STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

July 30, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Stanley D. Taylor, M.D.
480 Hopatcong Avenue
West Hempstead, New York 11552

Robert S. Asher, Esq.
295 Madison Avenue
New York, New York 10017

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

RE: In the Matter of Stanley Douglas Taylor, M.D.

Dear Dr. Taylor, Mr. Asher and Mr. Guenzburger:

Enclosed please find the Determination and Order (No. BPMC-93-101) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must than be delivered to the Office of Professional Medical Conduct in the manner noted above.

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

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Corning Tower -Room 2503
Empire State Plaza
Albany, New York 12237-0030

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

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

Very truly yours,

Tyrone T. Butler nam

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

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

IN THE MATTER	:	**DETERMINATION**
OF	:	**AND**
STANLEY DOUGLAS TAYLOR, M.D.	:	**ORDER**
----------X		NO. BPMC-93-101

Rufus A. Nichols, M.D., Chairperson, Eugenia Herbst, and **John H. Morton, M.D.** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Marilyn S. Reader, Esq.,** duly under contract with the New York State Department of Health as an Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	December 21, 1992
Statement of Charges dated:	November 18, 1992
First Amended Statement of Charges:	February 8, 1993
Second Amended Statement of Charges:	February 18, 1993
Pre-hearing conference:	January 19, 1993

Hearing dates:	January 26, 1993 February 9, 1993 March 2, 1993 March 23, 1993 April 12, 1993
Intra-hearing conferences:	January 26, 1993 February 9, 1993 March 2, 1993 March 23, 1993
Intra-hearing conferences by telephone:	January 27, 1993 February 4, 1993
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Deliberation dates:	May 13, 1993 May 25, 1993
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health By:Daniel Guenzburger, Esq. Assistant Counsel
Respondent appeared by:	Robert S. Asher, Esq. 295 Madison Avenue New York, New York 10017

Motions:

1. January 26, 1993 - Petitioner's motion to preclude testimony by Respondent's witnesses about Respondent's competence as a physician - DENIED IN PART AND GRANTED TO THE EXTENT Respondent's witnesses may testify about Respondent's conduct prescribing controlled substances to patients, his training with respect to prescribing controlled substances, and his responsibilities and conduct in supervising other medical personnel who prescribe controlled substances.

2. January 26, 1993 - Application by Petitioner to apply collateral estoppel - GRANTED.

3. January 27, 1993 - By telephone conference, the ALJ re-opened collateral estoppel issue and requested memoranda of law on collateral estoppel application of a stipulated settlement in an out of state professional conduct hearing, the application of Board of Regents v. Halyalkar and the effect, if any, of ¶7 in Exhibit 4, California Board of Medical Quality Assurance Stipulation, Decision and Order.

4. February 4, 1993 - Petitioner's application to withdraw its request to apply collateral application - GRANTED.

5. February 4, 1993 - Petitioner's application to reopen its case and be permitted to call additional witnesses - GRANTED.

6. February 4, 1993 - Petitioner's application to amend Statement of Charges to include revised factual allegations, the addition of factual allegations relating to Petitioner's application for his New York State medical license dated June 5, 1989 and adding specifications of Negligence on More Than One Occasion, Practicing with Gross Negligence and Aiding an Unlicensed Person to Practice Medicine - GRANTED.

7. February 4, 1993 - Respondent's application to recall Respondent for direct examination after Petitioner concludes presenting its direct case - GRANTED.

8. March 2, 1993 - Petitioner's application to further amend Statement of Charges to include factual allegations relating to Respondent's surrender on April 28, 1991 of his Federal Drug Enforcement Administration controlled substance certificate and re-application on September 5, 1991 for a controlled substance certificate - GRANTED.

WITNESSES

For the Petitioner:

1. Eric John Vanderbush, M.D.

For the Respondent:

1. Stanley Douglas Taylor, M.D., the Respondent
2. Samuel E. Sanderson
3. Ms. Bonita Spikes
4. Walter R. Stankewick, M.D.
5. Joseph Saccoccio, M.D.
6. Oralene Taylor
7. Jose Marti, M.D.

STATEMENT OF CHARGES

Essentially the Respondent is charged with professional misconduct by reason of:

1. Practicing medicine with negligence on more than one occasion;

2. Practicing medicine with gross negligence;

3. Aiding an Unlicensed Person to Practice Medicine;

4. An Out of State Finding of Professional Misconduct For Conduct Which Would Constitute Professional Misconduct If Committed in New York State;

5. Out of State Disciplinary Action Taken Against His License For Conduct Which Would Constitute Professional Misconduct If Committed in New York State;

6. Fraudulent Practice of Medicine; and

7. Willfully Making and Filing False Reports.

The charges are more specifically set forth in the second Amended Statement of Charges annexed hereto as Appendix A.

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.

GENERAL FINDINGS

1. Stanley Douglas Taylor, M.D., the Respondent, was duly licensed by the New York State Education Department to practice medicine in New York State by the issuance on April 6, 1979 of license number 137826 (Pet. Ex. 2).

2. The Respondent was registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at Apt. 1, 126 Wyckoff Street, Brooklyn, New York 11201 (Pet. Ex. 2).

3. This proceeding was commenced by the service of the Notice of Hearing and Statement of Charges upon the Respondent on December 23, 1992 (Pet. Ex. 1).

4. On February 9, 1992, an Amended Statement of Charges was filed against the Respondent (Pet. Ex. 1-A).

5. On March 2, 1992, a second Amended Statement of Charges was filed against the Respondent (Pet. Ex. 1-B).

6. On June 12, 1986, before the State of California Division of Medical Quality Board of Medical Quality Assurance ("California BMQA"), Respondent signed a Stipulation, Decision and

Order admitting to numerous acts of professional misconduct for which Respondent was disciplined. The California BMQA Stipulation, Decision and Order (Pet. Ex. 4-2) is annexed hereto as Appendix B and made a part of this decision and order.

FINDINGS OF FACT AS TO RESPONDENT'S CONDUCT AS A PHYSICIAN DURING HIS EMPLOYMENT AT LEIMERT PARK AND AMPA MEDICAL CLINICS IN CALIFORNIA

1. In March 1983, Respondent became the medical director of the Leimert Park Medical Clinic. His primary responsibility at the clinic was to supervise Willie Moses ("Moses"), a physician's assistant (Tr. 248-250).

2. Between March 1983 and August 1984, Respondent was paid a monthly salary by Moses to supervise Moses part time, initially at Leimert Park Medical Clinic, and later at the newly organized AMPA Medical Clinic (Tr. 251 and Appendix B [Pet. Ex. 4-2] at p. 5).

3. Respondent would countersign patient charts prepared by Willie Moses and write prescriptions the physician assistant was not allowed to write (Tr. 250) Prior to writing these prescriptions, Respondent did not see or examine patients himself (Tr. 251).

4. Without seeing or examining patients, Respondent signed prescriptions for Preludin (Tr. 251 and Appendix B [Pet. Ex. 4-2] at pp. 5, 8-9 and 10, 11-12). In 1983, Respondent issued 820 prescriptions for Preludin and 151 for Ritalin, which were filled at the Slauson Avenue Pharmacy. The majority were for the exact

same dosage and quantity which was the highest commercially available dosage and the highest commercially available quantity (Appendix B [Pet. Ex. 4-2] at p. 10).

5. In 1984, Respondent issued 435 triplicate prescriptions, 267 for Preludin and 168 for Ritalin, which were filled at the Slauson Avenue Pharmacy. The majority of the prescriptions were for the exact same quantity and dose, which was the highest commercially available dosage and quantity (Appendix B [Pet. Ex. 4-2] at p. 10-11).

6. Respondent prescribed Preludin in clearly excessive amounts and without medical indication during his tenure at Leimert Medical and AMPA Medical Clinics (Appendix B [Pet. Ex. 4-2] at p. 4-5 and 10-11).

7. Respondent prescribed Ritalin in clearly excessive amounts and without medical indication more than twenty times to various patients between April 1983 and July 1984 (Appendix B [Pet. Ex. 4-2] at p.4-5).

8. By providing prescriptions without seeing or examining patients, Respondent violated California Business and Professional Code §2242(a) which states "Prescribing ... dangerous drugs ... without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct" (Pet. Ex. 5-A).

