Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 15, 2020

CERTIFIED MAIL - RETURN RECEIPT REQUESTED AND EMAIL

David W. Quist, Esq.
Bureau of Professional Medical Conduct
New York State Department of Health
Corning Tower Building, Room 2512
Empire State Plaza
Albany, New York 12237

Andrew Knoll, Esq.
Cohen Compagni Beckman
Appler & Knoll, PLLC
507 Plum street, Suite 310
Syracuse, New York 13204

Jacob William Smith, M.D.

RE: In the Matter of Jacob William Smith, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 20-097) 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 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties <u>other than suspension or revocation</u> 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.

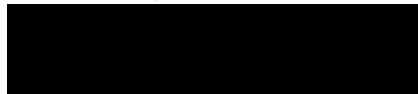
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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,



James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

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

COPY

IN THE MATTER OF JACOB WILLIAM SMITH, M.D.	DETERMINATION AND ORDER 20-097

A Notice of Hearing and Statement of Charges dated September 6, 2019 were duly served pursuant to § 230(10)(d)(i) of the Public Health Law (PHL) upon Jacob William Smith, MD (Respondent). [Exhibits 2 and 3; Appendix I.] Paul J. Lambiase, Chair, Rose Berkun, MD and Andrew J. Merritt, MD, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. PHL § 230(10)(e). Dawn MacKillop-Soller, served as the Administrative Law Judge. The Department of Health, Bureau of Professional Medical Conduct (Department), appeared by David W. Quist, Esq. The Respondent appeared and was represented by Andrew M. Knoll, Esq. A prehearing conference was held October 2, 2019 and the hearing was held October 7 and 8, 2019. A transcript of the proceeding was made (Transcript, p. 1-356).

The Hearing Committee examined documents from the Department (Exhibits 1-32) and the Respondent (Exhibits A-I). At the hearing, the Department presented as witnesses Stephen C. Gladysz, MD. and David Evlyn, MD. The Respondent produced as witnesses Kirk D. Tolhurst, MD; Helen Kaplan, LCSW-R; R.P. Singh, MD, MBBS; and John Bezirganian, MD. Post-hearing submissions were received December 2, 2019. Deliberations were held February 7 and 14, 2020.

The Hearing Committee voted 3-0 to sustain four specifications of misconduct as defined under Education Law § 6530: negligence on more than one occasion § 6530(3); practicing the profession of medicine fraudulently § 6530(2); being dependent on or a habitual user of narcotics § 6530(8); and failing

to maintain an accurate record for each patient which accurately reflects the evaluation and treatment of the patient § 6530(32). The Hearing Committee unanimously determined to impose the penalty of revocation of the Respondent's medical license pursuant to PHL § 230-a(4).

Findings of Fact

The Hearing Committee unanimously makes the following findings of fact:

1. Respondent Jacob William Smith, MD, was authorized to practice medicine in New York State on November 8, 2010, by the issuance of license number 259377. [Exhibit 4.]

2. In January of 2017, the Respondent was prescribed hydrocodone for knee surgery and experienced a relapse of his opioid addiction. He had been sober since May of 2007. His diagnoses include opioid use disorder with induced mood disorder. [Exhibits H, 32.]

3. The Respondent's prior history includes inpatient drug treatment in [redacted] and enrollment with the Committee for Physician Health (CPH) for substance abuse treatment and monitoring. A University of Rochester hospital audit had shown that while working as a resident, he diverted fentanyl by drinking it from a syringe he used to "take off the excess" from 20 cc vials. [Exhibits 19, 23; Transcript, p. 178-179.]

4. Pursuant to a Temporary Surrender of License dated August 21, 2007, the Board for Professional Medical Conduct prohibited the Respondent from seeking authorization to practice medicine due to substance abuse. By Stipulation and Order dated September 17, 2009, the Respondent admitted that between April and May of 2007, he violated PHL Article 33 by diverting fentanyl and failing to accurately record administrations of the drug to hospital patients. He agreed to pay a fine. [Exhibits 20 and 21.]

5. By Restoration Order dated July 31, 2010, following a proceeding at the Respondent's request before a Committee of Professional Medical Conduct pursuant to PHL § 230(13), the Respondent's "privilege to seek licensure to practice medicine and to engage in the practice of medicine"

was restored, subject to practicing and monitoring conditions and continued CPH enrollment for a period of five years. [Exhibits 23, 24.]

6. By letter dated October 24, 2013, the Respondent requested to end his monitoring and practicing conditions. The Respondent wrote: " I strongly feel that the combined efforts of therapy, 12 step programs, sobriety monitoring and the structure of CPH and OPMC monitoring has placed me firmly on a path of continued recovery from this disease and the lessons learned...will continue to serve me in the decades to come." In a letter dated March 3, 2014 to the Respondent, the Director of OPMC approved the Respondent's request. [Exhibits 25, 29.]

7. The subject of this proceeding involves the Respondent's diversion of drugs between February and May of 2017 in the care of Patients A, B, C, D, E, F, G, H, I, J, K, L and M at Cayuga Medical Center (CMC) and his incorrect documentation of drug amounts in their medical records to hide his diversion. The diversion was caught when a CMC hospital audit revealed opioid discrepancies in pharmacy and medical records. [Exhibits 1, 30; Transcript, p. 117-120, 239.]

8. Between May and July of 2017, the Respondent received inpatient treatment for his opioid abuse disorder [redacted]. Following his discharge, he began outpatient individual and group counseling sessions at [redacted]. He currently receives monthly injections of Vivitrol, an "injectable naltrexone" that "blocks opiate receptors," participates in regular self-help meetings and undergoes four monthly random urine drug screens. [Exhibits 19, 32; Transcript, p. 207-208.]

9. Between February and May of 2017, in the provision of anesthesia care to Patients A, B, C, D, E, F, G, H, I, J, K, L and M, the Respondent diverted Dilaudid and fentanyl for his own use. [Exhibit 30; Transcript, p. 140, 152, 162, 199-200, 242.]

10. Between February and May of 2017, in the provision of anesthesia care to Patients A, B, C, D, E, F, G, H, I, J, K, L and M, the Respondent intentionally documented their medical records with incorrect drug amounts to hide his diversion. [Exhibit 30; Transcript, p. 239.]

11. The Respondent's drug diversion and incorrect documentation of the medical records are serious deviations from the standard of care. [Transcript, p. 47, 67, 114.]

12. The type of anesthesia used for a procedure must be documented in the patient's medical record. Anesthesia care includes sedation, regional, general and local anesthetic. Spinal or nerve block anesthesia is a form of regional anesthesia used to anesthetize an area of the body for surgery. [Transcript, p. 20-22, 98.]

13. Patient A was under the Respondent's anesthesia care at CMC on April 14, 2017 for placement of an epidural catheter for spinal epidural analgesia during labor and delivery. The Respondent documented using a catheter to administer bupivacaine with epinephrine, three 100 mcg doses of fentanyl and three 1 mg doses of Dilaudid. [Exhibit 6.]

14. Patient B, age 96, was under the Respondent's spinal anesthesia care at CMC on April 21, 2017 for a left hip open reduction internal fixation with intramedullary nail to repair a fracture. Patient F, age 89, was under the Respondent's spinal anesthesia care at CMC on May 2, 2017 for a right total hip arthroplasty. Patient G was under the Respondent's spinal and reginal block anesthesia care at CMC on March 30, 2017 for revision of a left total knee arthroplasty procedure. The Respondent documented prescriptions for 300 to up to 500 mcg of fentanyl, 3.5 to up to 4 mg of Dilaudid, 2-5 mg of Versed, up to 12.5 mg of Duramorph, continuous infusion of propofol and Precedex drips and for Patient B, 20 mg of ketamine, and for Patients B and F, 25 to up to 100 mg of Demerol. [Exhibits 7, 11-12.]

15. Patient E was under the Respondent's general anesthesia care on April 19, 2017 for outpatient dilation and curettage, hysteroscopic and polypectomy procedures. In the pre-operative

evaluation, the Respondent recorded allergies to medications, including Dilaudid, codeine, Vicodin and morphine. Patient I, age 69, was under neurological evaluation at CMC on April 22, 2017 for mental status changes and was under the Respondent's anesthesia care for a lumbar puncture. The Respondent documented prescribing these patients 100 to 200 mcg of fentanyl, 1 to 2mg of Dilaudid and 2 to 4 mg of Versed and for Patient I, 1 mg of midazolam and 100 mg of Demerol. [Exhibits 10, 14.]

16. Patients C, D, H and K were under the Respondent's spinal and block anesthesia care at CMC on March 28, 2017, April 6, 2017, May 16, 2017 and March 28, 2017, respectively, for right total knee arthroplasty procedures. Patients L and M were under the Respondent's peripheral nerve block and spinal anesthesia care on May 2, 2017 and April 13, 2017, respectively, for left total knee arthroplasty procedures. Patient J, age 71, had the same procedure on March 23, 2017 under nerve block and general anesthesia care. For these patients, the Respondent documented prescriptions for 300 to up to 600 mcg of fentanyl, 2.5 to up to 4 mg of Dilaudid, 4 to up to 6 mg of Versed and propofol and Precedex drips. [Exhibits 8, 9, 13, 15-18.]

Factual Allegations

The Hearing Committee made the following determinations on the factual allegations in the Statement of Charges. All votes were unanimous (3-0):

Sustained: Factual Allegations A.2, B.1, B.3, C.2, C.3, D.2, D.3, E.2, E.3, F.1, F.3, F.4, G.2, G.3, H.1, H.3, H.4, I.1, I.3, J.1, J.2, J.3, K.2, K.3., L.1, L.3, L.4, M.1, M.3, M.4, N.

Not sustained: Factual Allegations A.1, B.2, C.1, D.1, E.1, F.2, G.1, H.2, I.2, K.1, L.2, M.2.

Evaluation of Witness' Testimony

The Department presented anesthesiology expert Stephen C. Gladysz, MD. [Transcript, p. 16-115] to testify in support of its charges against the Respondent involving the anesthesia care of his patients, which the Respondent did not refute. Dr. Gladysz has over 30 years' experience as a board-certified

specialist in anesthesiology. Currently, he is staff anesthesiologist and Chair, Department of Anesthesia, at Mercy Hospital in Buffalo, New York, and Chair, Department of Anesthesia, for the Catholic Health System Consortium Hospitals. Dr. Gladysz detailed the documented amounts of drugs, their inappropriateness had they been administered, and how the documentation suggests diversion. The Department also presented David Evlyn, MD, Vice President of Medical Affairs at CMC and the Respondent's drug monitor pursuant to the Board's prior monitoring conditions. Dr. Evlyn discussed the CMC hospital audit findings and the Respondent's admissions to drug diversion. The Hearing Committee found these witnesses' testimony credible and consistent with the evidence. [Exhibits 5, 31; Transcript, p. 116-131.]

The Respondent's witnesses were his AA sponsor Kirk Tolhurst, MD. [Transcript, p. 257-275]; psychotherapist Helen Kaplan, LCSW-R [276-297]; addiction therapist John Bezirganian, MD. [Transcript, p. 325-338]; and forensic psychiatrist R. P. Singh, MD, MBBS. [Transcript, p. 298-324.] Dr. Singh performed an Independent Medical Examination (IME) of the Respondent to evaluate his fitness to practice medicine. The Hearing Committee found these witnesses knowledgeable about addiction and recovery but was not persuaded by their opinions that the Respondent is able to safely resume the practice of anesthesia medicine because they were inconsistent with treatment records and testimony suggesting otherwise. [Exhibits B, C, D, H, 19, 32; Transcript, p. 305-306, 309-311, 315, 332-333, 337-338.]

The Respondent's testimony (Transcript, p. 133-256) was forthcoming about his history of opioid use disorder but less candid regarding the drugs he admits diverting. The August of 2017 Farley discharge summary states the Respondent's diverting at CMC as "fentanyl 400 mcg and 4 mg of Dilaudid IV…4 to 5 days a week." The Respondent testified, however, that he diverted fentanyl as "say…400 but only (gave) them 200," so he could "take 200," which he later changed to "closer to 400 and 300" mcg. For Dilaudid, he testified he "would have given (the patient) some and I, in that period, that three-month time period, I

would have diverted some of that as well" but later stated "2 to 3" mg. The Hearing Committee gave weight to these inconsistencies because they raised questions about whether any amounts were administered to patients. The Committee attributed the Respondent's evasiveness to his underlying disease and evaluated his testimony accordingly. [Transcript, p. 140, 199, 242.]

Conclusions of Law

Administration of Drugs

The Hearing Committee found the evidence failed to establish by a preponderance of the evidence twelve factual allegations in the Department's Statement of Charges that the Respondent "administered inappropriate anesthetic medications and/or other medications." (Factual allegations A.1, B.2, C.1, D.1, E.1, F.2, G.1, H.2, I.2, K.1, L.2, M.2.) The Hearing Committee credited the medical opinion of Dr. Gladysz that the large amounts of documented drugs would be inappropriate if administered to the patients. Dr. Gladysz also, however, described the documented drug amounts as neither "credible" nor "believable" and stated that such inappropriate dosing is "always a red flag" for diversion. The Committee concluded that based on the medical records showing a lack of complications for patients and the Respondent's admissions to drug diversion, the evidence fails to support these medications were actually given. [Exhibit 1; Transcript, p. 32, 36-37, 67, 89, 91, 99, 114.]

For example, the Respondent documented prescriptions for propofol and Precedex drips and up to 600 mcg of fentanyl, 4 mg of Dilaudid and 6 mg of Versed combined with anesthetic medications for peripheral nerve block and spinal, nerve block and general or spinal and block anesthesia for Patients C, D, H, J, K, L and M without any of them converting to general anesthesia or suffering respiratory distress. Patients B and F, both of whom were elderly, and Patient G, were prescribed similar excessive drug dosages combined with 12.5 mg of Duramorph and up to 100 mg of Demerol for Patients B and F, but none of them experienced breathing difficulties, respiratory arrest or respiratory depression. Patient A was

prescribed three 1mg doses of Dilaudid and three 100 mcg boluses of fentanyl consecutively during labor and delivery, yet the baby showed no signs of overdose. Patient I, who was under evaluation for mental status changes, was nonetheless prescribed up to 200 mcg of fentanyl, 2 mg of Dilaudid, 4 mg of Versed and 1 mg of midazolam and neither stopped breathing nor experienced increased combativeness or aggression. Patient E was prescribed similar drugs despite an allergy to Dilaudid but never suffered an allergic reaction. [Exhibits 6-18, 31; Transcript, p. 32, 43-45, 62-65, 70-77, 90-94, 99-100, 103, 111-113.]

Diversion and Medical Recordkeeping

The Hearing Committee sustained the factual allegations that the Respondent diverted drugs documented as administered to patients and failed to maintain a complete, legible record and/or documented administrations of excessive drugs. The Respondent admits the fifth and sixth specifications of misconduct, as defined in Education Law § 6530(8), "being dependent on or a habitual user of narcotics," and Education Law § 6530(32), "failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient." His admissions also include that between March and May of 2017, he intentionally documented patients' medical records with incorrect drug amounts to hide his diversion and that within that period, he diverted "some" Dilaudid and "by and large" fentanyl, which he gave "up front" to patients for regional anesthetics and spinals. [Exhibits 1, 30; Respondent's brief, p. 8; Transcript, p. 137, 140, 142, 160-162, 199, 239, 242.]

The Hearing Committee agreed with Dr. Gladysz that the Respondent seriously deviated from the standard of care in the anesthesia care of Patients A through M when he diverted drugs for his own use. The Respondent also seriously deviated from the standard of care by incorrectly documenting the medical records of Patients A through M with drug amounts he never administered to hide his diversion. Recording inappropriate dosages for drugs raises red flags for diversion and creates serious patient risk

because it can mislead subsequent providers in their post-procedure care of patients. [Transcript, p. 32, 46-47, 67-68, 71, 91-92, 114-115.]

Regardless of the absence of actual harm to these patients, Dr. Gladysz explained that the Respondent breached the standard of care by risking any harm to them at all. Dr. Gladysz deemed the Respondent's false documentation of drug amounts in patients' medical records to hide his diversion "wrong ethically" because subsequent providers could be misled into mistakenly believing patients' drug tolerances are unusually high or misdiagnosing surgical complications as drug related. The Respondent's deliberate use of his medical license to falsely document drug amounts to conceal his drug diversion was viewed by the Hearing Committee as a willingness to place his need to divert drugs above the effective and safe management of his patients' pain, particularly during the recovery period. [Transcript, p. 32, 46, 71, 92-93, 103, 114-115, 239.]

Although the Respondent denied diverting drugs other than Dilaudid and fentanyl, the Hearing Committee agreed with Dr. Gladysz that his documented dosages of other drugs are excessive and suggest diversion. Dr. Gladysz explained the purpose of an anesthesia record is to legibly and accurately document "what was done for the patient." The Hearing Committee noted many of the patients' anesthesia records are devoid of legible drug totals to show drugs administered intraoperatively, suggesting drugs wasted were never properly recorded. Indeed, Dr. Evlyn confirmed the CMC audit investigation findings showed the Respondent failed to maintain "documentation of wastage," a key indicator of drug diversion. Other suggestions of diversion at CMC included, according to Dr. Evlyn, the Respondent's unusual request of a nurse to obtain a drug and documentation of abnormally high dosages of drugs for the types of surgeries performed. [Exhibits 6-18; Transcript, p. 20-21, 51, 57, 62-65, 99, 119-121, 167.]

According to Dr. Gladysz, anesthesia records identify "notable" or "adverse" events, documentation the Hearing Committee considered critical to show clinical justification for drug dosages.

The Respondent failed to document medical rationales for any of his abnormally high dosages, presumably because he was diverting the drugs to himself. For instance, for Patient I to "sit still to hyperflex" for a lumbar puncture, the Respondent documented prescribing Dilaudid, which is long-acting, combined with fentanyl, Versed and Demerol to keep him "calm," which is hardly clinical justification for such a dangerous combination of drugs, especially for a patient with mental status changes and for a procedure that requires no sedation. He failed to document reasons for prescribing three 100 mcg boluses of fentanyl within 90 minutes combined with three 1 mg doses of Dilaudid for labor and delivery Patient A or Dilaudid for allergic Patient E when safer treatment options were available. The Hearing Committee rejected the Respondent's excuse of "drug shortages" for documenting questionable drugs. Even if drug scarcities existed, which the evidence failed to establish, he remained obligated to document reasons for his prescriptions. [Exhibits 6, 10, 14; Transcript, p. 21, 33-34, 44, 58, 63, 103, 143, 145, 155, 157, 162, 237.]

The Hearing Committee voted 3-0 that the Respondent's conduct constituted professional misconduct as defined under Education Law § 6530(3), negligence on more than one occasion. Negligence involves the "failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances." Bogdan v. State Bd. For Professional Med. Conduct, 195 AD2d 86, 88 (3d Dept. 1993). The Department is not required to prove harm to a patient. Youssef v. State Bd. For Professional Med. Conduct, 89 AD3d 824, 825 (3d Dept. 2004). Negligence can also be sustained when there is a relationship between inadequate medical records and patient treatment. Matter of Patin v. State Bd. For Professional Med. Conduct, 77 AD3d 1211, 1214 (3d Dept. 2010). The Hearing Committee sustains this charge on both grounds. The Respondent failed to exercise the required level of care when he diverted drugs and falsely documented drug amounts in medical records to hide his diversion. His documentation inaccuracies also risked harm to patients by deceiving subsequent providers in their medical decision-making.

The Hearing Committee voted 3-0 that the Respondent's conduct also constituted practicing the profession fraudulently under Education Law § 6530(2). Fraudulent practice requires "proof of either an intentional misrepresentation or concealment of a known fact." The Hearing Committee can infer the element of "intent or knowledge." Matter of Patin, 77 AD3d at 1214. The Respondent's admissions that he purposefully diverted drugs he "checked" out and "charted" for patients' procedures and falsely documented drug amounts to conceal his diversion are proof of intentional misrepresentations. The Respondent's knowledge can be inferred from his intentional creation of false medical records that could deceive other providers into believing drug amounts he diverted were given to patients. [Transcript, p. 142, 239.]

The Hearing Committee voted 3-0 not to sustain the specification of misconduct under Education Law § 6530(4), gross negligence on a particular occasion. Gross negligence involves a significant deviation from acceptable medical standards that creates the risk of grave consequences to the patient. Post v. NYS Dept. of Health, 245 AD2d 985, 986 (3d Dept. 1997). The Hearing Committee found that based on the Respondent's admissions to drug diversion and the medical records showing an absence of any drug-related side-effects or complications for patients, the evidence failed to establish that patients were administered drugs that placed them at risk for grave consequences.

The Hearing Committee also voted 3-0 not to sustain the specification of misconduct under Education Law § 6530(5), incompetence on more than one occasion. Incompetence includes a lack of the requisite knowledge or skill in the practice of the profession but does not require a showing of an act or omission constituting a breach of the duty of due care. Dhabuwala v. State Bd. For Professional Med. Conduct, 225 AD2d 209, 213 (3d Dept. 1996). The Hearing Committee, noting the Respondent's long-standing reputation among his colleagues for exceptional clinical practices and the successful completion

of his patients' procedures without problems related to his anesthesia care, concluded that he did not lack the requisite knowledge or skill to practice the profession. [Exhibits G, 26.]

Penalty

In considering the full spectrum of penalties under PHL § 230-a, including revocation, suspension, probation, censure and reprimand and the imposition of civil penalties, the Hearing Committee determined that the penalty of revocation of the Respondent's medical license is appropriate. The Hearing Committee considered the serious nature of the Respondent's opioid use disorder and history of relapse and found that based on treatment recommendations and his prognosis for recovery and relapse, he is currently incapable of safely practicing medicine.

Although the Respondent testified that CPH and other treatment providers deemed him "safe and appropriate" to return to the practice of medicine, the Hearing Committee interpreted these medical opinions differently. In a progress note dated May 7, 2019, Dr. Bezirganian, the Respondent's addiction physician, wrote he "(r)emains risky to resume full anesthesia practice." While Dr. Bezirganian later backed off this opinion, he conditioned the Respondent's safe return to practice on continuous monitoring and treatment, including the use of opioid blocker drugs such as Vivitrol. Dr. Singh, the psychiatrist who evaluated the Respondent's fitness to practice medicine, testified such conditions must be in place for the remainder of the Respondent's "professional life." The Department correctly points out that the March 2018 opinion of the Respondent's therapist, Carli Papas-Pasco, LCSW, that he is "fit to return to anesthesia," is erroneous because it is based on August 2017 Farley discharge recommendations made by John Colaluca, DO, who never authorized his return to practice. CPH never approved the Respondent's return to the practice of medicine either, recommending instead that he "consider alternatives to the kind of practice he was in" and "lower risk working environments." [Department's brief, p. 56; Exhibits E, F, 19, 32.]

The Hearing Committee, noting Dr. Evlyn's opinion that half of providers under active monitoring relapse and Dr. Singh's acknowledgment of the possibility of another relapse involving patients, concluded that even with such controls in place, the Respondent remains unsafe to practice medicine. The Hearing Committee was particularly concerned that the Respondent has already relapsed despite hospital audits and the vigilance of staff familiar with his history, and feels he remains vulnerable to another relapse. Dr. Singh discussed the major risk factors for relapse, including personal and career stress and mood disorders, stressors that persist for the Respondent. [Exhibits C, H, 32; Transcript, p. 123, 214, 305-306, 311-313, 330, 337-338.]

The Respondent made clear in his testimony and personal statement the toll his disease has taken on his family and career, but the Hearing Committee noted he never mentioned his patients, all of whom were victims of his diversion. Moreover, he never discussed the hospital from which he stole supplies and drugs or the harm in self-injecting opioids and then driving home. The Respondent described the mental energy devoted to diverting as "invasive" and "distracting," states of mind Dr. Singh agreed impair judgment and intensify as addiction worsens. [Exhibits I, 19; Transcript, p. 201, 310, 315.]

The Respondent argues that there is precedent for the Hearing Committee to impose a penalty short of revocation for his misconduct, such as a stayed period of suspension and probation with monitoring conditions. According to the Respondent, <u>Matter of Ryan Peterson, MD</u>, 2013 NY Phys. Dec. Lexis 365, involved a physician with a similar history of substance abuse and drug diversion in 2010 and 2011. In the Hearing Committee's view, however, science has since advanced to raise awareness of the serious dangers of addiction involving physicians and the need to protect the public. The Respondent also takes out of context a policy on physician impairment issued by the Federation of State Medical Boards, claiming that there is "no evidence" the Respondent "is or was impaired in the practice of medicine" when that policy specifically defines impaired as "the inability of a licensee to practice medicine with reasonable

skill and safety as a result of...substance-related disorders including abuse and dependency of drugs." Federation of State Medical Boards, Policy on Physician Impairment, p. 7, April 2011.

The Hearing Committee is concerned that only three years have passed since the Respondent's relapse, a minimal amount of time considering that relapse occurred after he was sober almost ten years and despite successfully completing an in-patient drug program and years of CPH and OPMC treatment and monitoring conditions. The Hearing Committee does not support the Respondent's desire to practice addiction medicine as an alternative to anesthesiology so he can give back to the recovery community because it would involve prescribing controlled substances, such as Suboxone. The Hearing Committee strongly feels it is critical that the Respondent eliminate any opportunity for diversion by choosing a different career path, such as teaching, to reach his goals. [Exhibit I; Transcript, p. 200, 212.]

Order

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The first, fourth, fifth and sixth specifications of professional misconduct set forth in the Statement of Charges are <u>Sustained</u>.

2. The second and third specifications of professional misconduct set forth in the Statement of Charges are <u>Dismissed</u>.

3. The Respondent's license to practice medicine in the State of New York is hereby <u>Revoked</u> under PHL § 230-a(4).

4. This Determination and Order shall be effective upon service on the Respondent in compliance with PHL § 230(10)(h).

DATED: Albany, New York
April 13, 2020

Paul J. Lambiase, Chairperson

Rose Berkun, MD
Andrew J. Merritt, MD

TO: David W. Quist, Associate Attorney
Bureau of Professional Medical Conduct
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Jacob William Smith, M.D.

APPENDIX I

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

IN THE MATTER OF JACOB WILLIAM SMITH, M.D.	STATEMENT OF CHARGES

JACOB WILLIAM SMITH, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 8, 2010, by the issuance of license number 259377 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about April 14, 2017, Respondent provided medical care to Patient A (all patients are identified in the Appendix), a 36-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient A failed to meet accepted standards of medical practice in that:

1. Respondent administered inappropriate anesthetic medications and/or other medications to Patient A.
2. Respondent diverted to himself for his own use some all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient A.

B. From on or about April 21, 2017 through on or about April 23, 2017, Respondent provided medical care to Patient B, a 96-year-old male at the time of treatment, at

Cayuga Medical Center. Respondent's care and treatment of Patient B failed to meet accepted standards of medical practice in that:

1. Respondent documented administration of excessive anesthesia to and/or other medications to Patient B.
2. Respondent administered inappropriate anesthetic medications and/or other medications to Patient B.
3. Respondent diverted to himself for his own use all or some some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient B.

C. From on or about March 28, 2017, Respondent provided medical care to Patient C, a 69-old male at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient C failed to meet accepted standards of medical practice in that:

1. Respondent administered inappropriate anesthetic medications and/or other medications to Patient C.
2. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient C.
3. Respondent failed to maintain a complete, legible record of Respondent's care of Patient C.

D. On or about April 6, 2017, Respondent provided medical care to Patient D, a 59-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's

care and treatment of Patient D failed to meet accepted standards of medical practice in that:

1. Respondent administered inappropriate anesthetic medications and/or other medications to Patient D.
2. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient D.
3. Respondent failed to maintain a complete, legible record of Respondent's care of Patient D.

E. On or about April 19, 2017, Respondent provided medical care to Patient E, a 32-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient E failed to meet accepted standards of medical practice in that:

1. Respondent administered inappropriate anesthetic medications and/or other medications to Patient E.
2. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient E.
3. Respondent failed to maintain a complete, legible record of Respondent's care of Patient E.

F. On or about May 2, 2017, Respondent provided medical care to Patient F, an 89-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient F failed to meet accepted standards of medical practice in that:

1. Respondent documented administration of excessive anesthesia to and/or other medications to Patient F.

2. Respondent administered inappropriate anesthetic medications and/or other medications to Patient F.

3. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient F.

4. Respondent failed to maintain a complete, legible record of Respondent's care of Patient F.

G. On or about March 30, 2017, Respondent provided medical care to Patient G, a 55-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient G failed to meet accepted standards of medical practice in that:

1. Respondent administered inappropriate anesthetic medications and/or other medications to Patient G.

2. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient G.

3. Respondent failed to maintain a complete, legible record of Respondent's care of Patient G.

H. On or about May 16, 2017, Respondent provided medical care to Patient H, a 65-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient H failed to meet accepted standards of medical care in that:

1. Respondent documented administration of excessive anesthesia to and/or other medications to Patient H.

2. Respondent administered inappropriate anesthetic medications and/or other medications to Patient H.

3. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient H.

4. Respondent failed to maintain a complete, legible record of Respondent's care of Patient H.

I. On or about April 22, 2017 2017, Respondent provided medical care to Patient I, a 69-year-old male at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient I failed to meet accepted standards of medical care in that:

1. Respondent documented administration of excessive anesthesia to and/or other medications to Patient I.

2. Respondent administered inappropriate anesthetic medications and/or other medications to Patient I.

3. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient I.

J. On or about March 23, 2017, Respondent provided medical care to Patient J, a 71-year-old male at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient J failed to meet accepted standards of medical care in that:

1. Respondent documented administration of excessive anesthesia to and/or other medications to Patient J.

2. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient J.

3. Respondent failed to maintain a complete, legible record of Respondent's care of Patient J.

K. On or about March 28, 2017, Respondent provided medical care to Patient K, a 74-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient K failed to meet accepted standards of medical care in that:

1. Respondent administered inappropriate anesthetic medications and/or other medications to Patient K.

2. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient K.

3. Respondent failed to maintain a complete, legible record of Respondent's care of Patient K.

L. On or about May 2, 2017, Respondent provided medical care to Patient L, a 66-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient L failed to meet accepted standards of medical care in that:

1. Respondent documented administration of excessive anesthesia to and/or other medications to Patient L.

2. Respondent administered inappropriate anesthetic medications and/or other medications to Patient L.

3. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient L.

4. Respondent failed to maintain a complete, legible record of Respondent's care of Patient L.

M. On or about April 13, 2017, Respondent provided medical care to Patient M, a 64-year-old female at the time of treatment, at Cayuga Medical Center. Respondent's care and treatment of Patient M failed to meet accepted standards of medical care in that:

1. Respondent documented administration of excessive anesthesia to and/or other medications to Patient M.

2. Respondent administered inappropriate anesthetic medications and/or other medications to Patient M.

3. Respondent diverted to himself for his own use all or some portion of the anesthetic medications and/or other medications which he had documented in the medical record as being administered to Patient M.

4. Respondent failed to maintain a complete, legible record of Respondent's care of Patient M.

N. Respondent, on one or more occasions after May 2007, has been a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, a/or other drugs having similar effects.

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 and A.2, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3, H and H.1, H and H.2, H and H.3, H and H.4, I and I.1, I and I.2, I and I.3, J and J.1, J and J.2, J and J.3, K and K.1, K and K.2, K and K.3, L and L.1, L and L.2, L and L.3, L and L.4, M and M.1, M and M.2, M and M.3, M and M.4, and/or N.

SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

2. A and A.1, A and A.2, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3, H and H.1, H and H.2, H and H.3, H and H.4, I and I.1, I and I.2, I and I.3, J and J.1, J and J.2, J and J.3, K and K.1, K and K.2, K and K.3, L and L.1, L and L.2, L and L.3, L and L.4, M and M.1, M and M.2, M and M.3, M and M.4, and/or N.

THIRD SPECIFICATION
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. A and A.1, A and A.2, B and B.1, B and B.2, B and B. 3, C. and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1, F and F.2, F and F.3, G and G.1, G and G.2, H and H.1, H and H.2, H and H.3, I and I.1, I and I.2, I and I.3, J and J.1, J and J.2, K and K.1, K and K.2, L and L.1, L and L.2, L and L.3, M and M..1, M and M.2, and/or M and M.3..

FOURTH SPECIFICATION
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:

4. A and A.1, A and A.2, B and B.1, B and B.2, B and B.3, C. and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3, H and H.1, H and H.2, H and H.3, H and H.4, I and I.1, I and I.2, I and I.3, J and J.1, J and J.2, J and J.3, K and K.1, K and K.2, K and K.3, L and L.1, L and L.2, L and L.3, L and L.4, M and M.1, M and M.2, M and M.3, and/or M and M.4.

FIFTH SPECIFICATION
BEING AN HABITUAL USER OR HAVING A PSYCHIATRIC CONDITION WHICH IMPAIRS THE ABILITY TO PRACTICE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(8) by being a habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, or having a psychiatric condition which impairs the licensee's ability to practice as alleged in the facts of the following:

5. A and A.1, A and A.2, B and B.1, B and B,2, B and B.3, C. and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1, F and F.2, F and F.3, G and G.1, G and G.2, H and H.1, H and H.2, H and H.3, I and I.1, I and I.2, I and I.3, J and J.1, J and J.2, K and K.1, K and K.2, L and L.1, L and L.2, L and L.3, M and M1, M and M.2, M and M.3, and/or N.

SIXTH 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 evaluation and treatment of the patient, as alleged in the facts of:

6. A and A.2, B and B.1, B and B.3, C and C.2 and C and C.3, D and D.2, D and D.3, E and E.2, E and E.3, F and F.1, F and F.3, F and F.4, G and G.2, G and G.3, H and H.1, H and H.3, H and H.4, I and I.1, I and I.3, J and J.1, J and J.2,

J and J.3, K and K.2, K and K.3, L and L.1, L and L.3, L and L.4, M and M.1, M and M.3, and/or M and M.4.

DATE: September 6, 2019
Albany, New York

Timothy J. Mahar, Esq.
Deputy Counsel
Bureau of Professional Medical Conduct