NEW YORK
THE STATE OF LEARNING

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

May 8, 1991

David Wasserman, Physician
124 Harbour Lane
Massapequa, N.Y. 11758

Re: License No. 034653

Dear Dr. Wasserman:

Enclosed please find Commissioner's Order No. 11656. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. Your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you may, pursuant to Rule 24.7 (b) of the Rules of the Board of Regents, a copy of which is attached, apply for restoration of your license after one year has elapsed from the effective date of the Order and the penalty; but said application is not granted automatically.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By: Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR

cc: Robert M. DePoso, Esq.
23 Willis Avenue
Syosset, N.Y. 11791

24.7 Review in other cases. The committee on the professions shall review and submit its recommendation to the Board of Regents for final determinations in the following cases:

(b) petitions for restoration of a professional license which has been revoked or surrendered pursuant to Education Law, section 6510 or 6510-a. At least one year shall have elapsed from the date of service of the order of revocation, acceptance of surrender, or denial of a prior application for restoration or reinstatement by vote of the Board of Regents, for the acceptance by the department of a petition to the Board of Regents for restoration of a license or certificate, except that a period of time during which the license was suspended during the dependency of the discipline proceeding may reduce the one-year waiting period. This section shall not apply to restoration of licenses which have been temporarily surrendered pursuant to Education Law, section 6510-b, or Public Health Law, section 230(13).

(1) Materials submitted in response to the Committee on the Professions' recommendation to the Board of Regents shall be filed no later than 15 days following the postmarked date of the written notification of the decision or recommendation of the Committee on the Professions.

(2) If an applicant has failed to remain current with developments in the profession, and a substantial question is presented as to the applicant's current fitness to enter into the active practice of the profession, the Board of Regents may require that the applicant take and obtain satisfactory grades on a proficiency examination satisfactory to the department prior to the issuance of a license or limited permit.

REPORT OF THE
REGENTS REVIEW COMMITTEE

DAVID WASSERMAN

[illegible] NO. 11656

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

DAVID WASSERMAN **No. 11656**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

DAVID WASSERMAN, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

This disciplinary proceeding was properly commenced and on four dates from April 26, 1990 to July 31, 1990 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the amended statement of charges, without the appendix of patient names, is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee unanimously concluded that respondent was guilty of the first through seventh specifications of the

charges and recommended that respondent's license to practice as a physician in the State of New York be revoked.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted in full, and that its recommendation as to penalty also be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On February 27, 1991, the scheduled date of our hearing, respondent appeared before us in person and was represented by his attorney, Robert M. DePoto, Esq., who presented oral argument on behalf of respondent. Roy Nemerson, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation is the same as the Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty.

Respondent's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was a suspension and respondent placed on probation. It was clarified at the hearing that respondent intended this to be a stayed suspension.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's February 11, 1991 memorandum.

DAVID WASSERMAN (11656)

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's findings of fact, conclusions as to guilt, and recommendation as to the penalty to be imposed, as well as the Commissioner of Health's recommendation as to those findings, conclusions, and recommendation be accepted;
2. Respondent be found guilty, by a preponderance of the evidence, of the specifications of the charges; and
3. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent has been found guilty.

Respectfully submitted,

J. EDWARD MEYER

JOHN T. McKENNAN

NANCY A. RUCKER

J. Edward Meyer
Chairperson

Dated: April 9, 1991

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

IN THE MATTER	:	AMENDED STATEMENT
OF	:	OF
DAVID WASSERMANN, M.D.	:	CHARGES

DAVID WASSERMANN, M.D., the Respondent, was authorized to practice medicine in New York State on January 27, 1938 by the issuance of license number 034653 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 31, 1989 through December 31, 1991 from 175 Jericho Turnpike, Syosset, New York.

FACTUAL ALLEGATIONS

A. During a period beginning on or about April 16, 1984, and continuing through on or about May 2, 1989, Respondent, an otolaryngologist, purported to treat Patient A for complaints of rhinological and cervical pain from his office located at 175 Jericho Turnpike, Syosset, N.Y. (Patient A and Patient B are identified in Appendix A). During this period Respondent prescribed controlled substances, including percodan, percocet, methadone,

Dept Ex 3 EVD
4.26.90 GS
EXHIBIT "A"

codeine and valium, to Patient A in approximately the following amounts;

Year	Percodan	Percocet	Methadone (10 mg.)	Tylenol & Codeine 4	Valium (10 mg.)
1984	200	200		460	280
1985	50	175		277	190
1986	231	558		294	107
1987	652	1352		102	296
1988	883	84	697	164	465
1989	308	125		21	101

(Dates of each patient contact and the prescriptions corresponding with each patient contact are specified in Appendix B.)

1. Throughout this period Respondent continued to issue prescriptions for increasing amounts of controlled substances without proper medical justification.

   a. Respondent failed to properly evaluate and monitor Patient A for her complaints before issuing these prescriptions for controlled substances.

b. Respondent failed to pursue alternative modes of treatment for Patient A's complaints before issuing these prescriptions for controlled substances.

2. During this prolonged period of prescribing increasing amounts of narcotic analgesics to Patient A, Respondent failed to perform or refer Patient A for complete physical examinations, including complete histories clinical examinations, routine laboratory studies, urinalyses and blood pressure readings.

3. During this period Respondent continued to prescribe large amounts of controlled substances to Patient A despite knowing that she was a narcotics addict.

4. On or about August 16, 1988 Respondent received $500.00 from Patient A in exchange for a prescription for methodone.

5. In 1984 Patient A visited Respondent 14 times and paid him $900.00. In 1985 Patient A visited Respondent 12 times and paid him $900.00. In 1986 Patient A visited Respondent 29 times and paid him $1,650.00. In 1987 Patient A visited Respondent 46 times and paid $5,775.00 In 1988 Patient A visited Respondent 45 times and paid him $28,850.00. During the first 4

months of 1989 Patient A saw Respondent 22 times and paid him $9,910.00.

B. During a period beginning on or about April 4, 1987, and continuing through on or about September 23, 1988, Respondent purported to treat Patient B for otolaryngological complaints, orthopedic complaints and insomnia on approximately 69 occasions from his office located at 175 Jericho Turnpike, Syosset, New York.

1. Throughout this period Respondent issued prescriptions for controlled substances, including barbituates and narcotics, without proper medical justification.

a. Respondent failed to properly evaluate and monitor Patient B for his complaints before issuing prescriptions for barbituates and narcotics.

b. Respondent failed to pursue alternative modes of treatment for Patient B's complaints before issuing prescriptions for controlled substances.

c. Respondent continued to prescribe large amounts of barbituates and narcotics despite the likelihood that Patient B had become addicted to these substances.

d. Respondent continued to prescribe large amounts of barbituates and narcotics to Patient B without performing and recording the results of a complete physical examination for evidence of chronic narcotic abuse.

2. Respondent failed to perform or order an X-ray of Patient B's sinuses despite Patient B's complaints of sinus related symptoms.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that during the period between April 1984 and May, 1989, Respondent practiced medicine with gross negligence, in that, Petitioner charges:

1. The facts in paragraph A and all the subparagraphs contained therein.

2. The facts in paragraph B and all the subparagraphs contained therein.

THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985) by practicing medicine with negligence on more than one occasion during the period between April, 1984 and May, 1989, in that, Petitioner charges that Respondent committed at least two or more of the following:

3. The facts in paragraph A and all the subparagraphs contained therein and/or the Facts in paragraphs B and all the subparagraphs continued therein.