9. By such repeated acts of clearly excessive prescribing of Ritalin and Preludin, Respondent violated California Business and Professional Code ¶725 which states "Repeated acts of

clearly excessive prescribing or administering of drugs ... is unprofessional conduct for a physician or surgeon ... Any person who engages in repeated acts of clearly excessive prescribing or administering is guilty of a misdemeanor ..." (Pet. Ex. 5-A).

10. During his tenure at Leimert Medical Clinic and AMPA Medical Clinics, Respondent issued, furnished and authorized prescriptions for controlled substances for other than legitimate medical purposes (Appendix B [Pet. Ex. 4-2] at p. 4, 5, 7, 11 and 12).

11. Respondent signed prescriptions for Preludin and gave them to Willie Moses without filling in patient names and addresses. The prescriptions were sold for cash by Willie Moses. At the time of the sale, fictitious names and addresses were written in the blank spaces of the prescription (Appendix B [Pet. Ex. 4-2] at pp. 8-9).

12. Specifically, on September 16, 1983 Respondent pre-signed ten (10) prescriptions for Preludin leaving the patient name and address blank and gave them to Moses. Moses filled in a patient name and address and sold the prescriptions for cash (Appendix B [Pet. Ex. 4-2] at pp.8-9).

13. Before the California BMQA, Respondent admitted he practiced medicine with gross negligence by providing on September 16, 1983 ten (10) pre-signed prescriptions for Preludin to Moses without filling in the names and addresses of any patient (Appendix B. [Pet. Ex. 4-2] at pp.8-9).

14. By providing pre-signed prescriptions for Ritalin

and Preludin and leaving the name and address of the patient blank, Respondent violated California Health and Safety Code §11164 (a) (Pet. Ex. 5-A).

15. Between February 16, 1984 and August 15, 1984, Respondent authorized Moses, the physician assistant, to sign his name to prescriptions for controlled substances, including 91 prescriptions for Schedule III and IV controlled substances (Appendix B [Pet. Ex. 4-2] at p.9-10).

16. Before the California BMQA, Respondent admitted he practiced medicine with gross negligence by authorizing Moses, a physician's assistant, to sign Respondent's name to prescriptions for Schedule III and IV controlled substances (Appendix B [Pet. Ex. 4-2] at pp.5 and 9-10).

17. Between January 1983 and August 1984, Respondent counter-signed patient charts prepared by Moses which indicated Moses had prescribed Citra Forte, Doriden and APC w/Codeine No.4 in irrational combinations with other medications and at inappropriate intervals (Appendix B [Pet. Ex. 4-2] at p.5-6). Respondent also authorized Moses to sign Respondent's name to prescriptions for Schedule III and IV controlled substances (Appendix B [Pet. Ex. 4-2] at p.5).

18. On numerous occasions between April 7, 1983 and July 31. 1984, Respondent prescribed the controlled substances APC w/ Codeine No.4, Ritalin and Preludin without medical indication, without a legitimate medical purpose, and in inappropriate combinations with other medications (Appendix B [Pet. Ex. 4-2] at

p. 4-5).

19. Respondent admitted to the California BMQA that he practiced medicine with gross negligence; that he authorized Moses, the physician's assistant, to sign his name to prescriptions for Schedule III and IV controlled substances and countersigned patient charts for prescriptions issued by Mr. Moses for Schedule III and IV controlled substances that were issued in irrational combinations and intervals without a medical indication for such combinations or intervals; that Respondent prescribed Schedule II controlled substances of Ritalin and Preludin without medical indication and in clearly excessive amounts; and that he gave Moses pre-signed blank prescriptions for Schedule II controlled substances leaving blank the patient name and address (Appendix B [Pet. Ex. 4-2] at pp. 3-13).

CONCLUSIONS AS TO RESPONDENT'S CONDUCT AS A PHYSICIAN DURING HIS EMPLOYMENT AT LEIMERT PARK AND AMPA MEDICAL CLINICS IN CALIFORNIA

1. Beginning in March 1983 and through August 1984, Respondent was the medical director of the Leimert Park Medical Clinic and AMPA Medical Clinic.

2. While Respondent was the medical director of Leimert and then AMPA Medical Clinics he supervised a physician assistant named Willie Moses.

3. At Leimert and then AMPA Medical Clinics, Respondent never saw or examined any patients. He would review and countersign medical charts prepared by Moses. These charts

included prescriptions issued by Moses for Schedule III and IV drugs in irrational combinations and intervals without a medical indication.

4. Respondent wrote prescriptions without seeing or performing a good faith prior examination of any patients while he was director of Leimert and AMPA Medical Clinics.

5. On numerous occasions between April 7, 1983 and July 31, 1983, Respondent prescribed Schedule II and Schedule III controlled substances in irrational combinations, without a legitimate medical purpose and without a medical indication.

6. In 1983 and 1984, Respondent repeatedly wrote Schedule II prescriptions for Ritalin and Preludin without seeing the patients, in irrational combination and without legitimate medical purpose or medical indication such that his conduct was egregious.

7. Respondent admitted to the California BMQA during 1983 and 1984, while Respondent was medical director of Leimert Park Medical Clinic and AMPA Medical Clinic, Respondent negligently practiced medicine by allowing Moses, a physician assistant, to sign Respondent's name to prescriptions for Schedule III and IV controlled substances.

8. Respondent admitted to the California BMQA that he practiced medicine with gross negligence; that he authorized Moses, the physician's assistant, to sign his name to prescriptions for Schedule III and IV controlled substances and countersigned patient charts for prescriptions issued by Mr. Moses for Schedule III and

IV controlled substances that were issued in irrational combinations and intervals without a medical indication for such combinations or intervals; that Respondent prescribed Schedule II controlled substances of Ritalin and Preludin without medical indication and in clearly excessive amounts; and that he gave Moses pre-signed blank prescriptions for Schedule II controlled substances leaving blank the patient name and address.

9. Respondent is highly educated and very articulate. His demeanor and responses before the Hearing Committee demonstrate he carefully phrases his responses to assure he is clear and not misunderstood. He vigilantly protests when he feels his rights are being abridged. There is no evidence Respondent was coerced at the time he made his admissions to the California BMQA. When Respondent made these admissions before the California BMQA and signed the stipulation (Pet. Ex. 4-2), Respondent thoroughly understood the admissions and their effect, knew what he was doing, and fully appreciated the seriousness of what he was signing and thereby admitting.

10. Respondent's conduct in 1983 and 1984 in the State of California, if committed in New York in 1983 and 1984 would constitute professional misconduct under N. Y. Education Law §6509, and currently would constitute professional misconduct under N.Y. Education Law §6530.

FINDINGS OF FACT AS TO RESPONDENT'S ADMISSIONS OF PROFESSIONAL MISCONDUCT BEFORE THE CALIFORNIA BOARD OF MEDICAL QUALITY ASSURANCE ("BMQA)

1. On June 12, 1986 Respondent signed a Stipulation,

Decision and Order with the California Board of Medical Quality Assurance ("BMQA") in which Respondent admitted he violated California Business and Professions Code §725 by excessively prescribing drugs; §2238 by violating a statute regulating drugs; §2242 by furnishing drugs without a prior examination; §2234(b) by performing repeated negligent acts; §2234(c) by practicing medicine with gross negligence; and also admitted violating California Health and Safety Code §§ 11153 and 11154 by unlawfully prescribing controlled substances and by prescribing controlled substances to a person not under his care (Appendix B [Pet. Ex. 4-2]).

2. Respondent admitted to unprofessional medical conduct during 1983 and 1984 when he was the medical director of the Leimert Park and AMPA Medical Clinics. See Appendix B, ¶¶9A-9K at pp. 3-13.

3. The California BMQA determined Respondent committed professional misconduct on several grounds and revoked his license, stayed the revocation, suspended Respondent's license for one year during which period he was prohibited from engaging in the practice of medicine and surgery in the State of California, and placed Respondent on probation for ten years with conditions limiting his practice of medicine (Appendix B [Pet. Ex. 4-2] at pp. 13-21).

4. If committed by Respondent in New York State, these acts in 1983 and 1984 would have constituted practicing with professional misconduct in New York State under Education Law §§6509(2) and (7) and currently constitute professional misconduct under Education Law §6530.

