STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

December 20, 1994

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrance Sheehan, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza-Sixth Floor
New York, New York 10001

Kenneth Kleiner, M.D.
48-45 65th Place
Woodside, New York 11590

RE: In the Matter of Kenneth Kleiner, M.D.

Effective Date: 12/27/94

Dear Mr. Sheehan and Dr. Kleiner:

Enclosed please find the Determination and Order (No. 94-268) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the Administrative Review

Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw

Enclosure

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

IN THE MATTER	DETERMINATION
OF	AND
KENNETH KLEINER, M.D.	ORDER
	BPMC94-268

A Notice of Hearing, dated September 30, 1994, and a Statement of Charges, dated August 7, 1994, were served upon the Respondent, Kenneth Kleiner, M.D. **SHARON C. H. MEAD, M.D. (Chair), GERALD BRODY, M.D., and EUGENIA HERBST**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Terrence Sheehan, Esq., Associate Counsel. The Respondent failed to appear in person and was not represented by counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges: October 11, 1994

Answer to Statement of Charges:
None

Pre-Hearing Conference:
None

Date of Hearings:
October 27, 1994

Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendation:
November 22, 1994

Received Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendation:
None Received

Witnesses for Department of Health: John C. Flynn

Robert J. Campbell, M.D.

Witnesses for Respondent:
None

Deliberations Held:
November 29, 1994

STATEMENT OF CASE

The Department has charged Respondent with fifteen specifications of professional misconduct regarding his medical care and treatment of eight patients. More specifically, the Department has charged Respondent with negligence on more than one occasion, violation of Article 33 of the Public Health Law, willful harassment, exercising undue influence, failure to

maintain records, failure to provide records, and moral unfitness to practice medicine. The Respondent failed to appear at the hearing and presented no defense to the charges.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Kenneth Kleiner, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State on June 13, 1980 by the issuance of license number 142335 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994. (Pet. Ex. #11).

2. Robert J. Campbell, M.D., testified as an expert witness for Petitioner. Dr. Campbell is a board certified psychiatrist and the Medical Director of Gracie Square Hospital. He is a professor of psychiatry at Cornell University Medical College and a past vice-president of the American Psychiatric Association. He is the author of academic articles and books,

including the Psychiatric Dictionary, an 811-page book published by Oxford Press. (29-30).

Patient A

3. Between in or about December, 1990, and in or about December, 1992, Respondent treated Patient A. (Pet. Ex. #6).

4. Dr. Campbell testified that a necessary element of proper patient care is the maintenance of adequate medical records. It is impossible to provide quality medical care on a continuing basis without maintaining accurate medical records. Respondent failed to maintain a medical record for Patient A. As a result, Dr. Campbell further testified that it must be concluded that Respondent failed to obtain adequate medical, family and personal histories and failed to perform an adequate physical examination of Patient A. (32-33; 38).

5. Respondent issued approximately 114 prescriptions to Patient A. The prescriptions were for the following medications: diazepam, Halcion, Percodan, Anexsia, Percocet, Voltaren, chloralhydrate, Trilisate, acetaminophen with codeine, amoxicillin, Materna, cortifoam aerosol, Nitrostat, Zantac, butalbitol, Habitrol patch, Ventolin syrup, Dimetane syrup, Fioricet, dicloxacillin, desipramine, Alupent inhaler, Inderal, amitriptyline, cyclobenzapine, sulfamethorozole, Provera, estrogen, and hydroxyzine HCL. (Pet. Ex. #6).

6. These 114 prescriptions were issued without medical indication. (37).

7. Diazepam, Halcion, Percodan, Anexsia, Percocet,

chloralhydrate and acetaminophen with codeine have a potential for addiction and habituation. (37).

8. by indiscriminately issuing prescriptions for those drugs, Respondent risked causing or perpetuating an habituation or addiction by Patient A to those medications. (37).

9. Respondent prescribed many of these addictive drugs for a period of years. There was no evidence of any attempt to withdraw the patient from any of these drugs. (37).

10. Dr. Campbell testified that the treatment rendered to this patient did not comport with the minimally accepted standards of medical practice and that the medical record does not constitute a minimally acceptable record. (37-38).

Patient B

11. Between on or about March 19, 1992 and on or about January, 1993, Respondent treated Patient B. During this period, Respondent issued seven prescriptions to Patient B - five for diazepam, one for Xanax, and one for dicloxacillin. These prescriptions were not medically indicated. (40-41; Pet. Ex. #6).

12. By issuing the prescriptions for diazepam, Respondent unnecessarily risked causing or perpetuating an addiction or habituation by Patient B to this medication. Respondent arbitrarily doubled the dosage on occasion. He went back and forth between a normal dosage and a double dosage. Dr. Campbell testified that there was no justification for this type of practice and that it is potentially hazardous. (41).

13. In or about May or June, 1993, Respondent contacted

Patient B and inquired whether she needed any prescription medication. The patient replied that she did not need any medication and there was no need for him to see her. Later that day, Respondent arrived at the patient's home and after she did not respond to her door buzzer, Respondent began pounding and kicking her door. Patient B hid in the apartment and told her adult son to answer the door. After the door opened, Respondent pushed her son aside, walked into the foyer, and demanded to know where Patient B was. After satisfying himself that Patient B was not present, Respondent left the premises. (Pet. Ex. #10).

14. On or about August 12, 1993, Respondent again contacted Patient B by phone and informed her that he would visit her the following day in order to give her new prescriptions. Patient B replied that she did not want to see him and that she already had another physician. The following day, Respondent arrived at the patient's house and again began banging on her door. The patient's son opened the door and told Respondent that Patient B wasn't home. Respondent then stated that he wanted to come into the house in order to play a political song for the son. The son refused his request and Respondent left. (Pet. Ex. #10).

15. The patient believed that Respondent, by engaging in this sort of behavior, was attempting to get her "hooked" on medications. (Pet. Ex. #10).

16. On another occasion in 1992, Respondent visited Patient B's home and indicated that he needed to obtain a blood sample. It took four attempts for Respondent to successfully

draw the blood. When he was done, Respondent left three used needles on the patient's kitchen table. By leaving the used hypodermic needles on the patient's table, Respondent failed to meet minimally acceptable standards of medical practice. (42-43).

17. Dr. Campbell testified that, pursuant to New York State law, diazepam must be prescribed on a triplicate prescription. This allows the Department to track physicians' prescribing practices concerning this potentially dangerous drug. Respondent and a pharmacy in Staten Island engaged in a practice to defeat the purpose of this law. Respondent would issued white-pad prescription to Patient B, and instructed her to have the prescription filled at a particular pharmacy, namely Midland Pharmacy in Staten Island. (44; Pet. Ex. #10).

18. The treatment rendered by Respondent to Patient B does not comport with minimally accepted standards of medical practice. Respondent failed to maintain a minimally adequate medical record. (45).

Patient C

19. Respondent treated Patient C between in or about June, 1989 and in or about December, 1992. (Pet. Ex. #6).

20. Respondent did not maintain a medical record for Patient C describing the patient's medical, family and personal histories and containing the results of complete physical examinations. On several occasions, according to Patient C, physical examinations were conducted inside Respondent's car. (Pet. Ex. #12).

21. Respondent prescribed Nitrostat for Patient C. Nitrostat is a heart medication which should not be given in the absence of a complete cardiac history and an adequate examination of the heart. There is no indication that Respondent satisfied either of these requirements. (46-47).

22. Respondent also issued approximately 27 prescriptions for diazepam, Percodan, Anexsia, and Percocet to this patient. Given the complete lack of a patient history and physical examination, these medications should not have been prescribed. (47; Pet. Ex. #6).

23. All of the medications listed in paragraph 22, above, present a risk of habituation or addiction. Respondent unnecessarily subjected Patient C to such risk. (47).

24. The treatment rendered to Patient C by Respondent did not meet minimum standards of medical standards. Respondent failed to maintain a minimally adequate record. (47-48).

Patient D

25. Respondent treated Patient D between in or about June, 1989 and in or about September, 1992. (Pet. Ex. #6).

26. During this period, Respondent issued approximately forty-five prescriptions for diazepam, Anexsia, Percocet, and oxycodone with APAP. These prescriptions were not medically indicated. (48; Pet. Ex. #6).

27. Respondent did not maintain a medical record for this patient. Consequently, there are no available medical, family and personal histories, or any results of physical examinations. (48, 51).

28. Each of the medications prescribed for Patient D by Respondent present the potential for habituation or addiction. There is no evidence that Respondent made any attempt to wean the patient from these medications. By failing to gradually reduce the frequency of prescriptions and the dosage of the medications, Respondent unnecessarily risked causing or perpetuating an habituation or addiction to these medications. (49).

Patient E

29. Between in or about March, 1989, and in or about December, 1993, Respondent treated Patient E. (Pet. Ex. #6).

30. Respondent did not maintain a medical record for this patient and therefore, failed to maintain adequate medical, family and personal histories, and failed to record the results of an adequate physical examination of Patient E. (52).

31. Respondent issued approximately 149 prescriptions to this patient. The prescriptions were for diazepam, Darvocet, Elavil, Noroxin, amitriptyline, Fastin, Prozac, propoxyphene, Ceclor, Pepcid, Flagyl, furosemide, Capoten, Lasix, and Klor-Con. These prescriptions were issued without medical indication. (51-52).

32. By prescribing diazepam and Darvocet to Patient E over a protracted period of time, he risked causing or perpetuating an habituation or addiction to these drugs. (52; Pet. Ex. #6).

33. The treatment rendered by Respondent to Patient E failed to meet minimally acceptable medical standards. (52).

Patient F

34. Respondent treated Patient F between in or about April, 1989, and in or about December, 1992. (Pet. Ex. #6).

35. Respondent issued 141 prescriptions to Patient F during this period. The prescriptions were for diazepam, Percocet, Anexsia, oxycodone with APAP, Seldane, Naprosyn, Tenormin, Amoxil, Atarax and Vistoril. None of these prescriptions were medically indicated in the treatment of this patient. (53; Pet. Ex. #6).

36. By issuing the prescriptions for diazepam, Percocet, Anexsia, and oxycodone with APAP, Respondent unnecessarily risked causing or perpetuating an habituation or addiction by Patient F to these medications. (53).

37. Respondent failed to attempt to reduce the frequency with which the patient received the medications or to wean the patient off these medications. (53).

38. The treatment rendered by Respondent to Patient F failed to meet minimally acceptable standards of medical practice. Further, Respondent failed to maintain a medical record for the patient. (53).

Patient G

39. Respondent treated Patient G between in or about January, 1991 and in or about March, 1993. (Pet. Ex. #6).

40. Respondent issued approximately thirty-five prescriptions to the patient during this period. The prescriptions were for diazepam, amoxicillin, Motrin, ibuprofen, Zantac, Carafate and Tessalon perles. None of these

prescriptions were medically indicated. (54).

41. Patient G admitted that during the period of time that she received prescriptions from Respondent, she was addicted to one or more controlled substances. (54; Pet. Ex. #12).

42. Respondent prescribed diazepam to Patient G in extremely high dosages without adequate medical documentation. The dosage was 10 mgs., 3 times daily, for a total of 30 mgs. By issuing the prescriptions for diazepam to Patient G, Respondent risked causing or perpetuating an habituation or addiction to the drug. (55).

43. The treatment rendered to Patient G by Respondent failed to meet minimally acceptable standards of medical practice. Respondent failed to maintain a medical record for the patient. (55).

Patient H

44. Between in or about December, 1991 and in or about January, 1994, Respondent treated Patient H. (Pet. Ex. #6).

45. This patient is the husband of Patient A. Respondent issued thirty-three prescriptions to Patient H. These prescriptions were for diazepam, Fiorinal with codeine, Tylenol with codeine, Fioricet, Amoxil, Ceclor, amoxicillin, Habitrol, Rondec drops, Feldene and Trilisate. None of these medications were medically indicated. (56; Pet. Ex. #6).

46. By prescribing diazepam, Fiorinal with codeine, Tylenol with codeine and Fioricet, Respondent risked causing or perpetuating an habituation or addiction by the patient. (56).

47. The treatment rendered by Respondent to this

patient failed to meet minimally acceptable standards of medical practice. Moreover, Respondent failed to maintain a medical record for the patient. (57).

Public Health Law Article 33

48. On or about June 13, 1994, the Commissioner of Health found, after an adjudicatory hearing, that Respondent had violated Article 33 of the Public Health Law in that Respondent, between July 10, 1993 and July 22, 1993, had failed to make available his official triplicate prescription prescribing records to representatives of the Department of Health, Bureau of Controlled Substances, in violation of Public Health Law §§3304(1) and 3370(2) (McKinney 1993) and 10 NYCRR 80.100(b). Respondent was assessed a civil penalty of $4,000. (Pet. Ex. #7).

Production of Records

49. On or about April 4, 1994, Respondent personally received a subpoena issued by the Department of Health which called for production of numerous patient medical records maintained by Respondent. In a reply dated April 4, 1994, Respondent refused to provide the requested records and to date the documents have not been produced. (Pet. Ex. #3; Pet. Ex. #4; Pet. Ex. #5).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a

unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A: (3-10);

Paragraph A.1: (4);

Paragraph A.2: (5);

Paragraph A.3: (6-8);

Paragraph A.4: (4, 10);

Paragraph B: (11-18);

Paragraph B.1: (18);

Paragraph B.2: (11);

Paragraph B.3: (12);

Paragraph B.4: (13);

Paragraph B.5: (14);

Paragraph B.6: (16);

Paragraph B.7: (17);

Paragraph B.9: (18);

Paragraph C: (19-24);

Paragraph C.1: (20, 24);

Paragraph C.2: (22;

Paragraph C.3: (23);

Paragraph C.4: (20, 24);

Paragraph D: (25-28);

Paragraph D.1: (27);

Paragraph D.2: (26);

Paragraph D.3: (28);

Paragraph D.4: (27);

Paragraph E: (29-33);

Paragraph E.1: (30);

Paragraph E.2: (31);

Paragraph E.3: (32);

Paragraph E.4: (30, 33);

Paragraph F: (34-38);

Paragraph F.1: (38);

Paragraph F.2: (35);

Paragraph F.3: (36);

Paragraph F.4: (38);

Paragraph G: (39-43);

Paragraph G.1: (43);

Paragraph G.2: (40);

Paragraph G.3: (41);

Paragraph G.4: (42);

Paragraph G.6: (43);

Paragraph H: (44-47);

Paragraph H.1: (47);

Paragraph H.2: (45);

Paragraph H.3: (46);

Paragraph H.4: (47);

Paragraph I: (48);

Paragraph J: (49).

The Hearing Committee further concluded that the

following Factual Allegations should not be sustained:

Paragraph B.8;

Paragraph G.5.

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each Specification:

First Specification: (Paragraphs A, A.1 through A.4, B, B.1 through B.3, B.6 and B.9, C, C.1 through C.4, D, D.1 through D.4, E, E.1 through E.4, F, F.1 through F.4, G, G.1 through G.4 and G.6, H, H.1 through H.4);

Second Specification: (Paragraph I);

Third Specification: (Paragraph B.4);

Fourth Specification: (Paragraph B.5);

Fifth Specification: (Paragraph B.7);

Sixth Specification: (Paragraphs A and A.4);

Seventh Specification: (Paragraph B and B.9);

Eighth Specification: (Paragraphs C and C.4);

Ninth Specification: (Paragraphs D and D.4);

Tenth Specification: (Paragraphs E and E.4);

Eleventh Specification: (Paragraphs F and F.4);

Twelfth Specification: (Paragraphs G and G.6);

Thirteenth Specification: (Paragraphs H and H.4);

Fourteenth Specification: (Paragraph J);

Fifteenth Specification: (Paragraphs B.4, B.5 and B.7).

DISCUSSION

Respondent is charged with fifteen specifications alleging professional misconduct within the meaning of Education Law §6530. More specifically, the Department has charged Respondent with negligence on more than one occasion, violation of Article 33 of the Public Health Law, willful harassment, exercising undue influence, failure to maintain records, failure to provide records, and moral unfitness to practice meidicine. Public Health Law §6530 sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definition contained in the memorandum was utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Neither the statute, the regulations nor the memorandum prepared by the General Counsel define the terms, "willful", "harassment", or "undue influence". Therefore, the Hearing Committee looked to other sources for guidance.

The Committee consulted Black's Law Dictionary (5th Ed.). Black's (at page 645) defines "harassment", in pertinent part, as "...Used in variety of legal contexts to describe words, gestures and actions which tend to annoy, alarm and abuse (verbally) another person....".

The term "willful" is defined (at page 1434), in pertinent part, as "...Proceeding from a conscious motion of the will; voluntary. Intending the result which actually comes to pass; designed; intentional; not accidental or involuntary...A willful act may be described as one done intentionally, knowingly, and purposely, without justifiable excuse, as distinguished from an act done carelessly, thoughtlessly, heedlessly or inadvertently....".

The term "undue influence" is defined in Blacks' (at page 1370), in pertinent part, as "...Any improper or wrongful constraint, machination, or urgency of persuasion whereby the will of a person is overpowered and he is induced to do or forbear an act which he would not do or would do if left to act freely...Misuse of position of confidence or taking advantage of a person's weakness, infirmity, or distress to change improperly that person's actions or decisions."

Utilizing these definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the Department has sustained its burden of proof with regard to each of the specifications of professional misconduct contained in the Statement of Charges. The rationale for the Committee's conclusions regarding each

specification of misconduct is set forth below.

Negligence On More Than One Occasion

The evidence established that Respondent repeatedly prescribed large quantities and varieties of controlled substances to each of the eight patients which are the subject of these proceedings. Because of the lack of any medical records which might justify the prescription of these drugs, the Hearing Committee concluded that there was no medical indication for the use of any of the various medications for each of these patients. Further, the Hearing Committee gave credence to the testimony of Dr. Campbell. Dr. Campbell testified that the indiscriminate use of controlled substances with a known potential for causing or perpetuating an habituation or addiction, was contrary to minimally accepted standards of medical practice. In addition, it is apparent that Respondent made no attempts to ever withdraw or reduce the amount of controlled substances prescribed for the patients. Moreover, Dr. Campbell testified that the maintenance of adequate medical records is an essential element of proper medical care.

Based upon the foregoing, the Hearing Committee concluded that Respondent failed to provide the medical care that a reasonably prudent physician would have provided, with respect to Patients A through H. Consequently, the Committee concluded that the First Specification (Negligence on more than one occasion), should be sustained.

Violation of Article 33 of the Public Health Law

The record clearly established that on June 14, 1994, an Order (# CS-94-10) was issued, by which Respondent was found guilty of failing to make readily available and promptly produce for inspection and copying by authorized represents of the Bureau of Narcotic Control, records required to be maintained by Article 33 of the Public Health Law. A civil penalty in the amount of $4,000.00 was assessed against Respondent.

By virtue of this adjudication by the Commissioner of Health, Respondent is guilty of professional misconduct within the meaning of Education Law §6530(9)(e). As a result, the Hearing Committee voted to sustain the Second Specification.

Willful Harassment

Respondent was also charged with willfully harassing, abusing or intimidating a patient either physically or verbally, in violation of Education Law §6530(31). The record established that on two occasions (in or about May or June, 1993, and on or about August 12, 1993) Respondent contacted Patient B by telephone. On both occasions, the patient told Respondent that she did not need any prescriptions and did not want to see him. Nevertheless, Respondent then came to the patient's home. When the patient refused to answer the door, Respondent began pounding and kicking the door. Patient B hid in the apartment and told her adult son to answer the door. On one occasion, Respondent pushed her son aside, walked into the foyer and demanded to know where Patient B was. On the second occasion, Patient B's son

opened the door and told Respondent that his mother wasn't home. Respondent then stated that he wanted to come into the house in order to play a "political song" for the son.

The Hearing Committee unanimously concluded that Respondent's conduct in this regard was both "willful" and "harassment", as defined by Black's Law Dictionary, above. Consequently, the Committee voted to sustain the Third and Fourth Specifications of professional misconduct.

Exercising Undue Influence

Respondent was charged with professional misconduct within the meaning of Education Law §6530(17) by exercising undue influence on a patient, including the promotion of the sale of services, goods, appliances or drugs in such manner as to exploit the patient for the financial gain of the licensee or of a third party.

The record established that Respondent induced Patient B to violate the triplicate prescription requirements of the Public Health Law. Respondent issued to the patient ordinary white-pad prescriptions for diazepam. In New York, prescriptions for diazepam must be written on triplicate prescriptions, a fact which was known to Patient B. Respondent induced Patient B to take the improper prescriptions to a specific pharmacy in Staten Island (Midland Pharmacy) because the owner supposedly "had his triplicates there". (See, Pet. Ex. #10, p. 2).

The Hearing Committee concluded that Respondent used his position of confidence and authority as a physician to induce Patient B to obtain diazepam in a manner contrary to her wishes,

as well as the requirements of New York law, for his benefit as well as the benefit of a third party (Midland Pharmacy). As a result, the Committee further concluded that Respondent's conduct constituted the exercise of undue influence with regard to Patient B, and voted to sustain the Fifth Specification.

Failure to Maintain Records

Respondent failed to produce any medical records for Patients A through H, despite the issuance of a subpoena for their production. The Hearing Committee therefore concluded that Respondent failed to maintain a record for each of these patients which accurately reflects the evaluation and treatment of the patient, in violation of Education Law §6530(32). Consequently, the Committee voted to sustain the Sixth through Thirteenth Specifications.

Failure to Provide Records

As was noted above, Respondent failed to produce the medical records for Patients A through H despite the issuance of a subpoena, served on or about April 4, 1994. Education Law §6530(28) defines professional misconduct as the failure to make available relevant patient medical records to the Department of Health within 30 days of Respondent's receipt of the request for such records.

As of the date of the hearing in this matter, Respondent had failed to produce any records for Patients A through H, or to give a credible explanation for such failure. As a result, the Hearing Committee voted to sustain the Fourteenth Specification.

· Moral Unfitness

Respondent is also charged with practicing the profession in a manner which evidences moral unfitness to practice medicine in violation of Education Law §6530(20). Conduct which evidences moral unfitness can arise either from conduct which violates a trust related to the practice of the profession or from activity which violates the moral standards of the professional community to which the Respondent belongs. The Hearing Committee unanimously concluded that Respondent's willful harassment of Patient B, as well as his exercise of undue influence over the patient in order to induce her to obtain controlled substances without medical indication, and in violation of New York law, constituted a serious breach of Respondent's professional trust. As a result, the Committee voted to sustain the Fifteenth Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be revoked. In addition, the Committee determined that a fine in the amount of $80,000.00 should be imposed. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The evidence produced at this hearing clearly

demonstrated that Respondent repeatedly breached the standards of practice expected of members of the medical profession. With regard to each of the eight patients presented, Respondent repeatedly prescribed controlled substances with a serious potential for causing or perpetuation habituation or addiction, without any medical indication. Respondent failed to maintain any medical records for these patients which might justify their treatment.

Moreover, Respondent repeatedly and willfully harassed one patient (Patient B) in an attempt to give her further prescriptions for drugs, even though she informed him that she did not need them and was seeing another physician. In addition, Respondent abused his position as a physician to induce Patient B to obtain diazepam in a manner clearly prohibited by law, purely for his benefit and the benefit of a third party. Each of the charges brought against Respondent would warrant the revocation of his license. Taken together, they present a compelling argument for revocation.

Respondent failed to appear at the hearing and presented no defense to the charges, nor offered any evidence in mitigation. Under the totality of the circumstances, the Hearing Committee concluded that revocation was the appropriate sanction. In addition, the Committee further determined that a fine was appropriate. The Committee determined that Respondent's continued prescription of dangerous drugs without medical indication was motivated by greed. As a result, the Committee determined that a fine in the amount of $80,000.00 ($10,000.00

per patient) should be imposed.

ORDER

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

1. The First through Fifteenth Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;

2. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED**;

3. A fine in the amount of **EIGHTY THOUSAND DOLLARS ($80,000.00)** be and hereby is assessed against Respondent. Payment of the aforesaid sum shall be made to the Bureau of Accounts Management, New York State Department of Health, Erastus Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York 12237 within thirty (30) days of the effective date of this Order;

4. Any fine not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32).

DATED: Albany, New York
15 December **1994**

SHARON C. H. MEAD, M.D. (CHAIR)

GERALD BRODY, M.D.
EUGENIA HERBST

TO: Terrence Sheehan, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Kenneth Kleiner, M.D.
48-45 65th Place
Woodside, New York 11377

APPENDIX I

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

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IN THE MATTER : NOTICE

OF : OF

KENNETH KLEINER, M.D. : HEARING

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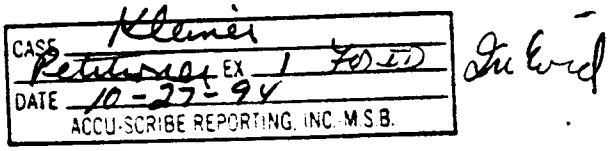
TO: KENNETH KLEINER, M.D.
48-45 65th Place
Woodside, NY 11377



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 27th day of October, 1994 at 11:00 in the forenoon of that day at 5 Penn Plaza, Sixth Floor, New York, New York 10001 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 Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), 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 (McKinney 1990 and Supp. 1994), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer 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 MEDICINE 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 (McKinney Supp. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York

Sept 30, 1994

CHRIS STERN HYMAN
Counsel

Inquiries should be directed to: TERRENCE SHEEHAN
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001
Telephone No.: 212-613-2601

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
KENNETH KLEINER, M.D.	:	CHARGES

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KENNETH KLEINER, M.D., the Respondent, was authorized to practice medicine in New York State on June 13, 1980 by the issuance of license number 142335 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, 1993 through December 31, 1994.

FACTUAL ALLEGATIONS

A. Between on or about December 11, 1990 and on or about December 16, 1992, Respondent treated Patient A at a location unknown to Petitioner. (Patient names are contained in the attached Appendix).

1. Respondent failed to obtain adequate medical, family and personal histories and failed to perform adequate periodic physical examinations of Patient A.

2. During this period, Respondent issued to Patient A approximately 114 prescriptions for diazepam, halcion, percodan, anexsia, percocet, voltaren, chloralhydrate, trilisate, acetaminophen with codeine, amoxicillin, materna, cortifoam aerosol, nitrostat, zantac, butalbitol, habitrol patch, ventolin syrup, dimetane syrup, fioricet, dicloxacillin desipramine, alupent inhaler, inderal, amitriptyline, cyclobenzapine, sulfamethorozole, provera, estrogen and hydroxyzine hcl, which prescriptions were not medically indicated.

3. By issuing the prescriptions for diazepam, halcion, percodan, anexsia, percocet chloralhydrate and acetaminophen with codeine, Respondent risked causing or perpetuating an habituation or addiction by Patient B to these medications.

4. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient complaints, history, examination, diagnoses, progress notes and treatment plan.

B. Between on or about March 3, 1992 and or about January 30, 1993 Respondent treated Patient B at Patient B's home in Staten Island.

1. Respondent failed to obtain adequate medical, family and personal histories and failed to perform an adequate physical examination.

2. During this period, Respondent issued to Patient B approximately 7 prescriptions, including 5 for diazepam, one for xanax and one for dicloxacillin, which prescriptions were not medically indicated.

3. By issuing the prescriptions for diazepam, Respondent risked causing or perpetuating an habituation or addiction by Patient B to this medication.

4. In or about May or June, 1993, Respondent telephoned Patient B and asked whether she needed any prescriptions. She indicated she was fine and there was no need for her to see him. A short time later Respondent appeared at her door and rang her buzzer. Patient B did not respond. Shortly, Respondent began pounding and kicking the door. Patient B hid elsewhere and told her 28 year old son to open the door. Respondent then pushed her son aside and walked into the front hallway demanding to know where Patient B was. The son screamed at Respondent to leave and after satisfying himself that Patient B was not present, Respondent left.

5. On or about August 12, 1993, Respondent again contacted Patient B by phone and informed her that she must need new prescriptions and that he would visit her the following day. Patient B replied that she did not want to see him and that she was seeing another physician. The following day Respondent arrived at her house. After she did not answer the buzzer Respondent began banging on the door. The patient's son opened the door and told Respondent that the patient wasn't home. After Respondent became convinced Patient B was absent he told the son that he wanted to come into the house in order to play for the son a political song he had written. The son refused this request and Respondent left.

6. On one occasion in 1992 Respondent visited Patient B's home and indicated that he needed to extract blood for a blood workup. It took four attempts before Respondent was able to successfully draw the blood. The procedure was performed in the Patient's kitchen. Before he departed Respondent left three used needles and a piece of bloody gauze on the patient's kitchen table.

7. On the occasions when Respondent would prescribe diazepam or other medications requiring a triplicate

prescription, Respondent would issue to Patient B a regular white pad prescription for the medication and tell Patient B to have the prescription filled at Midland Pharmacy in Staten Island, where Respondent purportedly kept his official triplicate prescriptions.

8. On one occasion in 1992 Respondent prescribed estrogen and provera for Patient B without ordering any blood tests.

9. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient complaints, history, examination, diagnoses, progress notes and treatment plan.

C. Between on or about June 30, 1989 and on or about December 16, 1992, Respondent treated Patient C at a location unknown to Petitioner.

1. Respondent failed to obtain adequate medical, family and personal histories and failed to perform an adequate physical examinations. On several occasions Respondent met Patient C in a car in a parking lot and attempted to perform the physical examination inside Respondent's car.

2. During this period, Respondent issued to Patient C approximately 27 prescriptions for diazepam, percodan, anexia, percocet, and nitrostat, which prescriptions were not medically indicated.

3. By issuing the prescriptions for diazepam, percodan, anexia, and percocet Respondent risked causing or perpetuating an habituation or addiction by Patient C to these medications.

4. Respondent failed to maintain a medical record for Patient C which accurately reflects the patient complaints, history, examination, diagnosis, progress notes and treatment plan.

D. Between on or about June 5, 1989 and on or about September 28, 1992, Respondent treated Patient D at a location unknown to Petitioner.

1. Respondent failed to obtain adequate medical, family and personal histories and failed to perform adequate periodic physical examinations of Patient D.

2. During the period, Respondent issued to Patient D approximately 45 prescriptions for diazepam, anexsia,

percocet and oxycodone, with APAP, which prescriptions were not medically indicated.

3. By issuing the prescriptions for diazepam, anexsia, percocet and oxycodone with APAP Respondent risked causing or perpetuating an habituation or addiction by Patient D to these medications.

4. Respondent failed to maintain a medical record for Patient D which accurately reflects the patient complaints, history, examination, diagnoses, progress notes and treatment plan.

E. Between in or about March 15, 1989 and on or about December 23, 1993 Respondent treated Patient E at a location unknown to Petitioner.

1. Respondent failed to obtain adequate medical, family and personal histories and failed to perform adequate periodic physical examinations of Petitioner E.

2. During this period, Respondent issued to Patient E approximately 149 prescriptions for diazepam, darvocet, elavil, noroxin, amitriplylline, fastin, prozac, propoxyph, ceclor, pepcid, flagyl, furosemide, capoten,

lasix, and klor-con, which prescriptions were not medically indicated.

3. By issuing the prescriptions for diazepam, darvocet and elavil Respondent risked causing or perpetuating an habituation or addiction by Patient E to these medications.

4. Respondent failed to maintain a medical record for Patient E which accurately reflects the patient complaints, history, examination, diagnoses, progress notes and treatment plan.

F. Between on or about April 13, 1989 and on or about December 22, 1992, Respondent treated Patient F at a location unknown to Petitioner.

1. Respondent failed to obtain adequate medical, family and personal histories and failed to perform adequate periodic physical examinations of Patient F.

2. During this period, Respondent issued to Patient F approximately 141 prescriptions for diazepam, percocet, anexsia, oxycodone with APAP, seldane, naprosyn, tenormin, amoxil, atarax and vistoril which prescriptions were not medically indicated.

3. By issuing the prescriptions for diazepam, percocet, anexsia and oxycodone with APAP Respondent risked causing or perpetuating an habituation or addiction by Paitent F to these medications.

4. Respondent failed to maintain a medical record for Patient F which accurately reflects the patient complaints, history, examination, diagnoses, progress notes and treatment plan.

G. Between on or about January 9, 1991 and on or about March 17, 1993, Respondent treated Patient G at a location unknown to Petitioner.

1. Respondent failed to obtain adequate medical, family and personal histories and failed to perform adequate periodic physical examinations of Petitioner G.

2. During the period, Respondent issued to Patient G approximately 35 prescriptions for diazepam, amoxicillin, motrin, ibuprofin, zantac, carafate, and jessalon perle, which prescriptions were not medically indicated.

3. During the period Patient G saw Respondent, Patient G was addicted to one or more controlled substances.

4. By issuing the prescriptions for diazepam, Respondent risked causing or perpetuating an habituation or addiction by Patient G to this medication.

5. On numerous occasions Respondent allowed Patient G's diazepam prescriptions to be picked up by a friend of Patient G. On these occasions Patient G would give her friend half the pills obtained with the prescriptions.

6. Respondent failed to maintain a medical record for Patient G which accurately reflects the patient complaints, history, examination, diagnosis, progress notes and treatment plan.

H. Between on or about December 3, 1991 and on or about January 22, 1994, Respondent treated Patient H at a location unknown to Petitioner.

1. Respondent failed to obtain adequate medical, family and personal histories and failed to perform adequate periodic physical examinations of Patient H.

2. During this period, Respondent issued to Patient H approximately 33 prescriptions for diazepam, fiorinal with codeine, tylenol with codeine, fioricet, amoxil,

ceclor, amoxicillin, habitral, rondec drops, feldene and trilisate, which prescriptions were not medically indicated.

3. By issuing the prescriptions for diazepam, fiorinal with codeine and tylenol with codeine Respondent risked causing or perpetuating an habituation or addiction by Patient H to these medications.

4. Respondent failed to maintain a medical record for Paitent H which accurately reflects the patient complaints, history, examination, diagnoses, progress notes and treatment plan.

I. On or about June 13, 1994 the Commissioner of Health found, after an adjudicatory hearing, that Respondent had violated Article 33 of the New York Public Health Law in that Respondent, between July 10, 1993 and July 22, 1993, had failed to make available his official triplicate prescription prescribing records to representatives of the Department of Health, Bureau of Controlled Substances, in violation of N.Y. Pub. Health Sections 3304(1) and 3370(2)(McKinney 1993) and 10 NYCRR 80.100(b). For these violations Respondent was assessed a civil penalty of $4,000.

J. On or about April 4, 1994, Respondent personally received a subpoena issued by the Department of Health which called for the forthwith production of numerous patient medical records maintained by Respondent. In a reply dated April 4, 1994, Respondent refused to provide the requested records and, to date, the documents have not been produced.

SPECIFICATIONS OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(3) (McKInney Supp. 1994) by practicing the profession with negligence on more than one occasion in that Petitioner charges two or more of the following:

1. A and A(1) through A(4), B and B(1) through B(3), B(6), B(8) and B(9), C and C(1) through C(4), D and D(1) through D(4), E and E(1) through E(4), F and F(1) through F(4), G and G(1) through G(6), H and H(1), H(2), H(3) and/or H(4).

SECOND SPECIFICATION

VIOLATION OF ARTICLE 33 OF THE PUBLIC HEALTH LAW

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(9)(e) (McKinney Supp. 1994) by virtue of his having been found by the Commissioner of Health to be in violation of Article 33 of the Public Health Law. Petitioner charges:

2. The facts in paragraph I.

THIRD AND FOURTH SPECIFICATIONS

WILLFULL HARRASSMENT

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(31) (McKinney Supp. 1994) by willfully harrassing, abusing or intimidating a patient either physically or verbally in that Petitioner charges:

3. The facts in paragraph B(4).

4. The facts in paragraph B(5).

FIFTH SPECIFICATION

EXERCISING UNDUE INFLUENCE

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(17) (McKinney Supp. 1994) by exercising undue influence on a patient, including the promotion of the sale of services, goods, appliances or drugs in such manner as to exploit the patient for the financial gain of the licensee or of a third party in that Petitioner charges:

5. The facts in paragraph B(7).

SIXTH THROUGH THIRTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1994) by his failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that Petitioner charges:

6. The facts in paragraph A and A(4).

7. The facts in paragraph B and B(9).

8. The facts in paragraph C and C(4).

9. The facts in paragraph D and D(4).

10. The facts in paragraph E and E(4).

11. The facts in paragraph F and F(4).

12. The facts in paragraph G and G(6).

13. The facts in paragraph H and H(4).

FOURTEENTH SPECIFICATION

FAILURE TO PROVIDE RECORDS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(28) by his failure to make available relevant patient medical records to the Department of Health within 30 days of Respondent's receipt of the request in that Petitioner charges:

14. The facts in paragraph J.

FIFTEENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with practicing the profession in a manner which evidences moral unfitness to practice medicine under

N.Y. Educ. Law Section 6530(20) (McKinney Supp. 1994), in that Petitioner charges:

15. The facts in paragraphs B(4), B(5) and/or B(7).

DATED: New York, New York
8/7/95

for:

CHRIS STERN HYMAN
COUNSEL
Bureau of Professional Medical
Conduct