FOURTH AND FIFTH SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509(9)(McKinney 1985) by committing unprofessional conduct as defined by the Board of Regents in its rules or by the Commissioner of the Department of Education in regulations approved by the Board of Regents, in that, Respondent committed unprofessional conduct within the meaning of 8 NYCRR 29.2(a)(7)(1987) by ordering excessive treatment not warranted by the condition of the patient, in that, Petitioner charges:

4. The facts alleged in paragraph A and all the subparagraphs therein.

5. The facts alleged in paragraph B and all the subparagraphs therein.

SIXTH AND SEVENTH SPECIFICATIONS

MORAL UNFITNESS TO PRACTICE MEDICINE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6509 (9)(McKinney 1985) by committing unprofessional conduct as defined by the Board of Regents in its rules or by the Commissioner of the Department of Education in that Respondent committed unprofessional conduct within the meaning of 8 NYCRR 29.1(b)(5)(1987) by conducting

himself in the practice of medicine in a manner which evidences moral unfitness to practice medicine, in that Petitioner charges:

6. The facts in paragraph A and all the subparagraphs therein.

7. The facts in paragraph B and all the subparagraphs therein.
B(1)(d).

DATED: New York, New York

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct

APPENDIX B

ANALGESIC MEDICATIONS AND CONTROLLED SUBSTANCES PRESCRIBED TO PATIENT A

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Empirin Comp. #3	Darvon Comp. 65
1984						
4-16	10/1		100/6			
5-1	10/1		100/6			
5-18	10/1		100/1			
5-24	10/1		100/6			
6-26	40/1			40/2		
8-7	40/2			80/2		
9-1	80/3					
9-10		80/3				
10-10		80/3		80/2		
10-22			10/4			
11-9		40/2		30/2		
11-13					25/4	
12-5				30/1	6/6	
12-27			50/6	20/1		
1985						
1-8				10/2		
5-6				90/2		

*Quantity in tablets/Maximum daily dose in tablets

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Empirin Comp. #3	Darvon Comp. 65
1985 Continued						
7▼5				90/3		
7▼30						30/4
3▼26			20/4			50/4
9▼7			12/4			
9▼19		25/2	60/4			
10▼7		25/2	60/4			
10▼28		50/2	50/4			
11▼19	50/2		25/4			
12▼17		75/3	50/4			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Vicodin
1986					
1▼13		50/3	50/4	20/2	
1▼23			30/3		
2▼5			50/4		
2▼25			12/3		
2▼28		30/3	30/3		
3▼19		60/3			
4▼1	30/3				
4▼11				10/2	
4▼23		30/3			
4▼30	6/3		15/3		
5▼16	15/3				
5▼17	50/3				
6▼9		60/3			3/3
6▼14		5/3			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Empirin Comp. #3	Darvon Comp. 65
1985 Continued						
7-5				90/3		
7-30						30/4
8-26			20/4			50/4
9-7			12/4			
9-19		25/2	60/4			
10-7		25/2	60/4			
10-28		50/2	50/4			
11-19	50/2		25/4			
12-17		75/3	50/4			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Vicodin
1986					
1-13		50/3	50/4	20/2	
1-23			30/3		
2-5			50/4		
2-25			12/3		
2-28		30/3	30/3		
3-19		60/3			
4-1	30/3				
4-11				10/2	
4-23		30/3	30/3		
4-30	6/3		15/3		
5-16	15/3				
5-17	50/3				
6-9		60/3			3/3
6-14		5/3			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Vicodin
1986 ▾ Continued					
8▾12			12/3		
3▾14			6/3		
3▾15	50/3			40/6	
3▾29		50/3			
3▾12		40/3			
3▾22	40/3		4/2		
10▾6	40/3		5/1		
10▾25		30/3	30/6		
11▾13		3/3			
11▾14		30/3			
12▾1		50/3			
12▾13		40/3		12/2	
12▾20		40/3			
12▾29		40/3	20/3	25/2	

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Roxicodone 5 mg.	Vicodin
1987						
1▾8	50/3					
1▾10		7/3				
1▾15		40/3	20/4			
1▾23					40/3	
1▾24						10/3
2▾5		5/3				
2▾9		50/3		30/3		

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Roxicodone 5 mg.	Vicodin
1987 Continued						
2♥16		50/3				
3♥2		50/3				
3♥16		50/3		30/3		
3♥27		50/3		30/3		
3♥31		6/3				
4♥5		40/3		20/3		
4♥17		50/3				
4♥24	25/3			20/3		
5♥4	40/3					
5♥15		45/3				
5♥23		50/3				
5♥29		40/3				
6♥6		45/3				
6♥15		45/3				
6♥19		80/3				
6♥25		90/3				
7♥2		50/3				
7♥17		50/6				
7♥24		50/12				
7♥31		30/3				
8♥6		32/4	12/2			
8♥13		60/4	12/2	12/1		
8♥21			18/6			
8♥24		50/6				
8♥31		30/3	5/6			
9♥3		25/6	20/1			
9♥10	32/3			10/3		
9♥17	55/6		15/3	12/6		
9♥26	55/6			12/6		
10♥1	50/3					

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Roxicodone 5 mg.	Vicodin
1987 Continued						
10▼8	90/6					
10▼19		60/6				
10▼26		60/6				
11▼2	60/6					
11▼5				20/1		
11▼7		6/6				
11▼9	60/3					
11▼12				10/3		
11▼16	60/6					
11▼23	75/8					
12▼28		6/4				
1▼30		50/3				

	Methadone	Percodan	Percocet	Tylenol 10 mg.	Valium 5 mg.	Tussionex
1988						
1▼4		30/3		30/2(#3)		
1▼6		15/3		10/3	30/1	
1▼11		50/3			30/3	
1▼21		60/6			30/3	
1▼27		40/4				
1▼30		30/4		20/4		
2▼3		75/4			30/2	
3▼7		60/3			20/6	
3▼9		20/3				
3▼11		45/6				
3▼15		40/6			24/6	

	Methadone	Percodan	Percocet	Tylenol 10 mg.	Valium 5 mg.	Tussionex
1988 Continued						
3▾18		20/6		20/3		21/3
3▾23		48/8		10/4	10/4	
3▾28			36/8	24/4	20/6	
4▾1	45/3					
4▾7	64/8				24/4	
4▾14	40/3				40/4	
4▾19		40/4			30/3	
4▾21	50/4					
4/30	30/4					
5▾4		20/4				
5▾7	60/6				20/6	
5▾12		50/4				
5▾16	30/6	10/3				
5▾20	60/6				30/6	
5▾21		25/4				
5▾28		12/6				
5▾30		8/6				
5▾31	60/6				30/4	
6▾3		40/6				
6▾5		12/6				
6▾7		30/6				
6▾10	30/6					
6▾13		25/6				
6▾15		8/6				
6/15	35/6					
6▾20		20/6		15/4		
6▾21				15/6		
6▾24	42/6			15/4		

	Methadone	Percodan	Percocet	Tylenol 10 mg.	Valium 5 mg.	Tussionex
1988 Continued						
6▼29		20/6				
7▼5						
7▼6	35/6			12/4		
7▼11	30/6			10/4		
7▼15	30/6					
7▼20		30/6		12/6		
7▼28			15/6		20/6	
7▼30			18/6			
8▼4	40/3					
8▼9	10/3				15/3	
8▼11	6/6					
8▼16			15/4			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.
1989				
1▼7	50/4			
1▼12	12/6			
1▼16	15/6			
1▼18	36/6			
1▼23	50/6			
1▼28	25/6			
2▼1		37/6		
2▼9	25/6			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.
1989 Continued				
2▼15	35/6		15/4	15/2
2▼21		40/6		20/1
2▼28	24/4			15/1
3▼7	6/4			
3▼8	30/4			15/1
3▼15				4/2
3▼16		24/6		16/2
3▼18			6/4	
3▼27		24/6		16/2

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

IN THE MATTER

OF

DAVID WASSERMANN, M.D.

REPORT OF

THE

HEARING COMMITTEE

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

DAVID C. MENDELSON, M.D. (Chair), MICHAEL A. GONZALEZ, R.P.A., and SHARON KURITZKY, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. LARRY G. STORCH, ESQ., served as the Administrative Officer.

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

EXHIBIT "B"

SUMMARY OF PROCEEDINGS

Date of Service of Notice of Hearing and Statement of Charges against Respondent:	March 1, 1990
Answer to Statement of Charges:	None
Dates and Places of Hearings:	April 26, 1990 May 10, 1990 June 14, 1990 July 31, 1990 (All Hearings were held at 8 East 40th Street New York, New York 10016)
Adjournments:	None
Received Petitioner's Proposed Findings of Fact and Conclusions of Law:	September 5, 1990
Received Respondent's Proposed Findings of Fact and Conclusions of Law:	September 5, 1990
Department of Health appeared by:	Dawn A. Dweir Associate Counsel
Respondent appeared by:	Giorgio and DePoto 23 Willis Avenue Syosset, New York 11791 Robert M. DePoto, Esq., of Counsel
Witnesses for Department of Health:	Stanley R. Yancovitz, M.D. Lewis Rothman, M.D. (in Rebuttal)

Witnesses for Respondent: David Wassermann, M.D.

STATEMENT OF CASE

Respondent was charged with professional misconduct relative to his treatment of two patients. He was charged with gross negligence, negligence on more than one occasion, excessive treatment and moral unfitness to practice the profession of medicine. The charges center on allegations that Respondent provided prescriptions for various controlled substances (narcotics and barbiturates) to drug addicts without medical justification.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. David Wassermann, M.D., hereinafter referred to as Respondent, was authorized to engage in the practice of medicine on January 27, 1938 by the issuance of license number 034653 by the New York State Education Department. (Dep't. Exhibit #4).

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 31, 1989 through December 31, 1991 from 175 Jericho Turnpike, Syosset, New York. (Dep't. Exhibit #4).

3. Respondent is currently a solo practitioner. He testified at this hearing that he specializes in ear, nose and throat and neck. At a disciplinary hearing held in 1987, Respondent testified that he limited his practice to ear, nose and throat. Respondent is board-certified in otolaryngology. (222, 266, 331).

4. Respondent has not been affiliated with any hospital since 1981. (266).

5. The Department's charges focus primarily on Respondent's prescription of addictive substances to two patients between 1984 and 1989. (Dep't. Exhibit #3).

6. The Department called two expert witnesses, Stanley Yancovitz, M.D. and Lewis Rothman, M.D. (Record as a Whole).

7. Dr. Yancovitz is board certified in internal medicine and infectious diseases. (16). He is presently chief of the Division of Chemical Dependency at Beth Israel Medical Center in New York City, Medical Director of Stuyvesant Square Chemical Dependency Program and Director of the Clinical AIDS activities at Beth Israel. (17; Dep't. Exhibit #5).

8. Dr. Yancovitz was accepted without objection as an expert in the field of medicine and chemical dependency. (18).

9. Lewis Rothman, M.D., was called as a witness to rebut Respondent's testimony that the X-rays of Patient A and B demonstrated pathology which was the competent producing cause of pain. (391-393).

10. Dr. Rothman is a board certified radiologist with a sub-specialization and current practice in neuroradiology. He is presently the Director of the Radiology Department at Lenox Hill Hospital in New York City. (531-532).

11. Dr. Rothman was accepted without objection as an expert in the field of radiology. (533).

Patient A

12. During a period which included December 1982 through May 1989, Respondent treated Patient A for facial and neck pain. (Dep't. Exhibit #6; Resp. Exhibit H).

13. In April 1989, Respondent prepared a typewritten summary of his office record regarding Patient A for the period April 16, 1984 through March 20, 1989, at the request of the Office of Professional Medical Conduct (OPMC). The Hearing Committee found substantial discrepancies between Respondent's hand-written notes, prepared contemporaneously with each patient visit (Dep't. Exhibit #6), and the typed summary (Dep't. Exhibit #7).

14. Most notable amongst the discrepancies are the notes for an April 16, 1984 visit. The entry for that date in the typed summary contains the representation that a comprehensive otolaryngological examination was performed on that date and that the following diagnoses and pathological findings were documented:

a. chronic allergic nasopharyngitis;

b. Scarred nasal columella causing 90% left nostril obstruction;

c. Nasal tip is bilaterally contracted due to intranasal scar tissue caused by accidental and/or surgical trauma;

d. Nasal pyramid is irregular and tender;

e. Nasal mucosa is dry and the nasal septum is deviated to the left causing 90% left nasal airway obstruction;

f. Chronically severe cervical syndrome due to cervical muscular spasm, degenerative arthritis of the cervical spine, narrowing of the neural foramina and straightening of the lordotic curve;

g. Tonsillectomy and adenoidectomy in childhood.

There is no such entry in Respondent's hand-written record for April 16, 1984. (Dep't. Exhibit #7, p.1; (Dep't. Exhibit #6).

15. Several of the above-referenced diagnoses are contained within a note dated December 29, 1982, found in Respondent's Exhibit H. Respondent presented this document at the hearing as Patient A's records for the period December 29,

1982 through April 16, 1984. However, a portion of diagnosis f. (as listed above) relating to"....narrowing of the neural foramina and straightening of the lordotic curve...." does not appear in any of Respondent's records until a radiology report, dated February 3, 1988. (Dep't. Exhibit #7).

16. Entries throughout Respondent's typed records contain qualitative descriptions of pain and conditions that do not exist in Respondent's original office records. Examples follow from the year 1984, with quotation marks used to show words which do not exist in Respondent's original hand-written office record:

a. 5-18-84: complains of "very severe" recurrent headaches and neck pain... Rx percodan on tab daily prn "for very severe headache and neck pain".

b. 8-7-84: Rx percodan..."for face pain" ...Rx valium "for anxiety".

c. 9-1-84: "severe acute exacerbation" of chronic nasopharyngitis. Rx percodan..."for severe headache" and valium..."for anxiety".

d. 9-18-84: Rx Percocet... "for face pain".

e. 10-10-84: "Allergy symptoms and face pain continue".

f. 11-9-84: "Severe chronic nasopharyngitis".

g. 12-5-84: recurrent "severe" headaches and "nasal congestion"

h. 12-27-84: " severe sore throat". (Dep't. Exhibit # 7, pp.1-3; Dept. Exhibit #6).

17. Respondent testified that he did not recall ever changing the records, and that the additional descriptive information could have been a clerical oversight. Respondent does not have an office staff. (274-276;610).

18. Despite the fact that Respondent's original records detail amounts of money received and due from Patient A, Respondent's typed records contain no references to fees. (Dep't Exhibit #6; Dep't. Exhibit #7).

19. Upon direct examination, Respondent testified that Patient A came under his care on May 1, 1984. He further testified that the hand-written records contained within Department's Exhibit #6 were the only records made contemporaneously with each office visit by the patient. However, under cross-examination, Respondent testified that Patient A came under his care on December 29, 1982. (232, 268, 290-291).

20. At the hearing, Respondent introduced records which purported to document his treatment of Patient A, commencing on December 29, 1982. (323; Resp. Exhibit H).

21. During the period between April 1984 and May 1989, Respondent prescribed controlled substances, including percodan, percocet, methadone, and codeine to Patient A in the following amounts:

Year	Percodan	Percocet	Methodone (10Mg.)	Tylenol & Codeine 4
1984	200	200		460
1985	50	175		277
1986	231	558		294
1987	652	1352		102
1988	883	84	697	164
1989	308	125		21

(Dep't. Exhibit #6; Dep't. Exhibit #7).

The dates of each patient contact and the prescriptions corresponding with each patient contact are set forth in Appendix A of this report.

22. Dr. Yancovitz testified that controlled substances such as percoden, percocet and methadone are indicated for moderate or severe conditions causing significant pain which is not relieved by less potent analgesic agents such as aspirin or acetaminophen. He further testified that such controlled substances are highly addictive. (20-21, 26, 27)

23. Respondent continued to prescribe controlled substances for pain related to Patient A's sinuses and neck. (233; Dep't. Exhibit #6).

24. Dr. Yancovitz testified that a prudent physician would have ordered x-ray examination of the involved areas within weeks of prescribing potent narcotic agents for Patient A's condition, if not on the first visit. (39).

25. The medical record is silent as to the performance of any laboratory or radiological examination of Patient A prior to February 3, 1988. (Dep't. Exhibit #6; Dep't Exhibit #7).

26. Respondent treated Patient A with large amounts of narcotic analgesics for more than four years before referring her for X-rays of the sinus and spine. (37).

27. Respondent relied on the X-rays of February 1988 when he testified that he had X-ray proof that Patient A "did have justification for her pain". (305).

28. When Respondent pointed out the areas that he felt were pathologies causing Patient A pain, Dr. Rothman testified that the sinus and facial bone films were within the range of normal. (535-537).

29. Dr. Rothman testified that if he were convinced that this patient was presenting with valid complaints of pain

over a period of many months he would order additional films or examination to verify the diagnosis. (547).

30. Dr. Yancovitz testified that an electromyelogram, CT scan or MRI would have helped determine the basis of Patient A's pain and whether she had a diagnosis consistent with her degree of pain. (74-75).

31. CT scans were routine procedures for further evaluation of Patient A's complaints at the time Respondent treated Patient A. (553).

32. Respondent testified that on two occasions, June 16, 1988 and July 6, 1988, he advised Patient A to have a CT scan. However, the office medical records for those dates refer to bone scans, a different procedure. (407; Dep't. Exhibit #6).

33. No CT scans, bone scans or other diagnostic procedures were performed on Patient A. (Dep't. Exhibit #6).

34. Dr. Yancovitz testified that before issuing prescriptions for controlled substances, a prudent physician would also have consulted with a neurosurgeon regarding whether the impingement noted on the X-rays was actually functionally significant and whether prolonged bedrest with any other modalities of treatment would be required. (59).

35. No neurological or neurosurgical consultation was sought by Respondent, as documented in the medical record maintained for Patient A. (Dep't. Exhibit #6).

36. Dr. Yancovitz testified that before issuing prescriptions for controlled substances, a prudent physician would have pursued alternate modes of treatment for Patient A's complaints such as the use of a cervical collar, physiotherapy or the use of a TENS unit. (59).

37. Patient A was concerned about her abuse of addictive drugs which she obtained:

a. Between March and June of 1987, Patient A was treated at the Pain Alleviation Center in Roslyn, New York. The goals of Patient A's treatment were directed at reducing and eventually eliminating her use of all narcotic analgesics. Modes of treatment for Patient A included therapeutic exercise, TNS, high voltage stimulation, moist heat, ice, acupuncture, biofeedback and behavior modification therapy. (Dep't. Exhibit #11).

b. In June 1987 Patient A reported to the Pain Alleviation Center that she was nearly headache free and was feeling considerably more energetic while under their treatment. (Dep't. Exhibit #11).

c. Patient A also underwent psychiatric drug therapy while admitted to North Shore University Hospital between November 24, 1987 and December 8, 1987. (Dep't. Exhibit #12).

38. Respondent admitted that as of Patient A's first office visit he "was very much aware" that Patient A was a drug addict. Nevertheless, Respondent proceeded to prescribe large amounts of narcotic analgesics to the patient despite his knowledge that she was a drug addict. (240, 266, 267).

39. Respondent made no entry in his hand-written office record to document Patient A's drug addiction. (Dep't. Exhibit #6)

40. Respondent was aware that Patient A was a school teacher. He never addressed any concerns regarding Patient A's interaction with children. (356).

41. Patient A's office medical record does not document any referral to drug rehabilitation programs by Respondent. (Dep't. Exhibit #6).

42. Respondent testified that his fees were based on the amount of time spent with the patient. (262).

43. Respondent stated that Patient A's first office visit lasted approximately 5-6 hours. (357-358, 420). The first office visit was the longest of all his office visits with

this patient. (359). His fee for this visit was $100.00. (Resp. Exhibit H).

44. As the amount of prescriptions increased, Respondent charged considerably more for each office visit:

a. In 1984, Patient A visited Respondent 14 times and paid him $900.00. In 1985, Patient A visited Respondent 12 times and paid him $900.00. In 1986, Patient A visited Respondent 29 times and paid him $1,650.00. In 1987, Patient A visited Respondent 46 times and paid $5,775.00. In 1988, Patient A visited Respondent 45 times and paid $28,850.00. During the first 4 months of 1989 Patient A saw Respondent 22 times and paid $9,910.00. (Dep't. Exhibit #6.

b. On April 21, 1988, Respondent charged Patient A $1,500.00 for an office visit at which he gave a prescription for methadone. (Dep't. Exhibit #6, pp. 39, 40).

c. On August 16, 1988, Respondent received $500.00 from Patient A in exchange for a prescription for methadone. (Dep't. Exhibit #6, p.49).

45. Dr. Yancovitz testified that Respondent showed extremely poor judgment in the prescription of a prolonged

massive amount of narcotic agents beyond any medical indication in the records. (28).

46. Respondent testified that when Patient A initially came to him in December 1982, she had an incurable condition. He based this determination solely upon his initial clinical findings. No diagnostic procedures (laboratory, radiological, etc.) were performed. (238-239; Dep't. Exhibit #6).

47. Respondent also testified that Patient A was a "definite permanent cripple" due to her condition, despite the fact that he observed the patient to be able to get around and act in a normal manner. (435-436).

48. At no time did Respondent attempt to obtain records from any of Patient A's prior or concurrent treating physicians, even though the patient related a history of using controlled substances. (233, 303, 423-424).

Patient B

49. During a period beginning April 4, 1987 and continuing through September 23, 1988, Respondent treated Patient B in his office on approximately 69 occasions. (Dep't. Exhibit #8).

50. At the initial visit on April 4, 1987, the patient's chief complaints were post-nasal drip and asthmatic bronchitis due to dust inhalation. No complaint of neck pain was recorded. Following an examination of the patient, Respondent noted the following findings in the record:

a. nasal septum spur pressing on the posterior end of the left inferior turbinate;

b. adhesions in the fossae of Rosenmuller;

c. lymphoid growths on the tongue, and

d. chronic cervical syndrome.

(472; Dep't. Exhibit #8).

51. Respondent noted a tentative diagnosis of neoplasm of the laryngopharynx and recommended a referral to a specialist for consultation. (472-473; Dep't. Exhibit #8).

52. Respondent testified that no biopsy was ever performed and the diagnosis of neoplasm of the laryngopharynx was never ruled out. (515, 516). Dr. Yancovitz testified that Respondent never adequately evaluated the tumor-like formations in the laryngopharynx. (152).

53. During the first five months of treatment of Patient B, prior to any documentation of patient complaints regarding insomnia and dreams, Respondent prescribed decadron, quibron, ephedrine, actifed, hycodan syrup, and robitussin syrup, as well as other medications. (Dep't. Exhibit #8).

54. On September 19, 1987, Respondent documented patient complaints of insomnia and dreams for the first time. (Dep't. Exhibit #8, p. 7).

55. On September 19, 1987, when Patient B first complained of insomnia and dreams, rather than stopping the medications that might be causing a toxic reaction, Respondent added a barbiturate (Seconal) to the medications prescribed for Patient B. Respondent never considered that the patient's complaint of insomnia and dreams might have been a drug related reaction. (623; Dep't. Exhibit #8, p. 7).

56. Respondent's records contain no reference to there being any connection between cervical pathology diagnosed five months earlier on April 11, 1987 and Patient B's complaints of insomnia on September 17, 1987. (580; Dep't. Exhibit #8). Respondent's entry on April 11, 1987 relating to the cervical spine x-rays indicates that there was no lordotic curve. Dr. Rothman testified that the only x-ray which would show the

lordotic curve, (Resp. Exhibit J-3), showed a normal lordotic curve. (562-564).

57. Dr. Yancovitz testified that when Patient B complained of insomnia and dreams on September 19, 1987, a prudent physician would have delved into the pattern of the sleep disorder and its likely causes. In the case of complaints of insomnia there should also be attention to whether the patient is a drug addict since a common complaint of drug addicts is insomnia. (131). Dr. Yancovitz described how a prudent physician would identify a drug addict at Page 137 of the transcript.

58. Without properly investigating the cause of Patient B's sleep complaints, pursuing alternative modes of treatment or making any attempt to identify whether Patient B was a drug abuser, Respondent embarked on a year of prescribing large and increasing amounts of barbiturates to Patient B. (525; Dep't. Exhibit #8).

59. During the period from September 1987 through September 23, 1988, Respondent issued the following prescriptions for barbiturates and narcotics to Patient B:

Date	Medication	Mg.	Total	Directions
9-19-87	Seconal	100	#30	1 cap. HS prn

10-06-87	Seconal	100	#30	1 cap HS
10-23-87	Seconal	100	#30	1 cap HS prn
10-31-87	Seconal	100	#30	1 cap HS prn for sleep
11-07-87	Tuinal	200	#30	1 cap HS for sleep prn
11-20-87	Tuinal	200	#30	to be given on 11-25
11-25-87	Tuinal	200	#30	Cap HS prn
12-11-87	Tuinal	200	#30	1 tab HS prn for sleep
12-29-87	Tuinal	200	#30	1 tab HS prn for sleep
2-17-88	Tuinal	200	#30	1 cap HS
3-11-88	Tuinal	200	#30	1 cap HS prn
3-21-88	Tuinal	200	#30	1 HS prn for sleep
3-29-88	Tuinal	200	#30	1 HS prn for sleep
4-04-88	Tuinal	200	#60	1 tab HS prn
4-15-88	Tuinal	200	#30	1 tab HS prn for sleep
4-28-88	Tuinal	200	#30	1 tab HS prn for sleep
5-10-88	Tuinal	200	#30	1 tab HS
6-06-88	Tuinal	200	#30	1 HS prn
6-15-88	Tuinal	200	#30	1 HS prn for sleep
6-22-88	Tuinal	200	#30	1 tab HS prn for sleep
6-28-88	Tuinal	200	#30	1 tab HS prn
7-07-88	Seconal	100	#30	1 cap 1-2 HS
7-19-88	Tuinal	200		1 cap HS prn for sleep
7-29-88	Tuinal	200	#30	1-2 tabs HS for sleep pr

	Seconal	100	#3	2 caps HS prn
8-03-88	Seconal	100	#30	1 cap HS prn for sleep
8-08-88	Tuinal	200	#30	2 caps for sleep HS
8-18-88	Tuinal	200	#6	2 tabs for sleep prn
	Seconal	100	#6	2 caps for sleep prn
8-22-88	Seconal	100	#30	2 caps HS
	Tuinal	200	#30	2 tabs HS for sleep
8-29-88	Percodan		#10	1 tab q.4 hours for chest pain prn
9-01-88	Dilaudid	2	#12	1 tab q.6 hrs for painful cough
9-03-88	Seconal	100	#30	2 caps HS
	Tuinal	200	#30	2 Tabs prn sleep
9-07-88	Dilaudid		#12	2 mg tab 1/2 tab q.6 hrs for painful cough sleep
9-08-88	Seconal	100	#30	2 caps for sleep adv. chest x-ray and repetition of all drugs
9-15-88	Dilaudid	2	#12	1 tab q.6 hrs
9-19-88	Tuinal	200	#30	2 tab HS prn for sleep
	Dilaudid	2	#7	tab q.6 hrs for chest pain
9-23-88	Tuinal	200	#30	1 cap HS for sleep
	Dilaudid	2	#30	1/2 tab q.6 hrs for chest pain

(Dep't. Exhibit #8).

60. Dr. Yancovitz testified that Tuinal and Seconal are barbiturates with a high addictive potential. (128-129).

61. The medical record is silent as to whether Respondent made any inquiries regarding Patient B's alcohol use despite the significant risks posed by combining alcohol with barbiturates. (215; Dep't. Exhibit #8).

62. Respondent agreed that throughout his treatment of Patient B he prescribed much more barbiturates than would have been necessary if Patient B took them as directed. (574).

63. In the period from September 19, 1987 through November 25, 1987, Respondent prescribed at least twice as much barbiturate as Respondent directed Patient B to take. (573-574; Dep't. Exhibit #8, pp. 7-9).

64. Although respondent embarked on a course of continuing prescriptions for barbiturates, he neither performed nor referred Patient B for a complete physical examination, including a complete history, clinical examination, blood pressure readings or routine laboratory studies of blood and urine. (Dept. Exhibit #8).

65. Dr. Yancovitz testified that a prudent physician would have done periodic CBC's and chemistries, both as routine tests and to check for complications that might ensue during the administration of long term medications. A prudent physician

would also have performed an eosinophil count in order to look for signs of allergy. (45, 80).

66. Respondent continued to prescribe large amounts of barbiturates and narcotics to Patient B without making efforts to identify whether or not Patient B was a drug abuser and despite the likelihood that Patient B had become addicted to the substances he was prescribing. (590-591; Dep't. Exhibit #8).