CONCLUSIONS AS TO RESPONDENT'S ADMISSIONS BEFORE THE CALIFORNIA BOARD OF MEDICAL QUALITY BOARD

1. Respondent admitted to the California BMQA that he practiced medicine with gross negligence; that he authorized Moses, the physician's assistant, to sign his name to prescriptions for Schedule III and IV controlled substances and countersigned patient charts for prescriptions issued by Mr. Moses for Schedule III and IV controlled substances that were issued in irrational combinations and intervals without a medical indication for such combinations or intervals; that Respondent prescribed Schedule II controlled substances of Ritalin and Preludin without medical indication and in clearly excessive amounts; and that he gave Moses pre-signed blank prescriptions for Schedule II controlled substances leaving blank the patient name and address.

2. Respondent is highly educated and intelligent. His demeanor and manner demonstrate he carefully phrases his responses to assure he is not misunderstood. There is no evidence Respondent was coerced at the time he made his admissions to the California BMQA. When Respondent made these admissions before the California BMQA and signed the stipulation (Pet. Ex. 4-2), Respondent fully understood the admissions and their effect, knew what he was doing, and thoroughly appreciated the seriousness of what he was signing and thereby admitting.

3. Respondent's conduct in 1983 and 1984 which constituted professional misconduct in the State of California, if committed in New York also would constitute professional misconduct under Education Law §6509, and currently Education Law §6530.

FINDINGS OF FACT AS TO RESPONDENT'S JUNE 5, 1989 REGISTRATION APPLICATION FOR HIS NEW YORK STATE MEDICAL LICENSE

1. On June 5, 1989, Respondent submitted a registration application under License No. 137826 to the New York State Department of Education to be permitted to practice medicine in New York for the period 1/01/89 to 12/31/91 (Pet. Ex. 6).

2. In the application, at question #1 Respondent was asked "Since you last registered, has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you?" (Pet. Ex. 6).

3. Respondent intentionally lied when he answered "No" to the first question, stating no state other than New York instituted charges against him for profession misconduct, unprofessional conduct, incompetence or negligence, or revoked or suspended, or accepted surrender of a professional license held by Respondent (Tr. 137-138 and 331-332 and Pet. Ex. 6).

4. At the time he answered this question Respondent knew California had found him guilty of professional misconduct and revoked his license, stayed the revocation, suspended his license and placed him on probation for ten years with strict conditions limiting his practice of medicine in California (Tr. 137-138 and 331-332 and Pet. Ex. 6).

5. Respondent knowingly and intentionally concealed the

California BMQA determination of professional misconduct to induce the New York State Department of Education to register him to practice medicine in New York during the period for which he applied (Tr. 138 and 331-332).

CONCLUSIONS AS TO RESPONDENT'S JUNE 5, 1989 REGISTRATION APPLICATION FOR HIS NEW YORK STATE MEDICAL LICENSE

1. On June 5, 1989, Respondent submitted a registration application for his New York State medical license to the New York State Department of Education to practice medicine in New York State for the period between 1/01/89 and 12/31/91.

2. Respondent answered "No" and lied in his response to question #1. When respondent lied in his response to question #1, he intentionally concealed that the California Board of Medical Quality Assurance on November 10, 1986 found him guilty of unprofessional conduct and negligence and had revoked his license, suspended the revocation and placed Respondent on probation for ten years with conditions limiting his practice of medicine.

3. Respondent lied because he feared were he to inform the State of New York Department of Education of his disciplinary action by the California BMQA, New York would deny his registration application to practice in New York. Respondent intentionally and knowingly concealed the California proceeding to induce the State of New York to permit him to practice medicine in New York during the period from 1/01/89 to 12/31/91.

FINDINGS OF FACT AS TO RESPONDENT'S APPLICATION DATED JUNE 22, 1989 FOR RESIDENCY TO BELLEVUE MEDICAL CENTER

1. On June 22, 1989, Respondent applied to Bellevue Medical Center for a position as a resident in the Department of Pediatrics (Tr. 84-85 and 332 and Pet. Ex. 7).

2. In the application to Bellevue Medical Center, Respondent knowingly made the false statements that he had a full and unrestricted license to practice medicine in California, License No. C-40570/1979 (Tr. 84-85, 134-137 and 332 and Pet. Ex. 7).

3. In the application to Bellevue Medical Center, Respondent knowingly gave a false response when he stated "No" to the question, "Has there ever been any action taken against you for professional misconduct or malpractice or has any disciplinary action been taken concerning your performance in prior residency training positions or in medical school (Tr. 84-85, 134-137 and 332 and Pet. Ex. 7).

4. In the application, Respondent knowingly and intentionally answered falsely when he responded "No" to the question, "Are there any pending and/or settled professional misconduct proceedings against you in New York State or any other state?" (Tr. 84-85, 134-137 and 332 and Pet. Ex. 7).

5. At the time Respondent stated these false responses on the Bellevue Medical Center application, Respondent knew he had been found guilty of professional misconduct by the California BMQA for issuing prescriptions for Schedule II, III and IV controlled

substances in violation of California law, practicing medicine with gross negligence, negligently practicing medicine and aiding an unlicensed person to practice medicine and that California BMQA had revoked his license to practice medicine, stayed the revocation and placed Respondent on probation for ten years with conditions limiting his practice of medicine. Respondent knowingly and intentionally concealed any and all of the facts of the California BMQA finding of professional misconduct against him and its penalty because he believed Bellevue Medical Center would not accept him into its residency program if the medical center knew about the California disciplinary proceedings against Respondent (Tr. 134-137 and 332-333 and Appendix B).

CONCLUSIONS AS TO RESPONDENT'S JUNE 22, 1989 APPLICATION TO BELLEVUE MEDICAL CENTER

1. On June 22, 1989, Respondent applied to Bellevue Medical Center for a residency position in pediatrics.

2. Respondent lied in his application and knowingly and intentionally concealed from Bellevue Medical Center that he was the subject of professional misconduct proceedings before the California BQMA, that he was found guilty of professional misconduct, issuing prescriptions for Schedule II, III and IV controlled substances in violation of California law, practicing medicine with gross negligence, negligently practicing medicine and aiding an unlicensed person to practice medicine.

3. Respondent intentionally concealed this information from Bellevue Medical Center in order to induce Bellevue to appoint him to the position of pediatric resident.

FINDINGS OF FACT AS TO RESPONDENT'S MAY 15, 1990 APPLICATION TO THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION TO PRESCRIBE AND ADMINISTER CONTROLLED SUBSTANCES

1. On May 15, 1990, Respondent applied to the United States Department of Justice Drug Enforcement Administration ("DEA") for a certificate permitting Respondent to prescribe and administer controlled substances (Pet. Ex. 8).

2. In his application to the DEA, Respondent lied when he falsely stated "No" to question # 4(b), "Has applicant ... ever surrendered or had a DEA registration revoked, suspended or denied, or ever had a State professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation?" (Tr. 139-140 and 334 and Pet. Ex. 8).

3. Respondent knowingly and intentionally concealed that the California BMQA found Respondent guilty of professional misconduct and imposed sanctions against him including revocation of his license, stay of the revocation, probation for ten years with conditions limiting his practice and including the surrender of his DEA certificate. Respondent intentionally concealed this information in order to induce the DEA to issue Respondent a DEA certificate to prescribe controlled substances (Tr. 140 and 334).

CONCLUSIONS AS TO RESPONDENT'S MAY 15, 1990 APPLICATION TO THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION TO PRESCRIBE AND ADMINISTER CONTROLLED SUBSTANCES

1. On May 15, 1990, Respondent submitted an application to the DEA for a certificate to prescribe controlled substances and lied when he falsely stated "No" to question # 4(b), "Has applicant ... ever surrendered or had a DEA registration revoked, suspended or denied, or ever had a State professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation?"

2. Respondent knowingly and intentionally concealed that he previously surrendered a DEA certificate as part of the California BMQA disciplinary action finding he committed unprofessional conduct. Respondent further knowingly and intentionally concealed that his license in California had been revoked with the revocation stayed, suspended from practicing medicine for one year and that he was placed on ten years probation with conditions limiting his practice of medicine. Respondent concealed these facts to induce the DEA to issue him a certificate to prescribe controlled substances.

FINDINGS OF FACT AS TO RESPONDENT'S APPLICATION DATED APRIL 1, 1991 TO WOODHULL MEDICAL CENTER

1. On November 10, 1991, Respondent applied to Medical Associates of Woodhull, P.C. for an appointment as an emergency room physician and assistant attending in the Department of Pediatrics (Pet Ex. 9).

2. Respondent was asked to give full details if he answered "yes" to any of the questions relating to Professional Conduct (Pet. Ex. 9).

3. Respondent truthfully responded yes to question #1 whether his license to practice medicine in another jurisdiction ever had been revoked or suspended. In his written statement in response to providing full details, Respondent stated:

> RESPONSE TO QUESTION 1 OF APPLICATION
> FOR APPOINTMENT TO MEDICAL STAFF
>
> In 1982-83, I worked part time in a clinic at which a physician assistant was employed. Although I was not physically present in the clinic during the working hours of the physician assistant, I was technically the supervisor of the physician assistant. My supervision consisted of reviewing and countersigning charts of patients seen by the PA. Though the charts did not reflect it, the PA was found to be excessively prescribing controlled substances in my name. In spite of having no direct involvement in the excessive prescribing, I was charged with negligence for allowing conditions exist where controlled substances could be dispensed in my name without my authorization. Disciplinary action resulted in suspension of my license for a period of 1987 (Pet. Ex. 9).

4. Respondent's written response intentionally failed to give full details about the unprofessional conduct Respondent admitted to in his Stipulation and Respondent purposefully omitted his admissions and California BMQA'a finding of guilt to unlawful issuance of prescriptions for controlled substances, excessively prescribing controlled substances, prescribing controlled substances in irrational combination and without proper medical indication, and gross negligence as a medical practitioner. Respondent knowingly and intentionally failed to inform Woodhull as to the extent and magnitude of the California BMQA determination of

Respondent's unprofessional misconduct (Pet. Ex. 9, Appendix B (Pet. Ex. 4-2) and Tr. 92-94, 109-110, 115-118, 335, 272-273 and 275).

5. Further, Respondent failed to fully advise Woodhull of the sanctions imposed against him by the California BMQA which included not only a one year suspension as indicated by Respondent in his response, but a ten year probation with conditions strictly limiting his practice and requiring surrender of his DEA certificate (Pet. Ex. 9, Appendix B (Pet. Ex. 4-2) and Tr. 92-94, 109-110, 115-118, 335, 272-273 and 275).

6. Respondent knowingly and intentionally concealed these facts in order to induce Woodhull Medical Center to appoint Respondent to the positions of assistant attending in the Department of Pediatrics and emergency room physician (Tr. 335).

CONCLUSIONS AS TO RESPONDENT'S APPLICATION DATED APRIL 10, 1991 TO WOODHULL MEDICAL CENTER

1. On April 10, 1991, Respondent applied to Woodhull Medical Center for a position as an assistant attending in the Department of Pediatrics and as an emergency room physician.

2. Respondent truthfully responded yes to question #1 whether his license to practice medicine in another jurisdiction ever had been revoked or suspended.

3. However, Respondent's written response intentionally failed to give full details as to the unprofessional conduct Respondent admitted to in his Stipulation. Respondent purposely omitted his specific admissions and California BMQA's finding of

guilt that Respondent unlawfully issued prescriptions for controlled substances, excessively prescribed controlled substances, prescribed controlled substances in irrational combinations and without proper medical indication, and practiced medicine with gross negligence.

4. Respondent knowingly and intentionally chose not to inform Woodhull as to the extent and magnitude of the professional misconduct the California BMQA determined Respondent committed.

5. Respondent knowingly and intentionally concealed this information in order to induce Woodhull Medical Center to appoint Respondent to the positions of assistant attending in the Department of Pediatrics and emergency room physician

FINDINGS OF FACT AS TO RESPONDENT'S APRIL 1991 APPLICATION TO THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION TO PRESCRIBE AND ADMINISTER CONTROLLED SUBSTANCES

1. In or about September 1991, Respondent applied to the United States Department of Justice Drug Enforcement Administration ("DEA") for a certificate permitting Respondent to prescribe and administer controlled substances (Pet. Ex. 13).

2. In his application to the DEA, Respondent stated "Yes" to question #4(b), "Has applicant ... ever surrendered or had a DEA registration revoked, suspended or denied, or ever had a State professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation?" Respondent submitted the same statement for his affirmative response to question #4(b) as Respondent submitted to Woodhull

Medical Center. See Findings of Fact as to Woodhull application, supra ¶3. (Tr. 336, 385-390 and Pet. Ex. 13).

3. Respondent's written response intentionally failed to give full details about the unprofessional conduct Respondent admitted to in his Stipulation and Respondent purposefully omitted his admissions and California BMQA'a finding of guilt to unlawful issuance of prescriptions for controlled substances, excessively prescribing controlled substances, prescribing controlled substances in irrational combination and without proper medical indication, and gross negligence as a medical practitioner. Respondent knowingly and intentionally failed to inform the DEA as to the extent and magnitude of the California BMQA determination of Respondent's unprofessional misconduct (Pet. Ex. 13, Appendix B (Pet. Ex. 4-2) and Tr. 336, 385 and 392).

4. Further, Respondent failed to fully advise the DEA of the sanctions imposed against him by the California BMQA which included not only a one year suspension as indicated by Respondent in his response, but a ten year probation with conditions strictly limiting his practice and requiring surrender of his DEA certificate (Pet. Ex. 13, Appendix B [Pet. Ex. 4-2] and Tr. 336 and 385-390).

5. Respondent knowingly and intentionally concealed these facts in order to induce the DEA to issue a certificate to prescribe controlled substances to him (Tr. 385-390).

CONCLUSIONS AS TO RESPONDENT'S APPLICATION IN SEPTEMBER 1991 TO DEA

1. In or about September 1991, Respondent applied to the United States Department of Justice Drug Enforcement Administration ("DEA") for a certificate permitting Respondent to prescribe and administer controlled substances.

2. Respondent's written statement to his affirmative response to question 4(b) insufficiently detailed his admissions of guilt to and the findings of professional misconduct against him by California BMQA, and the extent of the sanctions California imposed against Respondent.

3. The response further knowingly and intentionally concealed the fact Respondent had surrendered his DEA certificate as part of the penalty imposed by the California BMQA and again in or about April 1991.

4. Respondent intentionally concealed this information to induce the DEA to issue him the certificate.

VOTE OF THE HEARING COMMITTEE

THE HEARING COMMITTEE VOTES UNANIMOUSLY (3-0) AS FOLLOWS:

FIRST SPECIFICATION: We find that the Respondent practiced negligently on more than one occasion in that our findings of fact support Allegations A1 through A6.

SECOND SPECIFICATION: We find that the Respondent practiced with gross negligence in that our findings of fact support Allegations A1 through A6.

THIRD SPECIFICATION: We find that the Respondent aided an unlicensed person to practice medicine in that our findings of fact support Allegations A1 through A5.

FOURTH SPECIFICATION: We find Respondent guilty of professional misconduct based on an out-of-state finding of professional misconduct in that our findings of fact support Allegations A1 through A6 and B and were this conduct committed in New York State it would constitute professional misconduct under the laws of New York State.

FIFTH SPECIFICATION: We find Respondent guilty of professional misconduct based on an out-of-state disciplinary action taken against his license by a duly authorized professional disciplinary agency of another state in that our findings of fact support Allegations A1 through A6 and B and were the conduct resulting in the disciplinary action committed in New York State, such conduct would constitute professional misconduct under the laws of New York State.

SIXTH THROUGH TENTH SPECIFICATIONS: We find that the Respondent fraudulently practiced medicine in that our findings of fact support Allegations C, D, E, F and G.

ELEVENTH THROUGH FIFTEENTH SPECIFICATIONS: We find that the Respondent practiced with professional misconduct by willfully making or filing a false report in that our findings of fact support Allegations C, D, E, F and G.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

Because of the Respondent's unreliable and untrustworthy character, his self-serving conduct, his propensity to place his interests above the integrity of the profession as insured by state and federal medical licensing authorities and of the hospitals and professional institutions to which he applies for employment, his failure to accept responsibility for past misconduct, his failure to appreciate the significance of making fraudulent statements to licensing authorities and hospitals, and also, however, recognizing that Respondent has no criminal record and no patient was shown to have suffered serious physical injury, the Hearing Committee

unanimously determines the Respondent's license to practice medicine in the State of New York is **SUSPENDED FOR FIVE YEARS, stayed with probation for five years, the terms of which are:**

1. Respondent shall be monitored by the Office of Professional Medical Conduct;

2. Respondent shall surrender his U.S. Department of Justice Drug Enforcement Administration certificate for the duration of the suspension and probation;

3. During the duration of the suspension and probation, Respondent shall practice medicine only in a supervised setting; and

4. Respondent shall pay a fine of $10,000.00.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is **SUSPENDED FOR FIVE YEARS, stayed with probation for five years, the terms of which are:**

1. Respondent shall be monitored by the Office of Professional Medical Conduct;

2. Respondent shall surrender his U.S. Department of Justice Drug Enforcement Administration certificate for the duration of the suspension and probation;

3. During the duration of the suspension and probation, Respondent shall practice medicine only in a supervised setting; and

4. Respondent shall pay a fine of $10,000.00.

DATED: New York, New York
June 30, 1993

RUFUS A. NICHOLS, M.D.
Chairperson

Eugenia Herbst
John H. Morton, M.D

APPENDIX A

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Stanley D. Taylor, M.D.
Certificate #G-040570

No. D-3360

DECISION

The attached Stipulation is hereby adopted by the Division of Medical Quality of the Board of Medical Quality Assurance as its Decision in the above-entitled matter.

This Decision shall become effective on December 10, 1986.

IT IS SO ORDERED November 10, 1986.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

JOHN W. SIMMONS
Secretary-Treasurer
Division of Medical Quality

CAL BOARD OF CALIFORNIA
hereby certify that
document is true
and correct copy of the
original on file in this
office.

SIGNED 2-2-93 DATE

Asst to Custodian of files
TITLE

"Appendix B"

EXHIBIT
Petitioner's 4-2
3-2-93 EXD SAB

JOHN K. VAN DE KAMP, Attorney General
MARILYN H. LEVIN,
Deputy Attorney General
3580 Wilshire Boulevard
Los Angeles, California 90010
Telephone: (213) 736-2047

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
STATE OF CALIFORNIA

In the Matter of the Accusation Against: STANLEY DOUGLAS TAYLOR, M.D. P.O. Box 21041 San Bernardino, CA 92406 Physician's and Surgeon's Certificate No. G-040570, Respondent.	NO. D-3360 STIPULATION, DECISION AND ORDER

IT IS STIPULATED AND AGREED by and between Kenneth J. Wagstaff, complainant herein, by and through his attorneys John K. Van De Kamp, Attorney General of the State of California, by Marilyn H. Levin, Deputy Attorney General and Stanley Douglas Taylor, M.D., respondent herein as follows:

1. On or about August 13, 1979, respondent Stanley Douglas Taylor, M.D. (hereinafter "respondent") was issued Physician's and Surgeon's Certificate Number G-040570 by the Board of Medical Quality Assurance (hereinafter the

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"board"). At all times pertinent hereto, said certificate was in full force and effect except as set forth hereinbelow.

2. On June 7, 1985, respondent was enjoined from treating patients, prescribing controlled substances, possessing triplicate or regular prescriptions or practicing medicine at any place of employment other than the State Department of Rehabilitation in the case entitled, People of the State of California and Board of Medical Quality Assurance v. William Moses, David N. Michelson, M.D., Stanley Douglas Taylor, M.D. Leimert Park Medical Group, et al., L.A.S.C. No. C47841.

3. Complainant Kenneth J. Wagstaff, Executive Director, Board of Medical Quality Assurance made and filed as complainant Accusation No. D-3360 on June 19, 1985; First Amendment to Accusation No. D-3360 on June 4, 1986; First Supplemental Accusation No. D-3360 on June 4, 1986; and Second Supplemental Accusation No. D-3360 on June 5, 1986. Said Accusations are currently pending against respondent before the Division of Medical Quality, Board of Medical Quality Assurance (hereinafter the "Division").

4. Respondent was duly and properly served with Accusation No. D-3360, First Amendment to Accusation No. 3360, First Supplemental Accusation No. D-3360 and Second Supplemental Accusation No. D-3360. Said respondent filed a timely Notice of Defense.

5. Respondent has received and read Accusation, First Amendment to Accusation, and First and Second Supplemental

Accusations in Case No. D-3360 and understands that the charges contained therein constitute cause for discipline.

6. Respondent is fully aware of his right to an administrative hearing conducted pursuant to the California Administrative Procedure Act on the charges and allegations contained in said Accusation, First Amendment to Accusation, First Supplemental Accusation, and Second Supplemental Accusation in Case No. D-3360; his rights to reconsideration of any decision by the Committee adverse to him, and thereafter appeal to the Superior Court, and any and all rights which may be accorded to him pursuant to the California Administrative Procedure Act and the Code of Civil Procedure of the State of California. Respondent hereby fully and voluntarily waives these rights with regard to the Accusation, First Amendment to Accusation, and the First and Second Supplemental Accusation in Case No. D-3360.

7. The admissions made herein are for the purposes of this proceeding or a proceeding before the board and may not be used for any other purpose.

8. Respondent hereby stipulates that the pleadings in Case No. D-3360 may be amended to conform to the admissions as set forth hereinbelow in paragraph 9.

9. Respondent admits to the truth of the following:

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A. Respondent prescribed the following Schedule II and Schedule III controlled substances in irrational combinations[1/] without a legitimate medical purpose and without a medical indication therefor:

Date	Patient	Drug
4-7-83	Wendell Strong	60 APC w/Codeine No. 4 60 Ritalin 20 mg.
4-22-83	Samuel Thomas	"
4-26-83	Leonard Colman	"
5-26-83	Terry Turner	"
6-13-83	Melvin Washington	"
9-28-83	Robert Mitchell, Jr.	60 Ritalin 20 mg. 60 APC w/Codeine No. 4
7-31-84	Terry Turner	60 Ritalin 20 mg. 60 APC w/Codeine No. 4

B. Respondent prescribed the following Schedule II controlled substances in the following intervals without a medical indication and in clearly excessive amounts as follows:

Date	Patient	Drug
4-7-83	Wendell Strong	60 Ritalin, 20 mg.
5-12-83	"	"
9-27-83	"	"
5-4-83	Kermis Williams	60 Ritalin, 20 mg.
6-8-83	"	"

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1. Irrational combinations are prescriptions issued to one individual for similar or antagonistic drugs.

Date	Patient	Drug
6-14-83	Edna Williams	60 Ritalin, 20 mg.
7-29-83	"	"
12-14-83	"	"
10-10-83	Olena Coleman	60 Preludin, 75 mg.
10-10-83	"	"
5-26-83	Terry Turner	60 Ritalin, 20 mg.
6-27-83	"	"
7-25-83	"	"
8-24-83	"	"
9-27-83	"	"
6-3-83	Willie Green	60 Ritalin, 20 mg.
9-23-83	"	"
11-7-83	"	"
5-2-83	Edward Mayfield	60 Ritalin, 20 mg.
6-3-83	"	"
3-31-84	Terry Turner	60 Ritalin, 20 mg.
7-31-84	"	"

C. Respondent was paid a monthly salary by Mr. Moses, a Physician's Assistant, to supervise Mr. Moses part time in his clinic, Leimert Park Medical Clinic and Ampa Medical Clinic during 1983 and 1984. Respondent authorized Mr. Moses, a Physician's Assistant, to sign his name to prescriptions for Schedule III and IV controlled substances. Respondent countersigned patient charts for prescriptions issued by Mr. Moses for the following drugs in such irrational combinations and intervals without a medical indication therefor:

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Date	Patient	Drug
8-22-83	Sam Ogilvie	240 Citra Forte
9-9-83	"	"
9-9-83	"	60 APC w/Codeine No. 4
9-20-83	"	240 Citra Forte
10-10-83	"	"
10-21-83	"	"
11-21-83	"	"
11-28-83	"	"
12-12-83	"	"
2-27-84	"	240 Citra Forte
3-2-84	"	Doriden
4-2-84	"	240 Citra Forte
4-10-84	"	Doriden
4-20-84	"	240 Citra Forte
6-11-84	"	Doriden
6-25-84	"	240 Citra Forte
10-18-83	Jacqueline D. Tucker	240 Citra Forte 50 Talwin 50 mg. (Schedule IV)
10-18-83	Wendell McMillian	"
11-21-83	James Norris, Jr.	60 APC w/Codeine No. 4 240 Citra Forte
11-30-83	Earl McCall	60 APC w/Codeine No. 4 Citra Forte
3-2-84	Kenneth O.	60 APC w/Codeine No. 4 240 Citra Forte
5-31-84	"	60 APC w/Codeine No. 4 240 Citra Forte
7-9-84	"	"
7-26-84	"	60 APC w/Codeine No. 4 240 Citra Forte
5-24-84	Pauline A.	60 APC w/Codeine No. 4 240 Citra Forte
5-30-84	"	60 APC w/Codeine No. 4 240 Citra Forte
6-25-84	"	60 APC w/Codeine No. 4 240 Citra Forte
8-10-84	"	60 APC w/Codeine No. 4 240 Citra Forte
6-19-84	Helen R.	60 APC w/Codeine No. 4 240 Citra Forte
7-3-84	"	60 APC w/Codeine No. 4 240 Citra Forte

7-12-84	Melvin Washington	240 Citra Forte Doriden
8-14-84	William Richardson	240 Citra Forte Doriden
8-14-84	Eddie Harris	60 APC w/Codeine No. 4 240 Citra Forte
3-27-84 7-25-84	Samuel G. "	60 APC No. 4 "

D. The following prescriptions signed in the name of respondent were sold for cash by Mr. Moses. The body of the prescriptions, the dates and fictitious names were filled in by Mr. Moses. Respondent failed to monitor and supervise Mr. Moses. The prescriptions were issued without a legitimate medical purpose and without a medical indication therefor:

Dated	Patient	Drug
8-4-83	No patient	240 Citra Forte
8-4-83	No patient	240 Citra Forte
8-4-83	No patient	Doriden
8-4-83	No patient	Doriden
8-4-83	No patient	Doriden
8-4-83	No patient	Doriden
8-4-83	No patient	Doriden
8-4-83	No patient	60 APC w/Codeine No. 4
8-4-83	No patient	60 APC w/Codeine No. 4

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Date	Patient	Drug
8-4-83	No patient	60 APC w/Codeine No. 4
8-4-83	No patient	"
8-4-83	No patient	"
9-2-83	Everett Adams	240 Citra Forte
"	Evenua A. dejioyl	" "
"	Johnny Banks	" "
"	No Name	" "
"	Regina Banks	60 APC w/Codeine No. 4
"	Michael Capretta	"
"	Barbara Adams	Doriden
"	Pamy Campbell	"
"	Noimi Calvin	"
"	Barbara Davis	60 APC w/Codeine No. 4
"	Deanna Danner	"
"	Ronald Barban	"
"	Juan Barager	"
"	Barbara Adams	240 Citra Forte
"	Everette Adams	Doriden

E. Respondent engaged in acts of gross negligence by signing the following Schedule II prescriptions and giving them to Mr. Moses without filling in the names and addresses of any patients. Respondent filled in the body of the prescriptions. The prescriptions were sold for cash by Mr. Moses, a Physician's Assistant. Fictitious names and addresses were provided at the time of sale:

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Dated	Rx Number	Patient	Drug
9-16-83	83250-055-38	Jacqueline Brady 60	Preludin 75 mg.
"	83250-055-39	Doris Ephraim	"
"	83250-055-40	Curtis Meeks	"
"	83250-055-41	Hazel White	"
"	83250-055-42	Shirley Lavellies	"
"	83250-055-43	Frederick Jones	"
"	83250-055-44	Edna L. Ward	"
"	83250-055-45	Lavandell Bradshaw	"
"	83250-055-46	Shirley Brewer	"
"	83250-055-47	Elliot McClavin	"

F. On or about August 1984, an audit of Slauson Avenue Pharmacy was conducted for the period beginning on February 16, 1984 and ending August 15, 1984. The following prescriptions for Schedule III and IV controlled substances were written in the name of respondent without his countersignature during a period when respondent engaged in acts of gross negligence by authorizing a Physician's Assistant to sign his name to prescriptions for controlled substances:

Prescription Numbers:

016205, 016216, 016161, 016159, 016267, 016757, 016254, 106272, 106271, 016266, 016256, 016238, 016245, 016244, 016228, 016225, 016223, 016222, 016219, 016218, 016209, 016208, 016206, 016207, 016194, 016188, 016140, 016139, 016160, 016163, 016014, 016129, 016127, 016126, 016110, 016104, 016102, 016097, 106098, 016091, 016090, 016087,

Prescription Numbers:

016085, 016081, 016051, 016048, 016013, 016012, 016002, 015987, 015986, 015973, 015958, 015955, 015950, 015949, 015947, 015946, 015925, 015923, 015904, 015859, 015857, 015855, 015851, 015850, 015843, 015855, 015836, 015033, 015831, 015809, 015808, 015784, 015783, 015779, 015778, 015775, 015676, 015758, 015757, 015754, 015753, 015750, 015737, 015736, 015736, 014734, 015732, 015731, 015727.

G. Respondent engaged in acts of clearly excessive prescribing in issuing approximately 971 triplicate prescriptions in 1983. Of the approximately 76,000 licentiates in the State of California eligible to receive triplicate prescription blanks, respondent ranked 21st in the State. In 1983 respondent issued prescriptions for Schedule II drugs in approximately the following amounts:

820 - Preludin

151 - Ritalin

For the majority of the prescriptions, respondent prescribed the exact same dosage (highest commercially available) and the exact same quantity (highest commercially available) for each patient.

H. Respondent engaged in acts of clearly excessive prescribing in issuing approximately 435 triplicate prescriptions in 1984. Of those prescriptions, respondent issued prescriptions for Schedule II drugs in approximtely the following amounts:

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267 - Preludin

168 - Ritalin

In 1984, respondent was the 97th triplicate prescription writer in the State. In 1984, for Area 5, the mean or average numbering triplicate prescriptions written was 19. The median licentiate in Area 5 wrote three triplicate prescriptions.

For the majority of the prescriptions, respondent prescribed the exact same dosage (highest commercially available) and the exact same quantity (highest commercially available) for each patient.

I. Respondent engaged in acts of clearly excessive prescribing as follows:

On or about August 1984, an investigator conducted an audit of Slauson Avenue Pharmacy for the period beginning on February 16, 1984 and ending on August 15, 1984. The total Schedule II prescriptions audited (Preludin and Ritalin) was 860 or 54,880 dose units. Of those, 51 percent or 442 were written by five prescribers. Respondent was the top prescriber writing 122 prescriptions for Preludin and Ritalin. The total Schedule III and IV drugs audited (APC #4, Empirin #4, Tylenol #4, Doriden, Talwin, (Citra Forte) were 2041. Of those 63 percent were written by five prescribers. Respondent wrote at least 449 prescriptions for these drugs and was the top prescriber.

J. On or about November 8, 1983 Virgle Moss and four other women came to Slauson Avenue Pharmacy. All five

women had prescriptions for 60 Preludin 75 mg. and Lasix from respondent. On or about November 9, 1983 a telephone call was returned to Dave Hall from Arlene at respondent's Inglewood Pediatric Office. When Mr. Hall identified himself, he explained that five prescriptions were brought in by Virgle Moss and he needed approval from the doctor. Respondent called Mr. Hall later that day and gave approval to fill the five prescriptions.

K. Beginning in January 1983 and continuing through 1984, respondent issued, furnished and authorized prescriptions not for legitimate purposes as more particularly alleged hereinbelow:

(1) Respondent signed prescriptions for 60 Preludin 75 mg. in connection with the Leimert Park Medical Clinic and Ampa Medical Clinic on a monthly basis in exchange for a monthly salary paid by a Physician's Assistant, William Moses. Mr. Moses filled in the name and address of the patient.

(2) The patients filled their illegitimate prescriptions at Slauson Avenue Pharmacy for a fee.

