STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

June 2, 2004

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

Seth P. Stein, Esq.
Stein & Schonfeld
100 Quentin Roosevelt Boulevard
Garden City, New York 11530

Michael Robert Gray, M.D.
150 East 30th Street, Apartment 6C
New York, New York 10016

RE: In the Matter of Michael Robert Gray, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 04-118) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), 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.

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,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

IN THE MATTER
OF
MICHAEL ROBERT GRAY, M.D.

DETERMINATION
AND
ORDER
BPMC #04-118

COPY

Walter M. Farkas, M.D., Filippo DiCarmine, M.D., and **Henry Sikorski, Ph.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 Section 230 (1) of the Public Health Law, served as the Hearing Committee for this matter pursuant to Sections 230(10) (e) and 230 (12) of the Public Health Law. **Jane B. Levin, Esq.**, Administrative Law Judge, served as the Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	October 14, 2003
Answer dated:	October 27, 2003
Pre-Hearing Conference:	November 4, 2003
Hearing Dates:	November 12, 2003 January 14, 21, 2004 February 11, 26, 2004 March 3, 25, 2004 April 21, 2004

Deliberation Date:	May 12, 2004
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Petitioner appeared by:	Donald P. Berens, Jr. General Counsel NYS Department of Health By: Terrence Sheehan, Esq. Associate Counsel
Respondent appeared by:	Seth P. Stein, Esq. Stein & Schonfeld 100 Quentin Roosevelt Blvd. Garden City, New York 11530

WITNESSSES

For the Petitioner:

1) Andrei-Claudian Jaeger, M.D.

For the Respondent:

1) Laurence M. Westreich, M.D.
2) Stanley Portnow, M.D.
3) Barry Perlman, M.D.
4) Michael Robert Gray, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct in that he practiced with negligence, failed to maintain adequate records, practiced fraudulently, made or filed a false report and was morally unfit. The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parentheses refer to transcript pages or numbers of 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.

GENERAL FINDINGS

1. Michael Robert Gray, the Respondent, was authorized to practice medicine in the State of New York on or about July 1, 1986 by the issuance of license number 166679 by the New York State Education Department. He maintains an office for the practice of psychiatry at 156 E. 37th Street, Suite 1B, New York, NY 10016.

2. The Respondent graduated from the NYU Medical School in 1985 (T.1356). He completed a psychiatric residency at Bellevue Hospital between 1985 and 1989 (T. 1357), and became board certified in psychiatry in 1990 (T. 1357).

3. After completing his residency, the Respondent became an attending physician at Bellevue Hospital and opened a private practice. Many of his patients were on Medicaid, and some had been his patients at Bellevue. Others had been referred through his contacts at that institution (T. 1363-4).

4. Most of the Respondent's patients herein complained of panic attacks. Panic disorder, defined by the DSM IV, is a general condition, whose signs and symptoms persist for at least one month. These symptoms include recurrent panic attacks and a persistent concern of having another attack. A panic attack is a brief episode of sudden and intense

physical and mental symptoms, which may last ten minutes to an hour, including at least four of the following symptoms: difficulty breathing, rapid heart rate, nausea, tremor and a sense of impending doom (Pet.'s Ex. 14; T. 85).

5. Panic disorder can be a chronic disease, requiring long term treatment with medications such as Xanax, a benzodiazepine, SSRI's, or other medications (T. 168-9; 630-31; 1144-47; Pet.'s Ex. 14).

6. The APA Practice Guideline (Pet.'s Ex. 4) was published in 1998, after treatment had already begun for six of the eight patients herein, recognizes various medications as useful in treating this disorder. If a patient has a history of prior drug abuse, medications other than benzodiazepines should be considered, although benzodiazepines may be used in exceptional cases, as long as that class of drugs had not been abused in the past (T. 289-91; 1144).

7. Over time, an attempt should be made to reduce the dose of benzodiazepines, so that there is less likelihood of dependence (T. 191; 536). If this is not possible without an escalation of the patient's symptoms, the patient may remain on the same dose without a need to increase the dosage to control symptoms (T.44; 1147; 1152).

8. The Respondent maintained an office record for each of the eight patients at issue herein. Although there is no proscribed standard format for psychiatric records in an office practice (T.1133) there are certain components of the psychiatric evaluation that should be included: a comprehensive mental status exam, a history of present illness, the chief complaint, past history, family history, and a history of substance abuse. The record should also state the patient's diagnosis, treatment rationale and treatment (T.37-38; 1208).