67. Respondent failed to reevaluate why Patient B was seeking the barbiturates despite the fact that it was clear that he was taking much more than Respondent's prescriptions directed him to take. (144).

a. Patient B complained to Respondent of black sputum, a known sign of smoking crack. (137; Dep't. Exhibit #8, p. 11).

b. Respondent admitted that in May, 1988, when Patient B asked Respondent to prepare a statement about his use of Tuinal for his attorney, that it was a clue that Patient B might have been an addict. (591, 592).

c. Respondent admitted suspecting that Patient B was a drug addict as of the latter part of 1988. (511, 512).

d. Respondent issued a prescription for Tuinal on June 22, 1988 purportedly to replace a prescription that Patient B had lost. (Dep't. Exhibit #8, p. 16).

e. Reports of lost prescriptions are common ploys by drug addicts seeking excessive medication. (146).

f. For the service of writing a replacement Tuinal prescription on June 22, 1988 Respondent charged Patient B $100. (147, 596; Dep't. Exhibit #8, p. 16).

g. Patient B's autopsy, performed one month after Patient B's last office visit, showed evidence of chronic narcotic abuse. (Dep't. Exhibit #9). The "old tracking" noted by the pathologist is a well known sign of chronic intravenous drug use. (139). Respondent's medical record for Patient B does not mention the presence of needle tracks. (Dep't. Exhibit #8).

68. Respondent was acting as Patient B's primary care physician (i.e., other than the possible neoplasm, all of Patient B's complaints fell within the scope of primary care physicians). However, he did not perform any examination of the patient beyond the ear, nose, throat and chest. (215, 216, 217).

69. On August 29, 1988, Respondent prescribed percodan tablets for Patient B to relieve complaints of severe chest pain allegedly due to fractured lower left ribs. According to Respondent's office medical record, the fractures were confirmed by x-ray on August 27, 1988 at Central General Hospital. However, a set of aftercare instructions to Patient B by the Central General Hospital Emergency Department are dated August 29, 1988 at 1:10 p.m. Attached to those aftercare instructions were prescriptions for Tylenol #3 and Motrin. These prescriptions were never filled, yet Respondent prescribed percodan based on Patient B's assertion that Tylenol did not relieve his pain. (630-631; Dep't. Exhibit #8; Resp. Exhibit M).

70. There was no confirmation of a rib fracture documented in Respondent's office medical record for Patient B when he prescribed the percodan tablets on August 29, 1988. (Dep't. Exhibit #8).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise. Numbers in parentheses refer to the specific Findings of Fact which support each conclusion.

First Specification (Gross Negligence - Patient A): Sustained (1,2,12-48)

Second Specification (Gross Negligence - Patient B): Sustained (1,2,49-70)

DISCUSSION

Respondent is charged with professional misconduct within the meaning of Section 6509(2) of the Education Law by practicing medicine with gross negligence with regard to his treatment of Patients A and B. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum, dated September 19, 1988, prepared by Peter J. Millock, Esq., General Counsel for the Department. This document, entitled "Definitions of Professional Misconduct under the New York Education Law", sets forth, inter alia, a suggested definition for gross negligence (The Education Law does not set

forth definitions.) Gross negligence is defined, in pertinent part, as:

> "... a failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, a disregard of the consequences which may ensue from such failure and an indifference to the rights of others..."

Utilizing this definition as a framework for its deliberations, the Hearing Committee concluded that, by a preponderance of the evidence, the First and Second Specifications should be sustained. The rationale for this conclusion is set forth below.

Patient A

Patient A's primary problem was drug abuse. Respondent failed to properly evaluate the patient's complaints of facial and neck pain before embarking on a long-term course of treatment with controlled substances such as percodan, percocet and methadone. The Hearing Committee gave great weight to the testimony of Dr. Yancovitz. Dr. Yancovitz testified that a prudent physician would have ordered x-ray examination of the patient's sinuses and neck within weeks of prescribing such potent narcotics, if not on the first visit. Respondent treated Patient A with controlled substances for more than five years before ordering x-rays. The

sinus and facial bone x-rays, which were performed in February 1988, ultimately were found to show no significant pathology (i.e., all films were within the range of normal). Respondent never sought a neurological or neurosurgical consultation, as prudent practice would have dictated. In fact, Respondent ordered no laboratory or other diagnostic procedures for over five years.

The Hearing Committee gave little credence to Respondent's representation as to the actual level of pain suffered by Patient A. Respondent relied heavily on his typed summary of the patient's records (Dep't. Exhibit #7) to support this contention. However, the descriptions of pain contained in that document are not found anywhere in his hand-written records, prepared contemporaneous to each office visit. (Dep't. Exhibit #6). Indeed, there are so many discrepancies between the typed and hand-written records, that the Hearing Committee gave no credence to the typed version. As a result, it is apparent that Respondent failed to appropriately assess the level of pain suffered by Patient A. Instead, Respondent merely provided prescriptions for controlled substances to Patient A "on demand" to alleviate her supposedly severe pain, without any documented medical justification.

Respondent further failed to adequately manage the patient's growing drug dependency, or refer her for further

evaluation and treatment. The Hearing Committee was especially disturbed by Respondent's failure to even attempt to obtain the patient's prior medical records, even though he was aware that she had been given controlled substances prescriptions by other physicians.

The Hearing Committee is of the unanimous opinion that Respondent's conduct demonstrated a clear disregard of the consequences which may have ensured from his failure to exercise due care, as well as an obvious indifference to the rights of others. Respondent knew that Patient A was employed and functioning as a school-teacher, while using large amounts of narcotics on a daily basis. Respondent demonstrated little concern for the effect such prolonged drug use could have on either the patient or her students. He simply provided the patient with an endless stream of prescriptions.

Patient B

Patient B first came to Respondent on April 4, 1987. His chief complaints were post-nasal drip and asthmatic bronchitis due to dust inhalation. No complaints of neck pain were recorded at that visit (nor upon any subsequent visit). Following an otolaryngological examination, Respondent diagnosed, inter alia, chronic cervical syndrome, and a possible neoplasm of the

laryngopharynx. Respondent did recommend a consultation regarding the possible neoplasm but a consultation was never obtained. Respondent made no further attempt to follow-up on the possible neoplasm. Starting with this first visit, Respondent embarked on a course of treatment for Patient B which mainly consisted of repeated prescriptions for controlled substances such as decadron, quibron, ephedrine, actifed, hycodan syrup and Robitussin syrup, as well as other medications. Respondent never performed a complete history and physical examination of this patient, and obtained no diagnostic laboratory or radiology studies, except for one series of x-rays taken on April 11, 1987.

After approximately five months of the drug regimen, Patient B began to complain of insomnia and dreams (on September 19, 1987). A prudent physician would have explored the nature of the sleep disorder, with particular regard to whether a toxic reaction to the medication taken by the patient was the cause. Additionally, a prudent physician would have considered the possibility of drug abuse, insofar as insomnia is a common complaint of drug addicts. Rather than make such inquiries, or explore other possible therapies, Respondent immediately prescribed barbiturates for Patient B's insomnia. Respondent prescribed Seconal and Tuinal, both highly addictive barbiturates.

Respondent testified that Patient B's insomnia was caused by a lack of a lordotic curve in his spine. However, there is no documentation in the medical record connecting the insomnia to any alleged spinal problems. Further, the Committee accepted Dr. Rothman's testimony that the only x-ray which could properly visualize the lordotic curve, showed a normal curve. Therefore, the Hearing Committee discounted Respondent's testimony and concluded that he did not prudently prescribe barbiturates for this patient.

In fact, Respondent began a year-long course of prescribing increasingly large amounts of Seconal and Tuinal. During the period from September 19, 1987 through November 25, 1987, Respondent prescribed at least twice as much barbiturates as Patient B could take, if he followed the directions for proper usage. Respondent made no attempt to determine whether the patient was abusing drugs, despite clear evidence of addiction. Respondent never made an attempt to monitor the patient's condition or response to the drugs, either by follow-up examination or appropriate diagnostic laboratory studies. These are basic procedures which a prudent physician would have done.

As was the case with Patient A, Respondent essentially provided controlled substance prescriptions to Patient B "on demand", irrespective of the patient's true condition or needs.

A glaring example of this conduct occurred on August 29, 1988. Respondent gave Patient B a prescription for percodan tablets to relieve complaints of severe chest pain due to an alleged rib fracture. Respondent did not confirm the existence of the fracture. He wrote the prescription solely because the patient claimed that he did not get any relief from the Tylenol #3 and Motrin prescribed by a physician at the Central General Hospital Emergency Department. However, the record shows that the patient never filled the Tylenol and Motrin prescriptions. The Committee concluded that it was more likely than not that the patient went from the hospital directly to Respondent's office. Rather than exercise independent medical judgment as to the need for the percodan, Respondent simply wrote the prescription.

Based upon the above analysis, the Hearing Committee unanimously concluded that Respondent's conduct demonstrated a blatant disregard of the consequences to his patient, as well as an indifference to the rights of others. Therefore, the Committee concluded that Respondent's conduct constituted gross negligence with regard to Patient B, as set forth in the Second Specification.

Third Specification (Negligence on More than 1 Occasion): Sustained (1,2,12-70)

DISCUSSION

Given the conclusion that Respondent should be found guilty of gross negligence in his treatment of Patients A and B, it is axiomatic that he be found guilty of negligence on more than one occasion. This conclusion is further buttressed by the fact that Respondent repeatedly prescribed addictive drugs to these patients, without medical justification, over a period of years. Consequently, the Hearing Committee concluded, by a preponderance of the evidence, that the Third Specification should be sustained.

Fourth Specification (Excessive Treatment - Patient A): Sustained (12,14-16,20-26,28-30,33-36,38; Appendix A)

Fifth Specification Excessive Treatment - Patient B): Sustained (49,50,53,55-59,63,66,69,70).

DISCUSSION

Respondent has also been charged with committing unprofessional conduct within the meaning of Section 6509(9) of the Education Law by ordering excessive treatment not warranted by the condition of the patient, in violation of 8 NYCRR 29.2(a)(7). The Hearing Committee concluded, by a preponderance of the evidence, that Respondent did order excessive treatment with regard to both Patient A and Patient B, respectively.

The record clearly demonstrated that Respondent prescribed dangerous controlled substances over a long period to both patients without ever fully evaluating their individual complaints in order to determine an appropriate course of therapy. Respondent continually prescribed controlled substances to these patients, "on demand", without any documented medical justification.

Sixth Specification (Moral Unfitness - Patient A): Sustained (1,2,12-48)

Seventh Specification (Moral Unfitness - Patient B): Sustained (1,2,49-70)

DISCUSSION

Respondent has been charged with committing unprofessional conduct within the meaning of Section 6509(9) of the Education Law in that his conduct in the practice of medicine with respect to Patient A and Patient B, respectfully, evidences moral unfitness to practice the profession, in violation of 8 NYCRR 29.1(b)(5). By a preponderance of the evidence, the Hearing Committee concluded that the Sixth and Seventh Specifications should be sustained.

Conduct which evidence moral unfitness can arise either from conduct which violates a trust related to the practice of the

profession or from activity which violates the moral standards of the professional community to which the Respondent belongs. With regard to Patient A, the Hearing Committee concluded that Respondent's medical care primarily consisted of the issuance of prescriptions for controlled substances with virtually no additional medical care. These prescriptions were provided to the patient in exchange for unconscionably high fees. For example, in 1988 Patient A paid Respondent $28,850.00 for 45 visits at which she received controlled substance prescriptions. Specifically egregious examples include an office visit on April 21, 1988 at which Respondent charged Patient A $1,500.00 and issued a prescription for methadone. Additionally, on August 16, 1988, Respondent received $500.00 in exchange for a prescription for methadone. The Hearing Committee unanimously concluded that these charges were primarily for prescribing controlled substances and do not reflect compensation for Respondent's time spent with the patient.

Respondent also ignored obvious signs of drug abuse by Patient B and continued to prescribe a laundry list of controlled substances for him, without any medical justification. Again, Respondent provided the patient with prescriptions "on demand." This was exemplified by the issuance of a prescription for percodan tablets on August 29, 1988, ostensibly to relieve

complaints of severe chest pain due to an alleged rib fracture. Respondent wrote the prescription without obtaining any confirmation of the fracture. Further, he wrote it based solely on the patient's assertion that the Tylenol #3 and Motrin prescribed by the physicians at the Central General Hospital Emergency Department did not relieve the pain. This assertion was made notwithstanding the fact that the patient never filled the Tylenol and Motrin prescriptions. The patient simply asked for a percodan prescription and Respondent provided it -- for a fee.

The Hearing Committee unanimously concluded that Respondent's conduct with regard to Patients A and B represented a gross abuse of his authority. Respondent took advantage of these patients' addictions for his own personal gain. Such behavior demonstrated a blatant disregard for his patients' welfare, and is beyond any reasonable moral standard for the medical profession.

RECOMMENDATIONS

The Hearing Committee, pursuant to its Findings of Fact and Conclusions herein, unanimously recommends that Respondent's license to practice medicine in the State of New York be revoked. This recommendation was reached after due consideration of the full spectrum of available penalties, including suspension,

probation, censure and reprimand, or the imposition of civil penalties of up to $10,000 per violation.

Any individual who receives a license to practice medicine is placed into a position of public trust. Respondent's conduct with regard to his patients constituted a serious breach of the public trust. Respondent demonstrated a blatant disregard for the welfare of his patients. He prescribed increasingly large amounts of addictive controlled substances to Patient A and B, without medical justification, over an extended period of time. He took advantage of his patients' addictions for his own gain by charging unconscionably high fees for the prescriptions which he provided.

In addition, Respondent's testimony demonstrated a serious lack of knowledge about current medicine. This was exemplified by his confusion between a bone scan and CT scan, and the appropriate use of these standard diagnostic tools. Further, Respondent attempted to mislead the Hearing Committee with his confusion about dates and his altered records. He presented the typed summary of his records regarding Patient A as a "complete and accurate record." However, the typed document is replete with additions and inconsistencies when compared to his handwritten notes.

The members of the Hearing Committee were initially inclined to attribute Respondent's confusion and the discrepancies in his testimony to changes in mentation which naturally occur with age. However, a pattern of deceitful conduct developed during the course of the proceedings which showed a complete disregard for the moral standards which members of the medical profession should maintain.

Respondent's track record clearly demonstrates that a mere suspension of his license will not instill the moral character necessary to be a physician. Respondent is currently under suspension (stayed) and on probation for professional misconduct. By a Order dated April 3, 1989 (#8550), Respondent was found guilty of the fraudulent practice of medicine relating to the submission of false insurance claims. (see, Department's Exhibit #4).

It is clear that the imposition of a lesser penalty will not accomplish anything. Respondent has received one suspension without any positive change in his behavior. The only appropriate penalty is revocation.

Based upon the foregoing, the Hearing Committee made the following recommendations:

1. That the First through Seventh Specifications, as set forth in Department's Exhibit #3, be SUSTAINED; and

2. That Respondent's license to practice medicine in New York State be REVOKED.

DATED: Rochester, New York
October 26, 1990

Respectfully submitted,

David C Mendelson M.D.

DAVID C. MENDELSON, M.D.(Chair)

Michael A. Gonzalez, R.P.A.
Sharon Kuritzky, M.D.

APPENDIX A

APPENDIX

ANALGESIC MEDICATIONS AND CONTROLLED SUBSTANCES PRESCRIBED TO PATIENT A

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Empirin Comp. #3	Darvon Comp. 65
1984						
4-16	10/1		100/6			
5-1	10/1		100/6			
5-18	10/1		100/1			
5-24	10/1		100/6			
5-26	40/1					
8-7	40/2			40/2		
9-1	80/3			80/2		
9-10		30/3				
10-10		60/3		80/2		
10-22			10/1			
11-9		40/2		30/2		
11-13					25/4	
12-5				30/1	6/6	
12-27			50/6	20/1		
1985						
1-8				10/2		
5-6				90/2		

*Quantity in tablets/Maximum daily dose in tablets

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Empirin Comp. #3	Darvon Comp. 65
1985 Continued						
7-5				90/3		
7-30						30/4
8-26			20/4			50/4
9-7			12/4			
9-19		25/2	60/4			
10-7		25/2	60/4			
10-28		50/2	50/4			
11-19	50/2		25/4			
12-17		75/3	50/4			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Vicodin
1986					
1-13		50/3	50/4	20/2	
1-23			30/3		
2-5			50/4		
2-25			12/3		
2-28		30/3	30/3		
3-19		60/3			
4-1	30/3				
4-11				10/2	
4-23		30/3	30/3		
4-30	6/3		15/3		
5-16	15/3				
5-17	50/3				3/3
6-9		60/3			
6-14		5/3			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Vicodin
1986 - Continued					
3-12			12/3		
3-14			6/3		
3-15	50/3			40/6	
3-29		50/3			
4-12		40/3			
4-22	40/3		4/2		
10-6	40/3		5/1		
10-25		30/3	30/6		
11-13		3/3			
11-14		30/3			
12-1		50/3			
12-13		40/3		12/2	
12-20		40/3			
12-29		40/3	20/3	25/2	

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Roxicodone 5 mg.	Vicodin
1987						
1-8	50/3					
1-10		7/3				
1-15		40/3	20/4			
1-23					40/3	
1-24						10/3
2-5		5/3				
2-9		50/3		30/3		

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Roxicodone 5 mg.	Vicodin
1987 Continued						
2-16		50/3				
3-2		50/3				
3-16		50/3		30/3		
3-27		50/3		30/3		
3-31		6/3				
4-5		40/3		20/3		
4-17		50/3				
4-24	25/3			20/3		
5-4	40/3					
5-15		45/3				
5-23		50/3				
5-29		40/3				
6-6		45/3				
6-15		45/3				
6-19		80/3		40/3		
6-25		90/3		30/2		
7-2		50/3				
7-17		50/6		10/6		
7-24		50/12		10/6		
7-31		30/3				
8-6		32/4	12/2			
8-13		60/4	12/2	12/1		
8-21			18/6			
8-24		50/6				
8-31		30/3	5/6			
9-3		25/6	20/1			
9-10	32/3			10/3		
9-17	55/6		15/3	12/6		
9-26	55/6			12/6		
10-1	50/3					

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.	Roxicodone 5 mg.	Vicodin
1987 Continued						
10-8	90/6					
10-19		60/6				
10-26		60/6				
11-2	60/6					
11-5				20/1		
11-7		6/6				
11-9	60/3					
11-12				10/3		
11-16	60/6					
11-23	75/8					
12-28		6/4				
1-30		50/3				

	Methadone	Percodan	Percocet	Tylenol 10 mg.	Valium 5 mg.	Tussionex
1988						
1-4		30/3		30/2(#3)		
1-5		15/3		10/3	30/1	
1-11		50/3			30/3	
1-21		60/6			30/3	
1-27		40/4				
1-30		30/4		20/4		
2-3		75/4			30/2	
3-7		60/3			20/6	
3-9		20/3				
3-11		45/6				
3-15		40/6			24/6	

	Methadone	Percodan	Percocet	Tylenol 10 mg.	Valium 5 mg.	Tussionex
1988 Continued						
3•18		20/6		20/3		21/3
3•23		48/8		10/4	10/4	
3•28			36/8	24/4	20/6	
4•1	45/3					
4•7	64/8				24/4	
4•14	40/3				40/4	
4•19		40/4			30/3	
4•21	50/4					
4/30	30/4					
5•4		20/4				
5•7	60/6				20/6	
5•12		50/4				
5•16	30/6	10/3				
5•20	60/6				30/6	
5•21		25/4				
5•28		12/6				
5•30		8/6				
5•31	60/6				30/4	
6•3		40/6				
6•5		12/6				
6•7		30/6				
6•10	30/6					
6•13		25/6				
6•15		8/6				
6/15	35/6					
6•20		20/6		15/4		
6•21				15/6		
6•24	42/6			15/4		

	Methadone	Percodan	Percocet	Tylenol 10 mg.	Valium 5 mg.	Tussionex
1988 Continued						
6▼29		20/6				
7▼5			23/6			
7▼6	35/6			12/4		
7▼11	30/6			10/4		
7▼15	30/6					
7▼20		30/6		12/6		
7▼28			15/6		20/6	
7▼30			18/6			
8▼4	40/3					
8▼9	10/3				15/3	
8▼11	6/6					
8▼16			15/4			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.
1989				
1▼7	50/4			
1▼12	12/6			
1▼16	15/6			
1▼18	36/6			
1▼23	50/6			
1▼28	25/6			
2▼1		37/6		
2▼9	25/6			

	Percodan	Percocet	Tylenol Codeine #4	Valium 10 mg.
1989 Continued				
2▾15	35/6		15/4	15/2
2▾21		40/6		20/1
2▾28	24/4			15/1
3▾7	6/4			
3▾8	30/4			15/1
3▾15				4/2
3▾16		24/6		16/2
3▾18			6/4	
3▾27		24/6		16/2

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

IN THE MATTER	
	COMMISSIONER'S
OF	
	RECOMMENDATION
DAVID WASSERMAN	

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on April 26, 1990, May 10, 1990, June 14, 1990, July 31, 1990 Respondent, David Wasserman, M.D. appeared by Robert DePoto, Esq. The evidence in support of the charges against the Respondent was presented by Dawn A. Sweir, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be accepted; and

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

EXHIBIT "C"

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
December 27, 1990

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

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

DAVID WASSERMAN

CALENDAR NO. 11656

The University of the State of New York

IN THE MATTER

OF

DAVID WASSERMAN
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11656

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11656, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (April 26, 1991): That, in the matter of DAVID WASSERMAN, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's findings of fact, conclusions as to guilt, and recommendation as to the penalty to be imposed, as well as the Commissioner of Health's recommendation as to those findings, conclusions, and recommendation be accepted;
2. Respondent is guilty, by a preponderance of the evidence, of the specifications of the charges; and
3. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent has been found guilty;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of

Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 30th day of April, 1991.

Thomas Sobol

Commissioner of Education