(3) On or about October 6 and October 7, 1983 respondent agreed to re-date and re-sign ten (10) outdated triplicate prescriptions, all for 60 Preludin 75 mg. The triplicate prescriptions were originally signed by respondent and given to Mr. Moses. The body of the prescriptions were filled out by respondent. The name, address and original dates of September 17,

1983 and September 28, 1983 of the patients were written in a different handwriting. Respondent crossed out the original date, placed the date of October 7, 1983 and signed his name. Mr. Moses sold these prescriptions for cash.

10. Pursuant to the waivers, stipulations and admissions contained herein, cause for discipline has been established pursuant to Business and Professions Code Sections 2234(a), 725, 2234(b) and (c), 2238, 2242(a), 4036 in conjunction with Health and Safety Code Sections 11150, 11153, 11154(a), 11157, 11164(a), 11164(b)(1), 11210, 11172.

11. The Division of Medical Quality may issue the following decision:

DECISION AND ORDER

Physician and Surgeon's Certificate No. G-040570 heretofore issued to Stanley Douglas Taylor, M.D. is revoked, said revocation stayed and said respondent is placed on probation for a period of ten years, upon the following terms and conditions of probation:

A. Respondent's license is suspended for one year beginning the effective date of this decision. During that period of time respondent is prohibited from engaging in the practice of medicine and surgery in the State of California.

B. After the expiration of the one year suspension, respondent may apply for reinstatement of his license to practice medicine; however the reinstatement of respondent's license to engage in the

practice of medicine during the remainder of probation shall be subject to the following conditions prior to the reinstatement of his license:

(1) Respondent shall take and pass an oral clinical and/or written examination to be administered by the Division or its designee. If respondent fails these examinations, respondent must wait three months between reexaminations, except that after three failures respondent must wait one year to take each necessary examination thereafter. The Division shall pay the cost of the first examination and respondent shall pay the costs of any subsequent examinations. Respondent shall not practice medicine until respondent has passed this examination and has been so notified in writing.

(2) Respondent shall have submitted to the Division for its prior approval an educational program or course related to General Medicine and Medical Therapeutics which shall not be less than 40 hours per year for each year of probation following suspension. This program shall be in addition to the continuing medical education requirements for relicensure. Following the completion of each course, the Division or its designeee may administer an examination to test respondent's knowledge of the course. Respondent

shall submit proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition and were approved in advance by the Division.

(3) Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Division that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any triplicate prescription forms and federal order forms; thereafter, respondent shall not reapply for a new DEA permit until five years from the effective date of the decision. During suspension, respondent shall not prescribe, administer, dispense, order or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

(4) Respondent is prohibited from engaging in solo practice during probation. Respondent shall not practice medicine until a supervised structured environment has been approved in writing. Respondent shall submit to the Division in writing and receive its prior approval in writing for a plan of practice limited to a supervised structured environment in which respondent's practice will be supervised and

monitored by a physician duly licensed to engage in the practice of medicine in the State of California and whose qualifications to supervise the respondent are approved by the Division. The approval shall be based upon respondent's submittal of a written agreement by the respondent and the supervising physician. Said agreement shall contain, among others, the following terms and conditions:

a. At a minimum, the supervision should consist of weekly review of patient's charts for each patient examined by respondent; the supervisor shall meet with respondent at regular intervals but no less than once a week.

b. Supervisors shall submit regular monthly progress reports to the Division. Respondent shall not be allowed to practice medicine until respondent has been notified in writing that his plan of practice has been approved.

(5) During the suspension, Respondent shall have obeyed all federal, state and local laws and all rules and regulations substantially related to the practice of medicine including the prescribing and furnishing of controlled substances and dangerous drugs.

(6) During the suspension, Respondent shall have submitted quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

(7) During the suspension, Respondent shall have complied with the Division's probation surveillance program.

(8) During the suspension, Respondent shall have appeared in person for interviews with the Division Medical Consultant upon request at various intervals and with reasonable notice

C. Upon reinstatement of a restricted license as set forth hereinabove in paragraph B (pgs. 13-14), respondent shall comply with the following terms and conditions of probation during the remainder of his ten year probation:

(1) Respondent shall comply with the continuing education course requirements on an annual basis for each year of probation (except during suspension) as set forth hereinabove in paragraph B(2).

(2) Respondent shall comply with the requirement for a supervised structured plan of practice as set forth hereinabove in paragraph B(4). If the supervising physician withdraws from his agreement or changes the terms of the

agreement, respondent shall cease all practice until a suitable replacement is found and approved by the Division.

(3) Respondent shall comply with the restrictions involving controlled substances as set forth hereinabove in paragraph B(3). Respondent shall not prescribe, administer, dispense, order or possess any controlled substances as defined in the California Uniform Controlled Substances Act for a period of five years from the effective date of the decision. Respondent shall inform the Division prior to reapplication for a new DEA permit.

(4) Should respondent obtain a new DEA permit, respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by respondent during probation, showing all the following: 1) The name and address of the patient, 2) The date, 3) The character and quantity of controlled substances involved, and 4) The pathology and purpose for which the controlled substance was furnished. Respondent shall keep these records in a separate file or ledger, in chronological order, and shall make them available for inspection and copying by the Division or its designee, upon request.

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(5) Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act and dangerous drugs as defined by Section 4211 of the Business and Professions Code or any drugs requiring a prescription; except, however medications lawfully prescribed to respondent for a bona fide illness or condition by another practitioner.

(6) Respondent shall obey all federal, state and local laws and all rules and regulations substantially related to the practice of medicine including the prescribing and furnishing of controlled substances and dangerous drugs.

(7) Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

(8) Respondent shall comply with the Division's probation surveillance program.

(9) Respondent shall appear in person for interviews with the Division Medical Consultant upon request at various intervals and with reasonable notice.

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(10) Respondent shall exercise proper professional judgment prior to prescribing, dispensing or furnishing any drug. Specifically, respondent shall determine prior to prescribing, dispensing or furnishing any drug whether respondent has provided a good faith prior examination and a bona fide medical condition is indicated for the patient.

(11) Respondent shall exercise proper professional judgment and shall not prescribe or administer drugs or treatment in clearly excessive amounts (either dosages or quantities).

(12) Respondent is prohibited from becoming a supervisor of physician assistants in the State of California.

(13) Respondent shall submit to the Division for its prior approval a community service program in which respondent shall provide free medical services on a regular basis to a community or charitable facility or agency for at least 4 hours a month for the first 12 months of probation after suspension.

(14) In the event respondent should leave California to reside or practice out of state, respondent must notify the Division in writing of the dates of departure and return. Periods of residency or practice outside California will not

apply to the reduction of this probationary period.

(15) Should respondent violate probation in any respect the board after giving respondent notice and opportunity to be heard may revoke probation and set aside the stay order, may modify or change the terms and period of probation, or may take any other or further action as it deems proper. If a petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final.

D. Upon successful completion of probation, respondent's certificate shall be fully restored.

E. This stipulation shall be subject to the approval of the Division and unless and until adopted by the Division as its decision in Case Number D-3360, this stipulation shall have no force and effect in any present or future proceedings.

JOHN K. VAN DE KAMP, Attorney General
of the State of California
MARILYN H. LEVIN,
Deputy Attorney General

DATED: June 12, 1986

MARILYN H. LEVIN
Attorneys for Complainant

DATED: June 12, 1986

STANLEY DOUGLAS TAYLOR
Respondent

I have read the within stipulation, and its terms are understood by me and are agreeable and acceptable to me. I understand that I am waiving certain rights accorded me by the California Administrative Procedure Act and I willingly, intelligently, and voluntarily waive those rights. I understand that by the terms of this stipulation, my license is to be revoked, but said revocation stayed, and be placed on probation for ten (10) years under the terms and conditions set forth herein by decision and order upon this stipulation, including an actual suspension for one year.

DATED: June 12, 1986

STANLEY DOUGLAS TAYLOR
Respondent

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APPENDIX B

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

IN THE MATTER	AMENDED STATEMENT
OF	OF
STANLEY DOUGLAS TAYLOR, M.D.	CHARGES

STANLEY DOUGLAS TAYLOR, M.D., the Respondent, was authorized to practice medicine in New York State on April 2, 1979 by the issuance of license number 137826 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 December 31, 1990 to December 31, 1992 at 480 Hopatcong Avenue, West Hempstead, New York, 11552.

FACTUAL ALLEGATIONS

A. On or about and between January, 1983, and December 31, 1984, the Respondent supervised a physician's assistant's practice at the Leimart Park and Ampa Medical Clinics, California.

1. In exchange for a salary paid by the physician's assistant, the Respondent provided the physician's assistant with pre-signed prescriptions for Preludin. The physician's

"Appendix A"

assistant would fill in the name and address of a patient and make the prescriptions available to patients.

2. On or about September 16, 1983, the Respondent pre-signed 10 prescriptions for Preludin. The physician's assistant filled in a patient name and address and sold the prescriptions for cash.

3. The Respondent authorized the physician's assistant to sign his name to prescriptions for controlled substances, including 91 prescriptions for Schedule III and IV controlled substances issued between February 16, 1984 and August 15, 1984;

4. On or about and between January, 1983 and December, 1984, the Respondent counter-signed patient charts prepared by the physician's assistant which indicated that the physician's assistant had issued prescriptions for Citra Forte, Doriden, and APC w/Codeine No. 4 in irrational combinations with other medications and at inappropriate intervals;

5. On numerous occasions between April 7, 1983 and July 31, 1984 the Respondent prescribed the

controlled substances APC w/Codeine No. 4, Ritalin, and Preludin without medical indication, in excessive amounts, and in inappropriate combinations with other medications.

B. On or about November 10, 1986, the California Board of Medical Quality Assurance ("BMQA") adopted the Stipulation, Decision and Order entered into by the Respondent in which he admitted violating California Business and Professions Code Sections 725 ("Excessive prescribing of drugs"), Sec. 2238 ("Violating a statute regulating drugs"), Sec. 2242 ("Furnishing drugs without a prior examination"), Sec. 2234(b) ("Repeated negligent acts"), Sec. 2234(c) ("Gross negligence") and Health and Safety Code Sections 11153 ("Unlawful prescribing of controlled substances"), and Sec. 11154 ("Prescribing or furnishing controlled substances to a person not under the physician's care"). In the BMQA Stipulation, Decision, and Order, the Respondent admitted that he performed the acts previously alleged in paragraph A. These acts, if committed in New York State, would have constituted practicing the profession with negligence on more than one occasion under Educ. Law Sec. 6530(4) (McKinney Supp. 1993), practicing with gross negligence on a particular occasion in violation of

Educ. Law Sec. 6530(4) (McKinney Supp. 1993) and aiding an unlicensed person to practice medicine in violation of Educ. Law Sec. 6530(11) (McKinney Supp. 1993).

C. Respondent represented in his registration application for his New York State medical license dated June 5, 1989, that no out-of-state disciplinary agency had ever instituted charges against him for professional misconduct, unprofessional conduct, incompetence or negligence, or revoked, suspended or accepted the surrender of his professional license, when in fact he knew that on or about November 10, 1986, the California BMQA ordered the revocation of Respondent's medical license, stayed execution of the revocation, imposed one year actual suspension, and placed the Respondent on probation for 10 years. The terms of probation required that the Respondent surrender his DEA permit and refrain from prescribing and administering controlled substances for 5 years, restrict his practice of medicine to a supervised structured environment, accept a physician practice monitor and participate in a program of continuing medical education approved by the BMQA.

D. Respondent represented in his application for a residency position at the Bellevue Hospital Center dated June 22, 1989, that no state had a pending and/or settled professional misconduct proceeding against him, when in fact the Respondent knew that on or about November 10, 1986, the California BMQA found him guilty of professional misconduct and imposed the sanction set forth in paragraph B.

E. Respondent represented in his federal Drug Enforcement Administration application to prescribe and administer controlled substances dated May 15, 1990, that no state had ever revoked or suspended his medical license, and/or placed him on probation, when in fact the Respondent knew that the California BMQA had imposed the professional misconduct sanction set forth in paragraph B.

F. Although Respondent acknowledged in his application for appointment to the medical staff of Woodhull Medical and Mental Health Center dated April 10, 1991, that his license to practice medicine had been either revoked, suspended and/or reduced, he knowingly concealed and misrepresented both the reasons that he had been professionally disciplined in California and the sanction that the California BMQA imposed, in that:

1. Respondent represented in the application that he had been professionally disciplined in California because he negligently supervised a physician assistant who improperly dispensed controlled substances without his knowledge, when in fact Respondent knew that the California BMQA had found him guilty of professional misconduct for the reasons alleged in Paragraph A, including that the Respondent had authorized the physician's assistant to sign his name to prescriptions for controlled substances, that he had provided the physician's assistant with pre-signed prescriptions for controlled substances, and, further, that Respondent had personally prescribed controlled substances without indication.

2. The Respondent represented that the disciplinary proceeding in California resulted in his license being suspended for a period in 1987, when in fact the Respondent knew that the California BMQA sanction, as alleged in paragraph B, included a stayed revocation, one year actual suspension, and 10 years probation.

G. On or about April 1991, the federal Drug Enforcement Administration ("DEA") conducted an

investigation of the Respondent which was resolved by Respondent surrendering his DEA controlled substances certificate on April 28, 1991. On or about September 5, 1991, the Respondent reapplied to the Drug Enforcement Administration for a controlled substances certificate. Question 4b on the application asked the following: "Has the applicant ... ever surrendered or had a DEA registration revoked, suspended, or denied, or ever had a State professional license revoked, suspended, denied, restricted or placed on probation?" Respondent answered yes to the question and disclosed in a written explanation that he had been professionally disciplined in California. However, Respondent knowingly concealed the surrender of his Drug Enforcement Administration controlled substances certificate. Further, Respondent knowingly misrepresented both the reasons he had been professionally discliplined and the sanction imposed in the California disciplinary proceeding.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of

medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(3)(McKinney Supp. 1993), Petitioner charges that Respondent committed two or more acts of negligence, in that Petitioner charges:

1. The facts in Paragraph A.

SECOND SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence on a particular occasion within the meaning of N.Y. Educ. Law Section 6530(4), (McKinney Supp. 1993), in that Petitioner charges:

2. The facts in Paragraph A.

THIRD SPECIFICATION

AIDING AN UNLICENSED PERSON TO PRACTICE MEDICINE

The Respondent is charged with permitting, aiding and/or abetting an unlicensed person to perform activities requiring a license to practice medicine under N.Y. Educ. Law Section 6530(11)(McKinney Supp. 1993), in that Petitioner charges:

3. The facts in Paragraph A.

FOURTH SPECIFICATION

OUT-OF-STATE FINDING OF PROFESSIONAL MISCONDUCT

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(9)(b) (McKinney Supp. 1993), in that he has been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct resulting in the disciplinary action would, if committed in New York State, constitute professional misconduct under the laws of New York State, in that Petitioner charges:

4. The facts in Paragraph A and B.

FIFTH SPECIFICATION

OUT-OF-STATE DISCIPLINARY ACTION

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(9)(d) (McKinney Supp. 1993), in that he had disciplinary action taken against his license by a duly authorized professional disciplinary agency of another state, where the conduct resulting

in the disciplinary action would, if committed in New York State, constitute professional misconduct under the laws of New York State, in that Petitioner charges:

5. The facts in Paragraph A and B.

SIXTH THROUGH TENTH SPECIFICATIONS

FRAUD

Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law Sec. 6530(2) (McKinney Supp. 1993), in that Petitioner charges:

6. The facts in Paragraph C.

7. The facts in Paragraph D.

8. The facts in Paragraph E.

9. The facts in Paragraph F.

10. The facts in Paragraph G.

ELEVENTH THROUGH FIFTEENTH SPECIFICATIONS

FALSE REPORTS

Respondent is charged with professional misconduct pursuant to N.Y. Educ. Law Sec. 6530(21) (McKinney Supp. 1993), by willfully making or filing a false report, or inducing another person to do so, in that Petitioner charges:

11. The facts in Paragraph C.

12. The facts in Paragraph D.

13. The facts in Paragraph E.

14. The facts in Paragraph F.

15. The facts in Paragraph G.

DATED: New York, New York
February 18, 1993

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct