STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

LIC 130654

November 24, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Valerie B. Donovan, Esq.
NYS Department of Health
Corning Tower – Room 2412
Empire State Plaza
Albany, New York 12237

David Winkler, M.D.
887 Old Country Road
Suite D
Riverhead, New York 11935

RE: In the Matter of David Winkler, M. D.

Dear Parties:

Enclosed please find the Determination and Order (No. 99-292) 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.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB: mla

Enclosure

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

OF

DAVID WINKLER, M.D.

ORDER # 99-292

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COPY

DETERMINATION AND ORDER OF THE HEARING COMMITTEE

The undersigned Hearing Committee consisting of **SHARON C. H. MEAD, M.D.**, chairperson, **WALTER M. FARKAS, M.D.**, and **EUGENIA HERBST**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by DAVID WINKLER M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

SUMMARY OF PROCEEDINGS

Pre-Hearing Conferences: May 6, 1999

Hearing date: May 27, 1999

Place of Hearing: NYS Department of Health
300 Motor Parkway
Suite 110
Hauppauge, New York

Date of Deliberation: June 17, 1999

Petitioner appeared by: Valerie B. Donovan, Esq.
Associate Counsel
NYS Department of Health

Respondent appeared: pro se

WITNESSES

For the Petitioner:

Patient A
Patient B
Stephen Price, M.D.
Bruce R. Oudt

For the Respondent: Respondent, David Winkler, M.D.

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

Inaccurate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

Additionally, professional misconduct occurs when a physician fails to provide patients with copies of their records.

PATIENT A

1. Respondent treated Patient A from on or about October 1993 through of about October 29, 1997. (Pet. Exh. 10, T. 65)

2. On January 15, 1998, Patient A made a valid request for his medical records via registered return receipt letter, as directed by PHL Section 18 (Ex. 4; Exh 13; T. 17)

3. Respondent failed to send Patient A his records.

4. Respondent testified that he never received the Office of Professional Medical Conduct's request for Patient A's medical records although the return receipt was signed by Andrew Abrams dated July 8, 1998, a social worker who shared Suite D at 887 Old Country Road with Respondent. (T.185 - 186)

5. Mr. Oudt, who holds the position of Access Patient Information Coordinator and Supervisor of the Central Intake Unit at the Office of Professional Medical Conduct, testified that he observed at the Respondent's office building in Riverhead, a plaque with two names including the Respondent's name.(T. 156)

6. The Respondent testified that he treated Patient A at another address. (T.173)

7. Respondent contacted OPMC and told them that due to the numerous abbreviations in Patient A's records, he would like to send a summary. (Pet. Exh. 6)

8. OPMC directed the Respondent to send a verbatim transcription of his records. (T. 148)

9. In April, 1998, Patient A informed OPMC that a summary of his treatment sent to him by Respondent was incomplete and inaccurate (Pet. Ex. 7; T. 19)

10. On May 5, 1998, OPMC wrote to Respondent and informed him that the summary was not a verbatim transcription, and that Respondent was to send Patient A a copy of the original records. (Pet. Exh. 8)

11. OPMC called Respondent's office twice, but Respondent failed to return the calls. (T. 150)

12. In July 1998, OPMC requested that Respondent provide Patient A's records to the Department of Health pursuant to the authority granted by PHL Sec 230(10)(l); that is, as part of a professional misconduct investigation. (Pet. Exh 12)

13. Respondent then sent records of Patient A's to OPMC in response to the misconduct proceeding. (T. 187)

14. On March 9, 1998, the Office of Professional Medical Conduct (OPMC) requested that Respondent send Patient A his records. (Pet. Exh. 5) In this letter, OPMC informed Respondent of the procedure delineated by PHL Sec. 18, and provided the necessary denial access forms. (Pet. Exh. 5)

15. Respondent also testified that the chart was lost or at the home of his "billing lady" (T. 177-178)

16. Respondent testified that he did not send the records to Patient A, although he was required, because while treating Patient A, he had spoken in confidence with the Patient's wife. (T. 175)

17. The Respondent testified that he did not provide Patient A the records because he was paranoid. (T. 176)

18. Dr. Price testified that there was nothing in Patient's A's record that shouldn't have been forwarded to the Patient. (T. 102)

19. Dr. Price testified that the record does not document any sense of dangerousness in this patient or an indication of what the patient is paranoid about. (T. 81)

20. Dr. Price testified that, while there are no specifics on the amount of detail that would be needed to be in a record kept by a private practitioner, there is an overall guideline.(T. 87) Additionally he stated that the standard of care for record keeping is that the record should be sufficient to document the quality of the care provided, sufficient detail to assist him or her in recalling the specifics of diagnosis and treatment and the rationales for such treatment over time. Finally, a reasonably prudent practitioner would enter sufficient data so that a covering physician would have adequate information to assist the patient in the event of an emergency. Dr. Price testified that specifically the record would contain the identifying information of the patient, a referral source, a presenting complaint, a history of the presenting

complaint, sufficient family, medical and social history, and some narrative description of the patient's presentations to establish an operating diagnostic impression and treatment plan. (T. 87) Such guidelines are set forth in the Guidance for Practice in Clinical Psychiatry published in 1994. (T. 88)

21. Dr. Price testified that the purpose of keeping adequate records was so that the treating physician can remember details (T. 123) over time and that others can understand the patient's treatment (T. 56-57), thereby giving a covering physician adequate information regarding medication previously and presently taken by the patient. (T. 61)

22. Patient A's records do not reflect any presenting complaint (T. 58), no adequate history (T. 59, 107), no diagnosis (T. 60, 106), no adequate treatment plan (T. 61) (Pet. Exh. 10), insufficient information to support a diagnosis. (T. 107)

23. Patient A's records fail to reflect a discussion of side effects (T. 62), clear use of drugs or the rationale behind increasing or decreasing drugs (T. 63), patient's reaction to drugs (T. 64), no indication for changing medications (T. 75)

24. Dr. Price testified that Patient A's record had an inadequate amount of clinical information in notations and primarily and sometimes exclusively just a document of medications prescribed. (T. 84)

25. Dr. Price testified that Patient A's records did not contain enough information to know the patient's condition even just for the purpose of medication management. (T. 82)

26. Dr. Price testified that Patient A's records failed to give the Patient's history (T. 92 -93),

27. Dr. Price testified that in a patient's record, other health care givers are to make no assumptions, everything needs to be documented such a suicide attempt. (T. 104)

PATIENT B

28. Dr. Price testified that Patient B's records are sparse, difficult to decipher and presented scant information about this very elderly patient's complaint and history.

29. Patient B's record fails to record a treatment plan, sufficient information to support a diagnosis, changes in medication, side-effects of medications, coordination with the Patient's general practitioner. (T. 107-126)

30. Dr. Price testified that the Respondent continually noted "no change" and then changed medications without providing information regarding the necessity to change medications. Such information is necessary to a subsequent practitioner. (T. 107-109)

31. Respondent testified that his records are not intended for a subsequent doctor. (T. 192)

32. Dr. Price testified that there was no basis in the record for prescribing Vistaril to a geriatric patient.

33. Patient B's record reflects no rationale for discontinuing Vistaril (T. 109), prescribing Desyril (T. 110) and changing Desyrel to Inderal (T. 110).

34. Dr. Price testified that Patient B's records fail to reflect the reason for various treatments. (T 112)

35. Dr. Price testified that the Respondent's shorthand notes that he wrote for himself are an inadequate way to convey information to any other practicing physician. (T. 122)

36. Dr. Price testified that a patient's record serves a dual purpose, to refresh the treating physician's memory and a record for others. (T. 123)

37. Dr. Price testified that coordination of treatment with internist or family practitioner and considering multiple medications is essential to determining what medications might contribute to a patient's depression, anxiety or the impact of medication upon the patient's mental state. (T. 127)

38. The Respondent testified that he failed to report that Patient B was taking Inderal which would have an effect on the Patient's hypertension and perhaps other medications. (T. 219)

39. The Respondent testified that he did not take Patient B's blood pressure, nor did he know whether the Patient had his blood pressure checked by another physician. (T. 223)

40. The Respondent admitted that the Patient's blood pressure could be low because of cardiovascular, cerebral, chemical issues, possible anemia. (T. 224)

41. The Respondent testified that when he first gave Patient B the medication and subsequently feels dizzy that he tells the patient to check with his doctor as soon as possible. (T. 225)

42. The Respondent testified at the following visit the Patient was not dizzy. (T. 225)

43. The Respondent testified that Dr. Price's standard for medical record keeping is "not the standard in the real world, private outpatient care." (T.229)

44. The Respondent testified that he sees 300 to 400 patients a month. (T. 193)

DISCUSSION

The Respondent's testimony for his failure to provide records to patients was not credible.

The panel, after listening to the testimony and reviewing the evidence found the Respondent has a cavalier attitude in his practice, record keeping, and his presentation at the hearing. The panel found the Respondent's record keeping fail to state a past psychiatric history, including other treatments, doctors, dates, medical history, alcohol and drug abuse history, developmental history to include family, work, upbringing, education, social history and current and post support systems. Other critical information would include chief complaint, duration and nature of symptoms, diagnosis, treatment plan and most importantly, mental status examination. Such record keeping is necessary to subsequent treating physicians and a point of reference for himself. Medical records for the psychiatric patient should not be codified in a self-made scale that is highly exclusive in that no other assessment is made for organicity, psychosis, behavior, cognition for example that are vital to assess if one is prescribing medication.

Particularly noteworthy was the Respondent's treatment of Patient B where there was an egregious failure in record keeping which excluded a baseline blood pressure before prescribing a beta blocker, such as Inderal, that affects the cardiovascular system on this 89 year old patient. A follow-up blood pressure and its value should be made either by the prescribing physician or consultant especially in an 89 year old man complaining of dizziness and who may not recall instructions to follow up. The Respondent prescribed Inderal which is a substance which can seriously threaten the cardiovascular state, needs to be recorded, especially if there are questionable symptoms that might be related to its use.

The Respondent lacked insight into his deleterious behavior. He failed to see the danger to the patients of poor record keeping and did not accept it as an important part of medical practice. The panel viewed with particular concern one of the two patients records where the elderly patient with hypertension was dizzy after the Respondent prescribed a particular medication. The Respondent failed to check his blood pressure or contact the patient's family practitioner.(T. 219) Such prescribing methods potentially pose a serious threat to patients.

The Respondent's response towards the hearing process was that he felt annoyed with the process, showed no understanding of the standards set in medicine for record keeping nor an understanding of the necessity of keeping records and how that related to the well being of his patients.

PANEL'S DETERMINATION ON CHARGES

Paragraphs A, A(1) - A(2) is **SUSTAINED**

Paragraphs B, B(1) - B(2) is **SUSTAINED**

PANEL'S DETERMINATION ON SPECIFICATION

First and Second Specifications is guilty

Third and Fourth Specifications is guilty

PENALTY

The Hearing Committee, in a unanimous vote, after giving due consideration to all the penalties available have determined that the Respondent's license to practice medicine in the State of New York should be SUSPENDED FOR TWO YEARS wholly, such SUSPENSION is stayed for 21 months only if the Respondent successfully completes a retraining course for board certification in psychiatry. After the Respondent has taken such a course, his participation in the course should be submitted to the Office of Professional Medical Conduct for approval before his SUSPENSION is lifted.

The Hearing Committee, in a unanimous vote, after giving due consideration to all the penalties available have determined that the Respondent should practice psychiatry with a Practice Monitor for a period of one year. The Practice Monitor's name should be submitted to the Office of Professional Medical Conduct for approval.

The Hearing Committee, in a unanimous vote, after giving due consideration to all the penalties available have determined that the Respondent should be fined the amount of $2,000.00 for his failure to comply with New York State Law.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in the State of New York should be **SUSPENDED** for two (2) years wholly, such suspension is stayed for twenty-one (21) months only if the Respondent successfully completes a retraining course for board certification in psychiatry.

2. The Respondent should practice psychiatry with a Practice Monitor for a period of one year.

3. The Respondent should be fined the amount of Two Thousand Dollars ($2,000.00) for his failure to comply with New York State Law.

4. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

Dated: Massapequa, New York
22 November, **1999**

SHARON C. H. MEAD
CHAIRPERSON

WALTER M. FARKAS, M.D.
EUGENIA HERBST

APPENDIX I

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

December 2, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Valerie B. Donovan, Esq.
NYS Department of Health
Corning Tower – Room 2412
Empire State Plaza
Albany, New York 12237

David Winkler, M.D.
887 Old Country Road
Suite D
Riverhead, New York 11935

RE: In the Matter of David Winkler, M. D.

Dear Parties:

Enclosed please find the replacement for Appendix 1, Statement of Charges, for the recent decision you have received in the above matter.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB: mla

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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

----------X

DAVID WINKLER, M.D., the Respondent, was authorized to practice medicine in New York State on May 6, 1977, by the issuance of license number 130654 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine. His current address is 887 Old Country Road, Suite D, Riverhead, New York 11935.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in Appendix A) from on or about October 22, 1993, through on or about October 29, 1997, at his office located at 887 Old Country Road, Riverhead, New York 11901.

1. From on or about January 15, 1998, when Patient A made a valid request to Respondent for a copy of his medical records, until the present, Respondent has failed to release Patient A's medical record to Patient A, in violation of New York Public Health Law §18.
2. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient A.

B. Respondent treated Patient B from approximately December, 1996, through approximately September, 1977, in his office located at 887 Old Country Road, Riverhead, New York 11901.

1. From on or about March, 1998, when Patient B made a valid request to Respondent for a copy of his medical records, until the present, Respondent has failed to release Patient B's medical records to Patient B, in violation of Public Health Law § 18.
2. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient B.

SPECIFICATIONS OF MISCONDUCT

FIRST AND SECOND SPECIFICATIONS
FAILURE TO PROVIDE ACCESS

Respondent is charged with two specifications of professional misconduct within the meaning of N.Y. Educ. Law § 6530(40), in that he failed to provide access by a qualified person to patient information in accordance with standards set forth in New York Public Health Law § 18, in that Petitioner charges:

1. The facts in Paragraphs A and A.1.
2. The facts in Paragraphs B and B.1.

THIRD AND FOURTH SPECIFICATIONS
INADEQUATE RECORDS

Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of New York Education Law § 6530(32), in that Petitioner charges:

3. The facts in Paragraphs A and A.2.
4. The facts in Paragraphs B and B.2.

DATED: April 14 1999
Albany, New York

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