, and fraud.

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[4]Exhibit 13 was Respondent's medical record as produced in response to a court order in Patient A's litigation. It was produced to be reviewed by defense counsel in Patient A's civil litigation, which in no way involved the Respondent, but did involve any medical care provided to Patient A by any physician. That medical record, as produced by the Respondent in September 1994, contained no record of any reference to a drug screen for Patient A.

Prescriptions: Patient B came to Respondent with a history of multiple hospitalizations for alcohol abuse. This was documented on the first day of treatment. Patient B also continued in AA on and off through the time of her treatment by Respondent. During that time she was admitted to Bry-Lin Hospital on two occasions relating to her use of alcohol and/or benzodiazepines to excess. Despite all of this, Respondent continued to prescribe benzodiazepines to her -- Valium and Xanax at the same time.

Respondent nowhere denied this, and never offered an explanation as to why Patient B had in her possession at the time of her admission to Bry-Lin Hospital prescriptions for both Xanax and Valium signed by Respondent. (Ex. 18) Respondent's entire method of prescribing these medications to Patient B constitutes negligence on more than one occasion. Accordingly the Nineteenth Specification is **UPHELD.**

Therapeutic Boundary Violations: Respondent's interactions with Patient B became more and more inappropriate over time. Despite having certified that the patient was totally disabled from doing her work at People Incorporated in 1992, Respondent hired her. Not only was this employment contrary to the Respondent's representations of the patient's inability to perform work, but she was still receiving psychiatric treatment from him.

Dr. Pisetzner clearly identified the problems with this blurring of relationships with a current patient. (It was also recognized at Bry-Lin Hospital in 1993, when the patient was discovered to be both his employee and his patient -- this is obviously the reason why the transferral to Dr. Ashton was made). The guidelines of the American Psychiatric Association through their Committee on Medical Ethics makes clear that such a dual relationship with a psychiatric patient is unethical.

As outlined in Allegation B.7, Respondent continued to employ Patient B in his office after her discharge, beginning as early as May 27, 1993. Given the seriousness of the patient's psychiatric condition, this was inappropriate. Here, given the circumstances of hiring Patient B, Respondent was unethical. Accordingly, Specifications Sixteen (Negligence), Nineteen (Negligence) and Twenty-Five (Failure to Maintain Records) are **UPHELD.**

Dr. Levy's behavior became increasingly inappropriate in 1993-94, when he suggested that Patient B become involved with Patient A and other male patients. The inappropriateness of such a suggestion does not require expert testimony. Respondent attempted to use this young woman to serve his own needs. He intruded into her personal life through contacts with her at other than usual and customary office hours to discuss his problems with his marriage and his personal matters. These calls were made not only by the doctor, but also by his wife.

This behavior by Respondent constitutes gross negligence and negligence on more than one occasion. This supports upholding Specifications Sixteen and Nineteen.

Fraud: Respondent's pattern of fraud predictably continued in his contact with Patient B.

* **Prescription for Dilaudid:** Respondent directed Patient B to write a prescription for Dilaudid in her mother's name, to sign Respondent's name given his physical disabilities at that time, to fill it and to give the medication to him. She testified that Respondent requested this because he was in physical pain still from his May injuries. Respondent stipulated that he received Dilaudid during his hospitalization. Patient B has admitted to forgoing several prescriptions that she received from the Respondent for Dexedrine, but not for the Dilaudid prescription. Patient B should be believed.

* **Prescription for Valium:** Respondent admitted it was his signature on the January 3, 1994 Valium prescription for Patient C. The explanation he offered was that Patient B abused triplicate prescriptions pre-signed by the Respondent. Respondent's defense, therefore, shows him to have been grossly negligent in using triplicate prescriptions and is rejected given Respondent's lack of credibility and Patient B's consistent credible testimony.

* **Coercing a False Affidavit:** Patient B agreed that she signed the affidavit "retracting" assertions that she made regarding the Respondent (Ex. 34) -- yet the language is clearly not her own. Secretary A.L. testified that it was in fact Mrs. Levy's suggestion that brought Patient B to Mr. Lazroe's office regarding this matter. This corroborates Patient B's testimony as well as that of Patient B's mother, a.k.a. "Patient C" that Jesse Levy pestered her daughter about signing a document at Mr. Lazroe's office. This testimony is most credible.

* **Coercing False Request Not to Release Records:** Patient B testified that this handwritten note was done at the insistence of Dr. Levy and his wife. The language shows it to be unlikely to be from Patient B (e.g. referring to "doctor-patient confidentiality" being "a vital part of therapy". Patient B's testimony is the most credible and is accepted.

The misrepresentations can only be construed as intentional, given the evidence and Respondent's lack of credibility. Accordingly, Specification Two is **UPHELD.** Specification Twelve is also **UPHELD** since the signing of a triplicate prescription for Valium and Dilaudid in the name of a person for whom the medication was not intended is the filing of a false report. Finally, Respondent's fraudulent conduct constitutes moral unfitness. Therefore, Specification Seven is **UPHELD.**

By virtue of fraudulent prescription practices Specification Twenty-One is **UPHELD.**

DETERMINATION - PATIENT C

Patient B testified clearly and credibly on this issue; Respondent testified evasively and without credibility. The facts are undisputed that a triplicate prescription in the name of "Patient C" was signed by Respondent. Patient B testified that Respondent did this intentionally. This pattern was repeated by Respondent on the Dilaudid prescription.

The Specifications for fraud on this point (Fourth), Moral Unfitness (Eighth) and Wilfully Making and Filing a False Report (Thirteenth) are **UPHELD**. By virtue of fraudulent prescription practices, Specification Twenty-Two is **UPHELD.**

DETERMINATION - PATIENT D

For the same reasons described under the prescribing sections of Patient A and B, Specification Nineteen (Negligence) is **UPHELD.**

DETERMINATION - PATIENT E

For the same reasons described under the prescribing sections of Patients A, B and D, Specification Nineteen (Negligence) is **UPHELD.**

DETERMINATION - PARAGRAPH F

Respondent's pattern of deceit was demonstrated from what he did on or about January 1, 1995 and from what he said to the Hearing Committee. His January 1, 1995 re-registration submission to the Education Department - a form required by law to be filed with the Education Department - left a blank in response to two questions: Since he had last registered, had has privileges been suspended? Since he had last registered, had he resigned under fire? (Ex. 5)

Respondent was suspended from Bry-Lin Hospital from April 21, 1993 through July 6, 1994 when he resigned on the eve of a hearing after being served with charges of misconduct at the hospital. (Exs. 6-11) Dr. Levy did not give the accurate answer - he gave no answer. That was a misrepresentation.

In his explanation to the Hearing Committee, Dr. Levy gave several contradictory answers. First, he said he was not sure "where he stood with" Bry-Lin on the suspension issue when he filed the 1/1/95 form. (T. 406) He then changed that story to indicate that at the same time of his statement, what his situation was "on a permanent basis . . . I don't think . . . had been finalized in that fashion". (T. 407) This was not true.

He admitted that he had known of the resignation of his privileges on July 6, 1994 but he then again changed his story to say that, despite having been suspended, served with charges, and having resigned on the literal eve of the hearing, he argues that he did not resign to avoid charges, but for some other reason never given to the Hearing Committee, despite having been assured by the Administrative Hearing Officer that he would be given the fullest opportunity to tell his story.[5] Dr. Levy gave no other explanation.

The Hearing Committee finds that a false representation was made by the Respondent. The inconsistent explanations made to various questions about the absence of an answer justify a clear inference that Respondent knew his action was false and was intended to mislead or deceive.

Accordingly, the Respondent is held to have wilfully misrepresented the facts and circumstances of his suspension and resignation from Bry-Lin Hospital. This constitutes fraudulent practice under Specification Five, moral unfitness in the practice of medicine under Specification ten, wilfully making or filing a false report under Specification Fourteen, and a willful or grossly negligent failure to comply with state laws and regulations regulating the practice of medicine under Specification Twenty-Three. Each of these is **SUSTAINED.**

DETERMINATION - PARAGRAPH G

Respondent was served with a demand for original medical records of Patients A, B and C. The original records were not produced. Respondent professed to have no knowledge as to what was provided:

> Question: Have you provided original medical records of Patient B to the Office of Professional Medical Conduct?

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[5]ALJ Trost: For the doctor's information, you'll have an opportunity to make your explanations to this panel. This is not the proper time. Just answer the questions. You and your lawyer will have an opportunity later to say whatever you want to say.
The Witness (Dr. Levy): Thank you, your Honor. (T. 404)

Answer: I provided whatever my wife and Mr. Lazroe thought was proper to turn over.

Answer: I have to say I honestly don't know what you've got, whether you got originals or whether you got copies. (T. 391-392)

Counsel for the Department argued that the reason why original records were sought from Respondent became clear at the hearing - on a number of occasions, the exhibits in evidence, as certified by Mr. Lazroe, had been not legibly copied; on other occasions, the exhibits in evidence as provided by Respondent had not been fully copied; on other occasions, the exhibits in evidence did not fully disclose information as to when, for example, entries were made in the record.

A good example of this became clear on the last day of hearing, when the Petitioner marked in evidence Exhibit 44, i.e., one page from the original record of Patient B, including references on the back to Vicodin prescriptions. The entries for Vicodin on that page appear, by ink differences and location on the page, to have been entered after the fact. It was exactly to identify such subsequent entries that the original records were sought by the February 13, 1998 demand.

Dr. Levy never complied with the demand because Dr. Levy used the original records repeatedly during his testimony at the hearing in preference to using the marked exhibits.

Accordingly, Specification Twenty-Four (Failure to Provide Records upon Demand) is **UPHELD.**

DETERMINATION - PARAGRAPH H

Other than vague references to bankruptcy and financial distress, no testimony was offered by Dr. Levy or his wife regarding his failure to pay this fine. No documents were placed in evidence regarding Dr. Levy's inability to pay the fine. There is no basis for a finding that there were extenuating circumstances. Presumably, if such extenuating circumstances existed, they could have been proven with more than vague reference. Accordingly, Specification Twenty-Six, violating a condition imposed on the Respondent pursuant to §230, is **UPHELD.**

DETERMINATION - SPECIFICATIONS NOT UPHELD

SPECIFICATION 3

No evidence was offered regarding Allegation D-4. Thus, neither the allegation nor the specification based thereon are upheld.

SPECIFICATION 9

Again, this was based on D-4 and is not upheld.

SPECIFICATIONS 17, 18, 20 charge Incompetence

The Committee are of the opinion that the Respondent was adequately prepared to practice psychiatry because of superior intelligence (demonstrated by his academic achievements), training and experience. The evidence did not demonstrate a lack of skill or knowledge but rather a lack of due care. Therefore, those specifications charging incompetence were not upheld.

ALLEGATIONS A3, B3, D3, E3

These allegations were not sustained because they were viewed as inconsistent with the allegations of an inappropriate response to substance abuse alleged at A2, B2, D2 and E2, which allegations were sustained. It is not improper record keeping when the Respondent misses the diagnosis. The diagnosis (in this case the "response") was not recorded because it was negligently overlooked. Although this may have resulted in an inaccurate record, the offense had nothing to do with poor record keeping. Rather, it was negligent performance.

Although not sustained, these allegations did not play a major role in any single specification. There was overwhelming evidence to sustain the specifications without these record keeping allegations.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous)

SPECIFICATION 1	**SUSTAINED**
SPECIFICATION 2	**SUSTAINED**
SPECIFICATION 3	**NOT SUSTAINED**
SPECIFICATION 4	**SUSTAINED**
SPECIFICATION 5	**SUSTAINED**
SPECIFICATION 6	**SUSTAINED**
SPECIFICATION 7	**SUSTAINED**
SPECIFICATION 8	**SUSTAINED**
SPECIFICATION 9	**NOT SUSTAINED**
SPECIFICATION 10	**SUSTAINED**
SPECIFICATION 11	**SUSTAINED**
SPECIFICATION 12	**SUSTAINED**
SPECIFICATION 13	**SUSTAINED**
SPECIFICATION 14	**SUSTAINED**
SPECIFICATION 15	**SUSTAINED**
SPECIFICATION 16	**SUSTAINED**
SPECIFICATION 17	**NOT SUSTAINED**
SPECIFICATION 18	**NOT SUSTAINED**
SPECIFICATION 19	**SUSTAINED**
SPECIFICATION 20	**NOT SUSTAINED**
SPECIFICATION 21	**SUSTAINED**

SPECIFICATION 22	**SUSTAINED**
SPECIFICATION 23	**SUSTAINED**
SPECIFICATION 24	**SUSTAINED**
SPECIFICATION 25	**SUSTAINED**
SPECIFICATION 26	**SUSTAINED**

PENALTY

The evidence produced at the hearing demonstrated that Respondent engaged in a wide variety of professional misconduct, from which several distinct patterns emerge: a pattern of exploitation of patients; a pattern of misrepresentations and fraud; and a pattern of poor medical care. To these patterns can be added the almost incontrovertible evidence that Respondent failed to accurately respond to inquiries made by the New York Education Department as to whether privileges had ever been restricted or terminated; failed to provide records to the Department of Health in response to a written demand that clearly warned him that the failure to turn over the material could be misconduct; and failed to make more than token payments on a fine of $30,000 assessed in January 1994 by the Administrative Review Board of the Board for Professional Medical Conduct.

The evidence showed by a great preponderance that Respondent does not have the rigorous personal and professional integrity and responsibility so that he can be entrusted with the public's health. Therefore, Respondent's New York license to practice medicine is **REVOKED.**

All lesser penalties were considered and rejected. Since the evidence did not demonstrate incompetence, then retraining, monitoring, supervision, education or performance review would not be effective or appropriate. Supervision was thought to be only punitive or perhaps a wake-up call but it would not serve to protect the public. Dr. Levy's performance and his attitude appeared to be incorrigible and intractable. The only other explanation for his professional (mis)conduct and his demeanor at the hearing would be that he has become somehow impaired or unable to function because of loss of will.

Whatever the cause, the negligence towards patients was gross and repeated. His disregard for the law and rules of licensure appeared almost willful and was certainly reckless and illegal.

The most problematical aspect of his behavior was the consistent pattern of misconduct. In this regard the prior disciplinary proceedings were anticipatory of the events which led to the present proceeding. The determination of the Administrative Review Board in case 93-161 cited the concern of the Hearing Committee (at page 3) " . . . that the Respondent's poor judgment could, if not corrected, cross the line of acceptable medical conduct in the future". The pattern continued and the situation deteriorated. This deterioration is highlighted by the fact that the prior Committee found the Respondent to be a credible witness. This was decidedly not the case in the present proceeding. It must be stated here that the prior determination of the ARB was not seen by the Panel until the penalty phase of the Hearing and it played no part in this determination, in as much as the evidence in the present case was sufficiently overwhelming to support the penalty.

Another concern of the Committee was the apparent abdication of responsibility by the Respondent for running the office and perhaps even the practice. The Respondent admitted this on more than one occasion. Mrs. Levy, on the other hand, appeared not only to be in firm control of those matters but also to be making all the decisions, some of which, it was suspected, might have been beyond the limits of her authority as a registered nurse. Such a situation is most dangerous to the public and cannot be tolerated. The decision of each member of the Committee was the same. The vote to revoke was unanimous.

The Panel recommends that the Respondent should not be allowed to reapply for a license in New York State.

ORDER

IT IS HEREBY ORDERED THAT:

1. The license of Respondent, Ronald M. Levy, to practice medicine in New York State is hereby **REVOKED.**

2. This **ORDER** shall be effective upon service on the Respondent or Respondent's attorney by personal service or certified or registered mail.

DATED: **Pittsford, New York**
Nov. 17 **1998**

TRENA DeFRANCO, Chairperson

ROBERT KLUGMAN, M.D.
MARGARET McALOON, M.D.

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

IN THE MATTER
OF
RONALD M. LEVY, M.D.

AFFIRMATION

The undersigned, member of the Panel in the aforementioned proceeding was not present for that portion of the hearing held on June 17, 1998. I hereby affirm that I have read and considered all evidence offered at that hearing session and have read the transcript before the next hearing session.

Margaret McAlonan

Sworn to before me this
23 day of September, 1998

Shirley J. Todd
NOTARY PUBLIC ERIE CO N.Y.
EXP 7/11/00

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

IN THE MATTER
OF
RONALD M. LEVY, M.D.

AFFIRMATION

The undersigned, member of the Panel in the aforementioned proceeding was not present for that portion of the hearing held on 8/26, 1998. I hereby affirm that I have read and considered all evidence offered at that hearing session and have read the transcript before the next hearing session.

Irena B. DeFranco

Sworn to before me this
23 day of Sept., 1998.

Priscilla J. Trost
NOTARY PUBLIC ERIE CO. NY
EXP 7/11/00

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	**NOTICE**
OF	:	**OF**
RONALD M. LEVY, M.D.	:	**HEARING**

TO: RONALD M. LEVY, M.D.
1331 N. Forest
Suite 120
Williamsville, New York 14221

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct beginning on the 6th day of May, 1998, at 10:00 in the forenoon of that day at the Quality Inn, 4217 Genessee Street, Buffalo, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced

against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180, (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or

dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE AS A PHYSICIAN IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
March 31, 1998

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

MICHAEL A. HISER
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	AMENDED
OF	:	STATEMENT
RONALD M. LEVY, M.D.	:	OF CHARGES

----------X

RONALD M. LEVY, M.D., the Respondent, was authorized to practice medicine in New York State on June 23, 1969, by the issuance of license number 103809 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 January 1, 1997, through October 30, 1999, with an office address of 1331 N. Forest, Suite 120, Williamsville, New York 14221.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified in the Appendix), a male born 4/9/52, from on or about May 7, 1984, through on or about July 1, 1994. Patient A was treated at Respondent's office at 6325 Sheridan Drive, Williamsville, New York, 14221-4801 (hereafter "the office"), and at other health care facilities, including BryLin Hospital, Inc., 1263 Delaware Avenue, Buffalo, New York, 14209 (hereafter, "BryLin Hospital"). Patient A was 32 years old when first treated by Respondent. Respondent's care of Patient A was below accepted standards of medical practice as follows:

1. Respondent, beginning in or about July 1984, and continuing through approximately June 1994, inappropriately prescribed Xanax to Patient A, despite the patient's history of, and indications of ongoing problems with, substance abuse.

2. Respondent failed to appropriately respond to indications of substance abuse by Patient A.

3. Respondent failed to maintain records that accurately reflect his response to the indications of substance abuse by Patient A.

4. Respondent violated appropriate and therapeutic professional boundaries with Patient A by, among other things:

   a. Requesting that Patient A provide transportation for Respondent on multiple occasions in May 1994;

   b. Allowing Patient A to stay overnight at Respondent's home in May 1994;

   c. Divulging extensive information relating to Respondent's personal life to Patient A on numerous occasions, including regarding Respondent's own marital difficulties;

   d. Staying overnight at Patient A's house on or about May 30, 1994;

   e. Using Patient A's telephone on May 29 and 30 to conduct lengthy telephone calls with Respondent's former patient/girlfriend in the presence of Patient A;

   f. Repeatedly requesting and/or allowing Patient A to act as a contact person to arrange telephone calls between the Respondent and the Respondent's former patient/ girlfriend;

   g. Failing to reimburse Patient A for the numerous and lengthy personal long-distance phone calls made by Respondent to his girlfriend from Patient A's house, despite Patient A's request for reimbursement; and

   h. Suggesting that Patient A become romantically involved with Respondent's then secretary/patient, further identified below as "Patient B".

5. Respondent's medical record for Patient A fails to properly record or intentionally misrepresents the circumstances under which Patient A ceased being a patient of Respondent on or about June 20, 1994.

6. Respondent's documented medical record rationale inappropriately purports to discharge Patient A from 8 years of treatment without notice and without a proper termination note.

B. Respondent treated Patient B, a female patient born 7/11/64, from on or about February 16, 1988 through on or about September 1, 1994, at Respondent's office and at other health care facilities, including BryLin Hospital. Patient B was 23 years old when first seen by Respondent. Respondent's care of Patient B was below accepted standards of medical practice as follows:

1. Respondent, beginning in or about February 1988, and continuing through at least April 1993, inappropriately prescribed Valium, Xanax, and Halcion to Patient B, despite the patient's history of, and indications of ongoing problems with, substance abuse.

2. Respondent failed to appropriately respond to indications of substance abuse by Patient B.

3. Respondent failed to maintain records that accurately reflect his response to the indications of substance abuse by Patient B.

4. Respondent violated appropriate and therapeutic professional boundaries with Patient B by, among other things:

   a. Beginning on or about July 1, 1992, inappropriately employing Patient B in his psychiatric office when she was still receiving psychiatric treatment from him.

   b. Suggesting that Patient B become romantically involved with Patient A and other male patients.

c. Repeatedly contacting Patient B at her home at other than usual and customary office hours to discuss problems with his marriage, and other personal matters.

5. Respondent, beginning on or about July 1, 1992, wrote or ordered the writing of prescriptions for controlled substances in the name of Patients B and/or C (including a prescription for Dilaudid on June 21, 1994), and then requested that Patient B fill the prescriptions and provide the medications to him.

6. Respondent personally and through agents contacted Patient B during Patient B's hospitalization at Bry-Lin Hospital in April 1993, and suggested that she sign herself out of the hospital, despite Respondent having transferred her care to another psychiatrist.

7. Respondent, despite Patient B's psychiatric condition which required hospitalization from April 12, 1993 through April 22, 1993, continued to employ her in his office after her discharge, beginning as early as May 27, 1993.

8. Respondent, between May 1993 and May 1994, personally and/or through agents intimidated and coerced Patient B into signing a statement that falsely retracted the patient's earlier assertions regarding Respondent made during the patient's hospitalization at BryLin Hospital in April 1993, including the suggestion that she sign herself out of the hospital.

9. Respondent, between approximately May 1993 and July 1994, continued to provide and/or prescribe medications for Patient B, despite maintaining no medical records of such treatment and/or medications.

10. Respondent, in or about January 1994, personally and/or through agents intimidated and coerced Patient B into signing a statement which indicated Patient B did not want her medical records released. The statement was falsely dated "January 1992", so that the Respondent could use it as a basis not to release Patient B's records to the New York State Department of Health.

C. Respondent, on or about January 3, 1994, fraudulently signed a triplicate prescription for a 30 day supply of Valium

for a person identified as "Patient C", which was the name of Patient B's mother.

1. The prescription was fraudulent, as "Patient C" was never a patient of the Respondent, and Respondent knew this.

2. Respondent asked Patient B to fill the prescription, and to then give the medication to the Respondent.

D. Respondent provided medical care to Patient D, a male patient born 4/15/47, from on or about November 1, 1987, through on or about July 1, 1994. Patient D was treated at Respondent's office and at other health care facilities including BryLin Hospital. Patient D was 40 years old when first seen by Respondent. Respondent's care of Patient D was below accepted standards of medical practice as follows:

1. Respondent, beginning in or about November 1987, and continuing generally through at least April 1993, inappropriately prescribed Valium, Xanax, and Halcion to Patient D, despite the patient's history of, and indications of ongoing problems with, substance abuse.

2. Respondent failed to appropriately respond to indications of substance abuse by Patient D.

3. Respondent failed to maintain records that accurately reflect his response to the indications of substance abuse by Patient D.

4. Respondent, in early May 1994, personally and/or through agents sought to have Patient D sign a statement that indicated that Patient D did not want his medical records released, in order to prevent their release to the New York State Department of Health.

E. Respondent provided medical care to Patient E, a female

patient born 5/23/55, from on or about September 10, 1990, through on or about July, 1995. Patient E was treated at Respondent's office and at other health care facilities including BryLin Hospital. Patient E was 35 years old when treatment began. Respondent's care of Patient E was below accepted standards of medical practice as follows:

1. Respondent, beginning in or about January 1991, and continuing through at least July 1995, inappropriately prescribed Valium and Xanax to Patient E, despite the patient's history of, and indications of ongoing problems with, substance abuse.

2. Respondent failed to appropriately respond to indications of substance abuse by Patient E.

3. Respondent failed to maintain records that accurately reflect his response to the indications of substance abuse by Patient E.

F. Respondent, on or about January 1, 1995, completed his registration application to the New York Education Department to be licensed as a physician for the period January 1, 1995 through October 31, 1997.

1. Respondent knowingly and intentionally failed to provide details regarding the **restriction** of his hospital privileges, as required by that application, in response to Question 1(c), which read as follows:

> Since you last registered, has any hospital or licensed facility restricted or terminated your professional . . . privileges . . . ?

In fact, Respondent's privileges at BryLin Hospital had been summarily suspended beginning April 21, 1993 and continuing through July 6, 1994, all of which was after Respondent's last registration, and Respondent knew such facts.

2. Respondent knowingly and intentionally failed to provide details regarding the **resignation** of his privileges, as required by that application, in

response to Question 1(c), which read as follows:

> Since you last registered, has any hospital or licensed facility restricted or terminated your professional . . . privileges . . ., or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence, or negligence?
>
> In fact, Respondent had resigned from BryLin Hospital on July 6, 1994 after having been charged by the hospital on May 19, 1994 with acts constituting professional misconduct, unprofessional conduct, incompetence, and/or negligence, all of which was after Respondent's last registration, and Respondent knew such facts.

G. On or about February 13, 1998, the Buffalo Area Office of the New York State Department of Health, Office of Professional Medical Conduct, personally served a letter to the Respondent in accordance with §230 of the Public Health Law, requesting transmission of original medical records of Patient A, B, C, D and E. Respondent was advised in the letter that failure to transmit the records could be held to be punishable as professional misconduct under the New York Education Law. Respondent failed to transmit a copy of such record within thirty days, the time set forth in §230 of the Public Health Law.

H. By Administrative Review Board Determination and Order No. 93-161, issued on or about January 10, 1994, the Administrative Review Board of the Bureau of Professional Medical Conduct, Department of Health, State of New York, ("ARB") sustained a Hearing Committee Determination of October 8, 1993, that Respondent was guilty of professional misconduct, including fraud, wilfully making a false report, and inadequate record

keeping. The ARB confirmed that Respondent should receive a censure and reprimand, and that he should be fined $30,000 as a penalty. More than $29,000 of this fine remains due and owing.

SPECIFICATIONS OF MISCONDUCT

FIRST THROUGH FIFTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(2) (McKinney Supp. 1998) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. Paragraph A and A.5.
2. Paragraphs B and B.5, B and B.8, and/or B and B.10.
3. Paragraph D and D.4.
4. Paragraph C and C.1 and/or C and C.2.
5. Paragraph F and F.1 and/or F and F.2.

SIXTH THROUGH TENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) (McKinney Supp. 1998) by conduct in the practice of medicine which evidences moral unfitness to practice medicine, as alleged in the facts of the following:

6. Paragraphs A and A.4(g)and/or A and A.5.
7. Paragraphs B and B.5, B and B.6, B and B.8, and/or B and B/10.
8. Paragraph C and C.1 and/or C and C.2.

9. Paragraph D and D.4.

10. Paragraphs F and F.1 and/or F and F.2.

ELEVENTH SPECIFICATION

EXERCISING UNDUE INFLUENCE FOR FINANCIAL GAIN OF RESPONDENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(17) (McKinney Supp. 1998) by exercising undue influence on a patient in such manner as to exploit the patient for the financial gain of the Respondent, as alleged in the facts of the following:

11. Paragraphs A and A.4(a), A and A.4(d), A and A.4(f), and/or A and A.4(g).

TWELFTH THROUGH FOURTEENTH SPECIFICATIONS

WILFULLY MAKING OR FILING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) (McKinney Supp. 1998) by willfully making or filing a false report, or failing to file a report required by law or by the Department of Health or the Education Department, as alleged in the facts of the following:

12. Paragraphs B and B.5.

13. Paragraph C and C.1.

14. Paragraph F and F.1 and/or F and F.2.

FIFTEENTH AND SIXTEENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(4) (McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

15. Paragraphs A and A.4(a), A and A.4(b), A and A.4(c), A and A.4(d), A and A.4(e), A and A.4(f), A and A.4(g), A and A.4(h) and/or A and A.7.

16. Paragraphs B and B.4(a), B and B.4(b), B and B.4(c), B and B.6, B and B.7, and/or B and B.9.

SEVENTEENTH AND EIGHTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(6) (McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

17. Paragraphs A and A.4(a), A and A.4(b), A and A.4(c), A and A.4(d), A and A.4(e), A and A.4(f), A and A.4(g), A and A.4(h) and/or A and A.6.

18. Paragraphs B and B.4(a), B and B.4(b), B and B.4(c), B and B.6, B and B.7, and/or B and B.9.

NINETEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(3) (McKinney Supp. 1998) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

19. Paragraphs A and A.1, A and A.2, A and A.3, A and A.4(a), A and A.4(b), A and A.4(c), A and A.4(d), A and A.4(e), A and A.4(f), A and A.4(g), A and A.4(h), A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4(a), B and B.4(b), B and B.4(c), B and B.6, B and B.7, B and B.9, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, and/or E and E.3.

TWENTIETH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(5) (McKinney Supp. 1998) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

20. Paragraphs A and A.1, A and A.2, A and A.3, A and A.4(a), A and A.4(b), A and A.4(c), A and A.4(d), A and A.4(e), A and A.4(f), A and A.4(g), A and A.4(h), A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4(a), B and B.4(b), B and B.4(c), B and B.6, B and B.7, B and B.9, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, and/or E and E.3.

TWENTY-FIRST THROUGH TWENTY-THIRD SPECIFICATIONS

WILFUL OR GROSSLY NEGLIGENT FAILURE TO COMPLY WITH STATE LAWS AND REGULATIONS REGULATING THE PRACTICE OF MEDICINE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(16) (McKinney Supp. 1998) by his willful or grossly negligence failure to comply with substantial provisions of federal, state, or local laws, rules, or regulations governing the practice of medicine, as alleged in the facts of the following:

21. Paragraphs B and B.5.

22. Paragraph C and C.1.

23. Paragraphs F and F.1 and/or F and F.2.

TWENTY-FOURTH SPECIFICATION
FAILURE TO PROVIDE RECORDS UPON DEMAND

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(28) (McKinney Supp. 1998) by failing to respond within thirty days to written communications from the Department of Health and to make available any relevant records with respect to an inquiry or complaint about the licensee's professional misconduct, as alleged in the facts of the following:

24. Paragraph G.

TWENTY-FIFTH SPECIFICATION
FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) (McKinney Supp. 1998) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

25. Paragraph A and A.3, A and A.5, B and B.3, B and B.5, B and B.9, D and D.3, and/or E and E.3.

TWENTY-SIXTH SPECIFICATION

VIOLATING A CONDITION IMPOSED ON THE RESPONDENT PURSUANT TO SEC. 230

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(29)(McKinney Supp. 1998) by violating a condition imposed on him pursuant to Section 230 of the Public Health Law, as alleged in the facts of:

26. Paragraph H.

DATED: , 1998

Albany, New York

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