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

IN THE MATTER

OF

ARNOLD H. ZUCKER, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: ARNOLD H. ZUCKER, M.D.
120 East Prospect Avenue
Mount Vernon, NY 10550-2212

The undersigned, Antonia C. Novello, M.D., M.P.H., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by ARNOLD H. ZUCKER, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 2000), that effective immediately ARNOLD H. ZUCKER, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401 . The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on March ____, 2000, at 10:00 a.m., at the offices of the New York State Health Department, 5 Penn Plaza, Sixth Floor, New York, NY 10001, and at such other adjourned dates, times and places as the

committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the

administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a (McKinney Supp. 2000). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
March 10, 2000

ANTONIA C. NOVELLO, M.D., M.P.H.
Commissioner
New York State Health Department

Inquiries should be directed to:

Jean Bresler
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
145 Huguenot Street
New Rochelle, NY 10801
(914) 654-7043

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name_____Date of Proceeding_____

Name of person to be admitted_____

Status of person to be admitted_____
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

_____
Signature (of licensee or licensee's attorney)

This written notice must be sent to either:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

New York State Health Department
Bureau of Professional Medical Conduct
5 Penn Plaza
New York, NY 10001
Fax: 212-613-2611

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

IN THE MATTER
OF
ARNOLD H. ZUCKER, M.D.

STATEMENT
OF
CHARGES

ARNOLD H. ZUCKER , M.D., the Respondent, was authorized to practice medicine in New York State on or about March 30, 1955, by the issuance of license 076934 number by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (Patients identified in Appendix A), on multiple occasions from at least February 1983 through and including July, 1999. According to the Respondent, the patient was for some time simultaneously treated in a Methadone program, and was in dialysis for chronic kidney failure. Respondent further stated that Patient A was addicted to prescription opiates, and used street drugs. Respondent's care and treatment of Patient A deviated from acceptable medical standards in that he:

1. Failed to obtain or record adequate history, including medical history.
2. Failed to obtain or record a mental status evaluation.
3. Failed to obtain or record adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: oxycodone, diazepam, alprazolam, clonazepam, and/or hydrocodone.
5. Failed to provide Patient A with appropriate treatment for drug addiction, depression, pain and or

anxiety or refer him for such treatment.

6. Failed to record, obtain and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and/or medication changes, tapering schedule, and/or trials of non-narcotic medications.

B. Respondent treated patient B, a seventy year old woman, on multiple occasions from at least August 4, 1994 through and including June, 1999. Respondent's care and treatment of Patient B deviated from acceptable medical standards in that he:

1 Failed to record and/or obtain an adequate history including medical history.

2. Failed record or obtain a mental status evaluation

3. Failed to record or obtain adequate clinical information.

4. Inappropriately prescribed one or more of the following : diazepam, flurazepam, temazepam, syringes Halcion, Demerol tablets, and/or injectable Demerol.

5. Failed to record, obtain and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and/or medication changes, tapering schedule, and/or trials of non-narcotic medications.

6. Failed to provide Patient B with appropriate treatment for, depression, pain and or anxiety or refer her for such treatment.

C. Respondent treated Patient C on multiple occasions from at least 1990 through and including May, 1999. According to Respondent, Patient C suffered from depression, anxiety, arthritis, neuritis, and osteoporosis. Respondent's care and treatment of Patient C deviated from acceptable medical standards in that he:

1. Failed to record or obtain an adequate history including medical history.
2. Failed to record and/or obtain a mental status evaluation
3. Failed to record or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: oxycodone, Valium, Lorcet, and/or hydrocodone.
5. Failed to record, obtain, and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and/or medication changes, tapering schedule, and or trials of using non-narcotic medications.
6. Failed to appropriately treat Patient C for depression, anxiety, and/or pain.

D. Between August 12, 1998 and December 2, 1998, Respondent wrote thirteen prescriptions for a total of 310 syringes in the name of Respondent's wife which Respondent admitted were in fact intended for Patient D. Respondent admitted writing prescriptions in his wife's name for nalbuphen which were intended for Patient D. Respondent's care and treatment of Patient D deviated from acceptable medical standards in that he :

1. Inappropriately prescribed nalbuphen
2. Inappropriately prescribed syringes.

E. Respondent treated Patient E on multiple occasions from at least July 1998 through and including May 1999. Respondent diagnosed Patient E with personality disorder, recurrent depression, anxiety, and kleptomania. Patient E was identified by the Respondent as a drug addict. Respondent wrote prescriptions in another name which he provided to Patient E. Respondent altered medical records provided to the Office of Professional Medical Conduct, for this patient. Respondent's care and treatment of Patient E deviated from acceptable medical standards in that he :

1. Failed to record or obtain an adequate history including medical history.
2. Failed to record and/or obtain a mental status evaluation.
3. Failed to record and/or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: alprazolam, oxycodone, hydrocodone, phentermine, Ambien, and or diazepam.
5. Failed to record, obtain, and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and or medication changes, tapering schedule, and or trials of using non-narcotic medications.
6. Failed to appropriately treat Patient E for depression,

anxiety, personality disorder, kleptomania and or pain.

F. Respondent treated Patient F on multiple occasions from at least October 1998 through and including July 1999. Respondent diagnosed Patient F with mixed personality disorder, recurrent depression, and anxiety Patient F was identified by the Respondent as a drug addict, on methedone. Respondent's care and treatment of Patient F deviated from acceptable medical standards in that he :

1. Failed to record or obtain an adequate history including medical history.
2. Failed to record and/or obtain a mental status evaluation.
3. Failed to record and/or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: alprazolam, hydrocodone, and or flurazepam.
5. Failed to record, obtain, and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and or medication changes, tapering schedule, and or trials of using non-narcotic medications.
6. Failed to appropriately treat Patient F for depression, anxiety, mixed personality disorder, and or pain, or refer him for such treatment

G. Respondent treated Patient G on multiple occasions, from at least

May, 1997 through and including March, 1999. Respondent identified Patient G as a drug addict and an alcoholic. Respondent stated that Patient G suffered from headaches and arthritis. Respondent's care and treatment of Patient G deviated from acceptable medical standards in that he:

1. Failed to record or obtain an adequate history including medical history.
2. Failed to record or obtain a mental status evaluation
3. Failed to record or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: codeine, hydrocodone, alprazolam, Didrex, clonazepam, Ritalin, Prelu, promethazine, and or oxycodone.
5. Failed to record, obtain and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and/or medication changes, tapering schedule, and or trials of using non-narcotic medications.
6. Failed to appropriately treat Patient G for chronic alcoholism, drug addiction, pain, obesity, and/or anxiety or refer her for such treatment.

H. Respondent treated Patient H, an eleven year old child, between on or about January 1999 and April 1999. Respondent maintained no records for this patient. Respondent's care and treatment of Patient H deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed Ritalin for other than a legitimate medical purpose.
5. Inappropriately prescribed Ritalin.
6. Failed to appropriately treat Patient H for attention deficit disorder, and/or hyperactivity, or refer her for such treatment.

I. Respondent treated Patient I on multiple occasions between October 1995 through June 1999. Respondent treated Patient I for multiple personality disorders, migraines, disk disease, hyperparathyroidism, degenerative arthritis and stress reaction. Respondent identified Patient I as a drug addict. Respondent's care and treatment of Patient I deviated from acceptable medical standards in that he:

1 Failed to record or obtain an adequate history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: hydrocodone, alprazolam, codeine Valium and/or Fiorocet.
5. Failed to record, obtain and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and/or medication changes, tapering schedule, and or trials of using non-narcotic

medications.

6. Failed to appropriately treat Patient I or refer him for treatment for multiple personality disorders, migraines, arthritis, disk disease, hyperparathyroidism, and/or stress reaction.
7. Provided prescriptions, in the name of Patient I's son, for Valium, to patient I, a known drug addict.

J. Respondent prescribed medication for Patient J, on several occasions from on or about January, 1999 through and including April, 1999 . Respondent maintained no records for Patient J. Respondent's care and treatment of Patient J deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation
3. Failed to record or obtain any clinical information.
4. Prescribed Valium for other than a legitimate medical purpose.
5. Inappropriately prescribed Valium.