9. Although there is no specific required format for psychiatric records, they must accurately reflect a physician's evaluation and treatment of each patient. Pursuant to New York State Education Law §6530(32), a physician is guilty of professional misconduct by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.

10. A physician is negligent when he or she fails to exercise the care that a reasonably prudent physician would under the same circumstances. Pursuant to New York State Education Law §6530(3), a physician is guilty of professional misconduct by practicing the profession with negligence on more than one occasion.

FINDINGS OF FACT AS TO PATIENT A

1. Patient A, a male, was treated by the Respondent at his office from July 1995 through March 2001 (Pet.'s Ex. 3).

2. On the initial patient evaluation, the Respondent did not document a chief complaint, a mental status exam or a past psychiatric history. There is documentation of medical and family history. Patient A admitted a past history of polysubstance abuse that was in remission, although the substances abused and the duration of the abuse is not recorded (Pet.'s Ex. 3).

3. At the initial visit, the patient complained that he "need[s] maintenance on my medication of Xanax and Elavil." The record does not contain historical information as to when the medications were prescribed, for how long, for what conditions and if they were effective at reducing the symptoms (Pet.'s Ex. 3; T. 46-50; 3809).

4. The record documents a description by the patient of positive symptoms for panic attacks, without listing the specific symptoms. There is no diagnosis of panic disorder or treatment plan given (Pet.'s Ex. 3; T. 34).

5. The Respondent maintained Patient A on Xanax for five years. Although the record does not indicate the rationale for this treatment, the dosage was appropriate for panic disorder (Pet.'s Ex. 3; T. 92).

6. Over the course of treatment, the Respondent changed the medications prescribed, at times adding Elavil, Mellaril and Risperdal in appropriate dosages to treat possible psychotic symptoms and panic attacks (Pet.'s Ex. 3; T. 1249). These medications were discontinued after the patient reported that they were ineffective, and requested Xanax. The patient was maintained on a static dose of Xanax for over four years, although the chart does not contain on-going evaluations of the patient's presumable panic disorder, a treatment plan or rationale (Pet.'s Ex. 3).

7. The chart documents several discussions about lowering the dosage of Xanax. There are no notes of dose escalation or lost prescriptions, typical drug seeking behaviors (Pet.'s Ex. 3; T. 123; 168).

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient A because his record failed to accurately document that he performed a thorough psychiatric evaluation and diagnosis of the patient's condition, or that he reached a diagnosis, treatment plan, or treatment rationale based upon initial or follow-up evaluations.

2. Factual allegations A., A.1 (with the exception of medical and personal history), A.2, A.3 (with the exception of excessive strengths and amounts) and A.6 are sustained with respect to negligence and failure to maintain records. Allegations A.4 and A.5 are not sustained.

FINDINGS OF FACT AS TO PATIENT B

8. Patient B, a male, was treated by the Respondent at his office from June 1996 through April 2002 (Pet.'s Ex. 4).

9. On the initial visit, Respondent did not document a chief complaint, but stated that the patient had been receiving Xanax for the past 4 ½ years for anxiety and panic attacks and wanted to continue this regimen (Pet.'s Ex. 4; T. 216-17).

10. The record does not document a mental status exam. The patient reported a past history of IV drug abuse and current enrollment in a methadone maintenance program, and notes a positive history of anxiety disorder and panic attacks, without further details. There is a personal history (Pet. Ex. 4; T. 220-26; 369-70).

11. The record documents the patient's medical history, including Hepatitis C, elevated blood pressure, and the patient's concerns about elevated cholesterol. The record does not document contact with the patient's primary care physician, or any lab reports for medical conditions that could impact on the prescriptions given to Patient B (Pet.'s Ex. 4; T. 359-63).

12. The record minimally indicates the Respondent's treatment plan and rationale. Over the course of the years of treatment of this patient, Respondent prescribed Xanax and Valium in appropriate strengths, for the presumed panic disorder, varying and lowering

dosages slightly in response to the patient's reported symptoms and discussing lowering the dosages (Pet.'s Ex. 4; T. 239-41; 1868).

13. The chart does not document lost prescriptions or dose escalations, evidence of drug seeking behavior (T. 1869).

CONCLUSIONS AS TO PATIENT B

1. The Respondent met minimally acceptable standards of medical practice in his care of Patient B.

2. Factual allegations B., and B.1 (except with regard to psychiatric and drug abuse history) are not sustained. Allegations B.3-B.6 are not sustained with respect to negligence and failure to maintain records.

