STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

November 8, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ejder Karabag, M.D.
18 East Roe Boulevard
Patchogue, New York 11772-1602

Jeffrey Bettan, Esq.
229 Post Avenue
Westbury, New York 11590

Ralph J. Bavaro, Esq.
NYS Department of Health
Bureau of Professional
Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

RE: In the Matter of Ejder Karabag, M.D.

Dear Dr. Karabag. Mr. Bettan and Mr. Bavaro:

Enclosed please find the Determination and Order (No. ARB 93-113) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 than be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rg
Enclosure

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

IN THE MATTER	:	ADMINISTRATIVE REVIEW BOARD
OF	:	DETERMINATION AND ORDER
EJDER KARABAG, M.D.	:	ARB NO.93-113

The Administrative Review Board for Professional Medical Conduct (Review Board), consisting of **ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on October 8, 1993 to review the Professional Medical Conduct Hearing Committee's (Committee) August 9, 1993 Determination finding Dr. Ejder Karabag guilty of professional misconduct. The Respondent, Dr. Karabag, requested the review through a Notice which the Review Board received on August 19, 1993. **JAMES F. HORAN** served as Administrative Officer to the Review Board. The Respondent did not submit a brief to the Review Board.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing

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[1]. Dr. Price and Dr. Sinnott took place in the deliberations by telephone.

committee's findings of fact and conclusions of law; and

- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Office of Professional Medical Conduct charged the Respondent with negligence on more than one occasion, incompetence on more than one occasion, gross negligence, gross incompetence and fraudulently practicing the profession. The charges arose from the allegedly inappropriate and excessive prescribing of narcotic analgesics and other medications. The charges involved the Respondent's treatment of ten people, Patients A through J.

The Hearing Committee sustained the charges of gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion. The Committee did not sustain the charge of practicing the profession fraudulently. The Committee found that the Respondent had prescribed drugs in excessive quantities, without adequate evaluation in the cases of Patients A through I. In the cases of Patients A and F, the Committee found that the Respondent had

continued to prescribe narcotics, even though the Respondent should have known that the Patients were substance abusers. The Committee found that the Respondent had exhibited gross negligence, gross incompetence, incompetence on more than one occasion and negligence on more than one occasion over a long period of time. The Committee determined that they had no choice but to revoke the Respondent's license to practice medicine.

REQUESTS FOR REVIEW

Although the Respondent requested this review, the Respondent failed to file a brief with the Review Board. In the absence of any statement by the Respondent setting out what the Respondent felt were the reasons to overturn or modify the Committee's Determination, the Board reviewed this case under the criteria set out in Public Health Law Section 230-c(4)(b).

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below. The Review Board votes to sustain the Hearing Committee's Determination that the Respondent was guilty of gross and repeated acts of negligence and gross and repeated acts of incompetence. The Determination is consistent with the Hearing Committee's findings and conclusions.

The Review Board votes unanimously to sustain the Hearing Committee's Determination to revoke the Respondent's license to practice medicine in New York State. That

Determination is consistent with the Hearing Committee's findings and conclusions and the penalty is appropriate in view of the serious and repeated nature of the Respondent's misconduct. The Review Board sees no reason to modify the penalty.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The August 9, 1993 Determination by the Hearing Committee on Professional Medical Conduct, finding Dr. Ejder Karabag guilty of professional misconduct is sustained.

2. The Hearing Committee's Determination revoking the license of Dr. Karabag to practice medicine in New York State is sustained.

ROBERT M. BRIBER

MARYCLAIRE B. SHERWIN

WINSTON S. PRICE, M.D.

EDWARD C. SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF EJDER KARABAG, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Karabag.

DATED: **Albany, New York**
~~**October**~~ November 5, 1993

ROBERT M. BRIBER

IN THE MATTER OF EJDER KARABAG, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Karabag.

DATED: **Albany, New York**
~~**October**~~ November 5, **1993**

Maryclaire B. Sherwin
MARYCLAIRE B. SHERWIN

IN THE MATTER OF EJDER KARABAG, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Karabag.

DATED: Brooklyn, New York
~~**October**~~ November 5 **, 1993**

WINSTON S. PRICE

IN THE MATTER OF EJDER KARABAG, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Karabag.

DATED: Roslyn, New York
October 30, 1993

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF EJDER KARABAG, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Karabag.

DATED: **Syracuse, New York**
~~**October**~~ November 5, **1993**

William A Stewart
WILLIAM A. STEWART, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

August 9, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ejder Karabag, M.D.
18 East Roe Boulevard
Patchogue, New York 11772-1602

Jeffrey Bettan, Esq.
229 Post Avenue
Westbury, New York 11590

Ralph J. Bavaro, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

RE: In the Matter of Ejder Karabag, M.D.

Dear Dr. Karabag, Mr. Bettan and Mr. Bavaro:

Enclosed please find the Determination and Order (No.BPMC-93-113) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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Albany, New York 12237

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 than 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), "(t)he 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 all action 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
Corning Tower -Room 2503
Empire State Plaza
Albany, New York 12237-0030

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.

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

IN THE MATTER	:	DETERMINATION
OF	:	AND
EJDER KARABAG, M.D.	:	ORDER
		No. BPMC-93-113

Kenneth Kowald, Chairperson, George Hyams, M.D. and **Daniel A. Sherber, M.D.** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 230 (1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Jane B. Levin, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	February 2, 1993
Statement of Charges dated:	February 2, 1993
Pre-hearing conference:	March 3, 1993
Hearing dates:	March 3, 1993 May 4, 1993 May 26, 1993
Deliberation date:	June 30, 1993

Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Ralph J. Bavaro, Esq. Associate Counsel
Respondent appeared by:	Jeffrey Bettan, Esq. 229 Post Avenue Westbury, N.Y. 11590

MOTIONS

1. Respondent's motion on March 3, 1992 at the pre-hearing conference to determine the circumstances under which the records were obtained was DENIED.

2. Petitioner's motion on May 4, 1993 to generally exclude Respondent's introduction of exhibits which had not been included in the certified records, since said exhibits had not been produced prior to the hearing was DENIED.

WITNESSES

For the Petitioner:
1) Elmer Pater, M.D.

For the Respondent:
1) Edjer Karabag, M.D.

STATEMENT OF CHARGES

The Amended Statement of Charges essentially charges the Respondent with professional misconduct in that he was practicing with negligence on more than one occasion, was practicing with

gross negligence, was practicing with incompetence on more than one occasion, was practicing with gross incompetence, and was practicing fraudulently, because of his inappropriate and excessive prescribing of narcotic analgesics and other medications.

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

FINDINGS OF FACT

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

GENERAL FINDINGS

1. Respondent was authorized to practice medicine in New York State by the issuance of license number 081480 on September 22, 1958 (Pet.'s Ex. 2).

2. Respondent is currently registered to practice medicine with the New York State Department of Education (Pet.'s Ex. 2).

FINDINGS OF FACT AS TO PATIENT A

1. Patient A was first seen by Respondent on January 5, 1982, at age 36, with a history of a fall from a ladder and sustaining of a back injury (superficial left side of thorax) in May 1981. There is a notation that Patient A had had an x-ray done at the Veterans Administration Hospital but there is no report or indication of the x-ray findings in the record. His blood pressure was taken at 90/80 and weight at 143 (Pet.' Ex. 3; T. 35).

2. On March 23, 1982 Patient A visited Respondent and complained of lower back pain. His blood pressure was 110/80, weight 145. There was no evidence of further evaluation. Respondent prescribed 100 Tylenol with codeine #4. On May 15, 1982, the only notation is for a prescription for 90 Tylenol with codeine #41 t.i.d. no refills. No weight, blood pressure, history or physical examination were noted. On June 28, 1982, only a prescription is noted for 100 Tylenol with codeine #4. On August 14, 1982 Patient A's blood pressure was taken at 120/80, weight at 144. There was a complaint of back pain and a prescription given for 100 Tylenol with codeine #4. On September 25, 1982, in a handwriting other than Respondent's, the following is recorded: prescription for 100 Tylenol with codeine #4, one q.i.d. no refills, "must be examined before next prescription is given". On December 3, 1982, a blood pressure of 130/80 and weight of 146 is recorded with a prescription for

100 Tylenol with codeine #4. There was then a hiatus in office visits until December 3, 1985 (Pet.'s Ex. 3).

3. From December 3, 1985 until January 23, 1992, Patient A continued to see Respondent at intervals varying between approximately 1 and 6 weeks. With a few exceptions each visit essentially involved a complaint of back pain, a recording of blood pressure and weight, and a prescription for Tylenol with codeine #4 or Percodan. Occasionally there were other miscellaneous notations such as "chest clear" (5/14/86, 1/12/87, 2/14/87, 4/3/87, 5/13/88, 8/23/88, 1/4/89, 5/12/89, 11/1/89, 2/26/90, 10/16/90, 3/18/91, 6/22/91, 7/11/91), or "abdomen negative" (1/13/90, 2/26/90, 12/6/90/, 6/22/91, 9/5/91) (Pet.'s Ex. 3). There is no evidence of a complete or thorough physical examination at any time. There is no evidence of neurological evaluation or consultation. There is no evidence of an orthopedic evaluation or consultation. The only laboratory tests done were on July 10, 1990, when the following was recorded: RBC 4.34, and occult blood 4+ and albumin 4+ in the urine, and several other results such as specific gravity, glucose, globulin, etc. On August 7, 1990 there is a notation that the urine was clear. There was no further investigation of Patient A's hematuria or albuminuria indicated (Pet.'s Ex. 3; T. 40, 43).

4. Starting in December 1985, after the three year hiatus, through January 1992, Respondent gave Patient A 59 more prescriptions for 100 tablets of Tylenol with codeine #4, and 27

prescriptions for 100 tablets of Percodan. In many instances the prescriptions were issued less then 2 weeks apart and as little as 7 or 8 days apart (for example 12/5 12/12/91, and 3/1-3/9/88).

CONCLUSIONS AS TO PATIENT A

1. At no time, either at the initial visit or on subsequent visits over the course of ten years, did Respondent adequately evaluate Patient A, or attempt to investigate the etiology of his complaints of back pain. The indications, unfulfilled by Respondent, were for more complete history and physical examinations, radiology tests such as x-rays and/or scans, blood tests, and an orthopedic consultation (T. 42).

2. It was readily apparent that Patient A was either addicted to or dependent on narcotics. Yet Respondent continued to prescribe excessive amounts of a strong narcotic analgesic to Patient A without adequately evaluating him or rendering sufficient medical treatment (T. 40-44, 51).

FINDINGS OF FACT AS TO PATIENT B

1. Patient B first saw Respondent on June 18, 1984 at age 68, complaining of a cough. Patient B was a heavy smoker and had a history of polio at age 1-2. Respondent recorded blood pressure and weight, and found bilateral edema of the legs. Respondent diagnosed COPD (chronic obstructive pulmonary disease)

(Pet.'s Ex. 4). No chest x-ray was ordered as indicated (T. 57). Respondent then saw Patient B on June 11, 1985, October 11, 1985 and July 22, 1986 (Pet.'s Ex. 4).

2. Respondent began seeing Patient B again on a regular basis on September 11, 1987 and continued seeing him through 1992. During that period, notations of Patient B being a heavy smoker and complaining of coughing continued (Pet.'s Ex. 4). However Respondent made no effort to adequately investigate or treat Patient B's COPD, for example by ordering arterial blood gases and pulmonary function studies; a chest x-ray was not done until April 8, 1992, which showed extensive chronic lung disease (T. 55-57).

3. Beginning on June 7, 1988 until September 9, 1991, Respondent began prescribing Tylenol with codeine #4 in amounts of 30, 50, 60, and 80 (Pet.'s Ex. 4). During that time period Patient B had a total of 82 visits with Respondent, approximately once every two weeks. On 79 of those visits Patient B received a prescription for Tylenol with codeine #4, apparently for complaints of back or leg pain (Pet.'s Ex. 4). Respondent never investigated or characterized the etiology of the pain (T. 56).

CONCLUSIONS AS TO PATIENT B

1. Indications for Patient B's complaints of pain, unfulfilled by Respondent, were for more blood tests, and orthopedic and neurologic evaluation or consultation (T. 57).

2. As in the previous case, Respondent continued to prescribe excessive amounts of narcotic analgesics without adequately evaluating Patient B or rendering appropriate medical treatment.

FINDINGS OF FACT AS TO PATIENT C

1. Patient C first saw Respondent on June 9, 1984 at age 37. History was of car accident 1 1/2 years ago, "all kinds of tests were done" apparently negative (Pet.'s Ex. 5, T. 76, 77). Pulse, blood pressure and weight were the only signs of physical examination being done. There was no specific complaint and no diagnosis. Respondent prescribed 50 Tylenol with codeine #3 and 30 Halcion .5 mgs (Pet.'s Ex. 5).

2. Patient C also received prescriptions for Tylenol with codeine #3 on August 4, 1984 for a complaint of headache, and on September 8, 1984 for complaint of headache and lower back pain (Pet.'s Ex. 5). Patient C also received Halcion .5 mgs. on August 4, and September 8, 1984 presumably as a sleeping pill, however that is not stated in the record (T. 66-67). The next visit was on October 29, 1986 where Mellaril was prescribed. The next visit was not until November 16, 1988 where Tylenol with codeine #4 was prescribed for lower back pain (Pet.'s Ex. 5).

3. On June 14, 1989, Respondent began seeing Patient C on a more regular basis. Between June 14, 1989 and August 24, 1991, Patient C saw Respondent 46 times, approximately once every

two to three weeks. Patient C received prescriptions for 50, 80 or 100 (mostly 100) Tylenol with codeine #4 on every visit, with the exception of one visit on July 12, 1989 where he received phenobarbital (Pet.'s Ex. 5).

CONCLUSIONS AS TO PATIENT C

1. Throughout that period of prescribing Respondent did not investigate the etiology of Patient C's pain. There is no evidence of x-rays, laboratory work or orthopedic consultation (T. 65-66, 77).

2. As in previous cases, Respondent continued to prescribe excessive amounts of narcotic analgesics without rendering adequate evaluation or appropriate medical treatment (T.65,66).

FINDINGS OF FACT AS TO PATIENT D

1. Patient D began seeing Respondent on December 13, 1982 at age 41. The initial complaint was of disc problem in the back. There was history of having been examined by a neurosurgeon and orthopedist, and something about pain 5 years ago. Pulse, blood pressure, and weight were taken. Other physical findings indicated that Respondent looked at Patient D's back and legs (pain at lumbosacral region, pain aggravated with lifting hips, leg) (Pet.'s Ex. 6). There is no evidence of a more complete physical examination such as a neurological

evaluation, complete history, or tests such as x-rays, CT or MRI which were indicated (T. 83-84). Respondent prescribed Valium 10 mgs. t.i.d. and 100 Tylenol with codeine #4 (Pet.'s Ex. 6).

2. From the next office visit of March 23, 1984 until June 24, 1991, Patient D visited Respondent with a frequency of approximately one visit every one to two weeks apart. On every visit Patient D received prescriptions for one or more narcotic analgesics such as Tylenol with codeine #4, Vicodin, Synalgos, Darvon or Hycodan, in combination with a benzodiazepene such as Valium, Tranxene or Xanax. Each office visit entry in exhibit 6, with few exceptions, consists merely of a patient complaint of pain and/or cough and a list of prescriptions (Pet.'s Ex. 6). There is virtually no evidence of evaluations or other medical treatment. The only indication of any evaluation whatsoever, are occasional notations of "chest clear"; some weight and blood pressure readings; a notation of "going to have CAT scan" on 5/24/85 (no further mention of tests or results); and a CBC on 9/8/87 and 8/15/88 (T. 80-82).

CONCLUSIONS AS TO PATIENT D

1. Throughout that period of prescribing there is no evidence of adequate evaluation such as: physical examination, history, laboratory and radiology tests (T. 81-82, 92,93).

2. There were no indications for the prescriptions that were given.

FINDINGS OF FACT AS TO PATIENT E

1. Patient E first saw Respondent on September 9, 1981 at age 49. History given was pain over left shoulder since 1978; no injury; had been under care of Veterans Administration Hospital; Motrin 400 mgs. q.i.d. Examination consisted of blood pressure, weight and a notation "able to move left shoulder". X-ray was apparently suggested but there is no evidence that it was ever done. Respondent prescribed Motrin 400 mgs. q.i.d. On September 19, 1981 Patient E was admitted to Brookhaven Memorial Hospital having suffered a myocardial infarction (Pet.'s Ex. 7, T. 99).

2. From 1981 through August 19, 1991 Patient E had office visits with Respondent approximately every two to three weeks apart. Valium 10 mgs. was prescribed continuously from 1981 through 1988 (except for first two prescriptions of 5 mgs.). From approximately December 10, 1981 until January 28, 1986, and again from May 19, 1987 to December 23, 1988, Patient E regularly (almost every visit) received prescriptions for two benzodiazapines simultaneously: Valium and Dalmane 30 mgs. (1981-1986) or Valium and Halcion .5 mgs. (1987-1988) (Pet.'s Ex. 7). The Dalmane prescription increased from one HS (hour of sleep) to one-two HS. Prescriptions of sleeping medications such as the Dalmane and Halcion over a long period of time, as here, are considered habituating (T. 100). In addition, Patient E received prescriptions for, among other things, Tylenol with

Codeine #4 continuously (almost every visit) from August 20, 1984 through August 17, 1991 (Pet.'s Ex. 7).

CONCLUSIONS AS TO PATIENT E

1. There were no adequate indications for the prescriptions given to Patient E (T. 99-100, 127-128). Continuous prescribing of narcotic analgesics is not appropriate for the acute relief of pain (T. 101). There was likewise no evidence of adequate physical examination or history. There was some blood work (triglycerides and cholesterol elevated), EKG's, and radiology (knee x-ray 7/85, cerebral CT 1/88), however, those were insufficient in view of the prescriptions Patient E was receiving. Moreover, abnormal laboratory results were not evaluated as indicated. There was also no evidence of an orthopedic consultation as indicated (T. 127-129).

2. In view of Patient E's history of myocardial infarction, elevated cholesterol and triglycerides, nervousness and increasing dependence on prescriptions for narcotic analgesics and benzodiazapines, the continued prescribing engaged in by Respondent was contraindicated (T. 105-112).

3. Respondent excessively prescribed narcotic analgesics and benzodiazipines to Patient E and failed to render adequate evaluation or medical treatment (T. 100-101).

FINDINGS OF FACT AS TO PATIENT F

1. Patient F first saw Respondent on May 3, 1972 at age 15. The next relevant office visit was April 7, 1979 when Patient F was age 23 (T. 132). On that visit Patient F was noted to have an alcohol problem and possible pancreatitis. Physical evaluation apparently consisted of only a weight and blood pressure reading, and palpation of the abdomen. No laboratory tests such as liver or pancreatic function or amylase were ordered. Respondent prescribed Valium 5 mgs. q.i.d. (Pet.'s Ex. 8).

2. Patient F continued to see Respondent with increasing frequency until September 1991. Between 1980 and 1982 Patient F received several more prescriptions for Valium 5 and 10 mgs., as well as Dalmane (Pet.'s Ex. 8). Between 1984 and 1985 Patient F received prescriptions for codeine without adequate indications (T. 133). On February 15, 1985 the possibility of codeine abuse was first noted (Pet.'s Ex. 8). Beginning on March 3, 1986 Patient F received prescriptions for Darvon 65 on almost every visit for no apparent medical purpose (T. 133). The frequency of Patient F's visits and therefore prescriptions progressively increased, so that Patient F received large quantities (over 100 prescriptions in 5 year period) of Darvon 65 (T. 133, 134). From 1984 through 1987 there were usually 1 or 2 office visits per month. From 1988 through 1991 there were usually 3 or 4 office visits per month. In March 1989, August

and September 1990, and January and February 1991 there were 5 visits each month, and in June 1990 six visits. In December 1990 there were 8 visits, on the 4th, 6th, 8th, 12th, 19th, 21st, 26th, and 31st (listed out of order on 3 separate pages), with a prescription for 50 Darvon 65 each time (Pet.'s Ex. 8).

3. Darvon has an additive effect with alcohol and is a particularly dangerous combination (T. 134).

4. Respondent's office notes consist primarily of weight and blood pressure readings, 1 or 2 remarks such as "chest clear" or "abdomen tender", etc., and prescriptions. Respondent did not address Patient F's alcohol abuse and pancreatitis episodes (T. 133).

CONCLUSIONS AS TO PATIENT F

1. There is no evidence of the evaluation indicated for Patient F, such as a more thorough history; physical examination to ascertain whether there was an enlarged liver, enlarged spleen, jaundice, neurological symptoms or other stigmata; liver and pancreatic function tests; and other laboratory tests (T. 135). Complaints of gastric problems such as stomach and back pain in 1990 to 1991 were uninvestigated (T. 136-137).

2. Respondent prescribed benzodiazapines and in particular narcotic analgesics excessively to a patient whom Respondent knew or should have known was a substance abuser, without rendering adequate evaluation or medical treatment (T.135-36).

FINDINGS OF FACT AS TO PATIENT G

1. Patient G first visited Respondent on April 21, 1982 at age 64. Hypertension and knee pain were listed as complaints. Those parts of the record which were not illegible reveal that the physical findings included: pulse, blood pressure of 150/100, weight 250, obese, heart irregular, chest clear, abdomen obese, knees arthritic changes, EKG, sinus arrythmia. Diagnosis was listed as ASCVD, hypertensive, rheumatoid arthritis (Pet.'s Ex. 9). There is no evidence regarding the extent of arthritis, whether it was acute, chronic, degenerative, inflammatory, etc., (T. 139). Respondent placed Patient G on dyazide b.i.d., butazolidine t.i.d. and Valium 5 mgs. q.i.d. (Pet.'s Ex. 9).

2. Patient G received prescriptions for butazolidine intermittently for months at a time from April 1982 through December 1985. Specifically, Patient G received prescriptions for butazolidine on the following dates in 1982: 4/21, 7/14, 10/26, 11/22, 12/17; in 1983: 1/25, 2/21, 4/22, 9/20, 10/25; in 1984: 1/25; in 1985: 1/30, 3/29, 5/15, 6/5, 12/11 (Pet.'s Ex. 9).

3. Patient G also received prescriptions for 100 Valium 5 mgs. each on at least 14 occasions between April 1982 and October 1983, without any indication apparent from the record (Pet.'s Ex. 9).

4. Patient G also received at least 18 prescriptions for Tylenol with codeine #4, 50-80 tablets, between October 1987 and December 1991 apparently for knee pain (Pet.'s Ex. 9). Patient G

visited Respondent until January 22, 1992 (Pet.'s Ex. 9).

CONCLUSIONS AS TO PATIENT G

1. During Patient G's ten year history of knee and arthritic pain, Respondent failed to take any x-rays or obtain any orthopedic or rheumatology consultations.

2. Respondent prescribed narcotic analgesics, benzodiazapines and butazolidine to Patient G excessively, without adequate evaluation and monitoring such as complete history, physical examination, radiology and laboratory tests, and without rendering adequate medical treatment (T. 139-141).

FINDINGS OF FACT AS TO PATIENT H

1. Patient H saw Respondent for her first and only visit on June 5, 1990. Patient H went to Respondent for assistance in losing weight. Respondent weighed Patient H at 193, took a blood pressure reading of 140/90, and listened to her chest with a stethoscope. Respondent recorded regular sinus rhythm, past history of appendectomy and nephritis. Her thyroid was not palpable (Pet.'s Ex. 10).

2. Patient H remained fully clothed during the examination. Respondent asked Patient H whether she had any serious illnesses such as diabetes, to which Patient H responded in the negative (T. 8, 9, 22, 143). According to the chart and

Patient H's testimony, Respondent did no further evaluation.

3. Next Respondent took out a prescription pad, and asked Patient H what pills she wanted. Patient H responded that she did not know, and that she expected Respondent to tell her that (T. 9). Respondent's inquiry of Patient H regarding what drug she wanted, was a clear departure from standards (T. 146).

4. Respondent prescribed 60 Didrex 50 mgs. with three refills. Respondent did not, according to the chart and Patient H's testimony, speak to Patient H about diet or give her a diet to follow (Pet.'s Ex. 10, T. 11).

5. Respondent told Patient H that she could return for another prescription at no charge if the Didrex was not strong enough. Respondent did not request that the patient return for a follow-up visit (T. 10).

CONCLUSIONS AS TO PATIENT H

1. Because Didrex has the potential for abuse and indications are to discontinue it within approximately two to four weeks if the patient does not respond (i.e. lose weight), Respondent should have scheduled a follow up visit for Patient H to see if she responded to the medication (T. 144-45).

2. Didrex is intended only as an adjunct to dietary treatment for obesity and behavioral modification. It should only be prescribed in conjunction with dietary management. Respondent failed to do that here (T. 145).

FINDINGS OF FACT AS TO PATIENT I

1. Patient I, who first saw Respondent on March 12, 1984 at age 35, expressed a desire to lose weight. Respondent took Patient I's pulse, blood pressure at 120/80, and weight at 144. Respondent noted regular sinus rhythm and thyroid not palpable. Respondent prescribed Fastin 30 mgs. b.i.d. (Pet.'s Ex. 11).

2. Patient I was continued on Fastin from March 1984 to November 1991. Specifically, Patient I received prescriptions for 60 Fastin 30 mgs. with three to five refills on: 12/12/84, 3/1/86, 10/24/86, 3/2/87, 1/16/88, 3/18/89, undated 89, 8/25/89, 1/13/90, 5/7/90, 9/8/90, 1/8/91, ?/13/91, 11/15/91. During that period there was no significant weight loss by Patient I. Her weight fluctuated between approximately 141 and 168 (Pet.'s Ex. 11). She had started with a weight of 144 in 1984 and finished at a weight of 156 in 1991 (T. 154).

CONCLUSIONS AS TO PATIENT I

1. Respondent's evaluation during the period of prescribing consisted essentially of taking blood pressures and weight. No complete physical examination, history or chemical monitoring was done (T. 155).

2. Fastin should only be prescribed in conjunction with dietary management, which Respondent failed to do (T. 153-156).

FINDINGS OF FACT AS TO PATIENT J

1. Patient J first saw Respondent on December 1, 1987 at age 71. Patient J was noted to be schizophrenic. There is no evidence of a complete intake history or a complete physical examination (Pet.'s Ex. 12). Patient J, a former psychiatric inpatient, had been a resident of a boarding house since 1987 (Ex. R).

2. Beginning on May 18, 1988 Respondent began administering to Patient J Prolixin, 25 mgs. intramuscularly. Such administration continued for approximately 3 1/2 years until January 14, 1992 on roughly a monthly basis (Pet.'s Ex. 12).

3. A psychiatrist, Dr. Guiyab asked Respondent to administer this medication (T. 527).

CONCLUSIONS AS TO PATIENT J

1. Respondent adequately monitored the administration of medication to Patient J, who was under the care of a psychiatrist who had prescribed the drug (Pet.'s Ex. 12, Resp.'s Ex. R).

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous.)

FIRST SPECIFICATION:
(Practicing with negligence on more than one occasion)

SUSTAINED as to Paragraphs A and A1-A3, B and B1-B3, C and C1-C3, D and D1-D3, E and E1-E3, F and F1-F3, G and G1-G4, and H.

NOT SUSTAINED as to Paragraphs I and J.

SECOND SPECIFICATION:
(Practicing with gross negligence)

SUSTAINED as to Paragraphs B and B1-3, C and C1-C3, D and D1-D3, F and F1-F3.

NOT SUSTAINED as to Paragraphs A and A1-A3, E and E1-E3, G and G1-G4, H, I, J.

THIRD SPECIFICATION:
(Practicing with incompetence on more than one occasion)

SUSTAINED as to Paragraphs A and A1-A3, B and B1-B3, C and C1-C3, D and D1-D3, E and E1-E3, F and F1-F3, H.

NOT SUSTAINED as to Paragraphs G and G1-G4, I, J.

FOURTH SPECIFICATION:
(Practicing with gross incompetence)

SUSTAINED as to Paragraphs A and A1-A3, B and B1-B3, C and C1-C3, D and D1-D3, F and F1-F3.

NOT SUSTAINED as to Paragraphs E and E1-E3, G and G1-G3, H, I, J.

FIFTH SPECIFICATION:
(Practicing the profession fraudulently)

NOT SUSTAINED as to Paragraphs A and A3, B and B3, C and C3, D and D3, E and E3, F and F3, G and G4.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

Respondent has exhibited negligence, incompetence, and in some instances gross negligence and gross incompetence in the practice of his profession over a long period of time. The

Hearing Committee feels that is unfortunate that a physician with the training and background of the Respondent has allowed his medical standards to deteriorate to the point which has left the Committee with no alternative but to revoke his license.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT

1. Respondent's license to practice medicine in the State of New York be revoked.

Dated: New York, New York
July 21, 1993

KENNETH KOWALD
Chairperson

GEORGE HYAMS, M.D.
KENNETH A. SHERBER, M.D.

A P P E N D I X I

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

IN THE MATTER OF EJDER KARABAG, M.D.	NOTICE OF HEARING

TO: EJDER KARABAG, M.D.
18 East Roe Boulevard
Patchogue, NY 11772-1602

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1992) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1992). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 3rd day of March, 1993 at 10:00 in the forenoon of that day at 5 Penn Plaza, Sixth Floor, New York, NY 10016 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce

witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1992), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the

Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

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

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1992). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
February 2, 1993

CHRIS STERN HYMAN,
Counsel

Inquiries should be directed to: Ralph J. Bavaro
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza - 6th floor
New York, New York 10001

Telephone No.: (212) 613-2601

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

IN THE MATTER	:	STATEMENT
OF	:	OF
EJDER KARABAG, M.D.	:	CHARGES

EJDER KARABAG, M.D., the Respondent, was authorized to practice medicine in New York State on September 22, 1958 by the issuance of license number 081480 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at 18 East Roe Boulevard, Patchogue, New York, 11772-2602.

FACTUAL ALLEGATIONS

A. With respect to Patient A (all patients mentioned herein are identified in Appendix A), treated by Respondent in Respondent's office at 18 East Roe Boulevard, Patchogue, New York, from on or about January 1982 through November 1991, Respondent:

1. Inappropriately prescribed narcotic analgesics excessively.

2. Inappropriately prescribed narcotic analgesics without adequate initial and follow-up evaluations including but not limited to physical examinations, history, blood tests and/or x-rays.

3. Prescribed narcotic analgesics for other than a good faith medical purpose.

B. With respect to Patient B, treated by Respondent in Respondent's office from on or about June 1984 through September 1991, Respondent:

1. Inappropriately prescribed narcotic analgesics excessively.

2. Inappropriately prescribed narcotic analgesics without adequate initial and follow-up evaluations including but not limited to physical examinations, history, blood tests and/or x-rays.

3. Prescribed narcotic analgesics for other than a good faith medical purpose.

C. With respect to Patient C, treated by Respondent in Respondent's office from on or about June 1984 through August 1991, Respondent:

1. Inappropriately prescribed narcotic analgesics excessively.

2. Inappropriately prescribed narcotic analgesics without adequate initial and follow-up evaluations including but not limited to physical examinations, history, blood tests and/or x-rays.

3. Prescribed narcotic analgesics for other than a good faith medical purpose.

D. With respect to Patient D, treated by Respondent in Respondent's office from on or about December 1982 through June 1991, Respondent:

1. Inappropriately prescribed narcotic analgesics and benzodiazipines excessively.

2. Inappropriately prescribed narcotic analgesics and benzodiazipines without adequate initial and follow-up evaluations including but not limited to physical examinations, history, blood tests and/or x-rays.

3. Prescribed narcotic analgesics and benzodiazipines for other than good faith medical purpose.

E. With respect to Patient E, treated by Respondent in Respondent's office from on or about September 1981 through August 1991, Respondent:

1. Inappropriately prescribed narcotic analgesics and benzodiazipines excessively.

2. Inappropriately prescribed narcotic analgesics and benzodiazipines without adequate initial and follow-up evaluations including but not limited to physical examinations, history, blood tests and/or x-rays.

3. Prescribed narcotic analgesics and benzodiazipines for other than a good faith medical purpose.

F. With respect to Patient F, treated by Respondent in Respondent's office from on or about May 1972 through September 1991, Respondent:

1. Inappropriately prescribed narcotic analgesics and benzodiazipines excessively.

2. Inappropriately prescribed narcotic analgesics and benzodiazipines without adequate initial and follow-up evaluations including but not limited to physical examinations, history, blood tests and/or x-rays.

3. Prescribed narcotic analgesics and benzodiazipines for other than a good faith medical purpose.

G. With respect to Patient G, treated by Respondent in Respondent's office from on or about April 1982 through January 1992, Respondent:

1. Inappropriately prescribed narcotic analgesics and benzodiazipines excessively.

2. Inappropriately prescribed butazolidin excessively.

3. Inappropriately prescribed narcotic analgesics, benzodiazipines and butazolidin without adequate initial and follow-up evaluations, including but not limited to physical examinations, history, blood tests and/or x-rays.

4. Prescribed narcotic analgesics and benzodiazipines for other than a good faith medical purpose.

H. With respect to Patient H, who sought medical care from Respondent in his office on or about June 5, 1990, Respondent inappropriately prescribed Didrex for weight loss without adequate physical examination, history, and laboratory tests.

I. With respect to Patient I, treated by Respondent in his office from on or about March 1984 through November 1991, Respondent inappropriately prescribed Fastin for weight loss over an excessive period of time (from on or about March 1986 to November 1991) despite no significant weight loss by Patient I.

J. With respect to Patient J treated by Respondent in his office from on or about December 1987 through January 1992,

Respondent administered Prolixin intramuscularly without adequate physical or psychiatric monitoring from on or about May 1988 to October 1991.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1992) in that Petitioner charges at least two of the following:

1. The facts alleged in paragraphs A and A1-A3, B and B1-B3, C and C1-C3, D and D1-D3, E and E1-E3, F and F1-F3, G and G1-G4, H, I, and/or J.

SECOND SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1992), in that Petitioner charges:

2. The facts alleged in paragraphs A and A1-A3, B and B1-B3, C and C1-C3, D and D1-D3, E and E1-E3, F and F1-F3, G and G1-G4, H, I, and/or J.

THIRD SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1992), in that Petitioner charges at least two of the following:

3. The facts alleged in paragraphs A and A1-A3, B and B1-B3, C and C1-C3, D and

D1-D3, E and E1-E3, F and F1-F3, G and G1-G4, H, I, and/or J.

FOURTH SPECIFICATION

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence on more than one occasion under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1992), in that Petitioner charges:

4. The facts alleged in paragraphs A and A1-A3, B and B1-B3, C and C1-C3, D and D1-D3, E and E1-E3, F and F1-F3, G and G1-G4, H, I, and/or J.

FIFTH SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently on more than one occasion under N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1992), in that Petitioner, charges:

5. The facts alleged in paragraphs A and A3, B and B3, C and C3, D and D3, E and E3, F and F3, and/or G and G4.

DATED: New York, New York
February 2, 1993

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct