THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

February 1, 1991

Franklin Guneratne
37 Main Street
Walden, N.Y. 12586

Re: License No. 117499

Dear Dr. Guneratne:

Enclosed please find Commissioner's Order No. 11244. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:
Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er
Enclosures

CERTIFIED MAIL- RRR
cc: Wood & Scher, Esq.
The Harwood Bldg.
Scarsdale, N.Y. 10583

REPORT OF THE
REGENTS REVIEW COMMITTEE

FRANKLIN P. GUNERATNE

CALENDAR NO. 11244

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

FRANKLIN P. GUNERATNE **No. 11244**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

FRANKLIN P. GUNERATNE, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on June 29 and June 30, 1988, and January 25, May 8, May 9, May 15, October 17, and November 13, 1989, hearings were held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of the first, second, fourth, and fifth specifications of the charges,

and not guilty of the third, and sixth through tenth specifications of the charges. The hearing committee recommended that respondent's license to practice as a physician in the State of New York be suspended for two years, said suspension to be stayed and respondent to be placed on probation for two years in accordance with the terms of probation set forth in Appendix "A" of the hearing committee report.

The Commissioner of Health recommended to the Board of Regents that the findings of fact, conclusions, and recommendation of the hearing committee be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On November 7, 1990 respondent appeared before us in person, and was represented by an attorney, William L. Wood, Jr., Esq., who appeared before us and presented oral argument on respondent's behalf. Cindy M. Fascia, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was:

> "A two year stayed suspension, with Respondent to be placed on probation during the two year period of the suspension. The recommended terms of probation are set forth in Appendix A of the Report of the Hearing Committee."

Respondent's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was: "We join in recommendation of petitioner."

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's October 25, 1990 memorandum.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 78 findings of fact, conclusions as to the question of respondent's guilt, and recommendation as to the measure of discipline be accepted, and the Commissioner of Health's recommendation as to those findings of fact, conclusions, and recommendation be accepted;
2. Respondent be found guilty, by a preponderance of the evidence, of the first, second, fourth, and fifth specifications of the charges, and not guilty of the remaining charges; and
3. Respondent's license to practice as a physician in the State of New York be suspended for two years upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently, that execution of said suspensions be stayed, and respondent be placed on probation for two

years under the terms more specifically set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D".

Respectfully submitted,

GERALD J. LUSTIG, M.D.

MELINDA AIKINS BASS

PATRICK J. PICARIELLO

Gerald J. Lustig, MD

Chairperson

Dated: January 8, 1991

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
FRANKLIN P. GUNERATNE, M.D.	:	CHARGES

----------X

The State Board for Professional Medical Conduct, upon information and belief, charges and alleges as follows:

1. FRANKLIN P. GUNERATNE, M.D. hereinafter referred to as the Respondent, was authorized to engage in the practice of medicine in the State of New York on September 6, 1973 by the issuance of License Number 117499 by the State Education Department.

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 37 Main Street, Walden, New York 12586.

3. The Respondent is charged with professional misconduct within the purview of N.Y. Educ. Law §6509 (McKinney 1985 and Supp. 1988) as set forth in the attached Specifications.

EXHIBIT "A"

FIRST THROUGH FIFTH SPECIFICATIONS

4. The Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) in that, among other things and incidents:

(a) The Respondent was Patient A's family physician from December, 1981 through April, 1987 (Patient A and all other patients referred to herein are identified in Appendix A). The Respondent's care and treatment was not in accordance with accepted standards of medical practice in that between October, 1983 and January, 1986, on at least eighty-three occasions at the Respondent's office located at 37 Main Street, Walden, New York, the Respondent prescribed and/or administered Demerol and Morphine Sulfate, either orally or intramuscularly, to Patient A, a person known to the Respondent to have a history of intravenous drug abuse. The Respondent's repeated treatment of Patient A with Demerol and Morphine Sulfate for painful conditions which were non-terminal resulted in this patient's re-addiction.

(b) The Respondent was Patient B's family physician from August, 1983 through January, 1986. The Respondent's care and treatment was not in accordance with accepted

standards of medical practice in that between July, 1984 and January, 1986 the Respondent issued at least fifty-five prescriptions for Demerol and Methadone from his office in Walden, New York, to Patient B for treatment of non-terminal conditions associated with pain. The Respondent's repeated treatment of Patient B with these narcotic drugs resulted in this patient's addiction.

(c) The Respondent was Patient C's family physician from October, 1983 to April, 1987. The Respondent's care and treatment was not in accordance with accepted standards of medical practice in that between October, 1983 and March, 1987 the Respondent administered at least sixty-four intramuscular injections of Demerol or Morphine Sulfate and issued six Demerol and two Percodan prescriptions to Patient C at his office in Walden, New York for treatment of non-terminal painful conditions which had significant psychogenic overlay.

(d) The Respondent was Patient D's family physician from November, 1979 through October, 1983. The Respondent's care and treatment of Patient D was not in accordance with accepted standards of medical practice in that the Respondent frequently treated Patient D at his office in Walden, New York with Preludin throughout this period.

(e) The Respondent was Patient E's family physician from February, 1985 to July, 1985. The Respondent's care and treatment of Patient E was not in accordance with accepted standards of medical practice in that the Respondent continuously treated Patient E's tension headaches at his office in Walden, New York with Percocet from February 19, 1985 until treatment was terminated.

SIXTH THROUGH TENTH SPECIFICATIONS

5. The Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) in that, among other things and incidents:

The State Board for Professional Medical Conduct repeats the allegations of the First through Fifth Specifications.

DATED: Albany, New York
May 16, 1988

Peter D Van Buren

PETER D. VAN BUREN
Deputy Counsel
Office of Professional Medical Conduct

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

IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
FRANKLIN P. GUNERATNE, M.D.	:	COMMITTEE

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

PAUL M. DeLUCA, M.D. (Chair), LEO FISHEL, JR., M.D., and REVEREND JAMES H. MILLER, 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 Section 230(10)(e) of the Public Health Law. Jonathan M. Brandes, Esq., served as the Administrative Officer on the first two hearing dates in June, 1988. Thereafter, Larry G. Storch, Esq., replaced Mr. Brandes and served as the Administrative Officer on all subsequent dates with the exception of November 13, 1989. On that date, Michael P. McDermott, Esq. served as a substitute Administrative Officer.

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

SUMMARY OF PROCEEDINGS

Date of Notice of Hearing and Statement of Charges against Respondent:	May 16, 1988
Answer to Statement of Charges:	None
Pre-Hearing Conference:	June 29, 1988

EXHIBIT "B"

Dates and Places of Hearings:

June 29, 1988
Court of Claims, Rm. 818
Justice Building
Empire State Plaza
Albany, New York

June 30, 1988
Court of Claims, Rm. 818
Justice Building
Empire State Plaza
Albany, New York

January 25, 1989
99 Washington Ave., Rm. 1930
Albany, New York

May 8, 1989
Corning Tower Building
29th Floor
Empire State Plaza
Albany, New York

May 9, 1989
Corning Tower Building
29th Floor
Empire State Plaza
Albany, New York

May 15, 1989
Corning Tower Building
29th Floor
Empire State Plaza
Albany, New York

October 17, 1989
Corning Tower Building
39th Floor
Empire State Plaza
Albany, New York

November 13, 1989
Corning Tower Building
29th Floor
Empire State Plaza
Albany, New York

Adjournments:	August 4, 1988 September 1 and 12, 1988 (Granted to permit parties to pursue settlement) June 15, 1989 (Granted on June 5, 1989; Respondent's Counsel unable to travel due to injury)
Received Petitioner's Proposed Findings of Fact and Conclusions of Law:	December 12, 1989
Received Respondent's Proposed Findings of Fact and Conclusions of Law:	December 13, 1989
Final Deliberations:	December 20, 1989
Department of Health appeared by:	Paul R. White, Esq. Associate Counsel
Respondent appeared by:	Wood & Scher One Chase Road Scarsdale, NY 10583 William L. Wood, Jr., Esq. of Counsel
Witnesses for Department of Health:	William P. Nelson, III, M.D.
Witnesses for Respondent:	Franklin P. Guneratne, M.D. Stanley Mandell, M.D. George W. Benninger, M.D. Jonathan Goodson, M.D. Won Park, M.D. Loretta Trinzinsky Patient C Patient D Ronald Kanner, M.D. Richard S. Blum, M.D.

STATEMENT OF CASE

The Department's charges allege, in substance, that Respondent practiced medicine with negligence and incompetence on more than one occasion with respect to five patients treated by Respondent. More specifically, it is alleged that Respondent inappropriately treated Patients A, B, C and E with various narcotics, for benign chronic pain. Additionally, it is alleged that Respondent treated Patient D with Preludin, an amphetamine-like drug, without medical justification.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. 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.

1. Respondent was licensed to practice medicine in New York State on September 6, 1973 by the issuance of license number 117499 (552-553; Respondent's Exhibit D).

2. Respondent graduated from medical school in Ceylon in 1968. Respondent took a one year rotating internship at St. Luke's Hospital in Newburgh, New York in 1970 followed by a three year residency in internal medicine at the Catholic Medical Center of Brooklyn and Queens from July 1971 through June 1974.

Thereafter, Respondent started a private medical practice in Walden, New York in 1974. Respondent's medical practice has been limited to adult general practice since 1974. (552-556; Respondent's Exhibit D).

3. Respondent has privileges at St. Luke's Hospital in Newburgh. (555).

4. Respondent has served as associate medical director of the methadone program operated by St. Luke's Hospital, since the program's inception in 1977. (560).

Patient A

5. Patient A was first seen by Respondent in his office on December 21, 1981 with complaints of left lower quadrant pain and a history of lumbar disc surgery. (286; Department's Exhibit #26 - p. 1).

6. Patient A was well known to Respondent prior to this first office visit. Respondent knew Patient A from the Methadone Clinic at St. Luke's Hospital. Patient A's history of drug abuse and addiction were known to Respondent as well as the fact that Patient A was dismissed from the methadone program because of malfeasance and non-compliance. Patient A had been caught selling drugs to other methadone patients. (602-604, 620-621).

7. Respondent hospitalized Patient A on September 27, 1983 for an inflamed epithelial cyst of the left scapular region. Respondent noted at the time of this hospital admission that

Patient A had been off the methadone program since 1981. Respondent also noted that Patient A was allergic to Demerol, among other drugs. (289-292; Department's Exhibit #26 - p. 47 and 53).

8. Despite the fact that Respondent was well aware of Patient A's history of drug abuse and addiction and in spite of Patient A's allergy to Demerol, Respondent started treating Patient A with Demerol on October 17, 1983 for complaints of acute low back pain. On this date, the Respondent gave Patient A an intramuscular injection of Demerol and provided a prescription for 20 tablets of Demerol. (292-294; Department's Exhibit #26 - p. 4R).[1]

9. Patient A's back condition was long-standing and non-life threatening. Patient A had chronic pain from this condition. (294-296, 777).

10. Demerol is a potent, addictive narcotic. Patient A, with his history of drug abuse and addiction, was likely to become re-addicted to narcotics after taking Demerol for a relatively short time. (294-296).

11. Chronic benign pain should generally not be treated on a long term basis with major narcotics such as Demerol or

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[1] Exhibit 26, as well as several other exhibits, are two-sided medical records. The letter "R" following a page number refers to the reverse side of that page.

Morphine Sulfate. It was especially problematic to treat Patient A with these narcotics in light of history of drug abuse and addiction. (320, 321, 344-345, 791).

12. Respondent issued further prescriptions for Demerol tablets to Patient A on October 27, 1983, December 13, 1983, January 9, 1984 and February 10, 1984, in increasing quantities. (296-297; Department's Exhibit #26 - p. 5 and 5R, Exhibit #27).

13. Respondent prescribed Demerol or morphine sulfate on some days when Patient A was not seen in the office, i.e., March 12, 1984, April 24, 1984, December 7, 1984, February 15, 1985, April 18, 1985, May 30, 1985, July 30, 1985 and September 17, 1985. (299-300, 312-314; Department's Exhibits #26 and #27).

14. On at least six occasions, Respondent gave Patient A both an injection of morphine sulfate and a prescription for Demerol tablets, i.e., June 26, 1984, August 3, 1984, September 17, 1984, September 25, 1984, October 18, 1984 and November 8, 1984. (303-304, 306-307; Department's Exhibits #26 and 27).

15. Respondent repeatedly treated Patient A with morphine sulfate and Demerol from October 1983 through February 1985. This course of treatment caused Patient A to become re-addicted. This re-addiction was well established by June 1984. (305-309).

16. Narcotics were prescribed or administered to Patient A on the following occasions:

Date	Drug	Route
10-17-83	Demerol 75 mg. Demerol 100 mg.	IM prescription
10-27-83	Demerol 100 mg. #10	prescription
12-13-83	Demerol 100 mg. #30	prescription
1-09-84	Demerol 100 mg. #50	prescription
2-10-84	Demerol 100 mg. #60	prescription
3-12-84	Demerol 100 mg. #60	prescription
4-24-84	Demerol 100 mg. #60	prescription
5-15-84	Demerol 100 mg.	IM
5-29-84	Demerol 100 mg. #60	prescription
6-01-84	Morphine Sulfate 15 mg.	IM
6-08-84	Morphine Sulfate 15 mg.	IM
6-15-84	Morphine Sulfate 15 mg.	IM
6-26-84	Morphine Sulfate 15 mg. Demerol 100 mg. #60	IM prescription
7-03-84	Morphine Sulfate 15 mg.	IM
7-16-84	Morphine Sulfate 15 mg.	IM
7-27-84	Morphine Sulfate 15 mg.	IM
7-31-84	Morphine Sulfate 15 mg.	IM
8-03-84	Demerol 100 mg. #60 Morphine Sulfate	prescription IM
8-21-84	Morphine Sulfate 1 cc	IM
8-23-84	Morphine Sulfate 10 mg.	IM
9-04-84	Morphine Sulfate 15 mg.	IM
9-07-84	Demerol 100 mg.	IM

9-10-84	Demerol 100 mg.	IM
9-17-84	Demerol 100 mg. #60 Morphine Sulfate 15 mg.	prescription IM
9-25-84	Demerol 200 mg. Morphine Sulfate 15 mg/ml - 20 ml.	IM prescription
10-02-84	Morphine Sulfate 15 mg.	IM
10-04-84	Morphine Sulfate 30 mg.	IM
10-09-84	Morphine Sulfate 15 mg.	IM
10-16-84	Morphine Sulfate 15 mg.	IM
10-18-84	Demerol 100 mg. #60 Morphine Sulfate	prescription IM
10-22-84	Morphine Sulfate 30 mg.	IM
10-25-84	Morphine Sulfate 30 mg.	IM
11-05-84	Morphine Sulfate 30 mg.	IM
11-06-84	Morphine Sulfate 30 mg.	IM
11-08-84	Demerol 100 mg. #90 Morphine Sulfate 30 mg.	prescription IM
11-15-84	Morphine Sulfate 15 mg.	IM
11-20-84	Morphine Sulfate 15 mg.	IM

11-23-84	Morphine Sulfate 15 mg. Morphine Sulfate 15 mg/ml - 20 ml.	IM prescription
11-28-84	Morphine Sulfate 15 mg.	IM
11-30-84	Morphine Sulfate	IM
12-03-84	Morphine Sulfate 15 mg.	IM
12-06-84	Demerol 100 mg. #90	prescription
12-14-84	Morphine Sulfate 2 cc	IM
12-20-84	Morphine Sulfate 15 mg.	IM
12-24-84	Morphine Sulfate 15 mg.	IM
1-03-85	Morphine Sulfate 30 mg.	IM
1-07-85	Morphine Sulfate	IM
1-08-85	Morphine Sulfate 1.5 ml	IM
1-11-85	Morphine Sulfate 2 cc Morphine Sulfate 15 mg/ml - 20 ml.	IM prescription
1-14-85	Morphine Sulfate 15 mg.	IM
1-17-85	Morphine Sulfate 15 mg.	IM
1-22-85	Morphine Sulfate 1.5 cc	IM
1-24-85	Morphine Sulfate 1.5 ml	IM
1-29-85	Morphine Sulfate 15 mg	IM
2-08-85	Morphine Sulfate 1.5 cc	IM
2-11-85	Morphine Sulfate 1.5 cc	IM
2-12-85	Morphine Sulfate	IM
2-14-85	Morphine Sulfate 1.5 cc	IM
2-15-85	Morphine Sulfate 15 mg/ml - 20 ml.	prescription
3-07-85	Demerol 100 mg. #100	prescription
3-29-85	Demerol 200 mg.	IM

4-01-85	Morphine Sulfate 1/4 gr. #65	prescription
4-05-85	Morphine Sulfate 15 mg.	IM
4-09-85	Morphine Sulfate 15 mg.	IM
4-12-85	Morphine Sulfate	IM
4-15-85	Morphine Sulfate 10 mg.	IM
4-18-85	Morphine Sulfate 1/4 gr. #100	prescription
5-10-85	Demerol 100 mg.	prescription
5-13-85	Morphine Sulfate	IM
5-16-85	Morphine Sulfate 2 cc	IM
5-17-85	Morphine Sulfate 2 cc	IM
5-30-85	Morphine Sulfate 1/4 gr. #100	prescription
6-27-85	Morphine Sulfate 15 mg/ml - 20 ml.	prescription
7-05-85	Morphine Sulfate 15 mg. #100	prescription
7-30-85	Morphine Sulfate 15 mg #100	prescription
8-06-85	Morphine Sulfate	IM
8-23-85	Morphine Sulfate 15 mg. #100	prescription
9-16-85	Morphine Sulfate 15 mg. #100	prescription
10-12-85	Morphine Sulfate 15 mg. #100	prescription
11-11-85	Morphine Sulfate 15 mg. #100	prescription
11-25-85	Morphine Sulfate 2 cc	IM
12-06-85	Morphine Sulfate 15 mg. #100	prescription
1-02-86	Methadone 10 mg. #60	prescription
4-17-87 (Department's Exhibits #26, 27, 28).	Demerol 100 mg. #10	prescription

17. Respondent admitted Patient A to St. Luke's Hospital on February 18, 1985 because of the patient's intractable low back pain. In his admission note, Respondent inaccurately described his course of treatment for Patient A's back pain. The admission note stated that Patient A "has had severe back pain and has required Motrin as well as Tylenol with codeine for back pain." In fact, Respondent had been continually treating Patient A's back pain with Demerol and morphine sulfate for more than a year prior to this hospitalization. (309-310; Department's Exhibit #26 - p. 53).

18. In this same hospital admission note, Respondent stated that Patient A was allergic to Demerol and that "Demerol is not being used because the patient has an adverse reaction to Demerol", yet Respondent's office notes document that Demerol was repeatedly prescribed to Patient A for more than a year prior to this hospital admission. (310; Department's Exhibit #26 - p. 53 and 53R).

19. Respondent continued to treat Patient A with morphine sulfate following Patient A's discharge from St. Luke's Hospital on March 6, 1985. This course of treatment continued through December, 1985. (311-316).

20. Drug screens were performed on Patient A in October 1985 and again in September 1986. These drug screens indicated that Patient A was not taking the drugs which the Respondent had prescribed for him. (630-631, 640-642).

21. Respondent attempted to withdraw Patient A from Demerol and morphine sulfate on January 2, 1986 by issuing a prescription for methadone. (317; Department's Exhibit #26 - P. 14R and #27).

Patient B

22. Patient B initially consulted with Respondent on August 30, 1983 because the patient required a physical examination for school. (369; Department's Exhibit #29 - p. 1).

23. Patient B was seen by Respondent on July 31, 1984 because of a recurrence of back pain. On this date, Respondent provided Patient B with an intramuscular injection of Demerol and a prescription for 60 Demerol tablets. (373-374; Department's Exhibit #29 - p. 2; Department's Exhibit #31).

24. Respondent admitted Patient B to St. Luke's Hospital for approximately one month commencing on August 27, 1984 because of intractable low back pain. Diagnostic studies performed during this hospitalization did not support a finding of a mechanical problem in the lumbar spine. (384-388; Department's Exhibit #29 - pp. 16, 19, 23, 25).

25. During this hospitalization, Respondent did not request a neurosurgical or psychiatric consultation. (509-510).

26. Respondent treated Patient B with methadone on October 11, 1984, following the patients discharge from the hospital. A prescription for 250 tablets of methadone 5 mg. was issued. Methadone is a potent addictive narcotic similar to

Demerol and morphine sulfate but with fewer gastrointestinal side effects. (389-391; Department's Exhibit #29 - p. 2R; Department's Exhibit #31).

27. The methadone prescription was not provided as part of an effort to withdraw Patient B from Demerol. (391-392, 691-692).

28. One week after receiving the methadone prescription, Patient B was given prescriptions for Demerol ampuls, syringes and needles. (393-395; Department's Exhibit #29 - p. 3; Department's Exhibit #31).

29. Respondent re-admitted Patient B to the hospital on October 26, 1984 for treatment of low back pain associated with sciatica. Dr. Murthy, a neurosurgeon, saw the patient in consultation at the end of the hospital stay. Dr. Murthy suggested a repeat myelogram and possible surgery. (399-401; Department's Exhibit #29 - pp. 32, 37-40).

30. Following discharge from the hospital on November 9, 1984, Patient B returned to Respondent's office for further Demerol prescriptions. Over the course of the next three weeks, Respondent increased the Demerol dosage which Patient B took by 400%. Patient B's dosage of intramuscular Demerol increased from 75 mg. a day on November 12, 1984, to 150 mg. a day on November 19, 1984, to 300 mg. a day on November 30, 1984. (401-404; Department's Exhibit #29 - p. 3; Department's Exhibit #30).

31. Respondent continued to treat Patient B with intramuscular Demerol, which was self-administered, from December 1984 through February 1985. Patient B was addicted to Demerol during this time period. (407-410; Department's Exhibit #29 - p. 3R and 4; Department's Exhibit #31).

32. Respondent noted in February, 1985 that Patient B had failed to keep two appointments at a pain clinic. From a clinical point of view, it would have been highly desirable for Patient B to be evaluated by a pain clinic. (411-414).

33. On February 22, 1985, Respondent noted that Patient B was scheduled to see Dr. Stern, a neurosurgeon in White Plains on March 18, 1985. Despite the fact that Patient B did not keep this appointment (the third appointment she did not keep), Respondent continued to provide the patient with injectable Demerol during March, April and early May, 1985. (418-420, 502; Department's Exhibit #29 - pp. 4R, 5, 5R; Department's Exhibit #31).

34. Patient B was seen by Dr. Stern on May 6, 1985. Dr. Stern noted that there was a paucity of hard evidence to support Patient B's complaints of pain, although Dr. Stern did not doubt that the patient was experiencing real pain. Dr. Stern strongly suggested that Patient B's drug dependency be dealt with and that the Patient enroll in a chronic pain clinic (420-421; Department's Exhibit #29 - pp. 54 and 55).

35. Dr. Stern's treatment recommendations were not followed by Patient B or Respondent. Patient B's drug dependency was not dealt with nor was the patient treated in a pain clinic. (510-511, 529, 685).

36. Following Dr. Stern's evaluation, Patient B returned to the Respondent's office for further prescriptions of Demerol. The Respondent continued to treat Patient B with injectable Demerol through July 11, 1985. On July 11, 1985 a prescription for methadone was provided in an effort by the Respondent to wean Patient B off of Demerol. However, Respondent resumed treating Patient B with Demerol in August and September, 1985. (425-428, 486-487).

37. Respondent gave Patient B two further prescriptions for injectable Demerol on December 9, 1985 and December 27, 1985. These December, 1985 Demerol prescriptions followed Patient B's treatment with methadone from September 21, 1985 to December 9, 1985. (429-430; Department's Exhibit #29 - pp. 7, 7R; Department's Exhibit #31).

38. Patient B moved to Tobyhanna, Pennsylvania in October, 1985. Patient B's address on the October 10, 1985 prescription was listed as Maybrook, New York and for all subsequent prescriptions a Pennsylvania address was indicated. (430-431; Department's Exhibit #31).

39. Respondent continued to treat Patient B with Demerol and methadone after the patient left New York. This

treatment continued until January 20, 1986. (Department's Exhibit #29 - p. 8; Department's Exhibit # 31).

40. Respondent advised Patient B's spouse on January 25, 1986 that no more methadone would be provided. There was no further contact between the Respondent and Patient B. (432, 696; Department's Exhibit #29 - p. 8).

Patient C

41. Respondent first treated Patient C in 1974 when he opened his practice in Walden, New York. (839).

42. Respondent treated Patient C for a migraine headache but did not do a complete workup of the headache because the patient told him that a workup had been done at Montefiore Hospital a few years previously. (840).

43. There was no doubt as to the severity of her pain. (232).

44. Patient C was not able to take Cafergot. (840).

45. Ergots are not likely to be effective once an attack is underway. (1120).

46. Respondent recognized the need of obtaining a psychiatric consult and appropriately referred her. (236).

47. There was always a precipitating cause for the attacks and between attacks, the patient was symptom-free. (845).

48. When a migraine headache results in vomiting, injectable narcotics must be used. (808).

49. Patient C ceased being under the care of Respondent in 1979 or 1980. (841).

50. Patient C returned to his care in October, 1983 (842).

51. Since the migraine attacks were less than three a month on average, prophylactic treatment posed greater risk than treating each attack. (1113).

52. In addition to treating Patient C for headaches, Dr. Guneratne treated the patient for lower back pain and referred Patient C to Dr. Mandell for assistance with the low back pain. (845).

Patient D

53. Respondent first saw Patient D in his office on November 30, 1979. The patient presented with a history of chronic obesity and hypertension. (28; Department's Exhibit #2 - p. 1).

54. On the initial office visit Patient D weighed 186 pounds and was 5 feet 1 3/4 inches tall (30; Department's Exhibit #2 - p. 1R).

55. Respondent's initial diagnoses of Patient D were hypertension and obesity. Respondent's office records contain no history or diagnosis of narcolepsy or any "narcolepsy -like" disorder. (32; Department's Exhibit #2 - p. 1R).

56. On the first office visit, November 30, 1979, Respondent prescribed Preludin 75 mg. for Patient D and advised the Patient to return to his office in three months. (33; Department's Exhibit #2 - p. 1R).

57. Preludin is a sympathomimetic amine similar in pharmacologic action to an amphetamine. Preludin was indicated during Patient D's period of treatment only for the management of exogenous obesity on a short term basis. According to the Physician's Desk Reference, Preludin was not indicated for the treatment of depression, narcolepsy or "narcolepsy-like" symptoms. (33-35).

58. Preludin was contraindicated for Patient D in light of Respondent's diagnosis of hypertension. As a central nervous system stimulant, Preludin would tend to exacerbate hypertension. (47-48).

59. Three weeks after staring Patient D on Preludin, Respondent prescribed Valium. Valium is indicated for the management of anxiety and tension and has a sedative effect. Patient D's treatment with Valium would tend to neutralize the stimulant effect of Preludin. (40-41; Department's Exhibit #2 - pp. 1R).

60. Patient D gained six pounds during the first six weeks that the patient was on Preludin. Despite this weight gain, the Respondent prescribed more Preludin on January 18, 1980 and continued the Preludin regimen with prescriptions issued on

February 19, 1980, April 1, 1980, May 6, 1980, June 9, 1980, September 18, 1980, October 30, 1980, December 30, 1980, February 5, 1981 and March 6, 1981. (46-47, 56-58; Department's Exhibit #2 - pp. 2, 2R and 3).

61. Dr. Stanley Mandell, a neurologist, saw Patient D in consultation in March, 1980, January, 1982 and February, 1982. Dr. Mandell found no evidence that Patient D had narcolepsy. (705, 740-742).

62. New York State law changed as of September 1, 1981 making it unlawful for a physician to prescribe, dispense or administer any Schedule II sympathomimetic amine for the exclusive treatment of obesity, weight control or weight loss. (N.Y. Pub. Health Law §3304(b)).

63. Respondent continued to treat Patient D with Preludin after the change in the controlled substances law. Patient D received Preludin prescriptions through October, 1983. (60-61).

64. Patient D was hospitalized by Respondent on August 13, 1982. During this hospitalization Patient D was seen by Dr. Warren, a psychiatrist, who specifically concluded that this patient did not have a sleep disorder or any neurological disorder. In Dr. Warren's opinion, Patient D's fatigue and lack of energy were related to a reactive depression. (75-77; Department's Exhibit #10 - pp. 9 and 10).

65. Dr. Warren recommended psychiatric treatment and a trial on anti-depressant medication. (79-80; Department's Exhibit #10 - pp. 9 and 10).

66. Dr. Warren's August, 1982 treatment recommendations were not followed as Patient D did not receive psychiatric treatment nor a trial on anti-depressant medication. (Department's Exhibit #2).

67. Following Patient D's consultation with Dr. Warren, Respondent continued to treat Patient D with Preludin. Preludin prescriptions were issued to Patient D on August 20, 1982, January 25, 1983, April 15, 1983, June 6, 1983, July 19, 1983, September 29, 1983 and October 10, 1983. October 10, 1983 was Patient D's last day of treatment. (82-83; Department's Exhibit #2 - p. 5R, 6, 6R, 7 and 7R).

68. Respondent's office records contain an unsigned letter dated July 16, 1982 written on Respondent's stationery, stating that Patient D "has taken Preludin 75 mgs. intermittently since 1976 for treatment of a (narcolepsy-like illness) manifested by periods of mental depression and the desire to sleep for long periods." (Department's Exhibit #2 - p. 49).

69. Narcolepsy is a symptom complex which includes cataplexy, sleep paralysis, vivid hallucinations and narcoleptic attacks. A diagnosis of narcolepsy can be made based on clinical information alone. In the absence of the full symptom complex,

an abnormal EEG pattern is helpful in making a diagnosis of narcolepsy. (736-742).

70. Patient D did not demonstrate any of the elements of the symptom complex of narcolepsy and had a normal EEG pattern. (706, 714, 740-742).

71. Patient D's fatigue and desire to sleep could have been attributable to several factors other than narcolepsy: (a) Patient D's diabetes was difficult to control and fluctuations in blood sugar caused the patient to feel lethargic and fatigued; (b) Patient D had back pain and may have slept poorly at night; and (c) Patient D was mentally depressed. (83-87, 129-134, 747-748).

Patient E

72. Patient E first presented at Respondent's office on February 5, 1985 with a complaint of a severe headache for two weeks. Respondent diagnosed tension headaches and prescribed Tylenol with codeine. (140-141; Department's Exhibit #12 - p. 1).

73. Patient E returned to Respondent's office two weeks later on February 19, 1985, continuing to complain of headache pain. Respondent then prescribed 120 tablets of Percocet for Patient E. (144-145; Department's Exhibit #12 - p. 1; Exhibit # 14B).

74. During the course of treatment, Respondent did not obtain an adequate history or perform an adequate physical

examination in response to Patient E's headache complaints. (147-149, 153).

75. Respondent did not refer Patient E to a neurologist to evaluate the persistent headache complaints. (153, 159).

76. Respondent continued to treat Patient E's headache complaints with prescriptions for 120 tablets of Percocet on March 19, 1985, April 30, 1985 and June 3, 1985. (151-153; Department's Exhibit #12 - p. 1R and 2; Exhibit #14C).

77. Patient E was last seen in Respondent's office on July 5, 1985. The patient at that time had no headache complaint. Nonetheless, Respondent continued the Percocet regimen by prescribing an additional 120 tablets. (153-154; Department's Exhibit #12 - p. 2; Exhibit # 14D).

78. Following Patient E's last office visit, the patient's mother called Respondent's office and insisted that no drugs of any kind be given to the patient. (Department's Exhibit #12 - p. 2).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise. Numbers in parentheses refer to the specific Findings of Fact which support each conclusion.

The Hearing Committee concluded that the following specifications should be SUSTAINED:

First Specification [Para. 4(a) of Charges] by a vote of 2-1: (1, 2, 4, 5 - 21)

Second Specification [Para. 4(6) of Charges]: (1, 2, 22-40)

Fourth Specification [Para. 4(d) of Charges]: (1, 2, 53 -71)

Fifth Specification [Para. 4(e) of Charges]: (1, 2, 72 -78)

Discussion

The Respondent's use of controlled substances was placed at issue in this proceeding. Four of the patients involved (A, B, C and E) presented problems in the management of chronic pain of benign ("non-terminal") origin. The parties presented two opposing schools of thought regarding the use of controlled substances for chronic pain management. The Department, through its expert, Dr. Nelson, essentially argued that it is inappropriate to prescribe narcotics for an extended period for pain resulting from non-terminal conditions. Respondent, through the testimony of Drs. Kanner and Blum, argued that it is quite appropriate to treat such cases with narcotics under the proper circumstances.

However, it is not necessary for the Hearing Committee to determine whether or not either school of thought is "correct".

The issue to be decided concerns Respondent's medical management of the five specific patients set forth in the Statement of Charges. For the reasons set forth below, the Hearing Committee concluded, by a preponderance of the evidence, that Respondent practiced medicine with negligence on more than one occasion, with respect to Patient's A, B, D and E. Each patient will be discussed separately, below.

Patient A

Respondent knew Patient A to be both a drug addict and a drug dealer. He was aware that the patient had been terminated by the St. Luke's Hospital methadone clinic for selling street drugs to clinic patients. Nevertheless, on October 17, 1983 he began prescribing Demerol for the Patient's chronic pain (despite a stated allergy to Demerol). Respondent testified that he prescribed Demerol so that Patient A would not turn to street drugs for relief. He further stated that he started with small quantities of Demerol in order to closely monitor Patient A's drug usage. (Tr. pp. 604-605).

However, the record demonstrates that Respondent quickly lost control of Patient A's drug usage. Beginning on February 10, 1984, Respondent began prescribing Demerol tablets (100 mg.) in quantities of 60 tablets or more, in addition to frequent intramuscular injections of morphine sulfate. Despite Respondent's stated objective of providing Patient A with

prescriptions for narcotics instead of abusing street drugs, it is apparent that Patient A did not use the medication. For example, Respondent prescribed 100 tablets of Morphine Sulfate 15 mg. on October 12, 1985. Patient A was subsequently hospitalized for a possible drug overdose on October 19, 1985. A drug screen performed at that time did not detect any of the prescribed medication in Patient A's blood or urine. Respondent failed to appreciate the significance of the drug screen, as he again prescribed oral morphine sulfate 15 mg. (100 tablets) on November 11, 1985. The Hearing Committee concluded that it was more likely than not that Patient A sold or otherwise diverted at least a portion of the controlled substances prescribed by Respondent.

It is apparent that in February, 1985 Respondent realized that his management of Patient A was unacceptable. In this patient's February 18, 1985 hospitalization, Respondent misstated Patient A's course of treatment. He failed to disclose in the hospital admission note that he had been treating Patient A with morphine sulfate and Demerol for more than one year.

At the hearing, Respondent admitted that he exercised bad medical judgement by his prescription of narcotics in his management of Patient A (Tr. 646-647).

Patient B

Respondent believed that Patient B was experiencing genuine pain while under his treatment. (Tr. p. 667) and that a

series of accidents and emotional crises exacerbated the patient's condition, making treatment difficult. (Tr. pp. 668-670). Respondent felt that Patient B's back pain was so severe that injectable narcotics were required. (Tr. p. 672).

Respondent treated Patient B's back pain with injectable Demerol and/or methadone from July, 1984 through December, 1985. These narcotics should not have been used before trying less addictive medications, such as Tylenol with codeine. Respondent conceded that he didn't know whether such medication could have adequately relieved Patient B's pain. (Tr. 681-682).

Respondent provided Patient B with quantities of syringes and Demerol ampules which were, ultimately self-administered. Respondent lost control over Patient B's drug usage by November, 1984. During the course of a three week period, the quantities of medication taken by the patient increased, from 75 mg. of Demerol per day on November 12, 1984, to 300 mg. per day on November 30, 1984. Patient B was almost certainly addicted to Demerol by the end of 1984.

At two different points in Patient B's course of treatment Respondent attempted to detoxify the patient. First in July, 1985 and then again in October and November, 1985, Respondent attempted to withdraw Patient B from the addiction to Demerol. Inexplicably, in each instance Respondent resumed treating Patient B with Demerol, thereby re-establishing the addiction.

However, it was not until September, 1985 that Respondent concluded that Patient B had become addicted to narcotics. At this time Patient B was upset, agitated, shaky and had diarrhea, all of which are signs of drug withdrawal. (Tr. p. 673).

Respondent acknowledged that Dr. Stern, a consultant in neurosurgery, immediately recognized Patient B's drug dependency on the first (and only) occasion Patient B was seen by Dr. Stern in May, 1985. (Tr. p. 676-677). Respondent could not explain how this problem escaped his attention until September, 1985.

Respondent failed to ensure that Patient B was treated in a pain clinic. Respondent could have encouraged Patient B into seeking such treatment by withholding narcotic drugs.

Patient B continued to be treated by Respondent because he was the source of the drugs. Once Respondent made it clear that the supply of narcotics was cut off, Patient B did not return to his office.

Patient D

Respondent testified that he gave Patient D prescriptions for Preludin because the patient had a tendency to sleep for long periods. (Tr. p 699-700). He admitted on cross-examination that he did not think that Patient D had narcolepsy, but that the patient may have had some other kind of sleeping disorder. (Tr. p. 706-714). Respondent denied that Patient D was given Preludin for obesity.

However, Patient D's medical records, including the report of a consulting psychiatrist and neurologist, do not support a diagnosis of narcolepsy or any other neurological disorder. In fact, Respondent's office and hospital notes for Patient D do not contain any reference to a sleeping disorder. However, Respondent's office note for July 19, 1983 suggests that Preludin was being prescribed for weight loss. The note states: "... continue to lost wt. Preludin 75 mg. - OD". (Department's Exhibit #2 - p. 7). The Hearing Committee concluded that it is more likely than not that Patient D's fatigue and desire to sleep were attributable to the patient's mental depression, chronic back pain and diabetes, rather than a "narcolepsy-like" illness.

Respondent's treatment of Patient D was inappropriate for a number of reasons: (1) Preludin was contraindicated in light of Patient D's hypertension; (2) Patient D's obesity could not lawfully be treated with Preludin after September 1, 1981; (3) Patient D did not receive an anti-depressant medication and psychiatric treatment as recommended by Dr. Warren; and (4) Patient D received Preludin (a stimulant) and Valium (a depressant) simultaneously.

Patient E

Respondent treated Patient E's headache complaints with Percocet from February 19, 1985 until treatment was terminated in July, 1985.

Respondent failed to obtain an adequate history and perform an adequate physical examination in an effort to ascertain the etiology of Patient E's headache pain and come to a definitive diagnosis. In addition, Respondent should have consulted with a neurologist. Instead, Respondent treated Patient E's symptoms with excessive narcotic analgesics.

Respondent's use of Percocet in very substantial dosages over a period of many months was inconsistent with generally accepted standards of medical practice under the circumstances. Respondent's issuance of the final Percocet prescription on July 5, 1985 was completely inexplicable. The patient stated that he had no headache pain, yet Percocet was once again prescribed. (Tr. pp. 154-155).

Respondent admitted that the Percocet prescriptions which he wrote for Patient E were not medically appropriate. (Tr. p. 582). He conceded that he should have suspected that Patient E had a problem with drugs when the patient stated that only Percocet helped his headache (Tr. pp. 584-585). Respondent acknowledged that it is unusual for a patient to request a specific controlled substance (Tr. 585). In addition, Respondent admitted that he should also have suspected Patient E's motives when this patient wanted more medication, claiming that the medication bottle had broken (Tr. pp. 585-586). Respondent also conceded that he should have been concerned with the frequency of

Patient E's office visits for additional prescriptions (Tr. pp. 595-596).

The Hearing Committee further concluded that the following specifications should NOT BE SUSTAINED:

Third Specification [Para. 4(c) of Charges]: (1, 2, 41-52)

Sixth through Tenth Specifications [Para. 5 of Charges]: (1-78)

DISCUSSION

The Sixth through Tenth Specifications charge Respondent with practicing the profession with incompetence on more than one occasion. Incompetence has been defined as a lack of the skill or knowledge necessary to practice the profession. The Hearing Committee unanimously concluded that, based upon the record as a whole, Respondent's conduct did not demonstrate a lack of the skill or knowledge necessary to care for Patients A through E. As was set forth in greater detail above, Respondent failed to exercise the care that would be exercised by a reasonably prudent licensee, due to poor judgement on his part. This does not constitute incompetence. Therefore, the Hearing Committee concluded that these specifications should not be sustained.

The Third Specification charged Respondent with negligence on more than one occasion with respect to Patient C.

Contrary to the Department's assertions, the frequency of intramuscular injections of Demerol and morphine sulfate was not excessive. The records show that Patient C suffered a migraine headache less than twice per month, on average, between October, 1983 and March 1987. Given such a low frequency of attacks, prophylactic treatment may pave posed a greater risk to the patient than the Demerol or morphine sulfate. Further, the patient presented with a history of an inability to take ergotamine, thus precluding its use as a prophylactic.

Respondent also recognized Patient C's need for a psychiatric evaluation and an appropriate consultation was obtained. Unfortunately, the patient did not pursue psychiatric treatment at that time. It should also be noted that although he did not seek a neurological consultation regarding the migraine headaches, Respondent did obtain a consultation regarding Patient C's back pain. Respondent also did not obtain the patient's prior records concerning the migraine work-up performed at Montifiore Hospital. While it would have been desirable to obtain such records, it was not inappropriate to rely on the history provided by the patient, if the information provided was adequate to plan future treatment.

Based upon this analysis, the Hearing Committee concluded that Respondent's conduct regarding Patient C did not constitute negligence on more than one occasion. Therefore, the

Committee concluded that the Third Specification should not be sustained.

RECOMMENDATIONS

The Hearing Committee, pursuant to its Findings of Fact and Conclusions herein, unanimously recommends that Respondent's license to practice medicine in the State of New York be suspended for a period of two years. The Committee further recommends that this suspension be stayed, with Respondent placed on probation for the same two year period. Proposed terms of probation are contained in Appendix A. The Committee's recommendation was reached after due consideration of the full spectrum of available penalties, including revocation, censure and reprimand, or the imposition of civil penalties of up to $10,000 per violation.

The evidence in this case clearly established that potent and addictive Schedule II controlled substances were repeatedly over-prescribed by Respondent. With regard to Patients A, B, D and E, Respondent failed to adequately explore more appropriate alternative treatment modalities. Respondent apparently allowed his best medical judgement to be clouded by his personal involvement with his patients and his empathy for their troubles. He lacked either the professional distance or the judgement to refuse his patient's demands for drugs. Respondent's misconduct was serious, and warrants a significant penalty,one which is greater than a mere censure and reprimand.

However, no charge was made, nor evidence produced, that Respondent's motivation in over-prescribing the controlled substances was anything other than his genuine, if misguided, concern for the welfare of his patients. There was no evidence that the prescriptions were issued by Respondent for his own enrichment. Therefore, the Committee concluded that revocation was not warranted. Further, the Hearing Committee gave credence to Respondent's stated desire to learn from his past mistakes. This desire was further evidenced by Respondent's Exhibit F, which documents Respondent's attendance at a continuing medical education (CME) program on the office management of the chemically dependent patient. Such continuing education should be encouraged, and is made mandatory in the recommended terms of probation contained in Appendix A.

Based upon the foregoing, the Hearing Committee made the following recommendations:

1. That the First, Second, Fourth and Fifth Specifications, as set forth in Department's Exhibit #1 be SUSTAINED;

2. That the Third, and Sixth through Tenth Specifications NOT BE SUSTAINED, and

3. That Respondent's license to practice medicine in New York State be suspended for two years, said suspension to be stayed and Respondent to be placed on probation for two years in accordance with the terms of probation set forth in Appendix A.

Dated: Johnson City, New York
1990

Respectfully submitted,

Paul M. DeLuca, M.D.

PAUL M. DeLUCA, M.D.(Chair)

Leo Fishel, Jr., M.D.
Rev. James H. Miller

APPENDIX A
TERMS OF PROBATION
FRANKLIN P. GUNERATNE, M.D.

1. Dr. Guneratne shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Dr. Guneratne shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Dr. Guneratne shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Dr. Guneratne leaves New York to reside or practice outside the State, Dr. Guneratne shall notify the Director of the Office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. Guneratne shall have quarterly meetings with an employee or designee of the Office of Professional Medical conduct during the period of probation. During these quarterly meetings Dr. Guneratne's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed. In addition, Dr. Guneratne's controlled substance prescribing practice may be reviewed.

6. Dr. Guneratne shall maintain a legible written record of all controlled substances which he prescribes, dispenses or administers. This record shall indicate the name of the patient, the drug prescribed, dispensed or administered, including the amount, strength and directions for use and the date on which the controlled substance was prescribed, dispensed or administered. This written record shall be

distinct from, and in addition to, Dr. Guneratne's medical records for his patients.

7. Dr. Guneratne shall maintain legible medical records which accurately reflect his evaluation and treatment of his patients. In addition to any other relevant medical information, these records shall contain: a comprehensive history; physical examination as indicated; the patient's chief complaint or present illness; the diagnosis and treatment with data or findings which support the diagnosis and treatment; and in cases where controlled substances have been prescribed, dispensed or administered, the rationale for using the controlled substances as well as the amount, strength and directions for use of the controlled substance.

8. Dr. Guneratne shall have quarterly meetings with a monitoring physician who shall review Dr. Guneratne's controlled substance prescribing practice. This monitoring physician shall review Dr. Guneratne's written record of controlled substances which have been prescribed, dispensed or administered and shall randomly review selected medical records and evaluate whether Dr. Guneratne's prescribing practice and medical care comport with generally accepted standards of medical practice. This monitoring physician shall be selected by Dr. Guneratne and is subject to the approval of the Director of the Office of Professional Medical Conduct. The monitoring physician shall submit quarterly reports to the Director of the Office of Medical Conduct.

9. Dr. Guneratne shall complete at least fifty credit hours of Category I continuing medical education in internal medicine and/or family practice during each of the next two years. At least fifteen credit hours each year shall be in courses which include substantial discussion about the proper use of controlled substances. Dr. Guneratne shall submit written proof of successfully completion of CME courses to the Director of the Office of Professional Medical Conduct.

10. Dr. Guneratne shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of non-compliance. These declarations should be sent to the Director of the Office of Professional Medical Conduct at the address indicated above.

11. Dr. Guneratne shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If Dr. Gunerante elects not to

practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

12. If there is full compliance with every term set forth herein, Dr. Guneratne may practice as a physician in New York in accordance with the terms of probation; provided, however, that upon receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Dr. Guneratne pursuant to New York Public Health Law @230(19) or any other applicable laws.

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

IN THE MATTER :

OF :

FRANKLIN P. GUNERATNE, M.D. :

COMMISSIONER'S RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on June 29, 1988, June 30, 1988, January 25, 1989, May 8, 1989, May 9, 1989, May 15, 1989, October 17, 1989, and November 13, 1989. Respondent, Franklin P. Guneratne, M.D., appeared by William L. Wood, Jr., Esq. The evidence in support of the charges against the Respondent was presented by Paul R. White, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be accepted; and

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

EXHIBIT "C"

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
July 20, 1990

DAVID AXELROD, M.D., Commissioner
New York State Department of Health

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

FRANKLIN P. GUNERATNE

CALENDAR NO. 11244

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. Dr. Guneratne shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

   b. Dr. Guneratne shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State;

   c. Dr. Guneratne shall submit prompt written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   d. In the event that Dr. Guneratne leaves New York to reside or practice outside the State, Dr. Guneratne shall notify the Director of the Office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York;

   e. Dr. Guneratne shall have quarterly meetings with an employee or designee of the Office of Professional Medical Conduct during the period of probation. During these quarterly meetings Dr. Guneratne's professional performance may

be reviewed by having a random selection of office records, patient records and hospital charts reviewed. In addition, Dr. Guneratne's controlled substance prescribing practice may be reviewed;

f. Dr. Guneratne shall maintain a legible written record of all controlled substances which he prescribes, dispenses or administers. This record shall indicate the name of the patient, the drug prescribed, dispensed or administered, including the amount, strength and directions for use and the date on which the controlled substance was prescribed, dispensed or administered. This written record shall be distinct from, and in addition to, Dr. Guneratne's medical records for his patients;

g. Dr. Guneratne shall maintain legible medical records which accurately reflect his evaluation and treatment of his patients. In addition to any other relevant medical information, these records shall contain: a comprehensive history; physical examination as indicated; the patient's chief complaint or present illness; the diagnosis and treatment with data or findings which support the diagnosis and treatment; and in cases where controlled substances have been prescribed, dispensed or administered, the rationale for using the controlled substances as well as the amount, strength and directions for use of the controlled substance;

h. Dr. Guneratne shall, at his expense, have quarterly meetings with a monitoring physician who shall review Dr. Guneratne's controlled substance prescribing practice. This monitoring physician shall review Dr. Guneratne's written record of controlled substances which have been prescribed, dispensed or administered and shall randomly review selected medical records and evaluate whether Dr. Guneratne's prescribing practice and medical care comport with generally accepted standards of medical practice. This monitoring physician shall be selected by Dr. Guneratne and is subject to the approval of the Director of the Office of Professional Medical Conduct. The monitoring physician shall submit quarterly reports to the Director

of the Office of Professional Medical Conduct;

i. Dr. Guneratne shall complete at least 50 credit hours of Category I continuing medical education in internal medicine and/or family practice during each of the next two years. At least 15 credit hours each year shall be in courses which include substantial discussion about the proper use of controlled substances. Dr. Guneratne shall submit written proof of successful completion of CME courses to the Director of the Office of Professional Medical Conduct within 10 days of such successful completion;

j. Dr. Guneratne shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of non-compliance. These declarations should be sent to the Director of the Office of Professional Medical Conduct at the address indicated above;

k. Dr. Guneratne shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If Dr. Guneratne elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact; and

2. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

ORDER OF THE COMMISSIONER OF EDUCATION OF THE STATE OF NEW YORK

FRANKLIN P. GUNERATNE

CALENDAR NO. 11244

The University of the State of New York

IN THE MATTER

OF

FRANKLIN P. GUNERATNE
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11244

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11244, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (January 23, 1991): That, in the matter of FRANKLIN P. GUNERATNE, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 78 findings of fact, conclusions as to the question of respondent's guilt, and recommendation as to the measure of discipline be accepted, and the Commissioner of Health's recommendation as to those findings of fact, conclusions, and recommendation be accepted;
2. Respondent is guilty, by a preponderance of the evidence, of the first, second, fourth, and fifth specifications of the charges, and not guilty of the remaining charges; and
3. Respondent's license to practice as a physician in the State of New York be suspended for two years upon each specification of the charges of which respondent was found guilty, said suspensions to run concurrently, that execution of said suspensions be stayed, and respondent

be placed on probation for two years under the terms more specifically prescribed by the Regents Review Committee; and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 31st day of January, 1991.

Thomas Sobol

Commissioner of Education