STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 9, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Claudia Morales Bloch, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
Albany, New York 12237

Jacob Harris, M.D.
359 Main Street
Mount Kisco, New York 10549

William W. Wood, Esq.
Wood and Scher
The Harwood Building
Scarsdale, New York 10583

RE: In the Matter of Jacob Harris, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-96) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

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

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

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

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

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER

OF

JACOB HARRIS, M.D.

RESPONDENT

DECISION

AND

ORDER

OF THE

HEARING COMMITTEE

COPY

ORDER NO.
BPMC 03-96

The undersigned Hearing Committee consisting of **WALTER M. FARKAS, M.D.,** CHAIRPERSON, **THOMAS O. MULDOON, M.D.**, and **Mr. JAMES J. DUCEY** was duly designated and appointed by the State Board for Professional Medical Conduct. **Hon. JONATHAN M. BRANDES,** Administrative Law Judge, presided as Administrative Officer.

The hearing was conducted pursuant to the provisions of Section 230(10) of the New York State Public Health Law and Sections 301-307 and 401 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **JACOB HARRIS, M.D.** (hereinafter referred to as "Respondent").

The State Board for Professional Medical Conduct (hereinafter referred to as "Petitioner" or "The State") appeared by **DONALD P. BERENS, Jr.** General Counsel by **CLAUDIA MORALES BLOCH, ESQ.** Associate Counsel, Bureau of Professional Medical Conduct New York, New York 10001. Respondent appeared in person and was represented by **WILLIAM L. WOOD, ESQ.,** of counsel to Wood and Scher, The Harwood Building, Scarsdale NY 10583

RECORD OF PROCEEDING

Notice of Hearing and Statement of Charges Signed:	March 7, 2002
Notice of Hearing returnable:	April 11, 2002
Location of Hearing:	5 Penn Plaza New York, NY10001
Respondent's answer dated:	April 23, 2002
Respondent was authorized to practice medicine in New York State:	May 31, 1967
Respondent's Address:	359 Main Street #3a Mount Kisco, NY 10549
Respondent's License Number:	098756
Pre-Hearing Conference Held:	April 3, 2002
Hearings held on:	May 16, June 4, 28, July 11 and August 15 2002
Conferences held on:	April 3, May 16, June 4, 28, July 11 and August 15 2002

SUMMARY OF PROCEEDINGS

The Statement of Charges in this proceeding alleges twenty one grounds of misconduct:

Specification Number	Allegation
First	Violation of N.Y. Educ. Law §6530(3). Practicing in a negligent manner on more than one occasion;
Second	Violation of N.Y. Educ. Law §6530(4.) Practicing medicine with incompetence on more than one occasion;
Third through Eighth	Violation of N.Y. Educ. Law §6530(4). Practicing medicine with gross negligence
Ninth specification	Violation of N.Y. Educ. Law §6530(6) practicing medicine with gross incompetence.
Tenth through Fifteenth specification:	Violation of N.Y. Educ. Law §6530(35) by ordering excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient.
Sixteenth through Twenty-First specification	Violation of N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient

The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One. Respondent submitted a written answer which is attached hereto as Appendix Two

The State called Howard Telson, M.D., as an expert witness.

Respondent testified in his own behalf and called Richard Kaiser, M.D., as an expert witness.

SIGNIFICANT LEGAL RULINGS

There were originally eight patients brought before this Committee. After hearing the evidence on patients A and B, it became clear that the pattern of medical conduct upon which the State had based the charges was the same for each of the eight patients included. Therefore, in the interest of judicial economy, the Administrative Law Judge, upon consultation with the Committee, ruled that the hearing would be limited to the first four patients. The State was limited in its presentation to patients A, B, C and D. The remaining patient charges were not dismissed. They simply were not considered by the Committee herein.

It would be an extreme misunderstanding for any future reviewing body to consider the penalty imposed herein as a function of the number of patients heard as opposed to the number of patients originally charged. This decision will show the substandard and dangerous pattern of practice developed by the State against Respondent would warrant revocation were it established for four or forty patients. That is, it is the seriousness of the pattern of misconduct which established the findings and conclusions, not the number of patients reviewed. Given the virtually identical nature of the remaining charges, they would simply have been redundant rather than elucidative to have heard all eight patients.

The findings of fact in this decision were made after review of the entire record. Numbers in parentheses (T._) refer to transcript pages or numbers of exhibits (Ex._) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony may have been rejected as irrelevant.

The standard of proof in this proceeding is "preponderance of the evidence". This means that the State must prove the elements of the charges to a level wherein the trier of fact finds that a given event is more likely than not to have occurred. All findings of fact made herein by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

Instructions proposed by the parties were considered by the Administrative Law Judge. None of the proposals was deemed to warrant any change to the "Standard Instructions" distributed by the Administrative

Law Judge to counsel. The proposed instructions and all other persuasive documents submitted by the parties are considered part of the record herein whether received in evidence or submitted as a motion, brief, etc.

GENERAL FINDINGS OF FACT

1. For the entire period of time in the following allegations, Respondent maintained a psychiatric office at 359 East Main Street, #3 A, Mount Kisco, New York. Respondent treated Patients A through D at this office.

2. Respondent was authorized to practice medicine in New York State on May 31, 1967, by the issuance of license number 098756 by the New York State Education Department. (Ex. 2)

3. For the entire period of time charged by the Department in the Statement of Charges, Respondent maintained a psychiatric office practice and saw Patients A through D at his office located at 359 East Main Street, #3A, Mount Kisco, New York. (Ex. 1)

4. According to accepted standards of the practice of psychiatry[1] a patient record must, at a minimum, include:

   A. Notation of an initial comprehensive patient evaluation;
   B. Issues of the chief complaint
   C. A psychiatric history
   D. A mental status evaluation;
   E. A medical, social, substance abuse and educational history

[1] All statements which follow refer to accepted standards of medicine as established by the testimony and evidence herein. Each statement is designed to articulate acts required by accepted standards of medicine.

5. An entry in the record must be made for each visit or telephone contact with the patient The entry must contain some record of the patient's subjective report, objective findings by the psychiatrist, mental status findings and an assessment and plan of treatment. (T. 46-48)

6. An entry in the record must be made each time medication is prescribed. This notation must include dosage and instructions. (T. 48)

7. A mental status examination is a structured format for a psychiatrist to describe specific characteristics of a patient, including behavior, feelings and thinking, and any significant findings of psycho-pathology and any significant negative findings. (T. 48)

8. A clinical assessment of the patient and a diagnosis must be made before the initiation of treatment. (T. 48)

9. Reassessment of the diagnosis and the effectiveness of treatment is done on an ongoing process throughout the length of time the patient remains under a psychiatrist's care. (T. 48-50)

10. The standard for scheduling patient sessions for psychopharmacology treatment is weekly until a thorough diagnostic assessment has been made and treatment begins. (T. 48-50)

11. Thereafter, depending on how medications are introduced and any complications or side effects that may occur, a patient must be seen as warranted by the clinical situation. (T. 48-50)

12. Regular visits, closely separated in time, are necessary to assess the effectiveness of treatment, adverse side effects, diagnostic changes, medical status and mental status changes over time. (T. 50-53)

13. When prescribing a potentially addictive medication, a psychiatrist must closely follow the patient to assess any over use of the medication, signs of dependency, dosage changes and effectiveness. (T. 50-53)

14. A psychiatrist must be aware of any substance the patient takes which may be addictive. (T. 53-54)

15. In a typical psychiatric office based practice, a psychiatrist does not take responsibility for the organic care of the patient. The psychiatrist, as part of the initial assessment, should ascertain the patient's organic status, evaluate the potential for an organic cause of the psychiatric symptom(s) presented and note that information in the chart. (T. 54-55)

16. Should a psychiatrist undertake the entire care and treatment of a patient, thereby addressing all medical issues, the psychiatrist's responsibility regarding that care and treatment are the same as those standards applicable to a primary care physician. These include: charting, obtaining a complete history and performing a complete physical examination. (T. 55-57)

FINDINGS OF FACT WITH REGARD TO THE CARE AND TREATEMENT OF PATIENT A

17. Respondent undertook the care and treatment of Patient A from September 10, 1979 through March 16, 1993. (Ex. 4, T. 57-58)

18. When Respondent began the care and treatment of Patient A the patient primarily suffered from depression and a history of paranoid schizophrenia. (Ex. 4, T. 58)

19. Respondent failed to obtain and note an adequate, comprehensive psychiatric and medical history from Patient A. (Ex. 4, T. 58-59)

20. Respondent did not make or record a working diagnosis for Patient A. (Ex. 4, T. 59)

21. The record for Patient A, developed by Respondent, is not consistent with accepted standards for maintaining an accurate record of the care and treatment of a patient as follows:

A. It fails to include an adequate initial evaluation of Patient A;

B. It contains no comprehensive evaluation of psychiatric and medical history and areas of functioning;

C. It contains no complete mental status examination;

D. It fails to appropriately document medications prescribed;

E. There is no assessment of side effects

F. There is no assessment of the effectiveness of treatment.

G. Respondent's record for Patient A is not consistent with the standard format as set Finding of Fact 5#, supra. (Ex. 4, T. 60-63)

22. Respondent's initial entry in his office record for Patient A is dated September 10, 1979. (Ex. 4, pg. 8; T. 63-67)

23. In this record Respondent refers to a previous diagnosis made at Northern Westchester Hospital of paranoid schizophrenia. (Ex. 4, pg. 8; T. 63-67)

24. Respondent fails to conduct and note any current assessment of the previously stated diagnosis. (Ex. 4, pg. 8; T. 63-67)

25. Throughout the course of treatment, Respondent failed to address and note a diagnostic assessment of the patient and a treatment plan. (Ex. 4, pg. 8; T. 63-67)

26. Respondent recorded the patient "gets paranoid" when he cuts down on his medications. However, there is no evidence of an effort to assess what the patient meant when he spoke of paranoia. (Ex. 4, pg. 28; T. 67-70)

Respondent was aware that there had been a pre-treatment diagnosis of paranoid schizophrenia, for this patient. However, Respondent failed to recognize the fundamental presenting problem of paranoia and to assess whether the symptom was part of that diagnosis or as a side effect. (Ex. 4, pg. 28; T. 67-70)

28. Respondent failed to indicate the medications the patient was taking and the plan for reducing medication. He also failed to assess the relationship between the medication and the symptoms presented. He did not articulate a treatment plan. (Ex. 4, pg. 28; T. 67-70)

29. Respondent failed to assess the patient's condition at this time and to differentiate between real problems the patient may be having with his family and paranoid symptoms that are presented. (Ex. 4, pg. 38; T. 70-73)

30. Respondent failed to conduct a thorough assessment of the patient's emotions throughout the course of treatment. This is exemplified in Respondent's failure to assess the patient's mood after having noted on the initial visit "still depressed." (Ex. 4, pg. 8, 25; T. 73-76)

31. It is also demonstrated in the failure to assess the recurrent concerns of the patient over his mother's medical condition and fears of his own well being in light of her condition. (Ex. 4, pg. 8, 25; T. 73-76)

32. Respondent failed to explore the basis for the concerns of the patient. Respondent made no record of an assessment of whether his feelings for his mother's condition and the effect of that condition on him was a result of paranoia or an appropriate response to reality. (Ex. 4, pg. 8, 25; T. 73-76)

33. Respondent did not develop a plan of treatment to address the anxieties and concerns of the patient. (Ex. 4, pg. 8, 25; T. 73-76)

34. Respondent did not in the course of this patient's treatment, record a rational treatment plan. (Ex. 4, pg. 11; T. 77-80)

35. The treatment provided by Respondent was without continuity. (Ex. 4, pg. 11; T. 77-80)

36. In an entry in July, 1986 Respondent indicates that significant events have developed in the patient's life. There is no evidence that these events were addressed or assessed in light of the patient's psychotic disorder. (Ex. 4, pg. 11; T. 77-80)

37. Respondent's patient note indicates that the patient had left his job. He had also left school and had lost his girlfriend. The patient note also indicates his grandfather died. All this occurred in a two week period. Respondent did no assessment of how these environmental changes affected the patient's emotional functioning and the patient's illness. (Ex. 4, pg. 11; T. 77-80)

38. An entry by Respondent in his initial office record note of September 10, 1979, states, "asks for and I agree to antidepressant - (Nortryptaline) Norpramin 75 mg." Other than stating the patient's request for this medication, Respondent failed to provide a rationale medical indication or justification for the prescribing this medication. There is no follow up to this medication by the Respondent. (Ex. 4, pg. 8; T. 80-81).

39. Subsequent to the Norpramin noted on the initial visit, Respondent, does not reference any antidepressants until approximately 12 and a half years later when in a March 23, 1992 visit he merely notes "add Prozac." The Prozac was prescribed at this time without any justification or indication for it's use. Further, Respondent failed to address the patient's complaints of depression after that. (Ex. 4, pg. 33; T. 81-83)

40. The Committee finds that a failure to note a given act or thought by a physician is clear evidence the act was not performed or the thought was not considered.

41. Respondent prescribed Haldol and Prolixin (Stelazine to a lesser degree). These substances are known to cause significant muscular side effects, such as tremor and stiffening. Such side effects can often be uncomfortable to a patient and affect functioning. (T. 91-92, 97)

42. It is very important for a psychiatrist prescribing anti psychotic medication to regularly see the patient and monitor their course on the medication for both its psychiatric effect on the patient as well as any physical effect it may have on the patient. The committee finds that Respondent did not appropriately monitor the patient on Haldol and Stelazine within the accepted standards of care. (T. 91-93)

43. Xanax is a highly addictive anti-anxiety medication. Respondent prescribed Xanax to Patient A and inappropriately allowed the patient to monitor the amounts he was taking. (Ex. 4, pg. 9, T. 97)

44. The committee has before it numerous triplicate prescription forms[2] issued to Patient A by Respondent for Xanax. Respondent failed to document in his office record the specific issuance of

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[2]Official New York State Prescription forms are referred to as "triplicate forms" because unlike other prescription forms, the Official New York State forms have 3 parts.

any prescription for Xanax and the schedule of prescribing the medication. His failure to do so is a departure from accepted standards of practice. (Ex. 4, pg. 42-56; T. 97-98)

45. Respondent was aware that Patient A was taking varying amounts of Xanax.

A. On [10]/7/86, Respondent noted in his office record, "On Xanax 1mg up to 4/d [plus or minus] prolixin 5mg 1-2 day -he knows himself enough to monitor amount he's taking...";

B. On 11/1/86, the next entry, Respondent notes: "Xanax helped me straighten my thoughts out - we are concerned by his use of Xanax up to 10mg/day - he feels better with it than with Valium or Librium or Mellaril - prolixin was acceptable but had side effects he didn't like";

C. Respondent continued to prescribe Xanax. (Ex. 4, pg. 42-56; T. 97-98)

46. There is no evidence Respondent monitored or managed Patient A's risk of addiction and withdrawal from Xanax. (Ex. 4, pg. 42-56; T. 97-98)

47. On 8/20/92, a time when Patient A exhibited signs of paranoia, Respondent noted that, while Respondent was on vacation, the patient had gone to a walk in medical clinic and was prescribed Xanax. (Ex. 4, pg. 42-56; T. 97-98)

48. The conduct by Respondent in the use of Xanax for this patient is a gross departure from accepted standard of care:

A. Respondent demonstrated no recognition of the difficulties found in patients who become addicted or habituated to Xanax. (Ex. 4, pg. 42-56; T. 97-98);

B. Respondent failed to appropriately monitor and/or manage Patient A's risk of addiction;

C. Respondent varied the daily doses of Xanax the patient was taking;

D. Respondent noted, from time to time, that the patient is "trying but not succeeding to decrease his medications."

E. Respondent continued to prescribe large quantities of the medication;

F. Respondent did not have a plan of treatment for withdrawal nor did he evaluate the side effects of withdrawal on the patient. Hence, the risk of addiction and the risks of withdrawal from Xanax were not planned by Respondent within the appropriate standard of care; (T. 116-117)

G. Accepted standards of medicine warrant that the practitioner, where efficatious, try to limit the amount of the medication used by patients;

H. Respondent actually helped perpetuate this patient's dependance upon Xanax rather than help the patient deal with the problem. (Ex. 4, pg. 20, 23, 25, 34, 42-56; T. 109-115)

49. At various times during his care of Patient A, Respondent prescribed Tranxene, Valium and Xanax. (Ex. 4, pg. 33, 34; T. 117-119, 120-121)

50. Tranxene is another anti-anxiety agent in the benzodiazepine family, similar to Valium and Xanax. (Ex. 4, pg. 33, 34; T. 117-119, 120-121)

51. Tranxene, Valium and Xanax have the same addictive potential. (Ex. 4, pg. 33, 34; T. 117-119, 120-121)

52. Although these medication have similar actions, they all have different half lives. (Ex. 4, pg. 33, 34; T. 117-119, 120-121)

53. Respondent failed to appropriately differentiate between the effectiveness of each of these medications in treating the patient. Respondent did not provide a rationale for the various medications in the patient note. (Ex. 4, pg. 33, 34; T. 117-119, 120-121)

54. Respondent prescribed multiple medications to Patient A without evidence of a clear rationale for doing so. (T. 127-128)

55. Respondent evidenced no clear appreciation of the interactions between the medications prescribed and the addictive potential of some of those medications. (T. 127-128)

56. Accepted standards of care require that a treating psychiatrist must assess, on a regular basis, the relationship between the medications prescribed, the treatment recommended and the clinical outcome in a patient. Respondent evidenced no record that he conducted such assessment in his care of Patient A. (T. 129-130)

57. On a number of occasions, most specifically, February 14, 1989, Patient A expressed concern over "decompensating into psychosis".

58. A patient such as Patient A, with a history of paranoid schizophrenia, merits an ongoing assessment of the factors that cause decompensation and psychosis. Respondent failed to conduct any assessment in this regard and he failed to identify symptoms in Patient A that might reflect psychosis, psychotic ideas or a psychotic process.

59. A psychiatrist practicing within accepted standards of medicine would have worked with the patient to identify the best treatment to prevent psychosis including:

A. Evaluation of medications
B. Evaluation of life factors that might either help prevent psychosis or act to exacerbate psychosis.

60. Respondent failed to address any of these issues sufficiently to meet accepted standards of care. (Ex. 4, pg. 17; T. 130-132)

61. Patient A suffered from a respiratory condition and asthma on a number of visits to Respondent. Respondent prescribed erythromycin and ventolin.

62. The patient record refers to instructions that the patient see another physician regarding these medical conditions. However, there is no note to the effect that the patient followed these instructions. There is also no evidence Respondent made a referral or obtained a consultation with a medical physician. These failures are departures from accepted standards of care. (Ex. 4, pg. 13-15, 27; T. 134-138)

63. Once Respondent undertook the care of the patient's respiratory condition, Respondent failed to properly evaluate the patient within accepted standards of care:

A. He did not conduct a full physical examination of the patient;

B. he did not conduct a clinical assessment of the patient;

C. he did not consider and assess whether or not the psychotropic medications respondent was prescribing to Patient A could have been part of the reason for the patient's disrupted respiration threshold. (Ex. 4, pg. 13-15, 27; T. 134-138)

64. Respondent failed to appropriately refer and note a referral for Patient A for medical evaluation and consultation not just for his respiratory complaints but for his respiratory complaints combined with a history of seizure. (T. 134-138)

65. Throughout his care of Patient A, Respondent failed to appropriately assess the patient's potential danger to himself. (T. 1139-140)

66. On October 29, 1992, Patient A reported his thought that someone was coming into his room at night and stealing his money and that he needed prolixin to stop his thoughts from going crazy. He also reported to Respondent that he was "thinking strange thoughts." (Ex. 4, pg. 38, 39)

67. On the next visit of November 10, 1992, Respondent notes that the patient reported "trying to keep [his] sanity - one day at a time," and that he "need[ed] more prolixin." (Ex. 4, pg. 38, 39)

68. On November 11, Respondent reports receiving a telephone call from the patient's mother that she wanted Patient A hospitalized,"but he [didn't] see the need to please Mother in that regard."(Ex. 4, pg. 38, 39)

69. On January 5, 1993, Respondent's office note reads: "Just teetering on edge...feels increased tension ..thinking and worrying about DEATH...hard for him to put in perspective - add Adapin 50mg to prolixin 30mg/d, artane 15mg/d." (Ex. 4, pg. 38, 39)

70. A note dated of January 18, 1993 states: "Had to see him in ER of hospital several days ago in acute anxiety...feels jittery - wanted hospital stay - I suggested he need a few Artane and he'd be alright - so went home - today in more control...fearful of his failing eyesight - he must stop contact!! [contact lenses] Adapin 25mg BID, prolixin 5mg 6/d, Artane 5mg T.I.D.". (Ex. 4, pg. 38, 39)

71. Respondent's actions described above violate fundamental tenets of medical practice:

A. Respondent failed to assess whether the patient had attempted to hurt himself or had a plan to hurt himself;

B. Respondent did not evaluate the sources of support for the patient;

C. Respondent did not formulate a plan of treatment to address this patient's suicidal thinking. (T. 138-140)

72. Respondent violated accepted standards of medicine when he prescribed Adapin, Prolixin and Artane to the patient during this time:

A. Respondent knew the patient to be preoccupied with death;

B. Prescribing these medications without a full assessment of the patient's concerns about death has life threatening potential;

C. The practitioner must examine whether the patient's preoccupation with death is a reflection of a depressive illness, a psychotic disorder or anxiety;

D. These particular medications are known to pose a high risk of death or serious medical problems if a patient were to take an overdose. (T.140-141)

73. In his treatment of Patient A, Respondent:

A. Fails to address fundamental issues of an evaluation of the patient's potential danger to himself;

B. Fails to make an evaluation of the symptoms as depressive or psychotic;

C. Fails to assess the effectiveness of the treatment vis a vis the patient's psycho-pathology;

D. Fails to assess the anxiety experienced by the patient potentially caused by the multiple medications Respondent prescribed;

E. Fails to assess the danger to himself and others around him. (T. 142-144)

74. Respondent failed to appreciate the significance of the patient's emergency room visit and the patient's request for admission to the hospital.. (T. 142-4)

75. Respondent dismissed the concerns of the patient and his family.. (T. 142-4)

76. Under the circumstances presented, a reasonably prudent physician would have seen to it that an assessment of the source of the patient's anxiety was undertaken. (T. 142-4)

77. Prescribing Artane not only does not solve the problem, it falls far outside acceptable medical standards of considering side effects and psychosis. (T. 144-147)

78. Respondent's records for Patient A contain a seven year gap which Respondent cannot account for. (Ex. 7A; T. 683-684)

CONCLUSIONS WITH REGARD TO THE CARE AND TREATEMENT OF PATIENT A[3]

There are ten charges arising from the care and treatment of Patient A. Little, if any comment is required in that Respondent did not so much deny the allegations as try to justify the acts in the allegations. The State has proven by clear and convincing evidence[4] that Respondent:

1. Failed to obtain and/or note an adequate, comprehensive psychiatric and medical history from Patient A.

2. Failed to appropriately obtain and/or note Patient A's relevant psychiatric treatment and history from other health care providers.

3. Failed to perform or note a mental status examination of Patient A and periodic assessment of the patient's diagnosis, symptoms, medication, side effects and treatment.

4. Failed to develop and maintain a treatment plan for Patient A, or to note such a plan.

5. Inappropriately and without acceptable medical indication and/or justification, prescribed and/or maintained Patient A on various medications, to wit:
   A. Norpramin,
   B. Prozac,
   C. Stelazine,
   D. Haldol,
   E. Xanax,
   F. Prolixin,
   G. Valium,
   H. Tranxene,
   I. Adapin,
   J. Artane,
   K. Elavil.

6. Failed to appropriately monitor and/or manage Patient A's risk of addiction and withdrawal from Xanax; or to note same.

7. Failed to appropriately refer or note a referral for Patient A for medical evaluation and consultation.

8. Inappropriately undertook the care and treatment of or managed the care and treatment of Patient A's medical condition, including respiratory condition.

9. Failed to appropriately respond to or assess Patient A's potential danger to himself, and/or to note same.

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[3]All conclusions are based upon the findings of fact which precede them.

[4]A higher standard than is required.

10. Failed to maintain an office record for Patient A in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

Therefore, based upon the Findings of Fact set forth above,

Factual Allegation A. 1. **IS SUSTAINED**
Factual Allegation A. 2. **IS SUSTAINED**
Factual Allegation A. 3. **IS SUSTAINED**
Factual Allegation A. 4. **IS SUSTAINED**
Factual Allegation A. 5. **IS SUSTAINED**
Factual Allegation A. 6. **IS SUSTAINED**
Factual Allegation A. 7. **IS SUSTAINED**
Factual Allegation A. 8. **IS SUSTAINED**
Factual Allegation A. 9. **IS SUSTAINED**
Factual Allegation A. 10. **IS SUSTAINED**

FINDINGS OF FACT WITH REGARD TO THE CARE AND TREATMENT OF PATIENT B

80. Respondent's office record for Patient B, initially provided to the Office of Professional Medical Conduct (OPMC) reflects treatment by Respondent from July 26, 1990 through November 3, 1998. Within this time period, Respondent failed to maintain a record of his care and treatment of Patient B from November 29, 1993 through on or about February 2, 1995. Prescription and pharmacy records in evidence document that, despite a failure to maintain an office record for this time period, Respondent continued to prescribe medications to Patient B. (Exhs. 5A, 5B, 10; T. 1884-185)

81. At the time of hearing, Respondent offered into evidence a copy of the continuation of his treatment records, dating from December 15, 1998 through March 19, 2002. (Ex. C)

82. Respondent's treatment of Patient B focused mainly on clinical issues of depression and migraine headaches. (Ex. 5A, C, T. 186-187)

83. Respondent did not obtain an adequate, comprehensive psychiatric and medical history on Patient B. While Respondent, in his initial note for the patient, references various general terms, such as "classical headache" or a list of medications, he did not determine the pattern of headaches, the duration, nor use by the patient of various medications, their doses and effectiveness. Respondent failed to relate the various snippets of information to the overall clinical picture of the patient. (Ex. 5A, pg. 5,6; T. 187-189)

84. On the first visit, Patient B reported that his headaches were helped only by Percocet or Percodan and that he could not have blood drawn or go into the hospital. (Ex. 5A, pg. 5,6; T. 187-189)

85. A reasonably prudent physician would have been highly suspicious. (Ex. 5A, pg. 5,6; T. 187-189)

86. During the second visit of this patient, to Respondent, the patient note "states that he goes to the emergency room needing Dilaudid and Phenergan". (Ex. 5a, pg. 5-7; T. 189-190)

87. Respondent prescribed Percocet to Patient B along with, as of August 2, 1990, Lithium BID, Inderal 240mg.

88. On August 9, 1990 amitriptyline 200mg(Elavil) is added. (Ex. 5A, pg. 7, 8, 14; T. 190-191)

89. In his treatment of Patient B and, as reflected in his office record, Respondent regularly prescribed highly addictive medications. There is no evidence in the patient record that Respondent addressed issues of potential addiction, overuse and other substance abuse related problems. (Ex. 5A, T. 191-192)

90. Respondent failed to perform and to note a mental status examination of Patient B. (Ex. 5A, T. 192-193)

91. To comply with accepted standards of medicine, a diagnostic impression must be reasonably established by the treating psychiatrist. In this case, Respondent's initial note of July 26, 1990 states his impression as "Migraine..mixed vascular - hi threshold to meds". (Ex. 5A, pg 6-7; T. 195-197)

92. Respondent's records do not show any data or examination upon which he arrived at this "impression" or diagnosis. (Ex. 5A, pg 6-7; T. 195-197)

93. Respondent failed to distinguish the nature of the patient's symptoms, the duration of the problem and the specific factors that would define the headaches as migraine, as opposed to other types of headaches. (Ex. 5A, pg 6-7; T. 195-197)

94. Respondent never sought to investigate the patient's report of a high threshold for medications. There is no consideration of possible substance abuse or opiate-seeking behavior. (Ex. 5A, pg 6-7; T. 195-197)

95. Respondent did not, at any time during the course of his care of Patient B, arrive at or establish a treatment plan within the accepted standards of care. (Ex. 5A, T. 197)

96. On numerous occasions, Respondent prescribed Elavil to Patient B. On July 14, 1992, Patient B was admitted to the hospital for an overdose of Elavil. (Ex. 5A, pg. 7, 8,14, 16, 17, 21, 28; Ex. 5D; T. 197-202)

97. Post overdose by a patient, an assessment and notation should be made by the psychiatrist as to suicidal ideation and, thereafter, a plan for continued monitoring of the patient and control of access to supplies of medication. Respondent failed to do so. (T.282)

98. Respondent prescribed Lithium, a mood stabilizer to Patient B. (Ex. 5A, T. 202-203)

99. While Patient B was depressed, there is no indication or finding made by Respondent of mood swings nor periods of mania upon which to base a prescription for Lithium. (Ex. 5A, T. 202-203)

100. Respondent also prescribed Valium, an anti-anxiety medication, to Patient B. Valium is a highly addictive drug. Respondent provided no rationale for prescribing Valium. (Ex. 5A, T. 202-203)

101. In addition to prescribing Valium, at the same time, Respondent prescribed significant quantities of addictive pain medication. (Ex. 5A, T. 202-203)

102. There is no evidence Respondent considered the possibility of these medications augmenting each other's effects. (Ex. 5A, T. 202-203)

103. Respondent prescribed Thorazine, an anti-psychotic medication, to Patient B. (Ex. 5A, see pgs. 21, 23, 30; T. 202-203)

104. There is nothing noted by Respondent that would indicate psychotic symptoms or psychotic disorder demonstrated by Patient B. (Ex. 5A, see pgs. 21, 23, 30; T. 202-203)

105. Respondent simultaneously prescribed:

A. Elavil
B. Valium
C. Lithium
D. Thorazine
E. Percocet
F. Percodan

(Ex. 5A; T. 202-205)

106. Respondent failed to identify the purpose for which each was prescribed. (Ex. 5A; T. 202-205)

107. Respondent reflected no cognizance of the potential interactions of these medications. (Ex. 5A; T. 202-205)

108. He reflected no cognizance of the potential for inducing symptoms of depression and other psychological symptoms and the potential danger to the patient arising from the simultaneous prescriptions. (Ex. 5A; T. 202-205)

109. Respondent prescribed large quantities of both Percodan and Percocet to Patient B, in response to the patient's increasing demand for more in order to treat pain, ostensibly caused by migraine headaches. (Ex. 5A, see pg. 5, 27, 37, 44, 45, 48, 54; 5B, see pg. 19; T. 205-210)

110. Respondent also prescribed Dilaudid, another opioid to Patient B in response to the patient's reports of vomiting. (Ex. 5A, pg 20, 27; T. 211-213)

111. In a note dated March 17, 1997, Respondent writes: "nerves exposed, two broken teeth. Eyes red, severe headaches, called several times with hard-luck stories. Face blown up, infection, pain severe. Taking pain pills out of all proportion. Also at sheriffs because of his high tolerance for narcotics and intense pain, I will give him much more narcotics...." (Ex. 5A, pg 48; T. 219-220, 262)

112. Respondent, at the same March 17 visit, prescribed 100 Percocets. (Ex. 5A, pg 48; T. 219-220, 262)

113. Respondent's treatment of Patient B's headaches with opioids failed. Over time, the patient reported that the headaches increased in intensity. (Ex. 5A; T. 220-224)

114. Respondent did not follow through with a report by the patient that he had seen a Dr. Newman at the Montefiore Headache Clinic. Dr. Newman had apparently informed Patient B that he had to be

narcotic free for a period of time before effective treatment at the clinic could begin. (Ex. 5A; T. 220-224)

115. Respondent continued to prescribe narcotics. (Ex. 5A; T. 224-227)

116. Respondent did not perform or have Patient B undergo a necessary medical work up to address his headache complaints. (Ex. 5A; T. 224-227)

117. Patient B made numerous visits to the emergency room for complaints of migraine headaches. (Ex. 5D; T. 228-230)

118. Respondent was aware of the patient's frequent use of the emergency room for complaints of migraine headaches. The frequency of the trips to the emergency room indicate that the outpatient treatment being provided by Respondent was not meeting the patient's needs. Respondent failed to recognize this and to appropriately act upon it. (Ex. 5D; T. 228-230)

119. Respondent failed to follow up with any health care providers at the hospital with regard to the patient's ER visits and propensity to use addictive medications. (Ex. 5A, 5D; T. 230-231, 250-251)

. On August 19, 1993, Respondent records that the patient had gone to the emergency room "only two times in the past nine months." A review of the records clearly shows that this report was false, and, in fact, the patient had gone to the emergency twice that number of times. (Ex. 5A, 5D; T. 230-231, 250-251)

121. Respondent made note in his record that Patient B had obtained a gun license in connection with his employment. The patient also reported he was using more Percocet that he should, along with great job pressures and sleep-walking for hours. (Ex. 5A, pg. 24, 29; T. 238-242)

122. The patient again reported excessive use of Percocet, that he was up all night with severe headache and that he "nearly shot someone who approached him menacingly." Respondent did not respond to and assess the patient's potential danger to others in the context of having a gun and his other reported issues. (Ex. 5A, pg. 24, 29; T. 238-242)

CONCLUSIONS
WITH REGARD TO
THE CARE AND TREATMENT OF
PATIENT B

Once again, the State has proven by clear and convincing evidence that Respondent acted as set forth in the charges. The State has shown Respondent:

1. Failed to obtain and note an adequate, comprehensive psychiatric and medical history from Patient B.

2. Failed to perform and note a mental status examination of Patient B and periodic assessments of the patient's diagnosis, symptoms, medication side effects and treatment.

3. Failed to develop and maintain a treatment plan for Patient B, and to note such a plan.

4. Inappropriately and without acceptable medical indication or justification, prescribed and maintained Patient B on various medications, to wit:

   A. Amitriptyline
   B. Ascendin
   C. Dilaudid
   D. Lithium
   E. Thorazine
   F. Valium
   G. Vistaril
   H. Inderal
   I. Percodan
   J. Percocet

5. Failed to appropriately monitor and manage Patient B's risk of addiction to and harm from the use of prescribed opioid medications, and to note same.

6. Failed to appropriately refer and note a referral for Patient B for medical evaluation and consultation.

7. Failed to communicate with and coordinate the treatment of Patient B with other healthcare providers, including migraine specialists, and to note same.

8. Inappropriately undertook the care and treatment of and managed the care and treatment of Patient B's medical condition, including migraines.

9. Failed to appropriately evaluate and monitor Patient B's frequent emergency room visits, and to note same.

10. Failed to appropriately respond to and assess Patient B's potential danger to himself and others, and to note same.

11. Failed to maintain an office record for Patient B in accordance with accepted medical and psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

Therefore, based upon the Findings of Fact set forth above,

Factual Allegation B. 1. **IS SUSTAINED**
Factual Allegation B. 2. **IS SUSTAINED**
Factual Allegation B. 3. **IS SUSTAINED**
Factual Allegation B. 4. **IS SUSTAINED**
Factual Allegation B. 5. **IS SUSTAINED**
Factual Allegation B. 6. **IS SUSTAINED**
Factual Allegation B. 7. **IS SUSTAINED**
Factual Allegation B. 8. **IS SUSTAINED**
Factual Allegation B. 9. **IS SUSTAINED**
Factual Allegation B. 10. **IS SUSTAINED**
Factual Allegation B. 11. **IS SUSTAINED**

FINDINGS OF FACT WITH REGARD TO THE CARE AND TREATMENT OF PATIENT C

123. Respondent produced two sets of office records for his care and treatment of Patient C. The first set contains entries by Respondent during the period from March 21, 1970 through November 15, 1993. The second set of records contains entries by Respondent from July 22, 1997 through October 19, 1998.. (Ex. 6A-6C; T. 290-292)

124. Triplicate prescription forms in evidence reveal that Respondent continued to treat Patient C, on a continuous basis between November 15, 1993 and July 22, 1997. During this period, Respondent prescribed a variety of medications, including Oxycodone and Dalmane. It is not within the accepted standard of care for Respondent to have continued to prescribe these medications. (Ex. 6A-6C; T. 290-292)

125. At his initial visit with Respondent, Patient C was described as exhibiting:

A. Significant issues of anxiety (patient reportedly stated, "I think I am going crazy, I feel I am nuts");
B. Doriden dependency
C. Fears regarding death;
D. Family issues regarding medical illness. (Ex. 6A, pgs. 5-7; T. 292-297; 299)

126. The record indicates that Respondent did not see the patient again until two years later, on October 1, 1973 (Ex. 6A, pgs. 5-7; T. 292-297; 299).

127. Respondent prescribed medications to the patient during the entire period. (Ex. 6A, pgs. 5-7; T. 292-297; 299)

128. Doriden is a sleep medication known to be highly addictive. (T. 296)

129. Respondent failed to perform a thorough assessment of the patient, including a history of symptoms, the need for Doriden, its effectiveness and the surrounding circumstances. (Ex. 6A, pg. 5; T. 298-299)

130. Respondent showed no meaningful data or thought regarding creation of a future treatment plan and a preliminary diagnosis. (Ex. 6A, pg. 5; T. 298-299)

131. Respondent did not obtain an adequate medical and psychiatric history from the patient. (Ex. 6A, pg. 5; T. 298-299)

132. Respondent failed to assess the patient's clinical condition, diagnosis and treatment and responses to treatment, on an appropriate ongoing basis. (Ex. 6A; T. 299)

133. Throughout the patient record, Respondent described Patient C as having psychosomatic problems including gastrointestinal problems. Respondent undertook the treatment of the G.I. problems.

134. Respondent failed to undertake any medical evaluation or work up, or to refer the patient for evaluation by an appropriate specialist to determine whether there was a physiological cause for the patient's symptoms. (Ex. 6A, pg. 6; T. 300-302)

135. Respondent continued to prescribe Doriden as well as Dalmane. Respondent failed to perform periodic assessments of the patient's Doriden dependency during this time. He failed to properly monitor the patient on the medication and to address the addictive potential of the medication with the patient. (Ex. 6A; T. 302, 307-308)

136. Respondent did not perform a mental status examination of the patient at any time during his treatment. (Ex. 6A, 6B; T. 302-303)

Respondent prescribed Lithium for Patient C. Respondent failed to perform a baseline assessment of the patient, including laboratory studies, before initiating treatment with Lithium. Respondent knew this patient had a history of kidney problems. (6A; T. 303-304)

138. During the period of treatment, Patient C presented with various issues which required treatment, including weight reduction problems, alcohol binges and abuse, Doriden dependency and threatening

behavior. Respondent failed to devise a treatment plan for any of the issues presented. (Ex. 6A, 6B; T. 304-305)

139. Respondent did not have a treatment plan nor an explanation of the rationale for each of the therapeutic recommendations and interventions made. (Ex. 6A, 6B; T. 304-305)

140. In a letter contained with Respondent's office record, Respondent states that Patient C has several complicated problems, including colitis, low threshold for pain, anxiety symptoms, depressive elements, severe weight fluctuations, marked sleep difficulties, and, in order for her to function outside a hospital setting, she needs a wide variety and large quantity of medications. (Ex. 6A, 6B; T. 305-307)

141. Respondent saw Patient C very infrequently, often only once or twice a year. (Ex. 6A, 6B; T. 305-307)

142. Such a schedule is entirely inadequate and inappropriate to assess and evaluate this patient. (Ex. 6A, 6B; T. 305-307)

143. Respondent prescribed Percocet for Patient C on numerous occasions for complaints of pain resulting arising from back and leg or menstrual cramps. (Ex. 6A, 6B; T. 308-315)

144. With regard to the complaints of back and leg pain, the patient reported a fear of seeing a surgeon because she feared the prospect of surgery. (Ex. 6A, 6B; T. 308-315)

145. Respondent told the patient that "she needs to accept some level of pain and not rely on Percocet." Nevertheless, he continued to prescribe Percocet. (Ex. 6A, 6B; T. 308-315)

146. There is no record that Respondent recognized the possibility that prescribing Percocet might mask pain caused by a problem requiring surgical intervention. (Ex. 6A, 6B; T. 308-315)

147. The continued prescription of Percocet supported the patient's refusal to have the problem addressed organically. It also reinforced the patient's addiction to Percocet. (Ex. 6A, 6B; T. 308-315)

148. With regard to the complaint's of menstrual cramping, Respondent prescribed Percocet, and thereby undertook the gynecological condition of the patient without any appropriate history, examination or work up to rule out any other source of the pain, such as tumor or other organic condition. (Ex. 6A, 6B; T. 308-315)

149. Respondent also prescribed Dalmane to Patient C on a continuous basis despite evidence of addiction or habituation. (Ex. 6A, pgs. 7, 21, 25, Ex. 10; T. 315-317)

150. Respondent notes on March 9, 1989, "trying to wean her from Dalmane. But complains bitterly, she can't sleep. And then harangues her husband, threatening to kill self, and generally highly irritable. She won't go into hospital, (terrified to attempt a withdrawal). Hypnosis hasn't worked, has cut down on Valium and continues Imipramine, 25mg. QID". These notes are consistent with a physician who believes his patient is addicted or habituated. (Ex. 6A, pgs. 7, 21, 25, Ex. 10; T. 315-317)

151. Respondent never addressed the actual cause of the insomnia. Dependency on the medication he was prescribing could have caused insomnia. (Ex. 6A, pgs. 7, 21, 25, Ex. 10; T. 315-317)

152. There were a number of references by Respondent to suicidal ideation in the patient. Respondent failed to respond to these instances and to assess Patient C's potential danger to herself. (T. 317-319)

153. Medication interactions and interactions of the various medications Respondent prescribed with the patient's use of alcohol and "alcohol binges" were not assessed. This created a risk of the patient hurting herself. (Ex. 6A; T. 319-320)

154. Respondent prescribed the anti-psychotic medications, Mellaril, as well as Thorazine, to this patient consistently and in fairly large quantities. (Ex. 6A, pgs. 1, 11, 14; T. 320-323, 347-348)

The basis for prescribing these medications is not at all evident, nor are target symptoms identified. (Ex. 6A, pgs. 1, 11, 14; T. 320-323, 347-348)

156. Mellaril has the potential for significant side effects, especially with chronic use. Female patients with mood disorders, such as Patient C, are particularly at high risk. (Ex. 6A, pgs. 1, 11, 14; T. 320-323, 347-348)

157. Respondent failed to monitor the patient for side effects to this medication. (Ex. 6A, pgs. 1, 11, 14; T. 320-323, 347-348)

158. Respondent prescribed the antidepressant medications Prozac, Imipramine, Elavil and Triavil (combination of Elavil and Trilafon) to Patient C interchangeably throughout his treatment. (Ex. 6A, pgs. 5, 1424, 25; 6B, pg. 3; T. 320-322)

159. The patient record provides no reasonable rationale for using one drug rather than another. There is also no clear explanation of the indications for the use of either drug. (Ex. 6A, pgs. 5, 1424, 25; 6B, pg. 3; T. 320-322)

160. Respondent prescribed Valium to Patient C. There is no record that he periodically assessed its effectiveness and continued use. (Ex. 6A, pg. 1; 6B, pg. 3; T. 320-322)

161. Respondent prescribed Lomotil to Patient C; a medication for gastrointestinal distress. Lomotil is known to have the potential of causing alterations in mental status, particularly delirium (an acute confused state). (Ex. 6A; T. 323-324, 985-6).

162. The use of Lomotil must be carefully considered when prescribed in combination with the other psycho-tropic medications and pain medications Respondent prescribed. (Ex. 6A; T. 323-324, 985-986)

. The potential for undesirable results is also exacerbated when the patient is a known alcohol user. (Ex. 6A; T. 323-324, 985-986)

164. A letter from a neurologist contained in Respondent's office record, reports neurological findings. The neurologist wrote that seizures experienced by Patient C were drug withdrawal seizures. The neurologist also reported that Patient C had an abnormal electroencephalogram. The neurologist recommended that the Electroencephalogram be repeated in 6 months. Respondent ignored this recommendation. (Ex. 6A, pg. 10; T. 336-341, 352-353)

165. Given that these findings were known to Respondent, the committee finds he acted irresponsibly in continuing to prescribe addict medications to Patient C and in failing to appropriately manage her use and withdrawal from the medications he prescribed. (Ex. 6A, pg. 10; T. 336-341, 352-353)

166. Respondent undertook the treatment of the patient's gastrointestinal complaint with Lomotil. He did not perform any work up to ascertain the medical causes of her complaint. He also did not refer the patient to a specialist for treatment, nor did he consult with other healthcare providers. (T. 324-325)

167. Respondent failed to maintain an office record for Patient C which accurately reflects his care and treatment of the patient. (Ex. 6A, 6B; T. 330)

CONCLUSIONS WITH REGARD TO THE CARE AND TREATMENT OF PATIENT C

Once again, the State has proven by clear and convincing evidence that Respondent acted as set forth in the charges. The State has shown Respondent:

1. Failed to obtain or note an adequate, comprehensive psychiatric and medical history from Patient C.

2. Failed to perform or note a mental status examination of Patient C and a periodic assessments of the patient's diagnosis, symptoms, medication side effects or treatment.

3. Failed to develop and maintain a treatment plan for Patient C, or to note such a plan.

4. Failed to conduct treatment sessions with Patient C on an appropriate and clinically reasonable schedule, or to note same.

5. Inappropriately and without acceptable medical indication or justification, prescribed or maintained Patient C on the following medications:

   A. Doriden,
   B. Percocet,
   C. Dalmane,
   D. Prozac,
   E. Imipramine,
   F. Mellaril
   G. Triavil
   H. Elavil
   I. Valium
   J. Thorazine
   K. Lomotil.

6. Failed to appropriately monitor or manage Patient C's addiction and withdrawal from prescribed medications; and/or to note same.

7. Failed to appropriately manage Patient C's withdrawal from alcohol, or to note same.

8. Failed to appropriately refer or note a referral for Patient C for medical evaluation and consultation.

9. Failed to communicate with or coordinate the treatment of Patient C with other healthcare providers, or to note same.

10. Inappropriately undertook the care and treatment of Patient C's medical condition(s), including complaints of gastrointestinal problems and back pain.

11. Failed to appropriately respond to or assess Patient C's potential danger to others, or to note same.

12. Failed to maintain an office record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

Therefore, based upon the Findings of Fact set forth above,

Factual Allegation C. 1. **IS SUSTAINED**
Factual Allegation C. 2. **IS SUSTAINED**
Factual Allegation C. 3. **IS SUSTAINED**
Factual Allegation C. 4. **IS SUSTAINED**
Factual Allegation C. 5. **IS SUSTAINED**
Factual Allegation C. 6. **IS SUSTAINED**
Factual Allegation C. 7. **IS SUSTAINED**
Factual Allegation C. 8. **IS SUSTAINED**
Factual Allegation C. 9. **IS SUSTAINED**
Factual Allegation C. 10. **IS SUSTAINED**
Factual Allegation C. 11. **IS SUSTAINED**
Factual Allegation C. 12. **IS SUSTAINED**

FINDINGS OF FACT WITH REGARD TO THE CARE AND TREATMENT OF PATIENT D

168. Respondent initially saw Patient D on May 23, 1973 and treatment continued through May 5, 1998. The patient presented with a history of a breakdown and issues of chronic fatigue and amphetamine abuse. (Ex. 7A; T. 374-376)

169. Respondent failed to maintain his office records for Patient D in accordance with an accepted format for psychiatric office based care. (Ex. 7A; T. 377)

170. Respondent did not obtain nor note a comprehensive psychiatric and medical history of Patient D (Ex. 7A; T. 377-379, 580-589).

171. Respondent failed to explore the symptoms or course of treatment related to the patient's breakdown in 1955. (Ex. 7A; T. 377-379, 580-589)

172. With respect to the patient's amphetamine addiction, Respondent did not ascertain the onset, clinical course of the addiction, nor the amount taken by the patient and whether any treatment or intervention had been attempted. He failed to ask any questions with regard to suicidal ideation, especially with a history of manic depression. (Ex. 7A; T. 377-379, 580-589)

173. On the first visit, Respondent concluded that the patient had an amphetamine addiction which had become part of his normal functioning. (Ex. 7A pg. 3-4; T. 379-381)

174. Respondent made this conclusion without a sufficient evaluation and assessment. (Ex. 7A pg. 3-4; T. 379-381)

In the patient record, Respondent states there will be an attempt to stop using amphetamine and an attempt to cut down. Nevertheless, Respondent prescribed 100 Dexedrine pills with a suggestion of a hospital study to follow. (Ex. 7A pg. 3-4; T. 379-381)

176. Accepted standards of care would have required:

A. A complete evaluation
B. A small amount of medication
C. a planned schedule
D. a specific referral to an inpatient program or other mode of care. (Ex. 7A pg. 3-4; T. 379-381)

Respondent notes for his initial visit a "proviso" that the patient involve himself in a hospital study to determine a way of dealing with addiction. (Ex. 7A, pg. 5-8; T. 382-385)

178. Respondent does not make a meaningful referral nor follow through on his observation. (Ex. 7A, pg. 5-8; T. 382-385)

179. The entry for the next patient visit on June 6, 1973 states that the patient has agreed to go into a study at Columbia Presbyterian after he finishes a current work (Ex. 7A, pg. 5-8; T. 382-385)

180. As of November 25, 1974, no evaluation of this patient had been done. Respondent continued to prescribe and the patient continued to use five (5) Dexedrine a day. (Ex. 7A, pg. 5-8; T. 382-385)

181. From the initial visit in 1973 through August 3, 1987, there are repeated notations referring to Patient D wherein Respondent reiterates a need for this patient to engage in an inpatient evaluation. (Ex. 7A, pgs. 3-10, 13-15, 22; T. 386-392, 465-469)

182. The patient presents significant resistance to the idea. He presents a variety of reasons why he believes he requires the amphetamines to function. (Ex. 7A, pgs. 3-10, 13-15, 22; T. 386-392, 465-469)

183. During this period of time, Respondent continued to prescribe Dexedrine. The amounts that were prescribed were those requested by the patient. The continued prescription of Dexedrine maintained the patient's addiction. (Ex. 7A, pgs. 3-10, 13-15, 22; T. 386-392, 465-469)

184. There is no evidence that Respondent performed nor noted an appropriate mental status examination and assessment of the patient's diagnosis.

185. The initial notes mention difficulty with memory, yet Respondent did not consider an evaluation for a cognitive deficit, nor did he perform a serial seven test because he made an assumption it would be irrelevant since the patient was a "computer expert." (Ex. 7A; T. 392-393, 590-593)

186. Respondent failed to develop a treatment plan for Patient D. (Ex. 7A; T. 392-393)

187. As early as July 12, 1973, Patient D reported difficulty with sleeping at work, short-term memory loss, difficulty developing ideas in a clear fashion, strange behavior and fear of a breakdown. (Ex. 7A, pg. 6; T. 393-395, 398, 465-467)

188. Respondent noted, in response, "My opinion is that there are indications that the amphetamine abuse itself is causing behavioral problems, sleeping all night in the office, short-term memory defects could also be attributed to that." (Ex. 7A, pg. 6; T. 393-395, 398, 465-467)

189. Respondent did not develop and maintain a treatment plan that would address the problem of overuse. He did not implement an appropriate assessment. Had he done so, and reduced the amount of amphetamines prescribed, there is a high likelihood the patient would have experienced a normalization of behavior and improved work functioning. (Ex. 7A, pg. 6; T. 393-395, 398, 465-467)

190. On July 12, 1973, Respondent prescribes Stelazine. The record gives no reason for this prescription. (Ex. 7A, pg. 6; T. 395-396, 404-405)

191. Stelazine is an anti-psychotic medication. However, there is no reference to symptoms of psychosis in the patient record. (Ex. 7A, pg. 6; T. 395-396, 404-405)

192. Subsequent to the July 12, 1973 visit, Respondent did not see Patient D again until November 25, 1974. (Ex. 7A, T. 395-398)

193. After November 25, treatment sessions were very infrequent. The record shows gaps of months and years between visits. (Ex. 7A, T. 395-398)

194. The frequency of visits in this patient's record does not represent clinically reasonable practice. The infrequency does not allow an appropriate opportunity for necessary monitoring of the patient's use of medication and evaluation of symptoms. (Ex. 7A, T. 395-398)

195. On November 25, 1974, Respondent prescribed the drug Parnate. Parnate is an anti-depressant. The record gives no basis for the use of Parnate. The record does not identify any issues over the past year that lead to a decision to prescribe this medication. (Ex. 7A, pg. 8; T. 397-398)

196. Respondent's August 6, 1975 note for a visit by Patient D simply reads: "Petit Mal seizure at work - MAO - Parnate, Stelazine - Worried about M [Mother] --preoccupied him." (Ex. 7A, pg. 10-11; T. 398-403,469-474, 476-479)

197. A report of an EEG from August 12, 1975 includes a finding of a mild abnormality because of minimal left posterior hemisphere medial slow wave abnormality. The radiologist's comment was, "if clinically indicated, there should be a repeat study in three months to rule out the possibility of an expanding intra-cranial lesion". (Ex. 7A, pg. 10-11; T. 398-403,469-474, 476-479)

198. Respondent did not see the patient again until two years later. Respondent provided no intervening follow up nor evaluation. He never mentioned the seizure nor the abnormal EEG in his record. There is also no further neurological, medical or psychological evaluation or assessment. (Ex. 7A, pg. 10-11; T. 398-403,469-474, 476-479)

199. The next visit was February 7, 1977. Respondent continued the amphetamines and the Parnate. Respondent also adds Marplan, another anti-depressant to the patient's list of medications. (Ex. 7A; T. 403-405)

200. There is no record of the need or justification for the use of Marplan. (Ex. 7A; T. 403-405)

201. The February 7, 1977 note also references "Narcolepsy", without any explanation nor evaluation. (Ex. 7A, pg. 12; T. 406-407, 475-476, 566-567, 572)

202. Narcolepsy is not a disorder related to "chronic fatigue syndrome." (Ex. 7A, pg. 12; T. 406-407, 475-476, 566-567, 572)

203. Accepted standards of care require a patient suspected to have narcolepsy to be sent for laboratory studies, EEG and monitoring in a clinical setting. Respondent did not, in any way, evaluate the possibility of Narcolepsy in this patient. (Ex. 7A, pg. 12; T. 406-407, 475-476, 566-567, 572)

204. Chronic fatigue syndrome is a medical condition which warrants evaluation. Respondent deviated from accepted standards in his failure to appropriately refer the patient for a medical consultation and to incorporate any medical care received by the patient into his psychiatric care. (Ex. 7A; T. 407-410)

205. Lithium is prescribed for mood disorders. Prior to prescribing Lithium, baseline medical evaluation must be done. This would include a physical exam, laboratory tests especially thyroid and kidney function tests.

206. While the patient is maintained on Lithium, close monitoring is required of lithium levels on a regular basis. The accepted standard is every three to six months. (Ex. 7A, E, T. 411-417, 437-438)

207. Respondent failed to perform any evaluation prior to the prescription. After making the prescription, he failed to monitor the patient with a frequency consistent with accepted standards. (Ex. 7A, E, T. 411-417, 437-438)

208. Respondent continued to prescribe Lithium through his most recent treatment record in evidence of April, 2002. (Ex. 7A, E, T. 411-417, 437-438)

209. Respondent failed to explore the degree to which the amount of amphetamines used by Patient D may have led to symptoms which seem to be manic symptoms. (Ex. 7A; T. 415)

210. There is no evidence Respondent monitored or managed the patient's risk of addiction and withdrawal from amphetamines. (Ex. 7A, E, pg. 5; T. 418-422)

211. Throughout his treatment of Patient D, Respondent continued to prescribe quantities of amphetamines. There is no evidence that Respondent considered how the amphetamines would effect the patient's mood, behavior and physical condition. (Ex. 7A, E, pg. 5; T. 418-422)

212. Respondent offered into evidence his additional office record, which documents treatment up to and including April, 2002. Respondent continues to prescribe amphetamines to the patient. (Ex. 7A, E, pg. 5; T. 418-422)

213. A March 27, 2001 entry reads: "although depressed, wife pushed him to enter a writing contest. Needed to take more Dexedrine to be able to focus. Helps with falling asleep several times during the day." (Ex. 7A, E, pg. 5; T. 418-422)

214. While Respondent has continued to prescribe amphetamines to this patient, the patient's clinical status has deteriorated. Respondent's office records indicate the patient has:

A. Experienced a decrease in self-esteem;

B. Stopped working

C. Experienced more problems staying awake;

D. Suffered mood and memory problems. (Ex. E; T. 423-429, 438-439, 464-465)

215. Not only did Respondent fail to articulate a plan for responding to the patient's deteriorated condition, he did not reevaluate nor vary from his treatment approach. (Ex. E; T. 423-429, 438-439, 464-465)

216. In 1991, the Respondent, for the first time noted, "...rage under good control..discussed previous transient rage episodes." There was not a follow up nor evaluation of these "episodes of rage" by Respondent. (Ex. 7A, E; T. 429-433, 439, 479-480, 573-575)

217. In 1997, Respondent notes; "Retired one year, in depression, trouble organizing himself to do any specific task. Question worry re future with money deficiencies...Loss of hearing, some loss of memory. Some wandering thoughts of suicide." (Ex. 7A, E; T. 429-433, 439, 479-480, 573-575)

218. Respondent failed to do any risk assessment regarding a possible suicide plan, how much thinking of suicide was involved nor treatment intervention, if needed. (Ex. 7A, E; T. 429-433, 439, 479-480, 573-575)

219. Respondent failed to maintain an office record for Patient D in accordance with accepted standards of medical and psychiatric standards. (Ex. 7A, E; T. 439, 538-540, 606-608)

CONCLUSIONS WITH REGARD TO THE CARE AND TREATMENT OF PATIENT D

Once again, the State has proven by clear and convincing evidence that Respondent acted as set forth in the charges. The State has shown Respondent:

1. Failed to obtain and note an adequate, comprehensive psychiatric and medical history from Patient D.

2. Failed to perform and note a mental status examination of Patient D and a periodic assessment of the patient's diagnosis, symptoms, medication side effects and treatment.

3. Failed to develop and maintain a treatment plan for Patient D, and to note such a plan.

4. Failed to conduct treatment sessions with Patient D on an appropriate and clinically reasonable schedule, and to note same.

5. Inappropriately and without acceptable medical indication or justification, prescribed and maintained Patient D on various medications, to wit:

   A. Dextroamphetamine
   B. Stelazine
   C. Lithium
   D. Parnate
   E. Marplan
   F. Prozac

6. Failed to appropriately monitor and manage Patient D's risk of addiction or withdrawal from prescribed amphetamines; or to note same.

7. Failed to appropriately refer or note a referral for Patient D for medical evaluation/consultation.

8. Failed to communicate with and/or coordinate the treatment of Patient D with other healthcare providers, and/or to note same.

9. Inappropriately undertook the care and treatment of or managed the care and treatment of Patient D's medical condition(s), including complaints of chronic fatigue.

10. Failed to appropriately respond to or assess Patient D's potential danger to himself and others, or to note same.

11. Failed to maintain an office record for Patient D in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

Therefore, based upon the Findings of Fact set forth above,

Factual Allegation D. 1. **IS SUSTAINED**
Factual Allegation D. 2. **IS SUSTAINED**
Factual Allegation D. 3. **IS SUSTAINED**
Factual Allegation D. 4. **IS SUSTAINED**
Factual Allegation D. 5. **IS SUSTAINED**
Factual Allegation D. 6. **IS SUSTAINED**
Factual Allegation D. 7. **IS SUSTAINED**
Factual Allegation D. 8. **IS SUSTAINED**
Factual Allegation D. 9. **IS SUSTAINED**
Factual Allegation D. 10. **IS SUSTAINED**
Factual Allegation D. 11. **IS SUSTAINED**

CONCLUSIONS WITH REGARD TO SPECIFICATION OF CHARGES

Having found Respondent guilty of each and every factual allegation alleged, the Committee now turns its attention to whether any of the acts will support any specification.

CONCLUSIONS REGARDING THE FIRST SPECIFICATION NEGLIGENCE ON MORE THAN ONE OCCASION[5]

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

1. A, A(1) - A(4), A(5)(a) - A(5)(k), A(6) - A(10),
B, B(1) - B(3), B(4)(a) - B(4)(j), B(5) - B(11),
C, C(1) - C(4), C(5)(a) - C(5)(k), C(6) - C(12),
D, D(1) - D(4), D(5)(a) - D(5)(f), D(6) - D(11),

[5]This Case originally had eight patients and twenty-one specifications. The Committee considered 4 of the 8 patients. Therefore, specifications relating to the patients who were not consdered were not addressed here.

The Committee finds Respondent guilty, as charged. The basis for their finding will be presented under the discussion of gross negligence.

CONCLUSIONS REGARDING
THE SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. A, A(1) - A(4), A(5)(a) - A(5)(k), A(6) - A(10),
B, B(1) - B(3), B(4)(a) - B(4)(j), B(5) - B(11),
C, C(1) - C(4), C(5)(a) - C(5)(k), C(6) - C(12),
D, D(1) - D(4), D(5)(a) - D(5)(f), D(6) - D(11)

The Committee finds Respondent guilty, as charged. The basis for their finding will be presented under the discussion of gross incompetence.

CONCLUSIONS REGARDING
THE THIRD THROUGH EIGHTH SPECIFICATION
GROSS NEGLIGENCE

Negligence was defined for the Committee as a failure to exhibit that level of care and diligence expected of a physician in this state. Gross negligence was described as a single act of egregious proportions or actions which, in their totality represented an egregious deviation from standards.

The Committee was of one voice in its findings that Respondent had demonstrated, in each charge, an unacceptable level of care and diligence and that his failures were significant deviations from accepted standards of care. Respondent showed, at best, a haphazard approach to patient care. There were no basic

examinations recorded. Fundamental issues were unaddressed and drugs were prescribed without any reference to symptoms or other basis.

Each of the four patients examined herein was addicted to one or more medications. They represented very real potential danger to themselves and others. Yet Respondent continued to prescribe psychotropic medications and, in some cases combinations of these medications. There was not one example of a real effort to wean any of these patients from his or her chosen substance of abuse. There is virtually no proof of efforts to force patients to obtain organic examinations to rule out organic causes to the symptoms upon which the drugs were being prescribed.

Respondent showed almost a cavalier disregard for the safety and welfare of his patients. This constitutes egregious violations of accepted standards of care and diligence and hence gross negligence. Therefore, based upon the conclusions stated above,

The First Specification is **SUSTAINED**
The Third Specification is **SUSTAINED**
The Fourth Specification is **SUSTAINED**
The Fifth Specification is **SUSTAINED**
The Sixth Specification is **SUSTAINED**

CONCLUSIONS REGARDING THE SECOND AND NINTH SPECIFICATION INCOMPETENCE AND GROSS INCOMPETENCE

Respondent is charged with twenty four counts of incompetence and twenty four counts of gross incompetence. The Committee was instructed that incompetence was the failure to demonstrate that level of knowledge and expertise expected of a physician in this state. The Committee was instructed that gross incompetence was an egregious act of incompetence or a series of acts which by their totality constitute a an egregious violation of accepted standards. The Committee was also instructed that it did not need to look into the mind of the accused so as to determine what he knew and did not know. Rather, a finding of incompetence is based upon the actions of the accused. That is, the Committee was asked if Respondent had acted in a manner consistent with the knowledge and expertise expected of a physician in this state.

The Committee finds Respondent guilty as charged. The reasons cited above support both a finding of negligence and incompetence. The Committee expects a physician, acting within accepted standards of knowledge and expertise to act in an entirely different manner than Respondent. For instance, a competent physician does not continue to prescribe potent addictive drugs to a patient who is an addict. Respondent's behavior, by any fair interpretation of the standards was an extreme violation of accepted standards of competence.

Therefore, based upon the conclusions stated above,

The Second Specification is **SUSTAINED**
The Ninth Specification is **SUSTAINED**

CONCLUSIONS REGARDING
THE TENTH THROUGH THIRTEENTH NINTH SPECIFICATION
UNWARRANTED TREATMENT

The findings of fact in this case are full of references to drugs prescribed for no apparent reason. In some cases the medication was prescribed, another was apparently substituted and then the original substance was returned. The fact that Respondent rarely set forth his reasoning may still have allowed the Committee and the State's expert to ascertain why a given drug was given. However, in many cases there is neither a written justification nor commentary or data which would make the reason obvious.

In addition, in many cases, based upon the facts in the patient chart, drugs were given which were inappropriate for the condition of the patient. Each of the patients was addicted to at least one drug yet Respondent continued to prescribe. Treating a patient by providing medication to which he or she is addicted is, to say the least, the unwarranted provision of treatment.

Therefore, based upon the conclusions stated above,

The Tenth Specification is **SUSTAINED**
The Eleventh Specification is **SUSTAINED**
The Twelfth Specification is **SUSTAINED**
The Thirteenth Specification is **SUSTAINED**

CONCLUSIONS REGARDING
THE TENTH THROUGH THIRTEENTH NINTH SPECIFICATION
FAILURE TO MAINTAIN PATIENT RECORDS

The findings of fact in this case are full of references to drugs prescribed for no apparent reason. In some cases the medication was prescribed, another was apparently substituted and then the original substance was returned. The fact that Respondent rarely set forth his reasoning may still have allowed the Committee and the State's expert to ascertain why a given drug was given. However, in many cases there is neither a written justification nor commentary or data which would make the reason obvious.

In addition, in many cases, based upon the facts in the patient chart, drugs were given which were inappropriate for the condition of the patient. Each of the patients was addicted to at least one drug yet Respondent continued to prescribe. Treating a patient by providing medication to which he or she is addicted is, to say the least, the unwarranted provision of treatment.

Therefore, based upon the conclusions stated above,

The Sixteenth Specification is **SUSTAINED**
The Seventeenth Specification is **SUSTAINED**
The Eighteenth Specification is **SUSTAINED**
The Nineteenth Specification is **SUSTAINED**

CONCLUSIONS REGARDING PENALTY

The Committee has found Respondent guilty of each charge and each specification considered[6]. While the number of charges and specifications sustained is, in and of itself, irrelevant to penalty, in this case, each of the charges and specifications refers to numerous significant lapses of medical competence. The lapses in these cases had a real potential to have caused death or serious injury to the patients and to those around them. The patients in this case suffered from serious mental health disorders. Each of them, at one time or another, threatened harm to himself or others. It would appear that Respondent's only response was medication.

Respondent made very few meaningful entries in his records. He prescribed very potent drugs with high potential for abuse or addiction. In the absence of any real notes by Respondent, it is impossible for the Committee to know why Respondent would change from one drug to another where the drugs are both in the same family of medications and, by and large, have the same positive and negative potential for the patient.

One thing which can be discerned is that Respondent was, to say the least, haphazard in his prescribing practices. He prescribed medications to patients for lengthy periods of time when he knew the patients were addicted to the drug being prescribed. Indeed, there is a strong argument in favor of characterizing Respondent's prescribing practices as capricious. One certainly cannot say, Respondent prescribed solely in the best interest of the patient.

Respondent has demonstrated hubris in his medical care. There are two examples in these charts wherein Respondent prescribed medicine for organic, as opposed to psychiatric, purposes. In one case Respondent treated a patient for upper respiratory complaints. It is a paradox that the upper respiratory complaints may have arisen from the medications Respondent was prescribing. It is clear that Respondent saw no need to consult with any other physician or have the patient be examined by someone with superior training regarding upper respiratory problems.

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[6] Only four of the eight patients cited in the Statement of Charges were considered by the Committee.

In a similar light, Respondent addressed the gynecological needs of a patient by providing pain medication for menstrual pain. Respondent made no effort to consult with a gynecologist nor did he direct the patient to see one. By providing pain medication in the absence of an appropriate consultation, Respondent placed his patient in great jeopardy. There is a significant possibility that simply providing pain medication, could mask an organic disorder.

The statement by Respondent that the patient was afraid of hospitals and surgery does not insulate him from guilt in this matter. Where one is prescribing potentially addictive substances, the failure of the patient to follow instructions regarding other treatment modalities within a reasonable time, should result in the refusal, by the physician, to prescribe more of the medication.

Respondent demonstrated an over-inflated sense of his abilities by treating patients for organic disorders. By doing so, without consultation, Respondent created a very real likelihood of ignoring serious organic disorders. There is a very real potential for patient harm, to say the least, in such a circumstance.

Finally, this is not the first time Respondent has been found guilty of medical misconduct. After the final decisions about the facts and specifications in this case had been made, the Administrative Law Judge distributed a record of a prior action against Respondent's license. However, the prior finding of guilt simply served to confirm the Committee's choice of penalty.

Perhaps of greatest concern is that Respondent shows no remorse for his failure to meet the most minimum accepted standards. It would appear, based upon his demeanor during his testimony, that Respondent sees no fault or potential danger in his practices.

Respondent's practices are not even remotely within accepted standards of care. He shows no recognition that his practices were substandard. He presents a danger to his patients and those around them. Hence, revocation is the only appropriate penalty.

ORDER

WHEREFORE, Based upon the foregoing findings of fact and conclusions,

It is hereby **ORDERED** that:

1. The Factual allegations in the Statement of Charges regarding Patients A through D (attached to this Decision and Order as Appendix One) are **SUSTAINED;**

Furthermore, it is hereby **ORDERED** that;

2. The First through Sixth, Ninth, Tenth through Thirteenth and Sixteenth through Nineteenth Specifications[7] of Misconduct contained within the Statement of Charges (Appendix One) are **SUSTAINED**:

Furthermore, it is hereby **ORDERED** that;

3. Respondent's license to practice medicine in New York State is **REVOKED**;

Furthermore, it is hereby **ORDERED** that;

4. A civil penalty of **FIFTY THOUSAND DOLLARS** ($ 50,000) **SHALL BE IMPOSED**;

Furthermore, it is hereby **ORDERED** that;

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[7] Each Finding of Fact and each Specification considered by the Committee was sustained.

5. **That any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; and non-renewal of permits or licenses (Tax Law , section 171(27); State Finance Law, section 18; CPLR, section 5001; Executive Law, section 32);**

Furthermore, it is hereby **RECOMMENDED** that;

6. Future reviewing agents or bodies **NEVER GRANT** Respondent a license to practice medicine in New York State;

Furthermore, it is hereby **ORDERED** that;

7. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail.

DATED: Rockville Centre, New York

April 8, **, 2003**

REDACTED

WALTER M. FARKAS, M.D., CHAIRPERSON
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APPENDIX ONE

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

IN THE MATTER

OF

JACOB HARRIS, M.D.

STATEMENT

OF

CHARGES

JACOB HARRIS, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 31, 1967, by the issuance of license number 098756 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, at his office located at 359 East Main Street, #3A, Mount Kisco, New York, (hereinafter referred to as " his office") undertook the psychiatric care and treatment of Patient A (identity of all patients is set forth in the annexed Appendix) from on or about September 10, 1979 through on or about March 16, 1993. Respondent:

1. Failed to obtain and/or note an adequate, comprehensive psychiatric and medical history from Patient A.
2. Failed to appropriately obtain and/or note Patient A's relevant psychiatric treatment and/or history from other health care providers.
3. Failed to perform and/or note a mental status examination of Patient A and a periodic assessments of the patient's diagnosis, symptoms, medication side effects and/or treatment.
4. Failed to develop and maintain a treatment plan for Patient A, and/or to note such a plan.

5. Inappropriately and without acceptable medical indication and/or justification, prescribed and/or maintained Patient A on various medications, to wit:
   a. Norpramin,
   b. Prozac,
   c. Stelazine,
   d. Haldol,
   e. Xanax,
   f. Prolixin,
   g. Valium,
   h. Tranxene,
   i. Adapin,
   j. Artane,
   k. Elavil.
6. Failed to appropriately monitor and/or manage Patient A's risk of addiction and withdrawal from Xanax; and/or to note same.
7. Failed to appropriately refer and/or note a referral for Patient A for medical evaluation/consultation.
8. Inappropriately undertook the care and treatment of and/or managed the care and treatment of Patient A's medical condition, including respiratory condition.
9. Failed to appropriately respond to and/or assess Patient A's potential danger to himself, and/or to note same.
10. Failed to maintain an office record for Patient A in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

B. Respondent, at his office, undertook the psychiatric care and treatment of Patient B from on or about July 26, 1990 through on or about November 3, 1998 Respondent:

1. Failed to obtain and/or note an adequate, comprehensive psychiatric and medical history from Patient B.
2. Failed to perform and/or note a mental status examination of Patient B and a periodic assessments of the patient's diagnosis, symptoms, medication side effects and/or treatment.
3. Failed to develop and maintain a treatment plan for Patient B, and/or to note such a plan.
4. Inappropriately and without acceptable medical indication and/or justification, prescribed and/or maintained Patient B on various medications, to wit:
   a. Amitriptyline
   b. Ascendin
   c. Dilaudid
   d. Lithium
   e. Thorazine
   f. Valium
   g. Vistaril
   h. Inderal
   i. Percodan
   j. Percocet
5. Failed to appropriately monitor and/or manage Patient B's risk of addiction to and harm from the use of prescribed opioid medications, and/or to note same.

6. Failed to appropriately refer and/or note a referral for Patient B for medical evaluation/consultation.
7. Failed to communicate with and/or coordinate the treatment of Patient B with other healthcare providers, including migraine specialists, and/or to note same.
8. Inappropriately undertook the care and treatment of and/or managed the care and treatment of Patient A's medical condition, including migraines.
9. Failed to appropriately evaluate and monitor Patient B's frequent emergency room visits, and/or to note same.
10. Failed to appropriately respond to and/or assess Patient B's potential danger to himself and/or others, and/or to note same.
11. Failed to maintain an office record for Patient B in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

C. Respondent, at his office, undertook the psychiatric care and treatment of Patient C from on or about March 21, 1970 through on or about October 26, 1998. Respondent:

1. Failed to obtain and/or note an adequate, comprehensive psychiatric and medical history from Patient C.
2. Failed to perform and/or note a mental status examination of Patient C and a periodic assessments of the patient's diagnosis, symptoms, medication side effects and/or treatment.
3. Failed to develop and maintain a treatment plan for Patient C, and/or to note such a plan.
4. Failed to conduct treatment sessions with Patient C on an

appropriate and clinically reasonable schedule, and/or to note same.

5. Inappropriately and without acceptable medical indication and/or justification, prescribed and/or maintained Patient C on various medications, to wit:
   a. Doriden,
   b. Percocet,
   c. Dalmane,
   d. Prozac,
   e. Imipramine,
   f. Mellaril
   g. Triavil
   h. Elavil
   i. Valium
   j. Thorazine
   k. Lomotil.
6. Failed to appropriately monitor and/or manage Patient C's addiction and withdrawal from prescribed medications; and/or to note same.
7. Failed to appropriately manage Patient C's withdrawal from alcohol, and/or to note same.
8. Failed to appropriately refer and/or note a referral for Patient C for medical evaluation/consultation.
9. Failed to communicate with and/or coordinate the treatment of Patient C with other healthcare providers, and/or to note same.
10. Inappropriately undertook the care and treatment of and/or managed the care and treatment of Patient C's medical

condition(s), including complaints of gastrointestinal problems and back pain.

11. Failed to appropriately respond to and/or assess Patient C's potential danger to others, and/or to note same.

12. Failed to maintain an office record for Patient C in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

AMENDED 6/28/02

D. Respondent, at his office, undertook the psychiatric care and treatment of Patient D from on or about May 23, 1973 through on or about ~~November 18, 1994~~ APRIL 25 2002. Respondent:

1. Failed to obtain and/or note an adequate, comprehensive psychiatric and medical history from Patient D.

2. Failed to perform and/or note a mental status examination of Patient D and a periodic assessments of the patient's diagnosis, symptoms, medication side effects and/or treatment.

3. Failed to develop and maintain a treatment plan for Patient D, and/or to note such a plan.

4. Failed to conduct treatment sessions with Patient D on an appropriate and clinically reasonable schedule, and/or to note same.

5. Inappropriately and without acceptable medical indication and/or justification, prescribed and/or maintained Patient D on various medications, to wit:

   a. Dextroamphetamine

   b. Stelazine

   c. Lithium

d. Parnate

e. Marplan

f. Prozac

6. Failed to appropriately monitor and/or manage Patient D's risk of addiction and/or withdrawal from prescribed amphetamines; and/or to note same.

7. Failed to appropriately refer and/or note a referral for Patient D for medical evaluation/consultation.

8. Failed to communicate with and/or coordinate the treatment of Patient D with other healthcare providers, and/or to note same.

9. Inappropriately undertook the care and treatment of and/or managed the care and treatment of Patient D's medical condition(s), including complaints of chronic fatigue.

10. Failed to appropriately respond to and/or assess Patient D's potential danger to himself and/or others, and/or to note same.

11. Failed to maintain an office record for Patient D in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

E. Respondent, at his office, undertook the psychiatric care and treatment of Patient E from on or about August 1, 1994 through on or about November 10, 1998. Respondent:

1. Failed to obtain and/or note an adequate, comprehensive psychiatric and medical history from Patient E.

2. Failed to perform and/or note a mental status examination of Patient E and a periodic assessments of the patient's diagnosis, symptoms, medication side effects and/or treatment.

3. Failed to develop and maintain a treatment plan for Patient E, and/or to note such a plan.

4. Failed to conduct treatment sessions with Patient E on an appropriate and clinically reasonable schedule, and/or to note same.

5. Inappropriately and/or without acceptable medical indication and/or justification, prescribed and/or maintained Patient E on various medications, to wit:

   a. Prozac
   b. Zoloft
   c. Dalmane
   d. Valium
   e. Butalbital
   f. Seconal
   g. Zaroxolyn
   h. Theodur
   i. Asthmacort
   j. Beconase Inhaler
   k. Claritin
   l. Prilosec
   m. Erythromycin
   n. Codeine

6. Failed to appropriately monitor and/or manage Patient E's risk of addiction and/or withdrawal from prescribed sedative-hypnotics; and/or to note same.

7. Failed to appropriately refer and/or note a referral for Patient E for medical evaluation/consultation.

8. Inappropriately undertook the care and treatment of and/or managed the care and treatment of Patient E's medical condition(s), including asthma.

9. Failed to appropriately maintain and/or note communications with another mental health care provider seeing Patient E.

10. Failed to appropriately respond to and/or assess Patient E's potential danger to herself and/or others, and/or to note same.

11. Failed to maintain an office record for Patient E in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

F. Respondent, at his office, undertook the psychiatric care and treatment of Patient F from on or about April 21, 1987 through on or about March 10, 1998. Respondent:

1. Failed to obtain and/or note an adequate, comprehensive psychiatric and medical history from Patient F.

2. Failed to perform and/or note a mental status examination of Patient F and a periodic assessments of the patient's diagnosis, symptoms, medication side effects and/or treatment.

3. Failed to develop and maintain a treatment plan for Patient F, and/or to note such a plan.

4. Failed to conduct treatment sessions with Patient F on an appropriate and clinically reasonable schedule, and/or to note same.

5. Inappropriately and/or without acceptable medical indication and/or justification, prescribed and/or maintained Patient F on various medications, to wit:

a. Lithium

b. Nortriptyline

c. Synthroid

d. Trazodone

e. Allopurinol

f. Colchicine

g. Hydrochlorothiazide

6. Failed to appropriately refer and/or note a referral for Patient F for medical evaluation/consultation.

7. Inappropriately undertook the care and treatment of, and/or managed the care and treatment of, Patient F's medical conditions, including gout.

8. Failed to maintain an office record for Patient F in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts in paragraphs A, A(1) - A(4), A(5)(a) - A(5)(k), A(6) - A(10), B, B(1) - B(3), B(4)(a) - B(4)(j), B(5) - B(11), C, C(1) - C(4), C(5)(a) - C(5)(k), C(6) - C(12), D, D(1) - D(4), D(5)(a) - D(5)(f), D(6) - D(11), E, E(1) - E(4), E(5)(a) - E(5)(n), E(6) - E(11), F, F(1)

- F(4), F(5)(a) - F(5)(g), F(6) - F(8).

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. The facts in paragraphs A, A(1) - A(4), A(5)(a) - A(5)(k), A(6) - A(10), B, B(1) - B(3), B(4)(a) - B(4)(j), B(5) - B(11), C, C(1) - C(4), C(5)(a) - C(5)(k), C(6) - C(12), D, D(1) - D(4), D(5)(a) - D(5)(f), D(6) - D(11), E, E(1) - E(4), E(5)(a) - E(5)(n), E(6) - E(11), F, F(1) - F(4), F(5)(a) - F(5)(g), F(6) - F(8).

THIRD THROUGH EIGHTH SPECIFICATION

GROSS NEGLIGENCE

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

3. The facts in paragraphs A, A(1) - A(4), A(5)(a) - A(5)(k), A(6) - A(10).
4. The facts in paragraphs B, B(1) - B(3), B(4)(a) - B(4)(j), B(5) - B(11).
5. The facts in paragraphs C, C(1) - C(4), C(5)(a) - C(5)(k), C(6) - C(12).
6. The facts in paragraphs D, D(1) - D(4), D(5)(a) - D(5)(f), D(6) -

D(11).

7. The facts in paragraphs E, E(1) - E(4), E(5)(a) - E(5)(n), E(6) - E(11).

8. The facts in paragraphs F, F(1) - F(4), F(5)(a) - F(5)(g), F(6) - F(8).

NINTH SPECIFICATION

GROSS INCOMPETENCE

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

9. The facts in paragraphs A, A(1) - A(4), A(5)(a) - A(5)(k), A(6) - A(10), B, B(1) - B(3), B(4)(a) - B(4)(j), B(5) - B(11), C, C(1) - C(4), C(5)(a) - C(5)(k), C(6) - C(12), D, D(1) - D(4), D(5)(a) - D(5)(f), D(6) - D(11), E, E(1) - E(4), E(5)(a) - E(5)(n), E(6) - E(11), F, F(1) - F(4), F(5)(a) - F(5)(g), F(6) - F(8).

TENTH THROUGH FIFTHTEENTH SPECIFICATION

UNWARRANTED TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

10. The facts in paragraphs A and A(5)(a) - A(5)(k).

11. The facts in paragraphs B and B((4)(a) - B(4)(j).

12. The facts in paragraphs C and C(5)(a) - C(5)(k).

13. The facts in paragraphs D and D(5)(a) - D(5)(f).

14. The facts in paragraphs E and E(5)(a) - E(5)(n).

15. The facts in paragraphs F and F(5)(a) - F(5)(g).

SIXTEENTH THROUGH TWENTY-FIRST SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

16. The facts in paragraphs A, A(1) - A(4), A(6), A(7), A(9) and A(10).

17. The facts in paragraphs B, B(1) - B(3), B(5) - B(7) and B(9) - B(11).

18. The facts in paragraphs C, C(1) - C(4), C(6) - C(9), C(11) and C(12).

19. The facts in paragraphs D, D(1) - D(4), D(6) - D(8), D(10 and D(11).

20. The facts in paragraphs E, E(1) - E(4), E(6), E(7), and E(9) - E(11).

21. The facts in paragraphs F, F(1) - F(4), F(6) and F(8).

DATED: March 7, 2002
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX TWO

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

ORIGINAL

---------- X

IN THE MATTER

OF

JACOB HARRIS, M.D.

RESPONDENT'S ANSWER TO THE STATEMENT OF CHARGES

---------- X

JACOB HARRIS, M.D., by his attorneys, WOOD & SCHER, as and for his Answer to the Statement of Charges, alleges as follows:

FACTUAL ALLEGATION

Denies each and every factual allegation contained in the Statement of Charges.

SPECIFICATIONS OF PROFESSIONAL MISCONDUCT

Respondent denies each and every one of the specifications of professional misconduct, denies he engaged in any conduct which would warrant the sustaining of any specification and demands a hearing.

AS AND FOR AN AFFIRMATIVE DEFENSE

All of the allegations in this case will be resolved on the basis of whether or not clinical judgment was appropriately exercised under the existing circumstances and whether or not documentation of the care provided was adequate. These issues should be resolved in a

quality assurance proceeding or in academic debate, not in a disciplinary proceeding which places at risk the licensure and reputation of a physician who has spent 42 years providing professional care to psychiatric patients.

WHEREFORE, Dr. Harris requests a determination be issued dismissing the Statement of Charges in its entirety and granting such other and further relief as may be just.

Dated: Scarsdale, NY
April 23, 2002

WOOD & SCHER

By REDACTED
William L. Wood, Jr.

Attorneys for Dr. Harris
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Scarsdale, New York 10583

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New York State
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Office of Professional Medical Conduct
145 Huguenot St.
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Attn: Jonathan Brandes, Esq.
A.L.J.