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

April 12, 1990

Gerald W. Arthur, Physician
110 East 63rd Street
New York, N.Y. 10021

Re: License No. 075343

Dear Dr. Arthur:

Enclosed please find Commissioner's Order No. 10390. 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:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: George Weinbaum, Esq.
3 Barker Avenue
White Plains, N.Y.

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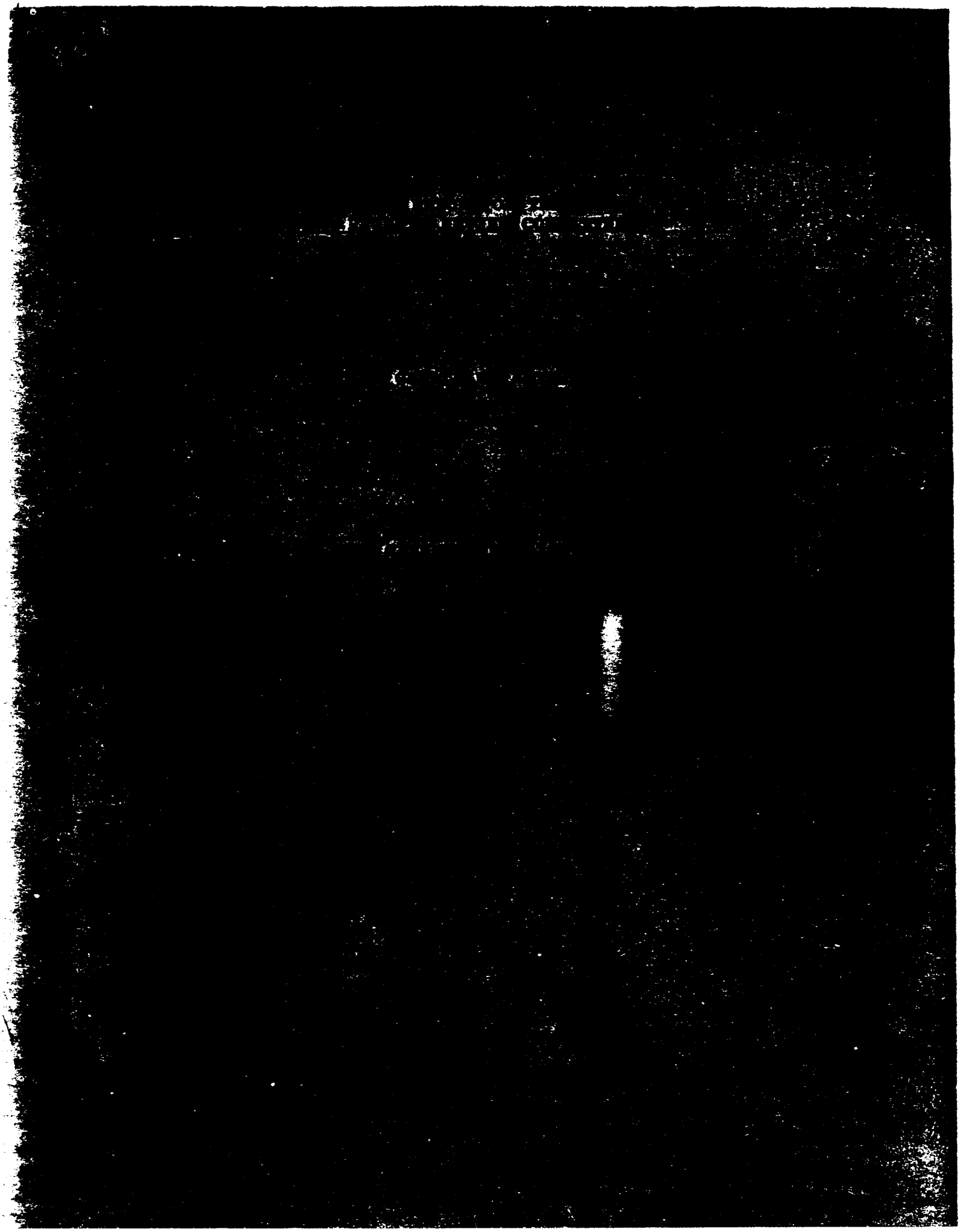
Office of Professional
Medical Conduct



The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

GERALD W. ARTHUR, M.D. **No. 10390**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

GERALD W. ARTHUR, 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. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

On March 15, 1989, April 19, 1989, and May 17, 1989, a hearing was held before a hearing committee of the State Board for Professional Medical Conduct.

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 name of a patient, referred to in the statement of charges as patient A was

unnecessarily used in the listing of witnesses, and is redacted at page 2 of said report. The hearing committee found and concluded that respondent was guilty of the twenty-fifth through the thirty-fourth specifications to the extent indicated by the hearing committee and was not guilty of the remaining charges, and recommended that respondent's medical practice be limited to the practice of dermatology, his privileges to prescribe any controlled substances be revoked, and he be censured and reprimanded as to respondent's failure to maintain adequate medical records, namely, the twenty-seventh through thirty-fourth specifications.

The Commissioner of Health recommended to the Board of Regents that the findings and conclusions of the hearing committee be accepted, the recommendation of the hearing committee be rejected, and respondent's license to practice be suspended for two years and such suspension stayed provided respondent comply with the standard terms of probation, and provided further that during such period respondent's practice be monitored with reports on a quarterly basis. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On December 20, 1989, respondent appeared before us and was represented by his attorney George Weinbaum, Esq., who presented oral argument on behalf of respondent. Terrence Sheehan, Esq., presented oral argument on behalf of the Department of Health.

Both petitioner and respondent recommended before us that the recommendation of the Commissioner of Health be accepted.

We have considered the record in this matter as transferred by the Commissioner Health.

The hearing committee noted that respondent's incompetence is evidenced by a "failure to obtain appropriate consultation and adequate work-up and evaluation", although the charges did not allege such failure. Our recommendation as to respondent's guilt is limited to the findings and conclusions in regard to that which has been charged.

The penalty recommended by the hearing committee is not authorized by law, except as to the recommended censure and reprimand.

We recommend the following to the Board of Regents:

1. The 31 findings of fact and the conclusions of the hearing committee and the recommendation of the Commissioner of Health as to those findings and conclusions be accepted, except the note in the hearing committee report on pages 12 and 13 not be accepted to the extent it refers to a "failure to obtain appropriate consultation and adequate work-up and evaluation";
2. Respondent be found, by a preponderance of the evidence, guilty of the twenty-seventh through thirty-fourth specifications, guilty to the extent indicated by the hearing committee of the twenty-fifth and twenty-sixth specifications except insofar as the hearing committee

refers to "a failure to obtain appropriate consultation and adequate work-up and evaluation", and not guilty of the remaining charges.

3. The recommendation of the hearing committee be rejected;

4. The recommendation of the Commissioner of Health as to the measure of discipline be modified; and

5. In agreement with the substance of the recommendation of the Commissioner of Health, 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, as aforesaid, said suspensions to run concurrently, and the execution of said suspension be stayed and respondent placed on probation for two years under the terms, which include monitoring regarding respondent's prescription practices, set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D".

Respectfully submitted,

EMLYN I. GRIFFITH

JAME M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith

Chairperson

Dated: 2/27/90

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
GERALD W. ARTHUR, M.D.	:	CHARGES

----------X

GERALD W. ARTHUR, M.D., the Respondent, was authorized to practice medicine in New York State on September 24, 1954 by the issuance of license number 075343 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 at 110 East 63rd Street, New York, New York 10022.

FACTUAL ALLEGATIONS

A. Between on or about September 30, 1983 and on or about January 20, 1988, Respondent, a dermatologist, treated Patient A for various dermatologic conditions at his office at 110 East 63rd Street, New York, New York 10022.

1. During that period, Respondent issued to Patient A approximately 36 prescriptions for psychotropic

medications, including Placidyl, Ativan, Halcion, and Lotusate, without medical indication.

2. Respondent failed to take precautions to prevent causing or perpetuating an addiction or habituation by Patient A to the psychotropic drugs Respondent prescribed.

3. In or about 1985, a friend of Patient A contacted Respondent and asked Respondent to stop prescribing Placidyl and Lotusate to Patient A because Patient A was addicted to these substances.

4. On or about January 15, 1988, Patient A attempted suicide by taking 60 tablets of Lotusate along with alcohol. He was admitted to St. Lukes/Roosevelt Medical Center, New York, New York, and recovered.

5. Respondent failed to record patient complaints, history, diagnoses or treatment plans pertaining to the psychotropic medications he prescribed.

6. The prescriptions for psychotropic medications Respondent issued to Patient A were issued not in good faith and not in the course of regular professional practice.

B. Between on or about September 7, 1984 and on or about December 29, 1987 Respondent treated Patient B at his office.

1. During that period, Respondent issued to Patient B approximately 57 prescriptions for psychotropic medications, including Lotusate, Valium and Didrex, without medical indication.

2. Respondent failed to take precautions to prevent causing or perpetuating an addiction or habituation by Patient B to the psychotropic drugs Respondent prescribed.

3. Respondent failed to record patient complaints, history, diagnoses or treatment plans pertaining to the psychotropic medications he prescribed.

4. During the three years Respondent treated Patient B, on a monthly basis, the only medical entries in Patient B's chart, aside from a listing of psychotropic drugs prescribed to Patient B, is the word "eczema" recorded on the visit of December 10, 1987 and the phrase "note injury cystitis" on the visit of June 17, 1987. No physical examinations, histories or treatment are recorded for these conditions.

5. The prescriptions for psychotropic medications Respondent issued to Patient B were issued not in good faith and not in the course of regular professional practice.

C. Between on or about August 20, 1980 and on or about April 16, 1987, Respondent treated Patient C for various dermatologic conditions at his office.

1. During that period Respondent issued to Patient C approximately 48 prescriptions for psychotropic medications, including Tuinal, Lotusate, Didrex, Valium and Placidyl, without medical indication.

2. Respondent failed to take precautions to prevent causing or perpetuating an addiction or habituation by Patient C to the psychotropic drugs Respondent prescribed.

3. Respondent failed to record patient complaints, history, diagnoses or treatment plans pertaining to the psychotropic medications he prescribed.

4. The prescriptions for psychotropic medications Respondent issued to Patient C were issued not in good

faith and not in the course of regular professional practice.

D. Between on or about January 21, 1983 and on or about April 16, 1987. Respondent treated Patient D for various dermatologic conditions at his office.

1. During that period Respondent issued to Patient D approximately 32 prescriptions for psychotropic medications, including Lotusate, Placidyl and Valium without medical indication.

2. Respondent failed to take precautions to prevent causing or perpetuating an addiction or habituation by Patient D to the psychotropic drugs Respondent prescribed.

3. Respondent failed to record patient complaints, history, diagnoses or treatment plans pertaining to the psychotropic medications he prescribed.

4. The prescriptions for psychotropic medications Respondent issued to Patient D were issued not in good faith and not in the course of regular professional practice.

E. Between on or about December 8, 1986 and on or about March 17, 1988, Respondent treated Patient E for various dermatologic conditions at his office.

1. During that period Respondent issued to Patient E approximately 48 prescriptions for psychotropic medications, including Placidyl, Didrex, Lotusate, Valium, and Tylenol with Codeine, without medical indication.

2. Respondent failed to take precautions to prevent causing or perpetuating an addiction or habituation by Patient E to the psychotropic drugs Respondent prescribed.

3. Respondent failed to record patient complaints, history, diagnoses or treatment plans pertaining to the psychotropic medications be prescribed.

4. The prescriptions for psychotropic medications Respondent issued to Patient E were issued not in good faith and not in the course of regular professional practice.

F. Between on or about January 30, 1985 and on or about July 20, 1987, Respondent treated Patient F for various dermatologic conditions at his office.

1. During that period Respondent issued to Patient F approximately 57 prescriptions for psychotropic medications, including Lotusate, Ativan, Didrex and Valium, without medical indication.

2. Respondent failed to take any precautions to prevent causing or perpetuating an addiction or habituation by Patient F to the psychotropic drugs Respondent prescribed.

3. Respondent failed to record any patient complaints, history, diagnoses or treatment plans pertaining to the psychotropic medications he prescribed.

4. The prescriptions for psychotropic medications Respondent issued to Patient F were issued not in good faith and not in the course of regular professional practice.

G. Between on or about December 6, 1977 and on or about April 6, 1988, Respondent treated Patient G for various dermatologic conditions at his office.

1. During that period Respondent issued to Patient G approximately 66 prescriptions for psychotropic medications, including Tuinal, Valium, Ativan, Didrex, Librium, Lotusate and Empirin with Codeine without medical indication.

2. Respondent failed to take any precautions to prevent causing or perpetuating an addiction or habituation by Patient G to the psychotropic drugs Respondent prescribed.

3. Respondent failed to record any patient complaints, history, diagnoses or treatment plans pertaining to the psychotropic medications he prescribed.

4. The prescriptions for psychotropic medications Respondent issued to Patient G were issued not in good faith and not in the course of regular professional practice.

H. Between on or about February, 1987 and on or about September 26, 1987, Respondent treated Patient H for dermititis at his office.

1. During that period Respondent issued to Patient H approximately 12 prescriptions for psychotropic

medications, including Lotusate and Didrex, without medication indication.

2. Respondent failed to take any precautions to prevent causing or perpetuating an addition or habituation by Patient H to he psychotropic drugs Respondent prescribed.

3. Respondent failed to record any patient complaints, history, diagnoses or treatment plans pertaining to the psychotropic medications he prescribed.

4. The prescriptions for psychotropic medications Respondent issued to Patient H were issued not in good faith and not in the course of regular professional practice.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH SPECIFICATIONS

PRACTICING FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges:

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

NINTH THROUGH SIXTEENTH SPECIFICATIONS

Practicing with gross negligence

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges:

9. The facts in paragraphs A and A.1-A.4.
10. The facts in paragraphs B and B.1, B.2.
11. The facts in paragraphs C and C.1, C.2.
12. The facts in paragraphs D and D.1, D.2.
13. The facts in paragraphs E and E.1, E.2.
14. The facts in paragraphs F and F.1, F.2.
15. The facts in paragraphs G and G.1, G.2.
16. The facts in paragraphs H and H.1, H.2.

SEVENTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS

Practicing with gross incompetence

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges:

17. The facts in paragraphs A and A.1- A.4
18. The facts in paragraphs B and B.1, B.2.
19. The facts in paragraphs C and C.1, C.2.
20. The facts in paragraphs D and D.1, D.2.
21. The facts in paragraphs E and E.1, E.2.
22. The facts in paragraphs F and F.1, F.2.
23. The facts in paragraphs G and G.1, G.2.
24. The facts in paragraphs H and H.1, H.2.

TWENTY-FIFTH SPECIFICATION

Practicing with negligence on more than one occasion

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section

6509(2)(McKinney 1985), in that Petitioner charges Respondent with having committed at least two of the following:

25. The facts in paragraphs A and A.1 - A.4, B and B.1, B.2, C and C.1, C.2, D and D.1, D.2, E and E.1, E.2, F and F.1, F.2, G and G.1, G.2 and H and H.1 and H.2.

TWENTY-SIXTH SPECIFICATION

Practicing with incompetence on more than one occasion

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6509(2)(McKinney 1985) in that Petitioner charges Respondent with having committed at least two of the following:

26. The facts in paragraphs A and A.1 - A.4, B and B.1, B.2, C and C.1, C.2, D and D.1, D.2, E and E.1, E.2, F and F.1, F.2, G and G.1, G.2 and H and H.1, H.2.

COMMITTING UNPROFESSIONAL CONDUCT AS DEFINED BY THE BOARD OF REGENTS

TWENTY-SEVENTH THROUGH THIRTY-FOURTH SPECIFICATIONS

Respondent is charged with unprofessional conduct under N.Y Educ. Law Section 6509(9)(McKinney 1985), in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient within the meaning of 8 N.Y.C.R.R. 29.2(a)(3)(1981), in that Petitioner charges:

27. The facts in paragraph A.5.
28. The facts in paragraph B.3 and B.4
29. The facts in paragraph C.3
30. The facts in paragraph D.3.
31. The facts in paragraph E.3
32. The facts in paragraph F.3
33. The facts in paragraph G.3
34. The facts in paragraph H.3

THIRTY-FIFTH SPECIFICATION

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6509(9)(McKinney 1985), in that he engaged in conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

35. The facts in paragraph A.6, B.5, C.4, D.4, E.4, F.4, G.4 and H.4.

DATED: Albany, New York
January 24, 1989

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
GERALD W. ARTHUR, M.D.	:	COMMITTEE

----------X

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

George Hyams, M.D., Chairman, George C. Simmons, Ed.D., and Karl R. Paley, M.D., 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. Michael P. McDermott, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

Notice of Hearing and Statement of Charges Dated:	January 24, 1989
Answer to the Statement of Charges Dated:	March 1, 1989
Hearing Dates:	March 15, 1989 April 19, 1989 May 17, 1989
Place of Hearing:	NYS Department of Health 8 East 40th Street New York, New York 10016

Final Deliberations:	May 24, 1989 August 2, 1989
Department of Health Appeared By:	Peter J. Millock, Esq. General Counsel By: Terrence Sheehan, Esq. Associate Counsel, of Counsel
Respondent Appeared By:	George Weinbaum, Esq. 3 Barker Avenue White Plains, NY 10601

WITNESSES

Witnesses for the Department

1. Robert A. Greenberg, M.D.
2. Barbara Yanofsky, D.E.A.
3. Paul Scher, Sr. Investigator, OPMC

Witnesses for the Respondent

1. Wayne Merrill Paquette
2. Dennis Vincent Sciurba
3. Glen Boles, Ph.D.
4. Eduardo Zappi, M.D.
5. Manuel Lopez
6. Paul Lewis Hecht
7. John Voget
8. Alvin R. Yapalater, M.D.

STATEMENT OF CHARGES

The Statement of Charges alleges that the Respondent practiced the profession fraudulently; with gross negligence; with gross incompetence; with negligence on more than one occasion; with incompetence on more than one occasion; and with unprofessional conduct in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient; and in that he engaged in conduct in the practice of medicine which evidences moral unfitness to practice medicine.

The charges against the Respondent are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACTS

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript pages unless otherwise noted. These citations represent evidence found persuasive by the Hearing Committee while arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Findings were reached by unanimous vote except where noted otherwise.

1. GERALD W. ARTHUR, M.D., the Respondent, was authorized to practice medicine in New York State on September 24, 1954 by the issuance of license number 075343 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 at 110 East 63rd Street, New York, New York 10022.

2. On April 22, 1988, the Respondent submitted a "Voluntary Surrender of Controlled Substances Privileges" to the Federal Drug Enforcement Administration as a result of an investigation by that agency concerning the Respondent's treatment of Patient "A." (Petitioner's Exs. 15 and 16; Tr. 172-176, 199-203).

As to Patient A

3. The Respondent, a dermatologist, treated Patient A for various dermatological conditions during the period September

1983 to September 1985 and again during the period June 1986 to January 1988, at his office at 110 East 63rd Street, New York, New York.

4. During those periods the Respondent issued approximately 36 prescriptions for psychotropic medications to Patient A. These medications included Placidyl, Ativan, Halcion and Lotusate and were frequently prescribed at the same time (Petitioner's Exs. 2 and 10).

5. There is nothing in Patient A's medical record which notes the patient's history and complaints nor the Respondent's diagnosis and treatment plan pertaining to the psychotropic medications which were prescribed.

6. Patient A is an admitted homosexual whose lover died of AIDS in April 1987. Patient A developed AIDS anxiety and states that he discussed this condition often with the Respondent. (Tr. 274-275).

7. In July 1987, Patient A sustained multiple fractures when he was struck by a taxicab and required hospitalization. (Petitioner's Ex. 11, Pg. 14; Tr. 276-277).

8. On January 15, 1988, Patient A attempted suicide by ingesting 60 Lotusate tablets along with alcohol. He was admitted to St. Luke's/Roosevelt Medical Center, New York, New York. (Petitioner's Ex. 11).

9. The St. Luke's/Roosevelt Medical Records for Patient A records "Apparently he was seen by another physician in October 1987 at which time he was told he was positive to HIV-AB test and

two weeks ago he was told of a toxo infection." The record continues, "Patient has a long history of drug abuse and has been seriously depressed since his lover's death - but has been resistant to any psychiatric intervention and over the past month he has been consuming 4-5 quarts liquor/week and varying amounts of barbiturates, codeine, cocaine (snorting) and Ativan." (Petitioner's Ex. 11; Pg. 15).

As to Patient B

10. During the period September 7, 1984 to December 29, 1987 the Respondent treated Patient B at his office. (Petitioner's Ex. 3).

11. During that period, the Respondent issued approximately 57 prescriptions for psychotropic medications to Patient B. These medications included Lotusate, Valium and Didrex and were frequently prescribed at the same time. (Petitioner's Ex. 3).

12. There is nothing in Patient B's medical record which notes the patient's history and complaints nor the Respondent's diagnosis and treatment plan pertaining to the psychotropic medications which were prescribed. (Petitioner's Ex. 3).

13. During the three years that the Respondent treated Patient B on a monthly basis, the only medical entries in Patient B's chart, aside from a listing of psychotropic drugs prescribed to Patient B, is the word "eczema" recorded on the visit of

December 10, 1984 and the phrase "note for jury - cystitis" on the visit of June 17, 1987. No physical examinations, histories or treatment are recorded for these conditions.

As to Patient C

14. The Respondent treated Patient C for various dermatological conditions during the period August 20, 1980 to April 16, 1987 at his office. (Petitioner's Ex. 14).

15. During that period, the Respondent issued approximately 48 prescriptions for psychotropic medications to Patient C. These medications included Tuinal, Lotusate, Didrex, Valium and Placidyl and were frequently prescribed at the same time. (Petitioner's Ex. 4).

16. There is nothing in Patient C's medical record which notes the patient's history and complaints nor the Respondent's diagnosis and treatment plan pertaining to the psychotropic medications which were prescribed. (Petitioner's Ex. 4).

As to Patient D

17. The Respondent treated Patient D for various dermatological conditions during the period January 21, 1983 to April 16, 1987 at his office. (Petitioner's Ex. 5).

18. During that period, the Respondent issued Approximately 32 prescriptions for psychotropic medications to Patient D. These medications included Lotusate, Placidyl and

Valium and were frequently prescribed at the same time. (Petitioner's Ex. 5).

19. There is nothing in Patient D's medical record which notes the patient's history and complaints nor the Respondent's diagnosis and treatment plan pertaining to the psychotropic medications which were prescribed. (petitioner's Ex. 5).

As to Patient E

20. The Respondent treated Patient E for various dermatological conditions during the period December 8, 1986 to March 17, 1988 at his office. (Petitioner's Ex. 6).

21. During that period, the Respondent issued approximately 48 prescriptions for psychotropic medications to Patient E. These medications included Placidyl, Didrex, Lotusate, Valium and Tylenol with Codeine and were frequently prescribed at the same time. (Petitioner's Ex. 6).

22. There is nothing in Patient E's medical record which notes the patient's history and complaints nor the Respondent's diagnosis and treatment plan pertaining to the psychotropic medications which were prescribed. (Petitioner's Ex. 6).

As to Patient F

23. The Respondent treated Patient F for various dermatological conditions during the period January 30, 1985 to July 20, 1987 at his office. (Petitioner's Ex. 7).

24. During that period, the Respondent issued approximately 57 prescriptions for psychotropic medications to Patient F. These medications included Lotusate, Ativan, Didrex and Valium and were frequently prescribed at the same time. (Petitioner's Ex. 7).

25. There is nothing in Patient F's medical record which notes the patient's history and complaints nor the Respondent's diagnosis and treatment plan pertaining to the psychotropic medications which were prescribed. (Petitioner's Ex. 7).

As to Patient G

26. The Respondent treated Patient G for various dermatological conditions during the period December 6, 1977 to April 6, 1988 at his office. (Petitioner's Ex. 8).

27. During the period November 1982 to April 6, 1988, the Respondent issued approximately 52 prescriptions for psychotropic medications to Patient G. These medications included Lotusate, Ativan, Didrex and Valium and were frequently prescribed at the same time. (Petitioner's Ex. 8).

28. There is nothing in Patient G's medical record which notes the patient's history and complaints nor the Respondent's diagnosis and treatment plan pertaining to the psychotropic medications which were prescribed during the period November 1982 to April 6, 1988.

As to Patient H

29. The Respondent treated Patient H for dermatitis during the period February, 1987 to September 26, 1987 at his office. (Petitioner's Ex. 9).

30. During that period, the Respondent issued approximately 12 prescriptions for psychotropic medications to Patient H. These medications included Lotusate and Didrex. (Petitioner's Ex. 9).

31. There is nothing in Patient H's medical record which notes the patient's history and complaints nor the Respondent's diagnosis and treatment plan pertaining to the psychotropic medications which were prescribed.

CONCLUSIONS

A review of all of the Respondent's medical records for Patients A, B, C, D, E, F, G and H revealed gross deficiencies in recording significant medical information and indications for the use of psychotropic medications.

Almost invariably annotations relating to dermatological problems were recorded.

The Hearing Committee was disturbed by the consistent use of psychotropic medications over long periods of time, very often with inappropriately excessive initial dosages, e.g. Placidyl in 750 mg. daily. Patient G, a 22 year old male, received a prescription for Tuinal 3 gr. on his initial visit. Evidence of dosage tapering was almost universally lacking.

The use of Didrex was never supported by any evidence of weight management and was continued over long periods without medical explanation.

In all cases laboratory tests were either absent or deficient. Physical examinations were limited to superficial and scanty notations.

In all cases the Respondent failed to take any precautions to prevent causing or perpetuating addiction or habituation by the patients involved. There is no evidence of any attempt to reduce dependence on psychotropic medications by lowering dosage or discontinuing medications.

The Respondent's failure to testify on his own behalf left the panel without any understanding of his methods of medical practice.

All physicians have the obligation to maintain adequate records that explain the rationale of diagnosis and treatment.

In complicated problems, physicians have the further obligation to utilize the expertise of other disciplines.

The concept that only a physician who is himself a homosexual can understand the medical problems of the gay community is fallacious. Compassion for patients and their problems, whether physical or emotional, should be, and is in most instances, the hallmark of competent medical practice.

In this case the expert testimony for the Respondent was unconvincing. Dr. Glen Boles, who is a psychologist cannot himself issue prescriptions. He testified that in situation where

he felt that the patient needed medication, he would refer the patient to a psychiatrist. The testimony of Dr. Alvin R. Yapalater was inconsistent and unpersuasive.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously (3-0) as follows:

First through Eight Specifications -- NOT SUSTAINED.

Ninth through Sixteenth Specifications -- NOT SUSTAINED.

Seventeenth through Twenty-Fourth Specifications -- NOT SUSTAINED.

Twenty-Fifth Specification - SUSTAINED.

Twenty-Sixth Specification - SUSTAINED.

Twenty-Seventh Specification through Thirty-Fourth Specification - SUSTAINED.

Thirty-Fifth Specification - NOT SUSTAINED.

HEARING COMMITTEE'S NOTE WITH REGARD TO ITS VOTE ON THE TWENTY-SIXTH SPECIFICATION:

The Respondent's incompetence evidenced itself whenever he went beyond the scope of his specialty in dermatology. Although the Hearing Committee recognizes that there is an interweaving of multiple disciplines in the care of all patients, the Respondent's charts failed to communicate any real comprehension of his patients complex needs as evidenced by a

failure to obtain appropriate consultation and adequate work-up and evaluation.

RECOMMENDATIONS

The Hearing Committee recommends unanimously (3-0) that the Respondent's medical practice be limited to the practice of dermatology and that his privileges to prescribe any controlled substances by REVOKED.

The Hearing Committee further recommends unanimously (3-0) that the Respondent be censured and reprimanded for his failure to maintain adequate medical records.

In view of the fact that the Respondent's capabilities as a dermatologist have not been questioned, the Hearing Committee does not feel that depriving the public of the Respondent's services in that discipline would serve any useful purpose.

DATED: Albany, New York
, 1989

Respectfully submitted,

George Hyams M.D.

GEORGE HYAMS, M.D., Chairman

George C. Simmons, Ed.D.
Karl R. Paley, M.D.

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

IN THE MATTER	:	COMMISSIONER'S
OF	:	RECOMMENDATION
GERALD W. ARTHUR, M.D.	:	

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

A hearing in the above-entitled proceeding was held on March 15, 1989, April 19, 1989 and May 17, 1989. Respondent, Gerald W. Arthur, M.D., appeared by George Weinbaum, Esq. The evidence in support of the charges against the Respondent was presented by Terrence Sheehan, 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 rejected and, in lieu thereof, Respondent's license to practice should be suspended for two years and such suspension stayed provided that Respondent comply with the standard terms of probation and provided further that during such period that Respondent's practice be monitored by a licensed physician approved in advance by Office of Professional Medical Conduct (OPMC). The monitoring physician should be obliged to report on a quarterly

EXHIBIT "D"
TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

GERALD W. ARTHUR

CALENDER NO. 10390

1. That, during the period of probation, respondent shall have respondent's practice monitored, at respondent's expense, in regard to the propriety and appropriateness of respondent's prescription practices as follows:

   a. That said monitoring shall be by a physician selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   b. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient, office, and prescription records as aforesaid, and respondent shall also be required to make such records available to said monitor at any time requested by said monitor;

   c. That respondent's prescription practices must be proper and appropriate for respondent to be in compliance with these terms of probation; and

   d. That said monitor shall submit a report, once every four months, regarding the above-mentioned monitoring of respondent's practice to the Director of the Office of Professional Medical Conduct;

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

GERALD W. ARTHUR

CALENDAR NO. 10390

The University of the State of New York

IN THE MATTER

OF

GERALD W. ARTHUR
(Physician)

DUPLICATE
ORIGINAL
VOTE AND ORDER
NO. 10390

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10390, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (March 23, 1990): That, in the matter of GERALD W. ARTHUR, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The 31 findings of fact and the conclusions of the hearing committee and the recommendation of the Commissioner of Health as to those findings and conclusions be accepted, except the note in the hearing committee report on pages 12 and 13 not be accepted to the extent it refers to a "failure to obtain appropriate consultation and adequate work-up and evaluation";
2. Respondent is, by a preponderance of the evidence, guilty of the twenty-seventh through thirty-fourth specifications, guilty to the extent indicated by the hearing committee of the twenty-fifth and twenty-sixth specifications except insofar as the hearing committee refers to "a failure to obtain appropriate consultation and adequate work-up and evaluation", and not guilty of the remaining charges;

3. The recommendation of the hearing committee be rejected;
4. The recommendation of the Commissioner of Health as to the measure of discipline be modified; and
5. In agreement with the substance of the recommendation of the Commissioner of Health, 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 is guilty, as aforesaid, said suspensions to run concurrently, and the execution of said suspension be stayed and respondent placed on probation for two years under the terms prescribed by the Regents Review Committee, which include monitoring regarding respondent's prescription practices;

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 30th day of March 1990.

Thomas Sobol

Commissioner of Education