K. Respondent treated Patient K on multiple occasions between on or about March 1996, through and including June 1999. Respondent's care and treatment of Patient K deviated from acceptable medical standards in that he:

1 Failed to record or obtain an adequate history including medical history.

2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: diazepam, alprazolam, meprobamate, hydrocodone, Tuinal, Placidyl, Ambien, and Didrex.
5. Failed to record, obtain and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and/or medication changes, tapering schedule, and or trials of using non-narcotic medications.
6. Failed to appropriately treat Patient K or refer her for treatment of obesity, neck pain, anxiety, depression, and/or insomnia.
7. Prescribe one or more of the following medications for other then a legitimate medical purpose: oxycodone diazepam, alprazolam, meprobamate, hydrocodone, Tuinal, Ambien, and/or Didrex.

L. Respondent treated Patient L on multiple occasions between on or about July, 1994 through and including June 1999. Respondent identified Patient L as a poly-drug abuser. Respondent wrote prescriptions for six other individuals with the same last name as Patient L (Patient M, N, O, P, Q, R and S). Respondent's care and treatment of Patient L deviated from acceptable medical standards in that he :

1 Failed to record or obtain an adequate history

including medical history.

2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain adequate clinical information.
4. Failed to record, obtain and /or provide information detailing medication effects, reactions, side effects, rationale for dosage and/or medication changes, tapering schedule, and/or trials of using non-narcotic medications.
5. Prescribed alprazolam in the names of other patients with reason to know such prescriptions were in fact intended for the use of Patient L.
6. Provided prescriptions, in the name of other patients, for alprazolam, to patient L, a known drug addict.
7. Failed to appropriately treat Patient L or refer him for treatment for drug addiction, depression, anxiety, and/or pain.
8. Inappropriately prescribed one or more of the following medications: clonazepam, Valium, alprazolam, and or oxycodone.
9. Prescribe one or more of the following medications for other then a legitimate medical purpose: clonazepam, Valium, alprazolam, and/or oxycodone.

M. Respondent prescribed alprazolam for Patient M in or around January 1999. Respondent maintained no medical records for Patient M. Respondent's treatment of Patient M deviated from

acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed alprazolam for no legitimate medical purpose.
5. Inappropriately prescribed alprazolam.

N. Respondent prescribed alprazolam for Patient N in or around January 1999. Respondent maintained no medical records for Patient N. Respondent's treatment of Patient N deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed alprazolam for no legitimate medical purpose.
5. Inappropriately prescribed alprazolam.

O. Respondent prescribed alprazolam for Patient O in or around February, and May 1999. Respondent maintained no medical records for Patient O. Respondent's treatment of Patient O deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history

including medical history.

2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed alprazolam for no legitimate medical purpose.
5. Inappropriately prescribed alprazolam.

P. Respondent prescribed alprazolam for Patient P in or around February 1999. Respondent maintained no medical records for Patient P. Respondent's treatment of Patient P deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed alprazolam for no legitimate medical purpose.
5. Inappropriately prescribed alprazolam.

Q. Respondent prescribed alprazolam for Patient Q in or around March 1999. Respondent maintained no medical records for Patient Q. Respondent's treatment of Patient Q deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.

3. Failed to record or obtain any clinical information.
4. Prescribed alprazolam for no legitimate medical purpose.
5. Inappropriately prescribed alprazolam.

R. Respondent prescribed alprazolam for Patient R in or around April 1999. Respondent maintained no medical records for Patient R. Respondent's treatment of Patient R deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed alprazolam for no legitimate medical purpose.
5. Inappropriately prescribed alprazolam.

S. Respondent prescribed alprazolam for Patient S in or around April 1999. Respondent maintained no medical records for Patient S. Respondent's treatment of Patient S deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.

4. Prescribed alprazolam for no legitimate medical purpose.
5. Inappropriately prescribed alprazolam.

T. Respondent prescribed Ritalin for Patient T, a 38 year old female on several occasions from at least on or about February 1999 through and including June 1999. Respondent's care and treatment of Patient T deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed Ritalin for no legitimate medical purpose.
5. Inappropriately prescribed Ritalin.
6. Failed to appropriately treat Patient T for hyperactivity and or attention deficit disorder, or refer her for such treatment

U. Respondent prescribed Ritalin for Patient U, a twelve year old child, on several occasions from at least on or about February 1999 through and including June 1999. Respondent's care and treatment of Patient U deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical

information.

4. Prescribed Ritalin for no legitimate medical purpose.
5. Inappropriately prescribed Ritalin.
6. Failed to appropriately treat Patient U for hyperactivity and or attention deficit disorder, or refer her for such treatment

V. Respondent prescribed Ritalin for Patient V, a 9 year old child on several occasions from at least on or about January 1999 through and including June 1999. Respondent's care and treatment of Patient V deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed Ritalin for no legitimate medical purpose.
5. Inappropriately prescribed Ritalin.
6. Failed to appropriately treat Patient V for hyperactivity and or attention deficit disorder, or refer her for such treatment

W. Respondent prescribed Ritalin for Patient W, A 41 year old Male on several occasions from at least on or about January 1999 through and including June 1999. Respondent's care and treatment of Patient W deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed Ritalin for no legitimate medical purpose.
5. Inappropriately prescribed Ritalin.
6. Failed to appropriately treat Patient W for hyperactivity and or attention deficit disorder, or refer her for such treatment.

X. Respondent prescribed Ritalin for Patient X, an 8 year old child on several occasions from at least on or about January 1999 through and including June 1999. Respondent's care and treatment of Patient X deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed Ritalin for no legitimate medical purpose.
5. Inappropriately prescribed Ritalin.
6. Failed to appropriately treat Patient X for hyperactivity and or attention deficit disorder, or refer her for such treatment

Y. Respondent prescribed Ritalin for Patient Y, an 11 year old child on several occasions from at least on or about January 1999 through and including June 1999. Respondent's care and treatment of Patient Y deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed Ritalin for no legitimate medical purpose.
5. Inappropriately prescribed Ritalin.
6. Failed to appropriately treat Patient Y for hyperactivity and or attention deficit disorder, or refer her for such treatment

Z. Respondent treated Patient Z on multiple occasions from at least July 1998 through and including June 1999. Respondent identified Patient Z as a drug addict. Respondent's care and treatment of Patient Z deviated from acceptable medical standards in that he:

1. Failed to record or obtain any history including medical history.
2. Failed to record or obtain a mental status evaluation.
3. Failed to record or obtain any clinical information.
4. Prescribed Placidyl, meprobamate and/or alprazolam for no legitimate medical purpose.
5. Inappropriately prescribed one or more of the following

medication: alprazolam, Placidyl, and/or meprobamate

6. Failed to treat patient Z appropriately for drug addiction, anxiety, depression, and or insomnia or refer her for such treatment.

AA. Patient AA was treated by the Respondent on multiple occasions from at least February 1997 through and including April 1999. Respondent identified Patient AA as a drug addict. Respondent's care and treatment of Patient AA deviated from acceptable medical standards in that he:

1. Failed to record and/or obtain a adequate history including medical history.
2. Failed to record and/or obtain a mental status evaluation.
3. Failed to record and/or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: Oxycodone, Xanax, Valium, Dilaudid.
5. Failed to record, obtain, and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and or medication changes, tapering schedule, and or trials of using non-narcotic medications.
6. Failed to appropriately treat him for drug addiction, anxiety and or pain or refer him for treatment.
7. Provided prescription(s) for Dilaudid, to patient AA, a known drug addict, for other then a legitimate medical purpose.

BB. Respondent treated Patient BB on multiple occasions from on or about February 1998 through and including April 1999. Respondent diagnosed anxiety and depression Respondent's treatment of Patient BB deviated from acceptable medical standards in that he:

1. Failed to record and/or obtain a adequate history including medical history.
2. Failed to record and/or obtain a mental status evaluation.
3. Failed to record and/or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: oxycodone, Xanax, Valium, Dilaudid.
5. Failed to record, obtain, and/or provide information detailing medication effects, reactions, side effects, rationale for dosage and or medication changes, tapering schedule, and/or trials of using non-narcotic medications.
6. Failed to treat the patient appropriately for anxiety, depression and/or pain or refer her for such treatment.

CC. Respondent treated Patient CC on multiple occasions from on or about April 1997 through and including November 1999. Respondent stated that Patient CC was addicted to street drugs. Respondent's care and treatment of Patient CC deviated from acceptable medical standards in that he:

1. Failed to record and/or obtain a adequate history including medical history.

2. Failed to record and/or obtain a mental status evaluation.
3. Failed to record and/or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: codeine and/or diazepam.
5. Failed to record, obtain and/or provide information detailing medication effects, reactions, side effects, and/or trials of using non narcotic-medications.
6. Prescribed codeine and/or diazepam for other then a legitimate medical purpose.
7. Failed to treat Patient CC for drug addiction, pain and/or anxiety or refer him for such treatment.

DD. Respondent treated Patient DD on multiple occasions from on or about March 1998 through and including June 1999. Respondent noted that Patient DD had rheumatoid arthritis and cluster headaches. He further noted that she is addicted to Fiorinol. Respondent's care and treatment of Patient DD deviated from acceptable medical standards in that she:

1. Failed to record and/or obtain a adequate history including medical history.
2. Failed to record and/or obtain a mental status evaluation.
3. Failed to record and/or obtain adequate clinical information.
4. Inappropriately prescribed one or more of the following medications: diazepam, alprazolam,

oxycodone, and/or hydrocodone.

5. Failed to record, obtain and /or provide information detailing medication effects, reactions, side effects, rationale for medication changes, tapering schedule, and/or trials of non-narcotic medications.
6. Failed to treat Patient DD appropriately for pain, and or anxiety, or refer her for such treatment.

EE. Respondent treated Patient EE on multiple occasions from on or about October 1997 through and including March 1999. On March 11, 1999, Patient EE died of acute cocaine, Methadone, and alprazolam intoxication. Respondent identified Patient EE as a drug addict concurrently taking methadone. Respondents care and treatment of Patient EE deviated from acceptable medical standards in that he:

1. Failed to record and/or obtain an adequate history including medical history.
2. Failed to record and/or obtain a mental status evaluation.
3. Failed to record and/or obtain adequate clinical information.
4. Inappropriately prescribed alprazolam.
5. Failed to record, obtain and/or provide information detailing medication effects, reactions, and side effects.
6. Failed to provide appropriate treatment for drug addiction, anxiety, and or depression or refer her for such treatment.

FF. On or about March 24, 1999, May 20, 1999, June 3, 1999, and June 17, 1999 Police Lt. John McCarthy posing as Patient FF, was treated by the Respondent at his private office at 128 E. Prospect Avenue, Mount Vernon, New York. On these dates Respondent provided Lt. McCarthy with prescriptions for alprazolam and/or hydrocodone in exchange for cash. Respondent:

1. Failed to obtain adequate clinical information.
2. Failed to obtain an adequate history including medical history.
3. Failed to obtain a mental status evaluation.
4. Prescribed hydrocodone for other then a legitimate medical purpose.
5. Prescribed alprazolam for other then a legitimate medical purpose.
6. Maintained no medical records for Patient FF.
7. Inappropriately prescribed alprazolam and/or hydrocodone.

GG. On or about April 14, 1999 Police Lt. John McCarthy posing as Patient GG, was treated by the Respondent at his private office at 128 E. Prospect Avenue, Mount Vernon, New York. On this date Respondent provided Lt. McCarthy with a prescription for alprazolam in exchange for cash. Respondent:

1. Failed to obtain adequate clinical information.
2. Failed to obtain an adequate history

including medical history.

3. Failed to obtain a mental status evaluation.
4. Prescribed alprazolam for other then a legitimate medical purpose.
5. Maintained no medical records for Patient GG.
6. Inappropriately prescribed alprazolam.

HH. On or about March 3, 2000, before the City Court of Mount Vernon, Westchester County, Respondent was convicted upon plea to the crime of Attempted Criminal Diversion of Prescription Medications and Prescriptions in the Fourth Degree in violation of Penal Law section 110/178.10, a Class B Misdemeanor.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2000) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A, A(1) through A(6), B, B(1), through B(6), C, C(1) through C(6), D and D(1) and D(2), E, E(1) through E(6), F, F(1) through F(6), G, G(1) through G(6), H, H(1) through H(6), I, I(1) through I(7), J, J(1) through J(5), K, K(1) through

K(7), L, L(1) through L(9), M, M(1) through M(5), N, N(1) through N(5), O, O(1) through O(5), P, P(1) through P(5), Q, Q(1) through Q(5), R, R(1) through R(5), S, S(1) through S(5), T, T(1) through T(6), U, U(1) through U(6), V, V(1) through V(6), W, W(1) through W(6), X, X(1) through (6), Y, Y(1) through Y(6), Z, Z(1) through Z(6), AA, AA(1) through AA(7), BB, BB(1) through BB(6), CC, CC(1) through CC(7), DD, DD(1) through DD(6), EE, EE(1) through EE(6), FF, FF(1) through FF(7), GG, GG(1) through GG(6).

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2000) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A, A(1) through A(6), B, B(1), through B(6), C, C(1) through C(6), D and D(1) and D(2), E, E(1) through E(6), F, F(1) through F(6), G, G(1) through G(6), H, H(1) through H(6), I, I(1) through I(7), J, J(1) through J(5), K, K(1) through K(7), L, L(1) through L(9), M, M(1) through M(5), N, N(1) through N(5), O, O(1) through O(5), P, P(1) through P(5), Q, Q(1) through Q(5), R, R(1) through R(5), S, S(1) through S(5), T, T(1) through T(6), U, U(1) through U(6), V, V(1) through V(6), W, W(1) through W(6), X, X(1) through (6), Y, Y(1) through Y(6), Z, Z(1) through Z(6), AA, AA(1) through AA(7), BB, BB(1) through BB(6), CC, CC(1) through CC(7), DD,

DD(1) through DD(6), EE, EE(1) through EE(6), FF, FF(1) through FF(7), GG, GG(1) through GG(6).

THIRD SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2000) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. Paragraphs A, A(1) through A(6), B, B(1), through B(6), C, C(1) through C(6), D and D(1) and D(2), E, E(1) through E(6), F, F(1) through F(6), G, G(1) through G(6), H, H(1) through H(6), I, I(1) through I(7), J, J(1) through J(5), K, K(1) through K(7), L, L(1) through L(9), M, M(1) through M(5), N, N(1) through N(5), O, O(1) through O(5), P, P(1) through P(5), Q, Q(1) through Q(5), R, R(1) through R(5), S, S(1) through S(5), T, T(1) through T(6), U, U(1) through U(6), V, V(1) through V(6), W, W(1) through W(6), X, X(1) through (6), Y, Y(1) through Y(6), Z, Z(1) through Z(6), AA, AA(1) through AA(7), BB, BB(1)through BB(6), CC, CC(1) through CC(7), DD, DD(1) through DD(6), EE, EE(1) through EE(6), FF, FF, FF(1) through FF(7), GG, GG(1) through GG(6).

FOURTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined

in N.Y. Educ. Law §6530(6)(McKinney Supp. 2000) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

4. Paragraphs A, A(1) through A(6), B, B(1), through B(6), C, C(1) through C(6), D, D(1) and D(2), E, E(1) through E(6), F, F(1) through F(6), G, G(1) through G(6), H, H(1) through H(6), I, I(1) through I(7), J, J(1) through J(5), K, K(1) through K(7), L, L(1) through L(9), M, M(1) through M(5), N, N(1) through N(5), O, O(1) through O(5), P, P(1) through P(5), Q, Q(1) through Q(5), R, R(1) through R(5), S, S(1) through S(5), T, T(1) through T(6), U, U(1) through U(6), V, V(1) through V(6), W, W(1) through W(6), X, X(1) through (6), Y, Y(1) through Y(6), Z, Z(1) through Z(6), AA, AA(1) through AA(7), BB, BB(1) through BB(6), CC, CC(1) through CC(7), DD, DD(1) through DD(6), EE, EE(1) through EE(6), FF, FF, FF(1) through FF(7), GG, GG(1) through GG(6).

FIFTH THROUGH TWENTY-EIGHTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 2000) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

5. Paragraph D
6. Paragraph E

7. Paragraphs H and H(4)
8. Paragraphs J and J(4)
9. Paragraphs K and K(7)
10. Paragraphs L and L(5) and/or L (9)
11. Paragraphs M and M(4)
12. Paragraphs N and N(4)
13. Paragraphs O and O(4)
14. Paragraphs P and P(4)
15. Paragraphs Q and Q(4)
16. Paragraphs R and R(4)
17. Paragraphs S and S(4)
18. Paragraphs T and T(4)
19. Paragraphs U and U(4)
20. Paragraphs V and V(4)
21. Paragraphs W and W(4)
22. Paragraphs X and X(4)
23. Paragraphs Y and Y(4)
24. Paragraphs Z and Z(4)
25. Paragraphs AA and AA(7)
26. Paragraphs CC and CC(6)
27. Paragraphs FF and FF(4)
28. Paragraph FF and FF(5)
29. Paragraph GG and GG(4)

THIRTIETH THROUGH FIFTY-SECOND SPECIFICATION

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined

in N.Y. Educ. Law §6530(35)(McKinney Supp. 2000) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

30. Paragraphs H and H(4)
31. Paragraphs J and J(4)
32. Paragraphs K and K(7)
33. Paragraphs L and L (9)
34. Paragraphs M and M(4)
35. Paragraphs N and N(4)
36. Paragraphs O and O(4)
37. Paragraphs P and P(4)
38. Paragraphs Q and Q(4)
39. Paragraphs R and R(4)
40. Paragraphs S and S(4)
41. Paragraphs T and T(4)
42. Paragraphs U and U(4)
43. Paragraphs V and V(4)
44. Paragraphs W and W(4)
45. Paragraphs X and X(4)
46. Paragraphs Y and Y(4)
47. Paragraphs Z and Z(4)
48. Paragraphs AA and AA(7)
49. Paragraphs CC and CC(6)
50. Paragraphs FF and FF(3)

FIFTY-FIRST THROUGH EIGHTY-THIRD SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2000) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

51. Paragraphs A, A(1) through A(3), A(6)
52. Paragraphs B, B(1) through B(5)
53. Paragraphs C, C(1) through C(5)
54. Paragraphs E, E(1) through E(5)
55. Paragraphs E, E(1) through E(5)
56. Paragraphs F, F(1) through F(5)
57. Paragraphs G, G(1) through G(5)
58. Paragraphs H, H(1) through H(4)
59. Paragraphs I, I(1) through I(5)
60. Paragraphs J, J(1) through J(3)
61. Paragraphs K, K(1) through K(3), and K(5)
62. Paragraphs L, L(1) through L(4)
63. Paragraphs M, M(1) through M(3)
64. Paragraphs N, N(1) through N(3)
65. Paragraphs O, O(1) through O(3)
66. Paragraphs P, P(1) through P(3)
67. Paragraphs Q, Q(1) through Q(3)
68. Paragraphs R, R(1) through R(3)
69. Paragraphs S, S (1) through S(3)
70. Paragraphs T, T(1) through T(3)
71. Paragraphs U, U(1) through U(3)
72. Paragraphs V, V(1) through V(3)
73. Paragraphs W, W(1) through W(3)
74. Paragraphs X, X(1) through X(3)

75. Paragraphs Y, Y(1) through Y(3)

76. Paragraphs Z, Z(1) through Z(3)

77. Paragraphs AA, AA(1) through AA(3)

78. Paragraphs BB, BB(1) through BB(3), and BB(5)

79. Paragraphs CC, CC(1) through CC(3), and CC(5)

80. Paragraphs DD, DD(1) through DD(3), and DD(5)

81. Paragraphs EE, EE(1) through EE(3), and EE(5)

82. Paragraphs FF, FF(2) and FF(4)

83. Paragraphs GG and GG(5)

EIGHTY-FOURTH SPECIFICATION

CRIMINAL CONVICTION (N.Y.S.)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(a)(i)(McKinney Supp. 2000) by having been convicted of committing an act constituting a crime under New York state law as alleged in the facts of the following:

84. Paragraph HH.

DATED: March 10, 2000
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct