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

June 29, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David C. Tinling, M.D.
86 Sibley Road
Honeoye Falls, New York 14472-9307

David R. Dudley, Esq.
Suite 101
112 State Street
Albany, New York 12207

Marta Sachey, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2438
Albany, NewYork 12237

RE: In the Matter of David C. Tinling, M.D.

Dear Dr. Tinling, Mr. Dudley and Ms. Sachey :

Enclosed please find the Determination and Order (No. 94-97) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

Office of Professional Medical Conduct
New York State Department of Health
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 then 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
Empire State Plaza
Corning Tower, Room 2503
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.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER	:	DETERMINATION
OF	:	AND
DAVID C. TINLING, M.D.	:	ORDER

Richard D. Milone, M.D., Chairman, **Leo Fishel, 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 Sections 230(10)(e) and 230(12) of the Public Health Law. **Michael P. McDermott, Esq., Administrative Law Judge,** served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee issues this **DETERMINATION AND ORDER.**

SUMMARY OF THE PROCEEDINGS

Statement of Charges dated:	July 14, 1993
Commissioner's Order and Notice of Hearing dated:	August 2, 1993
Pre-hearing Conference:	August 24, 1993
Amendments to Statement of Charges:	October 1, 1993 (Pet's. Ex. 1A) October 29, 1993 (Pet's Exs. 1B+1C)
Hearing Dates:	October 1, 1993 October 13, 1993 October 29, 1993 November 17, 1993 November 18, 1993 December 1, 1993 December 10, 1993 January 7, 1994 February 4, 1994
Place of Hearing:	New York State Department of Health Albany, New York on 10/1/93, 10/13/93, 10/21/93 and 12/1/93 Alliance Reporting Service

	Rochester, New York on 11/17/93 and 11/18/93
	New York State Department of Health New York, New York on 12/10/93 , 12/17/93, 1/7/94 and 2/4/94.
Dates of Deliberations:	March 8, 1994 March 30, 1994 April 21, 1994
Petitioner Appeared By:	Peter J. Millock, Esq., General Counsel, NYS Department of Health By: Marta Sachey, Esq., Associate Counsel
Respondent Appeared By:	David R. Dudley, Esq. Suite 101 112 State Street Albany, N.Y. 12207

WITNESSES

For the Petitioner:

1) Melvin J. Steinhart, M.D.
2) Frank J. Ayd, Jr., M.D.

For the Respondent:

1) David C. Tinling, M.D. (the Respondent)
2) Michelle Klepper
3) George L. Engel, M.D.
4) David Goldblait, M.D.
5) Donn A Wells, M.D.
6) Carol Markovics, Ph.D.
7) Patient D
8) Patient G
9) Patient E's wife
10) Patient K
11) Patient C
12) Patient H's mother
13) Aaron Satloff, M.D.
14) Patient I
15) Patient B
16) Louis Lasagna, M.D.
17) Ann Maxwell Eward, Ph.D.
18) Andrew A. Nierenberg, M.D.

SUMMARY ORDER

By Commissioner's Order and Notice of Hearing dated, August 2, 1993, the

Commissioner of Health "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," and **ORDERED** that effective immediately, the Respondent shall not practice medicine in the State of New York.

FIRST DAY OF HEARING - ADJOURNMENT

The first hearing date, originally noticed for August 13, 1993, was actually held on October 1, 1993. This was pursuant to the Respondent's request for an adjournment and an agreement regarding waiver of the time provisions of Public Health Law 230(12). Specifically, it was agreed that the ninety day statutory period would start to run on the first day the adjourned hearing actually began and that the Respondent waive the provision of the first hearing date commencing within ten days of service of the Commissioner's **ORDER** (ALJ Ex. 1).

AMENDMENTS TO THE STATEMENT OF CHARGES

On October 1, 1993 and October 29, 1993 the Petitioner's motions to make several corrections and amendments to the Statement of Charges were **GRANTED**. The corrections and amendments are set forth in Petitioner's Exhibits 1A, 1B and 1C.

INTERIM REPORT OF THE HEARING COMMITTEE

On December 14, 1993, the Hearing Committee issued an **INTERIM REPORT** recommending "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" (ALJ Ex. 2).

STATEMENT OF CHARGES:

The Statement of Charges, charges the Respondent with practicing with gross negligence; practicing with gross incompetence; practicing with negligence on more than one occasion; practicing with incompetence on more than one occasion; failing to maintain records which

accurately reflect the evaluation and treatment of the patient; with revealing information obtained in professional capacity; and with violations of Article 33 of the Public Health Law.

The Charges are more specifically set forth in the Statement of Charges and the amendments thereto, copies of which are attached hereto and made a part hereof.

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. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE:

Petitioner's Exhibits are designated by NUMBERS.

Respondent's Exhibits are designated by LETTERS.

T. = Transcript

F/F = Finding of Fact

/ = and/or

GENERAL FINDINGS

The Respondent is a physician duly licensed to practice medicine in the State of New York under license number 095606 issued by the State Education Department on September 30, 1965.

FINDINGS AS TO PATIENT A

1. The Respondent provided psychiatric care to Patient A at various times from approximately June 28, 1983 through at least approximately June 15, 1992 at the Respondent's office and by telephone (Ex. 6).

2. At the time of Patient A's initial visit to the Respondent on June 28, 1983, the patient was a twenty-four year old classical guitar graduate student in Ohio. The patient was

referred to the Respondent by another physician in June 1983 for psychiatric evaluation due to an eating disorder "bulimia", and depression. The patient had a history two years prior of globus hystericus following a choking episode which resolved spontaneously (Ex. 6, pp. 45-45; T. 29-30).

3. On Patient A's initial visit, the Respondent noted that the patient had a history of six weeks of depression following a breakup with his girl friend (Ex. 6, p. 46; T. 30). He also noted that the patient had a binging and laxative habit (Ex. 6, p. 46). In a 1989 letter to the patient's attorney, the Respondent diagnosed Patient A as having "Atypical Depression" since he began treating him (Ex. 6, 51-52; T. 30, 1462). In 1990, the Respondent felt that the patient was suffering from ADD (Attention Deficit Disorder) but did not address that problem because he was "spending his time helping the patient with being in jail" (T. 1485-1486).

4. During approximately nine years of treatment, the Respondent treated Patient A with psychotherapy and medication, including antidepressants, antidepressants with augmenting drugs and antidepressants with stimulants (Ex. 1, Appendix A; Ex. 6; T. 30).

5. There were several significant factors concerning Patient A during his course of treatment with the Respondent which should be noted. He was non-compliant with the dietary restriction of his medications. On December 7, 1984, while on Parnate, a monoamine oxidase inhibitor, which requires avoidance of foods containing tyramine, the patient took a double dose of Parnate and ate cheese. He developed a headache and became dizzy. The patient called the Respondent from his school in Ohio and the Respondent advised him to seek help at the school's medical center (Ex. 6, p. 36; T. 31).

In July 1986, Patient A was again non-compliant with his Parnate diet. He ate cheese and suffered an intracranial bleed. This necessitated surgery to remove an intracerebral blood clot and left the patient with some neurological impairment (Ex. 6, p.35; Ex. 6A, p.11; T. 31).

The patient would also independently adjust the doses of his medication, for example, Parnate (Ex. 6, p.36, 12/7/84 entry: double dose Parnate; p. 35, 8/1/86 entry: increased to 8 Parnate;

T. 31).

The patient also had legal problems as a result of his behavior toward his former girl friend and was jailed on two occasions. (Ex. 6, pp. 55-58; Ex. 6, p. 16, 3/5/90 and 5/1/90 entries: in jail; Ex. 6, p. 6, 10/28/91 entry: calls from jail; Ex. 6, p. 5, 1/7/92 entry: was released from custody; T. 31).

INITIAL PATIENT HISTORY AND MENTAL STATUS EVALUATION

6. Accepted standards of medical practice dictate that when a psychiatrist first starts treating a patient, the patient's history should be obtained within the first several treatment sessions, and that a mental status evaluation should be done at the first treatment session. Accepted standards of practice also require that the history and mental status evaluation be recorded in the patient's record (T. 32-36, T. 726-728).

7. A patient history should include:

* why the patient is seeking treatment or the chief complaint, and the history of that complaint or problem.
* previous psychiatric treatment, by whom and for what condition, including medication history.
* complete medical history, including past illnesses, health problems and treatment.
* education and work history.
* developmental history.
* history of relationships with significant persons, including family members.
* family history, including psychiatric illness and medical problems.
* alcohol and drug abuse history. (T. 32-33).

A history provides a frame of reference for the context of the patient's illness and

identifies factors that help in the understanding of that illness. It also provides a framework to build a diagnostic impression and evaluate possible treatment options (T. 33, 37, 726-728).

8. A mental status evaluation of the patient is essentially the psychiatric counterpart of a physical examination. It is a detailed overview of the patient's mental functioning and should include:

* observation of the patient and the patient's attitude, appearance, behavior at the interview, characteristics of speech.
* emotional state, mood and affect.
* thought content, e.g., does the patient have obsessions, recurring themes, delusions.
* orientation to time, place and person.
* general intellectual functioning, e.g., immediate and remote memory, appropriate processing of information, ability to calculate, abstract thinking.
* reasoning and judgment, e.g., patient's self- reflective ability regarding problem or illness.

A mental status evaluation is crucial in making a diagnosis of the patient and in ruling out other possible diagnoses (T. 34-35, 726-728).

9. The Respondent began treating Patient A on June 28, 1983. From June 28, 1983 through October 18, 1983, during which time the Respondent had five contacts with the patient, he failed elicit or record an adequate patient history (Ex. 6, pp. 44-46; T. 37, 726-728, 1625; F/F 6 and 7).

10. The Respondent's records contain no in-depth information regarding Patient A's chief complaints. The patient was depressed for six weeks, which occurred in the context of his breaking up with his girl friend. However, there is no characterization of the depression, nor is there any discussion of the girl friend or the reason for the break up.

Patient A reported a binging and laxative habit, which was also noted in the referring physician's letter to the Respondent. The referring physician also reported a history of weight problems. The Respondent failed to record any information about these conditions in the patient's record.

The Respondent failed to record any information about Patient A's family history or his relationships with his parents or others. The fact that Patient A had a sister was not recorded until an October 29, 1984 entry, over a year after the Respondent began treating the patient. This sister apparently had problems with bulimia and hallucinations, which would be significant information since Patient A also had a complaint of bulimia. There is no medical or developmental history nor is there a history regarding drug or alcohol use.

There is no psychiatric history or history of any previous psychiatric treatment. Notably, the referring physician indicated that the patient had seen a psychiatrist on one visit for globus hystericus and "was disappointed" with that encounter. However, the Respondent did not explore the history of this problem or the patient's contact with the former psychiatrist (Ex. 6, pp. 40, 44-47; T. 36-37, 726-728; F/F 6 and 7).

11. The Respondent did not obtain or record an adequate mental status evaluation of Patient A when he first started treating the patient. Although such an evaluation should be done at the first session, the Respondent's notes for the first five contacts, which occurred over an approximate four month period, have nothing that even touches upon the elements of an appropriate mental status evaluation. The Respondent's notes, such as, patient "looks good", do not reflect a mental status evaluation and would be meaningless to a subsequent physician or reviewer of the Respondent's patient record (Ex. 6, pp. 44-46; T. 37-39, 726-728; F/F 6 and 8).

SUPPLEMENTAL PATIENT HISTORIES/ SUPPLEMENTAL MENTAL STATUS EVALUATIONS

12. Accepted standards of medical practice require that the psychiatrist obtain and record a patient's on-going history and mental status evaluations during the course of treatment.

Significant events or changes in the patient's life should be explored. A mental status evaluation should be done, at least in part, each time a patient is seen. In this way the psychiatrist can evaluate what is happening with the patient in terms of the treatment plan, whether target symptoms are being addressed, and whether and how the patient is responding to treatment. Such evaluations determine the course that therapy will take (T. 39-40).

13. The Respondent failed to obtain or record adequate supplemental histories and mental status evaluations during the time that he treated Patient A. Essentially, there is nothing in the Respondent's entire patient record that even addresses the elements of a mental status evaluation. Supplemental historical information regarding the patient over the nine years of treatment provides little meaningful information (Ex. 6, T. 40-41).

14. The Respondent's failures to obtain or record this information are even more evident in view of the time gaps in the Respondent's contact with the patient. For example:

* During the ten month period between 9/29/87 and 7/13/88, the Respondent's supplemental history and mental status evaluation contain no interim information with respect to what has happened to Patient A. There is no history of the course of his depression, his eating disorder or his relationships with others. There is no mental status evaluation whatsoever. Rather, at the end of this ten month period, the Respondent only notes "he seems sad...feels exploitive." However, there is no context to, or exploration of, these descriptions (Ex.6, p.24).

* There is an approximate seven month period from 10/28/91, when Patient A called the Respondent from jail, to 6/3/92, when the Respondent next saw the Patient. The Respondent's history and mental status evaluation of Patient A at the end of this period were inadequate. The patient had been in jail, yet there is nothing noted regarding the impact of this incarceration on him. There is no record at all of what, if any, medical regimen he was on while in jail.

* A review of Patient A's record for the period 10/17/88 through 9/2/89, reveals inadequate supplemental histories and mental status evaluations. While some external specifics of the patient's life are recorded, there is no comment on the psychological impact of these events on the patient (Ex. 6, pp. 21-22).

* There is basically no information in the record regarding the patient's mental status or history during the period from 1/31/91 through 8/9/91. The Respondent's 3/28/91 notation, "doing well" is not the equivalent of an acceptable mental status evaluation (Ex. 6, p. 10; T.41-46).

When Patient A first saw the Respondent, he had problems of depression, eating disorders and problems with his girl friend. The Respondent never adequately evaluated or assessed these problems in terms of their history and as part of the patient's mental status during the entire nine year course of treatment (T. 46).

OTHER DIAGNOSTIC/EVALUATIVE/TREATMENT OPTIONS

15. There are occasions when a reasonable prudent psychiatrist will explore other diagnostic and/or treatment options for a patient. These occasions include the situation where a patient does not seem to be improving or making progress. In such a situation, the psychiatrist may consider a different diagnosis, securing an opinion from another psychiatrist, or ordering psychological testing to help get a better idea of what is occurring with the patient. Treatment options might also include utilizing psychotherapy without medication (T. 48-49, 977).

16. The Respondent failed to adequately explore other diagnostic, evaluative and/or treatment options for Patient A. Such steps were warranted in this case.

During the nine years of treatment, the patient did not appear to have gotten any better. There were issues very early on in Patient's A's treatment that indicated that the patient likely had a personality disorder. He frequently acted out; he self-adjusted his medications; and was non-compliant with dietary restrictions for the drugs he was taking. He got into legal problems because of his behavior toward a former girl friend. He violated court orders regarding contact with her and was incarcerated twice for such behavior.

Patient A's behavior was indicative of a characterologic disorder which the Respondent should have explored and addressed. There is no evidence in the records that he confronted the patient with these issues in a meaningful and therapeutic way. The Respondent should have at least gotten some type of psychological testing for the patient (T. 49-50; F/F 15).

In 1990, the Respondent determined that Patient A likely had ADD, but did not pursue this diagnosis because he was "spending his time helping the patient with being in jail". The Respondent treated the patient for a sufficient time after his release from jail to have pursued his presumptive diagnosis of ADD, but he failed to do so (Ex. 6, p. 11; T 1485-1486).

17. The Respondent should have referred Patient A for treatment to another psychiatrist in Ohio while Patient A was there attending school. For example, on 12/7/84, Patient A called the Respondent from school and told him that he took a double dose of Parnate and ate cheese which resulted in a headache and dizziness. Despite the fact that the patient increased the dosage of Parnate on his own, and was non-compliant with the Parnate diet, the Respondent thereafter, in July 1985, refilled the Parnate prescription at the request of the patient's mother and without having seen the patient since 1984 (T. 157-160, 1651-1654).

The Respondent testified that he did not suggest to the patient that he see another psychiatrist in Ohio because he felt that the patient would view such a referral as the Respondent's "abandoning" him (T. 1522-1523, 1654).

RECORD OF INDICATIONS FOR DRUGS/

CHANGES IN DRUGS OR DOSES/DRUG REGIMEN

18. Accepted standards of medical practice require that a psychiatrist record the indications for the medications he prescribes and the dosage and the instructions for use. He should also note when there are changes in the medication or dosages. When he issues prescriptions, they also should also be noted in the patient's record.

Accepted standards of medical practice also require that the patient's drug regimen be recorded on a regular basis, usually every time there is a contact with the patient, or if there is more than weekly contact, recording the drug regimen once a week is acceptable. These standards assure that there will be an understanding of the patient's drug therapy and a means to continue that care in the event that the treating physician is not available or another psychiatrist assumes the patient's care. Such record keeping is also a means of monitoring the patient's compliance with the

drug regimen (T. 52, 56-60).

19. The Respondent failed to make adequate notes regarding the indications for the drugs he prescribed for Patient A. He also failed to make adequate notes regarding any changes in those drugs or doses. For example:

* On 6/28/83, the Respondent noted that the patient s "better (x) three weeks" (Ex. 6, p. 46).

* On 8/9/93, the Respondent noted "[up and down] cinc[innatti] and the pattern persists". Also on 8/9/93, the Respondent prescribed Parnate for Patient A without adequately recording the indication for doing so (Ex. 6, p. 45).

* On 7/14/87, the Respondent increased the dose of thyroid by 25 mcg a week up to six a day without recording the indication for doing so (Ex. 6, p. 26).

* On 12/18/90, the Respondent prescribed Dexedrine for Patient A for the first time, but did not record the indications for doing so (Ex. 6, p. 11; T. 54-56; F/F 18).

20. The Respondent failed to adequately record Patient A's drug regimen. There are significant gaps in which there are no notations as to what medications the patient was taking, despite the Respondent's contact with the patient during the interim. For example:

* On 8/24/88, it is noted that the patient is taking two Prozac (Ex 6, p. 23). Prozac is not mentioned again until 7/14/89, almost a year later (Ex. 6, p. 22).

* From 1/16/89 through 5/8/89, the Respondent issued six prescriptions for Ritalin, yet he did not record them in the patient's record (Ex. 1, Appendix A; Ex. 7).

* After a 12/20/89 entry, Prozac is not noted in Patient A's records again until 4/2/90. That entry reads only "Prozac Refill x 1 yr." There is no notation of the amount prescribed or the instructions for use (Ex. 6 p. 16). There is no notation regarding Prozac again until 7/12/90, approximately three months later (Ex. 6, p.14).

* On 1/24/90, the Respondent noted that the patient is "on meds (Desip helps)" (Ex. 6, p. 18). However, there is no notation of the dose of the drug or the other drugs the patient was taking.

* On 7/14/87, there is a notation regarding "Thyroid" and the dosage (Ex. 6, p. 26). However, there is no further notation regarding this medication throughout the rest of the patient's records which continues to 6/15/92. There is no information as to whether the medication was continued and in what amounts, or if and when it was discontinued (Ex. 1, Appendix A; Ex. 6, pp. 4-26; T 64-65; F/F 18).

ADEQUATE RECORD KEEPING

21. Accepted standards of medical practice require that a patient's records should be sufficient to enable another psychiatrist to understand the patient and the care provided, and to assume that care if the need arises. Further, good record keeping is an important tool for the treating psychiatrist to assess treatment. A continuum of good record keeping is a means to assess the patient, target symptoms, and the efficacy of the treatment plan in a broader context than individual treatment sessions (T. 102-103, 728).

22. The Respondent failed to maintain adequate records for Patient A. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 65-66; F/F 6, 7, 8, 18, 19, 20, 21).

Cytomel

23. Cytomel is a synthetic thyroid hormone. It basically mimics what the thyroid gland does in producing thyroid hormones. Thyroid hormones maintain the body's metabolic rate.

Cytomel effects the cardiovascular system, increases heart rate and blood pressure, and can cause palpations and a hypermetabolic state if taken in excess (T. 67-68).

24. Cytomel has been used in psychiatry to treat depressed patients, particularly patients who are on tricyclic antidepressants. Cytomel augments the antidepressant's effect by sensitizing the receptor sites at which the antidepressant works.

Cytomel is effective within seven to fourteen days. Medical literature indicates that the maximum dose in the use of Cytomel as an adjuvant is 50 mcg a day. Patients generally respond

to 25 mcg and are usually started on that dose, or they may be started on an even lower dose of 12.5 mcg. Patients with myxedema, a profound state of hypothyroidism, usually receive only up to a 100 mcg dose.

Prescribing excessive doses of Cytomel, such as 100 mcg or over, for a psychiatric patient is inappropriate and very risky. There are cardiovascular effects, e.g., increased heart rate and palpations, and such high doses can precipitate congestive heart failure. High dosages of Cytomel can also create a hypermetabolic state, cause sweating and tremors, and eventually affect a patient"s thought processes. In a depressed patient, there is also the danger that Cytomel's energizing effect can energize a patient to act on suicidal thoughts (T. 68-69, 74-75, 728-729, 730-731).

25. Accepted standards of medical practice dictate that baseline thyroid tests should always be obtained before starting a patient on Cytomel, even if the drug is being used as an adjuvant to antidepressants. Failure to do so is a deviation from accepted standards of medical practice.

The cause of a patient's depression might actually be hypothyroidism itself, and if the patient is started on Cytomel without first determining the baseline and something untoward occurs, it is then too late to test the patient's baseline thyroid function.

Not knowing the patient's natural thyroid state before starting treatment with Cytomel can expose the patient to risk. For example, if the patient is, hypothyroid, use of the drug could exacerbate this condition.

Clinical evaluation, including observation of the patient, physical examination, palpating the thyroid gland and checking the pulse, is not sufficient excuse to forgo obtaining baseline thyroid function tests. There are many cases of thyroid disease that are not obvious on clinical examination (T. 71-73, 728, 810 1149-1150).

26. The Respondent prescribed Cytomel for Patient A on 3/17/87 without first obtaining baseline thyroid function tests. There is no indication in the Respondent's record that these

tests were either requested or secured, and there are no test results in the record. In fact, there is no indication that the Respondent even performed or secured the results of a clinical examination of the patient before prescribing the Cytomel (T. 71-73, 728, 1648-1650 F/F 23, 25)

The Respondent testified that he spoke to Patient A's referring physician at the time of referral in 1983. He claims that the referring physician evaluated the patient for endocrine abnormalities but he was not aware of any of the specific tests that might have been performed at that time (T. 1489-1490). It should be noted that the Respondent did not prescribe Cytomel for Patient A until approximately four years after the 1983 referral. In the interim, the patient's physiology could have changed.

27. On 3/17/87, The Respondent prescribed Cytomel as an adjutant is his treatment of Patient A. The starting dose was 50 mcg (Ex. 6, p. 29; T. 1474).

The Respondent testified that he does not start patients on the usual 25 mcg dose because he is not impressed that the 25 mcg dose does that much. He starts at the upper range of 50 mcg, and if there is a problem, he decreases the dose (T. 1494-1495).

On 3/31/87, the Respondent raised Patient A's Cytomel dose to 100 mcg (Ex. 6, p. 29). On 7/14/87, he instructed that the dose be raised to 150 mcg a day (Ex. 6, p. 26: increase thyroid by 25 mcg per week up to 6 a day).

The Respondent's prescribing of Cytomel 100 mcg and up to 150 mcg a day for Patient A was excessive and was a deviation from accepted standards of medical practice (T. 74-75, 148, 729-731; F/F 24).

RITALIN

28. Ritalin is a psychic energizer that increases psychomotor activity and heart and pulse rates, and often speeds up the thinking processes. It is usually used to treat narcolepsy and hyperactivity in children. It appears to benefit the thinking and mood of patients with AIDS dementia complex. Ritalin is also used in treatment-resistant depressed patients, who have been appropriately diagnosed as such (T. 75-76; T. 732).

29. When Ritalin is used to treat treatment-resistant depressed patients, the usual daily dose is 30 mg to 60 mg. Exceeding this dosage presents serious risks.

Ritalin has a significant psychological addiction potential. It can also cause tremors, tachycardia, psychomotor agitation and nervousness, and it increases the likelihood of seizures. Ritalin slows down the liver's ability to metabolize other drugs and thus can significantly increase the blood levels of other drugs being taken by the patient. Ritalin also has an anorexia effect and can produce toxic psychosis when taken in high doses (T. 76-78, 215-216, 732-734).

30. The Respondent prescribed Ritalin for Patient A in excessive amounts. He started the patient on Ritalin on 7/28/87, and by 8/3/87, the dose was up to 60 mg a day (Ex. 6, pp. 25-26). Thereafter, at various times the patient was on Ritalin 80 mg to 120 mg daily. For example:

* 10-22-87:	80 mg
* 7-13-88:	120 mg
* 7-12-89:	80 mg
* 7-25-89:	80 mg
* 8-21-89:	80 mg
* 10-2-89:	80 mg
* 11-28-89 through 12-10-90:	80 mg

(Ex. 1, Appendix A)

In view of the addiction potential of Ritalin and the amounts which the Respondent prescribed for Patient A, it is apparent that the patient was using the drug excessively. On 8/24/88, the Respondent noted "it is hard he says to [decrease] the Ritalin" (Ex. 6, p. 23).

During the period 1/16/89 through 12/20/90, the Respondent issued twenty-nine prescriptions for Ritalin in quantities, which if used in accordance with the directions for use, would amount to a 870 day supply. However, the tablets were used up in the course of 700 days (Ex. 7; T. 77-81, 148, 731-732; F/F 29).

31. The Respondent first prescribed Ritalin for Patient A on 7/28/87, at which time

he noted, "I say no to Parnate" (Ex. 6, p. 26). He did not record any indication for prescribing the Ritalin. Assuming that the Ritalin was a "substitute" for the Parnate, this would not be an acceptable rationale for use of Ritalin. The Respondent testified that Ritalin was needed to encourage the patient's artistic creativity. This is also not an acceptable use of Ritalin (T. 81-82, 1489).

DEXEDRINE

32. Dexedrine is a psychic energizer, similar to Ritalin, but more potent. It is more likely to produce addiction or toxic psychosis. It has a significant excitatory effects on the cardiovascular system, such as raising blood pressure. It is very important therefore, that patients on Dexedrine should have their blood pressure monitored (T. 75, 83-84).

33. The Respondent failed to monitor Patient A's blood pressure while the patient was on Ritalin and/or Dexedrine. Given the effects of these drugs on the cardiovascular system, such monitoring was indicated.

There was a period when Patient A was on both Ritalin and Dexedrine at the same time. On 12/10/90, the patient was taking Ritalin 80 mg daily and was given a prescription for 120 tablets. On 12/18/90, the Respondent prescribed Dexedrine 30 mg daily (Ex. 6, pp. 11-12).

34. Patient A had a history of suffering an intracranial hemorrhage while taking the drug Parnate (Ex. 6, p. 35; Ex. 6A; T. 84). This history made it mandatory for the Respondent to monitor Patient A's blood pressure while he was on Ritalin and/or Dexedrine. Failure to perform such monitoring exposed the patient to the risk of suffering another stroke.

The Respondent's records do not indicate any blood pressure monitoring or any notation of Patient A's blood pressure status (Ex. 6; T 84-85).

PROZAC

35. Prozac is an antidepressant. It is a serotonin re-uptake inhibitor, which means that it increases the amount of serotonin available at receptor sites in the brain by preventing re-

uptake into the cells. The usual effective dose of Prozac is 20 mg to 40 mg. Doses of 80 mg are exceptionally high and are used to treat patients with such problems as severe obsessive-compulsive disorder.

Prozac is very long-acting, with a half-life measurement in weeks. It has a profound effect on the liver and metabolic system and prevents the breakdown of other drugs. For example, 20 mg of Prozac taken with a drug like Ritalin will effectively double the plasma blood level of Ritalin and 80 mg of Prozac will likely triple the Ritalin level (T. 87-89, 736-737, 1138-1139).

36. The Respondent prescribed Prozac 80 mg and Ritalin 80 mg for Patient A at the same time (Ex. 6, p. 12; 10/29/90 and 10/31/90 entries). This drug combination was contraindicated because in combination each of these drugs effectively raised the blood level of the other (F/F 29 and 35). The risks of high doses of Ritalin would be even more pronounced. Patient A was exposed to a serious risk of stroke by the Prozac/Ritalin combination. In fact, this drug combination is at best experimental. There has not been any controlled studies for this regimen either in the United States or in Europe. The use of this drug combination at the dosage levels prescribed should have been done in a hospital setting (T. 87-90, 146, 736-740).

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to obtain and/or record an adequate history and mental status evaluation of Patient A when he first began treating the patient.

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

3. During the approximate nine years that he treated Patient A, the Respondent failed to adequately explore other diagnostic, evaluative and treatment options for the patient, including psychological testing and clinical consultation with another psychiatrist or a psychologist.

4. On numerous occasions, the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient A, the indications for the drugs, and the indications for changes in the drugs or doses prescribed.

5. On numerous occasions, the Respondent failed to adequately record Patient A's drug regimen, including the drugs Patient A was taking at any given time, the doses of the drugs, the directions for use, and when drugs were discontinued.

6. The Respondent failed to maintain adequate records for Patient A.

7. The Respondent prescribed Cytomel for Patient A without first obtaining baseline thyroid function tests.

8. At various times, the Respondent prescribed excessive doses of Cytomel for Patient A.

9. At various times, the Respondent prescribed excessive doses of Ritalin for Patient A.

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

11. On October 31,1990, the Respondent prescribed Prozac 80 mg daily for Patient A. At that time, the patient was also on Ritalin 80 mg daily. This drug combination was contraindicated.

FINDINGS AS TO PATIENT B

37. The Respondent provided psychiatric care to patient B from approximately January 3, 1984 through at least January 28, 1993 at his office and by telephone.

Patient B was thirty-eight years old when the Respondent first began treating her. She is married, the mother of four, and a registered nurse. She was referred to the Respondent, but there is no referral letter or other information regarding the referral in the patient's record.

The Respondent treated Patient B for at least nine years and his diagnosis was treatment-resistant depression. The patient was treated with psychotherapy, medication and ECT (electroconvulsive therapy). She was "very seriously ill". (Ex. 8, pp. 181-182; Ex. 12, p. 46; T. 170-171).

38. Patient B experienced two deaths in her family and the death of a friend in the year just prior to seeing the Respondent. She also had a sister who suffered from a depression similar to her own. This sister had attempted suicide several months before Patient B was first seen by the Respondent (Ex. 8, pp. 181-182; T. 170-171).

39. The Respondent had five contacts with Patient B during the first month of treatment. His initial history of the patient, recorded during the first month was inadequate. For example, there was no medical history. It was not until much later that it was noted that Patient B had a hysterectomy (Ex. 12, p. 184). There is no history of the patient's relationship with significant others, including her children and husband. The Respondent noted in a 1/9/84 entry that the patient did not tell her husband about her suicidal feelings. There is no indication in the record that the Respondent elicited the history of the patient's relationship with her husband (Ex. 8, pp. 180-182; T. 172-173, 726-728; F/F 6 and 7).

40. The Respondent's initial mental status evaluation of Patient B, was inadequate. There is no information regarding the patient's affect, thought content and processes, and cognitive function.

The Respondent did record that Patient B was suicidal. On 1/9/84, he noted that the

patient was feeling suicidal the previous evening and that morning. On 1/11/84, he noted "a little suicidal yesterday. Better today" (Ex. 8, p. 181). However, there is no development of this in the context of a mental status evaluation. There is no development in that context of significant events in the patient's recent history, such as the two deaths in her family; the death of a friend, and her sister's attempted suicide (Ex. 8, pp. 180-182; T. 174-175, 726-728; F/F 6 and 8).

41. The Respondent failed to periodically obtain or record adequate mental status evaluations of Patient B during the course of treatment. The Respondent's notations throughout the record, such as "pretty good" or "doing better; good" (Ex. 8, p. 174 3/7/84 and 3/12/84 entries), do not constitute adequate evaluations of the patient's mental status (Ex. 8, T. 175-177; F/F 12).

42. The Respondent failed to maintain adequate records regrading the indications for the drugs he prescribed for Patient B, or any changes in the drugs or dosages. For example:

* On 10/24/91, the Respondent notes that the patient is taking 7.5 estrogen (Ex. 8, p. 14). There is no notation of estrogen again until 1/16/92 (Ex. 8, p. 12). On that date he notes that Patient B is taking 10 estrogen ("Premarin"), but he failed to note the indications for increasing the Premarin dosage. In fact, the 1/16/92 entry, and the prior entry of 1/9/92, indicate that the patient is doing well and is considering resuming employment (Ex. 8, p. 12).

* On 12/5/85, the Respondent called in a prescription for Xanax without noting any indications for using this drug (Ex. 8, p. 132). On 1/03/87, the Respondent directed the patient to increase "Xanax hs" but does not record the indications for the increased dosage (Ex. 8, p 113; T. 177-182; F/F 18).

43. The Respondent failed to make adequate notes regarding Patient B's drug regimen. For example:

* On 7/18/85, the Respondent recorded for the first time that the patient was taking chloral hydrate for sleep, but the dosage is not indicated (Ex. 8, p. 141). The next entry regarding chloral hydrate was made on 11/30/87. At that time, the Respondent noted, "sleep is okay with chloral hydrate", but again, the dose is not indicated (Ex. 8, p. 90). During this twenty eight month period, there is no notation concerning the patient's chloral hydrate regimen.

* On 11/1/84, the Respondent noted that he started Patient B on

Premarin 1.25 mg (Ex. 8, p. 156). There is no further reference to Premarin until 1/20/87, (three years later), when the Respondent notes, "add Premarin 1.25. She's been off it" (Ex. 8, p. 111). The record does not indicate the dosage of Premarin the patient was taking, how long she was taking the drug, and when it was discontinued during the three year period. The record of Patient B's May, 1986 hospital admission indicates that she was on Premarin at that time (Ex. 11, p. 30).

* For the next thirteen months, from 1/20/87 to 12/21/88, the Respondent again did not record the patient's regimen with regard to Premarin (Ex. 8, pp. 67, 111). Yet again, from 10/24/91 through 1/16/92, and from 1/16/92 through 1/28/93, the Respondent still did not record the patient's Premarin regimen (Ex. 8, pp. 2-14).

* On 9/10/84, the Respondent recorded that Patient B is to increase Cytomel to 50 mcg bid (Ex. 8, p. 159). There is no further record of Cytomel in the patient's record until 10/3/85, when the Respondent noted that the patient is taking "3 Cytomel" (Ex. 8, p. 136). There is nothing in the record regarding the patient's Cytomel regimen during the period from 9/10/84 to 10/3/85, nor is there any notation when the dosage was increased from 100 mcg to 150 mcg (Ex. 1, Appendix B; T.182-191; F/F 18).

44. The Respondent failed to maintain adequate records for Patient B. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 191-192, 728; F/F 6, 7, 8, 12, 18, 21, 39, 40, 41, 42, 43,).

45. On 4/4/84, the Respondent started Patient B on Cytomel at a dose of 50 mcg/day (Ex. 8, p. 171). The Cytomel was given to augment antidepressants (T. 1545). Thereafter, the Respondent, at various times, had Patient B taking doses of Cytomel ranging from 50 mcg to 200 mcg/day. For example:

* 3/19/86: increase to 5 a day over 1 week, then 6 (Ex.8, p. 127).

* 3/24/86: on 5, better on Cytomel (Ex. 8, p. 118).

* 9/10/86: stay on 4 (Ex. 8, p. 78).

* 5/25/88: 50 mcg bid (Ex. 8, p. 78).

* 5/27/88: will go to 6 (Ex. 8, p. 37).

* 9/14/90: Cytomel 25 mcg, 2 tid (Ex. 8, p. 17).

* 7/24/91: Cytomel 50 mcg, 3 a day (Ex. 8, p.5).

* 1/16/92: Cytomel 50 mcg tid (Ex. 8, p. 4).

* 9/22/92: Rx Cytomel 50 mcg, 4/d (Ex. 8)

(Ex. 1, Appendix B, Ex. 8).

These doses of Cytomel were excessive and constitute a deviation from accepted standards of medical practice. The Respondent also failed to monitor the patient's thyroid status at the time the patient was on Cytomel (T. 196, 729-731; F/F 28).

46. The Respondent started Patient B on Premarin on 11/1/84 (Ex. 8, p. 156). It appears that Patient B was on this drug consistently form 1986 to 1993 (F/F 43). The dosage ranged from 1.25/day to 15 mg/day. For example:

* 11/1/84: 1.25 mg (Ex. 8, 156)
* 01/18/89: 3.75 mg. (Ex. 8, p 64)
* 02/15/89: 5 estrogen (Ex. 8, p 63)
* 02/27/89: increase to 7 estrogen (Ex. 8 p. 62)
* 03/2/89: increase to 8 estrogen (Ex. 8, p. 61)
* 04/29/89: 10 Premarin a day (Ex. 8, p 57)
* 05/10/89: 11 Premarin a day (Ex. 8, p. 55)
* 07/19/89: 6 tablets of 2.5 mg. Premarin a day (Ex. 8, p. 51)
* 01/16/92: Premarin 2.5 (Ex. 8, p. 12)

Premarin is a synthetic estrogen. The usual dose of Premarin in a non-psychiatric situation is 1.25 mg a day. While there is some literature indicating that Premarin can be used to treat depression, the drug can be dangerous. It may cause uterine cancer and it effects breast and vaginal tissue. Before prescribing Premarin for a patient, a psychiatrist should secure a gynecological consultation to evaluate whether or not the drug should be prescribed. Even considering that Patient A had a hysterectomy in 1980 (Ex 12, p. 184), such a consultation is

required because of the drug's potential to effect breast and vaginal tissue.

The fact that Respondent was using Premarin for psychiatric purposes, in doses well above those used for gynecological purposes, would make a gynecological consultation for Patient B even more important. However, there is no notation in the Respondent's records of any gynecological consultation for Patient B (Ex. 8, T. 202-207).

The Respondent was aware that Patient B saw her gynecologist on a regular basis, but he did not order a gynecological consultation before prescribing Premarin because he decided it was "psychiatric decision" (T. 1572-1573).

LITHIUM

47. Lithium is a salt which is used in psychiatry as a mood stabilizer. It normalizes mood in manic patients and it is also helpful with bipolar patients and in some depressions. Prior to prescribing Lithium for a patient, it is necessary that a lithium workup be obtained. This workup consists of an electrocardiogram, kidney function tests and thyroid function tests. These tests are necessary because of lithium's profound effects on various body systems. For example, it is absolutely contraindicated for patients with sick sinus syndrome because it can cause sudden death.

Lithium causes loss of intracellular potassium which can lead to cardiac arrhythmias, and it can flatten or reverse T waves which can lead to myocardial infarction. Lithium can markedly effect the ability of the kidney to absorb water and it is therefore necessary to test urine concentration and creatinine clearance on at least a yearly basis. Approximately thirty percent of the patients on lithium can develop non-toxic goiter which can lead to hyperthyroidism in a small percentage of those patients. It is therefore important to get thyroid function tests before instituting this drug.

Accepted standards of medical practice also require that a patient's blood plasma levels be monitored while the patient is on lithium. Lithium has a very low therapeutic index and a narrow therapeutic range. This means that the range at which it is effective is very narrow and the toxic dose is very close to the therapeutic dose. Without adequate workup and monitoring, lithium has the potential for creating thyroid problems, cardiac illness, coma, and other problems.

Without lithium level monitoring, the physician cannot know whether a patient achieved a therapeutic level. Clinical observation is not a substitute for a Lithium work-up or for monitoring lithium blood plasma levels (Ex. A, T. 211-213, 337-338, 680-681, 734-735, 993-994, 1144-1145, 1148, 1156-1163).

48. The Respondent started Patient B on lithium, 300 mg TID, on 1/20/87 (Ex. 8, p.111). Thereafter, the patient was on the drug at various times during 1987 and 1988. For example:

* 01/31/87:	600 Li (Ex. 8, p. 108)
* 02/01/87:	300 Li (Ex. 8, p. 108)
* 02/17/87:	600 Li (Ex. 8, p. 106)
* 02/24/87:	600 Li (Ex. 8, p. 105)
* 03/07/87:	900 Li (Ex. 8, p. 104)
* 03/13/87:	1200 Li (Ex. 8, p. 104)
* 03/19/87:	900 Li (Ex. 8, p. 103)
* 03/09/88:	300 Li (Ex. 8, p. 84)

There is no record of the Respondent's having obtained a lithium work-up prior to starting Patient B on lithium, nor is there any record that he monitored Patient B's lithium levels while the patient was taking the drug.

The Respondent's failure to obtain a lithium work-up, is a deviation from accepted standards of medical practice (Ex. 8; T. 213-214, 734-735; F/F 47).

49. At various times, the Respondent prescribed Ritalin 120 mg. daily for Patient B. For example: 12/6/89, 12/20/89, 3/13/90, 4/2/90, 4/11/90 through at least 1/93 (Ex. 1, Appendix B; Ex. 8). The dose of Ritalin 120 mg was excessive and not consistent with accepted standards of medical practice (T. 215-216, 731-732; F/F 28 and 29).

WELLBUTRIN

50. Wellbutrin is an antidepressant drug which has stimulant and amphetamine like effects. The major danger with using Wellbutrin is a lowering of the seizure threshold. It has a seizure percent of 0.4%, which is significant. The usual dose of Wellbutrin is in the 300 mg to 400

mg range with 450 mg being the upper limit (T. 216-217, 740).

51. On 1/16/92, the Respondent prescribed Prozac 40 mg and Wellbutrin 400 mg for Patient B. The combination of Prozac and Wellbutrin is experimental.

Prozac's effect on the liver inhibits the metabolism of Wellbutrin. Prozac, at 40 mg a day, would have the effect of doubling or even tripling the blood levels of Wellbutrin 400 mg, which is already at the upper limit of the normal dosage. By prescribing this combination the Respondent placed the patient at an increased risk for seizure (T. 217, 740-741; F/F 35 and 50).

52. On 9/22/92, the Respondent prescribed Cytomel 200 mcg for Patient B when the patient was already on Ritalin 120 mg (Ex. 8, p. 4, 9/16/92 and 9/22/92 entries). Cytomel and Ritalin are both drugs which increase cardiovascular activity and the Respondent prescribed both of them in amounts exceeding the recommended dosages. At best the effect of this drug combination was additive, doubling the potential for side effects that might occur (T. 217-219, 741-742; F/F 23, 24, 25, 28, 29).

54. At various times, including 1/16/92, the Respondent prescribed Ritalin 120 mg along with Prozac 40 mg (or more) daily for Patient B (Ex. 1, Appendix B; Ex 8, p. 12; Ex. 9).

The combination of Ritalin and Prozac is dangerous and a deviation from accepted standards of medical practice. Each of these drugs can raise the blood level of the other considerably, probably up to three times what the level of each drug would be if taken alone. When prescribed in combination , the risks of each drug, such as high blood pressure or seizure, would be more likely to occur (T. 219-221, 736-740; F/F 28, 29, 35).

54. At various times, including 1/16/92, the Respondent prescribed a drug combination of Ritalin 120 mg, Prozac 40 mg, and Cytomel 150 mcg for Patient B. This combination was a deviation from accepted standards of medical practice (Ex. 8, P. 12; T. 221-222; F/F 23, 24, 28, 29, 35, 52, 53).

55. At various times, including 1/16/92 (Ex. 8, p. 12), the Respondent prescribed a drug combination of Ritalin 120 mg, Prozac 40 mg, and Wellbutrin 400 mg daily for Patient B. This drug combination was dangerous and a deviation from acceptable standards of medical practice (T. 222; F/F 28, 35, 50, 51, 53).

NARDIL

56. Nardil is a monoamine oxidase inhibitor which acts as an antidepressant by inhibiting the breakdown of catecholamines. It has the capacity to lower blood pressure. The usual effective dose of Nardil is 30 mg to 60 mg a day (T. 223-224, 742-743).

ELAVIL

57. Elavil is a tricyclic antidepressant which prevents cellular re-uptake of catecholaminergic substances. The usual effective dose range of Elavil is 75 mg to 150 mg a day, but it can be used at higher doses.

Elavil has numerous side effects, including dry mouth and tachycardia, and it also lowers blood pressure.

Combining Elavil with an MAOI must be done with extreme caution because the combination can cause a hypertensive crisis and death due to markedly high blood pressure or hyperthermic reactions (T. 223-224, 276-277, 742-743).

58. In March 1987, the Respondent prescribed Nardil 135 mg in combination with Elavil 200 mg for Patient B (Ex. 8, p. 104). There is no evidence that the high doses prescribed were necessary for an antidepressant effect. The plasma levels of Nardil, already at the high dose of 135 mg, will be increased. There is a risk of severe hypertension and stroke with this drug combination.

Paradoxically, there was a risk of a severe hypotensive crisis because each of these drugs lowers blood pressure. It should be noted that when Patient B was on slightly lower doses of these drugs, she collapsed while at home and had to be hospitalized for severe hypotension (Ex. 11, p. 29; T. 222-285, 742-745; F/F 56 and 57).

59. On approximately 5/20/85, the Respondent prescribed Reserpine for Patient B after the patient had reported to the Respondent on 5/8/85 that she has been suicidal (Ex. 8, pp. 144, 146).

Reserpine (rauwolfia alkaloid) was one of the early neuroleptic-like agents used to calm psychotic or highly agitated patients. It has been recognized as causing suicidal depression, and in a patient who is already depressed or suicidal, the effect of Reserpine could even worsen the condition. The Respondent's use of this drug for Patient B, at a time she was suicidal, was not consistent with accepted standards of medical practice (T. 225-227; 745-746).

60. The Respondent's records indicate that he prescribed chloral hydrate for Patient B over a period of several years. For example:

* On 7/18/85, the Respondent noted "Ch for sleep" (Ex. 8, p. 141).

* On 11/30/87, he recorded that sleep is okay with chloral hydrate (Ex. 8, p. 90).

* On 12/12/87 he recorded that the patient got four hours sleep with three chloral hydrate (Ex. 8, p. 88).

Chloral hydrate is a hypnotic drug used to induce sleep and is usually given a half gram at night. It is given for very short periods of time because hypnotic drugs lose their effectiveness after three or four days of use (T. 227-232, 1567: "She was on it for a long time. I would say I had to give her sedatives for years").

CONCLUSIONS AS TO PATIENT B

1. The Respondent failed to obtain and/or record an adequate history and mental status evaluation of Patient B when he first began treating the patient.

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

3. On numerous occasions, the Respondent failed to make adequate notes concerning the drugs he prescribed for Patient B, the indications for the drugs, and the indications for changes in the drugs or doses prescribed.

4. On numerous occasions, the Respondent failed to make adequate notes concerning Patient B's drug regimen, including the drugs Patient B was taking at any given time, the doses of the drugs, the directions for use, and when drugs were discontinued.

5. The Respondent failed to maintain adequate records for patient B.

6. At various times, the Respondent prescribed excessive doses of Cytomel for Patient B.

7. The Respondent prescribed Cytomel for Patient B without adequately monitoring Patient B's thyroid status.

8. The Respondent prescribed Premarin for Patient B without first obtaining a gynecological consultation to exclude any contraindication.

9. The Respondent failed to obtain a lithium work-up before starting Patient B on lithium and failed to periodically monitor Patient B's serum lithium levels while she was on the drug.

10. At various times, the Respondent prescribed Ritalin 120 mg daily for Patient B. Ritalin 120 mg/day is an excessive dose.

11. On January 16, 1992, the Respondent prescribed Prozac 40 mg/day and Wellbutrin 400 mg/day. This drug combination was not indicated and/or contraindicated.

12. On September 22, 1992, the Respondent prescribed Cytomel 200 mcg/day while Patient B was also taking Ritalin 120 mg /day. This drug combination was not indicated and/or contraindicated.

13. At various times, including April 17, 1991 and January 16, 1992, the Respondent prescribed Ritalin 120 mg daily along with Prozac 40 mg (or more) daily for Patient B. This drug combination was not indicated and/or contraindicated.

14. At various times, including January 16, 1992, the Respondent prescribed Ritalin 120 mg daily along with Prozac 40 mg daily and Cytomel 150 mg daily for Patient B. This drug combination was not indicated and/or contraindicated.

15. In March 1987, the Respondent prescribed Nardil 135 mg daily along with Elavil 200 mg daily for Patient B. This drug combination was not indicated and/or contraindicated.

16. On approximately May 20, 1985, the Respondent prescribed Reserpine for Patient B after Patient B had reported on May 8, 1985 that she had been suicidal. Reserpine was not indicated and/or contraindicated under these circumstances.

17. The Respondent prescribed Chloral Hydrate for Patient B over an excessive period of time.

FINDINGS AS TO PATIENT C

61. The Respondent provided psychiatric care to Patient C from approximately 5/18/76 through at least 2/4/93 at his office and by telephone. Patient C was twenty-three years old when he was first seen by the Respondent and had been referred to the Respondent because of depression.

The Respondent treated Patient C for approximately seventeen years. His primary

diagnosis was depression. He later diagnosed the patient as having panic attacks and seasonal mood swings.

The Respondent treated Patient C mainly with medication and psychotherapy. He was treated with Xanax up to 4 mg a day. In addition, a combination of tricyclic antidepressants and MAO inhibitors were often used (Ex. 13; T. 256-257).

The patient had difficulty dealing with his homosexuality (Ex. 13, p. 113). In the approximately last two years of treatment, the Respondent's impression was that the patient had ADD (Adult Attention Deficit Disorder) (T. 1802, 1110).

62. The Respondent's initial history of Patient C was inadequate. There is essentially no family, educational, developmental, work or medical history. There is no psychiatric history of any prior psychiatric treatment. There is no history of the patient's relationships with significant others. Almost nothing is known about the patient from the Respondent's notes (Ex. 13, pp. 114-115; T. 258; F/F 6, 7).

The patient, in fact, had a history of behavior problems as a child in school which can be indicative of ADD. However, the Respondent did not elicit the developmental and school history, and it was not until after years of treatment that the Respondent considered ADD as a diagnostic possibility (T. 1110-1112, 1802).

63. The Respondent's mental status evaluation of Patient C was inadequate. Essentially, none of the elements of a mental status evaluation are noted in the patient's records during the initial treatment period. There are notations such as "not doing well of late.. would rather be dead" or "very down" (Ex. 13, p. 115: 5/18/76 and 5/25/76 entries). However, there is no explanation of the context of those descriptions in view of the patient's mental status (Ex. 13, pp. 114-115; T. 259; F/F 6,8).

64. The Respondent failed to record adequate periodic mental status evaluations of Patient C during the course of treatment. The Respondent's notes are mostly anecdotal descriptions

of the patient e.g. "He's in neutral", "still plateau" (Ex. 13, p. 114). Later records often note that the patient is panicky, but fail to describe the problem. The Respondent's records contain no notation concerning the patient's affect, mood, thought content and other elements of a sufficient mental status evaluation (Ex. 13; T. 259-260; F/F 12).

65. The Respondent failed to adequately explore other diagnostic and treatment options for Patient C. The Respondent should have sought consultation with another psychiatrist or ordered psychological testing for this patient because he was being treated over a very long period of time without any apparent improvement (T. 261-262, 293-294, 301-302; F/F 15).

66. Respondent failed to keep adequate notes concerning the indications for the drugs he prescribed for Patient C. He also failed to note changes in the drugs and doses. For example:

* On 8/9/83 the patient was put on "Xanax 1 bid.", but there is no indication as to why Xanax was prescribed (Ex. 13, p. 60) The last prior reference to Xanax in the record was on 9/29/82: "working on prn Xanax"(ex. 13, p. 64).

* On 9/14/83, the Respondent decreased the patient's Valium dosage without noting the indication for the decrease. (Ex. 13, p. 60)

* On 10/26/83, the Respondent noted that the patient was on Xanax while in Poland and then placed him on Xanax 1 mg without noting the indication for doing so. (Ex. 13, p. 59).

* On 5/28/86, the Respondent recorded "decrease MAOI", but did not record the indication for the decrease. (Ex. 13, p. 36).

* On 8/24/92, the Respondent decreased the patient's dose of Elavil substantially without recording the indication for doing so. "On 4 Elavil...will [decrease] to 50 mgm Elavil" (Ex. 13, p. 5; T 262-265, F/F 18).

67. The Respondent failed to record adequate notes regarding Patient C's drug regimen. For example:

* From 8/23/76 to 11/9/76, there were nine patient contacts, but there is not a single reference to the patient's drug regimen in the record, even though the patient apparently was on Desipramine, Valium, Dalmane, Meprobamate and Eutonyl at the time.

* On 11/15/76, the Respondent noted that the patient discontinued Eutonyl on his own, but when and why the patient discontinued the drug is not noted, despite the numerous patient contacts. (Ex. 13, p. 109).

* From 12/16/76 to 3/23/77, there is no notation concerning the patient's drug regimen despite five patient contacts during that period.

* From 4/19/77 to 6/14/78, there were eighteen patient contacts, but only one note of the patient's drug regimen is recorded.

* A note dated 7/12/77, only states "takes 100 Desip." However, the patient apparently was also on Valium and Norpramin at the time (Ex. 13, 12/2/76 entry).

* From 8/13/86 to 2/24/87, there is no notation of the patient's drug regimen, although the patient apparently was on Parnate, Elavil and Xanax at the time.

* On 5/28/86, the Respondent noted the instruction "decrease MAOI" (Parnate) but the dose is not recorded. The next mention of Parnate is on 3/11/87, ten months later.

* On 11/21/89, The Respondent issued a prescription for Xanax but did not record it in the patient's records (Ex.13, p. 23; Ex. 14).

* From 11/21/89, when it is noted that the patient was on five Parnate, there is no notation concerning Parnate again until 5/6/90.

* On 7/7/92, it was noted that the patient is on 7 Parnate and was instructed to try 8. Two months and three patient contacts later it was noted that the patient is on 3 Parnate. There is no record of when or why the drug dosage was decreased.

* On 10/19/92, the Respondent recorded "Went off Elavil!", yet when or why the patient discontinued the drug is not recorded (Ex. 1, Appendix C; Ex. 13; T. 265-270; F/F 18).

68. The Respondent failed to maintain adequate records for Patient C. The records are insufficient for a subsequent treating physician to provide a continuum to care for the patient (T. 270; F/F 6, 7, 8, 12, 18, 21, 62, 63, 64, 65, 66, 67).

PARNATE

69. Parnate is monoamine oxidase inhibitor used to treat depression. It prevents the

breakdown of catecholamines and thus there is more catecholamines available at receptor sites. In addition to this inhibiting action, Parnate is also partly a psychic energizer. The usual therapeutic dose of Parnate is 30 mg - 60 mg daily.

There are risks with the use of Parnate. It tends to cause overstimulation and agitation. There is the danger of a reaction with tyramine containing foods or interaction with some other drug. If a patient is predisposed to mania, Parnate can precipitate a hypermanic episode. Even with treatment-resistant depression, Parnate should not be used beyond the dosage limit. Rather, safer medications or ECT should be prescribed (T. 270-275).

70. At various times the Respondent prescribed Parnate for Patient C in doses exceeding 60 mg daily (Ex. 1, Appendix C) For example:

* 09/8/87:	Parnate 70 mg.
* 12/5/87:	Parnate 80 mg.
* 6/22/88:	Parnate 80 mg.
* 12/9/91:	Parnate 70 mg.
* 12/12/91:	Parnate 80 mg.

(Ex. 13, pp. 9, 14, 30, 32).

On 11/1/88, the Respondent instructed the patient to increase Parnate to 100 mg if his mood was not okay (Ex. 13, p. 28).

These doses of Parnate were excessive and not consistent with accepted standards of medical practice (T. 217-275; F/F 69).

71. On 4/23/92, the Respondent prescribed 50 Elavil tablets for Patient C and instructed him to increase the dosage, which at the time was 25 mg, 1 q.h.s. as needed.

Because Elavil is a potentially dangerous drug that can cause many side effects, the dosage of the drug should be under the control of the physician and not under the control of the patient (T. 275-277; F/F 57).

72. During the time that Patient C was instructed to increase his dosage of Elavil as needed, the Respondent also increased the patient's dose of Parnate to 70 mg on 6/25/92 and to 80

mg on 7/7/92 (Ex. 13, p 5; F/F 69).

The dose of Parnate was already at a high level and the dose of Elavil was to be determined by the patient. In this combination, Elavil would inhibit the metabolism of the Parnate, thereby increasing the blood plasma level of the Parnate. The risks associated with Parnate would be increased, particularly the risk of a hypertensive crisis.

It should be noted that when Patient C's dose of Parnate was within acceptable limits and he was also on Elavil, his primary care physician notified the Respondent that the patient had come to see her with a history of chest pains and palpitations. That physician recommended that the Respondent change the patient to an antidepressant with less cardiac toxicity (Ex. 13, p. 44).

CONCLUSIONS AS TO PATIENT C

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

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

3. During the approximate seventeen years he treated Patient C, the Respondent failed to adequately explore other diagnostic, evaluative and treatment options for the patient including psychological testing and clinical consultation with another psychiatrist or a psychologist.

4. On numerous occasions, the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient C, the indications for the drugs, and the indications for changes in the drugs or doses prescribed.

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

6. The Respondent failed to maintain adequate records for Patient C.

7. At various times, the Respondent prescribed excessive doses of Parnate for Patient C.

8. On April 23, 1992, the Respondent directed Patient C to increase his dose of Elavil as needed. On June 25, 1992, he directed Patient C to increase his dose of Parnate up to 70 mg daily, and on July 7, 1992, he again directed the patient to increase the Parnate dose to 80 mg daily. It was inappropriate for the Respondent to have instructed the patient to increase the Elavil dose "as needed" and the Parnate/Elavil combination was not indicated and/or contraindicated.

FINDINGS AS TO PATIENT D

73. The Respondent provided psychiatric care to Patient D from approximately 3/22/88 through at least 2/3/93 at his office and by telephone. Patient D was sixty-eight years old when he was first seen by the Respondent. The patient was married and had four children. He was referred to the Respondent by another psychiatrist, Dr. Wells, because of a depression he had suffered since retiring from work at age sixty-two. The patient's twenty-year old son and his aunt also had histories of depression. Reportedly, Patient D had no response to tricyclics, MAOIs or lithium.

The Respondent treated Patient D for at least five years. In May 1991, he changed the patient's diagnosis from depression to bipolar disorder (Ex. 15, p. 7). He treated Patient D with psychotherapy and medication and during the course of treatment the patient had a neurological workup for a tremor and a transurethroprostatic resection (T. 303)

74. The Respondent's initial history of Patient D, which was obtained during ten patient contacts in the first month of treatment was inadequate. For example, other than noting a history of tuberculosis, no other medical history is recorded. There is only a superficial psychiatric

history. There is insufficient details regarding treatment with the referring psychiatrist. There is no social, developmental or educational history and the work history is inadequate.

About nine months after he began treating Patient D, the Respondent noted that the patient had a head injury at age seventeen and had been shaking ever since (Ex. 15, p.19, 12/29/88 entry). This significant fact was not recorded until well after the Respondent commenced treatment, and even when it was noted, there is no information regarding the nature of the injury or treatment, if any.

There is insufficient information regarding the patient's family relationships in the patient's records (Ex. 15, pp. 27-30; T. 303-304; T. 726-728; F/F 6.7).

75. The Respondent's mental status evaluation of the patient, obtained during the initial treatment period, was inadequate. There is no description of the patient in terms of his thinking process, behavior, affect, cognitive ability, or of the other elements that should be addressed in an acceptable mental status evaluation. Although the Respondent noted at the time of the initial visit that the patient had decreased cognitive function, he did not evaluate or describe the condition.

The patient history and mental status evaluation were insufficient to arrive at a working diagnosis or appropriate course of treatment for the patient (Ex. 15, pp. 27-30; T. 305, 726-728; F/F 6, 8).

76. The Respondent failed to periodically obtain adequate mental status evaluations of Patient D during the course of treatment. His typical notations regarding the patient's status were "he is better." or "okay on the day after lithium". These are inadequate descriptions of the patient's mental status. For example,

* On 5/14/91, the Respondent noted that the patient has been "Hypomanic. Feels good. Thoughts race. Had an accident today. Irritable" (Ex. 15, p. 7). This is an inadequate description, especially in view of the fact that it is the Respondent's first recorded notation of the patient being hypomanic.

* From 7/15/92 to 2/3/93, the Respondent's notes regarding Patient D's mental status consisted only of remarks like, "in

good spirits", "looks good," "doing well", which are inadequate (Ex. 15; T. 306-307; F/F, 12).

77. The Respondent failed to adequately explore other diagnostic and treatment options for Patient D. There was a long period of time when there appeared to be no movement with the patient. Then the patient suddenly stopped taking all of his medications and had what appeared to be a hypomanic episode. More diagnostic evaluation was indicated.

Further, the onset of this patient's depression coincided with his retirement. The possible psychodynamic connection between retiring and the depression should have been explored. This patient could possibly have been treated with psychotherapy alone, without drugs (T. 307-309; F/F 15).

78. The Respondent failed to adequately record the indications for drugs Patient D was taking, and changes in the drugs or the doses. For example:

* On 5/3/88, the Respondent increased the dose of Prozac from one to two without noting the indication for doing so (Ex. 15, p. 26)

* On 3/6/90 the Respondent increased Ritalin from 80 mg to 120 mg without noting the indication for doing so (Ex. 15, p. 10; T. 309-310; F/F 18).

79. The Respondent failed to record adequate notes regarding Patient D's drug regimen. For example:

* On 5/24/88, the records indicate the patient is to go to 2 Prozac. There is no notation concerning Prozac again until 11/1/88 (Ex. 1, Appendix D; Ex. 15).

* On 7/18/89, it was noted that Patient D was on Prozac, 4/Li and 3/L-T4. Thereafter, L-Tryptophan is not noted again until 12/26/89, when the Respondent notes that the patient is out of the drug. The patient's Prozac regimen is not noted again until 9/15/90, except for a 8/17/89 note, "will see [with] Prozac how it works".

* On 9/15/90, the Respondent issued a Prozac prescription with an unreadable number of refills (Ex. 15, p. 9). Thereafter Prozac is not mentioned again in the Patient D's record.

* On 12/4/90, the Respondent issued a prescription for lithium 300 qid #120 with 12 refills (Ex. 15, p. 8). There is no notation of lithium again until 5/14/91, although there were about five intervening patient contracts.

* On 6/3/92, after patient contacts on 4/7/92, 4/27/92 and 5/6/92, the Respondent recorded "off Li[times] 2 mos!" (T. 1864). There should have been notations regarding the lithium regimen in the notes of the prior patient contacts (Ex. 1, Appendix D; Ex. 15; T. 310, 312-313; F/F 18).

80. The Respondent failed to maintain adequate records for Patient D. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 314; F/F 6, 7, 8, 12, 18, 21, 74, 75, 76, 78, 79).

81. On 4/12/88, the Respondent prescribed a combination of lithium 300 mg, L-Tryptophan 1 gram, and Prozac 80 mg for Patient D (Ex. 15, p. 28). This combination was inappropriate because it presented the real danger of precipitating the serotonin syndrome, which can be fatal. Excess serotonin can create a marked change in mental status, usually delirium and confusion, and autonomic discontrol. There is also an effect on blood pressure. Prozac tends to increase the plasma levels of other drugs because of its inhibitory effect on the liver. L-Tryptophan is a precursor of serotonin and its plasma levels will increase because of the Prozac. Lithium, also has a serotonin effect to some extent (T. 319-320, 746-747; F/F 35).

82. The Respondent prescribed Ritalin for Patient D, a man in his late sixties, in doses in excess of 80 mg and up to 120 mg. For example: 2/6/90: 80 mg; 3/6/90 & 4/3/90: 120 mg; 5/1/90 to 5/91: 120 mg (Ex. 1, Appendix D). These Ritalin doses were excessive and inconsistent with acceptable standards of medical practice.

Excessive doses of Ritalin for an older patient is a matter of concern. In older patients the usual adult doses of Ritalin should be decreased.

High doses of Ritalin were not indicated in this case. The patient had a tremor for many years, which could be exacerbated by a high dose of Ritalin. Also, Ritalin can cause

psychological dependency at the high doses that were prescribed. (T. 321-322, 731-732, 747-750; F/F 28, 29).

83. As of 10/2/90, the Respondent had prescribed a daily regimen of Prozac 80 mg, lithium 900 mg, and Ritalin 120 mg for Patient D (Ex. 1, Appendix D; Ex. 15, pp. 8, 9) This combination was highly dangerous, particularly because of the effects Ritalin and Prozac have on each other. Prozac at 80 mg would probably triple or quadruple the blood levels of Ritalin. The risks of serious cardiovascular problems could result (T. 322-324; F/F 28, 29, 35, 47).

CONCLUSIONS AS TO PATIENT D

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

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

3. During the approximate five years he treated Patient D, the Respondent failed to adequately explore other diagnostic, evaluative and treatment options for the patient, including psychological testing and/or clinical consultation with a another psychiatrist or psychologist.

4. On numerous occasions, the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient D, the indications for the drugs, and the indications for changes in the drugs or doses prescribed.

5. On numerous occasions, the Respondent failed to record adequate notes concerning Patient D's drug regimen, including the drugs Patient D was taking at any given time, the doses of the drugs, the directions for use, and when drugs were discontinued.

6. The Respondent failed to maintain adequate records for Patient D.

7. The Respondent failed to obtain a lithium work-up prior to prescribing lithium for Patient D, and he also failed to periodically monitor Patient D's serum lithium levels while the patient was on the drug.

8. On April 12, 1988, the Respondent prescribed lithium, Prozac and L-Tryptophan for Patient D. This drug combination was not indicated and/or contraindicated.

9. The Respondent prescribed Ritalin for Patient D despite his assessment that Patient D's normal state was suggestive of hypomania. Ritalin was not indicated and/or contraindicated for this patient.

10. At various times, the Respondent prescribed excessive doses of Ritalin for Patient D.

11. On September 15, 1990, the Respondent prescribed Prozac 80 mg daily for Patient D. On October 2, 1990, he prescribed lithium 900 mg daily. Patient D was also on Ritalin 120 mg at the time. The combination of Prozac/Lithium/Ritalin was not indicated and/or contraindicated.

FINDINGS AS TO PATIENT E

84. The Respondent provided psychiatric care to Patient E at various times from 1970 through at least 1/13/93 at Strong Memorial Hospital, at his office and by telephone. (The Respondent's evaluation, treatment and maintenance of records of patient E are relevant to the charges insofar as they occurred on or after 9/1/73.)

85. Patient E was forty years old when he was first seen by the Respondent. He was referred to the Respondent by a physician and has continued in treatment with the Respondent for

at least twenty-three years.

Patient E was a designer. He was described as having wide fluctuations in mood and homosexual tendencies. The Respondent made the diagnosis of manic depressive with three years of depression. A later diagnosis was bipolar disorder.

The Respondent treated the patient with medication, psychotherapy, and some conjoint therapy with the patient's wife. The Respondent also treated Patient E's wife separately on several occasions. The patient and his wife have remained married.

During the course of his treatment with the Respondent, the patient began to act upon his homosexuality. He practiced unsafe sex and contracted venereal warts in 1990. In June, 1992 he was admitted to the Menninger Clinic, a private psychiatric hospital in Kansas (Ex. 16; T. 339-341).

86. The Respondent failed to obtain adequate supplemental histories and mental status evaluations of Patient E during the course of treatment and also after significant time gaps in the his contacts with the patient. For example, on 11/15/76, the Respondent saw Patient E and noted that the patient was to see him on an as needed basis (Ex. 16, p. 58). The next contact with Patient E was six years later on 8/2/82. The Respondent's notes of that contact were totally inadequate relevant to the history of the patient during the almost six year hiatus, also, the notes did not include a mental status evaluation (Ex. 16, p. 57) The same inadequacies exist regarding the other gaps in treatment. For example:

* 8/20/82 to 1/4/83	(Ex. 16, p. 57)
* 1/4/83 to 4/23/85	(Ex. 16, p. 57)
* 7/29/86 to 1/6/88	(Ex. 16, pp. 38, 40)
* 1/6/88 to 2/14/89	(Ex. 16, p. 38)
* 2/14/89 to 6/14/89	(Ex. 16, p. 33)

Any intervening notes refer to the Respondent's treatment of Patient E's wife (T. 341-344,726-728).

87. The Respondent failed to adequately explore other diagnostic, evaluative and treatment options for patient E during the course of treatment after 1973. Although the patient

eventually went to a private psychiatric hospital in 1992, other steps should have been taken long before that time.

There was a long period of treatment without obvious improvement. Issues relating to the patient, such as acting out more behaviorally and engaging in unsafe sex, should have been more intensely addressed. Consultation with another psychiatrist or psychological testing might have solidified what was really going on with the patient. There seemed to be some personality factors in the patient which needed to be addressed (T. 344-346; F/F 15).

88. The Respondent failed to record adequate notes concerning indications for the drugs he prescribed for Patient E or changes in the drugs or doses. For example:

* On 1/31/86, The Respondent phases the patient off Merital but the indication for doing so is not noted (Ex. 16, p. 43).

* On 3/11/86, it is noted that the patient is on 2 Merital but there is no indication recorded as to why this medication was reinstituted (Ex. 16, p. 41).

* On 2/20/86, the Respondent prescribed Cytomel prn without recording any indication for doing so (Ex. 16, p. 42).

* On 3/17/86, the patient's Cytomel is increased to 3 a day without any indication for the increase being recorded (Ex. 16, p. 41).

* On 8/23/89, The Respondent started the patient on Ritalin without noting any reason for doing so (Ex. 16, p. 30; T.346-347).

89. The Respondent failed to record adequate notes concerning Patient E's drug regimen. For example:

* On 10/13/75, the patient's Nardil was increased to 6 a day On 11/16/75, the patient is instructed to decrease the dosage to 4 a day. The next notation of Nardil in the records is seven years later, 8/2/82, when the patient reports he is off Nardil. There is no information regarding the patient's use of Nardil in the interim period, when he was on the drug, or why he went off the drug (Ex. 16, pp.64, 57).

* On 9/20/89, the Respondent noted that Patient got off Cytomel, became depressed, and went back on it. Cytomel is not noted again until 10/15/90 (Ex. 16, pp. 29, 24).

* On 9/26/90, the patient was taking 4 Nardil, but the drug is not noted again until six months later, in a 3/28/91 entry (Ex. 16, pp. 24, 21; T. 347-348; F/F 18).

90. The Respondent failed to maintain adequate records for Patient E. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 348-349, 728; F/F 6, 7, 8, 12, 18, 21, 88, 89, 90).

91. The Respondent prescribed Cytomel for Patient E at various times during the course of treatment. For example:

02/20/82	:	25 mcg
03/17/86, 07/29/86	:	75 mcg
10/15/89, 5/4/92	:	100 mcg

(Ex. 1, Appendix E).

The Respondent failed to obtain baseline thyroid tests before prescribing Cytomel for Patient E (T. 349-350, 728; F/F 23, 24, 25).

92. The Respondent prescribed doses of Cytomel of 75 mcg and up to 100 mcg for Patient E. These doses were excessive and a deviation from the accepted standard of medical practice (T.350-351, 729-731, F/F 23, 24, 25, 91).

93. At various times the Respondent prescribed Ritalin 80 mg/day and up to 120 mg/day for Patient E. For example:

* On 7/27/89, the patient was instructed to increase Ritalin as needed to 40 mg three times a day for a total of 120 mg (Ex. 16, p. 32).

* On 11/14/89, 12/26/89, 1/31/90, and 2/28/90, Ritalin 20 and Ritalin SR 20 were prescribed each to be taken twice a day, for a total of 80 mg daily (Ex. 16, pp. 29, 28).

* On 5/2/90 and 5/29/90, Ritalin SR 20 was prescribed to be taken three times a day, and Ritalin 20 once a day (Ex. 16, p. 27).

* On 6/27/90, the patient was instructed to take a daily dose of 120 mg of Ritalin (Ex. 16, p. 27).

- * On 7/29/90, the total daily dose of Ritalin is again reported as 120 mg (Ex. 16, p. 25).

Such doses of Ritalin were excessive and a deviation from the accepted standard of medical practice (T.350-352, 731-732; F/F 28, 29).

94. In July and August of 1989, the Respondent prescribed Ritalin 40 mg daily to Ritalin 120 mg daily for Patient E. The patient was also on Cytomel 75 mcg at the time (Ex. 1, Appendix E; Ex. 16, pp. 30, 32).

This was a dangerous combination of drugs, even with the Ritalin at the lower dose of 40 mg. Both drugs have similar actions; they are energizing drugs. Cytomel will increase the metabolic rate of both Ritalin and Cytomel and can cause poor appetite, weight loss, agitation, and tremor. Cardiovascular problems could result and there was also a potential for seizures. The combination of Ritalin and Cytomel was a deviation from accepted standards of medical practice (T. 353-354, 750; F/F 23, 24, 28, 29).

95. On 5/4/92, the Respondent prescribed Cytomel 100 mcg for Patient E when the patient was also on Nardil 90 mg. This was done despite Patient E's history of bipolar depression (Ex. 16, p. 16).

In view of the patient's history, this drug combination was not appropriate. The Nardil dose of 90 mg was at the upper limit, the usual dose being 30 to 45 mg daily. The patient had been diagnosed with atypical bipolar disorder. Any antidepressant can produce a manic or hypomanic episode in a patient with such a condition. Coupled with Cytomel 100 mg, which is an excessive dose of an extremely energizing drug, the Nardil/Cytomel combination had the great risk of producing a manic or hypomanic episode (T. 355-356, 751).

96. On 8/20/82, the Respondent sent a prescription for Desyrel to Patient E when he had not seen the patient in a treatment session for at least a three, and possibly a six year period (Ex. 16, pp. 57, 58, T. 1895).

The Respondent should have seen the patient before issuing the Desyrel prescription and his failure to do so was a deviation from accepted standards of medical practice. The Respondent testified that he did not see the patient because he had worked with him for a long time and felt the telephone call was sufficient; "when we start talking, in three or four minutes we're very in tune with what's going on" (T. 1895, 356-357, 366-367, 1895)

97. On 1/6/88, the Respondent renewed prescriptions for Cytomel and Desipramine for Patient E, even though he had not seen the patient in a treatment session during the prior seventeen months (Ex. 16, pp. 38 and 40). Given the nature of these drugs it was essential that the Respondent see and thoroughly evaluate the patient before renewing the Cytomel and Desipramine prescriptions (T. 357-358, 366-367).

98. On 2/14/89, the Respondent again renewed prescriptions for Cytomel and Desipramine for Patient E even though he had not seen the patient for thirty-one months. In addition, the Respondent failed to evaluate or record the patient's response to these drugs which he had previously prescribed on 1/6/88 (Ex. 16, p. 38; F/F, 97).

The Respondent issued the prescriptions in question pursuant to the patient's request in a letter dated, 2/13/89. In the letter, the patient wrote "(i)t is time for prescription renewals and I would appreciate it if you would send prescriptions for..."(Ex. 16, p. 39). The Respondent's notation on 2/14/89, when he refilled the prescription is merely "Ditto". There is no indication that the Respondent even had a telephone contact with the patient before sending the prescription renewals.

The Respondent's actions in renewing Patient's E's Cytomel and Desipramine prescriptions on 1/6/88 and 2/14/89 without having seen the patient was a deviation from accepted standards of medical practice (T. 258-260, 366-367).

CONCLUSIONS AS TO PATIENT E

1. The Respondent failed to obtain and/or record adequate supplemental histories

and mental status evaluations of Patient E during the course of treatment.

2. During the approximate last twenty years he treated Patient E, the Respondent failed to adequately explore other diagnostic, evaluative, and treatment options for Patient E, including psychological testing and/or clinical consultation with another psychiatrist or a psychologist.

3. On numerous occasions, the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient E, the indications for the drugs, and the indications for changes in the drug or doses prescribed.

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

5. The Respondent failed to maintain adequate records for Patient E.

6. The Respondent prescribed Cytomel for Patient E without first obtaining baseline thyroid function tests.

7. At various times, the Respondent prescribed excessive doses of Cytomel for Patient E.

8. At various times, the Respondent prescribed excessive doses of Ritalin for Patient E.

9. In July and August, 1989, the Respondent prescribed Ritalin 40 mg to Ritalin 120 mg for Patient E when the patient was also on Cytomel 75 mcg. This combination was not indicated

and/or contraindicated.

10. On May 4, 1992, the Respondent prescribed Cytomel 100 mcg for Patient E when the patient was also on Nardil 90 mg daily. The patient had a history of bipolar depression and this drug combination was not indicated.

11. On August 20, 1992, the Respondent sent a prescription for Desyrel to Patient E despite the fact that he had not seen Patient E in a treatment session for at least three, and possibly six years.

12. On January 6, 1988, the Respondent renewed prescriptions for Cytomel and Desipramine for Patient E despite the fact that he had not seen Patient E in a treatment session since 1986.

13. On February 14, 1989, the Respondent renewed prescriptions for Cytomel and Desipramine for Patient E despite the fact that he had not seen Patient E in a treatment session since 1986.

FINDINGS AS TO PATIENT F

99. The Respondent provided psychiatric care to patient F from approximately 8/1/89 through 1/2/90 at his office and by telephone (Ex. 17). Patient F was a thirty year old divorced mother of two when she was first seen by the Respondent.

Patient F initially reported a two year history of complaints of poor sleep, sleep attacks, decreased energy and decreased cognitive ability. Several day later, she reported a migraine headache. The Respondent's first contact with the patient was by telephone on 8/1/82. The call was initiated by the Respondent because the patient did not keep her scheduled appointment on that day. The Respondent's 8/1/82 note indicated that the patient reported having seizures and he made a diagnosis of migraine. He treated the patient primarily with medication, Percocet,

Dexedrine and imipramine (Ex. 17, p. 17, T. 387-388).

100. The Respondent failed to obtain an adequate history of Patient F. Although there is a significant amount of history regarding incest and abuse, the history was inadequate, particularly with regard to medical history. For example, there is no information about the patient's history of migraines, when they started, their intensity, or previous treatment. There is no prior medical or psychiatric history. There is inadequate information regarding the patient's education and work history. The patient reported seizures, sleep attacks, decreased energy and decreased cognitive ability, yet there is no history of these complaints (Ex. 17, pp. 14-17; T. 387-388; F/F 6 and 7).

101. The Respondent failed to obtain an adequate mental status evaluation of Patient F when he first began treating the patient. For example, there is no description of mood, affect, appearance, thinking processes, or the other elements of a mental status evaluation. The patient specifically reported decreased cognitive ability, yet the Respondent did not describe or explore that problem (Ex. 17, pp. 14-17; T. 288-289; F/F 6,8).

102. The Respondent failed to maintain adequate records for Patient F. For example,

* On 8/17/89, the Respondent issued two prescriptions for Percocet, but did not record this in the patient's record (Ex. 1, Appendix F; Ex. 17, pp. 14-15; Ex. 18).

* On 8/10/89, a prescription for Percocet was issued but not recorded in the patient's record (Ex. 1, Appendix F; Ex. 18).

* The Respondent's progress notes are inadequate (Ex. 17, pp. 6, 7; T. 389-391; F/F 6, 7, 8, 18, 21, 100, 101).

103. The Respondent treated Patient F's migraines with Percocet which was not indicated (Ex. 17, 2/24/89, 9/7/89. 11/2/89. 12/14/89 and 1/2/90 entries; Ex. 18 [original prescription] issued on 8/4/89, 8/10/89 and 12/27/89).

Opiates, such as Percocet, should not be used for the treatment of migraine headaches

on an on-going basis because of their addicting nature. On a rare occasion, an opiate such as Demerol may be given in an emergency room setting to give a patient temporary relief.

There are standard treatments for migraines which are not addictive. In fact, the patient's use of Percocet reflected an addiction problem in that the patient was using the drug on a regular basis in doses higher than directed (Ex. 1, Appendix F; T. 391-393).

104. The Respondent failed to adequately evaluate Patient F's complaints of migraine headaches. He should have obtained a neurological evaluation since the headaches were frequent and not getting any better. A neurological evaluation could have ruled out other causes for the headaches and helped to ascertain the nature of the migraines.. Such an evaluation was particularly important for this patient who reported decreased cognitive functioning (T. 393-395).

105. The Respondent prescribed Dexedrine and/or Percocet for Patient F at times when he knew or should have known the patient was seeking drugs for abuse. The patient had a pattern of missing numerous appointments including the first one scheduled, e.g., she missed appointments on 8/1/89, 8/21/89, 9/12/89, 10/3/89, 10/9/89, 11/2/89, 11/18/89 and 11/22/89 (Ex. 17).

The Respondent continued to issue prescriptions for Dexedrine and Percocet despite his own recorded misgivings, and under circumstances in which a reasonable prudent physician would not have done so. For example:

* On 8/15/89 the patient reported that her purse was stolen. Respondent noted "Can I believe this?" and "I accept the theory of her meds." On that date, (8/15/89), the Respondent issued a prescription for 60 Percocet to be taken 12 a day (Ex. 17, p. 16).

* On 8/17/89, the patient reported that she left her medications at the lake (Ex. 17, p. 15). On that day the Respondent issued two Percocet prescriptions for a total of 120 tablets (Ex. 1, Appendix F; Ex. 18).

* Between 8/24/89 and 9/26/89, the Respondent issued prescriptions for 1000 Percocet tablets.

* On 10/9/89, the patient reported that she lost her Dexedrine

and the Respondent called in an emergency supply of 90 tablets for her (Ex. 17, p. 13).

* On 11/2/89, the Respondent recorded that the patient did not get the prescriptions for Percocet and Dexedrine. He further recorded "It is getting hard to believe" but sent the patient prescriptions for Percocet and Dexedrine nonetheless (Ex. 17, p. 10).

* On 11/15/89, the Respondent recorded "(s)he wants Dex. Off it for some time, says she never got Rx!" (Ex. 17, p. 10).

* On 11/27/89, the patient reported that she gave her medications to her sister (Ex. 17, p. 7).

* On 12/27/89, the patient reported that she did not get her medicine filled and the Respondent gave her prescriptions for 15 Dexedrine and 30 Percocet tablets. He noted "(h)er pattern I say is one of an addict. We'll have to work out a tighter system." (Ex. 17, p. 6).

* Pursuant to a phone call on 1/2/90, the Respondent issued prescriptions for a two week supply of Dexedrine and Percocet. (Ex. 17, p. 6).

Patient E was clearly abusing drugs and the Respondent did not develop a meaningful plan to get her off the drugs (T. 395-405).

The Respondent excused his prescribing practices by stating that he has several wealthy friends and Patient F "plugged into [his] notion that rich people have a problem because they got to have medicines and doctors wherever they go" (T. 1916-1917).

CONCLUSIONS AS TO PATIENT F

1. The Respondent failed to obtain and/or record an adequate history and mental status evaluation of Patient F when he first began treating the patient.

2. On numerous occasions, the Respondent failed to adequately monitor and record Patient"s response to pharmacotherapy and psychotherapy, and to record adequate progress notes of his sessions with Patient F.

3. The Respondent failed to maintain adequate records for Patient F.

4. The Respondent treated patient F's complaints of migraine headaches with Percocet, which was not indicated.

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

6. The Respondent issued prescriptions for Dexedrine and Percocet for Patient F when he knew, or should have known, that Patient F was abusing drugs.

FINDINGS AS TO PATIENT G

106. The Respondent provided psychiatric care to Patient G from approximately 5/4/83 through at least 2/93 at his office and by telephone.

Patient G was sixty-three years old when he was first seen by the Respondent. His chief complaints were increasing depression since 1980, a decrease in sexual desire and performance , weight loss, and decreased ability to concentrate. He was taking Dalmane for sleep.

The patient also complained of irritability and expressed some hostility toward his wife and son. His mother had a four year history of depression and his father was dead. He had a number of setbacks with his farm and he eventually lost the farm and declared bankruptcy.

During the course of treatment, the patient had benign prostatic hypertrophy and subsequently developed prostatic cancer. He was treated with radiation in 1985 and again in 1989 for a recurrence of the cancer.

The Respondent treated Patient G with medication and psychotherapy (Ex. 19; T 410-412).

107. The Respondent failed to obtain an adequate history of Patient G when he first began treating the patient. Although there is a significant amount of information in the record it is inadequate in view of the patient's chief complaint of depression.

There is no history of the patient's two year depression, whether it was ever treated,

what precipitated the condition or it's severity. Other elements of an adequate history are also missing. For example, there is essentially no medical history of the patient. It is recorded that the patient is taking Dalmane, but there is no note as to how long he was taking this drug or who had prescribed it. There is no developmental history except reference to the patient's Catholic upbringing (Ex. 19, pp. 59-61; T. 412-413; F/F 6 and 7).

108. The Respondent failed to obtain an adequate mental status evaluation of patient G when he first began treating him. The record fails to note the patient's cognitive functioning, thought content, insight and affect. Recorded anecdotal notations such as "more mellow times two weeks" or " spirits and dispositions high" do not suffice for a mental status evaluation (Ex. 19, pp. 59-61; T. 414; F/F 6, 8).

109. During the approximate ten years that he treated Patient G, the Respondent failed to periodically obtain adequate mental status evaluations of the patient. The patient's status is essentially frozen at points in time with regard to mood and there is no broader evaluative context of his mental status.

Another psychiatrist reviewing the patient's record would not get a sense of the patient's clinical course regarding his mental status (T. 415; F/F 12).

110. The Respondent failed to adequately explore other treatment or diagnostic options for Patient G during the ten year course of treatment. He failed to adequately treat the patient with psychotherapy or to provide a trial of such treatment without medication.

The patient seemed to have an essentially situational depression related to his farm, and his cancer had an emotional effect on him. He had very strong capabilities and personal resources. He had run a farm and expressed hopeful feelings of being able to continue to work and do other things. He sold the farm machinery successfully.

Treatment with psychotherapy alone without medication was warranted in this case. Instead, the Respondent had the patient on massive doses of numerous medications for at least ten

years (T. 415-417 F/F 15).

111. The Respondent failed to maintain adequate notes concerning the indications for the drugs he prescribed for Patient G or changes in the drugs or the doses. For example:

* On 5/8/91, the Respondent noted that the patient was to finish his supply of Asendin and then switch to Wellbutrin, but he did not note the indications for the change (Ex. 19, p. 19; T. 417-418; F/F 18).

* On 3/10/92, Patient G was started on Zoloft and Ludionil was discontinued. On 2/12/92, the Respondent had noted that the patient was doing better and cheerful. However, he failed to note the indications for changing the medication regimen (Ex. 19, p. 14).

112. The Respondent failed to record adequate notes regarding Patient G's drug regimen. For example:

* On 1/3/84 Xanax is to be used as a backup up to four a day. There is no notation of Xanax again until 9/5/84.

* On 10/30/84, it is noted that "sleep is ok [with] Xanax". Xanax is not noted again until 3/8/85.

* After 3/19/85, when Respondent noted that the patient is on .5 Xanax for sleep, the drug is not noted again in the patient's record. It is not known whether the patient was still on the drug, the dosage, the frequency, or if and when the drug was discontinued.

From 2/10/88 to 5/24/88, the Respondent saw the patient four times, but failed to make any note regarding the patient's drug regimen.

On numerous occasions, the Respondent issued prescriptions for Ritalin for Patient G but did not record them in the patient's record. For example, he issued Ritalin prescriptions on 1/31/89; 2/28/89; 4/15/89; 5/30/89; 6/27/89; 8/22/89; 11/14/89; 12/13/89; 1/10/90; 2/7/90; 3/7/90; 4/5/90; 6/6/90; 7/3/90; 3/6/91; 4/2/91 and 7/2/91 (Ex. 19; Ex. 20).

On 6/10/92, the Respondent noted that he had written a prescription for Cytomel. Thereafter there is no further note concerning Cytomel in the patient's record which ends on 2/3/93 (Ex. 1, Appendix G; T. 418-420; F/F 18).

113. The Respondent failed to maintain adequate records for Patient G. The records

are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 420; F/F 6. 7. 8. 12. 18. 21, 107, 108, 109, 111, 112).

114. Beginning on 9/2/86 and through 1993, the Respondent prescribed Ritalin for Patient G.

The patient was dysthymic, a chronic depression usually of not great severity. People are usually able to function with this type of depression, as was Patient G. Given the nature of the patient's depression and the potential side effects of Ritalin, the drug was not appropriate in this case (T. 420-422; F/F 32, 33).

115. At various times, the Respondent prescribed Ritalin 80 mg to 120 mg a day for Patient G. For example:

11/13/86	(80 mg)
12/11/86	(80 mg)
01/8/87	(100 mg)
03/3/87 through 7/20/87	(120 mg)
06/7/88 to 2/6/91	(120 mg)
02/6/91	(80 mg)
03/6/91	(80 mg)
04/2/91	(120 mg)
06/5/91 through 9/2/91	(80 mg)

(Ex. 1, Appendix G).

These doses of Ritalin were excessive and not indicated (T. 422-423; F/F 28, 29).

116. On 2/5/87, the Respondent prescribed Asendin for Patient G at a time when the patient was also on Ritalin 100 mg. On 3/3/87, the patient was on Asendin 150 and Ritalin 120 mg. Thereafter, there were times when the patient was on Asendin 250 and Ritalin 120 mg eg, 5/3/90 (Ex. 19).

Asendin or amoxapine is an antidepressant derived form the neuroleptic drug loxapine. Although it is an effective antidepressant, it has the disadvantage of lowering the seizure threshold more than most antidepressants. It also has a high incidence of extraparenteral side effects.

Ritalin alone can cause seizures and it was given in excessive doses to this patient. Ritalin will also increase the blood levels of Asendin, thereby increasing the seizure inducing potential of Asendin.

The Asendin/Ritalin combination was not appropriate (Ex. 1, Appendix G; T. 423-425; F/F 32, 33).

117. On 11/17/93, The Respondent directed Patient G to increase his Desyrel to 700 mg for three days, then increase it to 800 mg for three days, and then to decrease it to 300 mg if he was not better (Ex. 19, p. 55).

On 10/27/93, when the patient was on Desyrel 600 mg, he reported feeling like a workaholic and having no sex interest. On 11/17/93, the day the Respondent directed him to increase the Desyrel dose, the patient reported that the harvest was awful, he had no erection, and he was worrying about his wife. Yet, despite these negatives, the patient was hopeful, reporting how he saw that he could work and go on. The Respondent's direction to increase the Desyrel was not indicated.

The patient was dealing with realistic issues and functioning fairly well. He was already on a fairly high dose of Desyrel. Further, one of the problems the patient reported was an inability to get an erection. Desyrel (trazodone) is a drug that often causes that very problem (T. 425-426).

118. On 10/8/91, the Respondent directed Patient G to discontinue Ritalin and to use it biweekly for special events. This direction for the use of Ritalin was inappropriate.

When Ritalin is to be used to treat depression, it has to be used continually to maintain appropriate blood levels of the drug. Absent that purpose, Ritalin should not be used to energize someone sporadically as a "pick-me-up". Such use invites abuse (T. 426-428, 437; F/F 28, 29).

Patient G testified that the Respondent had advised him to take Ritalin whenever he felt he needed it. He said that he takes four a day whenever he thinks he needs them. Sometimes

he doesn't take Ritalin for a week or more. The patient testified that he takes Ritalin when he gets up in the morning and "doesn't feel like moving" or just sat around" (T. 1057-1059) This is not a proper use of Ritalin.

CONCLUSIONS TO PATIENT G

1. The Respondent failed to obtain and/or record an adequate history and mental status evaluation of Patient G when the Respondent first began treating the patient.

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

3. During the approximate ten years he treated Patient G, the Respondent failed to adequately explore other diagnostic, evaluative, and treatment options for the patient, including psychological testing and/or clinical consultation with another psychiatrist or a psychologist.

4. On numerous occasions, the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient G, the indications for the drugs, and the indications for changes in the drugs or doses prescribed.

5. On numerous occasions, the Respondent failed to record adequate notes concerning Patient G's drug regimen, including the drugs Patient G was taking at any given time, the doses of the drugs, the directions for use and when drugs were discontinued.

6. The Respondent failed to maintain adequate records for Patient G.

7. The Respondent prescribed Ritalin for Patient G. Ritalin was not indicated for this patient.

8. At various times the Respondent prescribed excessive doses of Ritalin for Patient G.

9. The Respondent prescribed Asendin for Patient G when Patient G was also on Ritalin. This drug combination was not indicated and/or contraindicated.

10. On November 17, 1983, the Respondent directed Patient G to increase his dose of Desyrel to 700 mg for three days, then to 800 mg for three days, and then to decrease his dose to 300 mg if no better, which directions were not indicated.

11. On October 8, 1991, the Respondent directed Patient G to use Ritalin "for special events", which was not a proper indication for using the drug.

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

FINDINGS OF FACT AS TO PATIENT H

119. The Respondent provided psychiatric care and/or pain management care to Patient H from approximately 4/4/88 to at least 2/3/93 at his office and by telephone.

Patient H was a twenty-six year old married woman with a history of panic attacks since age eighteen. She had temporomandibular joint surgery resulting in chronic pain. The Respondent's diagnosis was chronic pain and panic.

Patient H became depressed and the Respondent treated her with medications, including opioids and antidepressants. During the course of treatment, the patient began to abuse the pain medication and she was referred to a pain clinic in 1992 (Ex. 21; T. 422).

120. The Respondent failed to obtain and record an adequate history of Patient H when he first began treating her. During the approximate first two weeks of treatment, which

included four patient contacts, the history noted by the Respondent omitted many of the elements of an acceptable history, and other elements were often not adequately developed. For example, there was no medical history. The history, description and treatment history of the patient's reported panic attacks were inadequate. The patient's family history was inadequate. There was no developmental, work or educational history and there was no explanation of the patient's relationship with her parents, siblings or her husband (Ex. 21, pp. 84-85; T. 442-443; F/F 6, 7, 8).

121. The Respondent failed to obtain and record an adequate mental status evaluation of patient G when he first began treating her. None of the elements of a mental status evaluation are evident in the patient's record (Ex. 21, pp. 84-85; T. 443-444; F/F 6, 8).

122. the Respondent failed to periodically obtain and record adequate mental status evaluations of Patient H during the approximate five years of treatment. Generally, each session's record consisted mainly of the patient's subjective complaints but do not contain objective descriptions of the Respondent's assessment of the patient's mental status (T. 44; F/F 12).

123. The Respondent failed to record adequate notes regarding indications for the drugs he prescribed for Patient H and changes in the drugs or the doses. For example:

* On 8/8/89, the Respondent directed that the patient increase her Elavil dose to 150 mg or 200 mg a day without recording an indications for doing so. He had described the patient as doing "OK" on that date (Ex. 21, p., 64).

* On 9/189/89, the Respondent prescribed Tenuate without recording the indication for doing so (Ex. 21, p. 62)(Tenuate is an amphetamine-type drug usually used to treat obesity because of its antiappetite effect (T. 450-451; F/F 18).

124. The Respondent failed to maintain adequate notes regarding patient H's drugs regimen. For example:

* On 4/19/89 the Respondent recorded "Rx Percocet tabs." However, there is no notation regarding the dosage or the amount prescribed (Ex. 21, p. 70). Percocet is not noted

again until 5/31/89, despite several patient contacts in the interim. When it is noted again on 5/31/89, the notation is only "pain medicine - Percocet", but the dosage is not recorded (Ex. 21, p. 68).

* On 3/8/89, the Respondent noted a telephone conversation with the patient, "also send 3 mo K" [Klonopin]. However, the dosage and quantity of Klonodin prescribed are not recorded (Ex. 21, p. 73) On 3/21/89, Respondent notes "OK [increase] Klon", but did not record the dosage (Ex. 21. p. 72). The next note regarding Klonopin is dated, 4/26/89 (Ex. 21, p. 70).

* On 9/24/92, the Respondent recommended an increase in the patient's Imipramine to 225/250 (Ex. 21, p. 70). The next note regarding Imipramine was made on 1/14/93, "will increase to 300 Imip." (Ex. 21, p.3). There is no information regarding the patient's use of Imipramine in the four month interim.

* On 8/5/92, the Respondent issued a prescription for Tylenol with Codeine with five refills. Tylenol with Codeine is not noted again in the record until a 10/2/8/92 notation, "call re Tylenol [with] Cod."

On numerous occasions, the Respondent issued prescriptions without recording them in the Patient's H's records. For example:

* 07/25/89: (Percocet);
* 01/25/90: (Percocet, Valium)
* 07/24/90: (Percocet)
* 12/6/90: (Demerol, Percocet)
* 02/13/91: (Demerol, Valium);
* 03/21/91: (Percocet, Valium, Dalmane);
* 06/6/91: (Demerol);
* 07/17/91: (Demerol)

(Ex.1 appendix H; T. 451; F/F 18).

125. The Respondent failed to maintain adequate records for Patient H. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 452; F/F 6, 7, 8, 12, 18, 21, 120, 121, 122, 123, 124).

126. The Respondent prescribed Klonopin and Valium for Patient H at the same time, e.g. 2/8/89, 10/10/89. 12/27/89 with 1/4/90 (Ex. 1, appendix H).

Klonopin and Valium are drugs usually used to treat anxiety, but they also have many

other uses. They are hypnotic and anti-convulsants and are very similar, except that Klonopin is more potent. It was inappropriate for the Respondent to combine two drugs that essentially do the same thing.

The Klonopin/Valium combination results in an additive effect, magnifies the side effects of each drug and includes the risk of habituation.

The rationale for the combination, that Klonopin helps panic but Valium blocks anticipatory anxiety is not a generally accepted rationale. Klonopin alone addresses panic and also blocks anticipatory anxiety (T. 452-453).

127. The Respondent prescribed Demerol and Percocet for Patient H at the same time. For example, 1/25/90; 1/29/90 with 1/30/90; 2/21/90; 6/14/90 with 6/26/90; 9/5/90 with 9/18/90; 10/2/90 with 10/16/90; 10/23/90 with 10/30/90; 12/6/90; 1/1/91 with 1/10/91 5/20/91 with 5/23/91; 6/23/91 with 6/26/91; 1/21/92 (Ex. 1, appendix H).

Percocet is an opioid drug. Demerol is a synthetic opioid somewhat stronger than Percocet, and is used mainly in a hospital setting to relieve post operative pain.

It is inappropriate to combine two opioid drugs. There is the risk of addiction as well as increasing the side effects of each drug.

If the Respondent prescribed Demerol for a high level of pain with Percocet for a lower level pain, that still would not be an acceptable rationale of the combination. The stronger pain should have been addressed by a strong opioid, such as Demerol or Percodan, and the low-level pain by a non-opioid drug (T. 454-455).

128. In August 1989, the Respondent changed Patient H's doses of Elavil and imipramine. On 8/2/89, Patient H was taking 50-100 imipramine. On 8/8/89, the Respondent suggested adding Elavil 50, three to four times a day. At that time he noted that the patient is doing "OK. She is fine [with] Imip." Then on 8/10/89, imipramine is increased to 175 for one day and take 25 twice a day and go to 200 if not okay. On 8/30/89, Elavil is decreased by 25 a week and 150 imipramine increased as needed to 175-200 a day (Ex. 21, pp. 64-65).

The Respondent's directions for the use of the drugs was not appropriate. The two drugs are very similar, although Elavil is more sedating and anticholinergic. Based on the patient's status, as recorded by Respondent at the time, there was no logical rationale of the increases or deceases in the dosages of the drugs (T. 456-458).

129. the Respondent prescribed Demerol and/or Percocet for Patient H over an excessive period of time. She was on Percocet from 9/6/88 to 4/14/92, about three and one half years. She was on Demerol form 1/29/90 through 4/14/92, over two years.

These opiate drugs should not be used chronically. The major risk to the patient is addiction, and in fact, the patient's use of the drugs suggests that she did become addicted. Her use of the drugs increased over time and she used amounts greater than the instructions for use. For example:

* On 9/5/89, 120 tablets of Demerol, a month's supply, was prescribed. Thirteen days later, on 9/18/89, another 120 tablets was prescribed, to be taken every four hours as needed, or a twenty day supply. Nine days later, on 9/27/89, another prescription for Demerol was issued. The patient should have used 125 tablets if taken in accordance with the directions for use, but in fact, used 240 tablets or an average of 11 1/2 tablets per day.

* On 8/15/91, the Respondent noted that the patient asked for Percocet on that date, but he refused to issue a prescription for Percocet because one had already been issued on 7/24/91.

* On 11/23/92, another physician called the Respondent and advised that the patient had altered a prescription for Percocet from 60 to 160 (Ex. 21, p.5;; T. 459-461).

It should also be noted that during some of the time that Demerol and Percocet were prescribed, Patient H was misusing Valium to escape the circumstances of her marriage (Ex. 21, p. 35: "she has been way to high on Valium"; T. 1965-1966).

130. The Respondent failed to refer Patient H to a pain clinic or obtain a consultation

from such a clinic in a timely manner. The referral to a pain clinic in 1992, about four years after the Respondent began treating the patient, was too late. This patient was using large doses of opiate pain medications, in increasing amounts, for a prolonged period of time. She should have been referred to a pain clinic where other modalities could have been included in her treatment and where the drugs would be used in a controlled setting (T. 462-464).

CONCLUSIONS AS TO PATIENT H

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

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

3. On numerous occasions, the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient H, the indications for the drugs, and the indications for changes in the drugs or doses prescribed.'

4. On numerous occasions, the Respondent failed to record adequate notes concerning Patient H's drug regimen, including the drugs Patient H was taking at any given time, the doses of the drugs, the directions for use and when drugs were discontinued.

5. The Respondent failed to maintain adequate records for Patient H.

6. The Respondent prescribed Klonopin and Valium, both benzodiazepines, for Patient H at the same time. This drug combination was not indicated.

7. The Respondent prescribed Demerol and Percocet, both opioid analgesics, for Patient H at the same time. This drugs combination was not indicated.

8. In August, 1989, the Respondent changed Patient H's doses of Elavil and Imipramine. The dose changes were not indicated.

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

10. The Respondent failed to refer Patient H to a consultation form a pain clinic in a timely manner.

FINDINGS AS TO PATIENT I

131. The Respondent provided psychiatric care to Patient I from approximately 8/14/80 through at least 11/18/92 at his office and by telephone. At the time of the first visit, Patient I was a thirty-four year old, divorced father of four. He was a truck driver and computer technician.

On 10/1/86, the Respondent described the patient as having been a hyperactive child and hyperactive adult. On 1/25/90, he described the patient as hypomanic. He treated the patient with medication and psychotherapy (T. 496-499).

132. The Respondent failed to obtain or record an adequate history when he first began treating Patient I. The patient reported periodic depression since age four, but the Respondent failed to describe the condition. There was no history or details of any past psychiatric treatment. There were inadequate histories regarding primary relationships and his marriage and divorce. The patient reported that when he was very young, he tried to kill his brother, but there is no exploration of this episode.

There is no medical history except for a note that the patient had polio at age eight.

There was an inadequate history regarding educational background, work history and psychosocial development. After eight years into treatment, the Respondent describes the patient as a hyperactive kid and adult.

There is no history regarding drug or alcohol abuse except for a reference on 8/28/80,

"hasn't smoked any grass lately" (Ex. 23, pp. 59-61; T. 497-499, 500; F/F 6, 7).

At the hearing, Patient I testified that he had just stopped his long-term use of marijuana when he was first seen by the Respondent (T. 1172). The Respondent failed to note the patient's long-term marijuana use in the record.

133. the Respondent failed to obtain or record an adequate mental status evaluation of Patient I when he first began treating him. There is very little information regarding mental status. The patient's affect, insight and thought content are not noted. Descriptions of the patient such as "on a high," "jumpy" or "anxious" are not the equivalent of an appropriate mental status evaluation. (Ex. 23, pp. 59-61; T. 499; F/F 6, 8).

Patient I testified that when he first saw the Respondent he was "very suicidal" since he had stopped using marijuana (T. 1172).

The Respondent's notes are silent with regard to the patient's suicidal thoughts.

The Respondent testified that he did not record that the patient was suicidal because "one of the things may be that he's a very engaging person and right from the start we started working well together. And I don't think that was an issue." (T. 2002-2003).

134. The Respondent failed to obtain or record adequate supplemental histories and mental status evaluations of Patient I during the course of treatment and gaps in treatment. There were significant periods of time during which the Respondent had no contact with Patient I, and the Respondent did not provide any information regarding the patient in these interims. For example:

* There is a six month gap between 1/23/85 and 7/23/85, in which the Respondent did not see the patient. Other than noting that the patient had G.I. complaints, there is no information regarding the patient's mental status or interim history (Ex. 23, p. 19).

* From 4/15/86, to a phone contact on 10/1/86, a five and one half month period, there is insufficient information regarding the patient's history and mental status.

* From a 10/1/86 phone contact to the next patient contact, again a phone contact on 1/26/88, there is insufficient information regarding the patient's history or mental status

during the sixteen months interim (Ex. 23, p.15; T. 499-501; F/F 12).

135. The Respondent failed to adequately diagnose Patient I and failed to adequately explore other diagnostic, evaluative and treatment options for him.

Over the twelve year course of treatment the patient's diagnosis was changed back and forth a number of times from hypomania to attention deficit disorder (ADD).

* On the first visit he was described as "cycles as adult."
* On 10/1/86, he was described as a hyperactive kid and adult but there was inadequate evidence to support this description (Ex. 23, p. 15).
* On 1/25/90, he was described as a hypomanic (Ex. 23, p. 11).
* On 5/28/91, the Respondent wondered if the patient had an attention deficit disorder response (Ex. 23, p.6).

Psychological testing would have been helpful in identifying what was going on with this patient (T. 501-502; F/F 15).

136. The Respondent failed to maintain adequate records concerning the indications for drugs he prescribed for Patient I, and changes in the drugs and doses. For example:

* On 4/28/82, the Respondent prescribed Desyrel without recording the indication for doing so, other than noting that the patient was on the edge of depression, sedated and gaining weight. It should be noted that Desyrel is a drug that is very sedating and causes weight gain in most patients (Ex. 23, p.29).
* On 8/11/82, the Respondent added Cytomel to the patient's drug regimen without noting the indications for doing so (Ex. 23, p.27).
* On 7/30/85, the Respondent prescribed Xanax but no indication for doing so is noted (Ex. 23, p. 19).

On a number of occasions the Respondent not only did not record the indications for drugs prescribed, but allowed the patient to direct the drug therapy himself. For example:

* On 6/15/89 the patient stated that he wanted Ritalin. thereafter, the Respondent prescribed it without recording the indications for doing so (Ex. 23, p.. 11).

* On 7/23/85, the Respondent made a note regarding the drug regimen, "I can't figure out. So give approval." (Ex. 23, p. 19, T. 503-504; F/F 18).

137. The Respondent failed to maintain adequate notes concerning Patient I's drug regimen. For example:

* On 3/5/81, Parnate is first noted. It is noted again without a dose, on 3/18/81. Thereafter, there is no note regarding Parnate until 10/24/81.

* On 2/8/83, the Respondent noted "added Cytomel." The dose is not noted and the drug is not noted again in the record.

* On 8/14/89, the Respondent issued a prescription for Ritalin but did not record it in the patient's record.

* On 6/15/89, Prozac is first noted, but is not noted again until 11/27/89 (Ex. 1, Appendix I; T. 504; F/F 18).

138. The Respondent failed to maintain adequate records for Patient I. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 50-4; F/F 6, 8, 12, 18, 21, 133, 134, 135, 136).

139. The Respondent prescribed Cytomel for Patient I on 8/11/82 and 2/8/83 (Ex. 23, pp. 23, 25, 27). There is no evidence in the record that the Respondent obtained baseline thyroid function tests of the patient prior to prescribing the Cytomel (T. 505; F/F 23, 24, 25).

140. On 8/14/81, 10/2/85 and 2/11/86, the Respondent prescribed lithium for Patient I without obtaining a lithium workup for the patient.

If a patient is on lithium and it is discontinued and not prescribed again for several years, a lithium workup is still required. A patient's physiology can change over a period of time. Further, if a lithium workup is ordered but the patient does not comply, the psychiatrist should not start the patient on the drug (T. 505-507; F/F 47).

141. On 1/26/88, the Respondent first prescribed Prozac (flouxetine) for Patient I

pursuant to a telephone call with the patient. The Respondent had last seen the patient twenty months previously on 4/15/86.

The Respondent's prescribing of Prozac under these circumstances was inappropriate. Prozac is a very potent drug and the patient should have been seen before such a medication was prescribed (T. 507-508; F/F 35).

The Respondent testified that he did not see the patient because he knew the patient so well and a twenty to thirty minute phone call 'was perfectly adequate to go over the medicine" (T. 1993-1994).

142. On 10/10/92, the Respondent prescribed Zoloft for Patient I noting that the patient was "on [the] road". The Respondent had not seen the patient since 3/29/92 (Ex. 23, pp. 2, 6).

Zoloft is a drug similar to Prozac, a serotonin re-uptake inhibitor. The Respondent's prescribing of Zoloft for Patient I under these circumstances was not appropriate (T. 508-510).

143. The Respondent prescribed Ritalin for Patient I on 5/16/88; 3/29/89 through 12/12/89; 1/25/90 and 6/21/92 (Ex. 1 appendix I). Prescribing Ritalin was inappropriate in view of the Respondent's assessment of the patient's diagnosis and was a deviation from accepted standards of medical practice.

The Respondent described the patient as hypomanic and having mood swings (F/F 135). He also noted that the patient's father had been manic-depressive. Putting a patient with this history on a drug like Ritalin is much more likely to produce hypomanic episodes. If in fact, the patient had attention deficit disorder, there were alternative treatments available, such as Inderal, which would not pose the danger of precipitating a hypomanic episode (T. 510-512; F/F 28, 29).

144. The Respondent noted that in a 11/18/92 telephone call, Patient I had advised him that he was diagnosed by a physician as having diabetes mellitus and had a 400 blood sugar.

There is no evidence in the records that the Respondent followed-up on what the

patient had reported to him. His failure to do so was not consistent with accepted standards of medical practice.

Diabetes Mellitus is a significant and a serious illness, not only in itself, but with regard to the effect of any medication regimen. The Respondent should have secured a release to get the records of the physician who made the diagnoses. If this was not possible, the patient should have had another examination by an internist or family physician. Any follow-up should have been carefully documented in view of the significance of this diagnosis (T. 512-514, 516).

145. The Respondent prescribed Parnate in doses in excess of 60 mg and up to 150 mg and 180 mg for Patient I, e.g., 2/9/82(180 mg); 3/25/82 (150 mg); 12/7/84, 1/23/85, 7/30/85 (90 mg) (Ex. 1, appendix I). These excessive doses were inconsistent with accepted standards of medical practice.

Parnate is potentially a very dangerous drug. In this case it was given in excessible doses to a patient who had a history suggestive of mania (T. 514-515; F/F 69).

CONCLUSIONS AS TO PATIENT I

1. The Respondent failed to obtain and record an adequate history and mental status evaluation of Patient I when the Respondent first began treating the patient.

2. The Respondent failed to obtain and record adequate supplemental histories and mental status evaluations of Patient I during the course of treatment and after time gaps in the treatment.

3. During the approximate twelve years he treated Patient I, the Respondent failed to adequately explore other diagnostic, evaluative and treatment options for Patient I, including psychological testing and clinical consultation with another psychiatrist or a psychologist.

4. On numerous occasions, the Respondent failed to record adequate notes concerning

the drugs he prescribed for Patient I, indications for the drugs, and the indications for changes in the drugs or doses prescribed.

5. On numerous occasions, the Respondent failed to record adequate notes concerning Patient I's drug regimen, including the drugs Patient I was taking at any given time, the doses of the drugs, and the directions for use.

6. The Respondent failed to maintain adequate records for Patient I.

7. The Respondent prescribed Cytomel for Patient I without first obtaining baseline thyroid function tests.

8. The Respondent failed to obtain a Lithium work-up before prescribing Lithium for Patient I.

9. On January 26, 1988, the Respondent prescribed fluoxetine (Parnate) for Patient I although the Respondent had not seen Patient I in a treatment session since approximately April 15, 1986.

10. On October 10, 1992, the Respondent prescribed Zoloft for Patient I although the Respondent had not seen Patient I in a treatment session since March 29, 1992.

11. The Respondent prescribed Ritalin for Patient I despite Patient I's history of mood swings. Ritalin was not indicated and/or contraindicated.

12. The Respondent variously diagnosed Patient I's condition as "hyperactive kid and adult" (10/1/86) and/or as hypomanic (1/25/90) and/or as "also some evidence of Attention Deficit Disorder" (6/22/92) without adequate evaluation and/or adequate basis for such conclusions and

without recording such evaluations or basis.

13. The Respondent failed to adequately follow-up on Patient I's communication of November 18, 1992 that the patient was diagnosed as having Diabetes Mellitus and had a blood sugar of 400.

14. At various times, the Respondent prescribed excessive doses of Parnate for Patient I.

FINDINGS AS TO PATIENT J

146. The Respondent provided psychiatric care at his office and by a telephone to Patient J from approximately 9/19/89 until the patient's death on 9/6/90. The Respondent had treated this patient twenty nine years previously.

The patient had been married and had two stepchildren, but was separated since 1983. In 1988, he met a new girl friend. He was retired from the fire department after twenty-one years of service.

When he saw the Respondent in September, 1989, the patient complained of insomnia, decreased appetite, weight loss and decreased ability to concentrate. He had crying episodes several times over the previous few days. He and a long history of alcoholism but reported that he had stopped drinking. He was taking Darvocet for a back problem.

The Respondents' diagnosis of depression is more implied from the nature of the patient's complaints rather than explicitly noted.

The patient was started on imipramine and psychotherapy. During the course of treatment, the patient began drinking again on 5/15/90. He reportedly had blackouts and slurred speech on a number of occasions and was put on Antabuse.

The patient committed suicide on 9/6/90. The psychological autopsy report notes that the patient had a history of several suicide attempts, two in 1962 and one in 1963, in which he overdosed on chlorpromazine and aspirin and slashed his wrists (Ex. 25; T. 541-542).

147. The Respondent failed to obtain or record an adequate history of Patient J when he first began treating the patient. There is no information about the Respondent's prior treatment of the patient twenty-nine years prior. There is no adequate history or detail of the patient's drinking problem or any treatment he may have received for it. There is no adequate psychiatric history, especially regarding the three suicide attempts, which are not noted in Respondent's record. They are discussed in the psychological autopsy report (Ex. 31). Many components of an appropriate history are lacking, such as developmental history and family relationships (Ex. 25, pp. 2-5; T. 543-544, 575-577, 726-728; F/F 6, 7).

The Respondent made no notation or exploration of the issues regarding the Axis I diagnoses listed in the psychological autopsy: Major Depression, moderate; Alcohol Dependence, severe; Opioid Abuse, severe (Ex. 31).

148. The Respondent failed to obtain or record an adequate mental status evaluation of Patient J when he first began treating the patient . For example, there is no description of his affect or his mental status as it pertained to his complaints (Ex. 25, pp. 2-4; T. 544; F/F 6, 8).

149. The Respondent failed to periodically obtain or record adequate mental status evaluations of Patient J during the course of treatment. He failed to describe the patient's mental status in relation to the patient's clinical picture. (T 544-545; F/F. 12).

150. The Respondent failed to record adequate notes concerning the indications for drugs prescribed for Patient J or changes in the drugs or doses. For example:

* On 11/14/89, the Respondent increased Prozac and decreased imipramine but there is no indication as to why this was done. Further, the patient reported that his sleep was not good. Increasing Prozac would probably interfere with the patient's sleep, at least initially (Ex. 25, p. 5).

* On 4/28/90, the Respondent stated that the patient "[w]ill need Dalmane", but he failed to note any indication for the drug. In fact, the patient had described having short-term memory problems and blackouts, which contraindicate the use of Dalmane (T. 545-546; F/F 18).

151. The Respondent failed to maintain adequate notes concerning Patient I's drug regimen. For example:

* On 1/11/90, the patient is directed to go to "5 Prozac". On 2/6/90, there is a notation "[h]old same doses". However, on 2/20/90, the Respondent noted "[h]old...4 Prozac". There is no record of when or why the Prozac dose was decreased.

* On 5/8/90, the patient is "on Dalmane for sleep", but no dose is noted. Dalmane is not noted again until 6/26/90: "Rx Dalmane 30 #30" Dalmane is not noted thereafter in the patient's record (Ex. 1, appendix J; T. 546; F/F 18).

152. The Respondent failed to maintain adequate records for Patient J. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 546-547, 728; F/F 7, 8, 12, 18, 21, 147, 148, 149, 150, 151).

153. On 10/31/89, the Respondent prescribed lithium 300 hs for Patient J without obtaining a lithium work-up. Such a work-up was necessary even though the dose of lithium was low. The failure to obtain a lithium work-up was a deviation from accepted standards of medical practice (T. 547-548, 734-735; F/F 47).

154. On 10/24/89, the Respondent prescribed Cytomel 50 mcg for Patient J. There is no evidence that the Respondent obtained baseline thyroid function tests prior to prescribing the Cytomel. The failure to obtain baseline function tests was a deviation from accepted standard of medical practice (T. 548, 728; F/F 23, 24, 25).

155. On 10/3/89, the Respondent directed Patient J to increase his dose of imipramine from 175 mg to 225 mg over three days. On 10/10/89, he again directed the patient to increase the dosage from 225 mg to 300 mg.

These directed increases were premature. The patient had only been on the therapeutic dose of the drug (175 mg) for a short time. Imipramine takes three to six weeks to work and increasing the therapeutic dose does not make it work any faster. Its effectiveness is not related to blood levels. Rather, imipramine works by saturating receptor sites in the brain, a process which

takes three to six weeks (T. 550-551).

156. On 10/24/89, the Respondent added Cytomel 50 mcg to the patient's drug regimen of imipramine, an antidepressant. The purpose of the Cytomel was to augment the effect of the antidepressant. However, adding Cytomel at that time was premature. The patient had been on a therapeutic dose of imipramine for only three weeks. The usual time for imipramine to take effect is anywhere from three to six weeks. The Respondent should have waited to see if there was a therapeutic response to the imipramine before using the Cytomel (Ex. 1, Appendix J; Ex. 25, P.4; T. 549-551, 571-572, 751-752; F/F 23, 24).

157. The Respondent prescribed Prozac for Patient J when the patient was also on at least 100 mg of imipramine.

* On 11/7/89, the patient was directed to decrease imipramine to 200 mg, and Prozac 20 mg was added to the regimen.
* On 11/14/89, imipramine is to be decreased to 150 mg and Prozac raised to 40 mg.
* On 11/21/89, Prozac was raised to 60 mg and imipramine decreased to 100 mg.

The combination of imipramine with Prozac was not consistent with accepted standards of medical practice. Prozac will have a profound effect on the metabolism of imipramine, greatly increasing blood levels of the drug. The Prozac/imipramine combination increases the risks of side effects and the toxicity of the imipramine (Ex. 1, Appendix J; Ex. 25, pp. 5-6; T. 552-553, 567-568, 572-573, 752-753; F/F 35).

158. At various times, the Respondent prescribed Prozac 100 mg/day for Patient J, eg, 1/11/90; 1/20/90; 5/8/90 (Ex. 1, Appendix J).

Prozac 100 mg/day is an excessive dose and not consistent with accepted standards of medical practice. The usual dose of Prozac to treat depression is 20 mg to 40 mg a day (T. 553-554, 753-754; F/F 25).

159. On 2/20/90, the Respondent prescribed Elavil 25 mg daily for Patient J when the patient was also in imipramine 150 mg and Prozac 80 mg.

The addition of Elavil to the patient's drug regimen was not consistent with accepted standards of medical practice. Prozac is already increasing the blood levels of imipramine. Elavil will also cause this to occur, and in turn, Prozac will increase the level of the Elavil. All of these drugs will increase the levels of one another. The side effects and toxicity of the drugs will be increased, particularly the tricyclics (T. 554-555, 754-755; F/F 35, 57).

160. When Patient J was on Elavil and imipramine, the Respondent prescribed Dalmane for Patient J, despite the patient's reports of drinking episodes. Specifically:

* On 5/15/90, the patient reported having two drinks the previous evening.
* On 5/29/90, the Respondent noted: "So ROH now is always neg[ative]. I say stop it."
* On 6/12/90: "Drank again. Blackout" (Ex. 25, p.14).

It was a deviation from accepted standards of medical practice for the Respondent to have had Patient J taking Dalmane, given the patient's drug regimen and reports of drinking episodes.

Dalmane is a central nervous system depressant, as is alcohol. The patient was drinking heavily, "Blackout". He was on several other sedating drugs such as Elavil, and a high dosage of Prozac, which is increasing the blood levels of all the other drugs. The danger with this combination is coma and death from central nervous system depression.

If the patient was having difficulty sleeping, Dalmane was not the appropriate way to address this problem. The risks of coma and death far exceeded the sleep problem. The patient should have been hospitalized (T. 555-558, 564-565, 775-756, 1738).

CONCLUSIONS AS TO PATIENT J

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

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

3. On numerous occasions the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient J, the indications for the drugs and the indications for changes in the drugs or doses prescribed.

4. On numerous occasions, the Respondent failed to record adequate notes concerning Patient J's drug regimen, including the drugs Patient J was taking at any given time, the doses of the drugs, the directions for use, and when drugs were discontinued.

5. The Respondent failed to maintain adequate records for Patient J.

6. The Respondent failed to obtain a Lithium work-up before prescribing Lithium for Patient J.

7. The Respondent prescribed Cytomel for Patient J without first obtaining baseline thyroid function tests.

8. The Respondent prescribed Cytomel for Patient J on October 24, 1989, although Patient J had been on the usual therapeutic doses of imipramine only since October 3, 1989. Under the circumstances, the prescribing of Cytomel was premature and not indicated.

9. On October 3, 1989, the Respondent directed Patient J to increase his daily imipramine dose from 175 gm to 225 mg. On October 10, 1989, he directed the patient to continue to increase his dose of imipramine from 225 mg to 300 mg. The directed increases were premature and not indicated.

10. During November, 1989, the Respondent prescribed Prozac for Patient J while Patient J was also on daily doses of at least 100 mg of imipramine. This drug combination was not indicated and/or contraindicated.

11. At various times, the Respondent prescribed Prozac 100 mg a day for Patient J. This was an excessive dose of Prozac.

12. On February 20, 1990, the Respondent prescribed Elavil 25 mg daily for Patient J when the patient was also on imipramine 150 daily and Prozac 80 mg daily. This drug combination was not indicated.

13. The Respondent prescribed Dalmane for Patient J at a time when Patient J was also on imipramine and Elavil and was reporting drinking episodes to the Respondent. The use of Dalmane was not indicated and/or contraindicated.

FINDINGS AS TO PATIENT K

161. The Respondent provided psychiatric care to Patient K from December 1977 through approximately 1979 at Strong Memorial Hospital and from approximately July 1979 through at least 2/10/93 at his office and by telephone.

Patient K was referred to the Respondent by his sister. He was twenty-eight years old at the time of the first visit.

The patient reported three episodes of depression since high school and depression since the previous summer. He had been seen by another psychiatrist and had been treated with Elavil and Triavil for one week, but had side effects and was no better. The Respondent's implicit diagnosis was depression.

In 1986, the Respondent diagnosed the patient as having "environmental illness" or what is called multiple chemical sensitivity syndrome. The patient was treated with medication and some psychotherapy. Significant history included the patient's mother's report to the Respondent

that the patient may have had seizures (Ex. 26, p. 127, 9/20/78 entry). This was further reinforced in the Respondent's notes of his conversation with a neurologist. It is noted that the patient had seizures when young and currently had chronic subclinical temporal lobe seizures (Ex. 26, p. 77; 8/16/84 entry). Early in treatment , the Respondent described the patient as abusing Dexedrine (Ex. 26, p. 116, 1/17/80). The patient also abused other medications, as well as marijuana and alcohol at various times during the course of treatment. A sleep study was performed in April, 1984, which indicated increased REM sleep and was consistent with a diagnosis of depression (T. 580-582).

162. The Respondent failed to record or obtain an adequate history of Patient K when he first began treating the patient. During the first two months of treatment, there is essentially no meaningful patient history. The elements of an appropriate history, such as medical history and family relationships, are not recorded. It was a year after the Respondent had commenced treatment that the possibility of the patient's history of seizures was raised and this was done by the patient's mother (Ex. 26, pp. 135-136; T. 582-583, 726-728; F/F 6, 7).

163. The Respondent failed to obtain or record an adequate mental status evaluation of Patient K when he first began treating the patient. There was no pertinent information on the patient's demeanor, thought processes, insight, affect or the other important elements of a mental status evaluation (Ex. 26, pp. 135-136; T. 583, 726-728; F/F 6, 8).

164. The Respondent failed to periodically obtain or record adequate mental status evaluations during the course of Patient K's treatment. There is little content in the record regarding the patient's mental status. For example:

* On 5/10/78, the patient was recorded as having poor memory and confusion , but the condition is not described and there is no evaluation to corroborate or rule out that problem (Ex. 26, p. 132).

* On 6/30/78 the Respondent recorded the patient as being "better", but this description, has no context in relation to the patient's mental status (T. 583-584; F/F 12).

165. The Respondent failed to adequately explore other diagnostic, evaluative and treatment options for Patient K during the course of his treatment. Such steps would have been warranted in this case.

Patient K had a history of abusing drugs, possible seizure and other issues, yet none of these were adequately investigated. For example, the Respondent recorded in his notes a conversation he had with another physician and noted the patient's extreme obsessiveness, pseudoneurotic schizophrenia, narcissism and hypochondria, but none of these issues were adequately addressed or explored (Ex. 26, p. 77, 8/16/84 entry).

This patient's case is one where psychological testing would have been very important. It is clear, from reading the record, that Patient K had a personality disorder which should have been evaluated with psychological testing such as the MMPI.

The patient saw other health care professionals during the course of treatment. For example:

* 8/17/86: second opinion at family's request (Ex. 6, pp. 50, 157-158);

* 11/20/84: consult (Ex. 26, p. 72);

* 7/22/92: consult an allergist (Ex. 26, p. 4).

However, these consultations were not productive in view of the patient's treatment course (T. 584-587; F/F 15).

166. The Respondent failed to maintain adequate notes concerning the indications for the drugs he prescribed for Patient K or the changes in the drugs or doses. For example:

* On 1/24/79, imipramine is increased to 225 mg, but the indication for doing so is not noted. In fact, it is noted that the patient had a great day (Ex. 26, p. 125).

* On 2/17/78, Dexedrine is prescribed but no indication is given for doing so (Ex. 26, p. 135).

* On 5/13/86, the record indicates that Serentil will be tried but no indication for doing so is noted (Ex. 26, p. 53; T. 587-588; F/F 18).

167. The Respondent failed to maintain adequate notes concerning Patient K's drug regimen. For example:

* On 9/5/78, a prescription for chloral hydrate was issued but the drug is not noted again until 5/28/80, when another chloral hydrate prescription was issued.

* From 2/14/79 through 5/25/79, there is no recording of the patient's drug regimen, despite numerous patient contacts.

* On 2/14/81, it is noted that the patient is phasing out Valium. However, the last note regarding Valium was on 8/22/78.

* On 8/24/83, it is noted that Cytomel every five hours makes a difference. There is no notation of Cytomel again until 12/15/83. On 3/1/84, Cytomel is recorded, but no dose is noted. It is noted again on 8/14/84, but again the dose is not indicated.

* On 2/6/86, the patient is noted to be on "Merital, Desip, Viv, Aventyl, Desyrel, Caffeine, Sudafed, PA and Tyrosine and Cytomel." The doses of these drugs are not noted.

The Respondent issued numerous prescriptions for Patient K without recording them in the patient's record, e.g. 1/6/89; 1/19/89; 2/1/89; 2/28/89; 3/15/89; 3/29/89;/ 4/12/89; 4/26/89; 5/10/89; 5/24/89; 6/7/89; 6/21/89; 7/5/89; 7/19/89; 8/1/89; 8/2/89; 8/10/89; 8/15/89; 8/27/89; 8/30/89; 9/6/89; 9/24/89; 9/27/89; 10/28/89; 11/15/89; 11/29/89; 12/13/89; 12/26/89; 3/29/90; 4/12/90; 8/2/90; 8/16/90; 9/27/90; 11/21/90; 12/6/90; 1/28/91; 2/21/91; 3/20/91; 4/17/91; 7/24/91; 10/2/91; 10/16/91; 10/30/91; 11/13/91; 11/27/91; 12/11/91; 2/19/92; 3/4/92; 3/18/92; and 4/15/92 (Ex. 1, Appendix K; Exhibit 27 [original prescription] T. 588; F/F 18).

168. The Respondent failed to maintain adequate records for Patient K. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 588, 728; F/F 6, 7, 8, 12, 18, 21, 163, 164, 165, 167, 168).

169. The Respondent prescribed chloral hydrate for Patient K over an excessive period of time. The patient was on the drug, usually 1000 mg, occasionally 1500 mg, throughout most of the treatment period. Chloral hydrate, like most other hypnotic drugs, has a therapeutic effect that wears off after a short period of time. To be effective with long use, the dosage must be

increased, which is what happened with Patient K. The usual dose of chloral hydrate is 500 mg, but Patient K was usually taking 1000 mg. Further, the drug is addictive, and for this reason it should not be given over a long period of time.. This is especially true with Patient K, who had a history of abusing his medications (Ex. 1, Appendix K; T. 588-590).

170. The Respondent prescribed Dexedrine for Patient K when he knew or should have known that Patient K was abusing or addicted to the drug.

The Respondents records indicate that he knew of the patient's abuse of the drug. For example:

* "Wants Dex for diet and quick energy" (Ex. 26, p. 117, 12/12/79 entry).
* "So abuse Dex. I don't give Rx" (Ex. 26, p. 116, 1/17/80 entry).
* "wrote Rx for 120 (he wanted 180) I say next time a design for getting off meds" (Ex. 26, p. 111, 8/27/80 entry).
* "see how he is addicted to Rit and Dex" (Ex. 26, p.102, 9/2/81 entry).
* "wants Dex to motivate" (Ex. 26, p. 92, 5/25/83 entry).
* "so now into Rec[reational] pattern with Dex" (Ex. 26, p. 91, 6/2/83).
* "? using extra Dex" (Ex. 26, p. 80).
* "uses Dex and caffeine to energize" (Ex. 26, p. 5).
* "he resists my [decreasing] Dex" (Ex. 26, p. 41, 6/9/87 entry).
* "using Dex to external good times. I say we need a plan" (Ex. 26, p. 39, 10/28/87 entry).
* "Using Dex liberally" (Ex. 26, p. 28, 8/30/89 entry).

There was no therapeutic rationale for using Dexedrine for this patient. It was obvious that the patient was abusing Dexedrine for almost the entire time he was taking the drug (T. 590-593; F/F 32). Patient K's own testimony at the hearing regarding his abuse of the drug, "what I need to do is take it...in order to function" (T. 1090-1092).

171. The Respondent issued prescriptions for excessive amounts of Dexedrine for Patient K, in amounts which exceeded the instructions for use and over excessive periods of time. This was a departure from accepted standards of medical practice For example:

* From 3/15/89 through 8/27/89, the prescriptions issued had the patient taking 160 mg of Dexedrine a day.

* On 3/15/89, a prescription for a thirty day supply of Dexedrine was issued and three days later the Respondent issued a prescription for another thirty day supply.

* From approximately 4/28/86 through 9/92, the Respondent prescribed over 150,000 mg of Dexedrine for Patient K.

The Respondent issued prescriptions to Patient K under circumstances where the patient was cancelling appointments and the Respondent was not seeing the patient. For example:

* 6/2/87:	Cancels-late. Sent script Dexedrine.
* 11/30/88:	Cancels-asks for Dexedrine script-sent.
* 1/6/89:	Script for Dexedrine sent.
* 1/11/89:	Does not show - script for Dexedrine sent last week.
* 1/3/91:	Did not show - called - leave script for Dexedrine.
* 2/7/91:	Cancel late - sent script Dexedrine.
* 5/1/91:	Calls - emergency supply phoned in.
* 5/15/91:	Cancel - leave Dexedrine script.
* 6/12/91:	Cancel - Dexedrine script left.
* 9/30/92:	Script sent for Dexedrine tabs.

(Ex. 1, appendix K; T. 593-595; F/F 32, 170)

172. The Respondent prescribed Dexedrine for Patient K despite the patient's apparent history of seizures. On 9/28/78, the patient's mother reported to the Respondent that the patient may have had seizures (Ex. 26, p. 127). In 1984, the patient had an abnormal EEG (Ex. 26, p. 77, 8/16/84 entry).

Dexedrine can cause seizures in a patient such as Patient K. When the Respondent

learned that the patient may have suffered seizures, he should have ordered a complete neurological work-up and should not have prescribed Dexedrine (T. 595-596).

173. The Respondent prescribed lithium for Patient K on 9/6/86; 9/20/86; 10/7/86. There is no evidence in the record that the Respondent obtained a lithium work-up before instituting treatment with the drug (T. 597, 734-735; F/F 47).

174. The Respondent prescribed Cytomel for Patient K beginning on 10/28/82, without obtaining baseline thyroid function tests before doing so (T. 597-598, 728, 2028; F/F 23, 24, 25).

175. The Respondent prescribed Cytomel from 62.5 mcg to 150 mcg for Patient K. For example:

*	12/29/82	(62.5 mcg)
*	1/18/83	(75 mcg);
*	4/27/83	(100 mcg);
*	4/26/90	(150 mcg).

These were excessive doses of Cytomel. Prescribing such doses of Cytomel was especially serious in this case in view of the patient's possible history of seizures (T. 598, 729-731; F/F 23, 24, 25).

176. On 4/26/90, the Respondent had Patient K taking Cytomel 150 mcg, Dexedrine 20 mg and Prozac 40 mg. This drug combination carried with it the serious risks of seizure, cardiovascular reactivity and psychomotor agitation.

Prozac increases the blood level of Dexedrine. Cytomel, at an excessive dose, and a Dexedrine level increased by the Prozac, are marked psychic energizers and increase the metabolic rate. They also increase cardiovascular activity and can lead to tachycardia and increased blood pressure (T. 598-600, 756-758).

177. The Respondent prescribed Valium for Patient K on 9/5/78, 8/5/92 and 1/24/91. Prescribing Valium for this patient was not consistent with accepted standards of medical practice.

Valium is a benzodiazepine. It is a tranquilizer and essentially a nervous system depressant. There was no indication for prescribing Valium for this patient and in fact, it was inappropriate to do so in view of the other drugs the patient was taking.

On 9/5/78, the patient also was taking imipramine 75 mg, Amitriptyline 100 mg and chloral hydrate (Ex. 26, p. 121; T. 600-603).

On 1/24/91, the patient was taking Dexedrine 80 mg and Wellbutrin (Ex. 26, P. 16).

178. The Respondent prescribed Vivactil and Aventyl for Patient K at the same time, e.g., 10/7/86 and 12/86. This drug combination was not indicated.

Vivactil and Aventyl are tricyclic antidepressants. Vivactil is energizing while Aventyl is sedating. Both are extremely cholinergic and in combination there is an additive effect (T. 604, 758).

179. By 5/25/90, the Respondent had Patient K taking Dexedrine, Valium, chloral hydrate and Cytomel (Ex. 1, Appendix K). These drug combinations are irrational and not therapeutic.

Valium and chloral hydrate are both very sedating and will have an additive effect. Dexedrine and Cytomel are energizing. Prescribing two energizing drugs and two depressing drugs to be taken at the same time, is inappropriate and inconsistent with accepted standards of medical practice (T. 604-605 758-759).

180. By 2/6/86, Patient K was taking five antidepressants; (Merital, Desipramine, Vivactil, Aventyl and Desyrel) in addition to Dexedrine and Sudafed. The patient was also taking Phenylanine and Tyrosine (Ex. 26, p. 57). This drug regimen was a deviation from accepted standards of medical practice.

The Respondent noted in his records "Four plus CNS atropine side effects" and "I

propose seeing it as a narcolepsy-like problem". The Respondent also noted that the patient should be weaned from all the antidepressants except Desyrel, and his use of Dexedrine decreased. The Respondent apparently recognized the problem with the drug regimen, but this does not mitigate the fact that the Respondent's prescribing practices and failure to monitor the patient, resulted in the objectional drug regimen (T. 605-609).

181. On 6/21/90, the Respondent was asked by Patient K to prescribe Dexedrine "to counter" the Prozac 40 mg. The Respondent noted that he would consider it (Ex. 26, p. 199). Thereafter, the Respondent prescribed Dexedrine for the patient in combination with Prozac. This was an inappropriate combination because Prozac will markedly increase the blood levels of Dexedrine (T. 609-610, 759-760; F/F 32, 35).

182. On 6/18/92, the Respondent noted that the patient was ""off and on suicidal" (Ex. 26, p. 7). There is no other reference to, or discussion of, this problem in the record. The Respondent failed to adequately evaluate and record the patient's suicidal ideation. He should have explored and recorded the patient's suicidal thoughts in detail. Of further concern is that on the same day, the Respondent gave the patient a prescription for Dexedrine which could energize him to carry out a suicidal idea (T. 610-611).

CONCLUSIONS AS TO PATIENT K

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

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

3. During the approximate fifteen years he treated Patient K, the Respondent failed to adequately explore other diagnostic, evaluative and treatment options for Patient K including psychological testing or clinical consultation with another psychiatrist or a psychologist.

4. On numerous occasions, the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient K, the indications for the drugs and the indications for changes in the drugs or doses prescribed.

5. On numerous occasions, the Respondent failed to record adequate notes concerning Patient K's drug regimen, including the drugs Patient K was taking at any given time, the doses of the drugs, the directions for use, and when drugs were discontinued.

6. The Respondent failed to maintain adequate records for Patient K.

7. The Respondent prescribed Chloral Hydrate for Patient K over excessive periods of time.

8. The Respondent continued to prescribe Dexedrine for Patient K at various times after January 17, 1980, when he knew or should have known that Patient K was abusing the drug and/or addicted to it.

9. The Respondent issued prescriptions to Patient K for excessive amounts of Dexedrine, in amounts which exceeded the Respondent's instructions for use and over excessive periods of time. This was not indicated and/or contraindicated.

10. Respondent prescribed Dexedrine for Patient K despite Patient K's history of seizures. This was not indicated and/or contraindicated.

11. Respondent failed to obtain a Lithium work-up before prescribing Lithium for Patient K.

12. The Respondent prescribed Cytomel for Patient K without first obtaining baseline

thyroid function tests of Patient K.

13. At various times the Respondent prescribed excessive doses of Cytomel for Patient K.

14. On April 26, 1990, the Respondent prescribed Cytomel 150 mcg daily, Dexedrine 20 mg daily, and Prozac 40 mg daily for Patient K This drug combination was not indicated and/or contraindicated.

15. On September 54, 1978, January 24, 1991, and August 5, 1992, the Respondent prescribed Valium for Patient K, which was not indicated.

16. From February 21, 1985 to approximately October 17, 1985, from January 26, 1986 to approximately February 19, 1986 and from October 7, 1986 to approximately May 26, 1987, the Respondent prescribed Vivactil and Aventyl; both tricyclic antidepressants for Patient K. This drug combination was not indicated.

17. On approximately May 25, 1990, the Respondent prescribed Valium and Chloral Hydrate for Patient K at the same time Patient K was taking Cytomel and Dexedrine. This drug combination was not indicated and/or contraindicated.

18. By February 6, 1986, the Respondent had prescribed a drug regimen for Patient K which included five antidepressants, (Merital, Desipramine, Vivactil, Aventyl and Desyrel), in addition to Dexedrine and Sudafed. This drug combination was not indicated and/or contraindicated. The Respondent also failed to adequately monitor the patient's drug regimen.

19. In June, 1990, the Respondent prescribed Dexedrine for Patient K, who reported to the Respondent that he needed Dexedrine "to counter" Prozac. This was not an indicated use for

Dexedrine.

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

FINDINGS AS TO PATIENT L

183. The Respondent provided psychiatric care to Patient L from 1/19/88 through 2/1/88 at his office, by telephone and also through a psychologist Patient L also was seeing. The patient was referred to the Respondent by a psychologist for medication.

In fact, Patient L was an undercover employee of Blue Cross/Blue Shield involved with investigating the referring psychologist, not the Respondent.

The patient complained of increased sleep, being withdrawn, decreased ability to concentrate, and irritability. The Respondent's diagnosis was depression and he treated the patient with medications (Ex. 28; T. 625-626).

184. The Respondent failed to obtain or record an adequate history of patient L when he first began treating her. For example, the history was deficient regarding the complaint of depression. There is no developmental or educational history. There was no history regarding drug or alcohol abuse, despite the fact that the Respondent noted that the patient's father was an alcoholic. There was no work history although the Respondent did note that the patient did not want her employer to know she was getting treatment (Ex. 28, pp. 1-2; T. 626-627; F/F 6,7).

185. The Respondent failed to obtain or record an adequate mental status evaluation of Patient L when he first began treating her. The major elements of such an evaluation were not recorded in the patient's record.

For example, the Respondent wondered about suicide but there is nothing more regarding whether or not the patient had suicidal ideation. The Respondent's description of the patient "seems anxious, in a fog" was not the equivalent of an appropriate mental status evaluation.

The Respondent's role in treating the patient with medication while she received psychotherapy form a psychologist, is a common one. However, that role does not obviate the requirement that the medicating psychiatrist obtain his own history and mental status evaluation of the patient. This is crucial because the psychiatrist is choosing medications and adjusting them in the context of a diagnosis and symptomology which the psychiatrist must establish (Ex. 28, pp. 1-2; T. 627-629; F/F 6,8).

186. The Respondent failed to maintain adequate records for Patient L. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to the patient (T. 629; F/F 6, 7, 8, 12, 18, 21, 184, 185).

187. The Respondent prescribed Desipramine 25 mg for Patient L on her first visit (Ex. 28, p. 1). Desipramine is a tricyclic antidepressant. It is a nonadrenergic drug, which will theoretically increase norepinephrine.

The Respondent described the patient as noradrenalin deficient. Desipramine was not an inappropriate drug to address this patient's depression (Ex. 28, p. 1; T. 1748-1749).

188. The Respondent directed changes in Patient L's drug doses through the patient's psychologist without seeing the patient. For example:

* On 2/3/88, when the patient did not call the Respondent as scheduled, the Respondent called the psychologist and told her to encourage Patient L to increase the dose of Desipramine to 150 mg.

* On 2/17/88, the patient called and advised she was taking Desipramine 150 mg, and noted no change. The Respondent called the psychologist and told her to have the patient increase Desipramine to 175 mg and then to 200 mg.

* On 3/1/88, the psychologist told the Respondent that the patient was taking Desipramine 200 mg and doing well. The Respondent advised the psychologist to hold the dose at that level.

It was not consistent with accepted standards of medical practice for the Respondent

to have adjusted the patient's drug regimen through the psychologist and not directly with the patient. The psychiatrist is the one giving the medication and he should observe the patient first hand. He is the one with the medical expertise.

In this case, a loading dose of Desipramine was being given until a therapeutic level was reached, so it was very important to observe the patient. Further, this patient was depressed. One of the most important times in treating a patient for depression is early on. In some patients, as they begin to fell better, the likelihood of suicide tends to increase because they now have the energy to carry out a suicide (Ex. 28, p. 3; T. 631-635).

189. On 3/1/88, the Respondent advised Patient L to increase the dose of Desipramine from 200 mg to 225 mg. The patient had reported that she had a good week but was "a little down now". The fact that the patient was "a little down" at a given moment following a good preceding week, likely had nothing to do with depression and was not a basis to increase the medication (Ex. 28, p. 2; T. 635).

190. On 3/1/88, the Respondent advised Patient L to increase the dose of Desipramine to 225 mg three days and then increase it to 250 mg "PRN" or as needed.

With a potent medication such as Desipramine, the psychiatrist, not the patient, should make the decisions concerning drug dosage. Further, "prn" use of Desipramine is not appropriate. A depressed patient is subject to the ups and downs of daily living and those vicissitudes should not be dealt with by increasing the antidepressant drug dose (Ex. 28, p. 2; T. 636-637, 1751-1752).

CONCLUSIONS AS TO PATIENT L

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

2. The Respondent failed to maintain adequate records for Patient L.

3. At various times, the Respondent directed changes in Patient L's drug dosages through the psychologist without seeing the patient himself. This was inappropriate.

4. On 3/1/88, the Respondent directed Patient L to increase her dose of Desipramine to 225 mg daily, which was not indicated.

5. On 3/1/88, the Respondent also directed Patient L to increase her dose of Desipramine to 225 mg three days and then increase it to 250 mg "prn" or as needed, which was not appropriate.

FINDINGS AS TO PATIENT M

191. The 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.

Patient M was a twenty-two years old when the Respondent began treating him. The Respondent's treatment consisted of prescribing Xanax for the patient through the patient's father without actually seeing the patient. At the time, the patient had a history of insomnia and rituals which disrupted the family.

The Respondent actually saw the patient for the first time in 1988. He made a diagnosis of obsessive-compulsive disorder and treated the patient with medication and hypnosis.

In 1990 the patient reported that to the Respondent he had used cocaine and marijuana (Ex. 29; T. 644-645).

192. The Respondent failed to obtain or record an adequate history of Patient M when he began treating the patient in 1988. For example, the Respondent failed to record the history of the patient's depression or the rituals he performed in the Respondent's presence. The Respondent also failed to record the patient's developmental, work, and education history and a description of the patient's current life situation (Ex. 29, pp. 4-5; T. 645-646; F/F 6, 7).

193. The Respondent failed to obtain or record an adequate mental status evaluation of Patient M when he began treating the patient in 1988. The pertinent elements of such an evaluation such as affect, insight and cognitive functioning, are not recorded in the patient's record (Ex. 29, pp. 4-5; T. 646; F/F 6, 8).

194. the Respondent failed to obtain or record adequate supplemental histories and mental status evaluations of Patient M during the course of treatment and during gaps in the treatment. for example,

* On 8/30/88, Patient M called to cancel a scheduled appointment and was next seen on 12/5/88. Despite the three month lapse, there is essentially no history or evaluation of the patient's mental status (Ex. 29, p. 7)

* There was a gap in the Respondent's contact with the patient from 12/5/88 until 8/7/90, when there was a telephone contact. The patient was seen two days later on 8/9/90. There was virtually no supplemental history of the patient for the eighteen month interim and no mental status evaluation.

* On 8/7/90, the patient reported to the Respondent that he was on 2 Prozac a week. However, there is no history as to how the patient got the drug or who prescribed it for him.

* On 8/9/90. the patient reported that he had been using cocaine, but this was not explored (Ex. 29, p. 7; T. 646-650; F/F 12).

195. The Respondent failed to adequately record information regarding the indications for the drugs he prescribed for Patient M or changes in the drugs or doses. For example:

* On 12/5/88, the Respondent prescribed Cytomel 25 mcg for Patient M, but the indications are not noted (Ex. 29, p. 7).

* On 8/21/90, the Respondent prescribed Mellaril without noting an indication for doing so (Ex. 29, p. 8).

* On 11/28/90, the Respondent started Patient M on lithium but the reason for doing so was not noted (Ex. 29, p. 10) (T. 646; F/F 18).

196. The Respondent failed to maintain adequate notes of Patient M's drug regimen. For example:

* On 5/4/88, Patient M was given imipramine 10 qhs for sleep

and also imipramine 25. This drug is not noted again in the patient's records.

* On 8/7/90, after eighteen months of no contact, the patient called the Respondent and indicated he was on 2 Prozac a week, yet there are no notations in the record regarding the patient's drug regimen during the eighteen month interim period.

* The Respondent testified that during that eighteen month period, Patient M was using Prozac that was prescribed by him (T. 2094).

* On 12/5/88, Patient M was started on Cytomel 25 mcg but there is no note of this drug again until 11/7/90.

* On 8/9/90, Valium was prescribed, but there is no notation of this drug again throughout the rest of the patient's records.

* The last notation concerning Ritalin is on 10/15/90; but there is no record if or when the drug was discontinued (Ex. 1, Appendix M; T. 647; F/F 18).

197. The Respondent failed to maintain adequate records for Patient M. The records are insufficient for a subsequent treating psychiatrist to provide a continuum of care to patient (T. 647; F/F 6, 7, 8, 12, 18, 21, 192, 193, 194, 195, 196).

198. On 1/11/84, the Respondent prescribed Xanax for Patient M, who was then twenty-two years old, without having seen the patient on that date or at any prior time. This was inappropriate and a deviation from accepted standards of medical practice (Ex. 29, pp. 3, 4; T. 647-648, 1760-1761, 1779).

199. On 8/7/90, the Respondent, in a telephone conversation with Patient M, directed the patient to increase his Prozac to one or two per day. The patient was on two Prozac a week. The Respondent had not seen the patient in a treatment session since 12/5/88, eighteen months prior, and had no contact with patient in the interim. This was a deviation from accepted standards of medical practice. (Ex. 29, p. 7; T. 649-650).

200. On 8/7/90, Patient M reported to the Respondent that he had done two lines of

cocaine three weeks previously. On 8/9/90, the patient reported that he had used cocaine "(plus or minus) 12 times" (Ex. 29, p. 7). The Respondent's records indicate that he did nothing with regard to the patient's use of cocaine.

The nature of the patient's use of illicit drugs should have been rigorously explored and a history of such use should have been considered with respect to future medications prescribed for the patient , the patient's compliance with a prescribed drug regimen, and the possibility of future use of illicit drugs. Cocaine could affect the patient's other medications and the nature of his illness. The patient should have been scrupulously tracked by he Respondent with regard to illicit drug use during the course of treatment. There is no evidence that this was done (T. 650-652, 665-668).

201. On 8/9/90, the Respondent prescribed Desipramine 10 mg every morning and two Valium twice a day (strength unknown) for Patient M. On that date the Respondent recorded "?depressed" and also noted that the patient reported using cocaine. There was no mental status evaluation noted despite the fact that this was the first time that the Respondent had seen the patient in eighteen months.

Valium is a drug with a potential for abuse and was contraindicated in this case because of the patient's reported use of cocaine. The Respondent's impression of depression, which he noted with a question mark, was not a sufficient basis to prescribe Valium. There was insufficient information concerning the patient's status and prior eighteen month history to warrant prescribing the Valium and the Desipramine (Ex. 29, p. 7; T. 652-653).

202. The Respondent prescribed Ritalin for Patient M on 10/2/90; 10/14/90; and 10/15/90 (Ex. 1, Appendix M).

Ritalin was an inappropriate drug for this patient. The Respondent had diagnosed the patient as having obsessive-compulsive disorder. Ritalin can aggravate obsessive-compulsive disorder, and increase the rituals (Ex. 29, p. 4). Further, the patient had indicated to the Respondent that he had a history of cocaine use. Ritalin has many of the same effects as cocaine and there was a potential for abuse of the Ritalin given the patient's history of drug abuse (T. 653-654, 1777-1778).

203. The Respondent prescribed Cytomel for Patient M on 12/5/88 and 11/7/90 (Ex. 1, Appendix M). There is no evidence that the Respondent obtained baseline thyroid function tests before prescribing the Cytomel (T. 655; F/F 23, 24, 25) It should be noted that the patient had reported to the Respondent that he had been hypothyroid after he had been taking Cytomel (T. 2088, 2104-2106; F/F 205).

204. On 11/7/90, the Respondent prescribed Cytomel 25 mcg for Patient M and directed him to increase the dose to 200 mcg over a certain period of time (Ex. 29, p. 10, T. 2087). This was an excessive dose of Cytomel and a deviation from accepted standards of medical practice (T. 655-6546, 677; F/F 23, 24).

205. On 11/7/90, the Respondent noted that Patient M "has been hypothyroid" and also noted that the patient ran out of synthroid (Ex. 20, p. 10).

The Respondent failed to adequately evaluate or record the indication or basis for the patient's status with regard to being "hypothyroid". This was a deviation from accepted standards of medical practice.

The issue of hypothyroidism essentially came out of the blue. There is no previous mention of it or follow through in the Respondent's record. It warranted contact with the diagnosing physician, referral for a thyroid workup and a record of the Respondent's evaluation (T. 656-657).

206. The Respondent prescribed lithium for Patient M on 11/28/90 and 12/6/90, but there is no evidence that the Respondent obtained a lithium work-up prior to doing so. Further, the Respondent had noted that the patient had been hypothyroid prior to prescribing the lithium (F/F 209).

Lithium effects the thyroid and a lithium work-up would have included thyroid function tests and should have been done (T. 657-658; F/F 47).

207. In a 5/21/91 letter to the collection agency which was handling the Respondent's

account for money owed to him by Patient M, the Respondent revealed clinical information concerning Patient M that he had obtained in a professional capacity (Ex. 30). This was totally inappropriate and a deviation from accepted standards of medical practice.

That information included: a characterization of the patient as "hostile and difficult", the history that the patient's parents had tried to get the patient to see the Respondent years before; the patient's propensity for "lash[ing] out at those closest too [sic] him;" and that the patient will be "mean spirited" (T. 658-662, 1767-1768).

CONCLUSIONS TO PATIENT M

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

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

3. On numerous occasions, the Respondent failed to record adequate notes concerning the drugs he prescribed for Patient M, the indication for the drugs and the indications for changes in the drugs or doses prescribed.

4. On numerous occasions, the Respondent failed to record adequate notes concerning Patient M's drug regimen, including the drugs Patient M was taking at any given time, the doses of the drugs, the directions for use, and when drugs were discontinued.

5. The Respondent failed to maintain adequate records for Patient M.

6. On January 11, 1984, the Respondent prescribed Xanax for Patient M through Patient M's father and without having seen Patient M. This was not indicated and was a deviation from accepted standards of medical practice.

7. On August 7, 1990, the Respondent changed Patient M's drug regimen in a telephone conversation with Patient M, despite the fact that the Respondent had not seen Patient M in a treatment session since December 5, 1988.

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

9. On August 9, 1990, the Respondent prescribed Desipramine and Valium for Patient M without adequate evaluation of Patient M's mental status. This was not appropriate and was a deviation from accepted standards of medical practice.

10. The Respondent prescribed Ritalin for Patient M. This drug was not indicated and/or contraindicated.

11. The Respondent prescribed Cytomel for Patient M without first obtaining baseline thyroid function tests.

12. On November 7, 1990, the Respondent directed Patient M to increase his dose of Cytomel to 200 cmg daily, which was an excessive dose.

13. On November 7, 1990, the Respondent noted that Patient M "has been hypothyroid", without an adequate basis and without adequate evaluation of that condition, and without recording such basis or evaluation in the patient's record.

14. The Respondent failed to obtain a lithium work-up before prescribing lithium for Patient M.

15. In a letter dated 5/21/91, to a collection agency, the Respondent disclosed

information about Patient M which he had obtained in a professional capacity. The disclosure was made without Patient M's consent and was a deviation from accepted standards of medical practice.

FINDINGS AS TO ARTICLE 33 VIOLATIONS

208. By Stipulation and Order, CS-92-33, dated October 15, 1992, (Ex. 4), the Respondent admitted and the Commissioner of Health found that the Respondent had violated Sections 3304(1), 3332(3) of the Public Health Law and 10 NYCRR 80.62(b) and 80.678(c), in that:

a) During the period of 3/20/91 through 5/28/91, the Respondent issued four (4) official N.Y.S. prescriptions for Dexedrine 10 mg spansuiles, a Schedule II controlled substance, in the name of Patient A as the ultimate user. These additional prescriptions provided a supply of this drug which exceeded a thirty (30) day supply if the substance was used in accordance with the directions specified on the prescriptions. The Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply of this drug by the ultimate user.

b) During the period of 3/2/89 through 12/10/90, the Respondent issued nineteen (19) official N.Y.S. prescriptions for Ritalin 20 mg tabs, a Schedule II controlled substance, in the name of Patient A, as the ultimate user. These additional prescriptions provided a supply of this drug which exceeded a thirty (30) day supply if the substance was used in accordance with the directions specified on the prescriptions. The Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply of this drug by the ultimate user.

c) During the period of 8/26/89 through 11/29/89, the Respondent issued three (3) official N.Y.S. prescriptions for Dexedrine 5 mg tabs, a Schedule II controlled substance, in the name of Patient F, as the ultimate user. These additional prescriptions provided a supply of this drug which exceeded a thirty (30) day supply if the substance was used in accordance with the directions specified on the prescriptions. The Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply of this drug by the ultimate user.

d) During the periods of 9/27/90 through 12/6/90; 1/24/91 through 2/26/91; and 4/11/91 through 5/30/91, the Respondent issued thirteen (13) official N.Y.S. prescriptions for

Demerol 50 mg tabs, a Schedule II controlled substance, in the name of patient H as the ultimate user. These additional prescriptions provided a supply of this drug which exceeded a thirty (30) day supply if the substance was used in accordance with the directions specified on the prescriptions. The Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply of this drug by the ultimate user.

e) During the period of 10/23/90 through 5/1/91, the Respondent issued three (3) official N.Y.S. prescriptions for Valium 10 mg. Tabs, a schedule IV controlled substance (Benzodiazepine), in the name of Patient H, as the ultimate user. These additional prescriptions provided a supply of this drug which exceeded a thirty (30) day supply if the substance was used in accordance with the directions specified on the prescriptions. the Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply of this drug by the ultimate user.

f) On 10/10/89, and during the period of 10/23/90 through 5/1/91, the Respondent issued six (6) official N.Y.S. prescriptions for Valium 10 mg tabs, a Schedule IV controlled substance (Benzodiazepine) in the name of Patient H, as the ultimate user. These additional prescriptions provided a supply of this drug which exceeded a thirty (30) day supply if the substance was used in accordance with the directions specified on the prescriptions. The Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply of this drug by the ultimate user.

g) During the period of 12/24/89 through 10/16/90, the Respondent issued five (5) official N.Y.S. prescriptions for Klonopin .5 mg, a Schedule IV controlled substance (Benzodiazepine), in the name of Patient H, as the ultimate user. These additional prescriptions provided a supply of this drug for a three (3) month's supply, which is permissible pursuant to 10 NYCRR 80.67(d)(v) (i.e. panic disorder), if the substance is used in accordance with the directions specified on the prescriptions. The Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply by the ultimate user.

h) During the periods of 1/9/89 through 12/26/89, and 8/16/90 through 9/27/90, the Respondent issued thirty-three (33) official N.Y.S. prescriptions for Dexedrine 5 mg tabs in the

name of Patient K, as the ultimate user. These additional prescriptions provided a supply of this Schedule II controlled substance which exceeded a thirty (30) day supply if the substance was used in accordance with the directions specified on the prescription. The Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply of this drug by the ultimate user.

i) During the periods of 1/19/89 through 2/1/90, and 1/28/91 through 3/20/91, the Respondent issued thirty-four (34) official N.Y.S. prescriptions for Dexedrine 15 mg spansules in the name of Patient K, as the ultimate user. These additional prescriptions provided a supply of this Schedule II controlled substance which exceeded a thirty (30) day supply if the substance was used in accordance with the directions specified on the prescription. The Respondent issued these prescriptions prior to the exhaustion of all but a seven (7) day supply of this drug by the ultimate user.

209. The Respondent also admitted and the Commissioner found violations of 10 NYCRR 80.62(b), in that on numerous occasions during the period of January, 1989 through May, 1991, the Respondent failed to include notations in the medical records of Patients A, F, H and K concerning the amounts of various controlled substances he prescribed for these individual patients, directions for use of these controlled substances by the Patient F, the strengths of controlled substances prescribed by the Respondent for these patients and entries indicating his prescriptions of controlled substances to these patients.

VOTE OF THE HEARING COMMITTEE

(all votes were unanimous unless otherwise specified)

FIRST THROUGH ELEVENTH SPECIFICATIONS:

(Practicing with Gross Negligence)

SUSTAINED as to the charges specified in paragraph's

A.2, A.3 B.3, B.4, B.5, B.6, B.11, B.12, D.2, D.6, E.2, E.3, E.4, E.5, E.8, E.9 F.4 H.5 I.2, I.3, I.4 J.2,

J.3, K.3, K.4, K.5, K.6, K.7, K.8, K.9, K.12, K.13, K.14, M.2, M.3, M.4, M.6, M.7, M.8, M.9, M.10 of the Statement of Charges.

NOT SUSTAINED as to the charges specified in paragraphs

B.14 G.4 H.6 I.5, I.6 J.9 of the Statement of Charges.

The Petitioner withdrew the charges specified in paragraph B.2 of the Statement of Charges.

TWELFTH THROUGH TWENTY-SECOND SPECIFICATIONS:

(Practicing with Gross Incompetence)

SUSTAINED as to the charges specified in paragraphs.

F.4 K.3, K.4 M.4 of the Statement of Charges.

NOT SUSTAINED as to the charges specified in paragraphs

A.2, A.3 B.3, B.4, B.5, B.6, B.11, B.12, B.14 D.2, D.6 E.2, E.3, E.4, E.5, E.8, E.9 G.4 H.5, H.6 I.2, I.3, I.4, I.5, I.6 J.2, J.3, J.9 K.5, K.6, K.7, K.8, K.9, K.12, K.13, K.14 M.2, M.3, M.6, M.7, M.8, M.9 and M.10 of the Statement of Charges.

The Petitioner withdrew the charges specified in paragraph B.2 of the Statement of Charges.

TWENTY-THIRD SPECIFICATION:

(Practicing with Negligence on more than one occasion)

SUSTAINED as to the Charges specified in paragraphs A.1.a, A.1.b, A.1.c, A.1.e, A.1.f, A.1.g, A.2, A.3, A.4, A.5, A.6, B.1.a, B.1.b, B.1.d, B.1.e, B.1.f, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, B.13, B.14 C.1.a, C.1.b, C.1., C.1.e, C.1.f, C.1.g, C.2, C.3, C.4 D.1.a, D.1.b, D.1.c, D.1.e, D.1.f, D.1.g, D.2, D.3, D.4, D.5, D.6, E.1.a, E.1.b, E.1.d, E.1.e, E.1.f, E.1.g, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9 F.1.a, F.1.b, F.1.c, F.2, F.3, F.4 G.1.a, G.1.b, G.1.c, G.1.e, G.1.f, G.1.g, G.2, G.3, G.4, G.5, G.6, H.1.a, H.1.b, H.1.D, H.1.E, H.1.F, H.4, H.5 I.1.A, I.1.B, I.1.C, I.1.E, I.1.f, I.1.g, I.1, I.3, I.4, I.5, I.6, I.9, I.10 J.1.a, J.1.b, J.1.d, J.1.e, J.1.f, J.2, J.3, J.4, J.5, J.7, J.8, J.9 K.1.a, K.1.b, K.1.c, K.1.d, K.1.e, K.1.f, K.1.g, K.2, K.3, K.4, K.5, K.6, K.7, K.8, K.9, K.11, K.12, K.13, K.14, K.15

L.1.a, L.1.b, L.3, L.5

M.1.a, M.1.b, M.1.d, M.1.e, M.1.f, M.2, M.3, M.4, M.5, M.6, M.7, M.8, M.9 and M.10 of the Statement of Charges.

NOT SUSTAINED as to those charges specified in paragraphs B.15, G.7, H.2, H.3, H.6, I.7, J.6, J.10, K.10, L.2 and L.4 of the Statement of Charges.

The Petitioner withdrew the charges specified in paragraphs A.1.d, B.1.c, ,B.2, C.1.d, D.1.d, E.1.c, G.1.d, I.d, I.8, J.1.c, K.1.d, and M.1.c of the Statement of Charges.

TWENTY-FOURTH SPECIFICATION:

(Practicing with Incompetence on more than one occasion)

SUSTAINED as to the charges specified in paragraphs F.4, K.3, K.4

M.4 of the Statement of Charges.

NOT SUSTAINED as to the charges specified in paragraphs A.1.a, A.1.b, A.1.c, A.1.e, A.1.f, A.1.g, A.2, A.3, A.4, A.5, A.6 B.1.a, B.1.b, B.1.d, B.1.e, B.1.f, B.3, B.4, B.5, B.6, B.7, B.8 B.9, B.10, B.11, B.12, B.13, B.14, B.15 C.1.a, C.1.b, C.1.c, C.1.e, C.1.f, C.1.g, C.2, C.3, C.4 D.1.a, D.1.b, D.1.c, D.1.e, D.1.f, D.1.g, D.2, D.3, D.4, D.5, D.6 E.1a, E.1b, E.1.d, E.1.e, E.1.f, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9 F.1.a, f.1.b, F.1.c, F.2, F.3 G.1.a, G.1.b, G.1.c, G.1.e, G.1.f, G.1.g, G.2, G.3, G.4, G.5, G.6, G.7 H.1.a, H.1.b, h.1.d, H.1.f, H.2, H.3, H.4, H.5, H.6 I.1.a, I.1.b, I.1.c, I.1.e, I.,1.f, I.1.g, I.,2, I.3, I.4, I.5 I.6, I.7, I.9, I.10 J.1.a, J.1.b, J.1.d, J.1.e, J.1.f J.2, J.3, J.4, J.5, J.6, J.7, J.8, J.9, J.10 K.1.a, K.1.b, K.1.c, K.1.e, K.1.f, K.1.g, K.2, K.5, K.6, K.7, K.8, K.9, K.10, K.11, K.12, K.13, K.15 L.1.a, L.1.b, L.2, L.3, L.4, L.5 M.1.a, M.1.b, M.1.d, M.1.e, M.1.f, M.2, M.3, M.5, M.6, M.7, M.8, M.9, M.10, M.11 of the Statement of Charges.

The Petitioner withdrew the charges specified in Paragraphs: A.1.d, B.1.c, B.2, C.1.d, D.1.d, E.1.c, G.1.d, H.1.c, ,I.d, I.8, J.1.c, K.1.d, and M.1.c of the Statement of Charges.

TWENTY-FIFTH THROUGH THIRTY-SEVENTH SPECIFICATIONS:

(Inadequate Records)

SUSTAINED as to all the charges.

TWENTY-EIGHTH SPECIFICATION:

(Revealing information obtained in a professional capacity)

SUSTAINED as to the charges specified in paragraph M.11 of the Statement of Charges.

THIRTY-NINTH SPECIFICATION:

(Article 33 violations)

SUSTAINED as to the charges specified in Paragraphs N.1, N.2 of the Statement of Charges.

DETERMINATION OF THE HEARING COMMITTEE

The Respondent was on the faculty of the University of Rochester, Department of Psychiatry from 1965 through 1979, as an Assistant Professor from 1965-1971, and as a full tenured Associate Professor of Psychiatry from 1971-1979.

He was a member of the Medical-Psychiatric Liaison Group 1965-1979, Chief of Psychiatric Consultations Service, Strong Memorial Hospital 1969-1979 and Assistant to Dr. George Engel, University of Rochester Medical Psychiatric Liaison Group 1965-1979. He was also Co-Director Lithium Project, Strong Memorial Hospital 1966-1972.

The Respondent claims that during his work at the University of Rochester Department of Psychiatry and as a member of the Medical-Psychiatric Liaison Group, he developed an expertise in treating the most difficult patients, an expertise in Lithium therapy, an expertise in the treatment of pain, and developed an expertise in psychopharmacology.

In his early career, the Respondent was a prolific researcher and writer and even advocated some of the testing, such as blood testing, which he later abandoned. There has been a remarkable drop-off in his scientific production since the mid 1970's.

Since 1979, the Respondent has engaged in the private practice of psychiatry from his home in Honeoye Falls, New York, until the time that the Commissioner's Summary Suspension Order was served and took effect.

The Respondent practiced psychiatry on three days a week and had forty to fifty active patients. He devoted two days a week to his writings of poetry and novels.

The Respondent has not had a hospital affiliation since 1979, and has not published a scientific work since 1976.

During the course of the hearing the Respondent testified that he viewed his abilities and the nature of his practice as extraordinary. In all the groups in which he was involved, he became the intellectual and clinical leader (T. 2114-2116). His background and his work are unusual. He has never been a "standard psychiatrist" and "his work has not been the work of a standard psychiatrist" (T. 847, 852, 853). There "aren't people who do what [he does]" (T. 899-900).

The Respondent includes himself in the category of the small number of psychopharmacologists who are setting standards in going beyond the limits of drugs (T.1502). He considers himself a "clinical researcher" at this time, mostly involved in "gathering data" (T.1424).

The Respondent feels that his clinical skills are so "finely-honed" and "finely-tuned" that he rarely feels that there is something that he does not understand. Therefore, he rarely gets psychological tests or similar tests for his patients (T.882). His experience has been such that it would be rare that he would get a neurological evaluation for a patient (T. 1920). He considers himself an excellent history taker and interviewer (T. 1803-1804, 1928).

According to the Respondent, his poor record keeping was not a deficiency, but the result of his exceptional abilities and practice.

> "My notes are going to look different because I am writing them as a liaison person doing ongoing cognitive work and I am also someone who works with complex treatment resistant patients; so my notes are going to look different..."
>
> "I develop such a collaborative ongoing story with my patients, that I couldn't possibly write them down, I'd be writing a novel every week."
>
> (T. 2078, 906, 861, 833, 899, 907-908, 911-912, 1384).

The Hearing Committee has reviewed the Respondent's treatment of thirteen patients, Patients A-M. In summary, the Hearing Committee has concluded that:

1. The Respondent failed to obtain and/or record an adequate history and mental status evaluation for Patients A, B, C, D, E, F, G, H, I, J, K, L and M when he first began treating them.

2. The Respondent failed to periodically obtain and/or record adequate mental status evaluations of Patients B, D, G, H, I, J, K and M during the course of treatment.

3. The Respondent failed to adequately explore other diagnostic, evaluative and treatment options including psychological testing and clinical consultations with another psychiatrist or psychologist for Patients A, C, D, E, G, H, I and K.

4. On numerous occasions, the Respondent failed to make adequate notes concerning the drugs he prescribed for Patients A, B, C, D, E, G, H, I, J, K and M, the indications for the drugs, and the indications for changes in the drugs or doses prescribed.

5. On numerous occasions, the Respondent failed to make adequate notes concerning the drug regimen he prescribed for Patients A, B, C, D, E, G, H, I, J, K and M, including the drugs the patients were taking at any given time, the doses of the drugs, the directions for use, and when drugs were discontinued.

6. The Respondent failed to maintain adequate records for Patients A, B, C, D, E, F, G, H, I, J, K, L and M.

7. At various times, the Respondent prescribed drugs in excessive doses for Patients A, B, C, D, E, G, I, J and K.

8. The Respondent prescribed Premarin for Patient B without first obtaining a gynecological consultation to exclude any contraindications.

9. The Respondent prescribed Cytomel for Patients A, E, J, K and M without first obtaining baseline thyroid function tests.

10. The Respondent failed to obtain a Lithium work-up prior to prescribing Lithium for Patients B, D, I, J, K and M.

11. The Respondent prescribed various drugs and/or combinations of drugs which were either not indicated and/or contraindicated for Patients A, B, D, E, F, G, H, I, J, K and M.

12. The Respondent prescribed potent medications to Patients A, E, I and M despite the fact that he had not seen the patients in a treatment session for a considerable period of time.

13. The Respondent prescribed Chloral Hydrate for Patients B and K over excessive periods of time.

14. The Respondent failed to adequately evaluate and record Patient K's report that he was "off and on suicidal."

15. The Respondent failed to adequately address Patient M's use of cocaine.

16. The Respondent disclosed to a collection agency information about Patient M which he had obtained in a professional capacity. The disclosure was made without Patient M's consent.

17. The Respondent had violated provisions of Article 33 (Controlled Substances) of the Public Health Law.

The Respondent's treatment of Patients A and J were considered to be the most egregious and deserving of separate comment.

Patient A

Patient A was non-compliant with the dietary restriction of his medications. On

December 7, 1984, while on Parnate, a monoamine oxidase inhibitor, which requires avoidance of foods containing tyramine (e.g. cheese) since the parnate and tyramine may interact and cause severe headache, hypertension and possibly a cerebrovascular hemorrhage, the patient took a double dose of Parnate and ate cheese. He developed a headache and became dizzy. The patient called the Respondent from his school in Ohio and the Respondent advised him to seek help at the school's medical center.

Despite the patient's non-compliance, the Respondent continued prescribing Parnate over the course of a whole year (1985) without seeing the patient, based solely on a phone call from the patient's mother.

In July 1986, Patient A was again non-compliant with his Parnate diet. He ate cheese and this time he suffered an intracranial bleed. This necessitated surgery to remove an intracerebral blood clot and left the patient with some neurological impairment.

The Respondent never referred Patient A to another psychiatrist while the patient was at school out of state. He should have referred the patient to a psychiatrist in Ohio who would be in a better position to monitor treatment. The Respondent's explanation for failing to do so; that he felt that the patient would view such a referral as the Respondent "abandoning" him; reflects a disturbed understanding of the physician/patient relationship. The Respondent's failure to refer Patient A to another psychiatrist put the patient at serious risk and demonstrates poor judgment on the part of the Respondent.

Patient J The Respondent's records concerning Patient J contain no indication whatsoever that the patient was opioid dependent, yet Patient J died of an overdose of Fluoxetine and Propoxyphene. The Respondent had prescribed these drugs in excessive amounts for Patient J, and when Patient J died, the toxicology report revealed severe opioid abuse, which the Respondent never detected or recognized.

Further, the Respondent prescribed Dalmane, a potent sedative, for Patient J, despite the fact that there is a very grave risk in prescribing Dalmane for a patient with a known problem of substance abuse.

The Hearing Committee has voted to SUSTAIN the following charges against the

Respondent:

Gross Negligence	41 counts
Gross Incompetence	4 counts
Negligence on more than one occasion	150 counts
Incompetence on more than one occasion	4 counts
Inadequate records	81 counts
Revealing information obtained in a professional capacity	1 count
Violations of Article 33 of the Public Health Law	2 counts

This is a significant number of violations by any standard.

The Respondent evidenced a persistent sense of arrogance throughout the hearing leading a majority of the Hearing Committee to believe that a course of re-education and retraining would be, at best, problematic. The Respondent never demonstrated to the satisfaction of the majority that he would alter his prescribing practices.

The Hearing Committee votes (2-1) to **REVOKE** the Respondent's license to practice medicine in New York State.

DISSENTING OPINION

The dissenting Hearing Committee member, George C. Simmons, Ed.D., concurs in all of the Findings of Fact and all of the votes on the charges against the Respondent, but believes that the penalty **ORDERED** by the majority is too harsh.

The regrettable and unfortunate outcome in both the cases of Patient A and Patient J are directly attributable to Patients' own non-compliance with their drug regimens.

The Respondent's two expert witnesses, Louis Lasagna, M.D., a pharmacologist and Dean of the Tufts University School of Medicine, and Andrew A. Nierenberg, M.D., Assistant Professor of Psychiatry at Harvard Medical School and a practicing psychiatrist, with a specialty in psychopharmacology, both supported most of the high dosages and combinations of drugs

prescribed by the Respondent for his patients.

In effect then, the Respondent was not a "loose cannon", as it were in the medical community. While he was not in the so-called "main stream", the Respondent considered himself somewhat of an avant courier, testing limits and combinations of drugs to meet the present situation.

The testimony of Dr. Lasagna and Dr. Nierenberg was very impressive.

The Respondent's past and even part of his own testimony, represent him as rather over self confident, even arrogant to the point of hubris, with an air of condescension towards others in his specialty who were less venturesome than he was. But in the end, the Respondent appeared to be penitent. His attorney indicated that the Respondent was willing to modify his practice and particularly to pay careful attention to his record keeping which, by any count, was abysmal. Further, the Respondent's attorney stated that his client would be willing to have his practice monitored for an "appropriate time" and to attend seminars and retraining in note taking. Therefore, the Respondent should not be seen as incorrigible.

Punishment must deal with the past, imposing some pain on the offender; but it must also have an eye to the future, offering the offender an opportunity to renounce the past and return to the accepted standards of medical practice.

The preferred penalty in this case should be:

SUSPEND the Respondent's license for one year, stay the suspension, and place the Respondent on probation for a period of three years.

The terms of probation should include:

* Practice under supervision
* Limits on drug prescribing
* Monitoring by the Health Department
* Quality reports by the supervising physician to be submitted to the Health Department
* Possibly some public service

ORDER

IT IS HEREBY ORDERED that

1. The Respondent's license to practice medicine in the State of New York is **REVOKED**.

2. This **ORDER** shall be effective upon services on the Respondent or the Respondent's attorney by personal services or by certified or registered mail.

DATED: June 24, 1994
New York

Richard D. Milone, M.D.
Chairman

Leo Fishel, M.D.
George C. Simmons, EdD.