STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

February 24, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Edward M. Finck, M.D.
2993 Amboy Avenue
Staten Island, New York 11030

Dennis J. Peterson, Esq.
60 Bay Street, 8th Floor
Staten Island, New York 10301

Daniel Guenzburger, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: In the Matter of Edward M. Finck, M.D.

Dear Dr. Finck, Mr. Peterson and Mr. Guenzburger:

Enclosed please find the Determination and Order (No. BPMC-97-44) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

COPY

IN THE MATTER

OF

EDWARD M. FINCK, M.D.

DETERMINATION

AND

ORDER

BPMC-97-44

NORTON SPRITZ, M.D., Chairperson, **GERALD S. WEINBERGER, M.D.** and **DEAN RANDOLPH MANNING** 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 in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **MARILYN S. READER, ESQ.**, served as 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 dated:	May 1, 1996
Statement of Charges dated:	May 1, 1996
Pre-hearing conference:	May 21, 1996
Hearing dates:	May 21, 1996 July 18, 1996 July 31, 1996 September 16, 1996 October 16, 1996 October 22, 1996 December 5, 1996
Intra-hearing conferences:	May 21, 1996 September 16, 1996 December 5, 1996
Proposed findings of fact received:	January 3, 1997
Deliberation dates:	January 13, 1997 January 23, 1997

Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York 10001
Petitioner appeared by:	Henry M. Greenberg, General Counsel NYS Department of Health, Division of Legal Affairs BY: Daniel Guenzburger, Esq. Assistant Counsel
Respondent appeared in person and was represented by:	Dennis J. Peterson, Esq. 60 Bay Street, 8th Floor Staten Island, New York 10301 David Ironman, Esq. Of counsel to Mr. Peterson

MOTIONS:

5/30/96 -- Telephone application for adjournment by Dennis Peterson, Esq., to adjourn proceedings scheduled for May 31, 1996. Mr. Peterson was in car accident on May 30, 1996 when his vehicle was struck and crushed by a 18 wheeler truck which jack-knifed on the Brooklyn-Queens Expressway. Mr. Peterson went to emergency room, discharged and on May 30, 1996 was barely able to move about. Mr. Guenzburger, attorney for the Petitioner, consents to the adjournment. Application **GRANTED.**

5/31/96 -- Telephone conferences with counsel and panel members to schedule July 18, 1996 as the next date of hearing. This was the earliest date available to counsel, the panel members and the Department's expert.

7/18/96 -- Application of Mr. Guenzburger to withdraw Specifications 15, 16, 18 and 19 and Allegations C.7 and C.8 **GRANTED**.

7/30/96 -- *Ex Parte* telephone application by secretary to David Ironman, Esq., of counsel to Mr. Peterson, attorney for Respondent, requesting an adjournment of tomorrow's proceedings. Dr. Finck has telephoned her and told her he was told by his physician to stay in bed because of dehydration and gastroenteritis. Mr. Ironman is not available and she has no documentation from Respondent's physician re: Respondent's illness and incapacity. Application **DENIED**. I noted if, at tomorrow's proceedings, Respondent's counsel requests an adjournment, he should have documentation from a physician of Respondent' illness.

7/31/96 -- At the commencement of the proceedings, application by Mr. Peterson, attorney for Respondent, to adjourn today's proceedings because Respondent is ill. Mr. Peterson offered a letter from Respondent's physician (ALJ Ex. A). As Respondent is current witness and there are not other witnesses for today, Mr. Guenzburger consents to the adjournment. Application **GRANTED.**

9/16/96 -- Offer of proof for Exhibit 14 made by Mr. Guenzburger, counsel for Petitioner. Application to admit Exhibit 14 **DENIED.**

9/16/96 -- Application by Mr. Ironman, counsel for Respondent, to cancel the proceedings scheduled for September 27, 1996 was consented to by Mr. Guenzburger. Mr. Ironman has been ordered by U.S. District Court for the Southern District of Florida to appear for a hearing and will not be available on September 27, 1996. Mr. Peterson is committed and scheduled for a trip to Greece and will be unavailable until mid-October. Application **GRANTED.**

11/1/96 -- *Ex parte* telephone application to adjourn proceedings scheduled for November 4, 1996 made by Mr. Guenzburger on behalf of Mr. Peterson, attorney for Respondent. Mr. Guenzburger's office received a telephone call from Mr. Peterson's secretary, Emily Amorante, informing OPMC that Mr. Peterson suffered a heart attack and is admitted to Staten Island University Hospital (SIUH).

ALJ paged Ms. Amorante, who upon request, transmitted admission records (ALJ Ex. D) from SIUH to the ALJ. Mr. Ironman is out of town. Mr. Guenzburger consented to adjournment. Application **GRANTED** for adjournment *sine die*.

12/5/96 -- Application by Mr. Guenzburger to admit Exhibit 14 for penalty phase of deliberations if the Committee sustains any of the charges. Application DENIED as too stale and too remote to be probative.

12/16/96 -- Letter (dated 12/16/96) and telephone application by Mr. Guenzburger, attorney for Petitioner, to amend Statement of Charges §B8 to reflect the date of August 18, 1994 rather than August 28, 1994 and to include missing pages of Visiting Nurses record for Patient A (Resp. Ex. F). Advised Mr. Peterson, attorney for Respondent, consents to both applications. Application to conform Statement of Charges §B8 to the evidence and to include the omitted pages into Respondent's Ex. F **GRANTED.**

Review of the record by absent members of the panel: On July 18, 1996, Norton Spritz, M.D., was absent from the proceedings. On September 16, 1996, Dean Randolph Manning left the proceedings early. They have reviewed thoroughly the transcripts for the portion of the proceedings for which each was absent. ALJ Ex's. B and C.

WITNESSES

For the Petitioner:

1. Carole Agin, M.D.

For the Respondent:

1. Edward M. Finck, M.D., the Respondent
2. Patient A
3. Howard L. Rosner, M.D.

STATEMENT OF CHARGES

Essentially the Respondent is charged with professional misconduct by reason of:

a. Practicing the profession negligently on more than one occasion;

b. Practicing medicine incompetently on more than one occasion;

c. Practicing medicine with gross negligence;

d. Practicing medicine with gross incompetence;

e. Failing to maintain adequate records of patients;

f. Ordering excessive treatment;

g. Practicing the profession fraudulently;

h. Filing a false report; and

i. Failing to use acceptable infection control procedures.

The Statement of Charges is annexed hereto as Appendix A.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. **EDWARD M. FINCK, M.D.**, the Respondent, was duly licensed to practice medicine in New York State by the issuance on September 9, 1968, of license number 102179, by the New York State Education Department. (Pet. Ex. 2).

2. The Respondent currently is registered with the New York State Education Department to practice medicine. (Rspt. Ex. G).

3. This proceeding was commenced by the service of the Notice of Hearing and Statement of Charges upon the Respondent on May 1, 1996. (Pet. Ex. 1).

4. Respondent graduated from the Chicago Medical School in 1962. He performed an internal medicine residency at Jersey City Medical Center and a cardiology fellowship at Philadelphia General Hospital. He is board certified in internal medicine. (T. 283, 285).

5. Since 1968, Respondent has maintained a private medical practice in Staten Island. Although Respondent had privileges at Staten Island Hospital, Richmond Memorial Hospital, and St. Vincent's Hospital, he no longer maintains privileges at any hospital. (T. 481). He resigned from Richmond Memorial Hospital in lieu of appealing a decision of the medical executive credentials committee that he had backdated progress notes in patient charts. (T. 482).

6. Approximately 10 to 15% of Respondent's medical practice involves treating patients for either acute or chronic pain. (T. 479-480). Respondent has not had any specialized training in pain management or in treatment of patients, suffering from acute or chronic pain, with narcotics. (T. 480).

7. Respondent did not learn the procedures for administering trigger point injections or nerve blocks during his internal medicine training. Respondent learned to administer trigger point injections by reading and speaking to other physicians who had used the procedure. (T. 500)

8. Respondent, a board certified internist without any specialized training in pain management, is not qualified to perform regional nerve blocks. (T. 799)

9. There is an absence of documentation of the findings of physical and neurologic examinations on any of the patients. (Pet. Exs. 3, 5 and 9). Due to the lack of documentation, the Committee is skeptical that adequate physical and neurologic examinations were performed for any of the patients to determine the basis for their respective pain syndromes. (Pet. Ex. 3, 5 and 9).

10. Nubain is an agonist/antagonist, has analgesic qualities with a ceiling effect on respiratory depression and can cause physical and psychological dependency. Phenergan is a promethazine and typically is used as an adjunct to post operative analgesics with narcotics because it enhances the activity of an analgesic. (T. 39-40). Norflex is a muscle relaxant. (T. 36).

11. There are oral, suppository and skin patch type analgesic medicines that are alternative pain management medicines to injectable Nubain and Phenergan. (T. 52-53, 62 and 837).

FINDINGS OF FACT AS TO PATIENT A

12. For a period of time on or about November 21, 1985 and until at least August 25, 1994, the Respondent treated Patient A at his office located at 2993 Amboy Road, Staten Island, New York and in Patient A's home. Patient A was 42 years old at the onset of treatment. (Pet. Ex. 3).

13. Patient A was a complicated pain management case. (T. 795) She had an automobile accident in November, 1972. Subsequently, during surgery at Lenox Hill Hospital cervical discs C-5 and C-6 were removed. Patient A was bedridden for a year following surgery. In 1985, Patient A underwent surgery for the removal of additional cervical discs. (Pet. Ex. 3 at 1-3: T. 31-33).

14. In addition to her neurologic disorders, Patient A suffered from many gastrointestinal problems of inflammatory bowel syndrome, esophagitis, peptic ulcer disease, esophageal web or a decrease in esophageal motility (Pet. Ex. 3; T. 121 and 392-393). Due to her gastrointestinal disorders, Patient A had difficulty taking oral medications. (T. 393). Although Respondent claims that Patient A had a past history of unsuccessful treatment with oral analgesics, there is no documentation recorded in Patient A's past medical history to support such an assertion. (Pet. Ex. 3; T. 119-120).

15. Between November 21, 1985 and April 2, 1989, Respondent's treatment of Patient A was limited to general medicine. (Pet. Ex. 3 at 1-3; T. 31-33).

16. Respondent assumed primary responsibility for treating Patient A's pain on or about April 2, 1989. Patient A presented to Respondent with a chief complaint of left shoulder pain and spasm. Respondent notes that he administered a "block-the left shoulder." He also administered Phenergan and Nubain intra-muscularly (IM), an Norflex intra-venously. (Per. Ex. 3 at 14; T. 33).

17. Between April 1989 and January 1993, Respondent treated Patient A with injections for pain management. (Pet. Ex. 3 and T. 538). For many years, Respondent treated Patient A on an daily, sometimes twice daily basis, administering injections of Nubain and other injectable pain medication. (Pet. Ex. 3; T. 111-112 and 499) Nubain, Phenergan and Norflex are analgesics, but are not narcotic medications. (T. 36-40, 650-652).

18. Throughout this period, and specifically between April 2, to April 4, 1989, Respondent deviated from medically accepted record keeping standards by failing to adequately describe the procedure he followed so as to enable another physician reviewing Patient A's medical chart to discern whether the patient received a left shoulder trigger point injection or a nerve block. (Pet. Ex. 3 and T. 34-36, 41-43).

19. A trigger point is a superficial injection of a local anesthetic into an area of the body where the muscle is in spasm. A nerve block is a more invasive procedure in which the anesthetic is injected deeper into the body and is targeted at a specific nerve. (T. 34-36).

20. Respondent's decision to administer analgesics through injection before trying to manage Patient A on oral analgesics was inappropriate. Since multiple injections are painful, other routes of administering analgesics should first be attempted. In addition, frequent injections pose a significant threat of infection. Analgesics administered in injectable form have both a quicker onset and offset of analgesic effect. In order to address Patient A's chronic pain, Respondent should have selected a longer acting analgesic that would have provided more continuous pain relief and should have considered non-injectable pain medicine. (T. 52-53, 62 and 837).

21. Between April, 1989 and until at least September 30, 1992, Respondent repeatedly administered paravertebral nerve blocks and intercostal nerve blocks on Patient A. (Pet. Ex. 3; T. 45-48 and 222-223).

22. Whenever Respondent injected Patient A, Respondent billed the insurance company for a nerve block rather than a trigger point injection. (T. 546).

23. Respondent inappropriately continued to treat Patient A's pain with analgesic injections without modifying his treatment path despite Patient A's failure to show any improvement in her symptomatology. (Pet. Ex. 3; T. 57, 63) There is never a medical benefit for a patient to receive nerve blocks every day for many months. (T. 139-140).

24. On October 24, 1989, Respondent caused Patient A to suffer a left pneumothorax when injecting her in the left intercostal region. (Pet. Ex. 3 at 65; T. 507).

25. It is very unusual for a physician to cause a pneumothorax when administering a trigger point injection. (T. 501-502).

26. Respondent placed Patient A in great jeopardy by performing a right intercostal nerve block two days after Patient A suffered a left pneumothorax when Respondent administered the same procedure on the left side. (Pet. Ex. 3; T. 56, 72-74, 507 and 832).

27. Respondent failed to describe in the medical chart any physical or neurological examinations he may have performed on Patient A in order to determine the cause of her complaints of pain. (Pet. Ex. 3, T. 133-134). Nor did Respondent record his findings of such examinations, if performed. Further, Respondent failed to record that he had ordered tests to establish the source of Patient A's complaints of pain, and if ordered, Respondent did not record the test results. (Pet. Ex. 3; and T. 133-134) Due to the lack of documentation, the Committee is skeptical that adequate physical and neurologic examinations were performed to enable Respondent to diagnose the causes of Patient A's numerous complaints of pain.

28. Respondent maintained the necessary resuscitation equipment in his office and after he administered the Nubain and Phenergan IM, he monitored her response to that day's dose before discharging her from his office. (T. 291-293, 335, 337-338, 558-559, 563).

29. While Respondent was administering pain management injections to Patient A at least once daily during April and May, 1989, he failed to perform physical examinations such as palpating the target area and examining Patient A for improved range of motion to determine whether the pain treatment gave relief. (Pet. Ex. 3 and T. 48) Indeed, during the many years of treating Patient A with injections for pain management, Respondent failed to perform physical examinations that were necessary to evaluate her response to the treatment. (Pet. Ex. 3).

30. Nor did Respondent, during this period of time, obtain and record an adequate history between visits: Was there any change in Patient A's complaint? What Patient A felt between visits? Whether there were any benefits or side effects from the injected analgesics? If she had relief, if so, how long it lasted? Did she have any complications? Is the pain today better or worse? Is it the same pain? Is it in a different area? (Pet. Ex. 3; T. 56 and 41-42).

31 Respondent's treatment plan with Nubain and Phenergan IM and Norflex IV is inappropriate for a patient like Patient A with long term chronic pain. Nubain IM and Norflex IV are usually used for acute spasms. (T. 51) Respondent failed to recognize the need to change Patient A's treatment plan despite the failure of the treatment plan to alleviate Patient A's chronic pain. (T. 51 and 63) Respondent deviated from medically acceptable standards by failing to seek alternatives to his treatment with Nubain, Norflex and Phenergan, especially in light of the lack of improvement during the long course of treatment with this regimen. (T. 63).

32. Respondent prescribed a program of self-injection of Nubain to Patient A. Respondent did not indicate the initiation or any follow-up review of the self-injection program in Patient A's medical chart. (Pet. Ex. 3 and T. 130, 205 and 801).

33. As there was no long term use of Thorazine as administered to Patient A there was no risk of Tardive Dyskinesia occurring. (T. 780-781) The use of Thorazine following the administration of Phenergan did not put Patient A at any greater risk. (T. 781, 783).

34. On October 30 and 31, 1989, Patient A reported to Respondent that she had experienced possible temporal lobe seizures. (Pet. Ex. 3 at 68) Respondent inappropriately failed to measure Patient A's vital signs or to perform physical and neurological examinations to assess if there was any neurologic damage, residual weakness or bodily injury related to the seizures. (Pet. Ex. 3; T. 74-76).

35. Following Patient A's report of seizures in late October, 1989, Respondent inappropriately placed Patient A at a greater risk of injury in her home and outside by continuing to inject Patient A with Nubain and Phenergan before determining the cause of the seizures. (T. 77-78).

36. In September, 1989, five months after Respondent commenced administering injectable analgesic medication, Patient A developed abscesses in her buttocks. (Pet. Ex. 3 at 50, 395). The abscesses were caused by the multiple injections of pain medication Patient A received from Respondent and from the multiple injections Patient A gave to herself pursuant to Respondent's prescription. (Pet. Ex. 4 at 3, 4 and 34; T. 71; Pet. Ex. 7 and T. 803, 817).

37. After Patient A developed these abscesses, Respondent inappropriately continued to inject Patient A in the thigh and buttocks region and failed to stop Patient A's program of self-injecting Nubain in her thighs or buttocks. (Pet. Ex. 3; T. 71, 817).

38. After Patient A developed abscesses in the areas of her multiple injections, Respondent inappropriately failed to re-assess this method of treatment even though Patient A did not appear to be improving from this method of treatment. (T. 71-72).

39. Moreover, Respondent inappropriately resisted the diagnosis that the multiple injections were causing the abscesses in Patient A's thighs and buttocks. (Pet. Ex. 4 at 3, 4 and 34).

40. Respondent failed to adequately evaluate whether Patient A was becoming psychologically addicted to being injected by Respondent every day or other day. (T. 548).

CONCLUSIONS AS TO PATIENT A

In allegation A.1, it is stated Respondent failed to take adequate histories, including but not limited to failing to ascertain Patient A's response to treatment with pain. Respondent failed to take an adequate history of Patient A at the initial visit and all subsequent visits. Although Respondent claims Patient A had a past medical history of unsuccessful treatment with oral analgesics, there is no record in the patient's past medical history documenting such an assertion. In early April 1989, when Respondent began the regimen of nearly daily injections of analgesics, Respondent failed to obtain and record an acceptable history of the onset and course of pain and the limitations caused by the pain. After instituting the regimen of injecting Patient A with analgesics, Respondent failed to inquire and note whether there was any change in Patient A's complaint? What Patient A felt

between visits? Whether there were any benefits or side effects from the injected analgesics? If she had relief, if so, how long it lasted? Did she have any complications? Is the pain today better or worse? Is it the same pain? Is it in a different area? Was her range of motion improved? Was her ability to perform daily functions improved? When Patient A reported two possible seizures, Respondent failed to meet the acceptable medical standard of care by obtaining and recording when Patient A had the seizure, did she fall and hit her head, lose consciousness, was she bruised or did she notice any physical deficits since the seizure. After prescribing self-injections of Nubain, Respondent failed to periodically question Patient A about how often she self-injected, the relief she felt and for how long. After Patient A developed abscesses, Respondent failed to adequately obtain a history of the procedures Patient A used to self-inject Nubain. Without such inquiries neither Respondent nor a successor physician can evaluate the benefits or risks of the course of treatment given to Patient A.

Therefore, Allegation A.1 is sustained.

In Allegation A.2, Respondent is charged with failing to perform adequate physical examinations. Respondent failed to perform and record adequate physical examinations to determine the basis of Patient A's pain syndromes. During the course of Respondent's regimen of injecting Patient A with analgesics, Respondent failed to adequately examine Patient A periodically to evaluate whether there was any improvement, detriment or lack of change from the course of treatment. When Patient A complained of having two seizures, Respondent inappropriately failed to perform and record a physical examination to evaluate and assess her physical and neurologic condition. Nor did he examine her to determine whether she may have bruised herself, caused any internal injuries or was suffering any residual deficits.

Therefore, Allegation A.2 is sustained.

In Allegation A.3, Respondent is charged with the failure to adequately treat Patient A for chronic pain by, among other reasons, (a) inappropriately administering injectable short acting pain medication, (b) failing to appropriately adjust the therapeutic regimen in response to the failure of previously ordered treatment, adverse drug reactions, skin abscesses in areas where Respondent injected medication and patient history of syncope and seizures, and (c) ordering excessive treatment with injectable narcotic medication. Respondent inappropriately continued to use Norflex IV, Nubain and Phenergan IM for a long period of time without modifying the treatment plan although there was no reported change in symptoms and no evidence the treatment plan was alleviating Patient A's chronic pain. Respondent's treatment plan with injectable Norflex and Nubain may be appropriate for acute pain, but is not an acceptable course of treatment for chronic pain lasting years. After Patient A reported she had seizures, Respondent fell short of acceptable medical standards by continuing Patient A on IM Nubain and Phenergan and Nubain self-administered injections before determining the cause of the seizures. Respondent placed Patient A at great risk of harm from falls at home and outside. Once abscesses developed in the regions where injections were administered, Respondent inappropriately continued to administer injections in the infected region and inappropriately failed to discontinue Patient A's prescription for self-injected Nubain. However, since the drugs prescribed were Nubain and Phenergan, and since they are not regarded as a narcotic, the Committee was unable to find that the Respondent had failed to "discontinue treatment with IM injections of narcotic medication." Had the word "narcotic" not been specified in Allegation A.3(c), then the Committee would have sustained a finding that the drugs were seriously mismanaged.

Therefore, Allegations A.3(a) and A.3(b) are sustained.

Allegation A.3(c) is not sustained.

In Allegation A.4, Respondent is charged with deviating from accepted medical standards in the performance of nerve blocks by: (a) failing to either obtain written consent, and/or discuss with the patient the risks, benefits and alternatives; (b) failing to have emergency resuscitation equipment appropriately available when performing intercostal nerve blocks; (c) failing to comply

with medically accepted infection control procedures; (d) failing to adequately monitor the patient for possible complications from the procedure; (e) inappropriately administering an intercostal nerve block one day after Patient A had been diagnosed with a pneumothorax, and (f) ordering an excessive number of nerve blocks. Patient A suffered a pneumothorax on or about October 25, 1989 after Respondent performed a left intercostal nerve block. Although Respondent had already caused a pneumothorax performing an intercostal nerve block on Patient A, two days later Respondent performed a contra-lateral intercostal nerve block in disregard of Patient A's compromised pulmonary function. From the totality of the evidence, the Committee finds incredible Respondent's claim that he meant trigger point injections when he used the terms "intercostal nerve block," "paravertebral nerve block," "paracostal nerve block," "nerve block," or "block." Respondent consistently used the term "block" rather than trigger point injection. Respondent billed the insurance company for a nerve block rather than for a trigger point injection each time he injected Patient A. Significantly, Respondent caused a left pneumothorax on October 25, 1989 which is a complication of a nerve block and is not a complication of a trigger point injection, which is only a superficial insertion of a needle. Respondent lacked the qualifications to perform nerve blocks. However, for many years, Respondent administered nerve blocks. Although, Respondent had Patient A's consent and, indeed, persistent requests for such treatment, Respondent failed to exercise the necessary judgment of a prudent physician as to the appropriateness of administering the almost daily regimen for over a year. Respondent caused Patient A's abscesses in her thighs and buttocks by administering multiple injections and prescribing a self-injecting regimen to Patient A. After Patient A developed abscesses, Respondent failed to meet acceptable medical standards by continuing to administer Nubain and Phenergan IM to her thigh and buttocks, and failing to cease Patient A's program of self-injecting Nubain. Continuing to administer the Nubain and Phenergan IM although there was no reported change in symptoms and no evidence the treatment plan was alleviating Patient A's chronic pain is a deviation from acceptable medical practice.

Therefore, Allegations A.4(c) (e) and (f) are sustained.

Allegations A.4 (a), (b) and (d) are not sustained.

In Allegation A.5, Respondent is charged with inappropriately treating Patient A's condition of multiple abscesses by (a) inaccurately diagnosing the cause of the abscesses, (b) failing to appropriately adjust and/or discontinue treatment with IM injections of narcotic medication, (c) inappropriately administering corticosteriods. Respondent failed to meet acceptable medical standards by failing to recognize the analgesic injections were causing the abscesses and by failing to change the method of treatment and cease IM injections of Nubain and Phenergan in the thighs and buttocks area of Patient A. Most disturbingly, Respondent inappropriately remained blind to the compelling evidence that the multiple injections were causing the abscesses in Patient A's thighs and buttocks. However, since the drugs prescribed were Nubain and Phenergan, and since they are not regarded as a narcotic, the Committee was unable to find that the Respondent had failed to "discontinue treatment with IM injections of narcotic medication." Had the word "narcotic" not been specified in Allegation A.5(b), then the Committee would have sustained a finding that the drugs were seriously mismanaged.

Therefore, Allegation A.5(a) is sustained.

Allegations A.5(b) and A.5(c) are not sustained.

In Allegation A.6, Respondent is charged with having failed to appropriately address Patient A's nutritional status in light of her chronic vomiting. Respondent appropriately considered Patient A's gastro-intestinal disorders and referred her to a nutritionist.

Therefore, Allegation A.6 is not sustained.

In Allegation A.7, Respondent is charged with failing to adequately assess the risks, benefits and alternatives to the administration of Thorazine, in or about March, 1990. Respondent appropriately assessed the risks and benefits of administering Thorazine to Patient A. As administered to Patient A there was no risk of Tardive Dyskinesia.

Therefore, Allegation A.7 is not sustained.

In Allegation A.8, Respondent is charged with failing to maintain a record which accurately reflected the evaluation and treatment, including but not limited to failing to appropriately document that he had prescribed self-injectable narcotics. Although the Committee notes that Nubain is not a narcotic drug, the Committee finds that Respondent fell below acceptable professional standards of record keeping by failing to record in Patient A's chart that he had prescribed Nubain, an agonist/antagonist, for self-injection. Nubain is a potentially physically and psychologically addictive drug. Throughout the course of treating Patient A with frequent Nubain and Phenergan injections, Respondent fell below acceptable standards by failing to obtain and note a history of the beneficial, detrimental or absence of effects of the treatments on Patient A between visits. Without such information, Respondent could not adequately evaluate the effectiveness of the current regimen. After Patient A developed abscesses from the multiple injections, Respondent inappropriately failed to record any reassessment of this method of treatment even though Patient A did not appear to be improving from this method of treatment and was now experiencing morbidity. Respondent deviated from medically accepted record keeping standards by failing to adequately describe the procedure he followed so as to enable another physician reviewing Patient A's medical chart to discern whether the patient received trigger point injections or nerve blocks.

Therefore, Allegation A.8 is sustained.

FINDINGS OF FACT AS TO PATIENT B

41. On or about and between June 25, 1989 and January 1996, the Respondent treated Patient B, a 23 year old female. In June 1989, at the onset of treatment, Patient B was 23 years old. (Pet. Ex. 5).

42. On September 22, 1993, Patient B was admitted to Staten Island Hospital. During the course of her hospitalization, a substance abuse evaluation noted Patient B already had a 10 year history of substance abuse before she became Respondent's patient. (Pet. Ex. 6 at 22).

43. On or about April 25, 1991, Patient B was involved in an automobile accident in which she suffered lacerations on the chin, hip and thigh. Within three hours of the accident, Patient B received treatment at Doctor's Hospital. Three days after the accident, on April 28, 1991, Respondent first examined Patient B. He saw her at subsequent office visits dated June 19, July 9, and August 1, 1991. The progress notes for these visits do not indicate that Respondent administered treatment for pain. (Pet. Ex. 5 at 8).

44. The first documented treatment for pain is on or about October 29, 1991, when the Respondent administered intra-muscular Nubain and Phenergan and prescribed Robaxin. (Pet. Ex. 5 at 9; T. 149). On an undetermined date prior to March 30, 1994, Respondent also prescribed IM Nubain for self-administration. Respondent inappropriately failed to note in Patient B's medical chart that he prescribed IM Nubain for self-injection and such omission is a deviation from acceptable medical record keeping standards. (Pet. Ex. 5; T. 205 and 801) The information about Respondent's prescription for IM Nubain is in a progress note dated March 30, 1994, which indicates Patient B had been arrested for possession of injectable Nubain, promethazine and syringes prescribed by Respondent. (Pet. Ex. 5 at 99; T. 205).

45. On October 31, 1991, the next visit after Respondent began a regimen of injecting IM analgesics, Respondent inappropriately failed to elicit from Patient B and/or note a history of her response to the Nubain and Phenergan. (Pet. Ex. 5 at 8 and 9; T. 152). During this visit, Respondent again administered Nubain and Phenergan IM. However, in a separate progress note entry dated October 31, 1991, Respondent recorded that Patient B was on Vicodan, an agonist. (Pet. Ex. 5 at 8 and 9). Nubain, an agonist/antagonist, is contra-indicated for a patient on Vicodan, an agonist. A classic agonist/antagonist is like an antidote to a narcotic, an agonist. If a patient is chronically receiving a narcotic, administering an agonist/antagonist may cause a withdrawal syndrome in the patient. (T. 39-40).

46. By administering Nubain and Phenergan IM at eleven office visits from October 29, 1991 and through November 1991, Respondent deviated from acceptable medical standards. (T. 152) There is no documentation as to why the patient would require aggressive therapy with injections versus starting with more simpler treatment consisting of different trials of oral or other pain medicines. (Pet. Ex. 5 at 8 and 9).

47. Respondent's decision to administer analgesics through injection before trying to manage Patient B on oral analgesics was inappropriate. Other routes of administering analgesics should first be attempted as multiple injections are painful. In addition, frequent injections pose a significant threat of infection. Analgesics administered in injectable form have both a quicker onset and offset of analgesic effect. Treating chronic pain, Respondent should have selected a longer acting analgesic that would have provided more continuous pain relief and should have considered non-injectable pain medicine. (T. 52-53, 62, 152-153 and 837).

48. In addition, throughout the period Respondent administered Nubain and Phenergan IM, Respondent inappropriately failed to obtain a history and note the effects of the previous injections of Nubain and Phenergan IM as to any benefits or adverse effects and whether they helped her in any way. Nor did Respondent perform and note his findings of a physical examination to determine whether there is any improvement, increase in range of motion, lack of tenderness, less spasm or other indicia of the effects, if any, of the regimen. (Pet. Ex. 5) It is inappropriate to continue a regimen without evaluating its benefits, harm or ineffectiveness. (T. 151-152).

49. By continuing to administer Nubain, Phenergan and Norflex at 59 office visits between December 2, 1991 and May 3, 1992, Respondent inappropriately failed to alter Patient B's treatment in response to the documented lack of improvement of her condition. At practically each visit, Respondent noted severe low back pain and severe spasm. (Pet. Ex. 5 at 12-37; T. 155-156). In a letter addressed "To Whom It May Concern," dated April 21, 1992,

Respondent wrote, "She has severe low back pain syndrome, rheumatoid arthritis, and radiculopathy. As a result she is totally incapacitated and unable to work. Her back often gives out and she experiences recurrent severe pain in her low back." (Pet. Ex. 5 at 7).

50 On or about May 12, 1992, Patient B was involved in an automobile accident. Respondent wrote a report dated August 18, 1994 to Patient B's attorney describing her condition following the accident. Respondent knew that the report would be used in litigation involving injuries Patient B claimed to have sustained as a result of the motor vehicle accident. (T. 610) Contrary to both the April 21, 1992 note referred to in §49 *supra* and to Patient B's condition as documented in her chart, Respondent wrote in the August 18, 1994 report for Patient B's attorney, "Prior to the accident [Patient B] was happily and gainfully employed as an independent real estate contractor. Since May 12, 1992, she has been in constant pain and has not been able to function adequately in multiple aspects of life. This has resulted in significant depression necessitating the administration of anti-depressant medications. Furthermore, as a result of the severe persistent pain she has needed intermittent Percocet and /or Demoral p.o. and/or Nubain IM." (Pet. Ex. 5 at 108).

51. Respondent knowingly and intentionally omitted in the August 18, 1994 report that Patient B had a pre-existing condition of chronic pain that he had been treating with IM analgesics since 1989. He further knowingly and intentionally concealed that just three weeks prior to the car accident in May 1992, Patient B was "totally incapacitated and unable to work" and that "[h]er back often gives out and she experiences recurrent severe pain in her low back." (Pet. Ex. 5 at 106-109).

52. Respondent knowingly and intentionally falsely represented in the August 18, 1992 letter that Patient B was in constant pain, was unable to function in both professional and social capacities, and required treatment with Percocet, Demerol and Nubain as a result of the May 12, 1992 automobile accident, when Respondent knew that patient B's chronic pain, her treatment with pain medications and her inability to function in both professional and social capacities preceded the May 12, 1992 motor vehicle accident. (Pet. Ex. 5).

53. In the August 18,1994 report. Respondent further notes that as a "direct result" of the May 12, 1992 accident Patient B suffered a severe upper sternal trauma with anterior protrusion of manubrium and upper body sternum." (Pet. Ex. 5 at 109) Respondent's diagnosis is unsupported by and inconsistent with an x-ray finding dated December 22, 1993 that shows Patient B had a normal sternum. (Pet. Ex. 6 at 10) Further, Respondent failed to adequately confirm with positive findings of either an MRI or a CAT scan the diagnoses of possible herniated cervical disc, herniated lumbar disc and herniated thoracic disc which he attributed to the motor vehicle accident.

54. Respondent failed to perform and note his findings of a physical examination in response to Patient B's complaint that she had been involved in a motor vehicle accident two hours before her appointment with Respondent on May 12, 1992. (Pet. Ex. 5 at 38) As a result of the accident, Patient B complained of a headache, chest pain, severe neck and low back pain, right shoulder pain and pain down the left lower extremity posteriorly. At a minimum, Respondent should have checked her vital signs, performed a neurological examination and examined her for possible internal injuries. (T. 157-158).

55. Following the May 12, 1992 car accident, Respondent continued to treat Patient B with Nubain, Phenergan and Norflex injections. On or about October 18, 1992, Respondent noted Patient B had started Percodan the day before. (Pet. Ex. 5 at 57) Respondent inappropriately failed to note the dosage, duration of the prescription or any instructions for taking the medication. (T. 166-167 and 801).

56. Between the October 18, 1992 visit and the immediately next visit on November 5, 1992, there is no note in Patient B's medical chart indicating whether she had stopped taking Percodan, and if she had, when. On November 5, 1992, Respondent administered IM Nubain. (Pet. Ex. 5 at 57 and 61) Percodan is an agonist narcotic medication. (T. 162 and 167) Administering Nubain IM, an agonist/antagonist while a patient is taking Percodan, an agonist, falls below accepted medical standards. It is contra-indicated to administer Nubain IM to a patient taking Percodan since Nubain, an agonist/antagonist, is like an antidote to a

narcotic, an agonist. (T. 39-40 and 167). Respondent inappropriately failed to record whether Patient B had discontinued taking Percodan, and if so, when, before administering a contra-indicated application of IM Nubain. (T. 801).

57. At the January 5, 1993 visit, Patient B reported ecchymoses (black and blue bruises) on both arms, the back and left chest. (Pet. 5 at 65; T. 165) On March 18, 1993, Patient B reported severe ecchymosis on the medial aspect of both knees. (Pet. Ex. 5 at 70) Less than one month later, on April 5, 1993, Respondent once again noted marked ecchymosis.

58. The only documented evidenced that Respondent attempted to explore the cause of the bruises was a brief conclusory note "no history of trauma." (Pet. Ex. 5 at 70).

59. Respondent inadequately explored the causes of Patient B's multiple bruises, which he observed over a short period of time over various parts of her body. The appearance of the bruises should have raised a concern that the sedating effect of Nubain was making Patient B fall or injure herself or that Patient B may be excessively using the self-injected Nubain. Respondent failed to obtain and note an adequate history to explain the cause of the bruises and failed to assess whether the multiple medications given to Patient B were causing her injuries and should be adjusted or discontinued. (T. 165-167) Respondent inappropriately failed to inquire and record whether Patient B was taking any other medications which may have made her prone to bruising. (Pet. Ex. 5).

60. Respondent's testimony during the instant proceedings is inconsistent with his progress note that the bruises were not the result of trauma. Respondent testified that he asked Patient B what caused the bruises. He stated "well she, she gave various types of responses to that; sometimes she said that she fell; sometimes she said that she was in a fight with her roommate, Um, she always seemed to have some reason for specifically having the bruises." (T. 588-589).

61 In July 1993 Patient B developed abscesses on the buttocks. She was admitted to South Amboy Hospital on July 15, 1993 for treatment of the abscesses, and subsequently on September 22, 1993 she was admitted to Staten Island Hospital for further treatment of her abscesses. (Pet. Ex. 5 at 93 and Pet. Ex. 6).

62. The consulting plastic surgeon at Staten Island Hospital who evaluated Patient B during her September 1993 admission concluded that her bilateral buttocks abscesses were caused by multiple IM injections. (Pet. Ex. 6 at 69).

63. Respondent agreed that the abscesses were staph infections caused by the injections. (T. 616).

64. Patient B received and/or self-administered IM injections in inappropriate locations on the buttocks. The location of the abscesses in photographs of Patient B's buttocks indicates the injections were inappropriately administered or self-administered on the lateral right side next to the patient's hip bone and into the gluteal cleft and gluteal crease. Injecting into the gluteal crease increases the risk of infection because it is an area that is difficult to keep clean. (Pet. Ex. 8A-D; T. 180). Respondent failed to meet acceptable medical standards by either improperly administering the IM Nubain injections or by failing to periodically review the procedures used by Patient B to assure Patient B properly administered the Nubain self-injections so as to prevent infection.

65. Respondent failed to adequately address Patient B's multiple complaints of nervousness and depression. Respondent documented approximately 20 complaints of anxiety and depression between January 28, 1992 and August 1994. (Pet. Ex. 5) The psychological well-being of patients with chronic pain needs to be addressed because depression often exacerbates feelings of pain. (T. 209-210) Respondent inappropriately did not begin to treat Patient B's depression until one and half years after she began to complain of depression. (Pet. Ex. 5 at 82; T. 210) Although Respondent testified he repeatedly referred Patient B to psychiatrists,

such an assertion lacks credibility in light of the absence of any notation of referral, and Respondent's inability to recall the name of a psychiatrist to whom he made a psychiatric referral. (T. 599) Failure to document a psychiatric referral is a deviation from acceptable medical standards for record keeping. (T. 810).

66. Atropine was used to relieve abdominal spasms that were the cause of Patient B's pain. A small dosage of Atropine would not affect the Tachycardia condition in Patient B. (T. 601, 802).

67. Respondent failed to maintain adequate records by failing to note the finding of physical examinations on some periodic basis, vital signs, information about positive, adverse or lack of response to the treatment, rationales for adding new medications to the therapeutic regimen, a history of the causes for Patient B's multiple bruises, and a physical examination immediately after Patient B's car accident on May 12, 1992. (Pet. Ex. 5; T. 156-158, 165-166).

68. During Patient B's admission at Staten Island Hospital in September 1993, a psychiatrist evaluated Patient B as opiate dependent and another physician noted Patient B "demonstrated a questionable amount of treatable pain and was generally med seeking." (Pet. Ex. 6 at 46).

69. Respondent inappropriately failed to recognize and manage Patient B's apparent drug dependency despite many factors that should have raised his suspicion of substance dependency such as Patient B's numerous bruises, Patient B's evasive responses explaining the cause of the bruises, and Patient B's claim to having a phobia to oral analgesics. (T. 605, 807-810) Moreover, Respondent had received the discharge summary of the September 1993 Staten Island Hospital admission which noted Patient B was diagnosed as opiate dependent. (Pet. Ex. 6 at 13-15; T. 651) Despite receipt of the discharge summary, Respondent failed to discontinue or at least note a reassessment of the use of IM Nubain and Phenergan and self-injectable Nubain for Patient B.

70. Respondent was still administering IM Nubain to Patient B as late as October, 1994 despite evidence of Patient B's drug dependency. (Resp. Ex. 3, progress notes dated Oct. 17 and 29,

1994).

71. Respondent properly administered Thorazine to Patient B in January 1993. (Pet. Ex. 5; T. 781-782).

CONCLUSIONS AS TO PATIENT B

In allegation B.1, Respondent is charged with failing to take an adequate history, including but not limited to failing to adequately explore the cause of Patient B's multiple bruises, in or about July 1993 to March, 1994. Respondent observed numerous bruises on Patient B during this time period. Although Respondent testifies he asked Patient B how she received these bruises, Respondent failed to note the history or record her responses. The Committee finds Respondent inappropriately failed to obtain and note the history of these bruises. As Patient B was on a regimen of Nubain IM and self-administered Nubain injections Respondent deviated from acceptable medical standards by failing to delve into the possibility that Patient B was falling or getting injured due to over sedation. Respondent also failed to obtain and note an adequate history between visits after he began administering Nubain and Phenergan IM and prescribed self-injectable Nubain to Patient A. Respondent's failure to monitor the benefits, adverse reactions or absence of effect of the previous treatment was a deviation from acceptable medical practice.

Therefore, Allegation B.1 is sustained.

Allegation B.2 charges Respondent with failing to perform an adequate physical examination, including but not limited to failing to adequately examine Patient B after she had been involved in motor vehicle accidents, on or about April 28, 1991 and May 12, 1992. Patient B came to Respondent's office two hours after her car accident on May 12, 1992 complaining about the car accident. Respondent's failure to at least measure Patient A's vital signs, perform a physical and neurological examination and to examine her for possible internal injuries deviated from acceptable medical standards.

Therefore, Allegation B.2 is sustained.

In Allegation B.3, Respondent is charged with failing to adequately treat Patient B for chronic pain, including but not limited to (a) inappropriately administering injectable short acting medication, (b) failing to appropriately adjust the therapeutic regimen of narcotic medication in response to the failure of previously ordered treatment, multiple abscesses in areas where Respondent injected pain medication, and other adverse consequences from the treatment and (c) ordering excessive treatment with injectable narcotic medication. The Committee finds Respondent inappropriately administered Nubain and Phenergan IM. Analgesics administered in injectable form have both a quicker onset and offset of analgesic effect than other medications. Respondent deviated from acceptable medical standards by failing to administer a longer acting analgesic that would have provided more continuous pain relief and failing to consider the use of non-injectable analgesics. The Committee finds the evidence fails to prove Allegations B.3(b) and B.3(c). Since, the drugs prescribed were Nubain and Phenergan IM, and since neither drug is regarded as a narcotic, the Committee was unable to find that the respondent had failed to "appropriately adjust the therapeutic regimen of narcotic medication." Had the term "narcotic" not been specified, then the Committee would have sustained a finding that Nubain and Phenergan IM were seriously misused.

Therefore, Allegation B.3(a) is sustained.

Allegations B.3(b) and B.3(c) are not sustained.

In Allegation B.4, Respondent is charged with deviating from acceptable medical standards in the performance of nerve blocks by (a) failing to either obtain written consent and/or discuss with the patient the risks, benefits and alternatives to the procedure, (b) failing to comply with medically accepted infection control procedures, (c) failing to adequately monitor for possible complications, and (d) ordering an excessive number of nerve blocks. The Committee concludes that written consent is not required for the procedure and the Department failed to prove by the preponderance of the evidence that the nerve block was performed without consent and without discussing the risks,

benefits and alternatives to the procedure. The multiple injections administered to Patient B caused the abscesses in the buttocks. Patient B received and /or self-administered IM injections in inappropriate locations on the buttocks. Injections were inappropriately administered or self-administered on the lateral right side next to the patient's hip bone and into the gluteal cleft and gluteal crease. Injecting into the gluteal crease increases the risk of infection, because it is an area that is difficult to keep clean. Respondent failed to meet acceptable medical standards either by improperly administering the IM Nubain injections or by failing to periodically review the procedures used by Patient B to assure Patient B properly administered the Nubain injections to herself so as to prevent infection. Respondent failed to adequately monitor Patient B as to the proper procedures for self-injection to avoid infection, failed to adequately monitor the exacerbation of infection by continuing to administer injections in the thigh and buttocks area, and failed to adequately evaluate and monitor Patient B's drug dependency, despite clear tell-tale signs of drug dependency. Respondent continued to administer nerve blocks despite lack of evidence the regimen improved Patient B's medical condition.

Therefore, Allegations B.4(b), B.4(c) and B.4(d) are sustained.

Allegation B.4(a) is not sustained.

In Allegation B.5, Respondent is charged with failing to adequately address Patient B's complaints of nervousness and depression. Respondent failed to appropriately address Patient B's complaints of depression. Respondent documented over 20 complaints of depression over a period of one and half years before he dealt with Patient A's depression by prescribing Elavil. Respondent's failure to promptly address Patient A's depression is a deviation from acceptable medical standards for the treatment of patients with chronic pain. The pain patient's psychological well-being must be addressed since depression magnifies the sensation of pain felt by the patient. The Committee finds Respondents' testimony that he referred Patient A to psychiatrists but she refused his referrals to be incredible in light of the absence of any notation in her chart of a referral and/or her refusal to go to a psychiatrist to whom Respondent referred her, and Respondent's inability to provide a name of a

psychiatrist to whom he referred Patient A

Therefore, Allegation B.5 is sustained.

In Allegation B.6 and B.7, Respondent is charged with inappropriately ordering two phenothiazine medications for simultaneous use Thorazine and Phenergan in January, 1993 and inappropriately prescribing Atropine while Patient B was in a tachycardic state on or about December 28, 1993. Respondent exercised appropriate medical judgment when he administered Thorazine to Patient B in January 1993 and prescribed Atropine in December 1993.

Therefore, Allegations B.6 and B.7 are not sustained.

In Allegation B.8, Respondent is charged with knowingly and falsely representing in a letter dated August 18, 1994, that Patient B was in constant pain, was unable to function in both professional and social capacities, and required treatment with the medications Percocet, Demerol and Nubain as a result of an automobile accident dated May 12, 1992, when in fact, he knew that Patient B's chronic pain, treatment with pain medications, and inability to function in both professional and social capacities preceded the May 12, 1992 motor vehicle accident. Three weeks before the May 12, 1992 accident, in a letter addressed "To Whom It May Concern," dated April 21, 1992, Respondent wrote, "[Patient B] has severe low back pain syndrome, rheumatoid arthritis, and radiculopathy. As a result she was totally incapacitated and unable to work . Her back often gives out and she experiences recurrent severe pain in her low back." In his letter to Patient B's attorneys dated August 18, 1994, Respondent intentionally and knowingly omitted a description of Patient B's physical incapacity, medical regimen and inability to function socially and professionally prior to the May 12, 1992 accident. The Committee finds that Respondent knowingly and intentionally concealed Patient B's prior existing condition of chronic pain syndrome, the prior regimen of pain medication including Nubain and Phenergan IM injections and Patient B's self-injection program, and Patient B's prior total incapacity to function in social or professional spheres. The Committee further finds that Respondent knew Patient B's pre-existing severe low back pain syndrome and her severe physical

incapacities could be detrimental to any financial award Patient B might receive as a result of her injuries in the

car accident. Respondent knowingly and intentionally concealed Patient B's pre-existing condition in order to mislead the defendants, the insurers, the jury and/or the judge in the automobile accident tort litigation to believe Patient B's injuries and debilitation were new and completely due to the accident rather than an exacerbation of a serious pre-existing condition.

Therefore, Allegation B.8 is sustained.

In Allegation B.9, Respondent is charged with failing to maintain a record which accurately reflects the evaluation and treatment of the patient, including but not limited to failing to document that he had prescribed self-injectable narcotics. On or about October 18, 1992, Respondent noted Patient B had started Percodan the day before. Respondent inappropriately failed to note the dosage, duration of the prescription or any instructions for taking the medication. Respondent inappropriately failed to record whether Patient B had discontinued taking Percodan, and if so, when, before administering a contra-indicated application of IM Nubain. Beginning in January 1993, the appearance of numerous bruises should have raised a concern that the sedating effect of Nubain was making Patient B fall or injure herself or that Patient B may be excessively using the self-injected Nubain. Respondent failed to obtain and note an adequate history to explain the cause of the bruises and failed to record an assessment whether the multiple medications given to Patient B were causing her injuries and should be adjusted or discontinued. Respondent's failure to note he had prescribed self-injectable Nubain was a significant deviation from acceptable medical standards. Respondent should have noted the initial prescription and subsequent prescriptions and dosage. It is important to record the prescriptions, their frequency and dosage to enable a successor physician to properly evaluate the course of treatment Patient B received and for both Respondent and a successor physician to objectively assess whether Patient B developed a drug dependency to the medication.

Further, Respondent deviated from acceptable medical standards by failing to periodically record an assessment of the effectiveness of the regimen based upon physical examinations of Patient B and a history from Patient B whether the previous treatments relieved her symptoms and improved her physical condition.

Therefore, Allegation B.9 is sustained.

FINDINGS OF FACT AS TO PATIENT C

72. Between on or about June 11, 1992 and February 3, 1993, Respondent treated Patient C, a 35 year old male, at his office. Patient C suffered from chronic pain due to recurrent renal stone formation. (Pet. Ex. 9).

73. At the first visit on June 11, 1992, Respondent took a past history for Patient C. Respondent noted that Patient C had a history of kidney stones and diabetes, with blood glucose levels ranging between 90 and 400. On the date of the visit, Patient C's glucose level was reported as 275. (Pet. Ex. 9; T. 234-235) He also recorded a list of medications Patient C was currently taking. (Pet. Ex. 9; T. 677-678).

74. Respondent testified that Patient C had been diagnosed as Demerol dependent prior to the date Respondent treated him and that Patient C had received large doses of Demerol in 1988. (T. 679) However, Respondent did not record Patient C's history of drug dependency and treatment with Demerol. Respondent conceded that his failure to note such prior treatment and drug history was a significant oversight. (Pet. Ex. 9; T. 677-678).

75. Respondent testified that Patient C had a past history of abscesses from IM injections, but Respondent failed to note this history in Patient C's chart. (T. 680).

76. On an unspecified date prior to June 23, 1992, Patient C began to take oral Demerol. On June 23, 1992, Respondent made a note of a telephone conversation with Patient C in which Patient C reports he has been taking oral Demerol. (Pet. Ex. 9) Respondent's failure to note an adequate history of the use of the oral Demerol, its dosage and when the course of treatment began and when it will expire is a deviation from acceptable medical standards for record keeping. (T. 237) Demerol is a strong opiate agonist. (T. 244) Further, the oral form of Demerol is generally considered to be a poor choice for pain treatment because Demerol has poor bioavailability when administered orally. (T. 238-239).

77. On the same day, June 23, 1992, Respondent telephoned a prescription for Patient C to a pharmacy for Vicodan, an agonist. Later the same day, Respondent administered to Patient C an injection of Nubain, an agonist/antagonist. (Pet. Ex. 9; T. 240). The Respondent failed to note the times that Patient C took either the Demerol or the Vicodan. (Resp. Ex. 9 at back of 1; T. 240).

78. Respondent did not see Patient C between an emergency visit on June 24, 1992 and August 19, 1992. Respondent admitted that his progress note entry for August 19, 1992 failed to adequately address what happened to the Patient's pain during the approximately seven week interval between office visits. Nor did Respondent obtain and note the chief complaint of Patient C for the current visit or obtain a history of Patient C's medical condition since the last visit. (T. 696-697).

79. Beginning on October 4, 1992 and continuing through at least February 1993, Respondent inappropriately prescribed self-administered IM Demerol. Prior to prescribing injectable medication, the Respondent should have attempted to treat the patient with strong oral analgesic medications, such as morphine, Dilaudid or methadone. As noted *supra*, injectable

medications expose patients to the risk of infection and are shorter acting pain medicines.

Such risk of infection was heightened in this case by the fact the patient was a diabetic. (T. 244-245).

80. By October 24, 1992, Respondent was aware Patient C was abusing the IM Demerol Respondent had prescribed for self-injection. (Pet. Ex. 9 at 6; T. 670-671 and 694-695).

81. On or about November 14, 1992, Patient C developed an abscess on his right thigh which required incision and drainage at a hospital. (Pet. Ex 9 at 8; T. 251-252). Patient C developed abscesses on his thighs and one on his arm which are typical areas where injections are administered. The abscesses formed after he started his treatment with injectable narcotics. (T. 254). Respondent suspected the abscesses were due to the injections Respondent prescribed. (T. 673-674).

82. On December 5, 1992, Respondent administered a lumbar block to Patient C despite negative lumbosacral x-rays and a prior note that a kidney specialist consulted by Patient C felt his back pain was secondary to his kidney problems. (Pet. Ex. 9 at 10; T. 252-253). Respondent discussed the risks, benefits, side effects and alternatives to the procedure performed on December 5, 1992 and received consent from Patient C. (T. 671-672).

83. Respondent failed to adequately consider numerous "red flags" that Patient C's requests for larger doses of Demerol may have been motivated by an addiction to the medication. (T. 244-249) In October and November 1992, Patient C requested new prescriptions for Demerol before the supply of Demerol from the previous prescription order should have run out, sometimes by as much as a week early. There is no indication in the chart that Patient C's pain was escalating or the dosage of Demerol was ineffective. (Pet. Ex. 9 at 4-6; T. 247-250).

84. Although Respondent testified that he considered Patient C's requests for increasingly larger

doses of Demerol were due to a physical dependency to the medication. Respondent failed to document this awareness. Nor did he ever document that he felt Patient C's need for pain relief offered by Demerol outweighed the risks posed by Patient C's dependency on the drug. (Pet. Ex 9; T. 670-671).

85. Respondent failed to maintain an adequate medical record by failing to take an adequate past medical history for Patient C, recording his extended history of treatment for pain, by failing to record Patient C's prior history of dependency to Demerol, by failing to record Patient C had a history of abscesses from IM injection, by failing to take adequate histories of Patient C's responses to the treatment between visits, by failing to document his rationale for continuing to treat the patient with IM Demerol in the face of evidence that the patient had developed a dependency to the medication. (Pet. Ex. 9).

CONCLUSIONS AS TO PATIENT C

In Allegation C.1, Respondent is charged with failing to take an adequate history, including but not limited to failing to appropriately ascertain Patient C's response to treatment. At Patient C's initial visit on June 11, 1992, Respondent took a past history noting the patient is a diabetic, with blood glucose levels ranging between 90 and 400, and listed medications Patient C was currently taking. Respondent's failure to record that Patient C had taken narcotic medication, had received large doses of Demerol in 1988 and had been diagnosed as Demerol dependent prior to the date Respondent treated him is a deviation from acceptable medical standards for record keeping. On June 23, 1992, when Respondent learned in a telephone conversation that Patient C currently was taking oral Demerol, Respondent deviated from acceptable medical standards by failing to record the date Patient C started Demerol, the dosage and the termination date of the course of taking the medication. On June 23, 1992, Respondent inappropriately failed to record the times Patient C ingested either oral Demerol and/or Vicodan. Although from the end of June until August 19, 1992 Respondent had had no contact with Patient C, Respondent's failure to obtain and note an adequate

history of Patient C's pain during this period in order to understand the purpose of her August 19, 1992 visit falls short of acceptable medical standards.

Therefore, Allegation C.1 is sustained.

In Allegation C.2, Respondent is charged with failing to adequately treat Patient C for chronic pain. On June 23, 1992, while Respondent notes Patient C is on oral Demerol, Respondent telephoned to a pharmacy a prescription for Patient C for Vicodan, an agonist. Later the same day, Respondent administered IM Nubain, an agonist/antagonist. The Committee finds that on June 23, 1992, the use of multiple medications was inappropriate and ineffective. Beginning on October 4, 1992 and continuing through at least February 1993, Respondent inappropriately prescribed self-administered IM Demerol. Prior to prescribing injectable medication, the Respondent should have attempted to treat the patient with strong oral analgesic medications, such as morphine, Dilaudid or methadone. As noted with respect to Patients A and B, injectable medications expose patients to the risk of infection and are shorter acting pain medicines than other appropriate oral medicines. Such risk of infection was heightened in this case by the fact the patient was a diabetic.

Therefore, Allegation C.2 is sustained.

In Allegation C.3, Respondent is charged with failing to appropriately adjust and/or discontinue Patient C's treatment with IM injections of narcotic medication in response to Patient C's multiple skin abscesses. From October 1992 until the end of February 1993, Respondent prescribed self-injectable IM Demerol to Patient C, who was a diabetic. Even after Patient C developed abscesses in regions of injections on his thighs and one on his arm and in disregard of Respondent's suspicion that the IM Demerol caused the abscesses, Respondent inappropriately failed to discontinue the injections of Demerol. Respondent's failure to discontinue the IM Demerol on a diabetic patient who is developing abscesses falls below acceptable medical standards.

Therefore, Allegation C.3 is sustained.

In Allegation C.4, Respondent is charged with failing to maintain a record which accurately reflected the evaluation and treatment of Patient C, including but not limited to failing to appropriately document adequate findings to support prescribing injectable Demerol in or about and between October, 1992 and February, 1993. Respondent knew Patient C had a history of dependency to Demerol and knew Patient C was a diabetic. Prior to prescribing injectable medication, the Respondent should have attempted to treat the patient with strong oral analgesic medications, such as morphine, Dilaudid or methadone since injectable medications expose patients to the risk of infection and are shorter acting pain medicines. The risk of infection was heightened in this case since the patient was a diabetic. After the abscesses formed, Respondent should have discontinued use of IM Demerol. There is no record of an evaluation or assessment to support the initial use or the continuation of IM Demerol rather than more appropriate pain medications for a diabetic patient with a prior history of Demerol dependency. The absence of such an evaluation in Patient C's medical chart is a deviation from acceptable medical standards.

Therefore, Allegation C.4 is sustained.

In Allegation C.5, Respondent is charged with failing to adequately consider drug addiction as the motivation for Patient C's requests for larger doses of Demerol. Respondent knew Patient C had a prior history of drug dependency on Demerol. As of October 24, 1992, only three weeks after beginning a regimen of self-injectable IM Demerol, Respondent was aware Patient C was abusing his Demerol prescriptions. In October and November 1992, Patient C repeatedly requested new prescriptions for Demerol before the supply of Demerol from the previous prescription should have run out, sometimes by as much as a week early. Respondent inappropriately failed to address Patient C's drug dependency despite recognizing that Patient C was abusing his IM Demerol prescriptions. In light of the clear signs of dependency and Respondent's recognition of Patient C's abuse of Demerol by October 24, 1992, the Committee finds Respondent failed to adequately consider drug addiction as the motivation for Patient C's requests for larger doses of Demerol.

Therefore, Allegation C.5 is sustained.

In Allegation C.6, Respondent is charged with deviating from accepted medical standards in the performance of a lumbar block on or about December 5, 1992, by (a) failing to either obtain written consent, and/or discuss the risks and benefits, and alternatives with the patient, (b) failing to comply with medically accepted infection control procedures, and (c) failing to adequately monitor Patient C for possible complications. Respondent received consent after discussing the risks, benefits, possible side effects and alternatives to the procedure administered on December 5, 1992, complied with acceptable infection control procedures and appropriately monitored Patient C following the procedure. Although the Committee is unable to sustain the specific charges of C.6(a-c), it is concerned there was no documentation that the lumbar nerve block was indicated. **Therefore, Allegation C.6(a-c) are not sustained.**

VOTE OF THE HEARING COMMITTEE

THE HEARING COMMITTEE VOTES UNANIMOUSLY (3-0) AS FOLLOWS:

FIRST SPECIFICATION:

(Practicing the Profession Negligently on More than One Occasion)

The Hearing committee hereby determines that the First Specification is sustained. It is established by a preponderance of the evidence that Respondent's overall care of Patients A, B, and C were below the standard of care required for treatment of patients with chronic pain. Respondent on many occasions practiced negligently in his treatment of each of these patients.

SUSTAINED AS TO PARAGRAPHS: A, A.1, A.2, A.3(a-b), A.4(e-f), A.5(a), A.8, B, B.1, B.2, B.3(a), B.4(b-d), B.5, B.8, B.9, C, C.1, C.2, C.3, C.4, and C.5.

SECOND SPECIFICATION:

(Practicing the Profession with Incompetence on More than One Occasion)

The Hearing Committee hereby determines that the Second Specification is sustained. It is established by a preponderance of the evidence that Respondent lacked the competence to treat patients for chronic pain with multiple, repeated injections. On numerous occasions Respondent incompetently performed procedures and demonstrated incompetence in his medical judgment. Respondent lacked the competence to perform nerve blocks, incompetently performed the intercostal nerve block on Patient A that resulted in a pneumothorax, incompetently continued to inject patients in areas where they had developed abscesses and displayed incompetence in the recognition and management of drug dependency.

SUSTAINED AS TO PARAGRAPHS: A. A.1, A.2, A.3(a-b), A.4(c), A.4(e-f), A.5(a), A.8, B, B.1, B.2, B.3(a), B.4(b-d), B.5, B.8, B.9, C, C.1, C.2, C.3, C.4, and C.5.

THIRD SPECIFICATION:

(Practicing the Profession with Gross Negligence)

The Hearing Committee finds the evidence does not sustain the Third Specification.

NOT SUSTAINED

FOURTH SPECIFICATION:

(Practicing the Profession with Gross Negligence)

The Hearing Committee hereby determines that the Fourth Specification is sustained. It is established by a preponderance of the evidence that Respondent put Patient A at extreme risk by doing a contra-lateral intercostal nerve block one day after the patient was diagnosed as having a pneumothorax on the opposite side. Patient A was in a compromised respiratory condition from the pneumothorax which Respondent caused two days earlier while performing a left intercostal nerve

block. As Respondent lacked the necessary competence to perform a nerve block, administering the contra-lateral intercostal nerve block was a conspicuously bad deviation from acceptable medical standards. Moreover, Respondent's judgment to perform an intercostal nerve block at a time when Patient A was in a compromised respiratory condition constitutes an egregious deviation from acceptable medical standards. Also, the excessive nerve blocks Respondent administered to both Patient A and Patient B constitute an egregious deviation from acceptable medical standards.

SUSTAINED AS TO PARAGRAPHS: A, A.4 and A.4(e).

FIFTH AND SIXTH SPECIFICATIONS:

(Practicing the Profession with Gross Incompetence)

The Hearing Committee hereby determines the evidence does not sustain the Fifth and Sixth Specifications.

NOT SUSTAINED.

SEVENTH THROUGH NINTH SPECIFICATIONS:

(Failure to Maintain Adequate Records)

The Hearing Committee hereby determines the evidence sustains the Seventh through Ninth Specifications. It is established by a preponderance of the evidence that Respondent failed to maintain adequate records for all of the patients who are the subject of the charges. Neither prescriptions for self injection of Nubain or other potent pain medication were noted in the charts, significant facts of past medical histories were omitted, and there were never evaluations of the effectiveness of the prior treatments or reassessments of the treatment plans for any of the patients.

SUSTAINED AS TO PARAGRAPHS: A, A.8, B, B.9, C and C.4.

TENTH THROUGH THIRTEENTH SPECIFICATIONS:

(Ordering Excessive Treatment)

The Hearing Committee hereby determines the evidence sustains the Tenth through

Thirteenth Specifications. It is established by a preponderance of the evidence that Respondent committed professional misconduct by ordering excessive treatment not warranted by the conditions of Patient A and Patient B. For Patient A and Patient B, Respondent inappropriately continued to use Nubain IM and Phenergan IM for a long period of time without modifying the treatment plan although there was no reported change in symptoms and no evidence the treatment plan was alleviating Patient A's or Patient B's chronic pain. The Committee decided Allegations A.3(c) and B.3(c) were not proven only because the specifications were limited to "narcotic" medication and Nubain and Phenergan are not narcotic medications for prescription purposes. Had the term "narcotic" not been specified, then the Committee would have sustained a finding that Nubain and Phenergan IM were seriously misused and therefore would have sustained Allegations A.3(c) and B.3(c).

SUSTAINED SPECIFICATION 10 AS TO PARAGRAPHS A and A.3.

SUSTAINED SPECIFICATION 11 AS TO PARAGRAPHS A, A.4 and A.4(f).

SUSTAINED SPECIFICATION 12 AS TO PARAGRAPHS B and B.3.

SUSTAINED SPECIFICATION 13 AS TO PARAGRAPHS B, B.4 and B.4(d).

FOURTEENTH SPECIFICATION:

(Practicing Medicine Fraudulently)

The Hearing Committee hereby determines the evidence sustains the Fourteenth Specification. It is established by a preponderance of the evidence that Respondent in his August 18, 1994, letter knowingly and intentionally falsely concealed Patient B's chronic pain syndrome, her incapacity to function in social and professional situations and the pain medication she regularly needed prior to May 12, 1992 when Patient B was in a motor vehicle accident. Further, the Committee finds Respondent concealed this information with the intention to mislead the defendant, the defendant's attorney, the defendant's insurance company, the jury and the judge involved in the tort litigation arising from the May 12, 1992 accident as to the extent of injury and disability Patient B sustained as a direct result of the accident on May 12, 1992.

SUSTAINED AS TO PARAGRAPHS B and B.8.

SEVENTEENTH SPECIFICATION:

(Filing a False Report)

The Hearing Committee hereby determines the evidence sustains the Seventeenth Specification. It is established by a preponderance of the evidence that Respondent knowingly and intentionally wrote a false report in the August 18, 1994 letter and at the time he wrote the false report Respondent knew it to would be submitted to the insurance company for the defendant in the litigation arising from the May 12, 1992 accident and also knew it eventually could be submitted to the Court in which Patient B's litigation was conducted.

SUSTAINED AS TO PARAGRAPHS B and B.8.

TWENTIETH THROUGH TWENTY-SECOND SPECIFICATIONS:

(Failing to Use Acceptable Infection Control Practices)

The Hearing Committee does not sustain the Twentieth through Twenty-Second Specifications. Although the Hearing Committee finds Respondent deviated from acceptable medical standards by continuing injections despite the occurrence of abscesses in the injection sites in all three patients, it is not established, however, by a preponderance of the evidence that Respondent failed to use scientifically accepted barrier precautions and infection control practices established by the Department of Health pursuant to §230(a) of the New York State Public Health law.

NOT SUSTAINED.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Committee found that Respondent's practice of injecting pain medications and

prescribing self-injectable medications to all three patients evidenced treatment which falls below that level of care and diligence expected of a prudent physician in this state. Respondent repeatedly administered Nubain and Phenergan IM to Patients A and B and IM Demerol to Patient C without evaluating the effectiveness of the pain medicine regimen. Respondent continued to administer the injectable medications although there was no reported change in the patients' symptoms and no evidence the treatment plan was alleviating their chronic pain. Each of the three patients Respondent treated for chronic pain developed abscesses after the regimen of injections were initiated. Despite the abscesses, Respondent continued to inject the patients in the same regions where the abscesses had formed and continued the patients' regimen of self-injected medication. In addition, Respondent inappropriately used Nubain and Phenergan IM to treat patients with chronic pain rather than first trying to manage the patients on oral analgesics. Respondent's method of obtaining and recording the patients' histories and of failing to note pain medications he prescribed in the medical chart fell below acceptable standards for record keeping.

The Hearing Committee unanimously determines the following penalty:

1. Respondent's license is **SUSPENDED FOR A PERIOD OF TWO YEARS AND SAID SUSPENSION IS STAYED** on the following conditions:

   a. Respondent is placed on **PROBATION FOR A PERIOD OF TWO YEARS**;

   b. Respondent is subject to all standard terms of probation as stated in the Order; and

   c. Respondent shall attend a comprehensive continuing medical education course in Recognition and Management of Drug Dependency in Patients, or its equivalent. Within ninety (90) days of the effective date of this Order, Respondent shall select and submit course information to the Director or his designee, for prior written approval.

2. Respondent's license to practice medicine is permanently limited to preclude Respondent from treating patients for chronic pain and Respondent must refer these patients to pain management specialists.

3. For Specifications 14 and 17, Respondent is fined $10,000.00. In the event one of these

specifications is later dismissed, the Committee would still impose a fine of $10,000.00.

The Committee felt that the instances of negligence that it sustained were serious and that, in one instance, rose to gross negligence.

In choosing suspension, probation and the permanent limitation of licensure rather than revocation, the Committee took several factors into account. All of Respondent's infractions related to errors made in the treatment of the one category of patients -- those with chronic pain syndromes. There was no evidence presented to indicate that his motivation for caring for these patients was his personal gain rather than his professed concern for their welfare. While the state established his inability to properly manage this particularly difficult group of patients, no evidence was presented that he was unable to deliver care of acceptable standard to patients with other problems in medicine for which he was trained and which constitutes the bulk of his practice.

In the event one or more of the specifications are dismissed, the Committee's penalty of suspension, probation and permanent limitation of Respondent's license to practice medicine to preclude him from treating patients for chronic pain would remain the same.

Specifications 14 and 17 which relate to fraud in a letter to an insurance company were also seen as very serous infractions. These infractions, however, did not reflect on the Respondent's medical capability nor was evidence produced that it was motivated by personal gain. We felt that the fine of $10,000.00 is appropriate and proportionate to deter similar actions in the future.

ORDER

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

Respondent's license to practice medicine in the State of New York is;

1. SUSPENDED FOR A PERIOD OF TWO YEARS, SAID SUSPENSION IS STAYED ON THE FOLLOWING CONDITIONS:

A. Respondent is placed on **PROBATION FOR A PERIOD OF TWO YEARS** subject to the following terms;

(1) In order to monitor Respondent's compliance, Respondent will personally meet with a member of the Office of Professional Medical Conduct (OPMC) on a quarterly basis, unless otherwise agreed to.

(2) Respondent will conform fully:

(a) to the professional standards of conduct imposed by law and by his profession;

(b) with all civil and criminal laws, rules and regulations.

(3) Respondent will notify the OPMC of:

(a) any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency , institution or facility, within thirty days of each action;

(b) any and all changes in personal and professional addresses and telephone numbers and facility affiliations, within 30 days of such changes. This will include any change in practice location, within or outside of the State of New York. The date of departure from New York and the date of return, if any, must be reported in writing.

Failure to notify the OPMC of any of the above will be considered a violation of probation.

(4) Respondent will maintain legible and complete medical records which accurately reflect evaluation and treatment of patients. Records will contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record will contain all information required by state rules and regulations regarding controlled substances.

(5) If the Respondent does not practice medicine in the State of New York, the probation period will be tolled and the period will then be extended by the length of the period outside of New York. Any terms of probation which were not fulfilled while Respondent was in New York must be fulfilled upon return to New York State.

(6) A violation of any aspect of the terms of probation shall be considered professional misconduct, pursuant to §230 of the Public Health Law and §6530 of the New York State Education Law

(7) Respondent shall attend a comprehensive continuing medical education course in Recognition and Management of Drug Dependency in Patients, or its equivalent. Within ninety (90) days of the effective date of this Order, Respondent shall select and submit course information to the Director or his designee, for prior written approval.

2. RESPONDENT'S LICENSE TO PRACTICE MEDICINE IS PERMANENTLY LIMITED TO PRECLUDE RESPONDENT FROM TREATING PATIENTS FOR CHRONIC PAIN AND RESPONDENT MUST REFER THESE PATIENTS TO PAIN MANAGEMENT SPECIALISTS.

3. FOR SPECIFICATIONS 14 AND 17, RESPONDENT IS FINED $10,000.00. IN THE EVENT ONE OF THESE SPECIFICATIONS IS LATER DISMISSED, THE COMMITTEE STILL IMPOSES A FINE OF $10,000.00.

DATED: New York, New York
February 17, 1997

NORTON SPRITZ, M.D.
Chairperson

DEAN RANDOLPH MANNING
GERALD S. WEINBERGER, M.D.

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

IN THE MATTER OF EDWARD M. FINCK, M.D.	STATEMENT OF CHARGES

EDWARD M. FINCK, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 9, 1968, by the issuance of license number 102179 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about and between November 21, 1985 and August 25, 1994, the Respondent treated Patient A, a 42 year old female, at the onset of treatment (The identity of Patient A and the other patients in the Statement of Charges are identified in the attached Appendix.) Patient A had an extended history of treatment for recurrent neck and upper back pain, that included three operations of the cervical spine prior to 1987. Respondent treated Patient A at his office located at 2993 Amboy Road, Staten Island, New York, and in the patient's home. During the period of treatment regarding Patient A, Respondent:

1. Failed to take adequate histories, including but not limited to failing to ascertain Patient A's response to treatment with pain medication.
2. Failed to perform adequate physical examinations.
3. Failed to adequately treat Patient A for chronic pain, including but

not limited to:

a. Inappropriately administering injectable short acting pain medication.

b. Failing to appropriately adjust the therapeutic regimen in response to the failure of previously ordered treatment, adverse drug reactions, skin abscesses in areas where Respondent injected medication and patient history of syncope and seizures.

c. Ordering excessive treatment with injectable narcotic medication.

4. Deviated from accepted medical standards in the performance of nerve blocks by:

a. Failing to either obtain written consent, and/or discuss with the patient the risks, benefits and alternatives.

b. Failing to have emergency resuscitation equipment appropriately available when performing intercostal nerve blocks.

c. Failing to comply with medically accepted infection control procedures.

d. Failing to adequately monitor the patient for possible complications from the procedure.

e. Inappropriately administering an intercostal nerve block one day after Patient A had been diagnosed with a pneumothorax. Patient A had a pneumothorax on or about October 25, 1989.

Respondent performed the intercostal nerve block on or about October 26, 1989.

f. Ordering an excessive number of nerve blocks.

5. Inappropriately treated Patient A's condition of multiple abscesses by:

a. Inaccurately diagnosing the cause of the abscesses.

b. Failing to appropriately adjust and/or discontinue treatment with IM injections of narcotic medication.

c. Inappropriately administering cortiscosteroids.

6. Failed to appropriately address Patient A's nutritional status in light of her chronic vomiting.

7. Failed to adequately assess the risks, benefits and alternatives to the administration of Thorazine, in or about March, 1990.

8. Failed to maintain a record which accurately reflected the evaluation and treatment, including but not limited to failing to appropriately document that he had prescribed self-injectable narcotics.

B. On or about and between June 25, 1989 and August 11, 1994, the Respondent treated Patient B, a 23 year old female, at the onset of treatment Respondent treated Patient B at his office and in the patient's home. During the period of treatment regarding Patient B, Respondent:

1. Failed to take an adequate history, including but not limited to failing to adequately explore the cause of Patient B's multiple bruises, in or about and between July, 1993, and March, 1994.

2. Failed to perform an adequate physical examination, including but

not limited to failing to adequately examine Patient B after she had been involved in motor vehicle accidents, on or about April 28, 1991 and May 12, 1992.

3. Failed to adequately treat Patient B for chronic pain, including but not limited to:
   a. Inappropriately administering injectable short acting pain medication.
   b. Failing to appropriately adjust the therapeutic regimen of narcotic medication in response to the failure of previously ordered treatment, multiple abscesses in areas where Respondent injected pain medication, and other evidence of adverse consequences from the treatment.
   c. Ordering excessive treatment with injectable narcotic medication.
4. Deviated from acceptable medical standards in the performance of nerve blocks by:
   a. Failing to either obtain written consent and/or discuss with the patient the risks, benefits and alternatives to the procedure.
   b. Failing to comply with medically accepted infection control procedures.
   c. Failing to adequately monitor for possible complications.
   d. Ordering an excessive number of nerve blocks.
5. Failed to adequately address Patient B's complaints of nervousness and depression.

6. Inappropriately ordered two phenothiazine derivative medications for simultaneous use, Thorazine and Phenergan, in or about January, 1993.

7. Inappropriately prescribed Atropine while Patient B was in a tachycardic state, on or about December 28, 1993.

8. Knowingly and falsely represented in a letter dated August 28, 1994, that Patient B was in constant pain, was unable to function in both professional and social capacities, and required treatment with the medications Percocet, Demerol and Nubain as a result of an automobile accident dated May 12, 1992, when in fact, he knew that Patient B's chronic pain, treatment with pain medications, and inability to function in both professional and social capacities preceded the May 12, 1992 motor vehicle accident.

9. Failed to maintain a record which accurately reflects the evaluation and treatment of the patient, including but not limited to failing to document that he had prescribed self-injectable narcotics.

C. On or about and between June 11, 1992 and February 3, 1993, the Respondent treated Patient C, a 35 year old male, at his office. Patient C suffered from chronic pain due to recurrent renal stone formation. During the period of treatment regarding Patient C, Respondent:

1. Failed to take an adequate history, including but not limited to failing to appropriately ascertain Patient C's response to treatment.

2. Failed to adequately treat Patient C for chronic pain.

3. Failed to appropriately adjust and/or discontinue his treatment with IM injections of narcotic medication in response to Patient C's multiple skin abscesses.

4. Failed to maintain a record which accurately reflected the evaluation and treatment of Patient C, including but not limited to failing to appropriately document adequate findings to support the prescribing of injectable Demerol in or about and between October, 1992 and February, 1993.

5. Failed to adequately consider drug addiction as the motivation for Patient C's requests for larger doses of Demerol.

6. Deviated from accepted medical standards in the performance of a lumbar block on or about December 5, 1992, by:

   a. Failing to either obtain written consent, and/or discuss the risks, and benefits, and alternatives with the patient.

   b. Failing to comply with medically accepted infection control procedures.

   c. Failing to adequately monitor Patient C for possible complications.

7. Knowingly and falsely represented in Patient C's chart on or about October 8, 1992 that Patient C advised him that Dr. Coe strongly recommended continuing the treatment with self-injectable Demerol, when in fact, Respondent knew that Patient C never reported such information.

8. Knowingly and falsely represented that he was treating Patient C's wife with injectable Demerol by issuing prescriptions of said

medication in her name on or about January 12, 1993 and January 19, 1993, when in fact, Respondent knew that Patient C was going to fill the Demerol prescriptions and use the medication for his own personal use.

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)(McKinney Supp. 1996) 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. Paragraphs A, A1, A2, A3, A3(a), A3(b), A3(c), A4, A4(a), A4(b), A4(c), A4(d), A4(e), A4(f), A5(a), A5(b), A5(c), A6, A7, A8; B, B1, B2, B3, B3(a), B3(b), B3(c), B4, B4(a), B4(b), B4(c), B4(d), B5, B6, B7, B8, B9, C, C1, C2, C3, C4, C5, C6, C6(a), C6(b), C6(c), and/or C7.

SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1996) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of

two or more of the following:

2. Paragraphs A, A1, A2, A3, A3(a), A3(b), A3(c), A4, A4(a), A4(b), A4(c), A4(d), A4(e), A4(f), A5(a), A5(b), A5(c), A6, A7, A8; B, B1, B2, B3, B3(a), B3(b), B3(c), B4, B4(a), B4(b), B4(c), B4(d), B5, B6, B7, B8, B9, C, C1, C2, C3, C4, C5, C6, C6(a), C6(b), C6(c), and/or C7.

THIRD AND FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1996) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. Paragraphs A, A4 and A4(b).
4. Paragraphs A, A4 and A4(e).

FIFTH AND SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1996) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

5. Paragraphs A, A4 and A4(b).

6. Paragraphs A, A4 and A4(e).

SEVENTH THROUGH NINTH SPECIFICATIONS
FAILURE TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1996) 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:

7. Paragraphs A and A8.
8. Paragraphs B and B9.
9. Paragraphs C and C4.

TENTH THROUGH THIRTEENTH SPECIFICATIONS
ORDERING EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct pursuant to N.Y. Educ. Law §6530(35)(McKinney Supp. 1996) by ordering excessive treatment not warranted by the condition of the patient as alleged in the facts of the following:

10. Paragraphs A, A3 and A3(c).
11. Paragraphs A, A4 and A4(f).
12. Paragraphs B, B3 and B3(c).
13. Paragraphs B, B4 and B4(d).

FOURTEENTH THROUGH SIXTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined b N.Y. Educ. Law §6530(2)(McKinney Supp. 1996) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

14. Paragraphs B and B8.
15. Paragraphs C and C7.
16. Paragraphs C and C8.

SEVENTEENTH THROUGH NINETEENTH SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined i N.Y. Educ. Law §6530(21)(McKinney Supp. 1996) by reason of willfuliy making a false report, as alleged in the facts of:

17. Paragraphs B and B8.
18. Paragraphs C and C7.
19. Paragraphs C and C8.

TWENTIETH THROUGH TWENTY-SECOND SPECIFICATIONS

FAILURE TO USE ACCEPTABLE INFECTION CONTROL PRACTICE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(47)(McKinney Supp. 1996) by failing to use scientifically accepted barrier precautions and infection control practices as established by the Department of Health pursuant to §230(a) of the Public Health Law, as alleged in the facts of the following:

20. Paragraphs A, A4, and A(4)(c).

21. Paragraphs B, B4, and B(4)(b).

22. Paragraphs C, C6, and C(6)(b).

DATED: February , 1996
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct