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

BPMC No. 23-178

IN THE MATTER OF DAVID ISRAEL, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: DAVID ISRAEL

The undersigned, James V. McDonald, M.D., M.P.H., Commissioner of Health, after an investigation and a recommendation by a Committee on Professional Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that DAVID ISRAEL, M.D. ("Respondent"), is causing, engaging in or maintaining a condition which constitutes an imminent danger to the health of the people and that it is therefore prejudicial to the interests of the people to delay action until an opportunity for a hearing can be provided

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12)(a), that effective immediately, Respondent shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12)(a).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a Committee on Professional Conduct of the State Board for Professional Medical Conduct on August 31, at 9:30 a.m. The hearing may be conducted by video conference or at the offices of the New York State Health Department, and at such other

adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on the Respondent's behalf, to issue or have subpoenas issued on the Respondent's behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against the Respondent. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

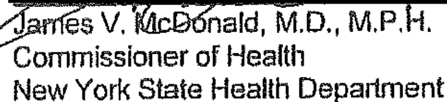
The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Riverview Center 150 Broadway - Suite 510, Albany, NY 12204-2719., ATTENTION: HON. NATALIE J BORDEAUX, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at

least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
August 22, 2023



James V. McDonald, M.D., M.P.H.
Commissioner of Health
New York State Health Department

Inquiries should be directed to:
Leslie Eisenberg
Associate Counsel
Bureau of Professional Medical Conduct
New York State Department of Health
Division of Legal Affairs
90 Church Street, 4th Floor
New York, New York 10007

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

IN THE MATTER OF DAVID ISRAEL, M.D.	STATEMENT OF CHARGES

David Israel, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 8, 2003, by the issuance of license number 229166 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent is engaging in the following conduct and/or permitting the following conduct to occur in his home, which Respondent also uses as a medical office:

1. Since May 2021, Respondent has lived at [redacted] [redacted], a walk-up apartment building with 4 units. Respondent uses his apartment as a medical office.

2. On numerous occasions, including but not limited to 5/28/22, 9/19/22, 1/26/23, 2/21/23, 3/5/23, 4/05/23, 4/16/23, 6/10/23, and 7/7/23, Emergency Medical Services (EMS) and/or the Fire Department of the City of New York (FDNY) and/or the New York City Police Department (NYPD) have responded to 911 calls at Respondent's apartment/medical office for calls of gunshots, overdoses, fighting, emotionally disturbed persons (EDP), and noise complaints. EMS have repeatedly observed multiple people, who do not appear to know each other, living in Respondent's apartment/medical office, and have found the apartment/medical

office to be in total disarray with bags, trash, needles, Narcan pods, and sex toys, strewn about everywhere.

3. Respondent allows patients and/or other individuals to live with him in his apartment/medical office. Patients and/or other individuals have been seen sleeping in the hallway outside Respondent's apartment/medical office, and Respondent has been heard yelling profanities and threats to patients and/or other individuals in his apartment/medical office, at all hours of the day and night.

4. Respondent provides keys to his apartment/medical office and/or entry to the locked building, to patients and/or other individuals. Visitors yell to Respondent from the street, at all hours of the day and night, and ring the bell of other tenants, to be allowed into the building.

5. On May 28, 2022, EMS responded to a call at Respondent's apartment/medical office for a gunshot wound. A male, (Patient D), who was living with Respondent, had suffered a self-inflicted gunshot wound, with his own gun, and fell down the stairs. EMS encountered the individual, completely naked, at the base of the stairs. EMS wrapped the individual in a blanket and transported him to Mt. Sinai West Hospital.

6. On September 19, 2022, EMS responded to a call at Respondent's apartment/medical office, for an overdose. Respondent was the patient. When EMS arrived, at least two people were present, and one reported to EMS that Respondent uses drugs recreationally. Respondent was unresponsive. EMS administered Narcan. Respondent awoke, was initially uncooperative, and then agreed to go to the hospital. EMS transported Respondent to Mt. Sinai West Hospital.

7. On January 26, 2023, EMS was called to Respondent's apartment/medical office, for a cardiac condition. Respondent was the patient. At least two people were present when EMS arrived. Respondent stated that he was yelling at a person who

had since left, and the yelling caused his chest pain. Respondent wanted an EKG, which was performed. Respondent reported he was in the medical field, and he refused to be transported to the hospital.

8. Due to an odor emanating from a hole in the ceiling of Respondent's apartment/medical office, a New York State licensed property inspector was engaged on January 26, 2023, to inspect the air coming from Respondent's apartment/medical office. The inspector obtained and tested an air sample. The results were positive for Methamphetamine.

9. On February 21, 2023, EMS was called to Respondent's apartment/medical office, for an overdose. A 23-year-old female was found unconscious on a bed in a back room. EMS administered Narcan and the individual became fully conscious. Respondent reported that he was a doctor and tried to have the individual refuse medical attention. EMS transported the individual to Mt. Sinai West Hospital. Upon arrival at the Emergency Room, the individual refused medical care and left with Respondent.

10. On March 5, 2023, EMS was called to Respondent's apartment/medical office for an individual with an altered mental status. At least two people were present when EMS arrived. A female, (Patient F), was found screaming and kicking and was held down by her roommate who reported that she took Gamma Butyrolactone (GBL). EMS transported this individual to Mt. Sinai West Hospital.

11. On April 5, 2023, EMS was called to Respondent's apartment/medical office for complaints of a person having difficulty breathing. Respondent was the patient. Upon arrival, EMS rang the bell but no one answered. Respondent then came down the stairs and informed EMS that he had chest pain, he is an Emergency medicine physician, and he had taken 4 baby aspirin and nitroglycerine, which

helped. Respondent stated that he wanted to be checked out, but he refused transport to the hospital.

12. On April 16, 2023, EMS responded to a call at Respondent's apartment/medical office, for an EDP. Upon arrival, NYPD was present and screaming could be heard. When EMS was permitted entry to the building, a male, (Patient D), was handcuffed in the hallway, outside [redacted]. EMS attended to the individual and then transported the individual to Mt. Sinai West Hospital.

13. The Office of Professional Medical Conduct (OPMC) has attempted to reach Respondent by mail, on more than one occasion. Respondent's mail was returned. Respondent acknowledged that his mailbox has been broken and he stated that his roommates steal his mail. On or about Friday May 12, 2023, Respondent was contacted by an OPMC investigator regarding the investigation and OPMC's attempts to reach him by mail. Respondent provided his email address as a means to receive communication. On Tuesday May 16, 2023, the OPMC investigator spoke again with Respondent, and informed him that the email was not going through. Respondent did not recall the conversation from May 12th and during this call his speech was slurred and jumbled.

14. On June 10, 2023, EMS was called to Respondent's apartment/medical office, for an overdose. At least three people were present when EMS arrived. EMS found a male on the floor of a backroom, unconscious, wet, and without a shirt. EMS administered Narcan and the individual became responsive. Respondent interjected that he was a physician, he would care for the individual and, he tried to persuade EMS that the male did not need to go with them to the hospital. The individual agreed to go to the hospital and EMS transported the individual to Mt. Sinai West Hospital.

15. On July 7, 2023, EMS was called to Respondent's apartment/medical office regarding a man with a head injury. Respondent was the patient. Upon arrival, EMS had difficulty gaining entrance to the building and could hear screaming

coming from upstairs. When EMS entered [redacted], there were at least two other people present. Respondent reported that he fought with a roommate, trying to get her to leave. The roommate hit him in the nose. While EMS was in the apartment attending to Respondent, NYPD observed an unconscious female on the floor in the back bedroom. EMS administered Narcan to the female and she responded. As EMS was loading the female into the ambulance, Respondent came downstairs and stated he wanted to get checked out. EMS transported the female and Respondent to Mt. Sinai West Hospital.

B. Respondent issued prescriptions to Patient A, a 51-year-old female, for medications including but not limited to Oxycodone, Adderall, Lorazepam, Alprazolam, Hydrocodone, and Promethazine/Codeine, from in or about September 2007 through in or about January 2023. This patient's address is the same as Patients B and C. OPMC requested medical records from Respondent in June 2020, in the form of a Director's Order of Comprehensive Review of Records. Respondent responded that he kept his patient records on a flash drive which was destroyed by his wife, in or about December 2019. Respondent did provide documentation reflecting visits in March and June 2020, and a prescription record demonstrating prescriptions between September 2007 and July 2020, including overlapping controlled substance prescriptions. (Patient names are listed in the Appendix.) Respondent deviated from minimally accepted medical standards in that he:

1. failed to:
    a. perform an adequate evaluation and/or detail an assessment or plan,
    b. review I-Stop while prescribing controlled substances for the patient,
    c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient, excluding March 7, 2020 - June 25, 2021 per New York State Executive Order #220.10.
2. inappropriately prescribed medications:
    a. without adequate medical justification,
    b. simultaneously,

c. at too frequent intervals.

C. Respondent issued prescriptions to Patient B, a 52-year-old male, for Oxycodone, Adderall, Lorazepam, Alprazolam, Percocet, and Promethazine/Codeine, from in or about January 2015 through in or about January 2023. This patient's address is the same as Patients A and C. OPMC requested medical records from Respondent in June 2020, in the form of a Director's Order of Comprehensive Review of Records. Respondent responded that he kept his patient records on a flash drive which was destroyed by his wife, in or about December 2019. Respondent did provide a prescription record demonstrating prescriptions between August 2019 and July 2020, including overlapping controlled substance prescriptions. Respondent deviated from minimally accepted medical standards in that he:

1. failed to:
   a. perform an adequate evaluation and/or detail an assessment or plan,
   b. review I-Stop while prescribing controlled substances for the patient,
   c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient, excluding March 7, 2020 - June 25, 2021 per New York State Executive Order #220.10.
2. inappropriately prescribed medications:
   a. without adequate medical justification,
   b. simultaneously,
   c. at too frequent intervals.

D. Respondent issued prescriptions to Patient C, an 18-year-old male, for Adderall, Lorazepam, Alprazolam, and Clonazepam, from in or about September 2015 through in or about January 2023. This patient's address is the same as Patients A and B. OPMC requested medical records from Respondent in June 2020, in the form of a Director's Order of Comprehensive Review of Records. Respondent responded that he kept his

patient records on a flash drive which was destroyed by his wife, in or about December 2019. Respondent did provide documentation of three telemedicine visits in January and December 2019 and February 2020, and a prescription record demonstrating prescriptions between July 2019 and June 2020, including overlapping controlled substance prescriptions. Respondent deviated from minimally accepted medical standards in that he:

1. failed to:
   a. perform an adequate evaluation and/or detail an assessment or plan,
   b. review I-Stop while prescribing controlled substances for the patient,
   c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient, excluding March 7, 2020 - June 25, 2021 per New York State Executive Order #220.10.
2. inappropriately prescribed medications:
   a. without adequate medical justification,
   b. simultaneously,
   c. at too frequent intervals.

E. Respondent issued prescriptions to Patient D, a 47-year-old male, for Oxycodone, Alprazolam and Buprenorphine-Naloxone, in or about June 2022 through in or about July 2023. Patient D has, at times, lived with Respondent in his apartment/medical office. Respondent did not maintain a medical record for Patient D. Respondent deviated from minimally accepted medical standards in that he:

1. failed to:
   a. perform an adequate evaluation and/or detail an assessment or plan,
   b. review I-Stop while prescribing controlled substances for the patient,
   c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient.
2. inappropriately prescribed medications:

a. without adequate medical justification,

b. with significant dose escalation.

F. Respondent prescribed Oxycodone and Dextroamphetamine for Patient E, a 45-year-old female, from in or about March 2023 through July 2023. Respondent did not maintain a medical record for Patient E. Respondent deviated from minimally accepted medical standards in that he:

1. failed to:
   - a. perform an adequate evaluation and/or detail an assessment or plan,
   - b. review I-Stop while prescribing controlled substances for the patient,
   - c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient.
2. inappropriately prescribed medications, without adequate medical justification.

G. Respondent issued prescriptions to Patient F, a 31-year-old female, for Buprenorphine, Clonazepam, and Oxycodone, from in or about November 2022 through in or about January 2023. Patient F has, at times, lived with Respondent in his apartment/medical office. Respondent did not maintain a medical record for the patient. Respondent deviated from minimally accepted medical standards in that he:

1. failed to:
   - a. perform an adequate evaluation and/or detail an assessment or plan,
   - b. review I-Stop while prescribing controlled substances for the patient,
   - c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient.
2. inappropriately prescribed medications:
   - a. without adequate medical justification,
   - b. simultaneously.

H. Respondent issued prescriptions to Patient G, a 37-year-old female, for Alprazolam, Dextroamphetamine, and Zolpidem, from in or about March 2023 through June 2023. Patient G has, at times, lived with Respondent in his apartment/medical office. Respondent did not maintain a medical record for the patient. Respondent deviated from minimally accepted standards in that he

1. failed to:
   a. perform an adequate evaluation and/or detail an assessment or plan,
   b. review I-Stop while prescribing controlled substances for the patient,
   c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient.
2. inappropriately prescribed medications, without adequate medical justification.

I. Respondent issued prescriptions to Patient H, a 43-year-old male, for Oxycodone, Alprazolam, and Dextroamphetamine, from in or about May 2023 through July 2023. Respondent did not maintain a medical record for the patient. Respondent deviated from minimally accepted standards in that he:

1. failed to:
   a. perform an adequate evaluation and/or detail an assessment or plan,
   b. review I-Stop while prescribing controlled substances for the patient,
   c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient.
2. inappropriately prescribed medications, without adequate medical justification.

J. Respondent issued prescriptions to Patient I, a 21-year-old-male, for Vyvanse, Adderall, and Lorazepam, from in or about October 2016 through February 2022.

OPMC requested medical records from Respondent in June 2020, in the form of a Director's Order of Comprehensive Review of Records. Respondent responded that he kept his patient records on a flash drive which was destroyed by his wife, in or about December 2019. Respondent did provide a prescription record demonstrating prescriptions between October 2016 and February 2020, including overlapping controlled substance prescriptions. Respondent deviated from minimally accepted standards in that he:

1. failed to:
   a. perform an adequate evaluation and/or detail an assessment or plan,
   b. review I-Stop while prescribing controlled substances for the patient,
   c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient, excluding March 7, 2020 - June 25, 2021 per New York State Executive Order #220.10.
2. inappropriately prescribed medications:
   a. without adequate medical justification,
   b. simultaneously, and
   c. at too frequent intervals.

K. Respondent issued prescriptions to Patient J, a 23-year-old-male, for Alprazolam, Diazepam, and Adderall, from in or about December 2016 through July 2018. OPMC requested medical records from Respondent in June 2020, in the form of a Director's Order of Comprehensive Review of Records. Respondent responded that he kept his patient records on a flash drive which was destroyed by his wife, in or about December 2019. Respondent did provide a prescription record demonstrating prescriptions between December 2016 and July 2018, including overlapping controlled substance prescriptions. Respondent deviated from minimally accepted standards in that he:

1. failed to:
   a. perform an adequate evaluation and/or detail an assessment or plan,
   b. review I-Stop while prescribing controlled substances for the patient,

c. maintain a record which accurately reflects the evaluation and treatment rendered to the patient.

2. inappropriately prescribed medications:
    a. without adequate medical justification,
    b. simultaneously,
    c. at too frequent intervals.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

MORAL UNFITNESS

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

1. Paragraph A and its subparagraphs.

SECOND-ELEVENTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

2. Paragraph B and its subparagraphs.

3. Paragraph C and its subparagraphs.

4. Paragraph D and its subparagraphs.

5. Paragraph E and its subparagraphs.

6. Paragraph F and its subparagraphs

7. Paragraph G and its subparagraphs.

8. Paragraph H and its subparagraphs.

9. Paragraph I and its subparagraphs.

10. Paragraph J and its subparagraphs.

11. Paragraph K and its subparagraphs.

TWELFTH-TWENTYFIRST SPECIFICATIONS

INCOMPETENCE ON MORE THAN ONE OCCASION

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

12. Paragraph B and its subparagraphs.

13. Paragraph C and its subparagraphs.

14. Paragraph D and its subparagraphs.

15. Paragraph E and its subparagraphs.

16. Paragraph F and its subparagraphs.

17. Paragraph G and its subparagraphs.

18. Paragraph H and its subparagraphs.

19. Paragraph I and its subparagraphs.

20. Paragraph J and its subparagraphs.

21. Paragraph K and its subparagraphs.

TWENTYSECOND-THIRTYFIRST SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

22. Paragraph B and 1c.

23. Paragraph C and 1c.

24. Paragraph D and 1c.

25. Paragraph E and 1c.

26. Paragraph F and 1c.

27. Paragraph G and 1c.

28. Paragraph H and 1c.

29. Paragraph I and 1c.

30. Paragraph J and 1c.

31. Paragraph K and 1c.

DATE: August 21, 2023
New York, New York

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct