STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

January 18, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anthony M. Benigno, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237-0032

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John M. Neander, M.D.
425 Main Street
Oneonta, New York 13820

RE: In the Matter of John M. Neander, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-36) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER

OF

JOHN M. NEANDER, M.D.

DETERMINATION

AND

ORDER

BPMC #02-36

KENDRICK A. SEARS, M.D., Chairperson, **SHELDON GAYLIN, M.D.** and **JOHN TORRANT,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.,** served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **DONALD P. BERENS, Jr.,** General Counsel, **ANTHONY M. BENIGNO, ESQ.,** Associate Counsel, of Counsel. The Respondent appeared by **LEVENE, GOULDIN & THOMPSON, ESQS., CARLTON F. THOMPSON, ESQ.,** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged thirty-one (31) specifications of professional misconduct, including allegations of negligence, incompetence, gross negligence, gross incompetence, patient abuse, failure to maintain records and unwarranted tests and/or treatments. The charges are more specifically set forth in the Statement of Charges dated August 16, 2001, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	August 16, 2001
Pre-Hearing Conference	September 13, 2001
Hearing Dates:	September 21, 2001
	October 5, 2001
	November 8, 2001
	November 9, 2001

WITNESSES

For the Petitioner:	Great Aunt of Patient A Father of Patient C Ian Goldberg, M.D. Tod Christopher
For the Respondent:	John M. Neander, M.D. Charles W. Popper, M.D.

FINDINGS OF FACT

1. Respondent was licensed to practice medicine in New York State on September 9, 1977, by the issuance of license number 132071 by the New York State Education Department (Petitioner's Exhibit 14, hereinafter Ex. 14). On August 22, 2001 the Respondent was personally served with a copy of the notice of hearing, statement of charges, and summary of the Department of Health hearing rules (Ex. 2)

Patient A

2. Respondent treated Patient A, a male born on August 2, 1991, from March 8, 1996 through and including March 22, 1996, at Respondent's medical office in Oneonta, New York. Patient A presented with a history of behavioral problems and was cared for by Respondent from March 8, 1996 to March 22, 1996 . (Ex. 3)

3. At the initial office visit of March 8, 1996, Patient A's guardian informed Respondent that the patient weighed forty pounds. Respondent failed to record the patient's weight in the medical record (Ex. 3, pages 2-3) (Transcript at page 26, hereinafter T. at 26).

4. Patient A's guardian called Respondent on or about March 10, 1996 to inform him that Patient A had adverse reactions to the medication. She informed Respondent that he

turned into a zombie with the Ritalin, "...it was like he was a little robot." At that time, she was giving two 20 mg per day sustained release Ritalin tablets to Patient A as prescribed. She informed him that she would not give any more Imipramine to Patient A and that she was going to give only one tablet of Ritalin per day to Patient A (T. at 26-27, 734)(Ex. 16). Respondent did not document the phone call nor adequately document the reported side effects (T. at 469, Ex. 3, at 4,).

5. Respondent failed to document medication instructions purportedly given which differed from the prescriptions he issued (Ex. 16, T. at 443-444).

6. Respondent's records did not serve the function of allowing a subsequent care provider to understand the previous treatment provided. According to his own expert, the working notes were spotty and left several areas uncovered (T. at 684-687). Respondent failed to document the patient's weight, the verbal medication instructions and the reason why he prescribed Imipramine. (T. at 91-93, T. at 744).

7. Respondent failed to adequately record developmental history, medical history of the patient and his family, and the child's mental status (T. at 87, T. at 686).

8. Prior to prescribing Imipramine, Respondent failed to obtain an electrocardiogram (EKG) (Ex. 3 at 4 & 6).

9. Imipramine causes conduction slowing in the heart, EKG prolongation. In approximately 1 in 1000 to 1 in 2000 cases, Imipramine causes arrhythmias, an uncommon, but potentially serious complication (T. at 672). A significant arrhythmia can result in death (T. at 732).

10. Respondent prescribed Imipramine two 10 mg tablets at 3 PM and four 10 mg tablets at bedtime. Patient A's great aunt filled the prescription on or about March 8, 1996 and began administering the Imipramine as per Respondent's instructions and the instructions on the prescription bottle (T. at 23).

11. Respondent did not provide verbal instructions contrary to the prescription and the written instructions contained on the prescription bottle (T. at 23).

12. Respondent did not discuss with Patient A's great aunt any of the potential cardiotoxic side effects of Imipramine (T. at 24, 460).

13. Patient A has a maternal family history of cardiac disease, including heart murmurs and death from heart attacks (T. at 24).

14. Respondent did not discuss the need for electrocardiogram (EKG) or other baseline testing prior to administering Imipramine (T. at 25).

15. Respondent indicated in a February 1, 1998 letter to Tod Christopher that Patient A had started Imipramine at 20 mg at 3 PM and 40 mg at bedtime (Ex. 15, p 2).

16. Respondent failed to timely obtain baseline evaluations for Patient A including, a complete blood count, liver function analysis, kidney function analysis, and electrolyte profiles (Ex. 3). Respondent did not order any baseline tests.

17. The physician's desk reference (PDR) for 1996 recommends starting children on Ritalin with 5 mg twice daily (T. at 429). Additionally, the PDR states that Ritalin SR tablets may be used in place of Ritalin tablets when the eight-hour dosage of Ritalin SR corresponds to the titrated eight-hour dosage of Ritalin (T. at 431).

18. Respondent failed to obtain Imipramine blood levels for Patient A (Ex. 3).

19. On March 8, 1996 during the office visit, Respondent pulled a handful of Patient A's hair on the crown of his head. (T. at 28).

20. On the third and final office visit of March 22, 1996, Respondent forcibly put Patient A down on the floor and pinned his arms tight against his back and his feet against his buttocks. Respondent used a great deal of force, at one point Respondent began to

perspire. Respondent stated, "on the next visit I'm going to have to bring a headband to keep the sweat from rolling off into my eyes" (T. at 30-32) (T. at 468).

Patient B

21. Respondent treated Patient B, a male born on May 24, 1983, from April 16, 1998 through and including August 31, 1998, at Respondent's medical office in Oneonta, New York. Patient B presented with a history of temper outbursts and a preoccupation with death (Ex. 4).

22. Respondent failed to adequately evaluate and/or record Patient B's mental status (T. at 170 -173).

23. Respondent failed to document whether or not the patient was suicidal/homicidal and whether or not the patient was at risk to himself (T. at 172).

24. It is customary and usual practice for psychiatric clinicians to clearly delineate the results of a mental status evaluation. (T. at 779).

25. Prior to prescribing medication a reasonably prudent physician should have a clear mental status evaluation of the patient. Respondent prescribed Sertraline to Patient B on April 16, 1998 without having a clear mental status evaluation of the patient (T. at 780).

26. Respondent failed to obtain a baseline EKG prior to prescribing Imipramine for Patient B (Ex. 4) (T. at 177).

27. Respondent failed to obtain baseline evaluations for Patient B, including a complete blood count, liver function analysis, kidney function analysis, electrolyte profiles (Ex. 4). (T. at 178-179).

28. Respondent ordered a Sertraline blood level. (Ex. 4)

29. Respondent failed to timely order an Imipramine serum level for Patient B. Respondent began prescribing Imipramine on May 28, 1998 (Ex. 4, page 20). Blood was not drawn until September 25, 1998 to test the Imipramine levels (Ex. 4, page 23).

30. Patient B had a history of poor impulse control and a preoccupation with violence and death (Ex. 4)(T. at 166-170, 173).

31. Respondent failed to record whether this patient was safe to be on an outpatient basis

(T. at 173).

Patient C

32. On September 8, 1997, Respondent treated Patient C, a male born on March 22, 1981. Patient C presented with a history of stomach discomfort, tingle in face, head and neck, with a decreased appetite and difficulty in falling asleep (Ex. 5, p. 2).

33. Respondent failed to obtain a toxicology screen for Patient C (Ex. 5).

34. Patient C reported a prior history of marijuana, alcohol and LSD use (T. at 209).

35. Prior to prescribing Imipramine to Patient C, Respondent failed to obtain an EKG (Ex. 5).

36. Respondent did not explain to Patient C or his parents the possible cardiotoxicity of Imipramine (T. at 67, 218).

37. Respondent failed to adequately record Patient C's mental status. (T. at 221-223).

38. Respondent failed to schedule a timely follow-up appointment. Respondent failed to get the appropriate baseline studies (T at 225-226).

39. Respondent exhibited inappropriate behavior in front of Patient C and his parents by taking Imipramine in front of them. (T. at 71-73,227).

40. During the session, Respondent told Patient C that if you understood 10 percent of what I'm saying I would consider that good (T. at 71).

Patient D

41. Respondent treated Patient D, a male born in June 28, 1964, from on or about March 21, 1997 through and including December 3, 1997, at Respondent's medical office in Oneonta, New York. Patient D presented with a long history of alcohol abuse dating back almost 20 years. His alcohol use was as much as a case of beer per day plus hard liquor (Ex. 6, p. 2).

42. Respondent failed to adequately record Patient D's mental status.

43. On March 21, 1997 Respondent prescribed Imipramine. (T. at 261-262).

44. Respondent failed to obtain a toxicology screen for Patient D. (Ex. 6,T. at 263).

45. Respondent failed to timely obtain baseline evaluations for Patient D including, but not limited to, a complete blood count, liver function analysis, kidney function analysis, electrolyte profiles and an EKG (Ex. 6).

46. On July 24, 1997, Respondent prescribed 150 tablets of Imipramine, 25 mg (Ex. 6, page 26) (a 25 day supply).

47. Respondent sold/gave Patient D 400 25 mg tablets of Imipramine on or about July 30, 1997 (Ex. 6, page 15) (a 100 day supply).

48. Respondent failed to timely obtain an Imipramine serum level. Respondent increased the maximum daily dosage on June 30, 1997, from 40 mg to 150 mg (Ex. 6, page 26).

Patient E

49. Respondent treated Patient E, a female born on October 11, 1961, from on or about February 21, 1997 through and including December 3, 1997, at Respondent's medical office in Oneonta, New York. Patient E presented with a history of a psychiatric disorder, schizophrenia, paranoid type. She had a long history of schizophrenia with multiple hospitalizations and presented in a state of depression, suicidadlity and psychosis

(Ex. 7, page 2) (T. at 288).

50. Respondent failed to timely obtain baseline evaluations for Patient E including, but not limited to, a complete blood count, liver function analysis, thyroid profile, kidney function analysis, electrolyte profiles and an EKG (Ex. 7).

51. At the initial visit of February 21, 1997, Respondent inappropriately prescribed to Patient B 90 milligrams per day of Imipramine, prescribing for her 90 tablets, 10 milligrams each (Ex. 7, page 46).

52. On September 17, 1997, Respondent inappropriately prescribed Lithium in the daily dose of 1,350 mg without baseline evaluations (T. at 321).

53. Respondent failed to obtain a toxicology screen for Patient E. (T. at 316).

54. Respondent failed to order timely serum levels for various medications he prescribed to Patient E. (T. at 640, Ex. 7 page 48). (Ex. 7, pages 48 & 55).

55. Respondent failed to adequately treat Patient E after she called him complaining of symptoms of a possible medication overdose on or about July 8, 1997.

Patient F

56. Respondent treated Patient F, a female born on January 7, 1953, on an urgent basis at his medical office in Oneonta, New York. Patient F presented with a history of anxiety and discomfort (Ex. 8).

57. At the conclusion of the session, Patient F refused to leave the office. She grabbed a partially written prescription from Respondent's desk. Respondent restrained her in an attempt to retrieve the prescription. Respondent grabbed her wrist and then had his arms around her. During the confrontation Patient F was wrestled or lowered the floor (T. at 647-648)(Ex. 8, page 9).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(2)	
Paragraph A.1:		(3,4,5)
Paragraph A.2:		(7)
Paragraph A.3:		(3 w/respect to records only)
Paragraph A.4:		(8)
Paragraph A.5	(16)	
Paragraph A.6:		(10,15,17)

Paragraph A.7:	Not sustained
Paragraph A.8	Not sustained
Paragraph B:	(21)
Paragraph B.1:	(22 w/respect to records only)
Paragraph B.2:	Not sustained
Paragraph B.3:	(26)
Paragraph B.4:	(27)
Paragraph B.5:	Not sustained
Paragraph B.6:	(28)
Paragraph B.7:	(30,31 w/respect to records only)
Paragraph C:	(32)
Paragraph C.1:	Withdrawn
Paragraph C.2:	Not sustained
Paragraph C.3:	(35)
Paragraph C.4:	(37 w/respect to records only)
Paragraph C.5:	(38)
Paragraph C.6:	(38)
Paragraph C.7:	(39)
Paragraph D:	(41)
Paragraph D.1:	(42 w/respect to records only)
Paragraph D.2:	Not sustained
Paragraph D.3:	(45)
Paragraph D.4:	(47)
Paragraph D.5:	Not sustained
Paragraph E:	(49)
Paragraph E.1:	Not sustained
Paragraph E.2:	Not sustained
Paragraph E.3:	Not sustained
Paragraph E.4:	Not sustained
Paragraph E.5:	Not sustained
Paragraph E.6:	Not sustained
Paragraph E.7:	(52)
Paragraph E.8:	Not sustained
Paragraph E.9:	Not sustained
Paragraph E.10:	(55)
Paragraph F:	(56)
Paragraph F.1:	(57)
Paragraph F.2:	Not sustained
Paragraph F.3:	Not sustained
Paragraph F.4:	Not sustained

Paragraph F.5: Not sustained

The Hearing Committee further concluded that the following Specifications are sustained. The citations in parenthesis refer to the Factual Allegations which support each Specification:

NEGLIGENCE ON MORE THAN ONE OCCASION

Paragraphs: (A and A.2,4.5,6)

Paragraphs: (B and B. 3,4,6)

Paragraphs: (C and C.3, 5,6,)

Paragraphs: (D and D.3,4)

Paragraphs: (E and E.7,9)

INCOMPETENCE ON MORE THAN ONE OCCASION

NOT SUSTAINED

GROSS NEGLIGENCE

NOT SUSTAINED

GROSS INCOMPETENCE

NOT SUSTAINED

PATIENT ABUSE

NOT SUSTAINED

FAILURE TO MAINTAIN RECORDS

Paragraphs: (A and A.1,2,3)

Paragraphs: (B and B.1,7)

Paragraphs: (C and C.4)

Paragraphs: (D and D.1)

The Hearing Committee further concluded that the following specifications should not be sustained:

Second Specification

Third through Twenty-Fourth Specifications

Twenty-Ninth through Thirty-First Specifications

DISCUSSION

Respondent is charged with thirty-one (31) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that five (5) of the thirty-one (31) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of the witnesses presented by the parties. The Department called the great aunt of Patient A, the father of Patient C, Ian Goldberg, M.D. and Investigator Tod Christopher as witnesses. The Hearing Committee finds Patient A's great aunt gave testimony and answered questions in a straight forward and reasonable manner. The Hearing Committee finds her to be a credible witness with respect to the facts pertaining to lack of verbal instructions contrary to the prescription and the physical interaction between Patient A and Respondent. Patient C's father also testified about a single office visit. The Hearing Committee finds that the father was a straightforward, non-evasive, credible witness who was disappointed by Respondent's care. The Hearing Committee further finds Investigator Christopher to be an unbiased credible witness.

Finally, the Department called Dr. Ian Goldberg as an expert witness. Dr. Goldberg is a clinical assistant professor of psychiatry at New York University School of Medicine and he also maintains a private practice in New York City. (Ex. 12) He is board certified in Adult Psychiatry and Child Psychiatry. (T. 85) The Hearing Committee found Dr. Goldberg to be a very knowledgeable, credible witness. However, they found him to be somewhat grandiose and

pompous in many of his statements. For example, on direct examination, Dr. Goldberg interpreted the maximum safe dose of Imipramine for Patient A as one approaching lethality. (T.97) However, when questioned by the Hearing Committee, he back-peddled from his ominous opinion to conform to standards found in the medical literature.(T. 141) As a result, the Hearing Committee found that Dr. Goldberg's testimony was less objective and frequently over broad.

The Respondent called Charles W. Popper, M.D. as his expert witness. Dr. Popper is a clinical instructor in psychiatry at Harvard Medical School. He has a private practice in Child and Adult Psychiatry and in Child and Adolescent Psychopharmacology. He is certified by the American Board of Psychiatry and Neurology. His certifications also include General Psychiatry and Child Psychiatry.(Ex. H) The Hearing Committee found Dr. Popper to be a thoroughly credible and reasonable witness, who did not overstate his opinions. They note that Dr. Popper did not destroy his own credibility in his attempt to protect Respondent's positions. They also note that Dr. Popper raised a legitimate issue that pediatricians give larger doses of Imipramine without ordering EKGS. (T.761)

The Respondent also took the stand on his own behalf. The Hearing Committee found Respondent not wholly credible because his testimony was not totally objective and he sometimes engaged in a self-protective effort. The Hearing Committee notes, however, that frequently Respondent was also chaste and he did not deny everything and conceded many of the charges.

PATIENT A

Charge A.1 alleges that Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient A. Charge A.2 alleges that Respondent failed to

maintain and/or record the patient's history. The Hearing Committee concurs with Dr. Goldberg's opinion for both charges and they are sustained. (T. 86-92)

Charge A.3 alleges failure to obtain and/or document the patient's weight. The Committee finds that the great aunt told Respondent that Patient A weighed 40lbs., but that it was not documented in the record.(T. 25-26) Charge A.4 alleges that Respondent failed to obtain an EKG prior to prescribing Imipramine. Both Dr. Goldberg (T. 97) and Dr. Popper (T. 673, 702-3) agreed that a reasonably prudent physician would have obtained an EKG when the dosage of Imipramine is over 25 milligrams per kilogram to a child. The Hearing Committee sustains this charge as an act of negligence only.

Charge A.5 alleges that Respondent failed to obtain baseline evaluations, i.e. complete blood count, liver and kidney function analysis and electrolyte profiles for Patient A. Dr. Goldberg stated that these tests are required to rule out any abnormalities, particularly those that would effect the metabolization of Imipramine in the body. (T. 99-100) The Hearing Committee notes that Dr. Popper reluctantly agreed. It was his opinion that these tests could be delayed if the patient started out with very low doses, i.e. 10 to 25 milligrams. (T. 681) However, the Committee believes that there is no proof in the medical record that Patient A started out with lower doses of Imipramine. Therefore, they find that Respondent was negligent for not ordering these preliminary tests.

Charge A.6 alleges that Respondent prescribed Imipramine and Ritalin inappropriately for Patient A's weight. Dr. Goldberg stated that prescribing 40 mg. per day of Ritalin fell below the generally accepted standards of medical practice. (T. 107) Even Dr. Popper acknowledged that 40 mg. is too high for an initial dosage.(T. 736) With respect to the Imipramine, Dr. Goldberg stated that prescribing 60mg per day constituted a gross deviation from the standard of care. (T. 101-102) The Hearing Committee finds this standard too rigid. Dr. Popper stated that 60mg is reasonable if you start out taking a lower dosage. As discussed above, since the lower dosage was not documented, the Hearing Committee does not find that Respondent gave the

instructions for the lower dosage. As a result, they find that Respondent was negligent for prescribing 60 mg initially.

Charge A.7 alleges that Respondent failed to obtain Imipramine blood levels for Patient A. Dr. Popper stated that while taking blood levels may be helpful, he does not view them as essential.(T. 727) The Hearing Committee accepts this as reasonable and rejects the Department's position as too rigid. (T. 107-109) Therefore, this charge is not sustained.

Charge A.8 alleges that Respondent inappropriately restrained Patient A and pulled his hair. Dr. Goldberg testified that he believed that the force used was excessive and inappropriate.(T. 111-112) Dr. Popper stated that if a child is "demonstrating provocative, difficult behavior, someone should have helped the child regain control. One, to protect the situation in general. Two, to protect the child from doing something that might have been problematic." (T. 993) Dr. Popper also stated that it is acceptable for the physician to do an educational demonstration to parents or guardians to teach them how to gain "some degree of physical control without hurting the child." (T. 694) The Hearing Committee notes that the record does not indicate that either Patient A's great aunt or mother intervened to restrain him, therefore Respondent had to take control. The Hearing Committee believes that it is appropriate for the physician to reasonably restrain an active child. They further find that there is insufficient proof in the record to establish that Respondent attacked Patient A in an inappropriate manner or that he violated the standard practice of care in this instance. This charge is not sustained by the Hearing Committee. The Hearing Committee further concludes that none of Respondent's actions rise to the level of incompetence, gross negligence, gross incompetence or patient abuse with respect to Patient A.

PATIENT B

Charge B.1 alleges that Respondent failed to adequately evaluate and/or record Patient B's mental status. The Hearing Committee finds that Patient B's mental status was not adequately recorded, but an evaluation appears in the overall record. The Hearing Committee sustains the charge only for inadequate records. Charge B. 2 alleges that Respondent failed to record the medical necessity for the use of polypharmacy. At the hearing, Respondent read from his record that Imipramine was prescribed subsequent to Sertraline to help the patient sleep and "to decrease bad dreams and dreams of death." (Ex. 4,p.9 , T. 496) The Hearing Committee finds this to be a reasonable explanation that was documented in the patient's record. Thus, the charge is not sustained.

Charge B.3 (failure to order EKG) and Charge B.4 (failure to obtain baseline evaluations) were previously discussed for Patient A. The Hearing Committee sustains both charges as acts of negligence based upon the opinions of both medical experts.

Charge B.5 alleges that Respondent ordered a Sertraline blood level without medical justification. Respondent explained that he ordered the serum levels to determine if Patient B was a slow or fast metabolizer of the drugs. When the results showed that Patient B, as an adolescent, was metabolizing the Sertraline more rapidly, Respondent was able to increase the dosage to a more effective level. (T. 497-499) Dr. Popper testified that this was a valid use. (T. 773) The Hearing Committee concurs and the charge is not sustained.

Charge B.6 alleges that Respondent failed to timely order Imipramine serum levels for Patient B. Dr. Goldberg testified that there was a 3 month lag between when the patient started the drug (Ex. 4, p. 20) and when the test was ordered (Ex. 4,p. 23). Dr. Goldberg stated that this test should be ordered within the first couple of weeks to see if the medication is working effectively.(T. 184) The Hearing Committee concurs that the test was not ordered timely.

Charge B.7 alleges that Respondent failed to determine and/or record whether or not the patient was safe to be on an out-patient basis in light of a history of poor impulse control and

pre-occupation with violence and death. The Hearing Committee finds that Respondent did make an adequate determination as to Patient B's out patient status. This is found in Respondent's explanation at the hearing and a review of the overall record. (T.501-504) The Hearing Committee, however, finds that the documentation is inadequate and sustains the inadequate record charge.

PATIENT C

Charge C.1 was withdrawn by the Department. Charge C.2 alleges that Respondent failed to obtain a toxicology screen for Patient C. Respondent explained that at the first and only session, he obtained a history of alcohol and drug use. He stated that he chose not to push too fast into this area with this particular family because there was a lot of silence at the beginning of the session. He indicated that Patient C waited for his father to tell the story. Respondent did not separate the patient from his family because he thought in this case, it" would have made things worse." (T. 543-545) Also Respondent saw no signs of agitation or impulse control difficulties. If he had seen the patient beyond the initial session, he could have recommended a toxicology screen if he noted particular difficulties with Patient C. The Hearing Committee accepts Respondent's judgment as reasonable in this instance and the charge is not sustained.

Charge 3.C is sustained as negligence regarding the EKG as previously discussed. Charge 4.C alleges that Respondent failed to adequately evaluate and record Patient C's mental status. The Hearing Committee finds that Respondent did note elements of mental status, i.e. no suicidal ideation, weight loss, decreased appetite, drug/alcohol use. Dr. Goldberg stated that one had to "read between the lines" to get a clear designation. (T. 221) The Hearing Committee finds that the evaluation met minimum standards. However, they find that listing the diagnostic code does not suffice as documentation of mental status, thus the record is inadequate.(T. 224)

Charge C.5 alleges that Respondent failed to schedule a timely follow-up appointment with Patient C. Dr. Goldberg stated that since Respondent had prescribed Imipramine for

Patient C he had an obligation to follow-up in some form, even if the family has gone to another physician. (T. 226) The Hearing Committee concurs and finds this to be an act of negligence.

Charge C. 6 alleges that Respondent failed to follow-up to determine whether or not Patient C was taking his medication and, if so, advise Patient C to acquire appropriate baseline studies. The Hearing Committee again concurs with Dr. Goldberg that once the drug was prescribed, the Respondent had a professional obligation "to see that the patient is safe."(T. 226) This omission is sustained as an act of negligence.

Charge C.7 alleges that Respondent acted inappropriately by taking Imipramine in front of Patient C and his parents. The Hearing Committee concurs with Dr. Goldberg that Respondent's act does not fall "within any parameters of prudent practice." (T. 227) The Hearing Committee finds this to constitute a single act of incompetence.

PATIENT D

Charge D. 1 alleges that Respondent failed to adequately evaluate and/or record Patient D's mental status. Dr. Goldberg states mental status is not adequately evaluated at the initial visit, but it does appear in the overall record.(T. 260) The Hearing Committee concurs and sustains this charge as inadequate records only.

Charge D.2 alleges that Respondent failed to obtain a toxicology screen for Patient D. Respondent explained that the patient had no insurance coverage for this test and he could not afford to have it done. Patient D also indicated that he was in a local chemical dependency program where he was screened randomly. (T. 565) The Hearing Committee does not sustain this charge because Respondent's explanation was acceptable. They, however, note that it would have been better practice if Respondent had obtained a copy of the toxicology screen from the local program.

Charge D. 3 alleges that Respondent failed to obtain various baseline evaluations and an EKG. The Hearing Committee concurs with Dr. Goldberg's opinion (T. 265-266). They sustain

this as negligence only for reasons previously discussed. Charge D.4 alleges that Respondent inappropriately sold/gave Patient D 400 25 milligram (10,000 milligrams) tablets of Imipramine on or about July 30, 1997 (an approximate 100 day supply) . The Hearing Committee notes that Imipramine is not a drug of choice for abusers and that there is nothing in the record to show that this prescription provided Respondent with pecuniary benefits. They note however, that Respondent did not provide a satisfactory answer when asked why he did not limit supply to one month. (T. 596) Therefore, the Hearing Committee finds this as an act of negligence.

Charge D.5 alleges that Respondent failed to timely obtain an Imipramine serum level. Dr. Popper testified that it is not necessary to obtain a serum level for Imipramine for an adult as the readings are not helpful. He stated that it can be used to make judgments about dosing, but there is no obligation to order one. (T. 784) The Hearing Committee concurs with his opinion in this instance, and the charge is not sustained.

PATIENT E

Charge E.1 alleges that Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient E. Charge E.2 alleges that Respondent failed to obtain and/or document an adequate history for Patient E. Charge E.3 alleges that Respondent failed to adequately evaluate and/or record Patient E's mental status. The Hearing Committee finds that Patient E made a lot of visits to Respondent's office and that he maintained an extensive chart. Thus, none of the aforementioned three charges are sustained.

Charge E.4 alleges that Respondent failed to obtain timely, various baseline evaluations and an EKG for Patient E. The Hearing Committee does not sustain this charge because Respondent testified that Patient E was highly resistant to having these tests done, although some were performed at a later date. (T. 623, 636) Dr. Popper also stated that some of these tests do not produce helpful readings for adults, particularly if the dose is not significant. (T. 673-674,728-731)

Charge E.5 alleges that on February 21, 1997, Respondent inappropriately prescribed 90 milligrams per day of Imipramine, giving or prescribing for her 90 tablets, 10 milligrams each. The Hearing Committee found Dr. Goldberg's testimony to be inconclusive on this issue. (T. 299-300) Therefore, the charge is not sustained. Charge E.6 alleges that Respondent failed to adequately monitor Patient E's vulnerabilities, including but not limited to impulse control, addictive behavior, drug and alcohol abuse and suicidal/homicidal ideation. The Hearing Committee notes that on cross examination of this issue, Dr. Goldberg acknowledged that in the 45 pages of handwritten records from February through early December 1997 (Ex.7), there is a "reflection of what was going on with this patient." (T. 323). The Hearing Committee finds the monitoring to be adequate and the charge is not sustained.

Charge E. 7 alleges that on September 17, 1997, Respondent inappropriately prescribed Lithium in the maximum daily dose of 1350 milligrams without baseline evaluations. Dr. Goldberg testified that this is an extremely high dosage to begin with. (T. 321) Since Lithium passes through the kidney, not the liver, you must do a baseline test" to know that the kidney is functioning." He also stated that the white cell count must also be checked. (T. 315) The Hearing Committee concurs with this opinion and the charge is sustained as negligence.

Charge E.8 alleges that Respondent failed to obtain a toxicology screen for Patient E. The Hearing Committee finds that Dr. Goldberg waffled in this opinion and referred to it as a "gray line." (T. 316-317) Therefore, the Hearing Committee does not sustain this charge. Charge E.9 alleges that Respondent failed to order serum levels for various medications he prescribed. Dr. Goldberg testified that a Lithium test was ordered eventually, although he believed it should have been done sooner not later. (T.318-320,322) He further acknowledged that the patient's record indicates that Respondent recommended that levels of Imipramine, Fluphenazine and Risperdal be checked. (Ex. 7, p.12, T. 326) Since Respondent did order or recommend these tests at some point, the Hearing Committee does not sustain this charge. They note that timeliness is not an element here.

Charge E.10 alleges that Respondent failed to adequately treat Patient E after she called him complaining of symptoms of a possible medication overdose on July 8, 1997. Dr. Goldberg testified that upon receiving this call, Respondent should have performed a fuller assessment of the patient by either seeing her in person or sending her to the hospital. (T. 309-310) Respondent testified that Patient E told him that she had taken 2 extra doses of 30 milligram Paxil and was suffering from slurred speech and discoordination. (Ex. 7,p. 21, T. 308) He further stated that he believed that she had no trouble speaking and that she "calmed within 4-5 minutes."(Ex. 7,p.21,T. 616) He called in a prescription for Risperdal and planned to follow up with an office visit on July 11, 1997. (Ex. 7, p.21, T. 311-312) He said that he learned at a later date that the patient had taken more drugs in addition to the Paxil. (T. 620) The Hearing Committee concurs that Respondent should have made a fuller assessment of the patient's condition, even though she may calmed down on the phone. They find that Respondent acted in a neglect manner in this instance.

PATIENT F

Charge F. 1 alleges that at the conclusion of the session, Patient F refused to leave the office. Patient F grabbed a partially written prescription from Respondent's desk. Respondent restrained her in an attempt to retrieve the prescription. During the confrontation, Patient F was wrestled or lowered to the floor of Respondent's office. The Hearing Committee concurs with the above factual scenario. However they agree with Dr. Popper's opinion that this was only a partial evaluation before tension developed between doctor and patient around the patient's expectation. (T. 796) Dr. Popper further stated that this situation was a matter of judgment and different physicians might have handled it in different ways. (T. 795) The Hearing Committee finds that this was not a standard office visit and it presented Respondent with extremely unusual events. They further fail to understand the Department's attempt to apply appropriate standards of practice to a highly unusual event. Therefore, the Hearing Committee sustains no charges with respect to Patient F.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be suspended for a period of two (2) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent will be placed on probation with a practice monitor. The complete terms of probation are attached to this Determination and Order as Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee voted for a two year stayed suspension with probation and a practice monitor because they do not believe that revocation is commensurate with the level of professional misconduct in this instance. The Hearing Committee believes that while there are clearly instances of negligence, none rise to the level of gross negligence. They note that there is also no evidence of incompetence on more than one occasion.

The Hearing Committee believes that Respondent conceded the need to order certain tests when prescribing drugs such as Imipramine. He indicated that he has changed his practice to conform to these safeguards. The Hearing Committee further believes that Respondent is a caring physician whose isolated practice allowed him to fall into a pattern of sloppiness. They believe that a two year stayed probation with a practice monitor effectively safeguards the public health in this instance. Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First, and the Twenty-Fifth through, Twenty-Eighth Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The Second, Third through Twenty-Fourth and the Twenty-Ninth through Thirty-First Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;**

3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **TWO (2) YEARS,** said suspension to be **STAYED;** and

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and

5. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Syracuse, New York
2/14/ **2002**

KENDRICK A. SEARS, M.D.
(Chairperson)

SHELDON GAYLIN, M.D.
JOHN TORRANT

TO: Anthony M. Benigno, Esq.
Associate Counsel
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John M. Neander, M.D.
425 Main Street
Oneonta, NY 13820

APPENDIX I

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

IN THE MATTER

OF

JOHN M. NEANDER, M.D.

NOTICE

OF

HEARING

TO: JOHN M. NEANDER, M.D.
425 Main Street
Oneonta, New York

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §23(and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on September 21, at 10:00 a.m., at the Offices of the New York State Department of Health, 5th Floor, Hedley Park Place, 433 River Street, Troy, NY, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth i the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF

ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 2001) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A

DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
August 16 ,2001

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Anthony M. Benigno
Assistant Counsel
Bureau of Professional
Medical Conduct
Corning Tower, Room 2509
Empire State Plaza
Albany, NY 12237
(518) 473-4282

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

IN THE MATTER

OF

JOHN M. NEANDER, M.D.

STATEMENT

OF

CHARGES

John M. Neander, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 9, 1977, by the issuance of license number 132071 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a male born on August 2, 1991, (Patient names are listed in Appendix A) from March 8, 1996 through and including March 22, 1996, at Respondent's medical office in Oneonta, New York. Patient A presented with a history of behavioral problems. Respondent's medical care of Patient A failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient A.
2. Respondent failed to obtain and/or record an adequate history for Patient A.
3. Respondent failed to obtain and/or document Patient A's weight.
4. Prior to prescribing Imipramine Respondent failed to obtain an electrocardiogram (EKG).
5. Respondent failed to timely obtain baseline evaluations for Patient A including, but not limited to, a complete blood count, liver function

analysis, kidney function analysis, and electrolyte profiles.

6. Respondent prescribed Imipramine and Ritalin inappropriately for Patient A's weight.
7. Respondent failed to obtain Imipramine blood levels for Patient A.
8. Respondent inappropriately restrained Patient A and pulled his hair.

B. Respondent treated Patient B, a male born on May 24, 1983, from April 16, 1998 through and including August 31, 1998, at Respondent's medical office in Oneonta, New York. Patient B presented with a history of temper outbursts. Respondent's medical care of Patient B failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate and/or record Patient B's mental status.
2. Respondent failed to record the medical necessity for the use of polypharmacy.
3. Respondent failed to obtain a baseline electrocardiogram prior to prescribing Imipramine for Patient B.
4. Respondent failed to timely obtain baseline evaluations for Patient B including, but not limited to, a complete blood count, liver function analysis, kidney function analysis, and electrolyte profiles.
5. Respondent ordered a Sertraline blood level without medical justification.
6. Respondent failed to timely order Imipramine serum levels for Patient B.
7. Respondent acquired a history of poor impulse control and pre-occupation with violence and death, yet failed to determine and/or record whether or not the patient was safe to be on an out-patient basis.

C. Respondent treated Patient C, a male born on March 21, 1981, on September 8, 1997, at Respondent's medical office in Oneonta, New York. Patient C presented with a history of stomach discomfort, tingle in face, head and neck, decreased appetite and some difficulty in falling asleep. Respondent's medical care of Patient C failed to meet accepted standards of medical care in the following respects:

withdrawn

~~1. Respondent failed to obtain and/or document an adequate developmental history for Patient C.~~

2. Respondent failed to obtain a toxicology screen for Patient C.
3. Prior to prescribing Imipramine to Patient C, Respondent failed to obtain an electrocardiogram (EKG).
4. Respondent failed to adequately evaluate and/or record Patient C's mental status.
5. Respondent failed to schedule a timely follow-up appointment with Patient C.
6. Respondent failed to follow-up to determine whether or not Patient C was taking his medication and, if so, advise Patient C to acquire appropriate baseline studies.
7. Respondent exhibited inappropriate behavior in front of Patient C and his parents, including, but not limited to, taking 3 tablets of Imipramine stating that he never prescribed anything he had not tried himself, or words to that effect, and stating to Patient C, "if he understood 10% of what he was saying he would consider that good" or words to that effect.

D. Respondent treated Patient D, a male born on June 28, 1964, from on or about March 21, 1997 through and including December 3, 1997, at Respondent's medical office in Oneonta, New York. Patient D presented, among other things, with a history of alcohol dependence. Respondent's medical care of Patient D

failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate and/or record Patient D's mental status.
2. Respondent failed to obtain a toxicology screen for Patient D.
3. Respondent failed to timely obtain baseline evaluations for Patient D including, but not limited to, a complete blood count, liver function analysis, kidney function analysis, electrolyte profiles and an electrocardiogram (EKG).
4. Respondent inappropriately sold/gave Patient D 400 25 milligram (10,000 milligrams) tablets of Imipramine on or about of July 30, 1997. Given the maximum daily dosage prescribed of 100 milligrams this constituted a 100 day supply.
5. Respondent failed to timely obtain an Imipramine serum level.

E. Respondent treated Patient E, a female born on October 11, 1961, from on or about February 21, 1997 through and including December 3, 1997, at Respondent's medical office in Oneonta, New York. Patient E presented with a history of a psychiatric disorder, schizophrenia, paranoid type. Respondent's medical care of Patient E failed to meet accepted standards of medical care in the following respect:

1. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient E.
2. Respondent failed to obtain and/or document an adequate history for Patient E.
3. Respondent failed to adequately evaluate and/or record Patient E's mental status.
4. Respondent failed to timely obtain baseline evaluations for Patient E including, but not limited to, a complete blood count, liver function analysis, thyroid profile, kidney function analysis, electrolyte profiles and an electrocardiogram

(EKG).

5. At the initial visit of February 21, 1997, Respondent inappropriately prescribed to Patient E 90 milligrams per day of Imipramine, giving or prescribing for her 90 tablets,10 milligrams each.
6. Respondent failed to adequately monitor Patient E's vulnerabilities, including but not limited to, impulse control, addictive behavior, drug and alcohol abuse and suicidal/homicidal ideation.
7. On September 17, 1997, Respondent inappropriately prescribed lithium in the maximum daily dose of 1350 milligrams without baseline evaluations.
8. Respondent failed to obtain a toxicology screen for Patient E.
9. Respondent failed to order serum levels for various medications he prescribed to Patient E.
10. Respondent failed to adequately treat Patient E after she called him complaining of symptoms of a possible medication overdose on or about July 8, 1997.

F. Respondent treated Patient F, a female born on January 7, 1953, on April 23, 1998, on an urgent basis at Respondent's medical office in Oneonta, New York. Patient F presented with a history of anxiety and discomfort. Respondent's medical care of Patient F failed to meet accepted standards of medical care in the following respects:

1. At the conclusion of the session Patient F refused to leave the office. Patient F grabbed a partially written prescription from Respondent's desk. Respondent restrained her in an attempt to retrieve the prescription. During the confrontation Patient F was wrestled or lowered to the floor of Respondent's office.
2. Respondent failed to obtain and/or document whether or not the patient was suffering withdrawal from medications or substances.

3. Respondent failed to obtain and/or record an adequate history.
4. Respondent failed to adequately document Patient F's mental status.
5. Respondent failed to do a differential diagnosis of Patient F's medical condition.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts in paragraphs A and A2, A and A3, A and A4, A and A5, A and A6, A and A7, A and A8, B and B1, B and B2, B and B3, B and B4, B and B6, B and B7, C and C1, C and C2, C and C3, C and C4, C and C5, C and C6, C and C7, D and D1, D and D2, D and D3, D and D4, D and D5, E and E2, E and E3, E and E4, E and E5, E and E6, E and E7, E and E8, E and E9, E and E10, F and F2, F and F3, F and F4, and F and F5.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. The facts in paragraphs A and A2, A and A3, A and A4, A and A5, A and A6, A and A7, A and A8, B and B1, B and B2, B and B3, B and B4, B and B6, B and B7, C and C1, C and C2, C and C3, C and C4, C and C5, C and C6, C and C7, D and D1, D and D2, D and D3, D and D4, D and D5, E and E2, E and E3, E and E4, E and E5, E and E6, E and E7, E and E8, E and E9, E and E10, F and F2, F and F3, F and F4, and

F and F5.

THIRD THROUGH TWELFTH SPECIFICATIONS

GROSS NEGLIGENCE

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

3. The facts in paragraphs A and A3, A and A4 and/or A and A6.
4. The facts in paragraphs B and B3.
5. The facts in paragraphs C and C3.
6. The facts in paragraphs D and D3.
7. The facts in paragraphs D and D4.
8. The facts in paragraphs E and E4.
9. The facts in paragraphs E and E5.
10. The facts in paragraphs E and E6.
11. The facts in paragraphs E and E7.
12. The facts in paragraphs E and E10.

THIRTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS

GROSS INCOMPETENCE

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

13. The facts in paragraphs A and A3, A and A4 and/or A and A6.
14. The facts in paragraphs B and B3.
15. The facts in paragraphs C and C3.

16. The facts in paragraphs D and D3.

17. The facts in paragraphs D and D4.

18. The facts in paragraphs E and E4.

19. The facts in paragraphs E and E5.

20. The facts in paragraphs E and E6.

21. The facts in paragraphs E and E7.

22. The facts in paragraphs E and E10.

TWENTY-THIRD AND TWENTY-FOURTH SPECIFICATIONS

PATIENT ABUSE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(31) by willfully harassing, abusing or intimidating a patient either physically or verbally, as alleged in:

23. The facts in paragraphs A and A8.

24. The facts in paragraphs F and F1.

TWENTY-FIFTH THROUGH THIRTIETH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

25. The facts in paragraphs A and A1, A and A2, and/or A and A3.

26. The facts in paragraphs B and B1, and/or B and B2, and/or B and B7.

27. The facts in paragraphs C and C1 and/or C and /C4.

28. The facts in paragraphs D and D1.

29. The facts in paragraphs E and E1, E and E2, and/or E.3

30. The facts in paragraphs F and F2, F and F3, and/or F and F4.

THIRTY-FIRST SPECIFICATION

UNWARRANTED TESTS/TREATMENT

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

31. The facts in paragraphs B and B5.

DATED: August 16, 2001
Albany, New York

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

APPENDIX II

TERMS OF PROBATION

1. Respondent shall conduct him/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19),

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Suite 303, Troy, New York12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. An approved practice monitor shall be in place within thirty (30) days of the effective date of this Order.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unaccounted basis at least monthly and shall examine a selection (no less than ten (10) charts per month) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor

shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

9. **Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and all assume and bear all costs related to compliance.** Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding any/or any such other proceeding against Respondent as may be authorized pursuant to the law.