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

IN THE MATTER	: INTERIM REPORT
OF	: OF THE
DAVID CAVERT TINLING, M.D.	: HEARING COMMITTEE

TO: Mark R. Chassin, M.D., Commissioner
New York State Department of Health

RICHARD D. MILONE, M.D., Chairman, LEO FISHEL, JR., M.D. and GEORGE C. SIMMONS, Ed.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 Section 230(10)(e) of the Public Health Law. Michael P. McDermott, Esq., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

On December 10, 1993 the Hearing Committee considered the summary suspension of the Respondent by the Commissioner of Health. The Committee reviewed testimony and evidence presented by both the Office of Professional Medical Conduct and the Respondent with particular regard as to whether or not the Respondent's practice of medicine constitutes an imminent danger to the health of the people of the State of New York.

The Hearing Committee unanimously (3-0) determines that the Respondent's practice of medicine constitutes an imminent danger to the health of the people of the State of New York and recommends that the Commissioner's Summary Order continue in effect until a final decision has been rendered by the Committee or, if a review is sought, by the Administrative Review Board.

DATED: Albany, New York
December 14, 1993

RICHARD D. MILONE, M.D.
Chairperson

LEO FISHEL, JR., M.D.
GEORGE C. SIMMONS, Ed.D.

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

IN THE MATTER	:	COMMISSIONER'S
OF	:	ORDER AND
DAVID CALVERT TINLING, M.D.	:	NOTICE OF HEARING

TO: DAVID CALVERT TINLING, M.D.
86 Sibley Road
Honeoye Falls, New York 14472-9307

The undersigned, Mark R. Chassin, M.D., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a committee on professional medica conduct of the State Board for Professional Medical Condu and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by DAVID CALVERT TINLING, M.D., the Respondent, constitutes an imminent danger to the health of the people of this State.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993), that effective immediately DAVID CALVERT TINLING, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless

modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993), and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1993). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 13th day of August, 1993 at 10:00 a.m. in the forenoon at the Empire State Plaza, Corning Tower Building, Conference Room 1432, Albany, New York 12237 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in 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. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health

Hearing Rules is enclosed. Pursuant to Section 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.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), 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. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

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 or sanction 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 FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1993). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
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MARK R. CHASSIN, M.D.
Commissioner of Health

Inquiries should be directed to:
E. MARTA SACHEY
Associate Counsel
N.Y.S. Department of Health
Bureau of Professional Medical Conduct
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237-0032
(518) 474-8266

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

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IN THE MATTER : STATEMENT

OF : OF

DAVID CALVERT TINLING, M.D. : CHARGES

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DAVID CALVERT TINLING, M.D., the Respondent, was authorized to practice medicine in New York State on September 30, 1965, by the issuance of license number 095606 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 at 86 Sibley Road, Honeoye Falls, New York 14477-9307.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric care to Patient A [all patients are identified in Appendix I] at various times from approximately June 28, 1983 through at least approximately June 15, 1992 at Respondent's office at 86 Sibley Road, Honeoye Falls, New York [hereafter "office"] and by telephone. Respondent prescribed drugs [the chemical names and actions of drugs prescribed for patients are listed in Appendix II] for

Patient A and recorded Patient A's drug regimen in his office records, as specified in Appendix A.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient A, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient A when Respondent first began treating Patient A.

   b. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient A during the course of treatment.

   c. Respondent, during the approximate nine years he treated Patient A, failed to adequately explore other diagnostic and/or evaluative and/or treatment options for Patient A, including, without limitation, psychological testing and/or clinical consultation with another psychiatrist or a psychologist.

   d. Respondent, on numerous occasions, failed to adequately monitor and/or record patient A's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient A.

   e. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs, and/or the indications for changes in the doses or drugs prescribed.

   f. Respondent, on numerous occasions, failed to record adequate notes concerning Patient A's drug regimen, including the drugs Patient A was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

   g. Respondent failed to maintain adequate records for Patient A.

2. Respondent prescribed Cytomel, a synthetic thyroid hormone, for Patient A without first obtaining baseline thyroid function tests of Patient A.

3. Respondent placed Patient A at various times on doses of Cytomel in excess of 50 mcg daily and up to 150 mcg daily, which were excessive doses.

4. Respondent placed Patient A at various times on doses of Ritalin in excess of 80 mg daily and up to 120 mg daily, which were excessive doses.

5. Respondent failed to monitor Patient A's blood pressure when he placed Patient A on Ritalin and/or Dexedrine despite Patient A's history of suffering an intracranial hemorrhage in July 1986, while on the drug Parnate.

6. Respondent placed Patient A on Prozac 80 mg daily on October 31, 1990 when Patient A was also on Ritalin 80mg daily, which combination was contraindicated.

B. Respondent provided psychiatric care to Patient B at various times from approximately January 3, 1984 through at least January 28, 1993 at his office and by telephone. Respondent prescribed drugs for Patient B and recorded Patient B's drug regimen in his office records, as specified in Appendix B.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient B, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient B when Respondent first began treating Patient B.

   b. Respondent failed to periodically obtain and/or record adequate mental status evaluations of Patient B during the course of treatment.

   c. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient B's

response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient B.

d. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs, and/or the indications for changes in the doses or drugs prescribed.

e. Respondent, on numerous occasions, failed to record adequate notes concerning Patient B's drug regimen, including the drugs Patient B was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

f. Respondent failed to maintain adequate records for Patient B.

2. Respondent prescribed Cytomel, a synthetic thyroid hormone, for Patient B without first obtaining baseline thyroid function tests of Patient B.

3. Respondent placed Patient B at various times on doses of Cytomel in excess of 100 mcg daily and up to 200 mcg daily, which were excessive doses.

4. Respondent placed Patient B on Cytomel without adequately monitoring Patient B's thyroid status.

5. Respondent prescribed Premarin for Patient B at various times without first obtaining gynecological consultation to exclude any contraindication.

6. Respondent failed to obtain a Lithium work-up before placing Patient B on Lithium and/or failed to periodically monitor Patient B's serum Lithium levels while she was on the drug.

7. Respondent placed Patient B at various times on 120 mg of Ritalin daily, which was an excessive dose.

8. Respondent, on January 16, 1992, placed Patient B on Prozac 40 mg daily and Wellbutrin 400 mg daily, which combination was not indicated and/or contraindicated.

9. Respondent, on September 22, 1992, placed Patient B on Cytomel 200 mcg daily while Patient B was also on Ritalin 120 mg daily, which combination was not indicated and/or contraindicated.

10. Respondent at various times, including April 17, 1991 and January 16, 1992, placed Patient B on Ritalin 120 mg daily with Prozac 40 mg or more daily, which combination was not indicated and/or contraindicated.

11. Respondent at various times, including January 16, 1992, placed Patient B on Ritalin 120 mg daily with Prozac 40 mg daily with Cytomel 150 mg daily, which combination was not indicated and/or contraindicated.

12. Respondent at various times, including January 16, 1992, placed Patient B on Ritalin 120 mg daily with Prozac 40 mg daily, and with Wellbutrin 400 mg daily, which was not indicated and/or contraindicated.

13. Respondent, in March, 1987, placed Patient B on Nardil 135 mg daily with Elavil 200 mg daily which combination was not indicated and/or contraindicated.

14. Respondent, on May 17, 1985, placed Patient B on Reserpine, when Patient B had reported on May 8, 1985 that she had been suicidal, which was not indicated and/or contraindicated.

15. Respondent placed Patient B on Chloral Hydrate over an excessive period of time.

C. Respondent provided psychiatric care to Patient C at various times from approximately May 18, 1976 through approximately June, 1979 at Strong Memorial Hospital, Rochester, New York [hereafter "Strong Memorial Hospital"] and from approximately July, 1979 through at least approximately February 4, 1993 at his office and by telephone. Respondent prescribed drugs for Patient C and recorded Patient C's drug regimen in his office records, as specified in Appendix C.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient C, failed to do the following:

a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient C when Respondent first began treating Patient C.

b. Respondent failed to obtain and/or record adequate mental status evaluations of Patient C during the course of treatment.

c. Respondent, during the approximate seventeen years he treated Patient C, failed to adequately explore other diagnostic and/or evaluative and/or treatment options for Patient C including, without limitation, psychological testing and/or clinical consultation with another psychiatrist or a psychologist.

d. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient C's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient C.

e. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs and/or the indications for changes in the doses or drugs prescribed.

f. Respondent, on numerous occasions, failed to record adequate notes concerning Patient C's drug regimen, including the drugs Patient C was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

g. Respondent failed to maintain adequate records for Patient C.

2. Respondent placed Patient C at various times on doses of Parnate in excess of 60 mg daily, which were excessive doses.

3. Respondent, on April 23, 1992, directed Patient C to increase his dose of Elavil as needed, which was not indicated.

4. Respondent directed Patient C, on June 25, 1992 to increase his dose of Parnate up to 70 mg daily and on July 7, 1992 to 80 mg daily, despite Respondent also directing Patient C on April 23, 1992 to increase his

dose of Elavil as needed, which combination was not indicated and/or contraindicated.

D. Respondent provided psychiatric care to Patient D at various times from approximately March 22, 1988 through at least approximately February 3, 1993 at his office and by telephone. Respondent prescribed drugs for Patient D and recorded Patient D's drug regimen in his office records, as specified in Appendix D.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient D, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient D when Respondent first began treating Patient D.

   b. Respondent failed to periodically obtain and/or record adequate mental status evaluations of Patient D during the course of treatment.

   c. Respondent, during the approximate five years he treated Patient D, failed to adequately explore other diagnostic and/or evaluative and/or treatment options for Patient D, including, without limitation, psychological testing and/or clinical consultation with another psychiatrist or a psychologist.

   d. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient D's response to pharmacotherapy and/or psycotherapy and/or record adequate progress notes of his sessions with Patient D.

   e. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs, and/or the indications for changes in the doses or drugs prescribed.

f. Respondent, on numerous occasions, failed to record adequate notes concerning Patient D's drug regimen, including the drugs Patient D was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

g. Respondent failed to maintain adequate records for Patient D.

2. Respondent failed to obtain a Lithium work-up before placing Patient D on Lithium and/or failed to periodically monitor Patient D's serum Lithium levels while he was on the drug.

3. Respondent, on April 12, 1988, placed Patient B on Lithium, Prozac and L-Tryptophan, which combination was not indicated and/or contraindicated.

4. Respondent placed Patient D on Ritalin, despite Respondent's assessment that Patient D's normal state was suggestive of hypomania, which was not indicated and/or contraindicated.

5. Respondent placed Patient D at various times on doses of Ritalin in excess of 80 mg daily and up to 120 mg daily, which were excessive doses.

6. Respondent placed Patient D on 80 mg. of Prozac daily on September 15, 1990 and/or 900 mg of Lithium daily on October 2, 1990 when Patient D was also on 120 mg of Ritalin daily, which combination was not indicated and/or contraindicated.

E. Respondent provided psychiatric care to Patient E at various times from approximately June 2, 1970 through approximately June, 1979 at Strong Memorial Hospital and from approximately, July, 1979 through at least approximately January 13, 1993 at Respondent's office and by telephone. Respondent prescribed drugs for Patient E and recorded Patient E's drug regimen in his office records, as specified in Appendix E.

1. Respondent, with regard to the evaluation, treatment, and/or maintenance of records of Patient E, insofar as they occurred on or after September 1, 1973, failed to do the following:

   a. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient E during the course of treatment and/or after the gaps in Respondent's treatment and/or records of that treatment between November 15, 1976 or November 2, 1979 and August 2, 1982 and/or between August 20, 1982 and January 4, 1983 and/or between January 4, 1983 and April 23, 1985 and/or between July 29, 1986 and January 6, 1988 and/or between January 6, 1988 and February 14, 1989 and/or between February 14, 1989 and June 14, 1989.

   b. Respondent, during the approximate last twenty years he treated Patient E, failed to adequately explore other diagnostic and/or evaluative and/or treatment options for Patient E, including, without limitation, psychological testing and/or clinical consultation with another psychiatrist or a psychologist.

   c. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient E's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient E.

   d. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for those drugs and/or the indications for changes in the doses or drugs prescribed.

   e. Respondent, on numerous occasions, failed to record adequate notes concerning Patient E's drug regimen, including the drugs Patient E was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

   f. Respondent failed to maintain adequate records for Patient E.

2. Respondent prescribed Cytomel, a synthetic thyroid hormone, for Patient E without first obtaining baseline thyroid function tests of Patient E.

3. Respondent placed Patient E at various times on doses of Cytomel of 75 mcg daily and up to 100 mcg daily, which were excessive doses.

4. Respondent placed Patient E at various times on doses of Ritalin in excess of 80 mg daily and up to 100 mg daily, which were excessive doses.

5. Respondent placed Patient E in July and August of 1989 variously on 40 mg up to 120 mg of Ritalin daily when Patient E was also on 75 mcg of Cytomel daily, which combination was not indicated and/or contraindicated.

6. Respondent placed Patient E on May 4, 1992 on 100 mcg of Cytomel daily when Patient E was also on 90 mg of Nardil daily despite Patient E's history of bipolar depression, which combination was not indicated.

7. Respondent, on August 20, 1982, sent a prescription for Desyrel for Patient E, although Respondent had not seen Patient E in a treatment session since November 15, 1976 or November 2, 1979 and/or kept no records of any such sessions.

8. Respondent, on January 6, 1988, refilled prescriptions for Cytomel and Desipramine for Patient E although Respondent had not seen Patient E in a treatment session since 1986 and/or kept no records of any such sessions.

9. Respondent, on February 14, 1989, refilled prescriptions for Cytomel and Desipramine for Patient E although Respondent had not seen Patient E in a treatment session since 1986 or January 6, 1988 and/or kept no records of any such sessions.

F. Respondent provided psychiatric care to Patient F at various times from approximately August 1, 1989 through approximately October 15, 1989 at his office and by telephone. Respondent prescribed drugs for Patient F and recorded Patient F's drug regimen in his office records, as specified in Appendix F.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient F, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient F when Respondent first began treating Patient F.

   b. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient F's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient F.

   c. Respondent failed to maintain adequate records for Patient F.

2. Respondent treated Patient F's complaints of migraine headaches with Percocet, which was not indicated.

3. Respondent failed to obtain a neurological evaluation of Patient F's complaints of migraine headaches.

4. Respondent issued prescriptions for Dexedrine and/or Percocet for Patient F after November 2, 1989 and/or after November 15, 1989 and/or on December 27, 1989 and/or on January 1, 1990 when Respondent knew or should have known that Patient F was seeking drugs for abuse.

G. Respondent provided psychiatric care to Patient G at various times from approximately May 4, 1983 through at least approximately February 3, 1993 at his office and by telephone. Respondent prescribed drugs for Patient G and recorded Patient G's drug regimen in his office records, as specified in Appendix G.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient G, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation

of Patient G when Respondent first began treating Patient G.

b. Respondent failed to periodically obtain and/or record adequate mental status evaluations of Patient G during the course of treatment.

c. Respondent, during the approximate ten years he treated Patient G, failed to adequately explore other diagnostic and/or evaluative and/or treatment options for Patient G, including, without limitation, psychological testing and/or clinical consultation with another psychiatrist or a psychologist.

d. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient G's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient G.

e. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for those drugs, and/or the indications for changes in the doses or drugs prescribed.

f. Respondent, on numerous occasions, failed to record adequate notes concerning Patient G's drug regimen, including the drugs Patient G was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

g. Respondent failed to maintain adequate records for Patient G.

2. Respondent placed Patient G on Ritalin, which was not indicated.

3. Respondent placed Patient G at various times on doses of Ritalin in excess of 80 mg daily up to 120 mg daily, which were excessive doses.

4. Respondent placed Patient G on Asendin when Patient G was also on Ritalin, which combination was not indicated and/or contraindicated.

5. Respondent, on November 17, 1983, directed Patient G to increase his dose of Desyrel to 700mg for three days, then to 800mg for three days, and then to

decrease his dose to 300mg if no better, which directions were not indicated.

6. Respondent, on October 8, 1991, directed Patient G to use Ritalin "for special events", which was not indicated.

7. Respondent failed to adequately treat Patient G with psychotherapy and/or provide a trial of such treatment without pharmacotherapy.

H. Respondent provided psychiatric and/or pain management care to Patient H at various times from approximately April 4, 1988 through at least approximately February 3, 1993 at his office and by telephone. Respondent prescribed drugs for Patient H and recorded Patient H's drug regimen in his office records, as specified in Appendix H.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient H, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient H when Respondent first began treating Patient H.

   b. Respondent failed to periodically obtain and/or record adequate mental status evaluations of Patient H during the course of treatment.

   c. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient H's response to pharmacotherapy and/or psychothearpy and/or record adequate progress notes of his sessions with Patient H.

   d. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs and/or the indications for changes in the doses or drugs prescribed.

e. Respondent, on numerous occasions, failed to record adequate notes concerning Patient H's drug regimen, including the drugs Patient H was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

f. Respondent failed to maintain adequate records for Patient H.

2. Respondent placed Patient H on Klonopin and Valium, both benzodiazepines, at the same time, which combination was not indicated.

3. Respondent placed Patient H on Demerol and Percocet, both opioid analgesics, at the same time, which combination was not indicated.

4. Respondent, in August, 1989, variously changed Patient H's doses of Elavil and Imipramine, which changes were not indicated.

5. Respondent prescribed Demerol and/or Percocet for Patient H over an excessive period of time, which was not indicated and/or contraindicated.

6. Respondent failed to refer Patient H to and/or obtain a consultation from a pain clinic in a timely manner.

I. Respondent provided psychiatric care to Patient I at various times from approximately August 14, 1980 through at least approximately November 18, 1992 at Respondent's office and by telephone. Respondent prescribed drugs for Patient I and recorded Patient I's drug regimen in his office records, as specified in Appendix I.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient I, failed to do the following:

a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation

of Patient I when Respondent first began treating Patient I.

b. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient I during the course of treatment and/or after gaps in Respondent's treatment and/or records of that treatment between January 23, 1985 and July 23, 1985 and/or April 15, 1986 and October 1, 1986 and/or October 1, 1986 and January 26, 1988 and/or June 25, 1991 and March 29, 1992.

c. Respondent, during the approximate twelve years he treated Patient I, failed to adequately explore other diagnostic and/or evaluative and/or treatment options for Patient I including, without limitation, psychological testing and/or clinical consultation with another psychiatrist or a psychologist.

d. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient I's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient I.

e. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs, and/or the indications for changes in the doses or drugs prescribed.

f. Respondent, on numerous occasions, failed to record adequate notes concerning Patient I's drug regimen, including the drugs Patient I was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

g. Respondent failed to maintain adequate records for Patient I.

2. Respondent prescribed Cytomel, a synthetic thyroid hormone, for Patient I, without first obtaining baseline thyroid function tests of Patient I.

3. Respondent failed to obtain a Lithium work-up before placing Patient I on Lithium and/or failed to adequately periodically monitor Patient I's serum Lithium levels while he was on the drug.

4. Respondent, on January 26, 1988, placed Patient I on Fluoxetine, although Respondent had not seen Patient I in a treatment session since approximately April 15, 1986 and/or had kept no records of any such sessions.

5. Respondent, on October 10, 1992, placed Patient I on Zoloft, although Respondent had not seen Patient I in a treatment session since at least approximately March 29, 1992 and/or had kept no records of any such sessions.

6. Respondent placed Patient I on Ritalin, despite Patient I's history of mood swings, which was not indicated and/or contraindicated.

7. Respondent variously diagnosed and/or evaluated Patient I's condition as "hyperactive kid and adult" (October 1, 1986) and/or as hypomanic (January 25, 1990) and/or as "also some evidence of Attention Deficit Disorder" (June 22, 1992) without adequate evaluation and/or adequate bases for such conclusions and/or without recording such evaluations or bases.

8. Respondent, on February 23, 1983, placed Patient I on Tegretol, which was not indicated.

9. Respondent failed to adequately follow-up on Patient I's communication on November 11, 1992 to Respondent that Patient I was diagnosed as having Diabetes Mellitus and had a blood sugar of 400 and/or record such follow-up.

10. Respondent placed Patient I at various times on doses of Parnate in excess of 60 mg daily and up to 90 mg daily, which were excessive doses.

J. Respondent provided psychiatric care to Patient J at various times from approximately September 19, 1989 through September 6, 1990 at his office and by telephone. Respondent prescribed drugs for Patient J and recorded Patient J's drug regimen in his office records, as specified in Appendix J.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient J, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient J when Respondent first began treating Patient J.

   b. Respondent failed to periodically obtain and/or record adequate mental status evaluations of Patient J during the course of treatment.

   c. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient J's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient J.

   d. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs, and/or the indications for changes in the doses or drugs prescribed.

   e. Respondent, on numerous occasions, failed to record adequate notes concerning Patient J's drug regimen, including the drugs Patient J was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

   f. Respondent failed to maintain adequate records for Patient J.

2. Respondent failed to obtain a Lithium work-up before placing Patient J on Lithium.

3. Respondent prescribed Cytomel, a synthetic thyroid hormone, for Patient J without first obtaining baseline thyroid function tests of Patient J.

4. Respondent placed Patient J on Cytomel on October 24, 1989 although Patient J had been on the usual therapeutic doses of Imipramine only since October 3, 1989, which was premature and not indicated.

5. Respondent, on October 3, 1989, directed Patient J to increase his daily Imipramine dose from 175 mg to 225 mg and/or on October 10, 1989 to continue to increase his dose from 225 mg to 300 mg, which increases were premature and not indicated.

6. Respondent, during November, 1989, placed Patient J on Prozac while Patient A was also on daily doses of at least 100mg of Imipramine, which combination was not indicated and/or contraindicated.

7. Respondent at various times placed Patient J on 100 mg of Prozac daily, which was an excessive dose.

8. Respondent on February 20, 1990, placed Patient J on Elavil 25 mg daily when Patient J was also on Imipramine 150 daily and Prozac 80 mg daily, which combination was not indicated.

9. Respondent prescribed Dalmane for Patient J at a time when Patient J was also on Imipramine and/or Elavil and was reporting drinking episodes to Respondent, which was not indicated and/or contraindicated.

10. Respondent refused to speak with Patient J's mother regarding the mother's concerns about Patient J.

K. Respondent provided psychiatric care to Patient K at various times from approximately December 13, 1977 through approximately June, 1979 at Strong Memorial Hospital and from approximately July, 1979 through at least approximately February 10, 1993 at his office and by telephone. Respondent prescribed drugs for Patient K and recorded Patient K's drug regimen in his office records, as specified in Appendix K.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient K, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and or mental status evaluation of Patient K when Respondent first began treating Patient K.

   b. Respondent failed to periodically obtain and/or record adequate mental status evaluations of Patient K during the course of treatment.

c. Respondent, during the approximate fifteen years he treated Patient K, failed to adequately explore other diagnostic and/or evaluative and/or treatment options for Patient K including, without limitation, psychological testing, and/or clinical consultation with another psychiatrist or a psychologist.

d. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient K's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient K.

e. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs, and/or the indications for changes in the doses or drugs prescribed.

f. Respondent, on numerous occasions, failed to record adequate notes concerning Patient K's drug regimen, including the drugs Patient K was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

g. Respondent failed to maintain adequate records for Patient K.

2. Respondent placed Patient K on Chloral Hydrate over excessive periods of time.

3. Respondent continued to prescribe Dexedrine for Patient K at various times after January 17, 1980 and throughout at least February 10, 1993, when Respondent knew or should have known that Patient K was abusing the drug and/or addicted to it, which was not indicated and/or contraindicated.

4. Respondent issued prescriptions for excessive amounts of Dexedrine for Patient K and/or in amounts which exceeded Respondent's instructions for use of the drug and/or over excessive periods of time, which were not indicated and/or contraindicated.

5. Respondent placed Patient K on Dexedrine despite Patient K's history of seizures, which was not indicated and/or contraindicated.

6. Respondent failed to obtain a Lithium work-up before placing Patient K on Lithium.

7. Respondent prescribed Cytomel, a synthetic thyroid hormone, for Patient K without first obtaining baseline thyroid function tests of Patient K.

8. Respondent placed Patient K at various times on doses of Cytomel of 62.5 mcg daily up to 150 mcg daily, which were excessive doses.

9. Respondent, on April 26, 1990, placed Patient K on Cytomel 150 mcg daily, Dexedrine 20 mg daily, and Prozac 40 mg daily, which combination was not indicated and/or contraindicated.

10. Respondent, on September 5, 1978, January 24, 1991, and May 29, 1993, placed Patient K on Valium, which was not indicated.

11. Respondent, on February 21, 1985 to approximately October 17, 1985, on January 26, 1986 to approximately February 19, 1986, on October 7, 1986 to approximately May 26, 1987 placed Patient K on Vivactil and Aventyl, both tricyclic antidepressants, which combination was not indicated.

12. Respondent, on approximately May 25, 1990, placed Patient K on Valium and Chloral Hydrate at the same time Patient K was on Cytomel and Dexedrine, which was not indicated and/or contraindicated.

13. Respondent, by February 6, 1986, had placed Patient K on and/or had given Patient K the means to be on and/or had failed to adequately monitor Patient K's drug regimen of, at the same time, five antidepressants, Merital, Desipramine, Vivactil, Aventyl and Desyrel and also Dexedrine, which was not indicated and/or contraindicated.

14. Respondent, in June, 1990, prescribed Dexedrine for Patient K, who reported to Respondent that he needed Dexedrine "to counter" Prozac, which was not indicated.

15. Respondent failed to adequately evaluate Patient K's report of June 18, 1992 that he was "off and on suicidal" and/or record such evaluation.

L. Respondent provided psychiatric care to Patient L at various times from approximately January 19, 1988 through February 1, 1988 at his office, by telephone and through a

psychologist Patient L also was seeing. Respondent prescribed drugs for Patient L and recorded Patient L's drug regimen in his office records, as specified in Appendix L.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient L, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient L when Respondent first began treating Patient L.

   b. Respondent failed to maintain adequate records for Patient L.

2. Respondent placed Patient L on Desipramine, which was not indicated.

3. Respondent, at various times, directed changes in Patient L's drug dosages through the psychologist Patient L was seeing and without seeing Patient L himself, which was not indicated.

4. Respondent, on March 1, 1988, suggested to Patient L that she increase her dose of Desipramine to 225 mg daily, which was not indicated.

5. Respondent, on March 1, 1988, suggested to Patient L that she increase her dose of Desipramine to 250 mg "prn" or as needed, which was not indicated.

M. Respondent provided psychiatric care to Patient M at various times from approximately 1984 through approximately January, 1991 at his office, by telephone and through Patient M's parents. Respondent prescribed drugs for Patient M and recorded Patient M's drug regimen in his office records, as specified in Appendix M.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient M, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation of Patient M when Respondent began treating Patient M in 1988.

   b. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient M during the course of treatment and/or after the gap in Respondent's treatment and/or records of that treatment between December 5, 1988 and August 7, 1990.

   c. Respondent, on numerous occasions, failed to adequately monitor and/or record Patient M's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his sessions with Patient M.

   d. Respondent, on numerous occasions, failed to record adequate notes concerning the drugs he prescribed and/or the indications for such drugs and/or the indications for changes in the doses or drugs prescribed.

   e. Respondent, on numerous occasions, failed to record adequate notes concerning Patient M's drug regimen, including the drugs Patient M was on at any given time and/or when such drugs were discontinued and/or the doses of such drugs and/or the instructions for use of such drugs.

   f. Respondent failed to maintain daily note records for Patient M.

2. Respondent, on January 11, 1984, prescribed Xanax for Patient M through Patient M's father and without having seen Patient M, which was not indicated.

3. Respondent, on August 7, 1990, changed Patient M's drug regimen in a telephone call with Patient M, despite Respondent not having seen Patient M in a treatment session since December 5, 1988.

4. Respondent failed to adequately address Patient M's use of cocaine, as reported to Respondent by Patient M on August 7, 1990 and August 9, 1990.

5. Respondent, on August 9, 1990, placed Patient M on Desipramine and/or Valium, which was not indicated and/or without adequate evaluation of Patient M's mental status.

6. Respondent placed Patient M on Ritalin, which was not indicated and/or contraindicated.

7. Respondent prescribed Cytomel, a synthetic thyroid hormone, for Patient M without first obtaining baseline thyroid function tests of Patient M.

8. Respondent, on November 7, 1990, directed Patient M to increase his dose of Cytomel to 200 mcg daily, which was an excessive dose.

9. Respondent noted on November 7, 1990 that Patient M "has been hypothyroid", without an adequate basis and/or without adequate evaluation of that condition, and/or without recording such basis or evaluation.

10. Respondent failed to obtain a Lithium work-up before placing Patient M on Lithium.

11. Respondent, without Patient M's consent, in a letter dated May 21, 1991 to a collection agency which was handling Respondent's account for money owed to him by Patient M, revealed information Respondent obtained in a professional capacity concerning Patient M.

N. Respondent, by Order dated October 15, 1992 pursuant to a Stipulation entered into by Respondent and the New York State Department of Health, was found by the Commissioner of Health to be in violation of Article Thirty-Three of the Public Health Law. Specifically:

1. Respondent issued prescriptions for controlled substances to Patient A (Dexedrine 10 mg; Ritalin 20 mg), Patient F (Dexedrine 5mg), Patient H (Demerol 50 mg; Valium 10 mg), and Patient K (Dexedrine 5 mg, Dexedrine 15 mg) which provided supplies of the prescribed drugs which exceeded thirty day supplies if the drugs were used in accordance with the directions specified on the prescriptions and prior

to the exhaustion of all but seven day supplies of the drugs in violation of Public Health Law §§3304(1), 3332(3) and 10 NYCRR §80.67(c).

2. Respondent issued prescriptions for the controlled substance Klonopin .5 mg to Patient H which provided a supply of the drug which exceeded a three month supply if the drug was used in accordance with the directions specified in the prescriptions and prior to the exhaustion of all but a seven day supply of the drug in violation of Public Health Law §§3304(1), 3332(3) and 10 NYCRR §8067.

3. Respondent, on numerous occasions during the period of January, 1989 through May, 1991, failed to include notations in the medical records of Patient A, Patient F, Patient H, and Patient K concerning the amounts, strengths, and directions for use of the controlled substances Respondent prescribed and entries indicating Respondent's prescriptions of controlled substances to these patients in violation of 10 NYCRR §80.62(b).

SPECIFICATION OF CHARGES

FIRST THROUGH ELEVENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

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

1. The facts in Paragraphs A and A.2 and/or A and A.3.

2. The facts in Paragraphs B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.11, B and B.12 and/or B and B.14.

3. The facts in Paragraphs D and D.2 and/or D and D.6.

4. The facts in Paragraphs E and E.2, E and E.3, E and E.4, E and E.5, E and E.8 and/or E and E.9.

5. The facts in Paragraphs F and F.4.

6. The facts in Paragraphs G and G.4.

7. The facts in Paragraphs H and H.5 and/or H and H.6.

8. The facts in Paragraphs I and I.2, I and I.3, I and I.4, I and I.5 and/or I and I.6.

9. The facts in Paragraphs J and J.2, J and J.3 and/or J and J.9.

10. The facts in Paragraphs K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.12, K and K.13 and/or K and K.14.

11. The facts in Paragraphs M and M.2, M and M.3, M and M.4, M and M.6, M and M.7, M and M.8, M and M.9 and/or M and M.10.

TWELFTH THROUGH TWENTY-SECOND SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) (McKinney Supp. 1993) by reason of his practicing the profession of medicine with gross incompetence, in that Petitioner charges:

12. The facts in Paragraphs A and A.2 and/or A and A.3.

13. The facts in Paragraphs B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.11, B and B.12 and/or B and B.14.

14. The facts in Paragraphs D and D.2 and/or D and D.6.

15. The facts in Paragraphs E and E.2, E and E.3, E and E.4, E and E.5, E and E.8 and/or E and E.9.

16. The facts in Paragraphs F and F.4.

17. The facts in Paragraphs G and G.4.

18. The facts in Paragraphs H and H.5 and/or H and H.6.

19. The facts in Paragraphs I and I.2, I and I.3, I and I.4, I and I.5 and/or I and I.6.

20. The facts in Paragraphs J and J.2, J and J.3 and/or J and J.9.

21. The facts in Paragraphs K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.12, K and K.13 and/or K and K.14.

22. The facts in Paragraphs M and M.2, M and M.3, M and M.4, M and M.6, M and M.7, M and M.8, M and M.9 and/or M and M.10.

TWENTY-THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE
ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) (McKinney Supp. 1993) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

23. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d, A and A.1.e, A and A.4.f, A and A.1.g, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1.a, B and B.1.b, B and B.1.c, B and B.1.d, B and B.1.e, B and B.1.f, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, B and B.13, B and B.14, B and B.15, C and C.1.a, C and C.1.b, C and C.1.c, C and C.1.d, C and C.1.e, C and C.1.f, C and C.1.g, C and C.2, C and C.3, C and C.4, D and D.1.a, D and D.1.b, D and D.1.c, D and D.1.d, D and D.1.e, D and D.1.f, D and D.1.g, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, E and E.1.a, E and E.1.b, E and E.1.c, E and E.1.d, E and E.1.e, E and E.1.f, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, F and

F.1.a, F and F.1.b, F and F.1.c, F and F.2, F and F.3, F and F.4, G and G.1.a, G and G.1.b, G and G.1.c, G and G.1.d, G and G.1.e, G and G.1.f, G and G.1.g, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, H and H.1.a, H and H.1.b, H and H.1.c, H and H.1.d, H and H.1.e, H and H.1.f, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, I and I.1.a, I and I.b, I and I.c, I and I.d, I and I.e, I and I.f, I and I.g, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, I and I.9, I and I.10, J and J.1.a, J and J.1.b, J and J.1.c, J and J.1.d, J and J.1.e, J and J.1.f, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8, J and J.9, J and J.10, K and K.1.a, K and K.1.b, K and K.1.c, K and K.1.d, K and K.1.e, K and K.1.f, K and K.1.g, K and K.2, K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.10, K and K.11, K and K.12, K and K.13, K and K.14, K and K.15, L and L.1.a, L and L.1.b, L and L.2, L and L.3, L and L.4, L and L.5, M and M.1.a, M and M.1.b, M and M.1.c, M and M.1.d, M and M.1.e, M and M.1.f, M and M.2, M and M.3, M and M.4, M and M.5, M and M.6, M and M.7, M and M.8, M and M.9, M and M.10, and/or M and M.11.

TWENTY-FOURTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5) (McKinney Supp. 1993) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following.

24. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d, A and A.1.e, A and A.4.f, A and A.1.g, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1.a, B and B.1.b, B and B.1.c, B and B.1.d, B and B.1.e, B and B.1.f, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, B and B.13, B and B.14, B and B.15, C and C.1.a, C and

C.1.b, C and C.1.c, C and C.1.d, C and C.1.e, C and C.1.f, C and C.1.g, C and C.2, C and C.3, C and C.4, D and D.1.a, D and D.1.b, D and D.1.c, D and D.1.d, D and D.1.e, D and D.1.f, D and D.1.g, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, E and E.1.a, E and E.1.b, E and E.1.c, E and E.1.d, E and E.1.e, E and E.1.f, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, F and F.1.a, F and F.1.b, F and F.1.c, F and F.2, F and F.3, F and F.4, G and G.1.a, G and G.1.b, G and G.1.c, G and G.1.d, G and G.1.e, G and G.1.f, G and G.1.g, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, H and H.1.a, H and H.1.b, H and H.1.c, H and H.1.d, H and H.1.e, H and H.1.f, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, I and I.1.a, I and I.b, I and I.c, I and I.d, I and I.e, I and I.f, I and I.g, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, I and I.9, I and I.10, J and J.1.a, J and J.1.b, J and J.1.c, J and J.1.d, J and J.1.e, J and J.1.f, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8, J and J.9, J and J.10, K and K.1.a, K and K.1.b, K and K.1.c, K and K.1.d, K and K.1.e, K and K.1.f, K and K.1.g, K and K.2, K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.10, K and K.11, K and K.12, K and K.13, K and K.14, K and K.15, L and L.1.a, L and L.1.b, L and L.2, L and L.3, L and L.4, L and L.5, M and M.1.a, M and M.1.b, M and M.1.c, M and M.1.d, M and M.1.e, M and M.1.f, M and M.2, M and M.3, M and M.4, M and M.5, M and M.6, M and M.7, M and M.8, M and M.9, M and M.10, and/or M and M.11.

TWENTY-FIFTH THROUGH THIRTY-SEVENTH SPECIFICATIONS

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1993) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

25. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.d, A and A.1.e, A and A.1.f, A and A.1.g, and/or N and N.3.

26. The facts in Paragraphs B and B.1.a, B and B.1.b, B and B.1.c, B and B.1.d, B and B.1.e, and/or B and B.1.f.

27. The facts in Paragraphs C and C.1.a, C and C.1.b, C and C.1.d, C and C.1.e, C and C.1.f and/or C and C.1.g.

28. The facts in Paragraphs D and D.1.a, D and D.1.b, D and D.1.d, D and D.1.e, D and D.1.f and/or D and D.1.g.

29. The facts in Paragraphs E and E.1.a, E and E.1.c, E and E.1.d, E and E.1.e, E and E.1.f, E and E.7, E and E.8 and/or E and E.9.

30. The facts in Paragraphs F and F.1., F and F.1.b, F and F.1.c and/or N and N.3.

31. The facts in Paragraphs G and G.1.a, G and G.1.b, G and G.1.d, G and G.1.e, G and G.1.f and/or G and G.1.g.

32. The facts in Paragraphs H and H.1.a, H and H.1.b, H and H.1.c, H and H.1.d, H and H.1.e, H and H.1.f and/or N and N.3.

33. The facts in Paragraphs I and I.1.a, I and I.1.b, I and I.1.d, I and I.1.e, I and I.1.f, I and I.1.g, I and I.4, I and I.5, I and I.1.7 and/or I and I.9.

34. The facts in Paragraphs J and J.1.a, J and J.1.b, J and J.1.c, J and J.1.d, J and J.1.e and/or J and J.1.f.

35. The facts in Paragraphs K and K.1.a, K and K.1.b, K and K.1.d, K and K.1.e, K and K.1.f, K and K.1.g, K and K.15 and/or N and N.3.

36. The facts in Paragraphs L.1 and/or L and L.1.b.

37. The facts in Paragraphs M and M.1.a, M and M.1.b, M and M.1.c., M and M.1.d, M and M.1.e, M and M.1.f and/or M and M.9.

THIRTY EIGHTH SPECIFICATION

REVEALING INFORMATION OBTAINED IN PROFESSIONAL CAPACITY

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(23) (McKinney Supp. 1993) by reason of his revealing information obtained in a professional capacity without the prior consent of the patient, in that Petitioner charges:

38. The facts in Paragraphs M and M.11.

THIRTY NINTH SPECIFICATION

Respondent is charged with professional misconduct under N.Y. Education Law §6530(9)(e) (McKinney Supp. 1993) by reason of his having been found by the Commissioner of Health to be in violation of Article Thirty-Three of the Public Health Law, in that Petitioner charges:

39. The facts in Paragraphs N and N.1, N.2 and N.3.

DATED: New York, New York
July 14, 1993

CHRIS STERN HYMAN
Chief Counsel
Bureau of Professional Medical
Conduct

APPENDIX II

DRUG	CHEMICAL NAME	ACTION
AMITRIPTYLINE	amitriptyline HCL	tricyclic antidepressant
ANTABUSE	disulfiram	alcohol-abuse deterrent
ASENDIN	amoxapine	tricyclic antidepressant
ATIVAN	lorazepam [benzodiazepine]	antianxiety
AVENTYL	nortriptyline	tricyclic antidepressant
BENTYL	dicyclomine HCL	anticholinergic/ antispasmodic
BUSPAR	buspirone HCL	antianxiety
CHLORAL HYDRATE	chloral hydrate	sedative/hypnotic
CYTOMEL	liothyronine sodium	thyroid hormone
DALMANE	flurazepam HCL [benzodiazepine]	hypnotic
DARVON	propoxyphene HCL [opioid derivative]	analgesic
DEMEROL	meperidine HCL	narcotic analgesic (sedative properties)
DESIPRAMINE	desipramine HCL	tricyclic antidepressant
DESYREL	trazodone HCL	antidepressant
DEXEDRINE	dextroamphetamine sulfate	stimulant (anorectic properties)
DOXEPIN	doxepin HCL	tricyclic antidepressant
ELAVIL	amitriptyline HCL	tricyclic

		antidepressant
ERGOSTAT	ergotamine tartrate	vasoconstrictor
ESTROGEN	estrogen	sex hormone
EUTONYL	pargyline HCL	antihypertensive
FENFLURAMINE	fenfluramine HCL	anorectic/serotonin depleter
FLORINEF	fludrocortisone acetate	adrenal cortical steroid
FLUOXETINE	fluoxetine HCL	antidepressant/ serotonin re-uptake inhibitor
HALCION	triazolam	sedative/hypnotic
HYDROCORTISONE	hydrocortisone	steroid hormone
HYDRODIURIL	hydrochlorothiazide	diuretic/ antihypertensive
IMIPRAMINE	impramine HCL	tricyclic antidepressant
INDERAL	propranolol HCL	antihypertensive
KLONOPIN	clonazepam [benzodiazepine]	antiseizure/ antianxiety
LASIX	furosemide	diuretic
LIBRIUM	chlordiazepoxide HCL [benzodiazepine]	antianxiety (sedative properties)
LITHIUM	lithium carbonate	antimanic/ antidepressant
LITHOBID	lithium carbonate	antimanic/ antidepressant
L-PHENYLALANINE	l-phenylalanine	amino acid/ neurotransmitter precursor
L-TRYPTOPHAN	l-tryptophan	
LUDIOMIL	maprotiline HCL	antidepressant/ antianxiety

MELLARIL	thioridazine	antipsychotic
MEPROBAMATE	meprobamate	antianxiety
MERITAL	nomifensive maleate	antidepressant
METHYLPHENIDATE	methylphenidate HCL	stimulant
MYCOSTATIN	nystatin	antifungal antibiotic
NAPROSYN	naproxen	anti-inflammatory/ analgesic
NARDIL	phenelzine sulfate	antidepressant/ MAOI
NORDETTE	levonorgestrel & ethinyl estradiol	contraceptive
NORFLEX	orphenadrine citrate	analgesic
NORPRAMIN	desipramine HCL	tricyclic antidepressant
NYSTATIN	nystatin	antifungal
PARNATE	tranylcypromine sulfate	antidepressant
PERCOCET	oxycodone HCL and acetaminophen	narcotic analgesic
PREMARIN	estrogen	
PROZAC	fluoxetine HCL	antidepressant/ serotonin re-uptake inhibitor
RESERPINE	resperpine	antihypertensive/ neurotransmitter depleter
RESTORIL	temazepam [benzodiazepine]	hypnotic
RITALIN	methylphenidate HCL	stimulant
SINEMET	carbidopa-levodopa MSD	antidyskinetic
SINEQUAN	doxepin HCL	tricyclic antidepressant
SURMONTIL	trimipramine maleate	tricyclic antidepressant