STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 23, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Carlton F. Thompson, Esq.
Levene, Gouldin & Thompson, LLP
P.O. Box F 1706
Binghamton, New York 13902-0106

Joseph Huberty, Esq.
NYS Department of Health
Corning Tower Room 2438
Empire State Plaza
Albany, New York 12237

Vincent I. Maddi, M.D.
44 Broad Street
Johnson City, New York 13790

RE: In the Matter of Vincent I. Maddi, M.D.

Dear Mr. Thompson, Mr. Huberty and Dr. Maddi:

Enclosed please find the Determination and Order (No. 97-155) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
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,

Tyrone J. Butler/nm

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

VINCENT I. MADDI, M.D.

DECISION AND ORDER OF THE HEARING COMMITTEE

ORDER NO.

BPMC 97- 155

The undersigned Hearing Committee consisting of **DENISE BOLAN, R.P.A.-C, Chairperson, ARSENIO G. AGOPOVICH, M.D., ALBERT M. ELLMAN, M.D.,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, Esq.,** Administrative Law Judge, served 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 **VINCENT I MADDI, M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDING

Original Notice of Hearing and Statement of Charges	Dated: October 7, 1996	Served: October 15, 1996
Notice of Hearing returnable:	November 14, 1996	
Location of Hearing:	Albany and Troy, New York	
Respondent's answer dated / served:		
The State Board for Professional Medical Conduct (hereinafter referred to as "Petitioner" or "The State") appeared by:	**HENRY M. GREENBERG, ESQ.** General Counsel by **JOSEPH HUBERTY, ESQ.** Assistant Counsel Bureau of Professional Medical Conduct Room 2429 Corning Tower Empire State Plaza Albany, New York 12037	
Respondent appeared in person and was represented by:	**CARLTON F. THOMPSON, ESQ.** Levene, Gouldin & Thompson, LLP P.O. Box F 1706 Binghamton, New York 13902-0106	
Respondent's present address:	44 Broad Street, Johnson City, N.Y. 13790	
Respondent's license:	Number: 087947	Registration Date: Sept. 1, 1996 to Aug 31, 1998
Pre-Hearing Conference Held:		
Hearings held on:	November 14, December 5, 1996 and January 2, 1997	
Conferences held on:		
Closing briefs received:	January 28, 1997	
Record closed:	January 28, 1997	
Deliberations held:	February 20, 1997	

SUMMARY OF PROCEEDINGS

The Statement of Charges in this proceeding alleges six grounds of misconduct:

1. Respondent has committed misconduct by **failing to maintain patient records** as set forth in N.Y. Education Law Section 6530 (32)

2. Respondent has committed **negligence on more than one occasion** as forth in N.Y. Education Law Section 6530 (3)

3. Respondent has committed **gross negligence** as set forth in N.Y. Education Law Section 6530 (4)

4. Respondent has committed **incompetence on more than one occasion** as set forth in N.Y. Education Law Section 6530 (5)

5. Respondent has committed **gross incompetence** as set forth in N.Y. Education Law Section 6530 (6)

6. Respondent has committed misconduct **by violating Article 33 of the Public Health Law** as set forth in N.Y. Education Law Section 6530 (9)(e)

The allegations arise from ten patients seen by Respondent from 1974 through 1993 and from two Stipulations and Orders, filed in 1992 and 1993. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One.

Respondent entered a verbal denial of each of the charges.

Petitioner called these witnesses:

Richard B. Toll, M.D.	Expert Witness

Respondent testified and called this witness:

Richard Rynes, M.D.	Expert Witness
Cynthia D. Welch	Character / Fact Witness

SIGNIFICANT LEGAL RULINGS
INSTRUCTIONS TO THE TRIER OF FACT

1. The Administrative Law Judge instructed the panel that negligence as used herein, is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state. Incompetence was defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. Likewise, gross incompetence was defined as a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct. The panel was told that the term egregious meant a conspicuously bad act or severe deviation from standards.

2. With regard to the keeping of medical records, the Committee was instructed that state regulations require a physician to maintain an accurate record of the evaluation and treatment of each patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given chart or record and be able to understand a practitioner's course of treatment and the basis for same.

3. With regard to Factual Allegations J. and K. as well as the Sixth and Seventh Specifications, Respondent is charged with violations of Article 33 of the Public Health Law. Article 33 of the Public Health Law and the regulations published under the authority of Article 33 set up the rules for prescribing controlled substances, more precisely, narcotic and narcotic-like substances. Under the rule of Collateral Estoppel, having signed two stipulations, Respondent is estopped from denying any

facts which the stipulations contain. As a matter of law, Respondent, has admitted he violated Article 33 when he signed the stipulations. The sole issue before the Committee here, is what if any penalty should be imposed based solely on the facts contained in the stipulations.

4. Pursuant to the general authority granted the Administrative Law Judge in Part 51 of the Commissioner's Regulations, (10 NYCRR Part 51, Uniform Hearing Procedures Rules of the New York State Department of Health), the Administrative Law Judge limited the proof in this proceeding to the first five patients of the total of eight patients brought up in the charges. It was the ruling of the Administrative Law Judge that the trier of fact had a sufficient basis upon which to draw fair and impartial conclusions based upon the pattern established by the first five patients. This made the additional three patients redundant and in the nature of bolstering. Redundant and bolstering evidence may be excluded in proceedings before the State Board For Professional Medical Conduct.

5. The standard of proof in this proceeding is a preponderance of the evidence. In assessing whether the proof adduced meets that standard, it was explained to the Committee that the State does not meet its burden of proof, and the charges cannot be sustained against Respondent merely by adducing testimony as to what some other physician would have done in circumstances similar to those found to have existed, at the time of treatment. In order to find that Respondent committed one or more of the Specifications of Charges, the State must demonstrate that Respondent's action, or failure to act, was a departure from accepted standards of medical care as they existed at that time.

6. With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility. The Committee was further instructed that it is not bound to the testimony offered by an expert witness. Notwithstanding the presentation and

qualification of a witness as an expert, the Committee was told it is free to reject some or all of the testimony as irrelevant, not probative, not credible or unpersuasive.

7. The Committee was further under instructions that with regard to a finding of medical misconduct, The Committee must first assess Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any. The Committee was instructed that patient harm need never be shown to establish negligence or incompetence in a proceeding before the State Board For Professional Medical Conduct.

FINDINGS OF FACT

The findings of fact which follow, were made after review of the entire record. Reference to transcript pages (Tr.__) and/or exhibits (Ex.__) denotes evidence that was found persuasive in determining a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous

GENERAL
FINDINGS OF FACT

1. Respondent was authorized to practice medicine in New York State on July 25, 1962 by the issuance of license number 087947 by the New York State Education Department.

2. Respondent is a Board certified internist who has been practicing medicine in the Broome County, New York area since 1965. (Ex. I; Tr. 184)

3. Respondent did a preceptorship in rheumatology at University Hospital in Syracuse with Dr. Pinals and he is a Fellow of the American College of Rheumatologists. (Tr. 185)

FINDINGS OF FACT
WITH REGARD TO
PATIENT A

1. Respondent saw Patient A as an office patient from December 5, 1991 to August 26, 1992. Patient A was an eighty-eight year old male. Respondent did not perform or record a complete medical history of patient A. (Tr. 15, 39, 217, 218, 219, 548, 549; Ex. IV & IV-A)

2. The office record for patient A's visit on December 5, 1991 does not indicate that patient A was suffering dementia. (Tr. 243, 244)

4. Respondent was not treating patient A for any complaints of an arthritic nature. (Tr. 208,209,565)

5. On March 2, 1992 patient A had an office visit. He listed the following complaints: "GI" (gastro-intestinal) upset, heartburn, discomfort in the periumbilical area and difficulty starting his urine stream. (Tr. 43, 226, 227 & 228, 232, 239; Ex. IV, p. 2)

6. Respondent's notes do not show a history of the onset of these complaints. The notes do not show that Respondent performed a physical examination or stated a diagnosis concerning any of the patient's complaints at this visit . (Tr. 43, 226, 227 & 228, 232, 239; Ex. IV, p. 2)

7. Accepted standards of medicine require a rectal examination to assess the prostate or to see if there is any occult blood present when an older male patient, such as Patient A, complains of difficulty starting his urine stream. (Tr. 47, 563, Ex.4, p.3)

8. There is no record of a rectal examination of patient A . (Tr. 47, 563, Ex.4, p.3)

9. Where a patient is unwilling to engage in a test protocol that the physician believes is warranted, accepted standards of medicine require that the refusal be documented in the patient's record . (Tr. 53, 54)

10. There is nothing in respondent's records for patient A to indicate that the patient refused any test protocol. (Tr. 54)

11. On August 26, 1992 Patient A complained of hallucinating, "running out of the house at night" and GI symptoms. Respondent prescribed Mellaril, 25mg three times a day and 50 mg. at bed time . (Tr. 17, 46; Ex. IV-A, p4)

12. Accepted standards of medicine require a physician to investigate the urinary tract and mental status of a patient before prescribing Mellaril . (Tr. 46)

13. Accepted standards of medicine require studies of the blood and urine in elderly patients complaining of confusion urinary difficulties and GI difficulties. (Tr. 45)

14. On August 26, 1992 Patient A complained of GI symptoms. No blood tests were ordered. No rectal examination was performed to look for occult blood. The only treatment rendered was medication for an undefined stomach problem . (Tr. 45)

15. Where a patient complains of "confusion", accepted standards of medicine require that there be a history, physical examination and adequate laboratory and imaging studies to determine the reason for the confusion. Respondent's record does not include any plan for any such evaluation . (Tr. 17, 46, 565)

16. Accepted standards of medicine require that an internist include the following areas of the body in a basic physical examination: the head, eyes, ears, nose, throat, lungs, cardio-vascular system and abdomen. In addition, to meet minimum standards, the practitioner must listen to the abdomen for aneurysms and look at the extremities for cyanosis, clubbing and edema. (Tr. 42-43)

17. Over an eight (8) month period Respondent lavaged patient A's ears and treated patient A for "nightmares", epigastric pain, tenderness over the periumbilical area, GI complaints, difficulty starting urine stream and heartburn. Respondent prescribed Prilosec, Haldol and Zantac for patient A. (Tr. 549, 550)

18. Accepted standards of medicine would require that at some time in the course of treatment of patient A Respondent was required to perform a comprehensive overall patient evaluation. (Tr. 15, 39, 217, 218, 219, 229, 230, 548-550 Ex. IV & IV-A)

19. From the date of patient A's first office visit on December 5, 1991 to his last office visit to Respondent on August 26, 1992, Respondent did not obtain a complete medical history that would meet minimum accepted standards of medicine. In addition, during the same period, Respondent did not perform a complete physical examination or full patient evaluation[1] that would meet minimum accepted standards of medicine. (Tr. 15, 39, 217, 218, 219, 229, 230, 548-550 Ex. IV & IV-A)

20. Respondent's records do not indicate patient A was being treated by any other primary treating physician. (Tr. 551,552-553)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE TREATMENT OF PATIENT A

ALLEGATION A.1

Respondent does not deny that he rendered medical care to patient A[2]. This patient's complaints included a hearing problem, heartburn, "GI" upset, discomfort in the periumbilical area and difficulty starting his urine stream. It is significant that Respondent did not refer Patient A to any other physician for any of

[1]The terms "complete medical history, complete physical examination and patient evaluation," are used herein to refer to that which would meet minimum accepted standards of medicine. Therefore, where the Committee makes a finding regarding any of these procedures, the finding must be read to include the phrase "that would meet minimum accepted standards of medicine."

[2]Respondent admitted treating each of the patients referenced herein.

the above complaints. The facts adduced show Respondent treated patient A for "nightmares", epigastric pain, tenderness over the periumbilical area, GI complaints, difficulty starting his urine stream and heartburn. Respondent prescribed Prilosec, Haldol, Mellaril and Zantac for patient A. For this reason as well as the overall nature of the care rendered, the Committee concludes that Respondent was this patient's primary physician.

The State has made five allegations arising from the care and treatment of Patient A. The first of these is that Respondent failed to obtain any significant initial history, physical examination, neurological examination or diagnosis. To obtain such an overall patient assessment, Respondent would have been required to perform a patient history, physical examination and a neurological examination. Clearly, Respondent fulfilled none of these obligations. However, Respondent counters by asserting he was not the patient's regular physician. Rather, according to Respondent, the patient only saw Respondent for certain limited complaints. Respondent examined the patient relative to those limited complaints and treated the patient in a limited manner. The Committee recognizes that a physician who is a consultant or treats a patient for a short period or for a single specific complaint is held to a lesser standard in reference to patient examination.

In this case however, the Committee rejects this defense as contrary to the record. First of all, as stated earlier, Respondent was acting as this Patient's primary physician. However, the Committee wishes to point out that any time an eighty year old patient visits a physician for the first time, an overall history, examination and evaluation of all body systems is warranted. Even if Patient A had only seen Respondent for lavage of the ears, given the advanced age of this patient, accepted standards of medicine would have required a basic review of the various body parts and systems. Therefore, the failure of Respondent to obtain and record a comprehensive overall history, evaluation and plan for this patient is a significant departure from

standards.

Therefore,

Factual Allegation A.1 IS SUSTAINED

ALLEGATION A.2

Factual Allegation A.2 is similar to Allegation A.1. The difference between the two is that A.1 focuses on Respondent's failure to obtain basic necessary facts through a comprehensive history and examination. Allegation A.2 cites Respondent for failure to make or record any conclusions as to the problems exhibited by this patient. Accepted standards of treatment require both an examination and history related to the needs of the patient and the extent of care provided. In addition, a physician practicing within accepted standards of medicine will create a treatment plan relevant to the patient problems being addressed, and record the plan as well as the basis for the plan in the patient's record.

Again, Respondent's record for this patient is devoid of any entries that would remotely comply with accepted standards of medicine in this regard. Again, Respondent defended his lack of records on the basis that he was not this patient's primary care physician. Again, the Committee rejects this defense. Assuming for argument that the Committee agreed that Respondent was not this patient's primary care physician, Respondent would still be required to record a plan for the various systems he treated. In the case of Patient A, Respondent treated him for "nightmares", epigastric pain, tenderness over the periumbilical area, GI complaints, difficulty starting his urine stream and heartburn. Respondent prescribed Prilosec, Haldol Mellaril and Zantac for patient A. Assuming Respondent was not this patient's primary care physician, he still was in clear violation of accepted standards of medicine because the patient record makes no reference to a plan for the treatment of nightmares, epigastric pain and urinary difficulty.

Medicine is not performed in a vacuum. What has happened to a patient, has an effect on what the physician does at the moment. Past treatment and present treatment control future treatment. Furthermore, treatment of one body system can have effects, both adverse and positive, on other body systems. It is for

this reason that a physician, in order to meet accepted standards of medicine, must consider and record an overall evaluation and plan relevant to the treatment provided. This is the theory upon which Factual Allegation A.2 is constructed. Respondent completely failed to fulfill this obligation to his patient.

Therefore,

Factual Allegation A.2 IS SUSTAINED

ALLEGATION A.3

In Allegation A.3, Respondent is charged with prescribing Mellaril to this patient in inappropriate doses. In sustaining this accusation, the Committee refers to the following unchallenged facts: Respondent was an 80 year old male; Respondent first sought treatment for, among other things, difficulty in starting his urine stream; Older men have a propensity for urinary difficulties; One of the known side-effects of Mellaril is urinary difficulties. In addition, Patient A exhibited and suffered from confusion. One of the known side effects of Mellaril is confusion.

Respondent was treating this patient for nightmares. There are a number of drugs which can aid a patient with such a complaint. Therefore, the choice of Mellaril for this patient is beyond the bounds of common sense, much less accepted standards of medicine. There is absolutely nothing in the record to mitigate in favor of the use of this drug, regardless of dose, while the record is replete with significant reasons to avoid Mellaril.

Therefore,

Factual Allegation A.3 IS SUSTAINED

ALLEGATION A.4

In Allegation A.4, the State cites Respondent for inadequate records. While this charge is similar to Allegations A.1 and A.2, it is the most general of the three. To meet accepted standards of medicine, a physician must produce a record for each patient which accurately reflects the care and treatment rendered. The record of a specialist, consultant or provider of limited treatment will be less comprehensive than the

patient record produced by the patient's primary care physician. This is because a record may be specific to the area of care provided. Moreover, one physician may rely upon the findings of another. Hence, where a given subject such as a comprehensive examination exists in the record and assuming it is timely and reliable on its face, there is no need for a subsequent treating physician to perform redundant actions and redundant records. The ultimate standard for a patient record is that it must allow subsequent or substitute providers and those required to review patient care, with a clear picture of the care provided and the reasoning in support of same.

It has already been established that Respondent had a duty to perform a comprehensive physical and neurological examination of this patient. Respondent also had the duty to record his plan of treatment and the basis for same. Not only did Respondent not consider either of these obligations, his record in this case, as well as the others presented, provides no clue as to his thought process. The record reviewed herein would not provide subsequent treatment providers and reviewers with even the minimum information required. Therefore the patient record does not meet accepted standards of medicine.

Therefore,

Factual Allegation A.4 IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT B

1. Patient B was under the care and treatment of Respondent from October 1989 to February 1993. (Tr. 56)

2. During the course of treatment, Respondent prescribed Valium, Dilaudid and Percocet, as well as other drugs for Patient B. (Tr. 57,58)

3. Respondent prescribed Valium for Patient B from 1974 to 1993. This is a period of nineteen (19) years. (Tr. 436-437, Ex. V and V-A)

4. On December 17, 1991, February 21 1992, July 17, 1992 and February 2, 1993 Respondent prescribed Dilaudid, Percocet and/or Valium for Patient B. (Tr. 411-13, Ex. V-A, p. 3,7,11)

5. On December 17, 1991, February 21 1992, July 17, 1992 and February 2, 1993, Respondent's records do not show any patient complaints, physical examination, or other findings. (Tr. 411; Ex. V-A, p. 3,7,11)

6. On December 17, 1991, February 21 1992, July 17, 1992 and February 2, 1993, the patient record does not disclose whether the patient was actually present in Respondent's office. (Tr. 411; Ex. V-A, p. 3,7,11)

7. During an office visit of June, 1992, Respondent prescribed Valium, Percocet and Dilaudid for Patient B. Respondent's records do not indicate that Respondent gave Patient B any instructions regarding the simultaneous or alternate use of these scheduled drugs. (Tr. 59, 424; Ex. V-A, p. 8)

8. On December 9, 1992, January 5, 1993 and February 2, 1993 Respondent prescribed Percocet Dilaudid, and Valium for Patient B. Respondent did not make or record a physical examination of Patient B on these occasions. (Tr. 413-414, Ex. V-A, p. 3)

9. Respondent's records for this patient contain some laboratory reports. These reports detect some abnormalities. The office records prepared by Respondent do not make any mention of these abnormalities. (Tr. 60)

10. On August 28, 1990 Patient B complained of pain in the right kidney. Respondent's records do not document any examination, findings or diagnosis performed according to accepted standards of medicine, related to Patient B's right kidney. (Tr. 422-423; Ex. V, p21)

11. On May 2, 1990, Patient B complained of pain in both knees. Respondent's records do not indicate an examination or evaluation of Patient B regarding the patient's complaint of pain in both knees. (Tr. 422-23; Ex. V, p22)

12. On February 2, 1990 and September 25, 1991 Respondent did not make or record any physical examination, findings or diagnosis regarding Patient B's complaints. (Ex. V, p.14, 23)

13. During the period of care, from 1989 through 1993, Respondent's medical records for Patient B do not indicate that Respondent ever conducted a complete physical examination performed according to accepted standards of medicine. Respondent also did not prepare a diagnosis or evaluation of Patient B. (Tr. 418; Ex. V-A)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE TREATMENT OF PATIENT B

ALLEGATION B.1

In Allegation B.1, the State alleges Respondent failed, at various times in the course of his treatment, to conduct a general physical examination or neurological examination of this patient. Furthermore, Respondent is charged with the failure to evaluate and record his evaluation of this patient. The facts adduced

in this proceeding establish that from November 3, 1974 to December 8, 1989, there is no adequate physical examination recorded for this patient. From December 8, 1989 to February 8, 1993, there is no physical examination at all of this patient. Therefore, Allegation B.1 is sustained. In so finding, the Committee cites the standards and discussion presented under Patient A.

Therefore,

Factual Allegation B.1 IS SUSTAINED

ALLEGATION B.2

Allegation B.2 states that Respondent prescribed Valium, Dilaudid and Percocet, all controlled substances, without adequate documentary justification for the prescriptions. The proof in this matter establishes that Respondent prescribed each of these substances, sometimes simultaneously, to this patient. The fact that these drugs are listed as controlled substances indicates that they are very potent and inherently subject to abuse. A physician exhibiting accepted standards of care would exercise caution whenever prescribing any one of these substances. The level of caution warranted when more than one of these substances is prescribed is multiplied exponentially. Respondent's records exhibit no clear basis for the prescribing of any one of these substances. There is absolutely no basis given for the prescription of all three.

Therefore,

Factual Allegation B.2 IS SUSTAINED

ALLEGATION B.3

Allegation B.3 charges Respondent with the failure to keep an appropriate patient record for Patient B. Citing the reasoning and standards set forth under Patient A, as well as the conclusions under Allegations B.1 and B.2, the Committee sustains this charge as well.

Therefore,

Factual Allegation B.3 IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT C

1. Respondent treated Patient C from September 1986 to February 1993. (Tr. 71; Ex. VI-A)

2. In May and June 1991 Respondent prescribed Meperidine for Patient C. (Tr. 72: Ex. VI-A p 22)

3. Meperidine is a potent narcotic analgesic. Accepted standards of medicine require a practitioner to present justification in a patient record when a potent narcotic analgesic is prescribed. (Tr. 72: Ex. VI-A p 22)

4. The examinations, findings and diagnoses recorded in the record for Patient C are, lacking in detail reasoning and analysis. (Tr. 72: Ex. VI-A p 22)

5. In March 1992, during the same office visit, Respondent prescribed Demerol and Percodan, simultaneously, for Patient C. The examinations, findings and diagnoses recorded in the record for Patient C are lacking in detail, reasoning and analysis. The patient record does not document any justification for the simultaneous prescription of these potent controlled substances. (Tr. 73,590; Ex. VI-A p. 302, 303)

6. Accepted standards of medicine require a physician to issue special instructions when prescribing more than one controlled substance concurrently. Respondent's records do not indicate any instructions or warnings concerning the concurrent use of these drugs. (Tr. 73,590; Ex. VI-A p. 302, 303)

7. Both Demerol and Percodan are scheduled drugs. As such, they are, by definition, potentially dangerous, addictive, subject to abuse and can be habit forming. (Tr. 589, 590)

8. In some cases Respondent prescribed Demerol, 100mg four times a day for Patient C. This is a large dose of Demerol. (Tr. 91,92)

9. Where a patient is abusing a scheduled substance through use of excessive amounts, the patient would be expected to complain of somnolence, lethargy, mental confusion and difficulty with everyday activities. Respondent's records for Patient C, do not reflect any such complaints. (Tr. 91,92)

10. "Tolerance" to an analgesic drug means that ever greater or larger doses of that drug are required to achieve analgesia with increasingly less than optimal relief. (Tr. 92)

11. The large dosages of Demerol prescribed by Respondent for Patient C, coupled with the absence of recorded signs or symptoms of excessive use, is consistent with a finding that Patient C had developed a tolerance to the medication (Tr. 91, 92)

12. Tolerance to Demerol is usually indicative of addiction to it. (Tr. 91, 92)

13. Respondent prescribed 180mg every four hours of Percocet and Percodan for Patient C. Accepted standards of medicine would characterize these prescriptions as substantial. The necessity for substantial doses of such potent analgesics can either reflect the severity of pain or the fact that the patient has developed tolerance for the drug. (Tr. 91, 92)

14. X-Rays and laboratory data do not demonstrate any cause for severe or chronic pain in Patient C. (Tr. 94; Ex. VI-A p. 37)

15. On September 14, 1988, Respondent was informed by a pharmacist that Patient C was receiving prescriptions for Scheduled drugs from physicians in addition to Respondent. (Tr. 97-100, 290)

16. On September 14, 1988 Respondent was made aware that Patient C was receiving Tylenol #4 from another provider. On this date, Patient C still had another refill for that drug remaining from the previous prescription written by Respondent. (Tr. 98, 99; Ex. VI-A p. 6, 7)

17. On September 14, 1988 Respondent gave Patient C a prescription for Tylenol #4 to be taken 3-4 times a day with five refills. (Tr. 98, 99; Ex. VI-A p. 6,7)

18. Respondent prescribed Tylenol with Codeine for Patient C many times after September 14, 1988. (Tr. 291; Ex. VI-A)

19. On May 17, 1991, Respondent prescribed Meperidine for Patient C. Respondent did not perform a physical examination of Patient C on this date. (Tr. 301,302; ex. VI-A p21)

20. Respondent did not record any instructions or warnings he gave to Patient C regarding the dangers of addiction and habituation in the use of Scheduled drugs. (Tr. 296)

21. On November 27, 1990 Respondent prescribed Xanax 0.25mg TID[3] and Stelazene 2mg TID simultaneously, on the same visit. Respondent's office records for Patient C do not indicate why he did so. (Tr. 95; Ex. VI-A p18)

22. Respondent's records indicate that Respondent administered 1,000 mcg of Vitamin B-12 to Patient C parenterally on the following dates in 1992: June 17, July 21, August 4, August 24, August 31, September 8, September 22, September 29, October 19, October 26, November 16, November 23, November 30, December 9, December 21, and December 30. (Ex. VI-A p. 26, 27, 28, 29, 30 & 31)

23. Respondent's records indicate that Respondent administered 1,000 mcg. of Vitamin B-12 to Patient C parenterally on the following dates in 1993: January 6, January 26, February 3, March I, March 8 and March 23. (Ex. VI-A p.30, 32)

24. The only recognized use for vitamin B-12 is in a documented deficiency state or a documented illness known to cause vitamin B-12 deficiency. (Ex. VI-A Tr. 95-96)

25. There is nothing in the patient records to indicate that Patient C was suffering a Vitamin B-12 deficiency. (Ex. VI-A Tr. 95, 96)

26. Respondent's records do not indicate any reason for the administration of Vitamin B-12 to Patient C. (Tr. 589)

---

[3]TID stands for three times per day.

27. Respondent ordered laboratory tests and X-Rays for Patient C and saw the patient in his office many times. The patient record does not disclose what, if any, follow up was made to the laboratory or x ray studies. (Tr. 87)

28. Patient C was under Respondent's care from at least October, 1986 to February 3, 1993. Respondent's records do not indicate that he performed or recorded a complete physical examination or evaluation of Patient C during the entire course of his treatment. (Tr. 303, Ex. VI-A VI-A)

29. Respondent was aware that at various times Patient C was receiving simultaneous treatment from a Doctor Major. Doctor Major was known by Respondent to be a psychiatrist. Respondent did not record what, if any, medications Patient C was receiving from Doctor Major. (Tr. 286, 287)

30. Respondent also became aware that at times Patient C was simultaneously being treated by another psychiatrist, Doctor Nemani. Respondent did not record this fact in his records. (Tr. 283)

31. Respondent discussed Patient C with Doctor Nemani. Respondent did not record any notes concerning his discussion or consultation with Doctor Nemani. Respondent did not record what, if any, medications were being prescribed for Patient C by Doctor Nemani. (Tr. 283, 288,289)

32. Respondent was aware that this patient was also being seen by yet another psychiatrist, Dr. Sandaford. Respondent was aware Dr. Sandaford was also prescribing narcotics for Patient C. (Tr. 255-56)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE TREATMENT OF PATIENT C

ALLEGATION C.1

Respondent is charged with prescribing Meperidine, in 100 mg doses, to be taken four times each day. The Charge goes on to say that Respondent did not perform, or record a physical examination of Patient C. Respondent is also cited for a failure to document his reasons for the use and quantity of the drug prescribed. The Committee sustains this charge.

Respondent did not dispute that Meperidine is a Schedule II controlled substance. Drugs included in Schedule II are the most dangerous, the most subject to abuse and the most potent of all the narcotic and narcotic-like drugs available. The most fundamental of accepted standards of medicine, indeed basic prudence, requires that a physician perform a thorough examination of a patient to justify the use of any Schedule II controlled substance. Moreover, the same standards warrant a note in the patient record with justification for the use of this substance, as opposed to all the other less potent, less dangerous and less abused analgesics available. Respondent met none of the obligations imposed by fundamental standards of medicine. Worse, Respondent prescribed Meperidine despite knowledge that would have led any responsible practitioner to exert the most extreme caution: Respondent was aware that this patient was seeing other physicians and receiving controlled substances from them.

Therefore,

Factual Allegation C.1 IS SUSTAINED

ALLEGATION C.2

In Allegation C.2, Respondent is charged with prescribing two Schedule II controlled substances during the same office visit. While the prescribing of Demerol and Percocet during the same visit may not constitute misconduct *per se*, in this case there is a clear act of misconduct in that these two dangerous drugs

were prescribed simultaneously without any significant examination, analysis, or justification. No discussion of the very real dangers of these substances was had or recorded. Furthermore, the substances were prescribed despite the known involvement of other practitioners making scheduled substances available for this patient. Such facts represent the height of medical irresponsibility.

Therefore,

Factual Allegation C.2 IS SUSTAINED

ALLEGATION C.3, C.4 AND C.5

In these allegations, Respondent is cited for failure to make and record any comprehensive neurological or physical examination (Allegation C.3), failure to perform or record any comprehensive evaluation of this patient (Allegation C.4), and failure to maintain a patient record (Allegation C.5). The Committee sustains these charges. In so doing, the Committee refers to the earlier charges brought under similar theories for a discussion of the standards involved.

Therefore,

Factual Allegation C.3 IS SUSTAINED
and
Factual Allegation C.4 IS SUSTAINED
and
Factual Allegation C.5 IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT D

1. During the months of August and November 1988; February 1989; February and April 1990; and May, June, November and December 1992, Respondent prescribed Tylenol with Codeine, Percocet and Percodan for Patient D. During this time there are no examinations that would meet accepted standards of medicine documented in the patient's record. (Tr. 106,107,108 377-88; Ex. VII-A)

2. Respondent's records of treatment of Patient D for the period January 1988 to February 1993, cover at least thirty-three (33) office visits. During this time, Respondent did not perform a single comprehensive physical examination of Patient D. (Tr. 109,600-601; Ex. VII-A)

3. Respondent's office records show that on October 24, 1989 Patient D visited Respondent's office. Patient D cited numerous complaints. The limited physical examination performed by Respondent on Patient D disclosed "questionable rebound". Respondent prescribed Tylenol with Codeine and Naprosyn 375mg for Patient D. There is no commentary in the record to disclose why Respondent issued the prescriptions. (Tr. 121; Ex. VII-A p. 6)

4. Tylenol with Codeine and Naprosyn are known to be stomach irritants. They are contraindicated in the presence of a finding of "questionable rebound". (Tr. 121; Ex. VII-A p. 6)

5. On September 26, 1990 Respondent prescribed Tylenol # 4 for Patient D. One hundred twenty (120) tablets were to be dispensed at each filling. They were to be taken QID[4] with five(5) refills. (Tr. 122; Ex. VII-A p. 9, 10)

6. On November 5, some forty days later, Percocet was prescribed for Patient D. One hundred eighty (180) tablets were to be dispensed at each filling. They were to be taken QID prn[5]. (Tr. 122; Ex. VII-A p. 9, 10)

---

[4]QID means four times per day.

[5]PRN means as needed. Therefore, this prescription instructed the patient to take up to four tablets daily, but only if needed.

7. On April 25, 1990 Respondent prescribed Tylenol with Codeine #4 for Patient D. One hundred twenty (120) tablets were to be dispensed at each filling and were to be taken QID. At the same time, Percocet was prescribed. One hundred eighty (180) were to be dispensed at each filling and the Percocet were to be taken every four hours. (Tr. 122; Ex. VII-A p. 9, 10)

8. On April 25, 1990, Naprosyn, 375mg was also prescribed. Ninety (90) tablets were to be dispensed at each filling and the drug was to be taken TID. Finally, Robaxin 750mg was prescribed. One hundred eighty (180) tablets were to be dispensed at each filling and the drug was to be taken TID. (Tr. 122; Ex. VII-A p. 9, 10)

9. Tylenol # 4, Percocet, Naprosyn and Robaxin are analgesics. The record does not disclose any reason for prescribing four different analgesics for Patient D at the same time. (Tr. 123-24, Ex. VII-A, p.8)

10. Tylenol with Codeine and Percocet are potent schedule II analgesics. Accepted standards of medicine would not warrant the use of both drugs at the same time except under extreme circumstances. Those circumstances were not present in Patient D. (Tr. 124,136-7, Ex. VII, p.8)

11. On March 21, 1988 Respondent diagnosed cervical spondylosis and radiculitis in Patient D. There were no neurologic or radiologic studies or findings or documented physical examination which support or corroborate such a diagnosis. (Tr. 125,379,380; Ex. VII-A p3)

12. Procardia is a calcium channel blocker. It can be used for peripheral vascular disease. Before using Procardia, accepted standards of medicine require that the patient be evaluated with regard to a patient history, physical examination and relevant laboratory data. (Tr. 127, 128)

13. If Procardia is to be used to treat vascular disease, the patient should be asked under what circumstances he or she has pain. In addition, there should be a physical examination of the feet disclosing the color of the patient's feet, the presence or absence of pulses and a toe nail description. (Tr. 127, 128)

14. Respondent's office records for Patient D do not show evidence of an adequate physical examination, or an appropriate history, as those terms are recognized in the practice of accepted standards of medicine. Furthermore, there are none of the laboratory tests necessary to properly evaluate the patient's medical problem prior to the use of Procardia on February 20, 1991. (Tr. 127-129; Ex. VII-A p11)

15. Procardia is not an innocuous drug. If used inappropriately it can produce very detrimental effects. (Tr. 129)

16. Respondent's records do not contain a problem list or a past medical history for Patient D. There is no compilation of past diagnoses. (Tr. 129, 368, 121; ex. VII-A, p11)

17. On occasion Respondent referred Patient D to other physicians for the care of certain conditions. The care rendered by consultants on referral by Respondent was focused. (Tr. 136)

18. Respondent rendered Patient D more general medical care than the consultant's focused care. (Tr. 136)

19. On January 28, 1988 Patient D presented with complaint of lumbo-sacral tenderness bilaterally at the Sacro-Iliac joints; spasm and tenderness of the para-spinal muscle; and straight leg raising to 60

degrees bi-laterally. Respondent diagnosed Patient D as suffering lumbo-sacral spondylosis. An "X-Ray of spine at Wilson Hospital in April, 1987 was negative" .No new X-Ray was ordered. (Tr. 376, 377; Ex. VII p2)

20. Until 1991, Respondent's records show no further studies to support Respondent's diagnosis of "LS Spondylosis". (Tr. 376,377; Ex. VII p2)

21. On March 2, 1988 Patient D complained of right shoulder pain and numbness in her right arm. Respondent did not address or comment on this complaint in his office record for that visit. (Ex. VII-A, p. 2 Tr.. 384-5)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE TREATMENT OF PATIENT D

ALLEGATION D.1

Respondent is charged with prescribing Tylenol with Codeine and Percocet and Percodan, all Schedule II substances, on various dates and in various combinations. The Charge goes on to say that Respondent did not perform, or record adequate, or in some case any physical examination of Patient D on these occasions. The Committee sustains this charge. In so finding, there is little for the Committee to say since the allegation merely cites Respondent for prescribing schedule II substances without performing requisite physical examinations. The record is clear on both counts. Respondent issued the prescriptions.

Respondent did not perform appropriate examinations.

Therefore,

Factual Allegation D.1 IS SUSTAINED

ALLEGATIONS D.2, D.3 AND D.4

In these allegations, Respondent is cited for failure to make and record any comprehensive neurological or physical examination (Allegation D.2), failure to perform or record any limited or comprehensive evaluation of this patient (Allegation D.3), and failure to maintain an appropriate patient record (Allegation D.4). The Committee sustains these charges. In so doing, the Committee refers to the earlier charges brought under similar theories for a discussion of the standards involved.

Therefore,

Factual Allegation D.2 IS SUSTAINED
and
Factual Allegation D.3 IS SUSTAINED
and
Factual Allegation D.4 IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT E

1. Respondent treated patient "E" from May 28, 1986 to at least February 15, 1993. (Ex. VIII)

2. Respondent's office records for Patient E do not disclose any evidence of a complete and comprehensive medical or social history, physical examination or evaluation of Patient E at any time during the course of treatment(Tr.. 139,491)

3. Respondent's office records show that on February 9, 1987, October 29, 1987, January 11, 1989, September 22, 1989 and April 10, 1990 and on other dates and times Respondent prescribed Tylenol

with Codeine and Xanax and Halcion individually and in various combinations for Patient E. On each of these occasions, there is no documentation that would satisfy accepted standards of medicine as to instructions for use. Likewise, there is no documentation that the patient was given any warnings regarding the side effects of the use of these drugs. (Tr. 139,140,141, Ex. VIII, p. 5, 6, 8, 10, 11)

4. On December 10, 1992 Patient E was admitted by Respondent to UHS Hospitals, Binghamton, N.Y. Patient E was discharged on December 18, 1992. The discharge diagnosis was Alcohol, Benzodiazepine, and Opiods (sic) Dependence as well as withdrawal. (Tr. 141,142,485; Ex. VIII p29)

5. The December admission is consistent with a finding that Patient E abused drugs. (Tr. 141,142,485; Ex. VIII p29)

6. On December 23, 1992 Respondent prescribed ProSom, 2mg for Patient E. Thirty (30) tablets were to be dispensed at each filling. On February 15, 1993, Respondent prescribed ProSom 2mg. Thirty (30)tablets were to be dispensed. Respondent also prescribed Tylenol with Codeine #4. One hundred twenty (120) Tylenol #4 were to be dispensed. (Tr. 142, 485; Ex. VIII, p29 Ex. VIII-A, p20)

7. On occasion between April 1992 and October 1992 Respondent prescribed ProSom for Patient E. Respondent's records do not disclose documentation of any warnings given Patient E concerning use of this drug. (Tr. 143; Ex. VIII-A)

8. Patient E had complained to Respondent of breathing problems from the time of her first visit. Respondent's records do not show a chest or lung examination of Patient E at any time. (Tr. 502, 503)

9. Benzodiazepine, a respiratory depressant, was prescribed by Respondent for Patient E. (Tr. 503,504)

10. Patient E had suffered from asthma much of her life. When treating such a patient accepted standards of medicine require the physician to use caution when prescribing narcotics. (Tr. 151, 152; Ex. VIII-A p. 2)

11. On June 24, 1992 Respondent noted in his records that Patient E consumed a pint of vodka a day. This constitutes heavy consumption of alcohol. (Tr. 145, Ex. VIII-A p17)

12. On June 24, 1992 Respondent prescribed ProSom 2mgs, 2 tablets at bed time for Patient E. (Tr. 145, Ex. VIII-A p17)

13. ProSom should be prescribed with extreme caution for a heavy consumer of alcohol. (Tr. 145,146; Ex. VIII-A)

14. On February 15, 1993 Respondent prescribed ProSom and Tylenol with Codeine for Patient E. (Tr. 153, Ex. VIII-A p20)

15. ProSom is a Benzodiazepine. Codeine is an opiate. The prescription of such highly addictive substances would be contra-indicated where a patient has recently been hospitalized for detoxification for the same class of drugs. (Tr. 153, Ex. VIII-A p20)

16. On May 11, 1992 Patient E suffered from 2+ pitting edema. Accepted standards of medicine require that a physician perform a cardiac examination, lung examination, and abdominal examination to develop a differential diagnosis where a patient exhibits 2+ edema. (Tr. 156)

17. On September 28, 1992 Respondent prescribed Procardia XL 30 for Patient E. There is no indication in Respondent's records why he did so. (Tr. 157; Ex. VIII-A p18)

18. When a physician prescribes Procardia, accepted standards of medicine require the physician to make the patient aware of the possible side effects of this drug. The physician is also required by these standards to perform follow-up examinations regarding possible side effects. Respondent's records do not disclose any warnings to the patient or any follow-up regarding use of this drug. (Tr. 165, 166)

19. Laboratory tests performed on June 8, 1992 showed multiple abnormalities, none of which are commented upon by Respondent in his records for Patient E. (Tr. 168)

20. The June 8 laboratory report shows liver abnormalities. Respondent made no attempt to modify his treatment of Patient E reflecting this abnormality. (Tr. 168, Ex. VIII, p. 29, 77)

21. Patient E was hospitalized between December 10 and 18, 1992. Laboratory tests performed during the hospitalization show abnormal liver function values. Respondent's records do not indicate any recommendation or change in therapy following these test results. Respondent continued to provide Patient E with the same medications as previously prescribed. (Tr. 171)

22. On May 31, 1989 Respondent prescribed 60 Halcion 0.25mg. for Patient E. Respondent did not record any reason for prescribing Halcion for Patient E. (Tr. 475; Ex. VIII-A p. 9)

23. On November 10, 1986, February 9, 1987, October 29, 1987, and October 25, 1988 Respondent prescribed Xanax for Patient E. Xanax is an anti-depressant drug. Respondent's records for Patient E do not disclose any complaint of depression or any diagnosis of depression for Patient E. (Tr. 490,491; Ex. VIII-A p. 4, 5, 6, 8)

24. Respondent's records do not document a diagnosis or treatment plan for Patient E. (Tr. 505)

25. There is no documentation in Respondent's office records showing any warnings to Patient E regarding the potential for habituation or addiction to scheduled drugs prescribed by Respondent. (Tr. 491,492)

26. Respondent's records do not indicate that Respondent inquired of Patient E whether she was being treated by any other physicians. (Tr. 512)

27. Radiologic studies of Patient E's cervical and lumbar spine show no significant findings in the cervical area and only mild arthritic changes in the lumbar spine. (Tr. 516,517, 518; Ex. VIII pp. 74, 75)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE TREATMENT OF PATIENT E

ALLEGATIONS E.1 AND E.4

In these allegations, Respondent is cited for failure to perform or record any comprehensive evaluation of this patient (Allegation E.1), and failure to maintain an appropriate patient record (Allegation E.4). The Committee sustains these charges. In so doing, the Committee refers to the earlier charges brought under similar theories for a discussion of the standards involved.

Therefore,

Factual Allegation E.1 IS SUSTAINED
and
Factual Allegation E.4 IS SUSTAINED

ALLEGATIONS E.2 AND E.3

In Allegation E. 2, Respondent is charged with prescribing Tylenol with Codeine (a schedule II substance) and Zanax (sic)[6] and Halcion (both Schedule II substances) on various dates and in various combinations. In Allegation E.3, Respondent is charged with prescribing ProSom (a Schedule IV substance). The Charges go on to say that Respondent did not :

1. make or record adequate notes regarding the prescriptions (Allegation E 2);
2. record the basis for the use of such drugs (Allegation E 2);
3. give any patient warnings about the use of the drugs (Allegation E 2 and E.3);
4. document that patient warnings were given (Allegations E 2 and E.3).

These charges are sustained. The patient records give no reason why these three drugs were given as opposed to no drugs at all, or some less potent combination. From a pure note-taking analysis, Respondent has, according to the style seen throughout this proceeding, given little more than a basic description of drugs

[6]The name of the drug in question is Xanax.

given. The reader is left to intuit why the drugs were given and in the combinations they were given in. Furthermore, there is no record of patient warnings being given or documented at any time.

In sustaining these charges, the Committee finds that accepted standards of medicine require the practitioner to inform future reviewers of the reason for the prescription of any substances. Greater amounts of discussion in a patient record are warranted when the substances prescribed are dangerous. Here, the danger was one of addiction, habituation, mental depression and many more. The danger of the individual substances given here is exaggerated exponentially because they were given in concert. Hence, given the very real and high danger of this form of patient management, extensive records setting forth the thinking of the practitioner were warranted. The records produced by Respondent were not remotely satisfactory in this regard. Furthermore, given the dangers set forth above, the patient should have been warned about substance abuse, and possible difficulties with the mental awareness necessary for the daily activities of life. Not only does the Committee not find any such warnings alluded to in the patient record, the Committee does not believe Respondent issued even the most rudimentary admonitions.

Therefore,

Factual Allegation E.2 IS SUSTAINED

and

Factual Allegation E.3 IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT F

1. Respondent treated Patient F from December 17, 1991 to at least January 27, 1993. (Ex. IX-A)

2. During the period of treatment Respondent did not obtain an adequate medical history from Patient F. (Tr. 344, 345)

3. During the period of treatment Respondent did not perform a comprehensive physical or neurological examination on Patient F. (Tr. 345-46)

4. During the period of treatment Respondent did not provide adequate documentation in the patient record to justify the on-going prescription of the drugs prescribed by Respondent for Patient F. (Tr. 346, 347)

5. There is nothing in Respondent's record for Patient F that accepted standards of medicine would recognize as documentation that Patient F was suffering from hypertension. Respondent's records do not indicate any diagnosis of hypertension. (Tr. 354,615)

6. Respondent prescribed Capoten for Patient F. The record does not show why Respondent prescribed Capoten for Patient F. (Tr. 354)

7. Respondent's records for Patient F do not indicate any inquiry of Patient F as to any prior or concurrent treating physicians. (Tr. 621)

8. Respondent's records do not indicate that Patient F came to Respondent as a referral or consultation from another physician. At the time of this proceeding, Respondent did not know on what basis Patient F came to him as a patient. (Tr. 622)

9. Patient F had office visits on January 20, 1992, March 30, 1992, June 24, 1992 and September 23, 1992. There is no entry in this patient's record on those dates that would constitute a physical examination performed according to accepted standards of medicine. (Tr. 354; Ex. IX-A)

10. There is nothing in Respondent's record for Patient F connecting the MRI finding of a bulging disc with the spinal injection of Celestone and Aristopan. (Tr. 356-57)

11. On March 30, 1992 Respondent prescribed Breathaire for Patient F. There is no documentation in Respondent's records that would explain why he prescribed Breathaire for Patient F. (Tr. 358, 614; Ex. IX-A p3)

12. At the time of this proceeding, Respondent did not know why he prescribed Breathaire for this patient (Tr. 358, 614; Ex. IX-A p3)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE TREATMENT OF PATIENT F

ALLEGATIONS F.1, F.2, F.3, F.4 AND F.5

In these allegations, Respondent is cited for failure to obtain or record an adequate medical history of this patient at the initial visit (Allegation F.1), failure to perform or record either a comprehensive physical examination or a neurological examination at any time (Allegation F.2), failure to adequately evaluate the patient (Allegation F.3), failure to record adequate notes concerning the drugs prescribed (Allegation F.4) and a failure to maintain an appropriate patient record (Allegation F.5). The Committee sustains these charges. In so doing, the Committee refers to the earlier charges brought under similar theories for a discussion of the standards involved. Suffice to say that the charges regarding Patient F fall into the pattern established early on. Respondent does not perform adequate examinations. He does not evaluate his patients either generally

or in regard to the specifics of a particular visit. He prescribes drugs without justification, warning or, apparently, any consideration of action and inter-action.

Therefore,

Factual Allegation F.1 IS SUSTAINED
and
Factual Allegation F.2 IS SUSTAINED
and
Factual Allegation F.3 IS SUSTAINED
and
Factual Allegation F.4 IS SUSTAINED
and
Factual Allegation E.5 IS SUSTAINED

FINDINGS OF FACT ARISING FROM STIPULATION AND ORDER #93-18

1. Following an investigation by the New York State Department of Health, Bureau of Controlled Substances, on or about August 6, 1993 Respondent entered into Stipulation and Order # CS-93-18 wherein Respondent admitted and the Commissioner of Health found :

   a) That between November 1991 and January 1992 Respondent did violate Public Health Law Sec. 3332(1) "in that Respondent did, on at least three occasions, issue prescriptions for a controlled substance to patient "LP", a patient he had never seen.". (Patient "LP" is identified in Schedule A annexed to the Statement of Charges.)

   b) That between March 1991 and January 1992 Respondent violated Public Health Law Sec. 3335(3) in that on at least ten. (10) occasions between March 1991 and January 1992 Respondent did issue prescriptions for controlled substances to eight. (8) patients prior to their having exhausted a previous prescription for all but a seven day supply of such controlled substance. (Ex. XIII)

2. Following an investigation by the New York State Department of Health, Bureau of Controlled Substances, on or about May 1, 1995 Respondent entered into Stipulation and Order #95-09 wherein Respondent admitted and the Commissioner found:

a) That Respondent had violated New York Public Health Law Sec. 3370(2) in that between the months of March 1991 and March 1992 Respondent did not maintain records of the purchase, administration and/or dispensing of Eight Hundred and Twenty Five. (825) regular strength Vicodin tablets and Eleven Hundred and Twenty Five. (1,125) Vicodin Extra Strength tablets. Vicodin tablets contain hydrocodone bitarate, a Schedule II controlled substance. (Ex. XIV)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM STIPULATION AND ORDER #CS-93-18 AND STIPULATION AND ORDER #95-09

Allegations J.1 and J.2 track findings of fact 1.a) and 1.b) above. Allegation K.1 recites the findings under finding of fact 2.a) above. As stated under the legal rulings of the Administrative Law Judge, the concept of Collateral Estoppel, prohibits Respondent from denying the findings set forth in the two stipulations set forth above. Indeed, Respondent did not deny the contents of the referenced stipulations. Nevertheless, as a formality, the Committee sustains these factual allegations.

Therefore,

Factual Allegation J.1 IS SUSTAINED
and
Factual Allegation J.2 IS SUSTAINED
and
Factual Allegation K.1 IS SUSTAINED

SPECIFICATIONS

CONCLUSIONS
WITH REGARD TO
THE FIRST SPECIFICATION
(FAILURE TO MAINTAIN ADEQUATE PATIENT RECORDS)

Throughout the discussion of the Factual Allegations, this Committee has cited Respondent for his failure to record relevant and necessary information in his patient records. Indeed, Respondent admitted that his records were less than adequate.

Therefore,

The First Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE SECOND SPECIFICATION
(NEGLIGENCE ON MORE THAN ONE OCCASION)

Respondent is charged with negligence in the care of Patients A through Patient F. As will be discussed later, with regard to Patient A, Patient C and Patient D, the Committee has found gross negligence. Therefore, as to those three patients, the lesser included offense of negligence is found. With regard to Patient B, Patient E and Patient F, the State did not charge gross negligence, however, the Committee finds Respondent treated each of these patients in a negligent manner and that Respondent treated each patient in a negligent manner on more than one occasion.

As was set forth under the instructions presented earlier, negligence is the failure to exhibit the level of care and diligence expected of a prudent physician meeting accepted standards of medicine. The Committee finds that Respondent violated this standard in his treatment of Patient B in that he prescribed Valium and Dilaudid for this patient and gave no warnings about the individual potency of the drugs nor the

particular dangers of the drugs if taken in concert. Furthermore, Respondent ignored kidney complaints raised by this patient. Each time Respondent prescribed Valium and Dilaudid, either individually or in combination, his failure to warn the patient constitutes an occasion of negligence. Likewise, each time Respondent failed to take notice of the kidney complaints referred to by this patient, Respondent is found to have acted in a negligent manner. In so finding, the Committee points out that each visit was a separate event at which Respondent could have cured or mitigated his negligence by issuing an appropriate warning or examining the kidney complaint.

Respondent was negligent on more than one occasion when he repeatedly prescribed narcotics and controlled substances to a known substance abuser, Patient E. Each time Respondent made such a prescription, he engaged in a separate occurrence of negligence. There is little that can be said about impropriety of prescribing the stuff of substance abuse to one who suffers from the illness of substance abuse. The Committee simply states that such activity is among the most egregious of violations of the most basic standards of medicine.

Finally, Respondent was negligent on more than one occasion in his care of Patient F. Respondent treated this patient without a basic overall examination and evaluation. Respondent made no effort to treat the bulging disc suffered by this patient and Respondent prescribed Breathaire but to this day does not know why. Each of these acts is a separate occurrence of negligence in that Respondent had more than one encounter with this patient and hence, more than one opportunity to exhibit appropriate levels of care and diligence.

Let the record be clear, that it is the finding of this body that care rendered to each individual patient herein contains various occurrences of negligence and equally, opportunities to provide acceptable levels of care. Respondent repeatedly and consistently acted in grievous violation of the most basic standards of care

with each individual visit of each individual patient.

Therefore,

The Second Specification IS SUSTAINED

CONCLUSIONS WITH REGARD TO THE THIRD SPECIFICATION (GROSS NEGLIGENCE)

Respondent is charged with gross negligence in the care of Patient A, Patient C and Patient D. The Committee finds Respondent treated each of these patients in a grossly negligent manner. As was set forth under the instructions presented earlier, negligence is the failure to exhibit the level of care and diligence expected of a prudent physician meeting accepted standards of medicine. Gross negligence is an egregious violation of accepted standards or a series of acts, which in combination constitute an egregious violation of accepted standards.

The Committee finds that Respondent committed gross negligence in his treatment of Patient A in that he performed no urinary or prostate examination despite the age of the patient and notwithstanding a specific complaint of difficulty in beginning the patient's urine flow. Furthermore, Respondent prescribed Mellaril for this patient. Mellaril can cause urinary problems. Perhaps worse, it can mask other possibly serious conditions. The Committee finds that the failure of Respondent to perform the urinary and prostate examination on a male of advanced years is an egregious violation of standards. That Respondent failed to do so in light of a known urinary complaint simply amplifies the violation. Likewise, under the circumstances, it was an egregious violation of accepted standards of care and diligence to have prescribed Mellaril for this patient.

Respondent committee gross negligence in his care and treatment of Patient C by repeatedly prescribing extremely potent narcotics to this patient without a remotely sufficient medical examination. Moreover, Respondent prescribed the drugs despite evidence of other practitioners also issuing prescriptions

and despite evidence that Patient C may have been addicted or habituated to narcotics. Such behavior is a clear and egregious violation of fundamental medical standards.

Finally, Respondent exhibited gross negligence in his care and treatment of Patient D. Respondent prescribed huge quantities of controlled substances in various combinations over an extended period without performing a basic physical examination. Even had he performed an examination of this patient, the prescription of Tylenol #4 and Percodan, at the same visit in large quantities, without clear justification, is an egregious violation of basic medical standards of care and diligence.

It is the finding of this body that care rendered to each individual patient herein contains numerous acts of gross negligence. Moreover, the care rendered to the three patients listed, in its totality, also represents a series of acts which in sum constitute egregious conduct. Finally, it is noteworthy that the care rendered to Patient B, Patient E and Patient F was not listed under the charge of gross negligence.

Therefore,

The Third Specification IS SUSTAINED

CONCLUSIONS WITH REGARD TO THE FOURTH SPECIFICATION (INCOMPETENCE ON MORE THAN ONE OCCASION)

Respondent is charged with incompetence in the care of Patients A through Patient F. As will be discussed later, with regard to Patient C, Patient D and Patient E, the Committee has found gross incompetence. Therefore, as to those three patients, the lesser included offense of incompetence is also found. It is the finding of this body that the care rendered to each of the patients presented herein constituted a dreadful departure from basic standards. However, as the charges were drafted, the Committee will limit itself to a consideration of simple incompetence as to Patient A, Patient B, and Patient F.

As was set forth under the instructions presented earlier, incompetence is defined as the failure to exhibit the level of knowledge and expertise expected of a physician meeting accepted standards of medicine.

The Committee finds that Respondent exhibited incompetence in his treatment of Patient A based upon findings similar to those set forth in the discussion of gross negligence. Respondent demonstrated incompetence in that a physician exhibiting acceptable levels of skill and expertise would have performed a urinary tract and prostate examination on this patient. The age of the patient, in and of itself, would have brought the competent physician to perform such examinations. In the case of Patient A, there was a specific complaint of difficulty in beginning the patient's urine flow. This complaint was ignored. Furthermore, Respondent prescribed Mellaril for this patient. Mellaril can cause urinary problems. Perhaps worse, it can mask other possibly serious conditions. A physician exhibiting acceptable levels of knowledge and expertise would not have prescribed Mellaril to a patient of this age who was known to have urinary and other difficulties.

Respondent exhibited incompetence in the care of Patient B in that he prescribed Valium and Dilaudid for this patient and gave no warnings about the individual potency of the drugs nor the enhanced risks of the drugs if taken in concert. In addition, a physician exhibiting an appropriate level of knowledge and expertise would not have ignored the kidney complaints raised by this patient. Each time Respondent prescribed Valium and Dilaudid, either individually or in combination, his failure to warn the patient constitutes an occasion of incompetence. Likewise, each time Respondent failed to take notice of the kidney complaints referred to by this patient, Respondent is found to have acted in an incompetent manner. In so finding, the Committee points out that each visit was a separate event at which Respondent could have cured or mitigated his incompetence by issuing an appropriate warning or examining the kidney complaint.

Finally, Respondent incompetence on more than one occasion in his care of Patient F. Respondent treated this patient without a basic overall examination and evaluation. Respondent made no effort to treat the bulging disc suffered by this patient and Respondent prescribed Breathaire for this patient but to this day does not know why. A physician exhibiting an acceptable level of knowledge and expertise would have performed an overall examination of this patient. He would have addressed this patient's bulging disc and he would have had and recorded an appropriate reason for prescribing any medication. Each of the failures

cited constitutes a separate occurrence of incompetence. This is because Respondent had more than one encounter with this patient and hence, more than one opportunity to exhibit appropriate levels of knowledge and expertise.

As was set forth in the discussion of negligence on more than one occasion, it is the finding of this body that care rendered to each individual patient herein contains various acts of incompetence and equally, opportunities to provide acceptable levels of care. Respondent repeatedly and consistently acted in grievous violation of the most basic standards of competence with each individual visit of each individual patient. Hence it follows that the facts under each individual patient constitute incompetence on more than one occasion. In addition, the care rendered to the three patients constitutes incompetence on more than one occasion.

Therefore,

The Fourth Specification IS SUSTAINED

CONCLUSIONS WITH REGARD TO THE FIFTH SPECIFICATION (GROSS INCOMPETENCE)

As was set forth under the instructions presented earlier, incompetence is the failure to exhibit the level of skill and expertise expected of a physician meeting accepted standards of medicine. Gross incompetence would be an egregious violation of standards or a number of acts which in their totality constitute an egregious violation of standards. The Committee finds that Respondent committed gross incompetence in his treatment of Patient C and Patient D and Patient E. While other acts of Respondent were clearly egregious violations of basic standards, only Patients C, D, and E were cited under this specification.

Respondent committed gross incompetence in his care and treatment of Patient C by repeatedly prescribing extremely potent narcotics to this patient without a remotely sufficient medical examination. Respondent also prescribed the narcotics and other known stomach irritants despite a notation of rebound

tenderness. Moreover, Respondent prescribed the drugs despite evidence of other practitioners also issuing prescriptions and despite evidence that Patient C may have been addicted or habituated to narcotics. Such behavior is a clear and egregious violation of fundamental medical standards in that a physician demonstrating the most rudimentary medical knowledge would know it is not in the best interest of a patient to prescribe controlled substances without an appropriate examination and in the face of possible abuse. It is axiomatic that one who demonstrates the most basic knowledge of medicine does not prescribe a stomach irritant to a patient exhibiting symptoms of stomach irritation.

Finally, Respondent exhibited gross incompetence in his care and treatment of Patient D. Respondent prescribed huge quantities of controlled substances in various combinations over an extended period without performing a basic physical examination on this patient. Even had he performed an examination of this patient, the prescription of Tylenol #4 and Percodan, at the same visit and in large quantities, without clear justification, is an egregious violation of basic medical standards of knowledge and expertise. A physician exhibiting the most fundamental levels of knowledge and expertise would neither prescribe the type nor the quantity of drugs prescribed by Respondent to this patient. That there was no appropriate examination serves to amplify what is already egregious conduct.

Finally, Respondent was grossly incompetent when he repeatedly prescribed narcotics and controlled substances to a known substance abuser, Patient E. As stated earlier, there is little that can be said about the blatant impropriety of prescribing the stuff of substance abuse to one who suffers from the illness of substance abuse. The Committee simply states that such activity is among the most egregious of all possible violations of the most basic standards of medicine.

Therefore,

The Fifth Specification <u>IS SUSTAINED</u>

CONCLUSIONS
WITH REGARD TO
THE SIXTH AND SEVENTH SPECIFICATION
(VIOLATIONS OF ARTICLE 33)

As was stated earlier, Respondent is estopped from denying that he admitted violating Article 33 of the Public Health Law on two separate occasions.

Therefore,

The Sixth Specification IS SUSTAINED
and
The Seventh Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
PENALTY

In the presentation of the charges herein, the State has shown a consistent and unmitigated pattern of distinctly and grossly substandard practice. Respondent prescribes medications which are contra-indicated under the circumstances. He prescribes medications for no discernable reason. He prescribes huge amounts of controlled substances with not the slightest attention to the possibility of patient abuse, addiction or habituation. He prescribes controlled substances without any effort to solve the underlying problem that gave rise to the patient complaint.

The public would be far safer if the deplorable records produced by this physician were the worst part of his practice. Under the evidence adduced in this proceeding Respondent represents a menace to the public because he prescribes narcotics to known substance abusers and prescribes medications which may harm his patients more than help them.

Respondent has shown himself to be unable to follow the rules regarding narcotic substances as witnessed by two prior citations by the Commissioner of Health. This physician showed not the slightest sign of remorse or the remotest sign that he has some inkling there is a problem with his practice techniques. This body sees no possibility for rehabilitation of this physician. Revocation is the only appropriate sanction under the facts and circumstances herein.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

It is hereby **ORDERED** that:

1. The Factual allegations in the Statement of Charges (Appendix One) are **SUSTAINED**;

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

2. The Specifications of Misconduct contained within the Statement of Charges (Appendix One) are **SUSTAINED**;

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

3. The license of Respondent to practice medicine in the State of New York is **REVOKED**;

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

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

Dated:
Newcomb, New York

June 20, **1997**

Denise M. Bolan, RPA-C

DENISE BOLAN, R.P.A.-C, Chairperson,
ALBERT M. ELLMAN, M.D.
ARSENIO G. AGOPOVICH, M.D.

TO:

CARLTON F. THOMPSON, ESQ.
Levene, Gouldin & Thompson, LLP
P.O. Box F 1706
Binghamton, New York 13902-0106

VINCENT MADDI, M.D.
44 Broad St.
Johnson City, N.Y. 13790

JOSEPH HUBERTY, ESQ.
Assistant Counsel
Bureau of Professional Medical Conduct
Room 2429 Corning Tower
Empire State Plaza
Albany, New York 12037

APPENDIX ONE

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER : STATEMENT

OF : OF

: CHARGES

VINCENT MADDI, M.D.

----------X

VINCENT MADDI, M.D. the Respondent, was authorized to practice medicine in New York State on July 25, 1962 by the issuance of license number 087947 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 September 1, 1996 through August 31, 1998, with a registration address of 44 Broad Street, Johnson City, New York 13790.

FACTUAL ALLEGATIONS

A. At various times from on or about December 5, 1991 to on or about September 2, 1992 Respondent provided medical care and services to Patient A (all patients are identified in Appendix A annexed hereto) at Respondent's office(s) 240 Riverside Drive and/or 44 Broad Street, Johnson City, New York and at Binghamton General Hospital, Binghamton, New York.

1. Respondent failed to obtain and/or document any significant initial history, physical and/or neurological examination and/or diagnosis for Patient A.

2. During the course of treatment and care of Patient A Respondent failed to make and/or record any comprehensive evaluation or define the general medical problems if any from which Patient A was then suffering.

3. Respondent prescribed Mellaril for Patient A in inappropriate dosages.

4. Respondent failed to maintain records for Patient A which adequately reflect the evaluation and treatment of Patient A.

B. At various times between on or about November 3, 1974 and on or about February 8, 1993 Respondent treated Patient B at Respondent's professional office(s), 240 Riverside Drive and/or 44 Broad Street, Johnson City, New York, United Health Services Hospital, Inc.-Binghamton General Hospital Division and United Health Services Hospital, Inc.-Wilson Hospital Division, Johnson City, New York.

1. At various times during the course of treatment Respondent failed to conduct a general physical and/or neurological examination of Patient B and adequately evaluate and record his evaluation of Patient B.

2. During the course of treatment Respondent prescribed large dosages of Valium, a Schedule IV Controlled Substance and Dilaudid and Percocet, both Schedule II Controlled Substances without adequate documentary justification for same.

3. Respondent failed to maintain records for Patient B which adequately reflect the evaluation and treatment of Patient B.

C. At various times from on or about September 1986 to on or about February 3, 1993 Respondent treated Patient C at his professional office(s), 240 Riverside Drive and/or 44 Broad Street, Johnson City, New York and at United Health Services Hospitals--Binghamton General Hospital Division, Binghamton, New York.

1. On or about May 1991 Respondent prescribed Meperidine (a Schedule II controlled substance) 100mg QID without having conducted and/or recorded a physical examination of Patient C and without adequate documentation for the use and quantity of the drug prescribed.

2. On or about March 1992, on a single office visit, Respondent prescribed both Demerol, a Schedule II Controlled Substance, and Percocet, a Schedule II Controlled Substance for Patient C.

3. Although having treated Patient C repeatedly between on or about September 1986 to on or about August 15, 1992 Respondent failed to make and/or record any comprehensive neurological or comprehensive physical examination of Patient C.

4. Respondent failed to evaluate and/or record any comprehensive evaluation of Patient C during the course of his treatment.

5. Respondent failed to maintain a record for Patient C which adequately reflects the evaluation and treatment of Patient C.

D. At various times between on or about January 1988 and on or about February 1993 Respondent treated Patient D at his professional office(s), 240 Riverside Drive and/or 44 Broad Street, Johnson City, N.Y.

1. On various dates in or about August and November, 1988; February and March 1989; February, March, April, June and November 1990; July and November 1991; May, June, July, November and December 1992 and February 1993 Respondent prescribed Tylenol with Codeine and Percocet and/or Percodan, all Schedule II Controlled Substances for Patient D without adequate or in some cases any physical examination.

2. Patient D was under Respondent's care and treatment from on or about January 1988 to on or about February 1993. During this time Respondent saw Patient D not less than fifty (50) times. At no time did Respondent make and/or record a comprehensive neurological and/or physical examination of Patient D.

3. Respondent failed to adequately evaluate and/or record any comprehensive evaluation of the condition of Patient D.

4. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment of Patient D.

E. Patient E was treated by Respondent at Respondent's professional offices (240 Riverside Drive and/or 44 Broad Street, Johnson City, N.Y.) from on or about May 28, 1986 to on or about February 15, 1993.

1. Respondent failed to perform a comprehensive evaluation of Patient E during the course of treatment.

2. On or about February 9, 1987, October 29, 1987, January 11, 1989, September 22, 1989, April 10, 1990 and at various other times during the course of treatment of Patient E Respondent prescribed Tylenol with Codeine #4, a Schedule II Controlled Substance, and Zanax and/or Halcion, Schedule IV Controlled Substances, and failed to make or record adequate notes and/or indications for the use of such drugs and/or give any warnings of possible side effects of the use of these drugs or document having given such warnings.

3. During the period from on or about April 1992 to on or about October 21, 1992 Respondent prescribed ProSom (a Schedule IV Controlled Substance) for Patient E on or about eleven (11) occasions. On none of the above occasions did Respondent give Patient E any warnings of the possible side effects of the use of this drug or document having given such warnings.

4. Respondent failed to maintain records for Patient E which accurately reflect the evaluation and treatment of Patient E.

F. Respondent provided medical care to Patient F at Respondent's professional offices from on or about December 17, 1991 to on or about January 27, 1993.

1. Respondent failed to obtain and record an adequate medical history from Patient F on that patient's initial visit to Respondent.

2. Respondent failed to perform and/or record a comprehensive physical and/or neurological examination of Patient F on that patient's initial visit to Respondent or at any other time.

3. Respondent failed to adequately evaluate and/or document such evaluation of Patient F during the course of Respondent's treatment of Patient F.

4. Respondent failed to record adequate notes concerning the drugs he prescribed for Patient F or the indications for such prescriptions and/or the instructions for use of said drugs.

5. Respondent failed to maintain a record for Patient F which accurately reflected the evaluation and treatment of Patient F.

G. Respondent treated Patient G at Respondent's professional offices from on or about July 31, 1990 to on or about November 30, 1992.

1. Respondent failed to adequately evaluate and/or record such evaluation during the course of treatment.

2. At various times during the course of treatment Respondent prescribed Lortab and Tylenol with Codeine #4, both Schedule II Controlled Substances without recording any indications for use of either of said drugs or setting forth instructions for use of same.

3. Respondent failed to maintain a record for Patient G which accurately reflected the evaluation and treatment of Patient G.

H. Respondent provided medical care to Patient H at various times from on or about December 9, 1982 to on or about January 25, 1993 at Respondent's medical office(s), Binghamton General Hospital, Binghamton, New York and Lourdes Hospital, Binghamton, New York.

1. Respondent failed to obtain an adequate initial history and/or conduct and record an adequate initial examination of patient H.

2. Respondent failed to adequately evaluate and/or document such evaluation of Patient H during the course of his treatment.

3. Respondent repeatedly failed to record adequate notes concerning the controlled substances (Percocet, Valium, Lortab and Bancap HC) he prescribed for Patient H or the indications for such use.

4. On or about the following dates Respondent prescribed Percocet, a Schedule II Controlled Substance for Patient H without benefit of any patient complaint, physical examination and/or diagnosis concerning Patient H: September 5, 1990, October 3, 1990, June 5, 1991, July 22, 1991, November 25, 1991, January 15, 1992 and February 19, 1992.

5. On or about the following dates Respondent prescribed Bancap HC, a Scheduled III Controlled Substance for Patient H without benefit of any physical examination, diagnosis or recorded indication for the use of said drug: November 16, 1984, July 17, 1985, December 20, 1985, June 10, 1986, October 27, 1986, August 20, 1987, September 23, 1987, March 23, 1988, September 19, 1988, February 20, 1989, July 31, 1989, January 9, 1990, February 12, 1990, April 17, 1990, May 21, 1990,

September 5, 1990, May 1, 1992, June 4, 1992, December 28, 1992, and January 25, 1993.

6. On or about the following dates Respondent prescribed Valium, a Schedule IV Controlled Substance, for Patient H without adequate or in some cases any patient complaint, physical examination and/or diagnosis. On all occasions Respondent failed to set forth adequate reasons for the use of the drug: December 9, 1982, January 31, 1983, January 20, 1984, July 16, 1984, January 15, 1985, July 17, 1985, December 20, 1985, June 10, 1986, October 27, 1986, August 20, 1987, September 23, 1987, March 23, 1988, September 19, 1988, February 20, 1989, March 17, 1989, July 31, 1989, October 3, 1989, November 4, 1989, December 7, 1989, January 9, 1990, February 5, 1990, February 12, 1990, March 12, 1990, April 17, 1990, June 6, 1990, June 29, 1990, August 7, 1990, September 5, 1990, October 13, 1990, November 1, 1990, February 13, 1991, March 22, 1991, June 5, 1991, July 2, 1991, August 19, 1991, October 15, 1991, November 25, 1991, January 15, 1992, February 19 1992, March 18, 1992, April 20, 1992, June 4, 1992, July 27, 1992, August 12, 1992, August 24, 1992, October 21, 1992, November 25, 1992, December 28, 1992, January 25, 1993.

7. On or about the following dates Respondent prescribed Tylenol with Codeine #4 (a Schedule II Controlled Substance) for Patient H with inadequate or in many cases no physical examination, no stated diagnosis and absent any patient complaint: February 18, 1991, July 22, 1991, May 1, 1992, and November 25, 1992.

8. On or about June 6, 1990 Respondent prescribed Lortab (a Schedule II Controlled Substance) in the absence of any patient complaint, without having conducted a physical examination or stating any diagnosis for Patient H.

9. Respondent prescribed Valium, Percocet, Bancap HC and Tylenol with Codeine #4 for Patient H in excessive amounts.

10. Respondent failed to maintain a record for Patient H which accurately reflects the evaluation and treatment of Patient H.

11. Respondent repeatedly prescribed Valium, a Schedule IV Controlled Substance, for use by Patient H and failed to warn and/or record any warnings to Patient H regarding the dangers of the use of Valium and the ingestion of alcohol.

I. Respondent provided medical care to Patient I at Respondent's medical office from on or about August 28, 1990 to on or about October 6, 1992.

1. Respondent failed to obtain or document an adequate initial history and/or initial examination, findings or diagnosis.

2. Respondent failed to adequately evaluate and/or document such evaluation of Patient I during the course of treatment.

3. On most occasions Respondent failed to record adequate or in fact any reasons for prescribing such drugs as were prescribed for Patient I and the quantity thereof.

4. At various times Respondent prescribed Valium, a Schedule IV Controlled Substance and Tylenol with Codeine #4 and Emperin with Codeine #4, both Schedule II Controlled Substances, without having examined Patient I, made any findings, performing a follow-up examination, stating a diagnosis and/or recording the foregoing regarding Patient I.

5. At various times Respondent prescribed Valium, Tylenol with Codeine #4 and Emperin with Codeine #4 for Patient I which was not medically justified by the existing documentation.

6. Respondent failed to maintain records for Patient I which accurately reflect the evaluation and treatment of Patient I.

7. Respondent prescribed Emperin with Codeine, a Schedule II Controlled Substance and Valium, a Schedule IV Controlled Substance, for Patient I when Respondent knew or should have known that Patient I was a drug abuser.

J. Following an investigation by the New York State Department of Health, Bureau of Controlled Substances, on or about August 6, 1993 Respondent entered into Stipulation and Order # CS-93-18 wherein Respondent admitted and the Commissioner of Health of the State of New York found:

1. That between November 1991 and January 1992 Respondent did violate Public Health Law Sec. 3332(1) "in that Respondent did, on at least three occasions, issue prescriptions for a controlled substance to patient "LP", a patient he had never seen." Patient "LP" is identified in Schedule "A" annexed hereto.

2. That between March 1991 and January 1992 Respondent violated Public Health Law Sec. 3335(3) in that on at least ten(10) occasions between March 1991 and January 1992 Respondent did issue prescriptions for controlled substances to eight(8) patients prior to their having exhausted a previous prescription for all but a seven day supply of such controlled substance.

K. Following an investigation by the New York State Department of Health, Bureau of Controlled Substances, on or about May 1, 1995 Respondent entered into Stipulation and Order # 95-09 wherein Respondent admitted and the Commissioner of Health found:

1. That Respondent had violated New York Public Health Law Sec. 3370(2) in that between the months of March 1991 and March 1992 Respondent failed to maintain records of the purchase, administration and/or dispensing of Eight Hundred and Twenty Five (825) regular strength Vicodin tablets and Eleven Hundred and

Twenty Five (1,125) Vicodin extra strength tablets. Vicodin tablets contain hydrocodone bitarate, a Schedule II Controlled Substance.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

FAILURE TO MAINTAIN ADEQUATE RECORDS

Petitioner charges Respondent with professional misconduct in that Respondent failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in violation of NY Educ. Law 6530(32) (McKinney Supp. 1996) [(formerly N.Y. Educ. Law 6509 (8 NYCRR 29.2 (3))] in that Petitioner charges:

1. The facts in paragraphs A, A.1, A.2, A.4, B, B.1, B.2, B.3, C, C.1, C.3, C.4, C.5, D, D.2, D.3, D.4, E, E.2, E.4, F, F.1, F.2, F.3, F.5, G, G.1, G.2, G.3, H, H.1, H.2, H.3, H.4, H.5, H.6, H.7, H.10, I, I.1, I.2, I.3, I.4, I.6, K and/or K.1.

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Petitioner charges Respondent with professional misconduct in that Respondent has been guilty of negligence on more than one occasion in violation of NY Educ. Law Sec. 6530(3) [(McKinney

Supp. 1996) (formerly NY Educ. Law 6509(2))] in that Petitioner charges that Respondent committed two or more of the following:

2. The facts in paragraphs A, A.1, A.2, A.3, B, B.1, B.2, C, C.1, C.2, C.3, C.4, D, D.1, D.2, D.3, E, E.1, E.3, F, F.1, F.2, F.3, G, G.1, H, H.2, H.4, H.5, H.6, H.7, H.8, H.9, H.11. I, I.1, I.2, I.4, I.5, I.7, J, J.1 and/or J.2.

THIRD SPECIFICATION

GROSS NEGLIGENCE

Petitioner charges Respondent with professional misconduct in that Respondent has been guilty of gross negligence in violation NY Educ. Law Sec. 6530(4)[(McKinney Supp. 1996) (formerly NY Educ. Law Sec. 6509(2))] in that petitioner charges:

3. The facts in paragraphs A, A.1, C, C.2, C.3, D, D.1, D.2, G, G.2, H, H.4, H.5, H.6, H.7, H.8, I, I.3, I.4 and/or I.7.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Petitioner charges Respondent with professional misconduct in that Respondent has been guilty incompetence on more than one occasion in violation of NY Educ. Law Sec. 6530(5) [(McKinney. Supp. 1996)(formerly NY Educ. Law Sec. 6509(2))] in that Petitioner charges:

4. The facts in paragraphs A, A.1, A.2, A.3, B, B.1, B.2, C, C.1, C.2, C.3, C.4, D, D.1, D.2, D.3, E, E.1, E.2, E.3, F, F.1, F.2, F.3, G, G.1, G.2, H, H.1, H.2, H.4, H.5, H.6, H.7, H.8, H.9, H.11, I, I.1. I.2, I.4, I.5 and/or I.7.

FIFTH SPECIFICATION

GROSS INCOMPETENCE

Petitioner charges Respondent with professional misconduct in that Respondent has been guilty of gross incompetence in the practice of medicine in violation of NY Educ. Law Sec. 6530(6) [(McKinney Supp. 1996)(formerly NY Educ. Law Sec. 6509(2)] in that petitioner charges:

5. The facts in paragraphs C, C.2, C.3, D, D.2, E, E.3, H, H.4, H.5, H.6, H.7 and/or H.8.

SIXTH AND SEVENTH SPECIFICATIONS

VIOLATIONS OF ARTICLE 33 OF THE PUBLIC HEALTH LAW

Petitioner charges Respondent with professional misconduct in that Respondent was found by the Commissioner of Health to be in violation of Article Thirty-Three of the Public Health Law, a violation of NY Educ. Law 6530(9)(e) in that petitioner charges:

6. The facts in paragraphs J, J.1 and/or J.2.

7. The facts in paragraphs K and/or K.1

Dated: Albany, New York
October 7, 1996

Peter D. Van Buren

PETER D. VAN BUREN
DEPUTY COUNSEL
BUREAU OF PROFESSIONAL MEDICAL
CONDUCT