Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

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

C. Maynard Guest, M.D.
Executive Secretary

August 2, 1993

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Roy Eriksen, M.D.
187 South Broadway
Nyack, New York 10960

RE: License #119911
Effective Date: 8/9/93

Dear Dr. Eriksen:

Enclosed please find Order #BPMC 93-117 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

Sincerely,

C. Maynard Guest

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

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

IN THE MATTER :

OF : ORDER

ROY ERIKSEN, M.D. : BPMC #93-117

Upon the application of Roy Eriksen, M.D., Respondent, for Consent Order, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED,

DATED: 29 July 1993

Charles J. Vacanti

Charles J. Vacanti, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER OF ROY ERIKSEN, M.D.	APPLICATION FOR CONSENT ORDER

STATE OF NEW YORK)
ss.:
COUNTY OF ROCKLAND)

ROY ERIKSEN, M.D., being duly sworn, deposes and says:

That on or about May 1, 1974, I was licensed to practice as a physician in the State of New York, having been issued License No. 119911 by the New York State Education Department.

I am currently registered with the New York State Education Department to practice as a physician in the State of New York for the period January 1, 1993 through December 31, 1994.

I understand that the New York State Board of Professional Medical Conduct has charged me with four Specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I admit guilt to all four specifications of the statement of charges in full satisfaction of the charges against me.

I hereby agree to the penalty of five years suspension, stayed, and that I be placed on five years probation in accordance with the attached Terms of Probation.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

Roy H. Eriksen

ROY ERIKSEN, M.D.
RESPONDENT

Sworn to before me this
17th day of July, 1993.

William J Cade

NOTARY PUBLIC

WILLIAM J CADE
Notary Public, State of New York
No 4991106
Qualified in Albany County
Commission Expires Jan. 21, 1994

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

IN THE MATTER	:	APPLICATION
OF	:	FOR
ROY ERIKSEN, M.D.	:	CONSENT
	:	ORDER

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

Date: 17 July '93

Roy H. Eriksen

ROY ERIKSEN, M.D.
RESPONDENT

Date: 17 July '93

William J Cade

~~BARRY GOLD~~, ESQ.
ATTORNEY FOR RESPONDENT

Date: July 19 1993

Marcia E. Kaplan (by EMS)

MARCIA E. KAPLAN
ASSOCIATE COUNSEL
BUREAU OF PROFESSIONAL
MEDICAL CONDUCT

Date: July 30, 1993

KATHLEEN M. TANNER
DIRECTOR
OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

Date: 29 July 1993

CHARLES J. VACANTI, M.D.
CHAIRPERSON
STATE BOARD FOR
PROFESSIONAL MEDICAL CONDUCT

EXHIBIT "B"

TERMS OF PROBATION

1. ROY ERIKSEN, M.D., during the period of probation, shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

2. Respondent shall submit written notification to the New York State Department of Health (NYSDOH), addressed to the Director, Office of Professional Medical Conduct, New York State Health Department, Corning Tower Building, 4th Floor, Empire State Plaza Albany, New York 12237 of any employment and practice, of Respondent's residence and telephone number, or any change in Respondent's residence and telephone number, or any proposed change in Respondent's employment or practice within or without the State of New York;

3. Respondent shall not begin any new employment until after he has obtained the approval of the Director of OPMC as to the terms of the monitoring and supervision at his new employment. The monitoring and supervision required as part of the Terms of Probation shall remain in effect and shall not be interrupted or interfered with in any way.

4. Respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that Respondent has paid all registration fees due and owing to the NYSED and Respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by Respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation;

5. Respondent shall submit written proof to the NYSDOH, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) Respondent is currently registered with the NYSED, unless Respondent submits written proof that Respondent has advised DPLS, NYSED, that Respondent is not engaging in the practice of Respondent's profession in the State of New York and does not desire to register, and that 2) Respondent has paid any fines which may have previously been imposed upon Respondent by the Board or by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

6. Any civil penalty 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 section 171(27); State Finance Law section 18; CPLR section 5001; Executive Law section 32).

7. Respondent shall remain drug and alcohol free.

8. Respondent's sobriety shall be monitored by a health care professional ("monitor") who shall be selected by the Respondent, subject to the approval of the Director of OPMC. Any successor monitor must also be approved by the Director of OPMC. The monitor shall not be a personal friend, nor a relative, of Respondent and shall be familiar with Respondent's history of psychiatric disorder, chemical dependency, and the Terms of Probation contained herein. The monitor shall acknowledge his/her willingness to comply with the monitoring by executing the acknowledgment provided by OPMC. The monitor shall see Respondent at least biweekly, and shall direct Respondent to submit to random, unannounced, observed tests of his blood, breath, and/or urine for the presence of drugs or alcohol ("screens"). The frequency of the screens shall be determined by the monitor with the approval of the Director of OPMC, however, during the first twelve months of probation, screens shall be conducted at least bi-weekly. The monitor shall report to OPMC within 24 hours after a positive test result or Respondent's refusal of a screen. The monitor shall report promptly to OPMC a pattern of noncompliance with the Terms of Probation. The monitor shall submit to OPMC quarterly reports either certifying Respondent's compliance or detailing his failure to comply with each of the terms of probation. The reports shall include the results of all body fluid and/or breath tests for drugs and/or alcohol performed during that quarter.

9. Respondent shall submit to periodic interviews with and evaluations by a psychiatrist designated by the Director. Said psychiatrist shall report to the Director regarding his condition and his fitness or impairment for the practice of medicine.

10. Respondent shall comply with the terms of a continuing after-care treatment plan that addresses the major problems associated with his psychiatric disorder and chemical dependency. Such plan shall include Respondent's continued treatment by the following treating health care professionals ("therapists"): Paul Teusink, M.D. or a successor psychiatrist, on at least a monthly basis, such psychiatrist to obtain lithium levels at monthly intervals, with the results of the lithium levels going directly to

Respondent's treating psychiatrist; Yvonne Porjesz, Ph.D., or a successor psychologist, on at least a weekly basis; Ray Griffin, Ph.D., or a successor substance abuse counselor, on at least a weekly basis. Any successor therapist must be approved by the Director of OPMC. Such plan shall also include Respondent's continued active participation in NA, Caduceus or other similar after-care programs. Respondent's therapists, or their successors, shall submit to OPMC monthly reports during the first twelve months of probation, and quarterly reports thereafter, certifying that Respondent is complying with treatment. The therapists shall report to the Director of OPMC within 24 hours after Respondent drops out of treatment or in the event of a significant pattern of absences from scheduled treatment sessions. Each of these therapists shall acknowledge his/her willingness to comply with the above-mentioned reporting by executing an acknowledgment provided by OPMC. In the event that any of Respondent's therapists determine that treatment is no longer necessary or that the specific requirements for treatment set forth in this paragraph should be altered, he/she shall so notify the Director of OPMC in writing, and the terms of this paragraph may be amended accordingly with the approval of the Director of OPMC.

11. Respondent shall inform all physicians or other health care practitioners from whom he seeks treatment of his history of bi-polar disorder and chemical dependency. In the event that Respondent is ever prescribed controlled substances, Respondent shall notify his monitor and the Director of OPMC before such medications are administered, or at the earliest opportunity after administration of controlled substances during emergency medical treatment. Respondent shall not self-prescribe any medications.

12. Respondent's office and hospital practice shall be supervised and monitored by a licensed physician in a position to regularly observe and assess Respondent's medical practice ("practice supervisor"). The practice supervisor shall review Respondent's professional performance and practice, shall evaluate whether Respondent's care and treatment comport with generally accepted standards of medical practice, and shall meet bi-weekly with the Respondent to discuss his practice. Supervision by the practice supervisor may include: unannounced review of Respondent's patient records; unannounced actual observation of his treatment of patients; unannounced review of his ordering, administering and inventorying of all controlled substances, interviews of Respondent, and any other reasonable means of monitoring Respondent's practice. The practice supervisor, or any successor supervisor, shall be selected by the Respondent, subject to the approval of the Director of OPMC, and shall not be a personal friend, nor a relative, of Respondent. The practice supervisor shall be familiar with Respondent's

history of psychiatric disorder, chemical dependency, and the Terms of Probation contained herein, and shall acknowledge his/her willingness to comply with the supervision and monitoring by executing an acknowledgement provided by OPMC. The practice supervisor shall have the authority to direct Respondent to submit to unannounced tests of his blood, breath, and/or urine for the presence of drugs or alcohol ("screens") and shall report to OPMC within 24 hours after Respondent's refusal of a screen, a positive screen, the receipt of information that Respondent had ingested drugs or alcohol, or any adverse change in Respondent's condition or practice. The practice supervisor shall submit to OPMC monthly reports during the first twelve months of probation, and thereafter quarterly reports, regarding the quality of Respondent's medical practice, any unexplained absences from work, and certifying his compliance or detailing his failure to comply with the Terms of Probation. The practice supervisor shall report immediately to OPMC any failure of the Respondent, at any time, to comply with the Terms of Probation.

13. Respondent, within the first three months of the period of probation, shall complete the evaluation phase (Phase I) of the Physician Prescribed Educational Program (PPEP), Department of Family Medicine, 475 Irving Avenue No. 200, Syracuse, N.Y. 13210. Dr. William D. Grant, Director of the PPEP, shall inform Kathleen M. Tanner, Director of OPMC, of Respondent's satisfactory completion of Phase I of the program and of the results of Respondent's evaluation.

14. Upon completion of Phase I of the PPEP and within six months of the commencement of the period of probation, Respondent shall apply for and enroll in the reeducation phase (Phase II) of the PPEP in Syracuse. Respondent shall remain enrolled and shall fully participate in Phase II of the program, in accordance with the findings made during Phase I. Respondent shall successfully complete Phase II of the PPEP within two years of the start of his participation in Phase I of the program.

15. Failure of the Respondent to be accepted into Phase II, to remain enrolled and fully participating in Phase II, or to successfully complete Phase II, will be deemed a violation of probation.

16. During Phase II, the preceptor assigned to Respondent shall submit monthly reports to OPMC certifying that Respondent is fully participating in Phase II and shall inform Kathleen M. Tanner, Director, OPMC, of the results of the Respondent's reevaluation or reassessment at the completion of his Phase II retraining. The preceptor shall report immediately to the Director of OPMC if Respondent withdraws from the program and shall report promptly to OPMC any significant pattern of absences by Respondent. The

preceptor shall acknowledge in advance his/her willingness to comply with the reporting by executing the acknowledgement provided by OPMC.

17. After Respondent has successfully completed Phase II, Respondent shall meet with an OPMC Medical Coordinator on a quarterly basis for the duration of the term of probation for review of Respondent's patient records and discussion of Respondent's medical practice.

18. Respondent shall assume and bear all costs related to compliance with the Terms of Probation.

19. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the order of the Board.

20. So long as there is full compliance with every term herein set forth, Respondent may continue to practice his or her aforementioned profession in accordance with the terms of probation; provided, however, that upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the Public Health Law.

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ROY ERIKSEN, M.D.	:	CHARGES

----------X

ROY ERIKSEN, M.D., the Respondent, was authorized to practice medicine in New York State on May 1, 1974 by the issuance of license number 119911 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 from 187 S. Broadway, Nyack, New York 10960.

SPECIFICATION OF CHARGES

FACTUAL ALLEGATIONS

A. Between on or about January 11, 1990 and on or about March 24, 1992, Respondent treated Patient A in his office at 187 South Broadway, South Nyack, N.Y. (hereinafter referred to as "his office") for back and neck pain. When first seen by Respondent, Patient A, who was 26, had a history of low back pain

and cervical pain for approximately five years, for which she took medications including Percocet, Valium and Dolobid. Patient A was examined by Dr. Perry Black, a neurosurgeon at Hahnemann Hospital in Philadelphia, PA, on December 12, 1989. Dr. Block recommended surgery, a decompressive laminectomy at L5-6 and L6-S1 with discectomies, which was performed on January 29, 1990. During the course of his care and treatment of Patient A, on virtually every visit, Respondent prescribed controlled substances for Patient A, including Percocet, 160-180 tablets, and/or Valium, 100-120 tablets. (The identities of Patients A - I are disclosed in the attached Appendix.)

1. Respondent failed to take or note a complete history.

2. Respondent failed to perform or note a complete initial physical examination and/or failed to perform or note follow-up examinations relative to the patient's presenting complaints or condition.

3. Respondent failed to consult with Patient A's neurologist, Dr. Perry Block, or to note such consultation.

4. Respondent prescribed controlled substances, including Percocet and/or Valium, inappropriately for Patient A, and/or failed to note appropriate medical indication for such prescriptions.

5. Respondent failed to treat Patient A appropriately for complaints of back or neck pain, or to note such treatment.

B. On or about January 16, 1990, Respondent treated Patient B, a 28 year old male, in his office for migraine

headache, back pain, and shoulder pain, and prescribed 100 Percocet and 100 Valium. On or about May 19, 1990, Respondent prescribed 30 Percocet for Patient B.

1. Respondent failed to take or note a complete history.
2. Respondent failed to perform or note a complete initial physical examination and/or failed to perform or note follow-up examinations relative to the patient's presenting complaints or condition.
3. Respondent failed to order, perform, or note appropriate laboratory or diagnostic tests, including x-rays.
4. Respondent prescribed controlled substances, including Percocet and/or Valium, inappropriately, and/or failed to note appropriate medical indication for such prescriptions.
5. Respondent failed to diagnose and/or treat appropriately Patient B's complaints of migraine headache, back pain and shoulder pain, or to note such diagnostic work-up and/or treatment.

C. From on or about September 27, 1984 to on or about April 1, 1992, Respondent treated Patient C in his office and at Nyack Hospital for various complaints and conditions, including arthritis, diabetes, diabetic neuropathy, and a tumor at the base of the tongue. Patient C was also obese. On repeated occasions, Respondent prescribed controlled substances for Patient C, including Percocet, Demerol, Vistaril, Hydrochlorothiazide, Valium, Tenormin, Tylenol -3 and Clinoril.

1. Respondent failed to take or note a complete history.

2. Respondent failed to perform or note a complete initial physical examination, including a comprehensive neurological evaluation, and/or failed to perform or note follow-up examinations relative to the patient's presenting complaints or condition.

3. Respondent failed to note the significant findings of Patient C's laboratory and diagnostic tests in the office record progress notes.

4. Respondent failed to enter appropriate notes in the office medical record accurately reflecting Patient C's evaluation and treatment during his hospitalization from August 9-13, 1986, and on November 14, 1986.

5. Respondent failed to evaluate and/or treat Patient C appropriately for arthritis, or to note such evaluation and treatment.

6. Respondent prescribed controlled substances, including Percocet, Demerol, Vistaril, Hydrochlorothiazide, Valium, Tenormin, Tylenol -3 and Clinoril inappropriately for Patient C.

7. Respondent treated Patient C for hypertension inappropriately in that Patient C did not have hypertension which required such treatment and/or failed to consider prescribed beta blockers and diuretics as a cause of Patient C's syncope and falls.

8. Respondent failed to diagnose Patient C's cancer in a timely manner and/or failed to perform or note repeated oral and throat examinations.

D. From on or about October 25, 1986 through on or about March 13, 1992, Respondent treated Patient D at his office for back and leg pain, and various other complaints. When first seen by Respondent, Patient D was 23 years old. Between on or about March 1, 1990 and on or about March 13, 1992, Respondent repeatedly prescribed large quantities of controlled substances for Patient D including Demerol, Percocet, Tylenol -4, Talwin, Dilaudid, Halcion, Dalmane, Vicodin, Vistaril and

Valium/Diazepam. Respondent also prescribed Prednisone on numerous occasions.

1. Respondent failed to take or note a complete medical history.

2. Respondent failed to perform or note a complete initial physical examination and/or failed to perform or note follow-up examinations relative to presenting complaints.

3. Respondent failed to evaluate and treat Patient D appropriately for orthopedic and/or neurological pain, and/or failed to note such evaluation and treatment.

4. Respondent prescribed controlled substances, including Demerol, Percocet, Tylenol -4, Talwin, Dilaudid, Halcion, Dalmane, Vicodin, Vistaril and Valium/Diazepam, as well as Prednisone inappropriately for Patient D and/or failed to note appropriate medical indication for such medications.

5. Respondent failed to refer Patient D to appropriate specialists in pain, addiction, psychiatry and/or neuro-orthopedic therapy.

E. From on or about October 25, 1986 through on or about October 28, 1991, Respondent treated Patient E at his office for various complaints and conditions, including cough, runny or stuffy nose, sore throat, insomnia, ulcer, and low back pain. During the period August 19, 1990 through June 10, 1991, Respondent prescribed Percocet, Halcion, Vicodin, and Tylenol -4 repeatedly for Patient E for back pain, including 720 Percocet tablets between November 20, 1990 and January 31, 1991. Respondent also prescribed Prednisone on numerous occasions.

1. Respondent failed to take or note a complete medical history.

2. Respondent failed to perform or note a complete initial physical examination and/or failed to perform or note follow-up examinations relative to presenting complaints.

3. Respondent prescribed Percocet, Halcion, Vicodin, Tylenol -4, and/or Prednisone inappropriately.

F. From on or about December 31, 1991 through on or about January 27, 1992, Patient F, a 68 year old female, was hospitalized at Nyack Hospital. Her admitting diagnoses were pneumonia, fever, acute exacerbation chronic obstructive pulmonary disease (COPD), and dehydration. Respondent, who had first treated Patient F for recurrent episodes of pneumonia in January, 1986, was one of the physicians who treated Patient F during her hospitalization. On or about January 9, 1992 at 12:05 a.m., while Patient F was in the intensive care unit, Respondent removed Patient F's nasal oxygen for seventeen minutes, and she became short of breath and cyanotic. Respondent then put Patient F back on nasal oxygen. Patient F, who was confused and disoriented at times, asked to go home and Respondent told her that she could sign out against medical advice in the morning and that he would drive her home himself. Respondent appeared at the nurse's station and talked at great length in a rambling and inappropriate manner.

1. Respondent removed Patient F's nasal oxygen inappropriately.

2. Respondent failed to render appropriate care and treatment to Patient F after she became short of breath and cyanotic after removal of her nasal oxygen.

3. Respondent practiced medicine while mentally impaired or impaired by drugs while rendering care and treatment to Patient F on or about January 9, 1992.

G. From in or about May 1986 to in or about September 1990, Respondent treated Patient G in his office, and from August 20 through August 23, 1990, Respondent treated Patient G at Nyack Hospital. Patient G, who was then 83 years old, was hospitalized by Respondent with a primary diagnosis of congestive heart failure (CHF). The discharge summary states that she was admitted after having several days of increasing shortness of breath with paroxysmal nocturnal dyspnea and urinary frequency, and that examination on admission revealed rales at the right base. The History and Physical form written by Respondent on admission gives Patient G's history as follows: "The pt is an 83 yr old female extremely weak. Recently fractured her right wrist. She is now in CHF. She is known to have calcific aortic stenosis." The physical examination, in pertinent part, shows "BP 110/70. Pulse 88 and reg. . . . LUNGS: Reveals lungs to be clear to percussion. There are coarse rales at the right base. HEART sounds, aortic stenosis murmur, unchanged from previous exams." On admission, a nurse recorded a pulse of 64, blood pressure of 110/70, and breath sounds as "clear." A chest x-ray on August 21, 1990 shows "both lung fields to be clear. The pulmonary vessels are not engorged. The heart is not enlarged. There is no

significant interval change since 4-14-90." The report of the chest x-ray reflects the conclusion "no acute pulmonary process." An x-ray of Patient G's fractured wrist on August 18, 1990 showed osteoporosis. Respondent made diagnoses of congestive heart failure, fracture of the right wrist, gastric ulcer, iron deficiency anemia, urinary incontinence and cystitis N.O.S. Among other medications, Respondent prescribed Premarin and Provera for Patient G. No pelvic examination was performed.

1. Respondent failed to take or note a complete medical history.
2. Respondent failed to perform or note a complete physical examination and/or failed to perform or note follow-up examinations relative to presenting complaints.
3. Respondent failed to order or perform appropriate laboratory and diagnostic tests.
4. Respondent made diagnoses of CHF, aortic stenosis, gastric ulcer, iron deficiency anemia and/or cystitis inappropriately.
5. Respondent prescribed Premarin, Provera, Ferrous Gluconate, Dalmane, Zantac and/or Proloprim inappropriately.
6. Respondent hospitalized Patient G inappropriately.

H. From August 19, 1988 through July 1, 1992, Respondent treated Patient H in his office. Patient H was hospitalized at Nyack Hospital, Nyack, New York on September 17, 1991, after an allergic reaction to a bee sting, which was treated by Respondent in his office with epinephrine. When Patient H reached the

Respondent called back to the private duty nurse at 4 a.m. to check to see if the patient was receiving his vitamin B12 daily injections.

1. Respondent was mentally impaired and/or impaired by drugs while rendering care and treatment to Patient I on or about January 8-9, 1992.

J. From in or before 1980 to on or about January 9, 1992, Respondent was dependent on or a habitual user of benzodiazepines and/or narcotics.

K. From in or about 1979 to date, Respondent has had a psychiatric disorder which has been diagnosed as a bipolar disorder, mixed type.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

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

The facts in paragraphs A, A.1, A.2, A.3, A.4, A.5, B, B.1, B.2, B.3, B.4, B.5, C, C.1, C.2, C.3, C.4, C.5, C.6, C.7, C.8, D, D.1, D.2, D.3, D.4, D.5, E, E.1, E.2, E.3, F, F.1, F.2, G, G.1, G.2, G.3, G.4, G.5, G.6, H and/or H.1.

SECOND SPECIFICATION

BEING DEPENDENT ON OR A HABITUAL USER OF NARCOTICS OR BARBITURATES

2. Respondent is charged with being dependent on or a habitual user of narcotics, barbiturates, or other drugs having similar effects, under N.Y. Educ. Law sec. 6530(8) (McKinney Supp. 1993) in that Petitioner charges:

The facts in paragraph J.

THIRD SPECIFICATION

PRACTICING WHILE IMPAIRED BY
DRUGS OR MENTAL DISABILITY

3. Respondent is charged with practicing the profession while the ability to practice is impaired by drugs or mental disability under N.Y. Educ. Law Section 6530(7) (McKinney Supp. 1993), in that Petitioner charges:

The facts in paragraphs J and/or K, and F and F.3 and/or I and I.1.

FOURTH SPECIFICATION

FAILING TO MAINTAIN ACCURATE RECORDS

4. Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1993), in that he failed to maintain a record for each of patients A-I which accurately reflects his evaluation and treatment of the patient, in that Petitioner charges:

The facts in paragraphs A, A.1, A.2, A.3, A.4, A.5, B, B.1, B.2, B.3, B.4, B.5, C, C.1, C.2, C.3, C.4, C.5, C.8, D, D.1, D.2, D.3, D.4, E, E.1, E.2, G, G.1, and/or G.2.

DATED: , 1993
New York, New York

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct

hospital, the respiratory distress had abated and the lungs were clear.

1. Respondent hospitalized Patient H inappropriately.

I. Respondent admitted Patient I, an 81 year old male, to Nyack Hospital on January 5, 1992 due to fever, shaking chills and disorientation in association with bilateral pleural effusions, and Patient I remained hospitalized until January 19, 1992. On or about January 8, 1992 at 6 p.m., in the presence of Patient I's son, Respondent visited with Patient I and spoke inappropriately about having cleaned a sink and about baby-sitting for his children. Respondent left the lab interims and 11/11/92 CAT scan results on the overbed table. Later that night, from 1-3:30 a.m., Respondent visited with Patient I and proceeded to talk with him, although Patient I wanted to sleep. Respondent read and re-read the chart in front of the private duty nurse, discussed treatment rationales, cancelled orders he had written only hours earlier, wrote new orders, and talked about his personal life. At about 2:15 a.m., Respondent ran to the nurse's station, yelling, "I don't know why I'm paying for private duty nurses when the lab results are not in the chart." The interim lab results were in the chart; the cumulative lab results were found at the nurse's station, where they had only recently been received. Respondent apologized to the nurses.