FINDINGS OF FACT AS TO PATIENT C

14. Patient C, a male, was treated by the Respondent in his office between November 2000 and February 2001 (Pet.'s Ex. 5).

15. On the initial evaluation, the Respondent did not document a chief complaint or a mental status exam. There were some details of the patient's psychiatric history. The record documented a brief medical and family/social history. There were minimal entries about Patient C's admitted past drug use, enrollment in a methadone maintenance program, and attempts to obtain Xanax illicitly to control his anxiety symptoms (Pet.'s Ex. 5; Resp.'s Ex. F; T. 392-4; 423-4).

16. The record for Patient C does not include a diagnosis, treatment plan or rationale (Pet.'s Ex. 5; T. 393-5; 402; 404).

17. Respondent prescribed Xanax in an appropriate amount for the patient's presumed panic disorder and discussed potential problems of abuse of the medication with the patient, although no rationale for the treatment is documented (Pet.'s Ex. 5; T.1916-1919).

18. The chart does not document lost prescriptions or dose escalations, evidence of drug seeking behavior (Pet.'s Ex. 5).

CONCLUSIONS AS TO PATIENT C

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient C because his record failed to accurately document that he performed a thorough psychiatric evaluation and diagnosis of the patient's condition, or that he reached a diagnosis, treatment plan, or treatment rationale based upon initial or follow-up evaluations.

2. Factual allegations C., C.1 (with the exception of medical and personal history), C.2-C.4 and C.6 are sustained with respect to negligence and failure to maintain records. Allegations C.5 is not sustained.

FINDINGS OF FACT AS TO PATIENT D

19. Patient D, a male, was treated by the Respondent at his office from November 1999 through February 2001 (Pet.'s Ex. 6).

20. On the initial evaluation, the Respondent did not document a complete mental status exam. There is some documentation of medical, personal, psychiatric and a negative drug abuse history (Pet.'s Ex. 6; Pet's Ex. F; T. 435-9).

21. The Respondent notes a diagnosis of generalized anxiety and a treatment plan of continuing Xanax at a lower dose than patient had reported receiving from a previous psychiatrist (Pet.'s Ex. 6).

22. Over the course of treatment, Respondent prescribed various psychotropic medications, including anti-depressants, in response to the patient's reports of symptoms. Patient's internist prescribed Paxil, and the Respondent adjusted the dosage, although he did not document contact with the internist. All dosages were within acceptable ranges, and cautionary discussions regarding potential abuse were documented (Pet's Ex. 6; T. 531-2).

23. The chart does not document lost prescriptions or dose escalations, evidence of drug seeking behavior (T. 1937).

CONCLUSIONS AS TO PATIENT D

1. The Respondent met minimally acceptable standards of medical practice in his care of Patient D.

2. Factual allegations D-D.6 are not sustained with respect to negligence and failure to maintain records.

FINDINGS OF FACT AS TO PATIENT E

24. Patient E, a female, was treated by the Respondent at his office from November 1995 through February 2001 (Pet's Ex. 7).

25. On the initial evaluation, there is no documentation of a chief complaint or mental status exam, but the record does document medical, psychiatric and personal

histories. A past history of marijuana was obtained on a later visit. A diagnosis of panic with agoraphobia is documented, as is a treatment plan (Pet.'s Ex. 7; T. 436-7).

26. Over the course of treatment, Respondent prescribed various psychotropic medications, including anti-depressants, in appropriate dosages. The Respondent documented the patient's reported response to these medications, adding a diagnosis of depression two years into treatment, and documented cautionary discussions with the patient about tolerance to these medications (Pet.'s Ex. 7; Resp.'s Ex. F).

27. The chart does not document lost prescriptions or dose escalations, evidence of drug seeking behavior (T. 1964).

CONCLUSIONS AS TO PATIENT E

1. The Respondent did not meet minimally acceptable standards of medical practice in his care of Patient E with regard to record keeping.

2. Factual allegations E, E.1-6 are not sustained with respect to negligence, but E.6 is sustained with regard to failure to maintain records.

FINDINGS OF FACT AS TO PATIENT F

28. Patient F, a female, was treated by the Respondent at his office from November 1995 through December, 2001 (Pet.'s Ex. 8).

29. On the initial patient evaluation, the Respondent did document adequate medical and personal histories. There is no mental status exam, and the psychiatric and drug abuse histories are not complete (Pet.'s Ex. 8).

30. The record reports the patient had severe anxiety symptoms, but there is no list of the symptoms, and no diagnosis. The patient is continued on her previous medication, Klonopin, without a treatment rationale (Pet.'s Ex. 8).

31. At subsequent visits, the Respondent prescribed other psychotropic medications, including Xanax and Elavil, in response to the patient's report of her symptoms, which later included depression. In one chart entry, the Respondent noted that some of the medications had poor to fair efficacy for this patient. The dosages of all medications are within acceptable ranges, but there are no diagnoses, treatment plans, or treatment rationales to support the changes in medications (Pet.'s Ex. 8, T. 548-50; 560-63; 571; 574; 666).

32. At several visits, the Respondent documented attempts to reduce dosages of Xanax and to having cautionary discussions with the patient (Pet.'s Ex. 8).

33. The chart does not document lost prescriptions or dose escalations, evidence of drug seeking behavior (Pet's Ex. 8).

CONCLUSIONS AS TO PATIENT F

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient F because his record failed to accurately document that he performed a thorough psychiatric evaluation of the patient's condition, or that he reached a diagnosis, treatment plan, or treatment rationale based upon initial or follow-up evaluations.

2. Factual allegations F., F.1 (with the exception of medical and personal history), F.2, F.3 (with the exception of excessive strengths and amounts) and F.6 are sustained with respect to negligence and failure to maintain records. Allegations F.4 and F.5 are not sustained.

FINDINGS OF FACT AS TO PATIENT G

34. Patient G, a male, was treated by the Respondent at his office from May1994 through November 2000 (Pet.'s Ex. 9).

35. On the initial patient evaluation, the Respondent did not document a chief complaint or a mental status exam. There is a limited past psychiatric history, noting depression and medications. There is documentation of medical and family history. Patient G originally denied a past history of substance abuse, but later visits document heroin and cocaine abuse, as well as methadone treatment (Pet.'s Ex. 9; T. 554-55).

36. At the initial visit, Xanax was prescribed in the same dosage as the patient reported he had previously been given. There is no initial diagnosis, treatment plan, or rationale for the medication. The record does not contain historical information as to when the medication was originally prescribed, for how long, and for what conditions by a previous physician (Pet.'s Ex. 9).

37. Over the course of treatment, the record documents a description by the patient of positive symptoms for anxiety, anxious depression, and psychosis, without documentation by the Respondent of mental status exams, diagnoses, or treatment plans (Pet.'s Ex. 9).

38. The record documents prescriptions for several psychotropic medications, and adjustments of dosages in response to the patient's reports of his changing symptoms. Although the record does not indicate the rationale for this treatment, the dosages were appropriate for the medications, and the medications were appropriate for presumed panic

disorder, anxious depression and the patient's described auditory hallucinations (Pet.'s Ex. 9; Resp.'s Ex. F).

39. The chart does not document lost prescriptions or dose escalations, typical drug seeking behaviors (Pet.'s Ex. 9; T. 1981).

CONCLUSIONS AS TO PATIENT G

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient H because his record failed to accurately document that he performed a thorough psychiatric evaluation of the patient's condition, or that he reached a diagnosis, treatment plan, or treatment rationale based upon initial or follow-up evaluations.

2. Factual allegations G., G.1 (with the exception of medical and personal history), G.2, G.3 (with the exception of excessive strengths and amounts) and G.6 are sustained with respect to negligence and failure to maintain records. Allegations G.4 and G.5 are not sustained.

FINDINGS OF FACT AS TO PATIENT H

40. Patient H, a male fictitious patient, was am undercover employee of the New York State Medicaid program. He was treated by the Respondent at his office on four occasions between June and November 1995 (Pet.'s Ex. 16).

41. On the initial patient evaluation, the Respondent did not document a chief complaint or a mental status exam. There is a limited past psychiatric history, noting the patient's complaints of anxiety symptoms and attacks, without delineation of the symptoms,

and a report by the patient of past psychiatric treatment. The record notes medical and family history and no past history of substance abuse (Pet.'s Ex. 16).

42. At the initial visit, there is a diagnosis of rule out panic disorder, and the treatment plan documents the continuation of Xanax in the same dosage as the patient reported he had previously been given. The record does not contain historical information as to when the medication was originally prescribed, for how long, and for what conditions by a previous physician (Pet.'s Ex. 16).

43. Over the course of treatment, the record documents prescriptions for Ambien for sleep impairment, in an appropriate dosage, and for Xanax in an appropriate dosage for a presumed panic disorder (Pet.'s Ex. 16).

44. On the visit of 11/3/95, the Respondent prescribes Dilaudid, at the request of the patient, for fibromyalgia symptoms, until the patient's regular physician returned from vacation. The Respondent documents that he discussed with the patient the risks/benefits of the medication, and that the patient would have to obtain this from his general medical doctor in the future (Pet.'s Ex. 16; T. 1986-87).

45. The chart does not document lost prescriptions or dose escalations, typical drug seeking behaviors (Pet.'s Ex.16; T. 1981).

CONCLUSIONS AS TO PATIENT H

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient H because his record failed to accurately document that he performed a thorough psychiatric evaluation of the patient's condition on initial or follow-up visits.

2. Factual allegations H, H.1 (with the exception of medical and personal history), H.3 (with the exception of excessive strengths and amounts) and H.6 are sustained with respect to negligence and failure to maintain records. Allegations H.2, H.4 and H.5 are not sustained.

FINDINGS OF FACT AS TO RESPONDENT'S EXCLUSION FROM MEDICAID

46. On April 1, 1998 the New York State Department of Social Services determined, after a formal evidentiary hearing, that the Respondent had violated regulations of the Medical Assistance Program on three occasions. Specifically, the Respondent was found to have falsely claimed to have provided 35 minutes of psychotherapy on each of three occasions, when, it was found, that he had provided some lesser amount of treatment to an undercover investigator posing as a patient. This was a violation of 18 NYCRR 515.2(b)(1)(i)(a) and 515.2(b)(2)(i), and Respondent was suspended for two years from the Medical Assistance Program. The agency determination was upheld on appeal to the New York State courts, and no further appeal is pending (Pet. Ex. 10).

CONCLUSIONS AS TO RESPONDENT"S EXCLUSION FROM MEDICAID

1. Factual allegations I. is sustained with respect to improper professional practice, but not with respect to willfully making a false report, or being morally unfit.

FINDINGS OF FACT AS TO FRAUD

47. There was no evidence presented by the Petitioner to prove the requisite elements of fraud, that the Petitioner acted knowingly, falsely and with the intent to deceive.

CONCLUSIONS AS TO FRAUD

1. The Petitioner failed to prove by a preponderance of the evidence the allegations with respect to fraud and the making of a false report.

2. Factual allegations H and H.4 with respect to fraudulent practice are not sustained.

3. Factual allegation I with respect to making a false report is not sustained.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous, unless specified.)

FIRST SPECIFICATION:
(Negligence)
Allegations A, A.1,with the exception of that portion which pertains to failure to obtain medical and personal history, A.2, A.3, with the exception of that portion which pertains to excessive strengths and amounts and A.6 are sustained; Allegations A.4 and A.5 are not sustained.

Allegations B, and B.1-6 are not sustained, except that portion of B.1 which pertains to psychiatric and drug abuse history.

Allegations C. and C.1-4 are sustained, with the exception of that portion of C.1 which pertains to medical and personal history; Allegation C.6 is sustained; Allegations C.5 is not sustained.

Allegations D and D.1-6 are not sustained.

Allegations E. and E.1-6 are not sustained.

Allegations F and F. 1-3 are sustained, with the exception of that portion of F. 1 which pertains to medical and personal history, and that portion of F.3 which pertains to excessive strengths and amounts; Allegation F.6 is sustained; Allegations F.4 and F.5 are not sustained.

Allegations G and G. 1-3 are sustained, with the exception of that portion of G.1 which pertains to medical and personal history, and that portion of G.3 which pertains to excessive strengths and amounts; Allegation G.6 is sustained; Allegations G.4 and G.5 are not sustained.

Allegations H and H. 1 are sustained, with the exception of that portion of H.1 which pertains to medical and personal history, Allegation H.3 is sustained, with the exception of that portion of H.3 which pertains to excessive strengths and amounts; Allegation H.2, 4, and 5 are not sustained.

SECOND SPECIFICATION:
(Fraudulent practice)

No allegations are sustained.

THIRD SPECIFICATION:
(Improper professional practice)

Allegation I is sustained.

FOURTH SPECIFICATION:
(False report)

Allegation I with respect to willful filing of a false report is not sustained.

FIFTH SPECIFICATION:
(Moral unfitness)

No allegations were sustained.

SIXTH THROUGH THIRTEENTH SPECIFICATIONS:
(Failure to maintain records)

All allegations were sustained, with the exception of B.6 and D.6.

CREDITABILITY OF WITNESSES

The Petitioner's expert witness, Dr. Jaeger, is board certified in psychiatry and neurology. He gave careful and thoughtfully considered testimony and was never glib. Although his answers to cross examination questions generally supported the Petitioner's position, in several instances his answers were helpful to Respondent. This made him a very credible witness.

In direct contrast to this testimony was that of the Respondent's chief expert witness, Dr. Barry Perelman. Dr. Perlman, also board certified, and with an impressive list of credentials, was an extremely articulate witness, but he lost credibility because his testimony was always supportive of the Respondent's actions. He was at times openly hostile to the Petitioner's attorney, and seemed to twist and turn under cross examination until he could come up with a response favorable to the Respondent no matter what the question.

Respondent also presented Dr. Portnow, who was the Respondent' supervisor during his training, and has a minor social relationship with the Respondent. Dr. Portnow was credible as a character witness, but his testimony added little value to the evidence about the patients at issue. Similarly, Dr. Westreich, whose testimony was not objective, was of little help to the Panel.

The Respondent appeared visibly nervous and uncomfortable as a witness. He was quite defensive about his treatment of the patients at issue, but not arrogant. He consistently testified, and seemed to genuinely believe, that his office records were maintained solely for his own use, and did not need to be kept in the same fashion as records in the hospital, which were meant to convey a patient's condition to other physicians. He was steadfast in his testimony that it was not mandatory to contact a patient's methadone treatment program, nor

a prior treating psychiatrist. He insisted that treating known drug addicts with potentially addictive benzodiazepines was not problematic. Prescribing Dilaudid for the fictitious patient on a single occasion was a lapse in judgment, but he gave no testimony that could indicate any bad faith purpose for doing so. Regarding the Medicaid charges, he was credible in testifying that it is acceptable psychiatric practice to bill for the entire time period a patient has reserved, whether or not the patient is late, or doesn't show up for an appointment. Although the Respondent was not always credible, the Panel did accept as believable much of his testimony.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee has carefully considered all of the allegations concerning Respondent's care and treatment of the eight patients herein, as well as the prior Medicaid findings. We have determined that although the Respondent did practice negligently in some aspects of his patient care, and did fail to keep adequate patient records, there was no indication of intentional fraud, no clear cut wrongdoing, and no patient harm in this matter. Far too often, the Respondent appeared to let the patient direct the course of treatment, and while his over all practice and medical records were clearly sub-optimal, it was not always so clearly sub-standard. The Committee feels that revocation is therefore not the appropriate penalty.

The Respondent is a relatively young, intelligent and well trained physician, and he has the potential to improve his practice and record keeping. He testified that his practice has evolved through the years, and his prescribing patterns have as well.

The Committee has determined that the appropriate penalty here is a two year suspension, with the entire period of the suspension stayed, coupled with probation. During this probation, the Respondent shall have a practice monitor, and seek CME credits in the areas of the treatment of addiction and anxiety disorders. The Committee feels confident that this penalty adequately protects the public, and at the same time punishes the Respondent for past misconduct, while allowing him the chance to correct his mistakes and elevate his professional practice to an optimal level.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is hereby suspended for a period of two years dating from the time of service of this order, with the entire period of suspension stayed.

2. During the period of suspension, Respondent shall be on probation, under the supervision of a practice monitor, and shall obtain fifty (50) hours of Category I CME in each year, twenty (20) hours of which shall be devoted to addiction medicine, and twenty (20) hours of which shall be devoted to the treatment of anxiety disorders. The terms of the probation are annexed hereto and made a part hereof.

Dated: New York, New York
May 28 **, 2004**

Walter M. Farkas, M.D.

WALTER M. FARKAS, M.D.
Chairperson

FILIPPO DiCARMINE, M.D.
HENRY SIKORSKI, PH.D.

TERMS OF PROBATION

1. Respondent shall conduct himself/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

2. Respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records that accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

7. Within thirty (30) days of the effective date of this Order, Respondent shall practice medicine only when monitored by a licensed physician board certified in psychiatry ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

8. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of no less than five (5) records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

9. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

10. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

11. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(180(b) of the Public Health Law. Proof of coverage shall be submitted to the director of OPMC prior to Respondent's practice after the effective date of this Order.

12. In each twelve (12) month period of probation, Respondent shall obtain fifty (50) hours of Category I CME, including twenty (20) hours in the topic of addiction medicine and twenty (20) hours in the topic of treatment of anxiety disorders. Respondent shall submit proof such attendance to the director of OPMC.

13. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.

APPENDIX I

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

IN THE MATTER
OF
MICHAEL ROBERT GRAY, M.D.

STATEMENT
OF
CHARGES

Michael Robert Gray, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1, 1986, by the issuance of license number 166679 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between 1995 and 2001, Respondent treated Patient A for psychiatric conditions at Respondent's office located at 156 East 37 Street, New York, New York. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to obtain and note adequate medical, personal, psychiatric and drug abuse histories.
2. Diagnoses and treatment plans are either improperly missing or inappropriate and without rationale.
3. Psychotropic medications, including Xanax, Elavil, Mellaril, Thorazine, and Risperdal, are prescribed without sufficient indication and in excessive strengths and amounts.
4. Changes in psychotropic medications are made abruptly and without requisite relation to Patient A's symptoms or history.
5. Respondent failed to take any precautions, such as employing gradual

titration and having cautionary discussions with Patient A, to prevent causing or perpetuating an addiction or habituation by Patient A to the medications Respondent prescribed.

6. Respondent did not maintain a medical record for Patient A which accurately reflects Patient A's history, symptoms, diagnoses, treatment plan, and rationales for medications prescribed.

B. Between 1996 and 2001, Respondent treated Patient B for psychiatric conditions at his office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to obtain and note adequate medical, personal psychiatric and drug abuse histories.
2. Diagnoses and treatment plans are either improperly missing or inappropriate and without rationale.
3. Psychotropic medications, including Xanax, Valium ~~and Vistaril~~ deleted 1/14/04, are prescribed without sufficient indication and in excessive strengths and amounts.
4. Changes in psychotropic medications are made abruptly and without requisite relation to Patient B's symptoms or history.
5. Respondent failed to take any precautions, such as employing gradual titration and having cautionary discussions with Patient B, to prevent causing or perpetuating an addiction or habituation by Patient B to the medications Respondent prescribed.
6. Respondent did not maintain a medical record for Patient B which accurately reflects Patient B's history, symptoms, diagnoses, treatment plan, and rationales for medications prescribed.

C. Between November 9, 2000 and February 5, 2001, Respondent treated Patient C for psychiatric conditions at his office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to obtain and note adequate medical, personal, psychiatric and drug abuse histories.
2. Diagnoses and treatment plans are either improperly missing or inappropriate and without rationale.
3. Respondent prescribed Xanax without sufficient indication and in an excessive strength and amount.
4. Patient C was in a methadone maintenance program during the period Respondent treated him. Respondent improperly failed to communicate with the medical personnel involved in that program, before prescribing Xanax, a known drug of abuse, to Patient C.
5. Respondent failed to take any precautions, such as employing gradual titration and having cautionary discussions with Patient C, to prevent causing or perpetuating an addiction or habituation by Patient C to the medications Respondent prescribed.
6. Respondent did not maintain a medical record for Patient C which accurately reflects Patient C's history, symptoms, diagnoses, treatment plan, and rationales for medications prescribed.

D. Between October 30, 1999 and February 22, 2001, Respondent treated Patient D for psychiatric conditions at his office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to obtain and note adequate medical, personal, psychiatric and drug abuse histories.
2. Diagnoses and treatment plans are either improperly missing or inappropriate and without rationale.
3. Psychotropic medications, including Xanax, Vistaril, Paxil, Thorazine, Zoloft and Desyrel, are prescribed without sufficient indication and in excessive strengths and amounts.
4. Changes in psychotropic medications are made abruptly and without requisite relation to Patient D's symptoms or history.
5. Respondent failed to take any precautions, such as employing gradual titration and having cautionary discussions with Patient D, to prevent causing or perpetuating an addiction or habituation by Patient D to the medications Respondent prescribed.
6. Respondent did not maintain a medical record for Patient D which accurately reflects Patient D's history, symptoms, diagnoses, treatment plan, and rationales for medications prescribed.

E. Between 1995 and 2001, Respondent treated Patient E for psychiatric conditions at his office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to obtain and note adequate medical, personal, psychiatric and drug abuse histories.
2. Diagnoses and treatment plans are either improperly missing or inappropriate and without rationale.
3. Psychotropic medications, including Xanax, Elavil, Ambien, Prozac and

Valium, are prescribed without sufficient indication and in excessive strengths and amounts.

4. Changes in psychotropic medications are made abruptly and without requisite relation to Patient E's symptoms or history.

5. Respondent failed to take any precautions, such as employing gradual titration and having cautionary discussions with Patient E, to prevent causing or perpetuating an addiction or habituation by Patient E to the medications Respondent prescribed.

6. Respondent did not maintain a medical record for Patient E which accurately reflects Patient E's history, symptoms, diagnoses, treatment plan, and rationales for medications prescribed.

F. Between 1995 and 2000 Respondent treated Patient F for certain psychiatric conditions at Respondent's office ~~located at~~ Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to obtain and note adequate medical, personal, psychiatric and drug abuse histories.

2. Diagnoses and treatment plans are either improperly missing or inappropriate and without rationale.

3. Psychotropic medications, including Xanax, Elavil, Klonopin and Ambien, are prescribed without sufficient indication and in excessive strengths and amounts.

4. Changes in psychotropic medications are made abruptly and without requisite relation to Patient A's symptoms or history.

5. Respondent failed to take any precautions, such as employing gradual

titration and having cautionary discussions with Patient F, to prevent causing or perpetuating an addiction or habituation by Patient F to the medications Respondent prescribed.

6. Respondent did not maintain a medical record for Patient F which accurately reflects Patient A's history, symptoms, diagnoses, treatment plan, and rationales for medications prescribed.

G. Between 1994 and 2001, Respondent treated Patient G for psychiatric conditions at his office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to obtain and note adequate medical, personal, psychiatric and drug abuse histories.
2. Diagnoses and treatment plans are either improperly missing or inappropriate and without rationale.
3. Psychotropic medications, including Xanax, Thorazine, Melleril and Klonopin, are prescribed without sufficient indication and in excessive strengths and amounts.
4. Changes in psychotropic medications are made abruptly and without requisite relation to Patient G's symptoms or history.
5. Respondent failed to take any precautions, such as employing gradual titration and having cautionary discussions with Patient G, to prevent causing or perpetuating an addiction or habituation by Patient G to the medications Respondent prescribed.
6. Respondent did not maintain a medical record for Patient G which accurately reflects Patient G's history, symptoms, diagnoses, treatment plan, and rationales for medications prescribed.

H. On July 26, 1995, September 15, 1995 and November 3, 1995, Respondent treated Patient H at his office. Respondent's care and treatment failed to meet minimum standards of medical practice in the following respects:

1. Respondent failed to obtain and note adequate medical, personal, psychiatric and drug abuse histories.
2. Diagnoses and treatment plans are either improperly missing or inappropriate and without rationale.
3. Psychotropic medications, including Xanax, Ambien and Dilaudid, are prescribed without sufficient indication.
4. Respondent issued the prescriptions for Xanax, Dilaudid and Ambien not in good faith and not in the course of regular professional practice.
5. Respondent failed to take any precautions, such as employing gradual titration and having cautionary discussions with Patient H, to prevent causing or perpetuating an addiction or habituation by Patient H to the medications Respondent prescribed.
6. Respondent did not maintain a medical record for Patient H which accurately reflects Patient H's history, symptoms, diagnoses, treatment plan, and rationales for medications prescribed.

I. On April 1, 1998, the New York State Department of Social Services determined, after a formal evidentiary hearing, that the Respondent, on three occasions, had violated regulations of the Medical Assistance Program, proscribing the submission of claims for payment containing false and fraudulent statements. Specifically, Respondent was found to have falsely claimed to have provided 35

minutes of psychotherapy on three occasions, when, in fact, only 5-10 minutes of treatment was provided, in violation of 18 NYCRR 515.2(b)(1)(i)(a) and 515.2(b)(2)(i). Respondent was suspended for two years from the Medical Assistance Program. No appeal is pending. In fact, the agency determination was upheld or appeal to the New York State courts.

The conduct Respondent was found to have committed would constitute professional misconduct under New York Education Law §§ 6530(2) and 6530(21).

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) 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:

1. A and A(1) - A(6), B and B(1) - B(6), C and C(1) - C(6), D and D(1) - D(6), E and E(1) - E(6), F and F(1) - F(6), G and G(1) - G(6), H and H(1) - H(3), H(5) and H(6).

SECOND SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

2. H and H(4).

THIRD SPECIFICATIONS

IMPROPER PROFESSIONAL PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(9)(c) by having been found guilty in an adjudicatory proceeding of violating a state or federal statue or regulation, pursuant to a final decision or determination, and when no appeal is pending, or after resolution of the proceeding by stipulation or agreement, and when the violation would constitute professional misconduct pursuant to this section.

3. I.

FOURTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully 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:

4. I

FIFTH SPECIFICATIONS

MORAL UNFITNESS

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

5. H and H(4) and I

SIXTH TO THIRTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

6. A and A(6).
7. B and B(6).
8. C and C(6).
9. D and D(6).
10. E and E(6).
11. F and F(6).
12. G and G(6).
13. H and H(6).

DATED: October 14, 2003
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct