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

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

July 6, 1990

Constantine Manoussakis
Physician
23 Morgan Lane
Staten Island, N.Y. 10314

Re: License No. 105608

Dear Dr. Manoussakis:

Enclosed please find Commissioner's Order No. 10549. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

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

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: Wilfred T. Friedman, Esq.
4 Park Avenue
New York, N.Y. 10016

REPORT OF THE
REGENTS REVIEW COMMITTEE

CONSTANTINE MANOUSSAKIS

CALENDAR NO. 10549

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

CONSTANTINE MANOUSSAKIS **No. 10549**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

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

The instant disciplinary proceeding was properly commenced. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A". The charges were amended at the hearing. See transcript page 8.

On July 17, 1989 and July 18, 1989 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct.

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

committee found and concluded that respondent was guilty of the ninth through seventeenth and the nineteenth specifications and was not guilty of the remaining specifications, and recommended that respondent's license to practice as a physician in the State of New York be revoked.

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

On April 5, 1990, respondent appeared before us and was not represented by an attorney. Respondent was informed of his right to obtain an attorney. Diane Abeloff, Esq., presented oral argument on behalf of the Department of Health.

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

Petitioner's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, which is the same as the recommendation of the Commissioner of Health, was that respondent's license to practice as a physician in the State of New York be revoked.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that the charges be rejected.

19 specifications of the charges were brought against respondent regarding 8 separate patients. The hearing committee's "general conclusions", by either a unanimous or a majority vote, are: guilty of gross incompetence (tenth through seventeenth specifications); not guilty of incompetence on more than one occasion (eighteenth specification); not guilty of gross negligence (first through eighth specifications); guilty of negligence on more than one occasion (ninth specification); and guilty of unprofessional conduct (nineteenth specification). The specific conclusions of the hearing committee show that the large numbers of medications prescribed for Patients A, B, E, F, G, and H do not meet acceptable medical standards. These prescriptions were for patients with a history of alcohol and drug abuse (Patients A and B), patients for whom respondent did not attempt to reduce their medication intake (Patients C, D, E, F, and G), patients for whom respondent did not alter his treatment (Patients C, D, and F), a patient with a previous history of alcohol abuse (Patient G), and a patient with a known habit of heroin abuse (Patient H). Also, the hearing committee concluded that respondent prescribed medication for Patients C and D without medical justification. Further, the hearing committee concluded for Patient C and found for Patients F, G, and H that respondent failed to maintain adequate medical records which accurately reflect the evaluation and treatment of these patients.

We agree with the findings and conclusions of the hearing committee and Commissioner of Health regarding gross incompetence, gross negligence, and negligence on more than one occasion. Petitioner demonstrated respondent's "complete ignorance" (transcript page 412) of proper and acceptable prescribing practices. The record reveals respondent's prescribing large numbers of one or more of the following medications to several patients over extended periods of time: Darvon, Valium, Elavil, Darvocet, Catapres, and Restoril. As shown above, this prescribing occurred for patients with a previous history of alcohol or drug abuse, for patients whom respondent did not attempt to reduce their medication intake, and for patients whom respondent did not alter his treatment.

Respondent's medical practices represent a significant danger to the public and to the patients he treats. For example, Patient A died of acute Darvon and Cocaine poisoning one day after respondent prescribed large numbers of Darvon. Respondent had to be told by a nurse and, on another occasion, by a medical coordinator at the clinic, about the inappropriateness of prescribing large numbers of potentially addictive medications to clinic patients. Nevertheless, respondent continues to maintain that he has no reason to consider changing his prescribing practices.

In our unanimous opinion, respondent demonstrated a complete lack of knowledge, skill, and understanding regarding proper and acceptable prescribing practices by a licensed physician for these eight patients as well as a lack of due care and diligence for these patients. We note our acceptance, based on the record, of the recommended conclusions that respondent, who believed he was overzealous on behalf of his patients, was not guilty of gross negligence.

The conclusions of the hearing committee and Commissioner of Health of not guilty of incompetence on more than one occasion are not consistent with the other findings and conclusions regarding gross incompetence and ordinary negligence under Education Law §6509(2). Respondent's conduct on more than one occasion concerning more than one patient rises to the level of both gross incompetence and ordinary negligence. In our unanimous opinion, such conduct clearly reaches the level of ordinary incompetence which does not require a finding of gross misconduct. Accordingly, the recommended conclusions by the hearing committee and Commissioner of Health regarding the eighteenth specification were erroneous and respondent is guilty of incompetence on more than one occasion.

Respondent treated Patient H on or about March 14, 1974 through October 23, 1987. Some of these record-keeping acts were committed by respondent before the definition of unprofessional

conduct alleged in the nineteenth specification became effective on October 1, 1977. Thus, contrary to the erroneous recommendations of the hearing committee and Commissioner of Health, respondent may not be found guilty of the nineteenth specification of unprofessional conduct for conduct occurring prior to October 1, 1977. Gould v. Board of Regents, 103 A.D.2d 897 (3rd Dept. 1984). Accordingly, we agree with the findings and conclusions of the hearing committee and Commissioner of Health regarding unprofessional conduct, except for record-keeping acts committed by respondent before October 1, 1977.

Other than for the charge of unprofessional conduct, the guilt which we recommend with respect to patient H, on the basis of the conclusions of the hearing committee and Commissioner of Health, relates to the charges concerning respondent's prescribing valium, clearly on more than one occasion, for approximately once a month from on or about September 28, 1982 through October 23, 1987. See hearing committee report page 14. These prescribing acts were committed by respondent after the relevant definition of professional misconduct became effective.

We unanimously recommend the following to the Board of Regents:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted, except to the extent that those

findings of fact solely support finding respondent guilty of unprofessional conduct on the basis of conduct committed by respondent before the Rules of the Board of Regents defining such professional misconduct became effective;

2. The conclusions of the hearing committee and Commissioner of Health are accepted, except that their conclusions regarding the eighteenth specification and, to the extent that they violate Gould v. Board of Regents, supra, their conclusions regarding the nineteenth specification not be accepted;

3. Respondent is guilty, by a preponderance of the evidence, of the ninth through eighteenth specifications, guilty of the nineteenth specification to the extent respondent's conduct was committed on or after October 1, 1977, and not guilty of the remaining specifications and charges;

4. The measure of discipline recommended by the hearing committee and Commissioner of Health be accepted and respondent's license to pactice as a physician in the State of New York be revoked upon each specification of the charges of which we recommend respondent be found guilty, as aforesaid. That respondent may, pursuant to Rule 24.7(b) of the Rules of the Board of Regents, apply for restoration of said license after one year has elapsed from the effective date of the service of the order of the Commissioner of Education to be issued herein, but said application shall not be granted automatically.

CONSTANTINE MANOUSSAKIS (10549)

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated: May 31, 1990

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

IN THE MATTER	:	STATEMENT
OF	:	OF
CONSTANTINE MANOUSSAKIS, M.D.	:	CHARGES

Constantine Manoussakis, M.D., The Respondent was authorized to practice medicine in New York State on February 26, 1980, by the issuance of license number ~~105068~~ 105609 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991 at 1090 Castletone Avenue, Staten Island, New York 10310.

Factual Allegations

A. From on or about September 9, 1974, to on or about September 11, 1986, Respondent was employed by the Long Island College Hospital (LICH) Outpatient Alcohol Clinic to provide medical treatment to recovering alcoholics and drug addicts. On or abut July 16, 1987, Dr. Felice Zwas, Medical Coordinator of the clinic, met with Respondent and informed him that prescribing potentially addictive medications such as valium or sleeping pills to clinic patients was inappropriate and against hospital policy.

EXHIBIT "A"

B. From on or about December 24, 1985, to on or about September 8, 1986, Patient A (Patient A and all other patients are identified in the attached appendix) was treated at the Long Island College Hospital (LICH) Outpatient Alcohol Clinic, Brooklyn, New York. On or about January 3, 1986, Patient A was examined at the LICH alcohol clinic by Respondent. Respondent performed a physical examination of Patient A at which time he leared of the patient's history of drug abuse and documented this information in the patient's record.

1. On or about February 21, 1986, Patient A sought treatment for a painful leg at the LICH outpatient alcohol clinic. Respondent examined the patient and prescribed 90 Darvon (Propoxyphene) 65 mg. to Patient A.

2. On or about September 8, 1986, Respondent against examined Patient A for a painful leg at the LICH outpatient alcohol clinic. He originally prescribed 90 Darvon 65 mg. to Patient A, but after a conversation with a nurse affiliated with the clinic he reduced the prescription to 45 Darvon capsules.

3. On or about September 9, 1986, Patient A was admitted to Maimonides Hospital, Brooklyn, New York with a diagnosis of drug overdose. He died later that day. An autopsy

was performed and the cause of death was acute propoxyphene and cocaine poisoning.

4. Respondent's prescriptions for Darvon, on or about February 21, 1986 and September 8, 1986, to Patient A, an individual with an extensive history of drug and alcohol abuse, were contraindicated.

C. From on or about June 30, 1986, to on or about August 25, 1986, Patient B was treat at the LICH Alcohol and Drug Outpatient clinic.

1. On or about August 22, 1986, Patient B sought treatment at that clinic for neck pains following "sudden movement". Respondent examined Patient B and prescribed 40 Darvon 65 mg. to her. This prescription was contraindicated given the patient's history of drug and alcohol abuse.

2. On or about August 25, 1986, Patient B was admitted by ambulance to Brooklyn Hospital, Brooklyn, New York. She was incoherent and vomitting. The history in the patient's hospital record revealed that she had ingested between 5 and 10 Darvon capsules.

D. From on or about October 10, 1981, through on or about November 28, 1988, Respondent treated Patient C at the West Brighton Medical Center, 1090 Castelton Avenue, Staten Island, New York. Respondent prescribed 90 Valium 5 mg. to Patient C at each of his approximately 81 visits. During that period of time:

1. Respondent failed to obtain a medical, family or social history of Patient C.

2. Respondent failed to perform and/or document physical examinations of Patient C.

3. Respondent failed to investigate the continuing cause of Patient C's anxiety and/or refer the patient for psychotherapeutic evaluation and treatment.

4. Respondent prescribed Valium for Patient C inappropriately, in that:

   a. Respondent prescribed Valium on approximately 81 visits without medical justification.

   b. Respondent failed to advise Patient C of the risks associated with Valium.

c. Respondent failed to attempt to reduce Patient C's intake of Valium or to alter his treatment of Patient C.

5. Respondent failed to maintain adequate medical records which accurately reflect the evaluation and treatment of Patient C.

E. From on or about August 20, 1986, through on or about August 20, 1988, Respondent treated patient D at the West Brighton Medical Center. During the course of the examination on August 20, 1986, Respondent documented in Patient D's chart that Patient D had a 20-year history of drug addiction. On or about August 20, 1986, Respondent's impression of Patient D's medical condition was "anxiety reactions, slightly frozen shoulder." On that visit and every visit thereafter for two years, Respondent prescribed 60 or 90 Valium 5 mg. to Patient D. During that period of time:

1. Respondent failed to obtain a psycho-social history of Patient D.

2. Respondent failed to perform and/or document physical examinations of Patient D.

3. Respondent failed to evaluate Patient D's medical problems and develop an overall treatment plan for Patient D's problems.

4. Respondent prescribed Valium to Patient D inappropriately, in that:

   a. Respondent prescribed Valium to an individual with a history of drug abuse and addiction.

   b. Respondent prescribed Valium to Patient D without medical justification.

   c. Respondent failed to advise Patient D and document in the record the risks associated with Valium.

   d. Respondent failed to attempt to reduce Patient D's Valium intake or to alter the treatment.

   e. Respondent failed to refer Patient D for psychotherapeutic evaluation or treatment.

5. Respondent failed to maintain adequate medical records which accurately reflect the evaluation and treatment of Patient D.

F. From on or about June 3, 1976, through on or about January 26, 1980, Patient E was treated by various physicians at the West Brighton Medical Center for complaints of nervousness, lack of appetite, insomnia, headache, sore throat, knee pain, shortness of breath, as well as for psycho-social problems. Patient E was seen monthly and received prescriptions for Valium, Elavil and/or Dalmane, Darvon and/or Darvocet. From on or about January 26, 1980, through on or about September 16, 1986, Respondent was the physician at the clinic primarily responsible for Patient E's care. Respondent saw Patient E monthly for two and a half years. At each visit he prescribed 90 Valium 5 mg., 30 Elavil 50 mg. and 90 Darvocet 100. During the 2 1/2 years that Respondent was responsible for Patient E's medical care:

1. Respondent failed to perform and/or document complete physical examinations on Patient E.

2. Respondent failed to evaluate Patient E's medical problems and develop and overall plan treatment plan for these problems.

3. Respondent prescribed Valium, Elavil and Darvon inappropriately, in that:

a. Respondent prescribed Valium, Elavil and Darvon without medical justification.

b. Respondent failed to advise Patient E of the addictive nature of Valium and Darvon.

c. Respondent failed to attempt to reduce Patient E's intake of the Valium and Darvon.

d. Respondent failed to refer the patient for psychotherapeutic evaluation and/or treatment.

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

G. From on or about June 7, 1978, through on or about June 12, 1986, Patient F was treated by various physicians at the West Brighton Medical Center. Patient F, a 28 year-old male, originally went to the clinic for treatment of his depression. Respondent treated Patient F on or about November 2, 1978; May 28, 1980; June 16, 1980 through July 12, 1982; September 9, 1982 through July 6, 1984; October 15, 1984 through March 20, 1985; May 20, 1985 through July 22 and, 1985 and from September 19, 1985 through July 9, 1986. Once a month from on or about September 9, 1982

through June 12, 1986, Respondent simultaneously prescribed to Patient F Catapress, Valium, Elavil and Darvon. During the period of time that Respondent was responsible for Patient F's medical care:

1. Respondent failed to obtain a medical, family or social history of Patient F.

2. Respondent failed to perform and/or document physical examinations of Patient F.

3. Respondent failed to evaluate the patient's medical problems and develop an overall treatment plan for handling these problems.

4. Respondent prescribed Catapress, Valium, Elavil and Darvon to Patient F inappropriately, in that:

   a. Respondent prescribed the above medications without medical justification.

   b. Respondent failed to advise Patient F and document in the record the risks associated with the above named medications.

c. Respondent failed to attempt to reduce Patient F's intake of the above named medications or to alter his treatment of Patient F.

d. Respondent failed to refer the patient for psychotherapeutic evaluation and/or treatment.

e. Respondent failed to maintain adequate medical records which accurately reflect the evaluation and treatment of Patient F.

H. From on or about March 19, 1983, through on or about April 16, 1988, Patient G, a 31 year-old male with a documented history of alcohol abuse, was treated for anxiety and seizures by various physicians at the West Brighton Medical Center. Respondent treated Patient G on or about November 4, 1985; from on or about February 21, 1986 through February 21, 1987; June 12, 1987 and from on or about September 28, 1987 through June 6, 1988. At every visit which Respondent treated Patient G, Respondent prescribed to Patient G 90 Valium 5 mg., 60 Darvocet 100 and 90 Dilantin 100 mg. Throughout the period of time that Respondent cared for and treated Patient G:

1. Respondent failed to obtain a medical and family history.

2. Respondent failed to perform and/or document physical examinations of Patient G.

3. Respondent failed to evaluate the patient's problems and develop an overall treatment plan for handling these problems.

4. Respondent prescribed Valium and Darvocet to Patient G inappropriately, in that:

   a. Respondent prescribed Valium and Darvocet to an individual with a documented history of alcohol abuse.

   b. Respondent prescribed these medications without any medical justification.

   c. Respondent failed to advise Patient G of the risks affiliated with Valium and Darvocet.

   d. Respondent failed to attempt to reduce Patient G's intake of the Valium and Darvocet, or to alter his treatment of Patient G.

5. Respondent failed to maintain adequate medical records which accurately reflect the evaluation and treatment of Patient G.

I. From on or about March 14, 1973 through on about October 23, 1987, Patient H, a 30 year-old woman, with a documented history of heroin addiction who had been on Methadone for four years, was treated for the majority of her medical needs by various physicians at the West Brighton Medical Center. Respondent treated her from on or about March 14, 1974 through June 13, 1977; July 20, 1977; October 24, 1978; January 9, 1980; August 17, 1981; from on or about October 16, 1981 through September 5, 1982; April 16, 1982 through August 28, 1982; January 29, 1982 through September 30, 1985; November 18, 1985 through January 5, 1987; March 3, 1987 through October 23, 1987. From on or about September 28, 1982 through October 23, 1987, approximately once a month, Respondent prescribed 90 Valium 5 mg. and 30 Restoril 30 mg. to Patient H. During the period of time that Respondent was responsible for Patient H's medical care:

1. Respondent failed to perform and/or document physical examinations of Patient H.

2. Respondent failed to evaluate Patient H's medical problems and develop an overall treatment plan for Patient H's problems.

3. Respondent prescribed Valium and Restoril to Patient H inappropriately, in that:

   a. Respondent prescribed Valium and Restoril to a patient with a known history of drug abuse.

   b. Respondent prescribed Valium and Restoril to Patient H without medical justification.

   c. Respondent failed to advise Patient H of the risks associated with those medications.

   d. Respondent failed to attempt to reduce Patient H's intake of Valium and Restoril, or to alter his treatment of Patient H.

4. Respondent failed to maintain adequate medical records which accurately reflect the evaluation and treatment of Patient H.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509 (2)(Mckinney 1985), in that he practiced the profession with gross negligence, in that Petitioner charges:

1. The facts in Paragraphs B, B1 through B4.

2. The facts in Paragraphs C, C1 and C2.

3. The facts in Paragraphs D, D1 through D5.

4. The facts in Paragraphs E, E1 through E5.

5. The facts in Paragraphs F, F1 through F4.

6. The facts in Paragraphs G, G1 through G5.

7. The facts in Paragraphs H, H1 through H5.

8. The facts in Paragraphs I, I1 through I4.

NINTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

9. The facts in Paragraphs B, B1 through B4; C, C1 and C2; D, D1 through D5; E, E1 through E5; F, F1 through F4; G, G1 through G5; H, H1 through H5; and I, I1 through I4.

TENTH THROUGH SEVENTEENTH SPECIFICATION

PRATICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that he practiced the profession with gross incompetence, in that Petitioner charges:

10. The facts in Paragraphs B, B1 through B4.

11. The facts in Paragraphs C, C1 and C2.

12. The facts in Paragraphs D, D1 through D5.

13. The facts in Paragraphs E, E1 through E5.

14. The facts in Paragraphs F, F1 through F4.

15. The facts in Paragraphs G, G1 through G5.

16. The facts in Paragraphs H, H1 through H5.

17. The facts in Paragraphs I, I1 through I 14.

EIGHTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

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

18. The facts in Paragraphs B, B1 through B4; C, C1 and C2; D, D1 through D5; E, E1 through E5; F, F1 through F4; G, G1 through G5; H, H1 through H5; and I, I1 through I4.

NINETEENTH SPECIFICATION

RECORD KEEPING

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509(9)(McKinney)(1985), in that he committed unprofessional conduct within the meaning of 8 N.Y.C.R.R. 29.2 (a)(3) (1987),in that he failed to maintain a record which accurately reflects the evaluation and treatment of his patients, specifically, the Petitioner charges,

19. The facts in Paragraphs C5, D5, E5, F4, G5, H5, I4.

Dated: New York, New York
~~April~~ June 22, 1989

Chris Stern Hyman Counsel
Bureau of Professional
Medical Conduct

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

IN THE MATTER	:	REPORT BY
OF	:	HEARING
CONSTANTINE MANOUSSAKIS, M.D.	:	COMMITTEE

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

The undersigned, Hearing Committee (the Committee) consisted of Conrad Rosenberg, M.D., (Chairman), Hong Chul Yoon, M.D., Kenneth A. DeBarth, R.P.A. The Committee was duly designated, constituted and appointed by the State Board for Professional Medical Conduct (the Board). The Administrative Officer was Harry Shechtman, Esq.

The hearing was conducted pursuant to the provisions of N.Y. Public Health Law Section 230 and N.Y. State Administrative Procedure Act Sections 301-307 to receive evidence concerning the charges that the Respondent has violated provisions of N.Y. Education Law Section 6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made.

The Committee has considered the entire record herein and makes this Report of its Findings of Fact, Conclusions and Recommendations to the New York State Commissioner of Health.

EXHIBIT "B" EXHIBIT "B"

Statement of the Case

The Respondent is charged with various acts of professional misconduct pursuant to Sections 6509(2), 6509(9) of the Education Law, and Part 29.2(a)(3) of 8 NYCRR, in that he practiced the profession with gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion and failure to maintain accurate records of the evaluation and treatment of his patients.

The charges are based on his treatment of eight patients, seven of whom had histories of either drug or alcohol abuse and were given any one of the following drugs, namely Valium, Elavil, Dalmane, Darvon, Darvocet, Catapres, Dilantin and Restoril during the course of treatment of the patients for various health problems.

Summary of Proceedings

Statement of Charges dated:	June 22, 1989
Notice of Hearing and Statement of Charges served upon Respondent:	June 23, 1989
Notice of Hearing Returnable:	July 17, 1989
Place of Hearing:	Regional Office of State Health Department 8 E. 40th Street New York, NY
Answer:	None Filed

Office of Professional Medical Conduct appeared by:	Dianne Abeloff, Esq. Assoc. Counsel
Respondent appeared:	Pro se
Hearings held on:	July 17 and 18, 1989
Record Closed on:	July 18, 1989
Deliberations held on:	August 7, 1989
Report submitted:	

Witnesses called by Department:

Colter Rule, M.D. expert witness

Felice Zwas, M.D. medical coordinator of the outpatient alcohol clinic of Long Island College Hospital.

The Respondent, Constantine Manoussakis, M.D., testified on his own behalf.

Findings of Fact

1. Constantine Manoussakis, M.D., the Respondent, was authorized to practice medicine in New York State on February 26, 1970 by the issuance of license number 105608 by the New York State Education Department. The Respondent is currently registered with the New York Education Department to practice medicine for the period January 1, 1989 through December 31, 1991 at 1090 Castletone Avenue, Staten Island, New York 10310.

2. From on or about September 9, 1974, to on or about September 11, 1986, Respondent was employed by the Long Island College

Hospital (LICH) Outpatient Alcohol Clinic to provide medical treatment to recovering alcoholics. On or about July 16, 1986, Dr. Felice Zwas, Medical Coordinator of the clinic, met with Respondent and informed him that prescribing potentially addictive medications such as Valium or sleeping pills to clinic patients was inappropriate and against hospital policy. (T. 190; Ex. 16)

Patient A.

Findings

1. From on or about December 24, 1985, to on or about September 8, 1986, Patient A was treated at the (LICH) Outpatient Alcohol Clinic, Brooklyn, New York. On or about January 3, 1986, Patient A was examined at the LICH alcohol clinic by Respondent. Respondent performed a physical examination of Patient A at which time he learned of the patient's history of drug abuse and documented this information in the patient's record. (Ex. 3, page 2 of entrance physical)

2. On or about February 21, 1986, Patient A sought treatment for a painful leg at the LICH outpatient alcohol clinic. Respondent examined the patient and prescribed 90 Darvon (Propoxyphene) 65 mg. to Patient A, to be taken one capsule three times a day. (Ex's 3 and 4)

3. On or about September 8, 1986, Respondent again examined Patient A for a painful leg at the LICH outpatient alcohol clinic. He originally prescribed 90 Darvon 65 mg. to Patient A, but after a conversation with a nurse affiliated with the clinic he reduced the prescription to 45 Darvon capsules, three times a day. (T 227, 228,232; Ex's 4 and 16)

4. The chart (Ex. 3) is incomplete in that a page referring to the September 8, 1986 examination is missing. (T 232; Ex. 4, Rx #12553 dated 9/8/86; Ex. 16)

5. On or about September 9, 1986, Patient A was admitted to Maimonides Hospital, Brooklyn, New York with a diagnosis of drug overdose. He died later that day. An autopsy was performed and the cause of death was acute propoxyphene and cocaine poisoning. (T 37-38; Ex. 5)

Conclusions

The prescribing of large numbers of Darvon capsules on February 21 and September 8, 1986 does not meet acceptable medical standards, particularly for a patient with a history of alcohol and drug abuse.

Patient B

Findings

1. From on or about June 30, 1986, to on or about August 25, 1986, Patient B was treated at the LICH Alcohol Outpatient clinic. On or about August 22, 1986, Patient B sought treatment at that clinic for neck pains following "sudden movement". Respondent examined Patient B and prescribed 40 Darvon 65 mg. to be taken 4 times a day. The patient had a history of drug and alcohol abuse. (Ex. 7)

2. On or about August 25, 1986, Patient B was admitted by ambulance to Caledonian Hospital, Brooklyn, New York. She was incoherent and vomiting. The history in the patient's hospital record revealed that she had ingested between 10 and 20 Darvon capsules, while drinking alcoholic beverages. (Ex. 9)

Conclusions

The prescribing of large numbers of Darvon capsules on August 22, 1986 does not meet acceptable medical standards, particularly for a patient with a history of alcohol and drug abuse.

Patient C

Findings

1. From on or about October 10, 1981, through on or about November 28, 1988, Respondent treated Patient C at his office at the West Brighton Medical Center, 1090 Castelton Avenue, Staten Island, New York. Respondent prescribed Valium 5 mg. to be taken 3 times a day by Patient C at each of his approximately 81 monthly visits. During that period of time: (Ex. 10)

   a. Respondent did not obtain a medical, family or social history of Patient C. (Ex. 10)

   b. Respondent did not perform and/or document physical examinations of Patient C. (Ex. 10)

   c. Respondent did not investigate the continuing cause of Patient C's anxiety and/or refer the patient for psychotherapeutic evaluation and treatment. (Ex. 10)

Conclusions

Respondent prescribed Valium for Patient C inappropriately, in that: Respondent prescribed Valium on approximately 81 visits without medical justification, and failed to attempt to reduce

Patient C's intake of Valium or to alter his treatment of Patien C.

Respondent failed to maintain adequate medical records which accurately reflect the evaluation and treatment of Patient C.

Patient D

Findings

1. From on or about August 20, 1986, through on or about Augus 20, 1988, Respondent treated Patient D at the West Brighton Medical Center. During the course of the examination on August 20, 1986, Respondent documented in Patient D's chart that Patient D had a 20-year history of drug addiction. Or or about August 20, 1986, Respondent's impression of Patien D's medical condition was "anxiety reactions, slightly froz shoulder." On that visit and every visit thereafter for tw years, Respondent prescribed 60 or 90 Valium 5 mg. for Patie D to be taken 2 or 3 times a day. (Ex. 11) During that per: of time:

   a. Respondent obtained a psycho-social history of and performed and documented physical examinations of Pati D.

b. Respondent evaluated Patient D's medical problems. (Ex. 11; T 285, 286)

c. Respondent did not attempt to reduce Patient D's Valium intake or alter the treatment and did not refer him for psychotherapeutic evaluation or treatment. (Ex. 11)

Conclusions

The Respondent prescribed Valium to Patient D without medical justification.

Patient E

Findings

1. From on or about June 3, 1976, through on or about January 26, 1980, Patient E was treated by various physicians at the West Brighton Medical Center for complaints of nervousness, lack of appetite, insomnia, headache, sore throat, knee pain, shortness of breath, as well as for psycho-social problems. Patient E was seen monthly and received prescriptions for Valium, Elavil and/or Dalmane, Darvon and/or Darvocet. From on or about January 26, 1980, through on or about September 16, 1986, Respondent was the physician at the clinic primarily responsible for Patient E's care. Respondent saw Patient E monthly for two and a half years. At each visit he prescribed

90 Valium 5 mg., 30 Elavil 50 mg., and 90 Darvocet 100. (Ex. 12)

2. During the 2 1/2 years that Respondent was responsible for Patient E's medical care Respondent performed and/or documented complete physical examinations on Patient E, and evaluated Patient E's medical problems.

3. Respondent did not advise Patient E of the addictive nature of Valium and Darvon.

4. Respondent did not attempt to reduce Patient E's intake of the Valium and Darvon.

5. Respondent did not refer the patient for psychotherapeutic evaluation and/or treatment.

Conclusions

The prescribing of large numbers of Valium, Elavil and Darvocet to this patient did not meet acceptable medical standards.

Respondent maintained marginal medical records which accurately reflect the evaluation and treatment of Patient E.

Patient F

Findings

1. From on or about June 7, 1978, through on or about June 12, 1986, Patient F was treated by various physicians at the West Brighton Medical Center. Patient F, a 28 year-old male, originally went to the clinic for treatment of his depression. Respondent treated Patient F on or about November 2, 1978; May 28, 1980; June 16, 1980 through July 12, 1982; September 9, 1982 through July 6, 1984; October 15, 1984 through March 20, 1985; May 20, 1985 through July 22 and, 1985 and from September 19, 1985 through July 9, 1986. Once a month from on or about September 9, 1982 through June 12, 1986, Respondent concurrently prescribed to Patient F Catapres, Valium, Elavil and Darvocet. (Ex. 13)

2. During the period of time that Respondent was responsible for Patient F's medical care Respondent did not obtain a medical, family or social history of Patient F, and did not perform and/or document adequate physical examinations of Patient F. (Ex. 13)

3. Respondent did not attempt to reduce Patient F's intake of the above named medications or to alter his treatment of Patient F. (Ex. 13)

4. Respondent did not document either a referral to a psychiatrist or refer the patient for ongoing continued psychiatric care and/or treatment. (Ex. 13)

5. Respondent did not maintain adequate medical records which accurately reflect the evaluation and treatment of Patient F. (Ex. 13)

Conclusions

The Respondent's prescriptions of large numbers of Catapres, Valium, Elavil and Darvocet to this patient did not meet acceptable medical standards.

Patient G

Findings

1. From on or about March 19, 1983, through on or about April 16, 1988, Patient G, a 31 year-old male with a documented history of alcohol abuse, was treated for anxiety and seizures by various physicians at the West Brighton Medical Center. Respondent treated Patient G on or about November 4, 1985; from on or about February 21, 1986 through February 21, 1987 June 12, 1987 and from on or about September 28, 1987 throug June 6, 1988. At every visit which Respondent treated Patien

G, Respondent prescribed to Patient G 90 Valium 5 mg., 60 Darvocet 100 and 90 Dilantin 100 mg. (Ex. 14)

2. Throughout the period of time that Respondent cared for and treated Patient G Respondent did not obtain a medical and family history and did not document an adequate physical examination of Patient G. (Ex. 14)

3. Respondent did not attempt to reduce Patient G's intake of Darvocet. (Ex. 13)

4. Respondent did not maintain adequate medical records which accurately reflect the evaluation and treatment of Patient G.

Conclusions

The prescribing of large numbers of Darvocet does not meet acceptable medical standards particularly for a patient with a previous history of alcohol abuse. Valium and Dilantin are to be considered as acceptable management of seizure disorders. Expert opinion (T 162).

Patient H

Findings

1. From on or about March 14, 1973 through on or about October 23, 1987, Patient H, a 30 year-old woman, with a documented

history of heroin addiction who had been on Methadone for four years was treated for the majority of her medical needs by various physicians at the West Brighton Medical Center. Respondent treated her from on or about March 14, 1974 through June 13, 1977; July 20, 1977; October 24, 1978; January 9, 1980; August 17, 1981; from on or about October 16, 1981 through September 5, 1982; April 16, 1982 through August 28, 1982; January 29, 1982 through September 30, 1985; November 18, 1985 through January 5, 1987; March 3, 1987 through October 23, 1987. From on or about September 28, 1982 through October 23, 1987, approximately once a month, Respondent prescribed 90 Valium 5 mg. and 30 Restoril 30 mg. to Patient H. (Ex. 15)

2. During the period of time that Respondent was responsible for Patient H's medical care Respondent performed and/or documented physical examinations of Patient H.

3. Respondent prescribed Valium and Restoril to Patient H who had a known history of heroin abuse.

4. Respondent did attempt to reduce Patient H's intake of Valium and Restoril.

5. Respondent failed to maintain adequate medical records which accurately reflect the evaluation and treatment of Patient H.

Conclusions

The prescribing of large numbers of Valium and Restoril does not meet acceptable medical standards particularly for a patient with a known habit of heroin abuse.

General Conclusions

The Committee by a unanimous vote concluded that acts and omissions as determined with regard to the eight patients herein and the First through Eighth Specifications did not rise to the level of gross negligence, but by a vote of two to one determined that as to the Ninth Specification the Respondent was guilty of negligence on more than one occasion under Section 6509(2) of the Education Law.

The Committee by a vote of two to one determined that with regard to the Tenth through Seventeenth Specifications the Respondent was guilty of gross incompetence. By a vote of two to one with regard to the Eighteenth Specification was not guilty of incompetence on more than one occasion.

The Committee by a unanimous vote with regard to the Nineteenth Specification concludes that the Respondent was guilty of failing to maintain records which accurately reflect the evaluation and treatment of patients.

Recommendations

The Committee by a vote of two to one recommends that the Respondent's license to practice medicine be revoked. The dissenting member of the Committee voted to suspend the license to practice medicine for a period of two years, with a stay of such penalty for a period of two years during which time the Respondent shall be on probation as provided for in Section 6511(a) of the Education Law.

The Hearing Committee was particularly disturbed by the fact that when queried by the Committee as to whether he would change his practice and procedures, the Respondent said he would not and saw no reason to consider such a change. This answer was in spite of the fact that three of the patients presented had been arrested for selling drugs, one was a suicide, one was a recovering suicide, and one had overdosed on drugs.

DATED: New York, New York
October 3, 1989

Respectfully submitted,

Conrad Rosenberg, M.D.
Chairman
Hong Chul Yoon, M.D.
Kenneth DeBarth, R.P.A.

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

IN THE MATTER :

OF :

CONSTANTINE MANOUSSAKIS, M.D. :
----------X

COMMISSIONER'S

RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on July 17, 1989 and July 18, 1989. Respondent, Constantine Manoussakis, M.D., appeared Pro se. The evidence in support of the charges against the Respondent was presented by Dianne Abeloff, Esq.

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

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

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

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

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

EXHIBIT "C"

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

DATED: Albany, New York
December 11, 1989

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

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

CONSTANTINE MANOUSSAKIS

CALENDAR NO. 10549

The University of the State of New York

IN THE MATTER

OF

CONSTANTINE MANOUSSAKIS
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 10549

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10549, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (June 22, 1990): That, in the matter of CONSTANTINE MANOUSSAKIS, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted, except to the extent that those findings of fact solely support finding respondent guilty of unprofessional conduct on the basis of conduct committed by respondent before the Rules of the Board of Regents defining such professional misconduct became effective;
2. The conclusions of the hearing committee and Commissioner of Health are accepted, except that their conclusions regarding the eighteenth specification and, to the extent that they violate Gould v. Board of Regents, supra, their conclusions regarding the nineteenth specification not be accepted;
3. Respondent is guilty, by a preponderance of the evidence,

of the ninth through eighteenth specifications, guilty of the nineteenth specification to the extent respondent's conduct was committed on or after October 1, 1977, and not guilty of the remaining specifications and charges; and

4. The measure of discipline recommended by the hearing committee and Commissioner of Health be accepted and respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent was found guilty, as aforesaid. That respondent may, pursuant to Rule 24.7(b) of the Rules of the Board of Regents, apply for restoration of said license after one year has elapsed from the effective date of the service of the order of the Commissioner of Education to be issued herein, but said application shall not be granted automatically;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

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

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

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 29th day of June, 1990.

Thomas Sobol

Commissioner of Education