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

December 7, 1990

John P. McCloy, Physician
4 Treeview Drive
Melville, N.Y. 11747

Re: License No. 073889

Dear Dr. McCloy:

Enclosed please find Commissioner's Order No. 11226. 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:

Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er
Enclosures

CERTIFIED MAIL- RRR
cc: Amy Kulb, Esq.
c/o Jacobson & Goldberg, Inc.
518 Stewart Avenue
Garden City, N.Y. 11530

REPORT OF THE
REGENTS REVIEW COMMITTEE

JOHN P. McCLOY

CALENDAR NO. 11226

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

JOHN P. McCLOY **No. 11226**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

JOHN P. McCLOY, 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 and on 11 separate dates between September 11, 1989 and January 23, 1990 hearings were held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

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 concluded that respondent was guilty of the first specification of the charges, the forty-fifth through

sixtieth specifications of the charges to the extent indicated in its report, and not guilty of the remaining charges.* The hearing committee recommended that respondent's license to practice as a physician in the State of New York be suspended for two years but that the suspension be stayed for the last year and nine months; that respondent be on probation with review of medical records particularly as they pertain to prescribing and record keeping of controlled substances for two years (the period of his suspension); and that respondent perform 100 hours of community service preferably in a substance abuse facility.

The Commissioner of Health recommended to the Board of Regents that the findings of fact, conclusions, and recommendation of the

---

*The hearing committee misnumbered the specifications when setting forth its conclusions at pages 23 and 24 of its report. At our hearing, petitioner and respondent entered into a written stipulation as follows: "We stipulate that the reference to the 'Seventeenth Through Thirteenth Specification' on page 23 should read, as follows: 'Seventeenth Through Thirtieth Specifications.' These specifications refer to the charge of practicing with gross negligence.

We stipulate further that the reference to the 'Thirty-Five Through Forty-Fourth Specification' on page 24 should read, as follows: 'Thirty-First Through Forty-Fourth Specifications.' These specifications refer to the charge of practicing with gross incompetence."

In accord with the stipulation of the parties, we deem the hearing committee report to be so amended. We also note that respondent was found not guilty of any of the charges of gross negligence or gross incompetence.

hearing committee be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On September 17, 1990 respondent appeared before us in person and was represented by an attorney, Amy T. Kulb, Esq., who presented oral argument on respondent's behalf. Marcia E. Kaplan, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State of New York be suspended for two years, three months actual and one year and nine months stayed; probation with review of medical records particularly as they pertain to prescribing and record keeping of controlled substances for two years (the period of suspension); and 100 hours of community service preferably in a substance abuse facility.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was: two year suspension, execution fully stayed, two years probation with community service and/or continuing education seminars.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as petitioner's and

respondent's September 17, 1990 stipulation.

With regard to the measure of discipline, we agree in substance with the hearing committee and Commissioner of Health. However, we would add to respondent's probation that he take a six month course of training in medical record keeping in order to address respondent's deficiencies in this area. We would also have respondent's period of probation coincide with the one year and nine months for which his suspension is stayed.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee report be deemed amended so that the heading "Seventeenth Through Thirteenth Specification" on page 23 of the report reads "Seventeenth Through Thirtieth Specifications", and the heading "THIRTY-FIVE THROUGH FORTY-FOURTH SPECIFICATION" on page 24 of the report reads "Thirty-First Through Forty-Fourth Specifications";
2. The hearing committee's findings of fact, and conclusions as to the question of respondent's guilt, as deemed amended as aforesaid, be accepted, and the Commissioner of Health's recommendation as to those findings of fact, and conclusions, as deemed amended as aforesaid, be accepted;
3. The hearing committee's and Commissioner of Health's

recommendations as to the measure of discipline be modified;

4. Respondent be found guilty, by a preponderance of the evidence, of the first specification of the charges, and the forty-fifth through sixtieth specifications of the charges to the extent indicated in the hearing committee report, and not guilty of the remaining charges; and

5. Respondent's license to practice as a physician in the State of New York be suspended for two years and respondent be required to perform 100 hours of public service in a substance abuse facility upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently and said public service to be performed concurrently and to total 100 hours, and that execution of the last 21 months of said suspensions be stayed at which time respondent then be placed on probation for said last 21 months under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D".

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith

Chairperson

Dated: 10/18/90

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JOHN P. McCLOY, M.D.	:	CHARGES

----------X

JOHN P. McCLOY, M.D., the Respondent, was authorized to practice medicine in New York State on August 6, 1953 by the issuance of license number 073889 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 from 345 E. Old Country Road, Hicksville, New York 11801.

FACTUAL ALLEGATIONS

A. Between on or about May 29, 1981 and on or about January 19, 1987, on approximately 80 occasions, Respondent prescribed Percodan, and on occasion Demerol or Percocet, for Patient A, who had a history of Paget's Disease of the right hip with joint changes and narrowing; anxiety with peptic ulcer; and a past history of lethargy and narcolepsy. (The identities of Patients A - N are disclosed in the attached Appendix.) At various times within that period, he also prescribed Calcitonin, Didronil and Dexadrine. During the

EXHIBIT

period from on or about May 29, 1981 through on or about January 19, 1987:

1. Respondent failed to take a complete history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to order appropriate laboratory or diagnostic tests (other than an X-ray of the pelvis and right hip and a GI series on June 5,1984), including routine blood work and urinalysis, a skeletal survey (series of X-rays), stool guiac test(s), and/or calcium levels while prescribing Calcitonin.

4. Respondent failed to refer Patient A to a neurologist, or to consult with one, for treatment of Patient A's narcolepsy.

5. Respondent failed to ascertain whether the patient was in pain, and if so, to what degree, and why.

6. Respondent prescribed Percodan, Demerol and/or Percocet inappropriately, in that:

   (i) Respondent failed to ascertain that Patient A experienced pain requiring Percodan, Demerol and/or Percocet notwithstanding the diagnosis of Paget's disease and a peptic ulcer.

   (ii) Respondent failed to attempt to reduce the daily dose of Percodan, Demerol and/or Percocet prescribed or to prescribe non-narcotic analgesics.

   (iii) Respondent failed to consult with specialists in pain management and/or chemical dependency.

7. Respondent failed to keep adequate medical records accurately representing Patient A's medical condition.

8. Respondent failed to document in the medical record Percodan, Demerol and/or Percocet he prescribed for Patient A, as follows:

Date	Drug	Quantity
5-29-81	Percodan	40
8-10-81	Percodan	100
8-24-81	Percodan	100
9-09-81	Percodan	100
9-23-81	Percodan	100
10-06-81	Percodan	100
10-24-81	Percodan	100
12-23-81	Percodan	100
1-16-82	Percodan	100
2-01-82	Percodan	100
2-20-82	Percodan	100
3-08-82	Percodan	100
3-30-82	Percodan	100
5-12-82	Percodan	100
6-02-82	Percodan	100
7-08-82	Percodan	100
7-26-82	Percodan	100
8-11-82	Percodan	100
8-28-82	Percodan	100
9-15-82	Percodan	100
9-27-82	Percodan	100
10-11-82	Percodan	100
11-10-82	Percodan	100
11-27-82	Percodan	100
12-21-82	Percodan	100
1-10-83	Percodan	100
1-31-83	Percodan	100
2-14-83	Percodan	100
3-05-83	Percodan	100
3-21-83	Percodan	100
4-08-83	Percodan	100
4-29-83	Percodan	100
5-20-83	Percodan	100
6-10-83	Percodan	100
6-29-83	Percodan	100
7-15-83	Percodan	100
8-31-83	Percodan	100
9-13-83	Percodan	100
10-12-83	Percodan	100
11-05-83	Percodan	100
12-03-83	Percodan	100
12-27-83	Percodan	100
1-20-84	Percodan	100
2-09-84	Percodan	100
2-27-84	Percodan	100
3-10-84	Percodan	100
3-31-84	Percodan	100
4-21-84	Percodan	100
5-07-84	Percodan	100

5-30-84	Percodan 100
6-21-84	Percodan 100
7-05-84	Percodan 100
7-28-84	Percodan 100
8-16-84	Percodan 100
9-01-84	Percodan 100
9-24-84	Percodan 100
11-05-84	Percodan 100
11-24-84	Percodan 100
12-08-84	Percodan 100
12-26-84	Percodan 100
1-12-85	Percodan 100
2-11-85	Percodan 100
3-02-85	Percodan 100
3-22-85	Percodan 100
4-06-85	Percodan 100
5-17-85	Percodan 100
9-14-85	Percodan 100
10-18-85	Percodan 100
11-06-85	Percodan 100
11-28-85	Percodan 100
1-02-86	Percodan 100
2-11-86	Percodan 100
5-16-86	Percodan 100
6-02-86	Percodan 100
7-23-86	Percodan 100
12-18-86	Demerol 100
12-27-86	Percocet 100
1-09-87	Percocet 100
1-19-87	Percocet 100

9. Respondent knew that the Percodan, Demerol and/or Percocet he prescribed was without medical indication.

B. Between on or about February 22, 1982 and on or about July 13, 1984, Respondent prescribed Percodan on approximately 9 occasions to Patient B, who had a history of a severe auto accident in approximately 1974 with a fractured scapula, cerebral concussion and fractured cervical vertebra. Respondent also gave Patient B Tylenol-3 for back and neck pain. During

the period from on or about February 22, 1982 through on or about December 14, 1988:

1. Respondent failed to take a complete history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to order appropriate laboratory or diagnostic tests, including routine blood work and urinalysis, and/or X-rays of the soft tissues of the neck, cervical and thoracic spine, and chest.

4. Respondent prescribed Percodan inappropriately, in that:

   (i) Respondent failed to assess the nature of the injuries sustained in the auto accident or their sequelae or to evaluate the patient's condition at appropriate intervals.

   (ii) Respondent failed to prescribe non-narcotic analgesics for Patient B's pain.

5. Respondent failed to keep adequate medical records accurately representing Patient B's medical condition.

6. Respondent failed to document in the medical record Percodan he prescribed for Patient B, as follows:

Date	Drug	Quantity
2-22-82	Percodan	24
11-27-83	Percodan	30
5-11-84	Percodan	30
5-18-84	Percodan	30
6-10-84	Percodan	24
6-18-84	Percodan	30
7-13-84	Percodan	30
11-27-86	Percodan	20
12-14-88	Percodan	24

7. Respondent knew that the Percodan he prescribed for Patient B was without medical indication.

C. Respondent treated Patient C from March, 1963 through October, 1985. On numerous occasions between 1976-1982 and on a continuous basis in 1982-1983, Respondent prescribed Demerol for Patient C, who had a history of Tietze's Syndrome and hypertension. Patient C presented with a variety of complaints on various occasions. In addition to Demerol, Patient C was treated with Prednisolone and a variety of other medications. During the period from on or about October 1, 1977 through on or about October 25, 1985:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to diagnose many of Patient C's various complaints.

4. Respondent failed to order appropriate laboratory or diagnostic tests, including routine blood work and urinalysis, electrocardiograms, chest X-rays, and/or failed to monitor Patient C's serum electrolytes while prescribing diuretic therapy.

5. Respondent failed to attempt to place Patient C on a weight reduction program despite weight measurements indicating obesity, musculoskeletal complaints and a diagnosis of hypertension.

6. Respondent prescribed corticosteroid therapy without medical indication.

7. Respondent prescribed Demerol inappropriately, in that:

   (i) Demerol was not medically indicated.

   (ii) Respondent failed to attempt to reduce Patient C's daily dose of Demerol.

   (iii) Respondent failed to consult with specialists in pain management and/or chemical dependency.

8. Respondent failed to keep adequate medical records accurately representing Patient C's condition.

9. Respondent failed to document in the medical record Demerol he prescribed for Patient C, as follows:

Date	Drug	Quantity
3-23-82	Demerol	30
6-28-82	Demerol	100
9-20-82	Demerol	100
10-30-82	Demerol	60
12-29-82	Demerol	100
2-15-83	Demerol	60
4-13-83	Demerol	100
5-19-83	Demerol	100
6-25-83	Demerol	100
7-30-83	Demerol	60
11-15-83	Demerol	50

10. Respondent knew that the Demerol he prescribed for Patient C was without medical indication.

D. Respondent treated Patient D from July, 1983 through August, 1986. On approximately 40 occasions between on or about July 6, 1983 and on or about August 12, 1985, the Respondent prescribed Demerol and Percodan for Patient D, who had a history of surgery for carcinoma of the testicle and lymph node resection. On various occasions, Patient D presented with a variety of complaints. In addition to Demerol and Percodan, Patient D was treated with various antibiotics and Xanax. During the period from on or about July 6, 1983 through August 9, 1986:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to perform appropriate diagnostic and laboratory tests, including routine blood work and urinalysis, and/or a urine culture on or about June 21, 1986 despite symptoms of a urinary tract infection.

4. Respondent failed to monitor Patient D's weight despite the diagnosis of cancer.

5. Respondent failed to consult with a urologist and/or an oncologist despite the diagnoses of testicular cancer and recurrent epididymitis.

6. Respondent prescribed antibiotics without medical indication on or about March 13, 1984 and/or on or about September 29, 1984.

7. Respondent prescribed Demerol and/or Percodan inappropriately, in that:

   (i) Respondent failed to ascertain that Patient D experienced pain requiring Demerol and/or Percodan.

   (ii) Respondent failed to attempt to reduce Patient D's daily dose of Demerol or to prescribe non-narcotic analgesics.

   (iii) Respondent failed to consult with specialists in pain management and/or chemical dependency.

8. Respondent failed to keep adequate medical records accurately representing Patient D's condition and/or the results of tests ordered.

9. Respondent failed to document in the medical record Demerol and Percodan he prescribed for Patient D, as follows:

Date	Drug	Quantity
7-06-83	Demerol	12
7-28-83	Demerol	4
8-19-83	Demerol	28
8-22-83	Demerol	60

9-02-83	Demerol	12
10-14-83	Demerol	4
11-09-83	Demerol	30
11-23-83	Demerol	30
12-13-83	Demerol	25
12-20-83	Demerol	6
1-06-84	Demerol	20
2-13-84	Demerol	10
3-14-84	Demerol	20
3-19-84	Demerol	20
3-24-84	Demerol	20
3-28-84	Demerol	10
3-31-84	Demerol	20
4-02-84	Demerol	20
4-12-84	Demerol	12
4-18-84	Demerol	20
4-24-84	Demerol	20
4-26-84	Demerol	20
6-05-84	Demerol	12
6-18-84	Demerol	20
8-06-84	Percodan	12
8-10-84	Demerol	10
8-21-84	Demerol	12
4-29-85	Demerol	30
8-12-85	Percodan	30

10. Respondent knew that the Demerol and/or Percodan he prescribed for Patient D was without medical indication.

E. Respondent treated Patient E from October, 1969 through June, 1988. On approximately 20 occasions between on or about March 24, 1982 and on or about June 24, 1988, the Respondent prescribed Percodan for Patient E, who had Crohn's Disease. The patient had an ileostomy following a total colectomy. He also had a history of cholelithiasis and nephrolithiasis and was diabetic. During the period from on or about October 1, 1977 through on or about June 24, 1988:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to take Patient E's temperature on repeated occasions despite a history of recurrent abscesses.

4. Respondent failed to perform appropriate diagnostic and laboratory tests, including routine blood work and urinalysis.

5. Respondent failed to perform the blood and urine tests he ordered on or about April 16, 1988, or failed to ascertain whether the tests were performed and/or failed to obtain the results.

6. Respondent failed to monitor Patient E's weight.

7. Respondent failed to evaluate Patient E appropriately to determine the adequacy of his nutritional status.

8. Respondent failed to instruct the patient as to diet despite the diagnosis of inflammatory bowel disease.

9. Respondent prescribed Percodan inappropriately, in that:

   (i) Respondent failed to ascertain that Patient E experienced pain requiring Percodan.

   (ii) Respondent failed to attempt to reduce Patient E's daily dose of Percodan or to prescribe non-narcotic analgesics.

   (iii) Respondent failed to consult with specialists in pain management and/or chemical dependency.

10. Respondent failed to keep adequate medical records accurately representing Patient E's condition and/or the results of tests ordered.

11. Respondent failed to document in the medical record Percodan, Percocet and Seconal he prescribed for Patient E, as follows:

Date	Drug	Quantity
3-24-82	Percodan	60
5-04-82	Percodan	100
1-12-83	Percodan	100
10-05-83	Percodan	100
11-12-83	Percodan	100
12-14-83	Percodan	100
1-20-84	Percodan	100
4-04-84	Percodan	100
4-28-84	Percodan	100
5-25-84	Percodan	100
6-16-84	Percodan	100
7-05-84	Percodan	100
9-17-84	Percodan	100
6-08-85	Percodan	100
9-18-85	Percodan	100
11-12-85	Percocet	100
6-26-86	Percodan	100
6-01-88	Seconal	30

12. Respondent knew that the Percodan he prescribed for Patient E was without medical indication.

F. Respondent treated Patient F from August, 1976 through March, 1985. On numerous occasions between on or about January 12, 1980 and on or about March 14, 1985, the Respondent prescribed Percodan and Valium for Patient F, who was stabbed in 1973 or 1974, which resulted in constant pain from the neck down. The patient also complained of "nerves." During the period from on or about October 1, 1977 through on or about March 14, 1985:

1. Respondent failed to take a complete medical history, including the history of the injury which was the source of the constant pain, any sequelae of the injury, ensuing disabilities, diagnostic tests and/or treatments performed at the time of the injury.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to assess the pain appropriately to determine whether any component of the pain was due to a correctable condition.

4. Respondent prescribed Percodan inappropriately, in that:

   (i) Respondent failed to attempt to reduce Patient F's daily dose of Percodan or to prescribe non-narcotic analgesics.

   (ii) Respondent failed to consult with specialists in pain management and/or chemical dependency.

   (iii) Respondent failed to refer the patient for rehabilitation, e.g. physical therapy.

5. Respondent prescribed Valium inappropriately, in that:

   (i) Respondent prescribed Valium for Patient F without medical indication.

   (ii) Respondent failed to attempt to reduce Patient F's daily dose of Valium.

   (iii) Respondent failed to refer the patient for psychotherapeutic evaluation and/or treatment of his "nerve" condition.

   (iv) Respondent failed to consult with specialists in pain management and/ or chemical dependency.

6. Respondent failed to keep adequate medical records accurately representing Patient F's condition.

7. Respondent failed to document in the medical record the Percodan he prescribed for Patient F, as follows:

Date	Drug	Quantity
1-30-81	Percodan	30
4-08-81	Percodan	30
5-06-81	Percodan	30
5-22-81	Percodan	30
6-22-81	Percodan	30
7-27-81	Percodan	30
8-10-81	Percodan	30

9-11-81	Percodan	30
11-24-82	Percodan	50
2-16-83	Percodan	60
3-02-83	Percodan	40
4-04-83	Percodan	60
4-15-83	Percodan	60
4-29-83	Percodan	60
5-23-83	Percodan	40
6-17-83	Percodan	40
8-03-83	Percodan	50
8-16-83	Percodan	50
8-31-83	Percodan	50
9-14-83	Percodan	60
9-28-83	Percodan	60
10-24-83	Percodan	50
11-09-83	Percodan	50
11-23-83	Percodan	50
12-20-83	Percodan	50

8. Respondent knew that the Percodan and/or Valium he prescribed for Patient F was without medical indication.

G. Respondent treated Patient G in his office between March, 1970 and October, 1984. Patient G had a history of degenerative osteoarthritis and rheumatoid arthritis following "flu" in 1978. She also presented on various occasions with a variety of other complaints. On numerous occasions between from on or about May 9, 1981 through on or about May 16, 1983, Respondent prescribed a virtual daily dose of Percocet for Patient G. In addition to Percocet, Patient G received Demerol, Prednisone, and Indocin. During the period from on or about October 1, 1977 through on or about October 27, 1984:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to identify the joints involved in patient G's arthritic condition, or to monitor Patient G for physical findings associated with arthritis, such as erythema, warmth, tenderness, or deformity.

4. Respondent failed to order appropriate laboratory or diagnostic tests, including X-rays, sedimentation rates, rheumatologic tests, or to record the results of routine tests ordered, e.g. those of 3-31-83.

5. Respondent failed to consult with a rheumatologist known to be involved in the care of the patient's arthritis.

6. Respondent prescribed Percocet inappropriately, in that:

   (i) Percocet was not indicated for the chronic arthritic condition for which it was prescribed.

   (ii) Respondent failed to attempt to reduce Patient G's daily dose of Percocet or to prescribe non-steroidal anti-inflammatory agents, other than Indocin on limited occasions, or salicylates (aspirin).

   (iii) Respondent failed to consult with specialists in pain management and/or chemical dependency.

7. Respondent failed to keep adequate medical records accurately representing Patient G's condition.

8. Respondent failed to document in the medical record Percocet he prescribed for Patient G, as follows:

Date	Drug	Quantity
8-15-81	Percocet	60
10-05-81	Percocet	60
11-11-81	Percocet	60
12-16-81	Percocet	60
2-11-82	Percocet	60
3-03-82	Percocet	60
3-31-82	Percocet	24
5-01-82	Percocet	60
5-21-82	Percocet	60
6-02-82	Percocet	60
6-22-82	Percocet	60
7-09-82	Percocet	60
8-04-82	Percocet	60
8-14-82	Percodan	40
9-16-82	Percocet	60
9-28-82	Percodan	100

10-25-82	Percocet	60
11-12-82	Percocet	60
11-26-82	Percocet	60
12-08-82	Percocet	60
12-24-82	Percocet	60
1-05-83	Percocet	90
1-29-83	Percocet	90
2-19-83	Percocet	90
3-10-83	Percocet	90
3-31-83	Percocet	90
4-20-83	Percocet	90
5-16-83	Percocet	90

9. Respondent knew that the Percocet he prescribed for Patient G was without medical indication.

H. Respondent treated Patient H from the 1960's through December, 1985. On numerous occasions between on or about July 29, 1981 and on or about December 31, 1985, the Respondent prescribed Percodan, Demerol and Seconal for Patient H, who had a history of "multiple injuries" after a fall in 1975, abdominal pain in 1979 with documented gastritis, duodenitis and evidence of a healing duodenal ulcer. Patient H was hospitalized in May 1985 for abdominal pain and a history was obtained of pain and heavy alcohol consumption. During that hospitalization he was found to have gastritis, duodenitis and probable chronic pancreatitis. Patient H had severe left leg pain beginning in July, 1985. Patient H presented with a variety of other complaints on various occasions. During the period from on or about October 1, 1977 through on or about December 31, 1985:

1. Respondent failed to take a complete medical history, including a history or description of the "multiple

injuries" and their sequelae, ensuing disabilities, diagnostic tests and/or treatments performed at the time of the injury.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to perform appropriate laboratory and diagnostic tests, including routine blood work and urinalysis, ~~liver function~~ tests, ~~amylase~~ levels and/or stool guiac tests.

4. Respondent failed to assess Patient H's pain appropriately to determine whether any component of the pain was due to a correctable condition.

5. Respondent failed to evaluate and/or treat the patient for alcoholism and/or to refer the patient for alcoholism treatment.

6. Respondent prescribed Percodan and/or Demerol inappropriately, in that:

   (i) Respondent failed to attempt to reduce Patient H's daily dose of Percodan and/or Demerol or to prescribe non-narcotic analgesics.

   (ii) Respondent failed to consult with specialists in pain management.

7. Respondent prescribed Valium, Seconal and/or Halcion inappropriately, in that:

   (i) Respondent prescribed Valium, Seconal and/or Halcion to Patient H without medical indication.

   (ii) Respondent failed to attempt to reduce Patient H's daily dose of Valium, Seconal, and/or Halcion or to alter the treatment.

8. Respondent failed to keep adequate medical records accurately representing Patient H's condition.

9. Respondent failed to document in the medical record Percodan, Demerol and/or Seconal he prescribed for Patient H, as follows:

Date	Drug	Quantity
7-29-81	Percodan	100
8-14-81	Percodan	100
10-30-81	Percodan	100
11-25-81	Percodan	100
9-17-82	Percodan	30
9-22-82	Percodan	30
2-09-83	Demerol	24
3-18-83	Percodan	30
4-28-83	Seconal	30
5-24-83	Seconal	30
6-07-83	Percodan	30
7-05-83	Percodan	30
7-25-83	Percodan	30
8-17-83	Percodan	30
9-07-83	Percodan	30
10-19-83	Demerol	30
10-26-83	Percodan	30
11-07-83	Percodan	60
11-28-83	Percodan	60
12-23-83	Percodan	60
1-20-84	Percodan	60
2-17-84	Percodan	60
3-14-84	Percodan	60
4-13-84	Percodan	60
5-11-84	Percodan	60
6-08-84	Percodan	60
7-06-84	Percodan	60
8-29-84	Percodan	60
9-26-84	Percodan	90
11-05-84	Percodan	60
11-17-84	Percodan	60
12-10-84	Percodan	90
1-30-85	Percodan	70
2-15-85	Percodan	90
3-30-85	Percodan	90
4-19-85	Percodan	90
5-10-85	Percodan	90
6-08-85	Percodan	60
7-29-85	Percodan	100
8-09-85	Percodan	100
9-09-85	Percodan	100
9-18-85	Percodan	200
11-19-85	Percodan	100
11-27-85	Percodan	100
12-11-85	Percodan	100

10. Respondent knew that the Percodan, Demerol, Valium, Seconal and/or Halcion he prescribed for Patient H was without medical indication.

I. Respondent treated Patient I from the 1960's through March, 1989. On approximately 8 occasions between on or about June 5, 1981 and on or about March 1, 1989, the Respondent prescribed Tuinal for Patient I, who had a history of "severe menopausal depression," and who did not respond to antidepressants. The patient had numerous other complaints and there is clinical and radiologic evidence that the patient had chronic obstructive pulmonary disease (COPD). During the period from on or about October 1, 1977 through on or about March 1, 1987:

1. Respondent failed to take a complete medical history, including symptoms of depression and/or a history regarding cigarette smoking.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to perform laboratory tests, including complete blood counts and/or pulmonary function tests.

4. Respondent failed to use influenza and pneumococcal vaccines, given Patient I's history of COPD.

5. On or about March 17, 1988, Respondent failed to evaluate appropriately Patient I's complaint of fever and/or prescribed the antibiotic Lincocin without medical indication.

6. Respondent failed to refer Patient I to a psychiatrist, or to consult with one, regarding the patient's possible depression.

7. Respondent prescribed Tuinal inappropriately, in that:

(i) Respondent prescribed Tuinal without medical indication.

(ii) Respondent failed to attempt to reduce Patient I's daily dose of Tuinal.

(iii) Respondent failed to consult with specialists in chemical dependency.

8. Respondent failed to keep adequate medical records accurately representing Patient I's condition.

9. Respondent failed to document in the medical record Tuinal he prescribed for Patient I, as follows:

Date	Drug	Quantity
6-05-81	Tuinal	30
8-04-81	Tuinal	30
8-31-81	Tuinal	60
10-02-81	Tuinal	30
11-02-81	Tuinal	30
2-19-82	Tuinal	30
3-19-82	Tuinal	30
4-16-82	Tuinal	30
5-18-82	Tuinal	30
6-18-82	Tuinal	30
7-17-82	Tuinal	30
8-14-82	Tuinal	30
9-13-82	Tuinal	30
10-13-82	Tuinal	30
11-12-82	Tuinal	30
12-13-82	Tuinal	30
1-08-83	Tuinal	30
2-08-83	Tuinal	30
3-09-83	Tuinal	30
4-08-83	Tuinal	30
5-09-83	Tuinal	30
6-08-83	Tuinal	30
7-08-83	Tuinal	30
8-04-83	Tuinal	30
9-02-83	Tuinal	30
10-05-83	Tuinal	30
11-04-83	Tuinal	30
12-07-83	Tuinal	30
1-17-84	Tuinal	30
2-16-84	Tuinal	30
3-17-84	Tuinal	30
4-13-84	Tuinal	30

5-16-84	Tuinal	30
7-18-84	Tuinal	30
8-16-84	Tuinal	30
10-15-84	Tuinal	30
11-15-84	Tuinal	30
12-14-84	Tuinal	30
1-14-85	Tuinal	30
2-12-85	Tuinal	30
3-14-85	Tuinal	30
5-13-85	Tuinal	30
6-12-85	Tuinal	30
7-15-85	Tuinal	30
8-13-85	Tuinal	30
9-10-85	Tuinal	30
10-11-85	Tuinal	30
11-13-85	Tuinal	30
12-11-85	Tuinal	30
1-12-86	Tuinal	30
2-10-86	Tuinal	30
3-13-86	Tuinal	30
4-12-86	Tuinal	30
5-10-86	Tuinal	30
6-11-86	Tuinal	30
7-11-86	Tuinal	30
8-11-86	Tuinal	30
9-09-86	Tuinal	30
11-07-86	Tuinal	30
12-06-86	Tuinal	30
1-07-87	Tuinal	30
2-05-87	Tuinal	30
3-09-87	Tuinal	30
4-08-87	Tuinal	30
6-06-87	Tuinal	30
7-07-87	Tuinal	30
8-05-87	Tuinal	--
10-03-87	Tuinal	30
11-02-87	Tuinal	30
12-03-87	Tuinal	30
1-02-88	Tuinal	30
2-03-88	Tuinal	30
6-01-88	Tuinal	30

10. Respondent knew that the Tuinal he prescribed for Patient I was without medical indication.

J. Respondent treated Patient J from February, 1978 through November, 1987. Patient J had a history of a war injury in 1951

which shattered his left lower leg. He received orthopedic and rehabilitative treatments at various times. He was also treated for hypertension and back pain. On numerous occasions between on or about December 12, 1980 and on or about February 22, 1986, Respondent prescribed a virtual daily dose of Tylox, Percodan or Demerol. During the period from on or about February 23, 1978 through on or about November 14, 1987:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to assess the condition of the patient's leg, or to obtain details of the patient's leg pain.

4. Respondent failed to order appropriate laboratory or diagnostic tests, including chest x-rays, EKGs, electrolytes, renal function tests, or liver function tests.

5. Respondent prescribed Percodan, Tylox and/or Demerol inappropriately, in that:

   (i) Respondent failed to ascertain that Patient J experienced pain requiring narcotics.

   (ii) Narcotics were not medically indicated as prescribed, virtually every day for many years.

   (iii) Respondent failed to attempt to reduce Patient J's daily dose of narcotics or to prescribe non-narcotic analgesics on more than one occasion.

   (iv) Respondent failed to consult with specialists in pain management and/or chemical dependency.

6. Respondent failed to keep adequate medical records accurately representing Patient J's condition.

7. Respondent failed to document in the medical record the drugs he prescribed for Patient J, as follows:

Date	Drug	Quantity
1-09-81	Tylox	120
1-14-81	Tylox	120
2-06-81	Tylox	120
2-20-81	Tylox	120
3-21-81	Tylox	120
4-04-81	Tylox	120
4-13-81	Tylox	120
5-06-81	Tylox	120
5-19-81	Tylox	120
5-27-81	Tylox	120
6-06-81	Tylox	120
6-16-81	Tylox	120
6-19-81	Seconal	60
6-26-81	Tylox	120
7-06-81	Tylox	120
7-10-81	Tylox	120
7-10-81	Seconal	30
7-22-81	Tylox	120
9-10-81	Tylox	120
9-25-81	Tylox	120
10-05-81	Tylox	120
10-19-81	Tylox	120
10-30-81	Tylox	120
11-28-81	Tylox	120
2-08-82	Demerol	100mg./20cc.
2-15-82	Demerol	100mg./20cc.
2-20-82	Demerol	100mg./20cc.
3-13-82	Demerol	100mg./20cc.
4-14-82	Percodan	60
5-07-82	Percodan	60
5-22-82	Percodan	60
6-05-82	Percodan	60
6-14-82	Percodan	100
6-26-82	Percodan	100
7-10-82	Percodan	100
7-24-82	Percodan	100
7-30-82	Percodan	100
8-07-82	Percodan	100
9-01-82	Tylox	100
9-16-82	Percodan	100
9-23-82	Tylox	100
10-02-82	Tylox	100
10-11-82	Tylox	100
10-29-82	Tylox	100
11-04-82	Tylox	100
11-17-82	Tylox	100
11-24-82	Tylox	100
12-04-82	Tylox	100

1-13-83	Tylox	100
1-29-83	Tylox	100
2-11-83	Tylox	100
3-12-83	Tylox	100
5-07-83	Tylox	100
5-21-83	Tylox	100
12-10-83	Tylox	100
7-12-84	Tylox	100
8-04-84	Tylox	100
8-25-84	Percodan	50
9-27-84	Percodan	50
11-14-84	Tylox	50
12-08-84	Tylox	50
12-29-84	Tylox	50
7-20-85	Tylox	100
8-17-85	Tylox	60
9-21-85	Tylox	100
11-12-85	Tylox	100
12-28-85	Tylox	100
2-22-86	Tylox	100

8. Respondent knew that the Percodan, Tylox and/or Demerol he prescribed for Patient J was without medical indication.

K. Respondent treated Patient K from March, 1981 through February, 1989. Patient K had a history of insomnia and Seconal use. On numerous occasions between on or about March 24, 1981 and on or about February 25, 1989, Respondent prescribed a virtual daily dose of Seconal. During the period from on or about March 24, 1981 through on or about February 25, 1989:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to order appropriate laboratory or diagnostic tests, including routine blood work and urinalysis.

4. Respondent diagnosed and treated Patient K's arthritis on or about May 14, 1988 without any substantiating data from history or physical examination.

5. Respondent prescribed Seconal and/or Valium inappropriately, in that:

   (i) Seconal was not medically indicated as prescribed, virtually every day for many years.

   (ii) Valium was not medically indicated as prescribed.

   (iii) Respondent failed to attempt to reduce Patient K's Seconal intake or to alter the treatment.

   (iv) Respondent failed to consult with specialists in sleep disorders, chemical dependency, and/or psychiatry.

6. Respondent failed to keep adequate medical records accurately representing Patient K's condition.

7. Respondent failed to document in the medical record the drugs he prescribed for Patient K, as follows:

Date	Drug	Quantity
2-22-86	Seconal	60
3-15-86	Seconal	60
2-09-87	Seconal	60
5-04-87	Seconal	60
10-16-87	Seconal	60
4-11-88	Seconal	60
4-23-88	Seconal	60
9-14-88	Seconal	60
10-29-88	Seconal	60

8. Respondent knew that the Seconal and/or Valium he prescribed was without medical indication.

L. Respondent treated Patient L from May, 1956 through February, 1989. Patient L was seen on various occasions for a variety of complaints. On approximately 30 occasions between on or about October 24, 1979 and on or about February 15, 1989,

Respondent prescribed Percodan. During the period from on or about October 1, 1977 through on or about February 27, 1989:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to order appropriate laboratory or diagnostic tests, including routine blood work and urinalysis, and EKGs.

4. Respondent diagnosed arthritis on or about December 19, 1984 without any substantiating data from history or physical examination.

5. Respondent diagnosed "intercostal myositis" on or about January 24, 1986 and/or on or about August 18, 1986 without any substantiating data from history or physical examination.

6. Respondent prescribed Percodan inappropriately, in that:

   (i) Percodan was not medically indicated as prescribed.

   (ii) Respondent failed to attempt to reduce Patient L's daily dose of Percodan or to prescribe non-narcotic analgesics.

   (iii) Respondent failed to consult with specialists in pain management and/or chemical dependency.

7. Respondent failed to keep adequate medical records accurately representing Patient L's condition.

8. Respondent failed to document in the medical record the drugs he prescribed for Patient L, as follows:

Date	Drug	Quantity
1-07-84	Percodan	100
4-17-84	Percodan	100
6-28-84	Percodan	100
8-29-84	Percodan	100
11-26-85	Percodan	100
1-31-87	Percodan	100
3-12-88	Percodan	100

9. Respondent knew that the Percodan he prescribed for Patient L was without medical indication.

M. Respondent treated Patient M from September, 1965 through October, 1988. Patient M was seen on various occasions for a variety of complaints. On numerous occasions between on or about June 9, 1983 and on or about June 25, 1984, the Respondent prescribed Percodan for Patient M. During the period from on or about October 1, 1977 through on or about October 25, 1988:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to perform appropriate diagnostic and laboratory tests, including routine blood work and urinalysis.

4. Respondent failed to perform tests ordered by him on or about June 28, 1983, or failed to ascertain if the tests were performed, and/or failed to obtain the results.

5. Respondent prescribed Percodan inappropriately, in that:

   (i) Respondent prescribed Percodan without medical indication.

   (ii) Respondent failed to attempt to reduce Patient M's daily dose of Percodan or to prescribe non-narcotic analgesics.

6. Respondent failed to keep adequate medical records accurately representing Patient M's condition, and/or failed to record the results of tests ordered.

7. Respondent failed to document in the medical record Percodan he prescribed for Patient M, as follows:

Date	Drug	Quantity
3-13-84	Percodan	40
3-28-84	Percodan	30
4-13-84	Percodan	40
4-23-84	Percodan	60
5-09-84	Percodan	40
5-22-84	Percodan	40
6-04-84	Percodan	40

8. Respondent knew that the Percodan he prescribed for Patient M was without medical indication.

N. Respondent treated Patient N from November, 1956 through March, 1989. Patient N had a history of a previous MI on an EKG of on or about September 21, 1976. Patient N was seen on various occasions for a variety of complaints. On numerous occasions between on or about July 31, 1979 and on or about November, 1986, Respondent prescribed Demerol or Percodan. During the period from on or about October 1, 1977 through on or about February 4, 1989:

1. Respondent failed to take a complete medical history.

2. Respondent failed to perform a complete physical examination and/or failed to perform follow-up examinations relative to presenting complaints.

3. Respondent failed to order appropriate laboratory or diagnostic tests, including routine blood work and urinalysis, and/or a stool guiac and CBC on or about April 24, 1987.

4. Respondent failed to evaluate appropriately Patient N's complaints of chest pain on or about October 29, 1981, diaphoresis with exertion on or about March 12, 1982, angina on or about January 2, 1986, and chest pain on or about November 8, 1986 and January 31, 1987, given the evidence of a previous MI on an EKG of January 21, 1976.

5. Respondent failed to evaluate appropriately Patent N's complaint of dark stools on or about April 24, 1987.

6. Respondent prescribed Demerol and/or Percodan inappropriately, in that:

(i) Respondent prescribed Demerol and/or Percodan without medical indication.

(ii) Respondent failed to attempt to reduce Patient N's daily dose of Demerol and/or Percodan or to prescribe non-narcotic analgesics.

(iii) Respondent failed to consult with specialists in pain management and/or chemical dependency.

7. Respondent failed to keep adequate medical records accurately representing Patient N's condition or the results of tests ordered.

8. Respondent failed to document in the medical record the drugs he prescribed for Patient N, as follows:

Date	Drug	Quantity
1-07-84	Demerol	100
2-24-84	Demerol	100
9-15-84	Demerol	100
6-20-85	Percodan	100
9-26-85	Percodan	100
3-06-86	Percodan	100
5-08-86	Demerol	100

9. Respondent knew that the Demerol and/or Percodan he prescribed was without medical indication.

O. On or about March 17, 1982, the Commissioner of Health issued an Order, based upon the Respondent's admissions as set forth in an annexed Stipulation, finding that the Respondent had violated Article 33 of the Public Health Law Sections 3304 and 3343(2), and the Commissioner's Rules and Regulations on Controlled Substances, 10 N.Y.C.R.R. 80, Sections 80.105 and

80.112, in that during the period from January 30,1979 through December 2, 1981 he improperly dispensed and administered 5,500 Percodan tablets, 500 Dexadrine 15 mg. tablets, 10 twenty mg./cc. dosage units of Demerol, 100 Emperin -4 tablets and 100 Valium 10 mg. tablets without maintaining any record of such dispensing or administration and failed to maintain a biennial inventory of all controlled substances which the Respondent had in possession on May 1, 1979 and May 1,1981. Respondent pled mitigating circumstances. A $500 fine was imposed.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

HAVING BEEN FOUND IN VIOLATION OF ARTICLE 33

Respondent is charged with having been found by the Commissioner of Health to be in violation of article thirty-three of the public health law in violation of Educ. Law Section 6509(5)(c)(McKinney 1985), in that Petitioner charges:

1. The facts in paragraph O.

SECOND THROUGH SIXTEENTH SPECIFICATIONS

PRACTICING FRAUDULENTLY

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

2. The facts in paragraphs A.1, A.2, A.3, A.4, A.5, A.6(i), A.6(ii), A.6(iii), A.7, A.8, and/or A.9.

3. The facts in paragraphs B.1, B.2, B.3, B.4(i), B.4(ii), B.5, B.6, and/or B.7.

4. The facts in paragraphs C.1, C.2, C.3, C.4, C.7(i), C.7(ii), C.7(iii), C.8, C.9, and/or C.10.

5. The facts in paragraphs D.1, D.2, D.3, D.7(i), D.7(ii), D.7(iii), D.8, D.9 and/or D.10.

6. The facts in paragraphs E.1, E.2, E.4, E.9(i), E.9(ii), E.9(iii), E.10, E.11, and/or E.12.

7. The facts in paragraphs F.1, F.2, F.3, F.4(i), F.4(ii), F.4(iii), F.5(i), F.5(ii), F.5(iii), F.5(iv), F.6, F.7, and/or F.8.

8. The facts in paragraphs G.1, G.2, G.4, G.6(i), G.6(ii), G.6(iii), G.7, G.8, and/or G.9.

9. The facts in paragraphs H.1, H.2, H.3, H.4, H.5, H.6(i), H.6(ii), H.7(i), H.7(ii), H.8, H.9, and/or H.10.

10. The facts in paragraphs I.1, I.2, I.3, I.6, I.7(i), I.7(ii), I.7(iii), I.8, I.9, and/or I.10.

11. The facts in paragraphs J.1, J.2, J.3, J.4, J.5(i), J.5(ii), J.5(iii), J.5(iv), J.6, J.7, and/or J.8.

12. The facts in paragraphs K.1, K.2, K.3, K.5(i), K.5(ii), K.5(iii), K.6, K.7, and/or K.8.

13. The facts in paragraphs L.1, L.2, L.3, L.4, L.5, L.6(i), L.6(ii), L.6(iii), L.7, L.8, and/or L.9.

14. The facts in paragraphs M.1, M.2, M.3, M.4, M.5(i), M.5(ii), M.6, M.7, and/or M.8.

15. The facts in paragraphs N.1, N.2, N.3, N.6(i), N.6(ii), N.6(iii), N.7, N.8, and/or N.9.

16. The facts in paragraph O.

SEVENTEENTH THROUGH THIRTIETH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

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

17. The facts in paragraphs A.1, A.2, A.3, A.4, A.5, A.6(i), A.6(ii), A.6(iii), A.7, and/or A.8.

18. The facts in paragraphs B.1, B.2, B.3, B.4(i), B.4(ii), B.5, and/or B.6.

19. The facts in paragraphs C.1, C.2, C.3, C.4, C.5, C.6, C.7(i), C.7(ii), C.7(iii), C.8, and/or C.9.

20. The facts in paragraphs D.1, D.2, D.3, D.4, D.5, D.6, D.7(i), D.7(ii), D.7(iii), D.8, and/or D.9.

21. The facts in paragraphs E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9(i), E.9(ii), E.9(iii), E.10, and/or E.11.

22. The facts in paragraphs F.1, F.2, F.3, F.4(i), F.4(ii), F.4(iii), F.5(i), F.5(ii), F.5(iii), F.5(iv), F.6, and/or F.7.

23. The facts in paragraphs G.1, G.2, G.3, G.4, G.5, G.6(i), G.6(ii), G.6(iii), G.7, and/or G.8.

24. The facts in paragraphs H.1, H.2, H.3, H.4, H.5, H.6(i), H.6(ii), H.7(i), H.7(ii), H.8, and/or H.9.

25. The facts in paragraphs I.1, I.2, I.3, I.4, I.5, I.6, I.7(i), I.7(ii), I.7(iii), I.8, and/or I.9.

26. The facts in paragraphs J.1, J.2, J.3, J.4, J.5(i), J.5(ii), J.5(iii), J.5(iv), J.6, and/or J.7.

27. The facts in paragraphs K.1, K.2, K.3, K.4, K.5(i), K.5(ii), K.5(iii), K.6, and/or K.7.

28. The facts in paragraphs L.1, L.2, L.3, L.4, L.5, L.6(i), L.6(ii), L.6(iii), L.7, and/or L.8.

29. The facts in paragraphs M.1, M.2, M.3, M.4, M.5(i), M.5(ii), M.6, and/or M.7.

30. The facts in paragraphs N.1, N.2, N.3, N.4, N.5, N.6(i), N.6(ii), N.6(iii), N.7, and/or N.8.

THIRTY-FIRST THROUGH FOURTY-FOURTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

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

31. The facts in paragraphs A.1, A.2, A.3, A.4, A.5, A.6(i), A.6(ii), A.6(iii), A.7, and/or A.8.

32. The facts in paragraphs B.1, B.2, B.3, B.4(i), B.4(ii), B.5, and/or B.6.

33. The facts in paragraphs C.1, C.2, C.3, C.4, C.5, C.6, C.7(i), C.7(ii), C.7(iii), C.8, and/or C.9.

34. The facts in paragraphs D.1, D.2, D.3, D.4, D.5, D.6, D.7(i), D.7(ii), D.7(iii), D.8, and/or D.9.

35. The facts in paragraphs E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9(i), E.9(ii), E.9(iii), E.10, and/or E.11.

36. The facts in paragraphs F.1, F.2, F.3, F.4(i), F.4(ii), F.4(iii), F.5(i), F.5(ii), F.5(iii), F.5(iv), F.6, and/or F.7.

37. The facts in paragraphs G.1, G.2, G.3, G.4, G.5, G.6(i), G.6(ii), G.6(iii), G.7, and/or G.8.

38. The facts in paragraphs H.1, H.2, H.3, H.4, H.5, H.6(i), H.6(ii), H.7(i), H.7(ii), H.8, and/or H.9.

39. The facts in paragraphs I.1, I.2, I.3, I.4, I.5, I.6, I.7(i), I.7(ii), I.7(iii), I.8, and/or I.9.

40. The facts in paragraphs J.1, J.2, J.3, J.4, J.5(i), J.5(ii), J.5(iii), J.5(iv), J.6, and/or J.7.

41. The facts in paragraphs K.1, K.2, K.3, K.4, K.5(i), K.5(ii), K.5(iii), K.6, and/or K.7.

42. The facts in paragraphs L.1, L.2, L.3, L.4, L.5, L.6(i), L.6(ii), L.6(iii), L.7, and/or L.8.

43. The facts in paragraphs M.1, M.2, M.3, M.4, M.5(i), M.5(ii), M.6, and/or M.7.

44. The facts in paragraphs N.1, N.2, N.3, N.4, N.5, N.6(i), N.6(ii), N.6(iii), N.7, and/or N.8.

FORTY-FIFTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

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

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

45. The facts in paragraphs A.1, A.2, A.3, A.1, A.2, A.3, A.4, A.5, A.6(i), A.6(ii), A.6(iii), A.7, A.8, B.1, B.2, B.3, B.4(i), B.4(ii), B.5, B.6, C.1, C.2, C.3, C.4, C.5, C.6, C.7(i), C.7(ii), C.7(iii), C.8, C.9, D.1, D.2, D.3, D.4, D.5, D.6, D.7(i), D.7(ii), D.7(iii), D.8, D.9, E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9(i), E.9(ii), E.9(iii), E.10, E.11, F.1, F.2, F.3, F.4(i), F.4(ii), F.4(iii), F.5(i), F.5(ii), F.5(iii), F.5(iv), F.6, F.7, G.1, G.2, G.3, G.4, G.5, G.6(i), G.6(ii), G.6(iii), G.7, G.8, H.1, H.2, H.3, H.4, H.5, H.6(i), H.6(ii), H.7(i), H.7(ii), H.8, H.9, I.1, I.2, I.3, I.4, I.5, I.6, I.7(i), I.7(ii), I.7(iii), I.8, I.9, J.1, J.2, J.3, J.4, J.5(i), J.5(ii), J.5(iii), J.5(iv), J.6, J.7, K.1, K.2, K.3, K.4, K.5(i), K.5(ii), K.5(iii), K.6, K.7, L.1, L.2, L.3, L.4, L.5, L.6(i), L.6(ii), L.6(iii), L.7, L.8, M.1, M.2, M.3, M.4, M.5(i), M.5(ii), M.6, M.7, N.1,

N.2, N.3, N.4, N.5, N.6(i), N.6(ii), N.6(iii), N.7, and/or N.8.

FORTY-SIXTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

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

46. The facts in paragraphs A.1, A.2, A.3, A.4, A.5, A.6(i), A.6(ii), A.6(iii), A.7, A.8, B.1, B.2, B.3, B.4(i), B.4(ii), B.5, B.6, C.1, C.2, C.3, C.4, C.5, C.6, C.7(i), C.7(ii), C.7(iii), C.8, C.9, D.1, D.2, D.3, D.4, D.5, D.6, D.7(i), D.7(ii), D.7(iii), D.8, D.9, E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9(i), E.9(ii), E.9(iii), E.10, E.11, F.1, F.2, F.3, F.4(i), F.4(ii), F.4(iii), F.5(i), F.5(ii), F.5(iii), F.5(iv), F.6, F.7, G.1, G.2, G.3, G.4, G.5, G.6(i), G.6(ii), G.6(iii), G.7, G.8, H.1, H.2, H.3, H.4,

50. The facts in paragraphs D.8 and/or D.9.

51. The facts in paragraphs E.10 and/or E.11.

52. The facts in paragraphs F.6 and/or F.7.

53. The facts in paragraphs G.7 and/or G.8.

54. The facts in paragraphs H.8 and/or H.9.

55. The facts in paragraphs I.8 and/or I.9.

56. The facts in paragraphs J.6 and/or J.7.

57. The facts in paragraphs K.6 and/or K.7.

58. The facts in paragraphs L.7 and/or L.8.

59. The facts in paragraphs M.6 and/or M.7.

60. The facts in paragraphs N.7 and/or N.8.

DATED: ,1989
New York, New York

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct

H.5, H.6(i), H.6(ii), H.7(i), H.7(ii), H.8, H.9, I.1, I.2, I.3, I.4, I.5, I.6, I.7(i), I.7(ii), I.7(iii), I.8, I.9, J.1, J.2, J.3, J.4, J.5(i), J.5(ii), J.5(iii), J.5(iv), J.6, J.7, K.1, K.2, K.3, K.4, K.5(i), K.5(ii), K.5(iii), K.6, K.7, L.1, L.2, L.3, L.4, L.5, L.6(i), L.6(ii), L.6(iii), L.7, L.8, M.1, M.2, M.3, M.4, M.5(i), M.5(ii), M.6, M.7, N.1, N.2, N.3, N.4, N.5, N.6(i), N.6(ii), N.6(iii), N.7, and/or N.8.

FORTY-SEVENTH THROUGH SIXTIETH SPECIFICATIONS

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6509(9)(McKinney 1985), in that he failed to maintain a record for each of patients A-O which accurately reflects his evaluation and treatment of the patient within the meaning of 8 N.Y.C.R.R. 29.2(a)(3)(1987), in that Petitioner charges:

47. The facts in paragraphs A.7 and/or A.8.

48. The facts in paragraphs B.5 and/or B.6.

49. The facts in paragraphs C.8 and/or C.9.

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

IN THE MATTER	:	REPORT BY
OF	:	THE HEARING
JOHN P. MCCLOY, 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), Julia Cullen, M.D., Mr. William Brainin. The Committee was duly designated, constituted and appointment by the State Board for Professional Medical Conduct (the Board). The Administrative Officer was Harry Shechtman, Administrative Law Judge.

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

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.

Statement of the Case

The charges consist of sixty specifications. The first specification alleges that the Respondent had been found by the Commissioner of Health to be in violation of Article 33 of the Public Health Law and fined $500.00.

The second through sixteenth specifications allege that the Respondent practiced the profession fraudulently under Section 6509(2) of the Education Law, based upon his treatment of fourteen patients and the facts in support of the first specification.

The seventeenth through the thirtieth specifications allege that the Respondent practiced the profession with gross negligence under Section 6509(2) of the Education Law based upon his treatment of the fourteen patients above referred to.

The thirty-first through the forty-fourth specifications allege that the Respondent practiced the profession with gross incompetence under Section 6509(2) of the Education Law based upon his treatment of the fourteen patients above referred to.

The forty-fifth specification alleges that the Respondent practiced the profession with negligence on more than one occasion under Section 6509(2) of the Education Law based upon his treatment of the fourteen patients above referred to.

The forty-sixth specification alleges that the Respondent practiced the profession with incompetence on more

than one occasion under Section 6509(2) of the Education Law based upon his treatment of the fourteen patients above referred to.

The forty-seventh through sixtieth specifications allege that the Respondent failed to maintain a record for each of the fourteen patients above referred to which accurately reflects his evaluation and treatment of each of them under 8 NYCRR 29.2(a)(3).

SUMMARY OF PROCEEDINGS

Statement of Charges Dated:	August 3, 1989
Notice of Hearing and Statement of Charges Served Upon Respondent:	August 7, 1989
Notice of Hearing Returnable:	September 11, 1989
Place of Hearing:	8 East 40th Street New York, N.Y.
Answer:	None filed
Office of Professional Medical Conduct Appeared by:	Marcia E. Kaplan, Esq.
Respondent Appeared by:	Jacobson & Goldberg, Esqs. Amy T. Kulb, Esq. of Counse
Pre-Hearing Conference Held On:	September 7, 1989

Hearings Held On:	September 11, 1989 September 26, 1989 October 16, 1989 November 13, 1989 November 27, 1989 December 4, 1989 January 8, 1990 January 9, 1990 January 22, 1990 January 23, 1990
Proposed Finding of Fact filed by Petitioner on:	March 5, 1990
Proposed Finding of Fact served by Respondent on:	March 2, 1990
Deliberations Held On:	March 12, 1990 April 24, 1990
Report Submitted On:	April 30, 1990

OCTOBER 23, 1989 <

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. The Hearing Committee unanimously reached each of the following findings of fact unless otherwise noted.

JOHN P. McCLOY, M.D., the respondent, was authorized to practice medicine in New York State on August 6, 1953 by the issuance of license number 073889 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 from 345 E. Old Country Road, Hicksville, New York 11801.

PATIENT A.

1. Between on or about May 29, 1981 and on or about January 19, 1987, on approximately 80 occasions, Respondent prescribed Percodan, and on occasion Demerol or Percocet, for Patient A, who had a history of Paget's Disease of the right hip with joint changes and narrowing; anxiety with peptic ulcer; and a past history of lethargy and narcolepsy. At various times within that period, he also prescribed Calcitonin, Didronil and Dexedrine. (T. 658-664; Ex. 4c).

2. Respondent did not document a complete history. (Ex. 4c).

3. Respondent did not document a complete physical examination and follow-up examinations relative to presenting complaints. (Ex. 4c).

4. There came a time when respondent and said orthopedist learned of an experimental drug, Calcitonin, for the treatment of Paget's disease. Patient "A" was referred to a team of endocrinologists at Brooklyn Jewish Hospital who were authorized to administer Calcitonin for treatment of Paget's disease. Said endocrinologists treated Patient "A" with Calcitonin for several years, during which time said endocrinologists ordered appropriate laboratory tests to monitor

Patient "A"'s condition and specifically calcium levels. (T. 663-669; Ex. G).

5. There is no evidence with regard to narcolepsy during the period covered by the charges. (T. 682).

6. Respondent ascertained whether the patient was in severe pain. (T. 679, 1195-1201).

7. Respondent ascertained that Patient A experienced pain requiring Percodan, Demerol and/or Percocet (T. 679, 1195-1201).

8. Respondent attempted to alleviate the pain with anti-inflamatory agents and with Tylenol with Codeine, but was unsuccessful. (T. 679).

9. There was no probative evidence of any chemical dependency that required consultation.

10. Respondent did not keep adequate medical records which accurately represented Patient A's medical condition (Ex. 4c).

11. Respondent did not adequately document in the patient's medical record Perecodan, Demerol and Percocet he prescribed for Patient A from May 29, 1981 to May 7, 1984. (Ex. 4c).

PATIENT B.

1. Between on or about February 22, 1982 and on or about December 14, 1988, Respondent prescribed Percodan on approximately 9 occasions to Patient B [redacted]

who had a history of a severe auto accident in 1974 in which he sustained a fractured scapula, cerebral concussion and fractured cervical vertebra. (T. 735-738; Ex. 5).

1. Respondent did not document a complete history. (Ex. 5)

2. Respondent did not document a complete physical examination and follow-up examinations relative to presenting complaints. (Ex. 5).

3. Respondent had Patient "B"'s condition regularly monitored at appropriate intervals by orthopedists who ordered appropriate tests. On occasions when Patient "B"'s pain persisted and required Percodan, and specifically in March, 1982 and July, 1984, radiological studies were ordered, and Patient "B" was further evaluated by an orthopedist. (T. 738).

4. Respondent assessed the nature of the injuries sustained in the auto accident and referred the patient to orthopedists. (T. 735-755).

5. Respondent prescribed non-narcotic analgesics for Patient "B"'s pain (T. 737).

6. Respondent did not keep adequate medical records accurately representing Patient "B"'s medical condition. (Ex. 5).

7. Respondent did not document in the medical record Percodan he prescribed for Patient B, on nine occasions from February 22, 1982 to December 14, 1988. (Ex. 5).

PATIENT C.

1. Respondent treated Patient C from March, 1963 through October, 1985. On numerous occasions between 1976 and 1982 and on a continuous basis in 1982 and 1983, Respondent prescribed Demerol for Patient C, who had a history of Tietze's Syndrome and hypertension. Patient C presented with a variety of complaints on various occasions.

2. Respondent did not document a complete medical history. (Ex. 6).

3. Respondent did not document a complete physical examination and follow-up examinations relative to presenting complaints. (Ex. 6).

4. Respondent diagnosed many of Patient C's complaints. (T. 775-780; Ex. 6).

5. Respondent prescribed 860 Demoral tablets from March 23, 1982 to November 15, 1983. (Ex. 6).

6. Respondent did not keep adequate medical records accurately representing Patient C's condition. (T. 181-184; Ex. 6).

7. Respondent did not document in the medical record, Demerol he prescribed for Patient C, from March 23, 1982 to November 15, 1983.

PATIENT D

1. Respondent treated Patient D from July, 1983 through August, 1986. On approximately 40 occasions between on or about July 6, 1983 and on or about August 12, 1985, the

Respondent prescribed Demerol and Percodan for Patient D, who had a history of surgery for carcinoma of the testicle and lymph node resection. In addition to Demerol and Percodan, Patient D was treated with various antibiotics and Xanax. (T. 255-256; Ex. 7).

2. Respondent did not document a complete medical history. (Ex. 7).

3. Respondent did not document a complete physical examination and follow-up examination relative to presenting complaints. (Ex. 7).

4. Respondent performed appropriate diagnostic and laboratory tests, i.e., urinalysis. (Ex. 7).

5. That Respondent did not monitor Patient D's weight despite the diagnosis of cancer, does not indicate misconduct.

6. The Patient was under the care of oncologists at Sloan-Kettering (T. 819-821; Ex.7).

7. Respondent prescribed antibiotics on March 13, 1984 and September 29, 1984 in response to a respiratory infection. (T. 247 line 11; Ex. 7).

8. Respondent prescribed Demerol and Percodan as initiated by Sloan-Kettering and continued Demerol medication for pain associated with testicular cancer. (T. 800-823; Ex. 7).

9. Respondent did not keep adequate medical records accurately representing Patient D's condition and/or the results of tests ordered. (Ex. 7).

10. Respondent did not document in the medical record Demerol and Percodan he prescribed for Patient D, from July 6, 1983 to August 12, 1985. (Ex. 4).

PATIENT E.

1. Respondent treated Patient E from October, 1969 through June, 1988. On approximately 20 occasions between on or about March 24, 1982 and on or about June 24, 1988, the Respondent prescribed Percodan for Patient E, who had Crohn's Disease. The patient had an ileostomy following a total colectomy. He also had a history of cholelithiasis and nephrolithiasis and was diabetic. (Ex. 8).

2. Respondent did not document complete medical history. (Ex. 8).

3. Respondent did not document a complete physical examination and follow-up examination relative to presenting complaints. (Ex. 8).

4. There is no record that Respondent took Patient E's temperature on repeated occasions despite a history of recurrent abscesses. (Ex. 8).

5. Respondent did not perform appropriate diagnostic and laboratory tests, which were performed during Patient's hospitalization. (Ex. 8; 8c and 8e).

6. Respondent did not keep adequate medical records accurately representing Patient E's condition and the results of tests ordered. (Ex. 8).

7. Respondent did not document in the medical record Percodan, and Seconal he prescribed for Patient E, from March 24, 1982 to June 1, 1988.

PATIENT F.

1. Respondent treated Patient F from August, 1976 through March, 1985. On numerous occasions between on or about January 12, 1980 and on or about March 14, 1985, the Respondent prescribed Percodan and Valium for Patient F, who was stabbed in 1973 or 1974, which resulted in constant pain from the neck down. The patient also complained of "nerves." (Ex. 9).

2. Respondent did not document a complete medical history, including the history of the injury which was the source of the constant pain, any sequelae of the injury, ensuing disabilities, diagnostic tests and/or treatments performed at the time of the injury. (Ex. 9).

3. Respondent did not document a complete physical examination and follow-up examination relative to presenting complaints. (Ex. 9).

4. Respondent was aware that Patient's pain was due to a correctable condition and referred the Patient to rehabilitation therapy for treatment. (T. 909-913; Ex. 9).

5. Respondent attempted to reduce Patient's F's daily dose of Percodan and to prescribe non-narcotic analgesics. (T. 911).

6. Respondent referred the Patient for rehabilitation, e.g. physical therapy. (T. 909-910).

7. Respondent prescribed Valium for anxiety. (T. 931).

8. Respondent referred the patient for psychotherapeutic evaluation and/or treatment of his "nerve" condition. (T. 909-911; Ex. 9 d).

9. Respondent did not keep adequate medical records accurately representing Patient F's condition. (Ex. 9).

10. Respondent did not document in the medical record the Percodan he prescribed for Patient F, from January 30, 1981 to December 20, 1983. (Ex. 9).

PATIENT G.

1. Respondent treated Patient G in his office between March, 1970 and October, 1984. Patient G had a history of degenerative osteoarthritis and rheumatoid arthritis following "flu" in 1978. She also presented on various occasions with a variety of other complaints. On numerous occasions between from on or about May 9, 1981 through on or about May 16, 1983, Respondent prescribed Percocet for Patient G. In addition to Percocet, Patient G received Demerol, Prednisone, and Indocin. (Ex. 10).

2. During the period from on or about October 1, 1977 through on or about June 18, 1987 Respondent did not document a complete medical history, a complete physical examination and follow-up examination relative to presenting complaints, or identify the joints involved in patient G's arthritic condition, or to monitor Patient G for physical findings associated with arthritis, such as erythema, warmth, tenderness, or deformity. (Ex. 10).

3. Respondent ordered appropriate laboratory diagnostic tests, including X-rays, sedimentation rates, rheumatologic tests. (T. 936-937, Ex. 10 d).

4. Respondent consulted with a rheumatologist known to be involved in the care of the patient's arthritis. (T. 943-944; Ex. 10 c).

5. Respondent prescribed Percocet for the chronic arthritic condition for which it was prescribed. (T. 573-575).

6. Respondent did not keep adequate medical records accurately representing Patient G from August 15, 1981 to May 16, 1983.

PATIENT H.

1. Respondent treated Patient H from the 1960's through December, 1985. On numerous occasions between on or about July 29, 1981 and on or about December 31, 1985, the Respondent prescribed Percodan, Demerol and Seconal for Patient H, who had a history of "multiple injuries" after a fall in 1975,

abdominal pain in 1979 with documented gastritis, duodenitis and evidence of a healing duodenal ulcer. Patient H was hospitalized in May 1985 for abdominal pain and a history was obtained of pain and heavy alcohol consumption. During that hospitalization he was found to have gastritis, duodenitis and probable chronic pancreatitis. Patient H had severe left leg pain beginning in July, 1985. Patient H presented with a variety of other complaints on various occasions. (Ex. 11).

2. Respondent did not document a complete medical history, including a history or description of the "multiple injuries" and their sequelae, ensuing disabilities, diagnostic tests and/or treatments performed at the time of the injury. (Ex. 11).

3. Respondent did not document a complete physical examination and follow-up examinations relative to presenting complaints. (Ex. 11).

4. Respondent referred the patient to specialists who performed indicated tests. (T. 1953-1981, 1261-1294; Ex. 11-A).

5. Respondent assessed Patient's H's pain appropriately. (T. 958).

6. Respondent did not evaluate and/or treat the patient for alcoholism and/or refer the patient for alcoholism treatment. (T. 1043-1044).

7. There was no evidence that Percodan and Demerol may not have been indicated for a patient with pancreatitis.

8. In view of the Patient's many illnesses there was no evidence that Valium or Halcion was inappropriate.

9. Respondent did not keep adequate medical records accurately representing Patient H's condition. (Ex. 11).

10. Respondent did not document in the medical records accurately representing Patient H's condition. (Ex. 11).

PATIENT I.

1. Respondent treated Patient I from the 1960's through March, 1989. On approximately 8 occasions between on or about June 5, 1981 and on or about June 5, 1981 and on or about March 1, 1989, the Respondent prescribed Tuinal for Patient I, who had a history of "severe menopausal depression," and who did not respond to antidepressants. The patient had numerous other complaints and there is clinical and radiologic evidence that the patient had chronic obstructive pulmonary disease (COPD). (Ex. 12).

2. During the period from on or about October 1, 1977 through on or about March 1, 1987:

A. Respondent did not take a complete medical history, including symptoms of depression and/or a history regarding cigarette smoking. (Ex. 12).

B. Respondent did not perform a complete physical examination and perform follow-up examinations relative to presenting complaints. (Ex. 12).

C. Respondent did not perform laboratory tests including complete blood counts and/or pulmonary function tests. (Ex. 12).

D. Respondent did not administer influenza and pneumococcal vaccines, given Patient I's history of COPD. (Ex. 12).

E. Respondent prescribed Tuinal excessively and did not attempt to reduce the Patient's daily dose of Tuinal (T. 330-334; Ex. 12).

F. Respondent did not keep adequate medical records accurately representing Patient I's condition. (Ex. 12).

G. Respondent did not document in the medical record Tuinal he prescribed for Patient I. (Ex. 12).

PATIENT J.

1. Respondent treated Patient J from February, 1978 through November, 1987. Patient J had a history of a war injury in 1951 which shattered his left lower leg. He received orthopedic and rehabilitative treatments at various times. He was also treated for hypertension and back pain. On numerous occasions between on or about December 12, 1980 and on or about February 22, 1986, Respondent prescribed a virtual daily dose of Tylox, Percodan or Demerol. (Ex. 13).

2. During the period from on or about February 23, 1978 through on or about November 14, 1987. (Ex. 13).

A. Respondent did not take a complete medical history. (Ex. 13).

B. Respondent did not perform a complete physical examination and did not perform follow-up examinations relative to presenting complaints. (Ex. 13)

C. Respondent did not assess the condition of the Patient's leg, and obtain details of the Patient's leg pain. (Ex. 13).

D. Respondent did not order appropriate laboratory or diagnostic tests, including chest x-rays, EKGs, electrolytes, renal function tests, or liver function tests. (Ex. 13).

E. Respondent prescribed Percodan, Tylox and/or Demerol but did not ascertain that Patient J experienced pain requiring narcotics, and did not attempt to reduce Patient J's daily dose of narcotics and did not prescribe non-narcotic analgesics on more than one occasion. (Ex. 13).

F. Respondent did not keep adequate medical records accurately representing Patient J's condition. (Ex. 13).

G. Respondent did not document in the medical record the drugs he prescribed for Patient J. (Ex. 13).

PATIENT K.

1. Respondent treated Patient K from March, 1981 through February, 1989. Patient K had a history of insomnia and

Seconal use. On numerous occasions between on or about March 24, 1981 and on or about February 25, 1989, Respondent prescribed a virtual daily dose of Seconal (Ex. 14).

2. During the period from on or about March 24, 1981 through on or about February 25, 1989:

A. Respondent did not take a complete medical history. (Ex. 14).

B. Respondent did not perform a complete physical examination and did not perform follow-up examinations relative to presenting complaints. (Ex. 14).

C. Respondent did not order appropriate laboratory or diagnostic tests, including routine blood work and urinalysis. (Ex. 14).

D. Respondent diagnosed and treated Patient K's arthritis on or about May 14, 1988 without any substantiating data from history or physical examination. (Ex. 14).

E. Respondent prescribed Seconal virtually every day for many years without medical indication and did not attempt to reduce Patient K's Seconal intake or to alter the treatment. (T. 377-379; Ex. 14).

F. Respondent did not keep adequate medical records accurately representing Patient K's condition. (Ex. 14).

G. Respondent did not document in the medical record the drugs he prescribed for Patient K. (Ex. 14).

PATIENT L.

1. Respondent treated Patient L from May, 1956 through February, 1989. Patient L was seen on various occasions for a variety of complaints. On approximately 30 occasions between on or about October 24, 1979 and on or about February 15, 1989, Respondent prescribed Percodan. (Ex. 15).

2. During the period from on or about October 1, 1977 through on or about February 27, 1989:

A. Respondent did not take a complete medical history. (Ex. 15).

B. Respondent did not perform a complete physical examination and did not perform follow-up examinations relative to presenting complaints. (Ex. 15).

C. Respondent did not order appropriate laboratory or diagnostic tests, including routine blood work and urinalysis, and EKGs. (Ex. 15).

D. Respondent diagnosed arthritis on or about December 19, 1984 without any substantiating data from history or physical examination. (T. 400-401; Ex. 15).

E. Respondent diagnosed "intercostal myositis" on or about January 24, 1986 and or about August 18, 1986 without any substantiating data from history or physical examination. (T. 400-404; Ex. 15).

F. Respondent prescribed Percodan which was not medically indicated as prescribed and Respondent did not attempt

to reduce Patient L's daily dose of Percodan or to prescribe non-narcotic analgesics. (T. 404-405, 408; Ex. 15).

G. Respondent did not keep adequate medical records accurately representing Patient L. (Ex. 15).

H. Respondent did not document in the medical record the drugs he prescribed for Patient L. (Ex. 15).

PATIENT M.

1. Respondent treated Patient M from September, 1965 through October, 1988. Patient M was seen on various occasions for a variety of complaints. On numerous occasions between on or about June 9, 1983 and on or about June 25, 1984, the Respondent prescribed Percodan for Patient M. (Ex. 16).

2. During the period from on or about October 1, 1977 through on or about October 25, 1988:

A. Respondent did not take a complete medical history. (Ex. 16).

B. Respondent did not perform a complete physical examination and did not perform follow-up examinations relative to presenting complaints. (Ex. 16).

C. Respondent ordered appropriate diagnostic and laboratory tests, including routine blood work and urinalysis. (Ex. 16-E).

D. Respondent prescribed Percodan excessively, and there is no documentation of attempt to reduce Patient M's daily

dose of Percodan or to prescribe non-narcotic analgesics. (T. 520, 1148; Ex. 16).

E. Respondent did not keep adequate medical records accurately representing Patient M's condition, and did not record the results of tests ordered. (Ex. 16).

F. Respondent did not document in the medical record Percodan he prescribed for Patient M. (Ex. 16).

PATIENT N.

1. Respondent treated Patient N from November, 1956 through March, 1989. Patient N had a history of a previous MI on an EKG on or about September 21, 1976. Patient N was seen on various occasions for a variety of complaints. On numerous occasions between on or about July 31, 1979 and on or about November, 1986, Respondent prescribed Demerol or Percodan. (Ex. 17).

2. During the period from on or about October 1, 1977 through on or about February 4, 1989:

A. Respondent did not take a complete medical history. (Ex. 17).

B. Respondent did not perform a complete physical examination and did not perform follow-up examinations relative to presenting complaints. (Ex. 17).

C. Respondent did not order appropriate laboratory or diagnostic tests, including routine blood work and

urinalysis, and a stool guaiac and CBC on or about April 24, 1987. (Ex. 17).

D. Patient N was a known cardiac with hospital admissions for myocardial infections and therefore complete re-revaluation for each original episode was not necessary.

E. Respondent prescribed Demerol and Percodan excessively, and Respondent did not attempt to reduce Patient N's daily dose of Demerol or Percodan or to prescribe non-narcotic analgesics. (T. 630, 634-635; Ex. 17).

F. Respondent did not keep adequate medical records accurately representing Patient N's condition or the results of tests ordered. (Ex. 17).

G. Respondent did not document in the medical record the drugs he prescribed for Patient N. (Ex. 17).

ARTICLE 33 PROCEEDINGS

On or about March 17, 1982, the Commissioner of Health issued an Order, based upon the Respondent's admissions as set forth in an annexed Stipulation, finding that the Respondent had violated Article 33 of the Public Health Law Sections 3304 and 3343(2), and the Commissioner's Rules and Regulations on Controlled Substances, 10 N.Y.C.R.R. 80, Sections 80.105 and 80.122, in that during the period from January 30, 1979 through December 2, 1981 he improperly dispensed and administered 5,500 Percodan tablets, 500 Dexedrine 15 mg. tablets, 10 20 mg./cc. dosage units of Demerol, 100 Emperin -4 tablets and 100 Valium

10 mg. tablets without maintaining any record of such dispensing or administration and failed to maintain a biennial inventory of all controlled substances which the Respondent had in possession on May 1, 1979 and May 1, 1981. Respondent pled mitigating circumstances. A $500 fine was imposed. (Ex. 3).

CONCLUSIONS

All conclusions were arrived at by unanimous vote of the committee.

First Specification, violation of Article 33 of the Public Health Law. The order of the Commissioner is a matter of public record therefore the committee sustains this specification.

Second Through Sixteenth Specification. Practicing the profession fraudulently. The committee is of the opinion that the acts and omissions of the Respondent do not come within the purview of Section 6509(2)d of the Education Law. There was no evidence of an intentional misinterpretation or concealment expressed or inferred from any acts on the part of the Respondent. These specifications are therefore not sustained.

Seventeenth Through Thirteenth Specification

Practicing with gross negligence. The committee applied the definition of gross negligence as defined by the Court of Appeals in Matter of Jensen vs. Fletcher, 303 N.Y. 639, in which it stated:

> "It is recognized in this state that "gross negligence" is something more than "ordinary negligence"...Such negligence is defined as "disregard of the consequences which may ensue from the act, and indifference to the rights of other"...In order to find a "reckless disregard for life or property of others", there must, of necessity, be evidence of a consciousness on the part of the (licensee) of impending dangerous consequences if he persists in his conduct and his failure to desist from such conduct regardless of the consequences. "Recklessness" is defined as "(t)he state of mind accompanying an act, which either pays no regard to its probably or possibly injurious consequences, or which, though foreseeing such consequences, persists in spite of such knowledge."

The committee found no evidence that any act or omission by the Respondent came within the above definition and accordingly does not sustain these specifications.

THIRTY-FIVE THROUGH FORTY-FOURTH SPECIFICATION

Practicing with gross incompetence. The definition of gross incompetence as expressed by Peter J. Millock, Esq., General Counsel to the Health Department states that

> "When a practitioner shows a complete lack of ability necessary to perform an act in connection with the practice of the profession, that practitioner is grossly incompetent. Unlike ordinary incompetence, gross incompetence involves a total and flagrant lack of necessary knowledge or ability to practice."

There was no evidence produced by the Petitioner that the Respondent showed a complete lack of ability necessary to perform any act in connection with the manner in which he treated his patients. These specifications are therefore not sustained.

FORTY-FIFTH AND FORTY-SIXTH SPECIFICATIONS

Practicing with negligence and incompetence on more than one occasion. The committee has carefully weighed the testimony of the Department's expert witness as well as that of the Respondent and has scrutinized the documentary evidence produced by both sides.

The committee has carefully considered the care and treatment of each of the Patients who are the subject matters of these proceedings and concludes that the Respondent practiced with both negligence and incompetence as reflected in the findings of fact with regard to each of these patients. Under the circumstances the committee herewith sustains the Forty-fifth and Forty-sixth specifications.

FORTY-SEVENTH THROUGH SIXTIETH SPECIFICATIONS

Failing to maintain accurate records. Even a casual perusal of the medical charts kept by the Respondent indicates a woeful inadequacy in complying with minimum standards of record keeping. The committee therefore sustains these specifications.

RECOMMENDATION

Factual allegation o. states that:

> "On or about March 17, 1982, the Commissioner of Health issued an Order, based upon the Respondent's admissions as set forth in an annexed Stipulation, finding that the Respondent had violated Article 33 of the Public Health Law Sections 3304 and 3343(2), and the Commissioner's Rules and Regulations on Controlled Substances, 10 N.Y.C.R.R. 80, Sections 80.105 and 80.112, in that during the period form January 30, 1979 through December 2, 1981 he improperly dispensed and administered 5,500 Percodan tablets, 500 Dexedrine 15 mg. tablets, 10 twenty mg./cc. dosage units of Demerol, 100 Emperin -4 tablets and 100 Valium 10 mg. tablets without maintaining any record of such dispensing or administration and failed to maintain a biennial inventory of all controlled substances which the Respondent had in possession on May 1, 1979 and May 1, 1981. Respondent pleaded mitigating circumstances. A $500 fine was imposed."

It is to be noted that the charges herein relate to the prescribing of controlled substances in excessive amounts without proper documentation in patient's medical records, which is similar to the Article 33 violation above set forth.

While there is no indication of venality on the part of the Respondent, nevertheless the patterns of practice engaged in by the Respondent are not consonant with accepted standards of medical practice. Controlled substances were prescribed excessively and with minimal medical indication and without proper documentation in the medical records of the patients.

The committee therefore recommends that Dr. McCloy's license to practice medicine be suspended for a period of two years but that the suspension be stayed for the last year and

nine months; that he be on probation with review of medical records particularly as they pertain to prescribing and record keeping of controlled substances for two years, (the period of his suspension); and that he perform 100 hours of community service preferably in a substance abuse facility.

Dated: New York, New York
June 2, 1990

Conrad Rosenberg

CONRAD ROSENBERG, M.D., Chairman

Julia Cullen, M.D.
William Brainin

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

IN THE MATTER :

OF :

JOHN P. MC CLOY, M.D. :

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 September 11, 1989, September 26, 1989, October 16, 1989, November 13, 1989, November 27, 1989, December 4, 1989, January 8, 1990, January 9, 1990, January 22, 1990, and January 23, 1990. Respondent, John P. McCloy, M.D., appeared by Amy T. Kulb, Esq. The evidence in support of the charges against the Respondent was presented by Marcia E. Kaplan, 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
July 6, 1990

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

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

JOHN P. McCLOY

CALENDAR NO. 11226

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall act in all ways in a manner befitting respondent's professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by respondent's profession;

   b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of

Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

e. That respondent, during the period of probation has successfully performed 100 hours of public service in a substance abuse facility to be selected by respondent and previously approved, in writing, by said employee, and satisfactory written proof of the successful completion of said public service shall be submitted to said employee within 10 days of such completion;

2. That respondent shall, at respondent's expense, enroll in and diligently pursue a course of training in medical record-keeping, said course of training to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, said course to consist of six months and to be satisfactorily completed during the period of probation, such completion to be verified in writing and said verification to be submitted to the Director of the Office of Professional Medical Conduct within 10 days of such completion;

3. That, during the period of probation, respondent shall, at respondent's expense, be subject to random selections and review of respondent's patient records and office records by a physician selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, to review respondent's professional performance with regard to his medical record-keeping and his prescribing of controlled substances, and said physician shall submit a report once every three months regarding said review to the Director of the Office of Professional Medical Conduct;

4. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

The University of the State of New York

IN THE MATTER

OF

JOHN P. McCLOY
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11226

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11226, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (November 16, 1990): That, in the matter of JOHN P. McCLOY, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee report be deemed amended so that the heading "Seventeenth Through Thirteenth Specification" on page 23 of the report reads "Seventeenth Through Thirtieth Specifications", and the heading "THIRTY-FIVE THROUGH FORTY-FOURTH SPECIFICATION" on page 24 of the report reads "Thirty-First Through Forty-Fourth Specifications";
2. The hearing committee's findings of fact, and conclusions as to the question of respondent's guilt, as deemed amended as aforesaid, be accepted, and the Commissioner of Health's recommendation as to those findings of fact, and conclusions, as deemed amended as aforesaid, be accepted;
3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;

4. Respondent is guilty, by a preponderance of the evidence, of the first specification of the charges, and the forty-fifth through sixtieth specifications of the charges to the extent indicated in the hearing committee report, and not guilty of the remaining charges; and

5. Respondent's license to practice as a physician in the State of New York be suspended for two years and respondent be required to perform 100 hours of public service in a substance abuse facility upon each specification of the charges of which respondent was found guilty, said suspensions to run concurrently and said public service to be performed concurrently and to total 100 hours, and that execution of the last 21 months of said suspensions be stayed at which time respondent then be placed on probation for said last 21 months under the terms prescribed by the Regents Review Committee;

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 25th day of November 1990.

Thomas Sobol

Commissioner of Education