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

September 6, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Arnold H. Zucker, M.D.
1005 Pelhamdale Avenue
Pelham, NY 10803

Jean Bresler, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
145 Huguenot Street
New Rochelle, NY 10801

Mark A. Varrichio, Esq.
3144 Westchester Avenue
Bronx, NY 10461

RE: In the Matter of Arnold H. Zucker, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.00-245) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the

registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays 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.

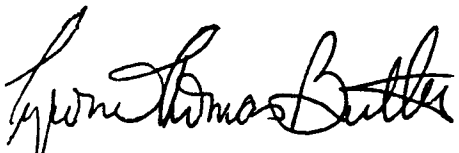
The notice of review served on the Administrative Review Board should be forwarded to:

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: ndc
Enclosure

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

COPY

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

DETERMINATION
AND
ORDER

BPMC#00-245

MICHAEL R. GOLDING, M.D., Chairperson, **NAOMI GOLDSTEIN, M.D.**, and **DANIEL W. MORRISSEY, O.P.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this summary suspension action pursuant to § 230(10)(e) and (12) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, served as Administrative Officer for the Hearing Committee.

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

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with negligence on more than one occasion (one specification) and incompetence on more than one occasion (one specification), with gross negligence on a particular occasion (one specification) and gross incompetence (one specification), having practiced the profession of medicine fraudulently (twenty-five specifications), having ordered excessive tests or treatment not warranted by the

condition of the patient (twenty-one specifications), by failing to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient (thirty-three specifications), and by having been convicted of committing an act constituting a crime under New York state law (one specification).

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to this Determination and Order as Appendix I.

SUMMARY OF PROCEEDINGS

Commissioner's Order and Notice of Hearing and Statement of Charges Dated:	March 10, 2000
Date of Service of Commissioner's Order and Notice of Hearing and Statement of Charges:	March 15, 2000[1]
Answer to Charges Dated:	March 20, 2000
Prehearing Conference Date:	March 17, 2000
Hearing Dates:	March 20, 2000 March 27, 2000 March 28, 2000 March 30, 2000 March 31, 2000 April 3, 2000 April 5, 2000 April 17, 2000 May 1, 2000 May 3, 2000 May 4, 2000

[1] See stipulation appearing on page 16 of the transcript of the Prehearing Conference conducted on March 17, 2000.

Deliberation Dates:	June 6, 2000 July 25, 2000
Place of Hearing:	NYS Department of Health 5 Penn Plaza, 6th Floor New York, New York
Petitioner Appeared By:	Jean Bresler, Esq. Associate Counsel NYS Department of Health, Bureau of Professional Medical Conduct
Respondent Appeared By:	Mark A. Varrichio, Esq. 3144 Westchester Avenue Bronx, N.Y. 10461

WITNESSES

For the Petitioner:	Police Lieutenant John McCarthy Cheryl Seaman, M.D. Jack Richard, M.D.
For the Respondent:	Sister Elizabeth J. Kolb Father James Bernard Rosenblum LLoyd Rabbi Ely J. Rosenzveig Patient A Michelle Flower Patient E Patient F Samuel Pauker, M.D. Jesse Schomer, M.D. Patient Z Arnold H. Zucker, M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations denote evidence that the Hearing Committee found persuasive in determining a

particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Arnold H. Zucker, M.D. ["the Respondent"] was authorized to practice medicine in New York State on March 30, 1955 by the issuance of license number 076934 by the New York State Education Department (Ex. 2).
2. The Respondent was certified in General Psychiatry by the American Board of Psychiatry and Neurology in 1963 (Ex. B). He was also certified as a Psychoanalyst by Columbia University in 1971 (Tr. 1577; Ex.C).
3. Other than general training in child psychiatry during his postgraduate education in the 1950s, the Respondent has had no specialized training in child psychiatry or in hyperactivity and attention deficit disorder (Tr. 1998-1999).
4. Although pain management is now a medical subspecialty, the Respondent has had no training in the current approaches to pain management. He had only limited experience with pain management in the 1950s. (Tr. 1985-1987).

GENERAL FINDINGS AS TO MEDICAL ISSUES

5. The Respondent's failure to obtain and record a complete history, which includes a medical history, mental status evaluation, a social history, a history of treatment, a history of past and present drug use, as well as a description of the patient's current problems and the past and present impact of such problems on the patient's life, was not in accordance

with acceptable psychiatric standards for the treatment of a patient with a substance abuse disorder and a history of opiate addiction (Tr. 292-293).

6. The Respondent's failure to maintain any clinical records for patients being prescribed benzodiazopines and narcotics, represents a serious deviation from acceptable standards of medical care and potentially exposed such patients to harm (Tr. 326-331).

7. The Respondent's failure to obtain and record information regarding medications prescribed, including names of such medications, dosages, effects, side effects, improvement or worsening of symptoms being treated and a plan for continued treatment, represents a deviation from acceptable standards for psychiatric treatment (Tr. 335-336).

8. It is inappropriate to prescribe any medication for pain without first obtaining a history of the pain and performing a physical (Tr. 337-338).

9. In order to comply with appropriate standards for the practice of psychiatry a psychiatrist should obtain a history which includes a description of the patient's current problems and how long these problems have been affecting the patient, a history of past treatments, medications, a social history, a medical history including last physical exam, laboratory tests, medical conditions and medications, a developmental history, a history of hospitalizations, any suicide attempts, and a mental status evaluation. If the patient has a history of drug abuse, the initial history should include a history of the substances abused, treatment for substance abuse, current substance abuse and prior efforts to achieve abstinence. It is important to write this information down for accuracy and to be able to refer back to this information during treatment. (Tr. 292-297).

10. The American Psychiatric Association has published guidelines for the treatment of patients with substance abuse disorders. Such treatment should begin with a thorough

evaluation. The goal of all treatment is to reduce relapse and maintain abstinence from addictive drugs. The therapeutic approach is educational, psychosocial and pharmacological. (Tr. 300-301).

11. When benzodiazopines are used during detoxification, they are administered in rapidly decreasing amounts (Tr. 304-305). In the treatment of substance abuse disorders, it is acceptable to use benzodiazopines in detoxing from alcohol but unacceptable when detoxing from opiates, including heroin. This is because all benzodiazopines are addictive. The use of Alprazolam and Diazepam with addicts presents special problems. These are the most frequently abused benzodiazopines. They have a rapid onset, create euphoria and are themselves addictive. (Tr. 305-310, 382 and 768). Alprazolam or Xanax are often sold by addicts on the street. The street value of a 2-mg. tablet of Alprazolam or Xanax varies between $3 and $7. (Tr. 50-51).

12. The use of benzodiazopines for maintenance treatment of addicts is not recognized as an acceptable mode of treatment (Tr. 309-310). There was absolutely no evidence produced that any institution or recognized authority endorsed the use of benzodiazopines in the treatment of anxiety in narcotics addicts.

13. In order to comply with acceptable standards in the treatment with psychotropic medications, a psychiatrist should regularly obtain information concerning the effectiveness of the medication, any adverse effects, dosages, and changes. It is important to write this information down for the future reference of the psychiatrist. (Tr. 312-313).

14. If a physician is not treating the underlying cause of pain, he should not prescribe pain medication, including narcotics (Tr. 311).

15. Oxycodone and Hydrocodone are both Codeine derivatives. Oxycodone is more potent and more addictive. It requires a triplicate prescription. Hydrocodone, on the other hand, does not. Hydrocodone is also called Vicodin and Oxycodone is also called Percodan and Percocet. (Tr. 763).

16. When prescribing narcotics for pain, including Oxycodone and Hydrocodone, a reasonably prudent physician would obtain a complete history and perform a physical examination to determine the cause of the pain (Tr. 770). The history should include a description of the pain, the duration of the pain, other attempts at treating the pain, the severity of the pain and other illnesses which might effect the physician's decision about how to treat the pain (Tr. 770-772).

17. If a physician uses narcotics to treat a patient's pain, a reasonably prudent physician would record at each visit exactly what was prescribed, including strength and quantity (Tr. 772).

18. When prescribing narcotics to treat pain for a patient with a history of addiction, the physician must be highly alert and cautious. The treating physician must be extremely careful about the amounts prescribed and that the medication is indeed being used for pain. (Tr. 773). It is unreasonable for the treating physician to rely solely on the triplicate books as the only record of the narcotics prescribed. Triplicate books are not organized by patient. They are merely chronological records of prescriptions written for narcotics. (Tr. 774).

19. Using narcotics to treat chronic pain presents the problem of habituation. Therefore, the physician should initially try to use a non-narcotic pain medication and other non-narcotic therapy. (Tr. 775).

20. Once the decision has been made to use a narcotic to treat pain, the patient should be seen at regular intervals in order to make an assessment as to whether the medication is effectively treating the pain. (Tr. 776).

21. When prescribing narcotics for pain to a patient who is in a Methadone maintenance program, the physician must assess the potential risk of overdose and the narcotics' effect on the Methadone treatment. Narcotics may have an additive effect on the Methadone. By providing narcotics the physician is altering the balance created by the use of Methadone. (Tr. 777).

22. Overdose is always a risk when using narcotics to treat a patient who has an addictive personality disorder (Tr. 777).

23. When a patient is being treated by more than one physician and there is no communication between physicians and no ground rules as to which physician will be prescribing which medications, there is an increased likelihood that the patient will be either over-medicated or poorly medicated (Tr. 779).

24. Dilaudid, a synthetic opiate, is one of the most potent, orally effective opiates (Tr. 762-763).

25. Oxycodone and Hydrocodone are both Codeine derivatives. Oxycodone is more potent, addictive and requires a triplicate prescription. Percodan and Percocet are the trade names for Oxycodone. Vicodin is the trade name for Hydrocodone. (Tr. 763).

26. Nalbuphen is an opiate antagonist and has some of the properties of an opiate. It is administered by injection for pain and is short acting. (Tr. 764).

27. Demerol, a trade name for Maperadean, is synthetic Morphine and can be administered by injection or orally. It is far more effective by injection. When administered orally it is

probably less effective then Oxycodone. (Tr. 764-765).

28. Prelu, an appetite suppressor in the amphetamine class, is a stimulant (Tr. 766).

29. Fiorocet is a barbiturate which patients may become habituated to (Tr. 766).

30. Placidyl is a sedative, a sleeping medication that is highly addictive. It is rarely prescribed today because there are other sleeping medications that are far less addictive. (Tr. 767).

31. Tylox is an Oxycodone (Tr. 767).

32. Lorcet is similar to Vicodin (Tr. 767).

33. Xanax or Alprazolam and Valium or Diazepam are both benzodiazopines which can cause habituation or addiction (Tr. 768-769).

34. Before treating pain with a narcotic analgesic the reasonably prudent physician would take an appropriate history and perform an appropriate physical exam to attempt to determine the cause of the pain. The history would include the present illness, how long the patient has been in pain, other treatments the patient has received for the pain, and how successful these other treatments were. The physician must then asses the likely duration and severity of the pain. The physician must also determine what other illnesses the patient has that might be affected by treatment. Next, the reasonably prudent physician would attempt to treat the cause of the pain. If the physician chooses a narcotic to treat the pain, the physician would record each interaction with the patient as well as the name, strength and amount of the drug or drugs prescribed. (Tr. 772).

SPECIFIC FINDINGS AS TO EACH PATIENT

Patient A

35. The Respondent treated Patient A from February 1983 through July 1999 (Tr. 552; Exs. 3 and 3A).

36. Patient A began abusing street drugs in the 1960s (Tr. 549). Since that time he has gone in and out of Methadone maintenance programs (Tr. 551). At the time he testified he stated that he was currently in a Methadone program that he had been in for some time (Tr. 551). Patient A suffered from kidney disease, was on dialysis, and was being regularly treated for this disease by other physicians.

37. The Respondent maintained some clinical records for this patient from 1983 through September 1988 (Ex.3A). Between 1994 and 1995 the Respondent maintained only billing records and dates of treatment. Petitioner's Exhibit 3 establishes that during this period the Respondent saw Patient A regularly, at least once a week, but kept no clinical records of treatment (Ex. 3). This constitutes a deviation from acceptable medical standards (Tr. 312-313).

38. The Respondent failed to treat Patient A for depression, anxiety, and drug addiction in accordance with acceptable standards of psychiatric practice (Tr. 331-333). Treatment of Patient A, a drug addict, with Diazepam and Alprazolam is not treatment in accordance with acceptable standards for the treatment of a patient with a history of opiate addiction (Tr. 305-310, 382 and 768).

39. At the time Patient A was being treated by the Respondent, Patient A was also being treated by a surgeon, a family physician, and another physician for kidney disease. Under these circumstances it was inappropriate for the Respondent to prescribe any

narcotics for pain without at least first conferring with these other physicians. The Respondent's failure to confer with these other physicians under these circumstances subjected Patient A to potential harm from the risk of receiving excessive or inappropriate medication. (Tr. 773, 828 and 830-831).

40. The Respondent prescribed both Diazepam and Alprazolam for Patient A. Since they are both long acting benzodiazopines, there was no legitimate reason for prescribing these medications together. (Tr. 847). Together they were an excessive dose of benzodiazopines. Additionally, Patient A had a history of Diazepam abuse.

41. The Respondent failed to obtain sufficient information regarding this patient's history of Diazepam abuse (Tr. 314). The Respondent's prescribing of Diazepam to Patient A under these circumstances constituted a deviation from acceptable medical practice.

42. The Respondent failed to obtain a history of Patient A in accordance with acceptable medical standards (Tr. 292-297 and 770-772).

43. From 1998 through July 1999, the Respondent wrote prescriptions for Patient A for Oxycodone and Hydrocodone, both narcotics and for Alprazolam, Diazepam and Clonazepam, all benzodiazopines. The Respondent maintained no medical records for Patient A during this time. (Exs. 3, 3A and 3B). This constitutes a deviation from acceptable medical standards (Tr. 312-313).

44. The Respondent prescribed Oxycodone and Hydrocodone for Patient A because the patient suffered from many disabilities and had a low pain tolerance (Tr. 826). The Respondent stated that the patient's other physicians would not prescribe narcotics for the patient. The Respondent's prescribing of narcotics was inappropriate because he did not perform a complete history or physical exam, and he did not confer with the other

physicians who were treating the patient for the underlying causes of the pain.

Patient B

45. According to the Respondent's medical records he began treating Patient B, a 70 year old woman, in 1994 (Tr. 402). His initial history indicated an habituation to Demerol. The Respondent's initial history and workup of this patient fail to meet appropriate medical standards in that there is no medical history, no drug dependence history, no medication history, inadequate psychiatric history, no records regarding the patient's last physical exam or plans for a referral for a physical exam, no records of laboratory testing or plans for referral for such testing, and no notes regarding other or prior treating doctors (Tr. 404-405).

46. The pharmacy records and triplicate prescription records indicate that the Respondent prescribed excessive amounts of the narcotic Demerol, injectable and pills. The Respondent prescribed large amounts of benzodiazopines, Flurazepam and Diazepam, and sedatives during the years 1998 through 1999. (Tr. 406). The Respondent maintained no medical records for this patient during this period of time. This constitutes a deviation from acceptable practice. (Tr. 411-414; Exs. 4, 4A, 39 and 41).

47. The Respondent failed to record an adequate history related to the patient's pain to warrant treating her with injectable narcotics (Tr. 770-772).

48. The Respondent failed to perform or record a physical exam or refer her for one prior to treating her with narcotics for pain. This constitutes a deviation from acceptable medical standards. (Tr. 433-434).

49. It is a deviation from acceptable medical practice to prescribe Demerol to a patient who has a history of Demerol addiction or habituation (Tr. 406).

50. The amounts of Demerol prescribed suggest that Patient B had a long-standing addiction to Demerol which the Respondent perpetuated and did not attempt to treat (Tr. 406-407 and 448-449; Ex.39).

51. There is no medical justification for the Respondent prescribing Demerol, Diazepam, Flurazepam, Temazepam and Halcion for Patient B from 1998 through 1999 (Tr. 435-436). Additionally, there was no appropriate medical indication for the excessive amounts of these medications prescribed (Tr. 435-437 and 444).

52. The Respondent's failure to maintain any progress notes regarding his care of this patient between 1998 and 1999 constitutes a deviation from acceptable medical standards (Tr. 444).

Patient D

53. Patient D is the Respondent's son.

54. Between August 12, 1998 and December 2, 1998, the Respondent wrote fourteen prescriptions for a total of 350 syringes in the name of the Respondent's wife (Ex. 39). The Respondent admitted that most of these prescriptions for insulin syringes which he wrote in his wife's name were intended for the use of his son. (Tr. 859-860).

55. During this time period the Respondent also wrote multiple prescriptions for Nalbuphen, a narcotic, in his wife's name (Ex. 39). The Respondent admitted that most of these prescriptions which were written in his wife's name were intended for treatment of his son's elbow pain. (Tr. 859-861).

56. The Respondent maintained no medical records for treatment of his son, Patient D, or his wife.

57. The Respondent wrote prescriptions in his wife's name rather than in the name of his son,

so that his wife could submit bills for these prescriptions to her insurance company. At the time Patient D had no insurance. (Tr. 861).

Patient E

58. Patient E first saw the Respondent on October 10, 1998. The Respondent failed to obtain a psychiatric or medical history. This included failure to obtain a history related to her joint pain, and her reason for taking Vicodin. The Respondent failed to obtain information regarding prior psychiatric treatment, including the reason that she was taking 10 mg. of Xanax per day. He failed to obtain her history of drug addiction and treatment with Methadone, including her current dose of Methadone. (Ex. 6). The Respondent failed to obtain a medical or psychiatric history that comported with acceptable medical standards. (Tr. 292-297 and 770-772).

59. The Respondent failed to obtain a mental status evaluation (Exs. 6 and 6A). This constitutes a deviation from acceptable medical standards.

60. On December 7, 1998 the Respondent indicated an increase in Vicodin without noting any rationale or description of the pain. On December 31, 1998 he noted in his records that he prescribed Fasten without noting any rationale and he failed to note on that date that he also prescribed Xanax.

61. On January 19, 1999, February 1, 1999, February 22, 1999, March 17, 1999, April 5, 1999, April 21, 1999 and May 2, 1999 the Respondent prescribed 120, 2-mg. tablets of Xanax, without a single progress note to indicate that he has prescribed this medication, his reasons for prescribing it or the effect of the medication. The Respondent's failure to keep any progress notes concerning these medications constitutes a deviation from acceptable medical practice. (Tr. 312-313; Exs. 6, 6B, and 40, pp. 15, 25 and 31).

62. On February 22, 1999 the Respondent noted that the patient states "suicide" without documenting any further evaluation or treatment. This constitutes a serious departure from acceptable medical practice. (Tr. 708).

63. On January 19, 1999 the Respondent wrote a prescription for Patient E for 120, 2-mg. tablets of Alprazolam. On the same date he wrote a prescription for Xanax "daw" for Patient E. In addition, on the same date he also wrote a prescription for Alprazolam under the same last name as Patient E, but with a different first name - Mary. Patient E had no explanation for the two prescriptions written in her name and she indicated that there was no person that she knew with the first name Mary and the same last name as her's. The progress note for this date merely states "renew". Therefore, the Respondent prescribed Xanax and Alprazolam in the name of Patient E for no legitimate medical reason. (Exs. 6, 6A and 6B).

64. The Respondent inappropriately prescribed high doses of Xanax to Patient E, a known drug addict (Tr. 309-310; Ex. 6).

65. The Respondent inappropriately prescribed Xanax to Patient E without sufficient workup or follow-up (Tr. 319-331; Ex. 6).

66. The Respondent inappropriately prescribed narcotics: Hydrocodone on November 25, 1998, December 31, 1998 and January 23, 1999 (Ex. 39, p. 4 and Ex. 40, pp. 26 and 31); and Oxycodone on February 1, 1999 (Ex. 40, p. 25). He failed to obtain a sufficient history of her pain, failed to perform a physical exam or insure that one was performed, and he failed to note the amount of Methadone that Patient E was taking. (Tr. 311, 337-338, 763, 770-772 and 777).

67. On March 17, 1999, for no legitimate reason, the Respondent prescribed Valium to

Patient E in her married name and Xanax to her in her maiden (Tr. 703-704; Ex. 6B). This constitutes a serious departure from acceptable medical practice (Tr.702-705 and 707-708).

68. The Respondent failed to evaluate or treat Patient E for alcohol abuse and kleptomania (Tr. 685; Ex. 6).

69. The Respondent inappropriately prescribed opiates and benzodiazopines without evaluating the extent of her alcohol abuse. Because of the cumulative and synergistic effect of these agents, the Respondent exposed Patient E to risk of overdose. (Tr. 687-688). This constitutes a very serious departure from acceptable medical practice (Tr. 708).

Patients G and H (Mother and Daughter)

Patient G

70. Patient G was first treated by the Respondent on May 22, 1997. The Respondent failed to obtain an adequate psychiatric and medical history for this patient. (Tr. 293-297, 770-772 and 960).

71. From 1998 through 1999 the Respondent prescribed the following medications for this patient: Xanax, Klonopin, Hydrocodone, Oxycodone, Didrex, Prelu, Tylenol with Codeine, and Fiorinol (Exs. 8A, 38 and 40). During this period of time the Respondent did not maintain progress notes tracking the patient's symptoms, the drugs effects, side effects, the status of the underlying conditions the patient was being treated for, the quantity of medications prescribed, and the rationale for continuing treatment with large doses of addictive medications. This represents a serious deviation from acceptable medical standards. (Tr. 312-313, 772, 961-967 and 1006-1008; Ex. 8).

72. The Respondent prescribed Klonopin and/or Xanax, both benzodiazopines, on at least 15 occasions between July 1998 and April 1999 without medical justification (Tr. 965-966; Exs. 8B and 40).

73. Patient G suffered from drug addiction, alcoholism, headaches and arthritis. The Respondent failed to provide this patient with treatment for her addictions in accordance with acceptable medical standards. (Tr. 292-297, 300-301, 309-310 and 970).

74. The Respondent failed to treat Patient G, a known drug abuser, for anxiety in accordance with acceptable medical standards. Prescribing high doses of benzodiazopines over a long period of time is not an acceptable method for treating anxiety in a known opiate abuser. Other non-addictive medications, including antidepressants, are available for treatment of anxiety. (Tr. 309-310, 991-992 and 995-996).

75. The Respondent failed to treat Patient G for pain related to arthritis and headaches in accordance with acceptable medical standards since he failed to obtain an appropriate history or conduct an appropriate physical exam. The Respondent failed to attempt treatment with non-narcotic medication. The Respondent also failed to track the quantities and effectiveness of the narcotic medications prescribed. (Tr. 772-774, 776 and 970-971; Ex. 8).

76. The Respondent prescribed Prelu on October 26, 1998 and December 6, 1998, and Didrex on January 20, 1999, March 8, 1999, March 15, 1999, and March 18, 1999. Both are stimulants and were prescribed to Patient G without medical indication. (Exs. 8 and 40).

77. The Respondent inappropriately prescribed these medications to Patient G, a known addict, without a physical examination. Stimulants can be used to produce a high or

euphoria. Stimulants also present a serious risk to the cardiovascular system and to the nervous system. (Tr. 997).

Patient H

78. Patient H was the 10 or 11 year old daughter of Patient G. The only medical reference to Patient H appears in the medical chart for Patient G on May 22, 1997 (Ex. 8). The Respondent prescribed Ritalin for Patient H from May 15, 1998 through April 1, 1999 on at least 11 occasions (Exs. 10 and 40).

79. The Respondent prescribed Ritalin to Patient H without medical justification (Tr. 972-974 and 996).

80. The Respondent failed to treat Patient H for hyperactivity in accordance with acceptable medical standards in that he failed to obtain an adequate history. The Respondent failed to conduct a physical exam or obtain information indicating that such an exam was performed. The Respondent also failed to obtain a history concerning school performance and any prior psychological testing. (Tr. 973-975 and 1956-1957).

81. The Respondent's training in child psychiatry was limited to approximately one year during his postgraduate education in the 1950s. (See finding 3, *supra*).

Patients I and J (Father and Son)

Patient I

82. The Respondent treated Patient I on multiple occasions between October 1995 and June 1999 (Exs. 10 and 10A).

83. In an interview with representatives of the Office of Professional Medical Conduct ["the OPMC interview"] the Respondent stated that Patient I was an established addict with serious personality disorders, posttraumatic arthritis, various injuries and migraine

headaches (Tr. 878; Ex.10).

84. The Respondent provided Patient I with triplicate prescriptions for Diazepam in the name of Patient I's son, Patient J (Tr. 1961-1963). This constitutes a deviation from acceptable medical standards (Tr. 885-886).

85. The Respondent prescribed Codeine, Hydrocodone and Oxycodone for Patient I, a known addict, without medical indication (Tr. 898-900; Ex. 10 and Ex. 40, pp. 67 and 70). The Respondent prescribed Codeine on June 4, 1998 and July 6, 1998, authorizing four refills (Ex. 40, pp. 10, 16, 40 and 50).

86. On May 27, 1998, July 23, 1998, September 16, 1998, October 31, 1998, January 6, 1999, February 10, 1999, March 10, 1999 and April 21, 1999, the Respondent wrote prescriptions for Patient I (Tr. 880; See finding 91, *infra*). The Respondent's records for Patient I for this period consist of dates only. Neither clinical information nor medication information is recorded. This constitutes a serious deviation from acceptable medical standards. (Tr. 319-331, 335-336, 894-896 and 898-900; Ex.10).

87. The Respondent prescribed Diazepam, Alprazolam, Codeine, Hydrocodone, Vicodin and Fiorocet for Patient I (Tr. 879; Exs.10, 10A and 40). The Respondent failed to prescribe these medications in accordance with acceptable medical standards in that he failed to obtain an appropriate history, including psychiatric history and medical history. He failed to obtain a mental status evaluation. He failed to perform or obtain a physical exam before prescribing narcotics to this known addict (Tr. 906). The Respondent also failed to keep appropriate progress notes detailing medication effects and side effects (Ex.10).

88. The Respondent prescribed high doses of Xanax to a known drug addict. This method of

treating drug addiction does not comport with acceptable standards of medical practice. (Tr. 305-310, 382, and 768).

Patient J

89. Patient J, a young man who drove motorcycles and regularly used marijuana and other street drugs, is the son of Patient I (Tr. 1963, 1999-2003 and 2043-2044).

90. The Respondent prescribed Diazepam to Patient J (Ex 11).

91. The Respondent stated at the OPMC interview that he saw Patient J only once and that he wrote prescriptions for Patient J on several occasions (Tr. 878). However, the Respondent's records for Patient I indicate two joint visits with Patients I and J (Ex. 10). Furthermore, the Respondent stated at this hearing that the first triplicate prescription for Valium that he wrote for Patient J, he gave to Patient J in person. However, he admitted that the other times he wrote triplicate prescriptions for Valium for Patient J, he gave the prescriptions to Patient I. (Tr. 1961-1963). Proctor Pharmacy records for the period May 1998 through July 1999, indicate that the Respondent wrote prescriptions for Patient J for Valium or Diazepam on eight separate dates - May 27, 1998, July 23, 1998, September 16, 1998, October 31, 1998, January 6, 1999, February 10, 1999, March 10, 1999 and April 21, 1999 (Ex. 40, pp. 8, 16, 23, 30, 42, 49, 57 and 67). The Respondent deviated from acceptable medical standards when he wrote prescriptions for Patient J without seeing Patient J (Tr. 883-886).

92. The Respondent maintained no medical records or progress notes for Patient J (Tr. 886). The Respondent's failure to maintain medical records or progress notes on a patient for whom Valium is prescribed constitutes a deviation from acceptable medical practice (Tr. 319-331, 335-336 and 886-887).

Patient K

93. The Respondent began treating Patient K on March 5, 1996. The last date recorded in the Respondent's medical record for Patient K is August 7,1997. (Ex. 12). Pharmacy printouts and triplicate records indicate that the Respondent continued treating Patient K through July 1999 (Tr. 1180-1181; Exs. 12A and 40).

94. In the Respondent's medical record for this patient, the Respondent diagnosed panic attacks. The Respondent prescribed tranquilizers, sedatives and analgesics, particularly Percodan and Hydrocodone. (Tr. 1183-1184; Exs. 12 and 12A).

95. On March 5, 1996, the Respondent's initial meeting with Patient K, the Respondent failed to obtain a history in accordance with acceptable medical standards (Tr. 293, 770-772 and 1184; Exs. 12 and 12A).

96. On May 12 (year unknown) the Respondent wrote a prescription for 120 Percodan tablets without any medical indication for this narcotic. There is no record of a physical exam, no record of the cause, nature or severity of the pain, and no record of attempts at using non-narcotic pain medication or other modalities to treat the pain. On this occasion the Respondent prescribed Percodan for no legitimate medical purpose. This conduct does not comport with acceptable medical standards. (Tr. 1184-1185).

97. The Respondent prescribed Oxycodone on June 19, 1998, July 28, 1998, September 16, 1998 and November 5, 1998 (Ex. 40) and on December 4, 1998 (Ex. 41). The Respondent also prescribed Hydrocodone on October 22, 1998, March 3, 1999, April 29, 1999, May 19, 1999, June 17, 1999 and July 17, 1999 (Ex. 40). The Respondent maintained no medical records for these dates. This conduct constitutes a deviation from acceptable medical standards. The Respondent prescribed narcotic pain medication to

Patient K on each of these dates for no legitimate medical purpose. (Tr. 1184-1185).

98. The Respondent failed to treat Patient K for pain in accordance with acceptable medical standards (Tr. 1200-1201).

99. Prescription records from Proctor Pharmacy indicate that the following sedatives were prescribed for Patient K by the Respondent: Tuinal on October 4, 1998; Ambien on December 18, 1998 and February 20, 1999; and Placidyl on June 3, 1998, June 29, 1998, July 28, 1998 and September 28, 1998. The Respondent maintained no medical records for these dates. This conduct deviates from acceptable medical practice. (Tr. 1187-1189; Exs. 12, 12A, 39 and 40).

100. The Respondent prescribed sedatives on each of these dates for no legitimate medical purpose (Tr. 1187-1189; Exs. 12 and 12A).

101. The Respondent prescribed Placidyl, a highly addictive sedative which is rarely used today, without maintaining any medical record. This failure to maintain medical records constitutes a deviation from acceptable medical standards. (Tr. 767 and 1189-1194).

102. The Respondent failed to treat Patient K for sleep difficulty in accordance with acceptable medical standards (Tr. 1196).

103. The Respondent prescribed Xanax to Patient K on September 13, 1998, November 5, 1998, April 6, 1999 and April 29, 1999 (Ex. 40), and on December 4, 1998 and April 13, 1999 (Ex.41), and on March 16, 1999, May 10, 1999, June 7, 1999 and July 7, 1999 (Exs.12 and 12A). The Respondent maintained no medical records for any of these dates. Each one of these prescriptions is for 120, 2-mg. tablets. The Respondent prescribed large quantities of Xanax to Patient K without obtaining and recording appropriate clinical information. This constitutes a deviation from acceptable medical standards (Tr.

1194-1195).

104. The Respondent prescribed Xanax to Patient K for no legitimate medical purpose on each of these dates (Tr. 1195).

105. The Respondent failed to treat Patient K for anxiety and panic in accordance acceptable medical standards (Tr. 1197).

Patients L through S (The L Family)

106. The only medical records provided by the Respondent for Patients L through S are contained in Exhibits 13 and 13A. Although the Respondent was asked to produce records concerning Patients M through S, he provided none. (Tr. 909; Ex. 21).

107. Patients M through S all have the same last name as Patient L.

108. Patient N is the same person as Patient L (Tr. 1922 and 1984).

109. On numerous occasions the Respondent wrote prescriptions for Xanax in the names of Patients M through S (Exs.14-20).

110. Despite the fact that the Respondent had no records for Patients M through S, he wrote multiple prescriptions for Xanax for these individuals (Exs. 14-20). When asked at the OPMC interview why he wrote these prescriptions, he stated that he thought they needed something to help them out. (Tr. 909-910).

111. On more then one occasion the Respondent provided to Patient L prescriptions in the names of Patients M through S (Tr. 910). This is a gross deviation from acceptable medical practice since Patient L, according to the Respondent's own notes, was a sociopathic drug abuser who had a history of selling Xanax on the street (Tr. 910-911 and 914-916; Ex. 13A).

112. It is a deviation from acceptable medical standards to prescribe benzodiazopines to

individuals without obtaining a psychiatric history and a medical history (Tr. 292-297, 312-313 and 319-331).

113. It is a deviation from acceptable medical standards to prescribe benzodiazopines for a patient without obtaining information from the patient regarding the effectiveness of the medication and any side effects related to the medication (Tr. 319-331).

114. It is a deviation from acceptable medical standards to prescribe benzodiazopines to a patient without recording the name and amount of the medication prescribed (Tr. 335-336).

115. It is a deviation from acceptable medical standards to prescribe Xanax to a patient while maintaining no medical records (Tr. 319-331).

116. There is no credible evidence that Xanax was prescribed for a legitimate medical purpose to Patients L through S (Tr. 922-923).

Patient L

117. The Respondent treated Patient L from July 1994 through June 1999 (Tr. 916-918; Exs.13, 13A, 14, 38 and 40).

118. The Respondent described Patient L as a 44 year old HIV positive addict with a sociopathic personality and a long history of polydrug abuse (Tr. 908).

119. According to the PDR, the maximum daily dose of Xanax is 8 mg. (Tr. 911).

120. The Respondent prescribed 120, 2-mg. tablets of Xanax for Patient L on January 7, 1999, January 11, 1999 (Patient N), January 20,1999, January 26, 1999, February 8,1999, February 20, 1999, March 31, 1999, April 7, 1999, April 26, 1999, May 22, 1999, May 29,1999, June 15, 1999, and June 20, 1999. On December 15, 1998, January 11, 1999 and February 8, 1999 the Respondent prescribed 90, 10-mg. tablets of Valium, another

benzodiazopine, for Patient L. If Patient L took all the medication prescribed, he would at times have taken as much as 23 mg. per day of Xanax. Additionally, in January and February 1999, the Respondent prescribed Valium for Patient L as well. (Tr. 911; Exs. 13B, 15, 38 and 40).

121. This pattern of prescribing represents a deviation from acceptable medical practice as it is either enabling an addiction or providing drugs to be sold on the street (Tr. 912). Xanax is believed to be the most addicting of all the benzodiazopines (Tr. 913).

122. On February 20, 1999, the Respondent provided a prescription for Patient L for Percocet, a narcotic pain medication (Ex. 13B).

123. The Respondent maintained no medical records for Patient L during the entire year 1999 (Tr. 1912-1913; Ex. 13).

124. Providing a narcotic to a known drug abuser without obtaining any history or clinical information is a deviation from acceptable medical standards (Tr. 770-772).

125. After March 1998, the Respondent maintained no notes or clinical records for Patient L. The Respondent prescribed excessive amounts of benzodiazopines and narcotics during 1998 and 1999. (Exs. 13B, 40 and 41).

Patient M

126. The Respondent prescribed Xanax for Patient M on September 13, 1998 and February 22, 1999 (Ex. 40, p. 22) and on February 11, 1999 (Ex.14).

127. The Respondent maintained no records for this patient. (See finding 106, *supra*).

Patient N

128. Patient N is the same patient as Patient L. (See finding 108, *supra*).

Patient O

129. The Respondent prescribed Xanax for Patient O on May 28, 1998, October 8, 1998, November 17, 1998 and February 8, 1999 (Ex.40), and on March 25, 1999 (Ex. 16), and on May 10, 1999 (Ex.38)

130. The Respondent maintained no records for this patient. (See finding 106, *supra*).

Patient P

131. The Respondent prescribed Xanax for Patient P on February 16, 1999 and May 19, 1999 (Ex 38, p. 1).

132. The Respondent maintained no records for this patient. (See finding 106, *supra*).

Patient Q

133. The Respondent prescribed Xanax for Patient Q on June 13, 1998, July 10, 1998 and March 29, 1999 (Ex. 38, p. 1), and on May 20, 1998, June 22, 1998, January 12, 1999 and March 9, 1999 (Ex. 40), and on March 29, 1999 (Ex.18).

134. The Respondent maintained no records for this patient. (See finding 106, *supra*).

Patient R

135. The Respondent prescribed Xanax for Patient R on December 22, 1998 and April 7, 1999 (Ex.19 and Ex. 38, p. 1).

136. The Respondent maintained no records for this patient. (See finding 106, *supra*).

Patient S

137. The Respondent prescribed Xanax for Patient S on October 8, 1998 and April 9, 1999 (Ex. 40, p. 10) and on April 7, 1999 (Ex.20).

138. The Respondent maintained no records for this patient. (See finding 106, *supra*).

Patients T through Y (The T Family)

139. Patients T through Y are all members of the same family and were all treated by the

Respondent with Ritalin (Tr. 1010; Exs. 22-28).

140. Patients T and W are both adults. Patients U, V, X and Y are children who were between the ages of eight and thirteen (Exs. 22-28).

141. The Respondent prescribed Ritalin for each of these individuals on multiple occasions. Each prescription was for 2, 10-mg. tablets, three times per day, or 60 mg. per day. (Tr. 1013-1014; Exs. 22-28). 60 mg. per day is a high dose of Ritalin, especially for an 8 year old child (Tr. 1014).

142. It is highly unlikely that the same dose of Ritilan would be appropriate for all these individuals. A Ritilan dose is based upon the patient's size and the severity of the symptoms. (Tr. 1019).

143. Although the Respondent was asked to produce his medical records concerning Patients T through Y, he provided none (Ex. 22).

144. The Respondent failed to obtain a history and physical exam for each of these patients. This constitutes a deviation from acceptable medical standards. (Tr. 1015 and 1021-1022).

145. The Respondent failed to provide follow-up treatment for each of these patients. This constitutes a deviation from acceptable medical standards. (Tr. 1015 and 1021-1022).

146. There is no credible evidence that Ritalin was prescribed for a legitimate medical purpose for any of these individuals. (Tr. 1015 and 1021-1022).

Patient T

147. The Respondent prescribed Ritalin for Patient T, a 38 year old female, on February 17, 1999, February 24, 1999, March 17, 1999, April 22, 1999, June 9, 1999 and June 28, 1999 (Ex. 23).

148. The Respondent maintained no records for this patient. (See finding 143, *supra*).

Patient U

149. The Respondent prescribed Ritalin for Patient U on February 17, 1999, April 8, 1999 and June 28, 1999. Patient U was an 11 year old boy on the date of the first prescription. (Ex. 24).

150. The Respondent maintained no records for this patient. (See finding 143, *supra*).

Patient V

151. The Respondent prescribed Ritalin for Patient V, a 9 year old boy, on January 27, 1999, March 17, 1999, April 8, 1999 and June 9, 1999 (Ex. 25).

152. The Respondent maintained no records for this patient. (See finding 143, *supra*).

Patient W

153. The Respondent prescribed Ritalin for Patient W, a 41 year old male, on March 23, 1999, April 22, 1999 and June 28, 1999 (Ex. 26).

154. The Respondent maintained no records for this patient. (See finding 143, *supra*).

Patient X

155. The Respondent prescribed Ritalin for Patient X, an 8 year old boy, on February 17, 1999, March 17, 1999, April 8, 1999 and June 9, 1999 (Ex. 27).

156. The Respondent maintained no records for this patient. (See finding 143, *supra*).

Patient Y

157. The Respondent prescribed Ritalin for Patient Y, an 11 year old girl, on January 27, 1999 (Ex. 28).

158. The Respondent maintained no records for this patient. (See finding 143, *supra*).

Patient Z

159. The Respondent's medical record for Patient Z, a 40 year old female with a history of drug abuse, consists of an entry for a single date - February 2, 1999 (Ex. 29).

160. The Respondent stated at the OPMC interview that Patient Z was a drug addict who, at the time of the interview, was in a rehabilitation center (Tr. 1216-1217).

161. Patient Z had been in jail for 6 months for possession of benzodiazopines. On February 2, 1999 she had been "detoxed" and was not on Methadone. (Tr. 1218; Ex. 29).

162. The Respondent's workup of the patient on February 2, 1999 did not comport with acceptable medical standards in that: there was no history taken; no mental status evaluation performed; no detailed history of the patient's drug abuse and treatment; and, no history as to the patient's present status or current complaints. (Tr. 1218-1219).

163. The Respondent prescribed Placidyl and Meprobamate to Patient Z. There is no medical justification for prescribing these two addictive medications to this patient. In view of the addictive potential of Placidyl it was dangerous and a deviation from acceptable medical standards to prescribe this medication to Patient Z, an addict, who had just been released from jail and was described as "detoxed". (Tr. 1189 and 1221-1222; Exs. 29 and 29A).

164. On February 13, 1999 Patient Z refilled the prescription for Meprobamate (Ex. 40, p. 22) and on February 18, 1999 Patient Z refilled the prescription for Placidyl (Ex. 40, p. 21).

165. According to the Respondent's records, Patient Z had been in jail for illegal possession of benzodiazopines. On February 22, 1999, only three weeks after her first appointment with the Respondent and a short time after her release from prison, the Respondent prescribed 120, 2-mg. tablets of Alprazolam (Xanax), a benzodiazopine. This occurred just three weeks after the Respondent's February 2, 1999 note that the patient had been

"detoxed". Additionally, the Respondent made no record of the prescription written or the patient's condition at the time of the prescription. (Exs. 29 and 29A).

166. 120, 2-mg. tablets per month is a maximum dose of Alprazolam (Xanax), which is among the most addictive of the benzodiazopines. The Respondent's conduct on February 22, 1999 regarding this patient represents a total disregard for her health and well being. The Respondent prescribed a maximum dose of the most addictive of the benzodiazopines to a person who had a history of addiction and criminal activity with benzodiazopines. (Tr. 1218-1221; Ex. 58).

167. After February 22, 1999, the Respondent wrote for Patient Z eleven additional prescriptions for 120, 2-mg. tablets of Xanax or Alprazolam. These prescriptions were written on March 9, 1999, March 24, 1999, April 8, 1999, April 13, 1999, May 6, 1999, May 13, 1999, May 20, 1999, May 27, 1999, June 4, 1999, June 16, 1999 and June 28, 1999. (Ex. 29A).

168. If Patient Z was taking all of this medication, she would have been taking approximately 23-30 mg. per day. The maximum acceptable dose of Xanax or Alprazolam is 8 mg. per day. This constitutes a deviation from acceptable medical standards. (Tr. 1219-1221 and 1228-1230; Ex 58).

169. The Respondent wrote prescriptions for Meprobamate, which were filled and refilled on February 2, 1999, February 13, 1999, March 9, 1999, March 23, 1999 and May 13, 1999. No rationale was provided for prescribing Meprobamate at the same time as prescribing Xanax. Therefore, the Respondent prescribed Meprobamate without any legitimate medical purpose. (Tr. 1222).

170. The Respondent's conduct enabled Patient Z's addiction to benzodiazopines (Tr. 1220).

Patients AA and BB (Husband and Wife)

171. Patients AA and BB were husband and wife (Tr. 924-925).

Patient AA

172. Patient AA is an adult male with a history of drug abuse who complained of cervical disk pain (Tr. 925, 927 and 1833).

173. The Respondent's medical record for Patient AA indicates three visits from February 3, 1997 through 1998 and that the Respondent prescribed Xanax and Percocet (Ex. 30). Triplicate prescription records indicate that the Respondent prescribed to Patient AA Dilaudid on April 5, 1999 and Percocet on an unspecified date (Ex. 30A).

174. There are no medical records for Patient AA for the year 1999 (Ex. 30).

175. There is no reference to a mental status evaluation in the existing medical record for 1997 (Ex. 30).

176. At the OPMC interview the Respondent stated that Patient AA was a known drug addict who would "use anything including crack" (Tr. 925).

177. At this hearing the Respondent stated that Patient AA would steal his wife's Dilaudid (Tr. 1835 and 1906-1907), which is a highly potent oral, narcotic, pain medication (Tr. 926-927).

178. The only justification for prescribing Dilaudid, is evidence of severe pain, unresponsive to other less potent analgesics. There is no indication that this was the case for Patient AA. (Tr. 926-927).

179. Before prescribing narcotics to Patient AA for pain, a reasonably prudent physician would have obtained a complete history related to the pain and would have conducted or referred the patient for a physical examination. There is no credible evidence that a

history was obtained or physical examination performed. There is no credible evidence that the Respondent consulted a physician competent to treat cervical disk disease (Tr. 926-929; Ex. 30).

180. The Respondent prescribed narcotics to a known drug abuser without medical indication. This constitutes a deviation from acceptable medical standards.

Patient BB

181. Patient BB, an adult female who used the first names Marjorie and Margaret, is the wife of Patient AA (Tr. 924-925 and 1835). She had breast cancer and was being treated by an oncologist (Tr. 929-930, 1832 and 1835; Ex. 31).

182. The Respondent treated Patient BB on multiple occasions from February 1998 through April 1999 (Tr. 931-932).

183. In 1999 the Respondent prescribed Xanax, Percocet and Dilaudid for Patient BB (Tr. 934; Ex. 31A).

184. The Respondent maintained no medical records for Patient BB during 1999 (Ex. 31). This constitutes a deviation from acceptable medical practice (Tr. 770-774 and 934-935).

185. The Respondent failed to obtain an appropriate history before prescribing narcotics to this patient (Tr. 770-774 and 929-930).

186. Since Patient BB had breast cancer and was being treated by an oncologist for the breast cancer, a reasonably prudent physician would refer Patient BB to her oncologist for treatment of pain (Tr. 930 and 937-939).

Patients CC and DD (Husband and Wife)

187. Patients CC and DD were husband and wife (Tr. 1838-1845).

Patient CC

188. The Respondent first treated Patient CC, a 45 year old male with a history of drug abuse, on April 1, 1997. During this first visit the Respondent prescribed Diazepam for Patient CC. (Tr. 1239; Ex. 32).

189. The Respondent's treatment of Patient CC during this first visit deviated from acceptable medical standards because the Respondent failed to obtain or record a medical history and a psychiatric history. He failed to perform a mental status evaluation. He failed to identify the patient's complaints. He also failed to obtain or record a history of drug addiction. Failure to obtain or record this information departs from acceptable medical practice. (Tr. 293, 337-338 and 1239-1240; Ex. 32).

190. On May 1, 1997 the Respondent prescribed Codeine for Patient CC without an appropriate evaluation of the patient's pain. This constitutes a deviation from acceptable medical standards. (Tr. 1241).

191. On the second page of the Respondent's medical record for Patient CC, only dates of treatment with the word "review" are listed. This sparse entry constituted the entirety of the Respondent's progress notes for Patient CC for the 16 visits during the period from June 23, 1997 through November 11, 1999. (Ex. 32). During this period the Respondent, on multiple occasions, prescribed Diazepam and Hydrocodone (Ex. 32A and Ex. 40, pp. 8, 13, 16 and 21).

192. Diazepam is used to treat anxiety. The Respondent failed to perform a sufficient evaluation to justify prescribing Diazepam. (Tr. 1244).

193. Between 1997 and 1999 the Respondent failed to keep medical records for Patient CC which comport with appropriate medical standards. (Tr. 319-331, 770-772 and 1244).

Patient DD

194. Patient DD, who was 39 years old in March 1998, is the wife of Patient CC (Ex. 33).

195. The Respondent treated Patient DD on multiple occasions from March 1998 through June 1999 (Tr. 1248).

196. At the OPMC interview the Respondent stated that Patient DD had been addicted to Fiorinol which she took for cluster headaches (Tr. 1248-1249). This information also appears in the Respondent's medical record for Patient DD (Ex.33).

197. On March 17,1999 the Respondent prescribed for Patient DD the following: Alprazolam, 2-mg., 120 tablets, which is the maximum daily amount; Diazepam, 10-mg., 60 tablets, to be taken at night; and, Diazepam, 10-mg., 120 tablets, to be taken every six hours (Tr. 1249-1250; Ex.33A). These three prescriptions, all written on the same date, are all for benzodiazopines. If the medication in these prescriptions was taken as written, the amount taken would constitute an excessive amount of benzodiazopines. (Tr. 1250-1251 and 1256-1258; Ex.40, p. 15).

198. On November 23, 1998 the Respondent prescribed Oxycodone for Patient DD. Oxycodone is an opiate used to treat pain. There is nothing in the Respondent's medical record for Patient DD for this date that would justify prescribing Oxycodone. (Tr. 1253; Ex. 41).

199. On February 17, 1999, March 10, 1999 and March 29, 1999 Patient DD filled prescriptions for Hydrocodone, 7.5 mg., at Proctor Pharmacy (Ex. 40, pp. 13, 16 and 22). There is nothing in the patient's medical record that would warrant these prescriptions (Tr. 1252-1253).

200. The Respondent failed to treat Patient DD for pain in conformity with acceptable medical standards (Tr. 1253-1254).

201. The Respondent failed to address Patient DD's Fiorinol addiction in conformity with acceptable medical standards (Tr. 1254).

Patient EE

202. The Respondent first treated Patient EE, a 40 year old female with a history of drug abuse, on October 9, 1997 (Tr. 1847; Ex. 34). Thereafter, the Respondent treated Patient EE on multiple occasions until her death on March 11, 1999. Patient EE died of acute Cocaine, Methadone and Alprazolam intoxication. (Tr. 1280; Ex. 34A and Ex. L).

203. The Respondent's medical record for Patient EE consists of a few notations written on October 9, 1997 (Ex. 34).

204. The copy of Patient EE's medical record admitted into evidence at this hearing was certified by Christine M. O'Connor, an Assistant District Attorney in the Westchester County District Attorney's Office, as a complete, true and exact copy of the medical files pertaining to Patient EE which were recovered during a search of the Respondent's medical office. The search was conducted on June 30, 1999 by the Mount Vernon Police Department pursuant to a search warrant. (Ex. 34).

205. At the OPMC interview the Respondent identified Patient EE as exhibiting delinquent and addictive behavior since her teens. He also stated that she was in a Methadone program, used crack, had been incarcerated several times, and that she died approximately six months prior to the interview. (Tr. 1275-1276).

206. Prescription records from Proctor Pharmacy indicate that the Respondent prescribed Alprazolam for Patient EE on May 20, 1998, June 17, 1998, July 15, 1998, July 20, 1998, September 26, 1998, October 20, 1998, November 16, 1998 and March 3, 1999 (Ex. 40, pp. 39, 44, 48, 57, 63 and 66). There is nothing in the patient's medical record that would

justify these prescriptions (Tr. 1278).

207. The Respondent placed Patient EE at risk by prescribing Alprazolam since Patient EE had a long history of drug addiction and was on Methadone, an opiate. The addictive effects of these medications posed a potential harm to Patient EE. (Tr. 1280).

208. On October 9, 1997, the only visit recorded, the Respondent failed to obtain a history for Patient EE in accordance with acceptable medical standards. The Respondent failed to obtain a history concerning her addiction, her treatment, her medical history, her psychiatric history, and a mental status evaluation. (Tr. 293, 1276 and 1278; Ex. 34).

209. The Respondent failed to provide Patient EE with appropriate treatment for anxiety (Tr. 1281-1282).

210. The Respondent failed to provide Patient EE with appropriate treatment for drug addiction (Tr. 299-301 and 1280-1281).

211. The Respondent failed to provide Patient EE with appropriate treatment for depression (Tr. 1281-1282).

Patients FF and GG (Police Lt. John McCarthy)

212. Police Lieutenant John McCarthy is employed by the City of Rye Police Department and is on special assignment with the Westchester County District Attorney's Narcotics Initiative Task Force, a specialized unit involved in narcotics investigations throughout Westchester County (Tr. 32-33).

213. Lt. McCarthy assisted in a narcotics investigation of the Respondent that arose from the death of a drug addict (Patient EE), who had died in possession of prescriptions written by the Respondent (Tr. 33-34 and 48-49).

214. During this investigation Lt. McCarthy acted as the undercover officer who had the

responsibility to pose as a patient and attempt to purchase prescriptions from the Respondent (Tr. 34-35).

215. On March 24, 1999, April 14, 1999, May 20, 1999, June 3, 1999 and June 17, 1999, Lt. McCarthy met with the Respondent at the Respondent's office and obtained prescriptions for Alprazolam (Exs. 35 and 36). On June 3, 1999 Lt. McCarthy also obtained a second prescription for Hydrocodone (Ex. 48).

216. At each of these meetings Lt. McCarthy wore a concealed transmitting or recording device and a tape recording was made of Lt. McCarthy's conversations with the Respondent. (Tr. 36 and 97-133; Exs. 49, 50, 51, 52 and 53).

217. On each occasion the Respondent provided the prescription without asking a single question directed toward evaluation of the patient's physical and mental health or the patient's drug history. (Tr. 188; See findings 219 through 227, *infra*). This failure constitutes a deviation from acceptable medical practice. (See finding 9, *supra*).

218. Furthermore, at no time does Lt. McCarthy remember seeing the Respondent make any notations on any chart or paper other than prescription pads (Tr. 61 and 181). The failure to maintain any clinical records for Patients FF and GG is a departure from acceptable standards of medical care. (See finding 6, *supra*).

Patient FF (John Roberts)

219. Lt. McCarthy first met the Respondent on March 24, 1999 when he went to the Respondent's office with a police informant. The informant, who was a drug addict and a former patient of the Respondent, introduced Lt. McCarthy to the Respondent as John Roberts (Patient FF). After a brief meeting between Lt. McCarthy and the Respondent, the Respondent gave Lt. McCarthy a prescription for 120, 2-mg. tablets of Alprazolam

and Lt. McCarthy gave the Respondent $60 in cash. (Tr. 36-40; Ex. 35).

220. During this initial meeting Lt. McCarthy told the Respondent that he worked for the Phone Company; he had recently been transferred to the area from Rochester, New York; and he took the day off to see the Respondent. The Respondent, without asking a single question about his medical or psychiatric history, stated to Lt. McCarthy that "* I'll give you a script now and I'll talk to you another time." The Respondent then asked: "What do you use?" Lt. McCarthy answered: "Xanax". The Respondent inquired if he had been getting the drug on the street. Lt. McCarthy replied that he had been getting the drug on the street down here, but upstate he had someone he was dealing with. The Respondent then asked Lt. McCarthy about his name, age, address and the dosage of the Xanax that he takes. The Respondent stated that background for a chart is needed and that Lt. McCarthy should call the Respondent a week before he wants to come in so they can make an appointment. Finally, the Respondent stated "I charge you fifty". (Tr. 97-102; Exs. 49 and 49A). Lt. McCarthy gave the Respondent $60 in cash (consisting of three $20 bills) and received from the Respondent a prescription for 120, 2-mg. tablets of Alprazolam. Lt. McCarthy did not receive any money back from the Respondent. (Tr. 39-40; Ex. 35).

221. At the initial office visit the Respondent didn't ask Lt. McCarthy anything about his medical history, treatment for drug addiction, therapy, whether he was taking other medications, or whether he was being treated by a private medical physician. (Tr. 38; Exs. 49 and 49A).

222. Lt. McCarthy, using the name John Roberts, obtained prescriptions from the Respondent on three additional dates – May 20, 1999, June 3, 1999 and June 17, 1999 (Exs. 35 and

48).

223. On May 20, 1999 Lt. McCarthy met with the Respondent at the Respondent's office, received a prescription for 120, 2-mg. tablets of Alprazolam, and paid the Respondent $50 in cash. (Tr. 46, 51 and 71; Ex. 35). The Respondent provided the prescription without evaluating the physical or mental health of the patient or the effects of the medication that had been previously prescribed (Tr. 46-47, 113-115 and 117-121; Exs. 51 and 51A).

224. On June 3, 1999 Lt. McCarthy met with the Respondent at the Respondent's office, received a prescription for 120, 2-mg. tablets of Alprazolam and a prescription for Hydrocodone, and paid the Respondent $50 in cash. (Tr. 61-65; Exs. 35 and 48). The Respondent again provided the prescriptions without evaluating the physical or mental health of the patient or the effects of the medication that had been previously prescribed (Tr. 63-64, 121-126; Exs. 52 and 52A).

225. Lt. McCarthy's last meeting with the Respondent at the Respondent's office was on June 17, 1999. At that final meeting Lt. McCarthy received another prescription for 120, 2-mg. tablets of Alprazolam and paid the Respondent $50 in cash. (Tr. 72-76; Ex. 35). Once again, the Respondent provided the prescription without evaluating the physical or mental health of the patient or the effects of the medication that had been previously prescribed (Tr. 73-74 and 126-133; Exs. 53 and 53A).

Patient GG (John Sanders)

226. On April 14, 1999 Lt. McCarthy met with the Respondent at the Respondent's office while using a different name – John Sanders (Patient GG). Even though this was the first time that Lt. McCarthy met with the Respondent while posing as John Sanders, the

Respondent still gave Lt. McCarthy a prescription for 120, 2-mg. tablets of Alprazolam. Lt. McCarthy then gave the Respondent $50 in cash. (Tr. 43-45, 51 and 59-61; Ex. 36).

227. The Respondent provided the prescription without evaluating the physical or mental health of the patient or inquiring about the patient's medication history (Tr. 44-45 and 103-113; Exs. 50 and 50A).

FINDINGS AS TO PRIOR CRIMINAL CONVICTION

228. As a result of the undercover investigation conducted by Lt. McCarthy, the Respondent was arrested for the crime of Criminal Sale of a Prescription for a Controlled Substance, a Class C Felony, under § 220.65 of the New York State Penal Law ["the Penal Law"] (Ex. 47, p. 2).

229. The felony charge was subsequently reduced to a misdemeanor - Attempted Criminal Diversion of Prescription Medications and Prescriptions in the Fourth Degree, a Class B Misdemeanor, under § 110/178.10 of the Penal Law (Ex. 47, pp. 1 and 2).

230. The superseding information containing the new misdemeanor charge specified that on March 24, 1999 at about 2:26 p.m. at 120 East Prospect Avenue, Mount Vernon, New York, the Respondent, a duly licensed physician, having never met Lt. John McCarthy before and never conducting any physical or mental examination to determine if Lt. McCarthy had a legitimate need for Alprazolam (Xanax), a controlled substance under Title IV of the Public Health Law, did knowingly attempt to sell Lt. McCarthy a prescription for Xanax in exchange for $50 U.S. currency (Ex. 47, p. 1).

231. On March 3, 2000, before Hon. Colleen D. Duffy in the City Court of Mount Vernon,

County of Westchester and State of New York, the Respondent, upon his plea of guilty, was convicted of the crime of Attempted Criminal Diversion of Prescription Medications and Prescriptions in the Fourth Degree, a Class B Misdemeanor, in violation of § 110/178.10 of the Penal Law (Ex. 47, pp. 2 and 3; Ex. H).

232. Immediately following the Respondent's guilty plea, the Respondent was sentenced to Probation for a term of one year and to pay Restitution in the amount of $335 (Ex. 47, pp. 2 and 3).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless otherwise specified.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, B, D, E, G, H, I, J, K, L, M, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF and GG, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did practice medicine with incompetence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients H, K, U, V, X and Y.

The Respondent did practice medicine with gross negligence on a particular occasion. The Petitioner has proved by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patients H, I, J, K, L, M, T, U, V, W, X, Y, Z and EE, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Respondent did practice medicine with gross incompetence. The Petitioner has proved by a preponderance of the evidence that the Respondent showed a total and flagrant lack of the necessary knowledge, skill or ability to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients H, U, V, X and Y.

The Respondent did practice medicine fraudulently or beyond its authorized scope. The Petitioner has proved by a preponderance of the evidence that there was an intentional misrepresentation or concealment of a known fact by the Respondent in connection with the Respondent's treatment of Patients D, E, H, J, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, FF and GG.

The Respondent did order excessive tests or treatment not warranted by the condition of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent inappropriately prescribed and/or provided a variety of controlled substances for Patients H, J, M, T, U, V, W, X, Y, Z, AA and FF.

The Respondent did fail to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent in connection with the Respondent's treatment of the Patients A, B, E, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA,

BB, CC, DD, EE, FF and GG, failed to maintain adequate records that accurately reflect the Respondent's evaluation and treatment of each of these patients.

The Respondent had been convicted of committing an act constituting a crime under New York state law. The Petitioner has proved by a preponderance of the evidence that the Respondent had been convicted of Attempted Criminal Diversion of Prescription Medications and Prescriptions in the Fourth Degree, a Class B Misdemeanor, under § 110/178.10 of the Penal Law.

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

The Petitioner relies primarily upon the factual testimony of Police Lieutenant John McCarthy and the medical testimony of Cheryl Seaman, M.D., and Jack Richard, M.D., in its efforts to establish its case against the Respondent. Lt. McCarthy testified about his involvement in an undercover police investigation and his attempts to purchase prescriptions

from the Respondent. Drs. Seaman and Richard testified with regard to the Respondent's medical care and treatment of the various patients listed in the Statement of Charges.

The Hearing Committee found Lt. McCarthy to be honest, straightforward and non-evasive. He was frank and direct and did not attempt to avoid difficult questions. Furthermore, his testimony was supported by other independent objective evidence. The Hearing Committee believes him and finds his testimony highly credible.

Following the testimony of Lt. McCarthy, the Petitioner presented Cheryl Seaman, M.D., as an expert in the field of psychiatry. Dr. Seaman is Board Certified in General Psychiatry, Geriatric Psychiatry and Adolescent Psychiatry and has an impressive medical background (Tr. 264-269; Ex 54). The Hearing Committee found Dr. Seaman to be a convincing and highly credible witness. She was knowledgeable, straightforward and non-evasive. She was also reflective and when she was asked a difficult question, it was apparent that she gave considerable thought to her answer. Furthermore, her testimony was balanced and unbiased.

The Petitioner presented Jack Richard, M.D., an expert in the field of internal medicine, as its final witness. Dr. Richard is Board Certified in Internal Medicine and Endocrinology & Metabolism and also has an impressive medical background (Tr. 758-760; Ex. 55). The Hearing Committee found Dr. Richard to be a convincing and highly credible witness. He was knowledgeable, organized and concise and his testimony was balanced and unbiased. Additionally, his testimony was straightforward and non-evasive.

The Hearing Committee unanimously agreed that Drs. Seaman and Richard were effective expert witnesses whose collective testimony was the most persuasive out of all the other medical testimony presented at this hearing.

The Respondent's case relies primarily on medical, factual and character type[2] evidence. The Respondent and ten additional witnesses - Sister Elizabeth J. Kolb, Father James Bernard Rosenblum Lloyd, Rabbi Ely J. Rosenzveig, Patient A, Michelle Flower, Patient E, Patient F, Samuel Pauker, M.D., Jesse Schomer, M.D. and Patient Z – testified in support of the Respondent's case.

Of the ten additional witnesses who testified on behalf of the Respondent, five - Sister Elizabeth J. Kolb, Father James Bernard Rosenblum Lloyd, Rabbi Ely J. Rosenzveig, Michelle Flower and Patient F[3] - were essentially character type witnesses who testified as to the Respondent's good character and/or his general custom or practice. These witnesses provided a series of testimonials about the Respondent, describing him as a dedicated, caring and skilled physician and an unselfish, altruistic and exemplary human being. Although these witnesses testified about their individual experiences with the Respondent and his favorable reputation in the community, in actuality their testimony shed no light on the Respondent's medical care and treatment of any of the patients listed in the Statement of Charges, was cumulative and competely irrelevant to the issues which are the subject of this hearing.

Three of the ten additional witnesses – Patient A, Patient E and Patient Z – were essentially factual witnesses. Although each of these witnesses highly praised the Respondent and the medical care and treatment that he provided, their individual testimony appeared rehearsed and did not have the ring of truth. At times each of these witnesses was furtive and evasive. They lacked objectivity and their testimony was unbalanced. Consequently, the Hearing Committee has strong reservations about the credibility of Patient A, Patient E and Patient Z.

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[2] Included in the character type evidence is evidence relating to the Respondent's general custom or practice.
[3] Patient F was not a factual witness since all of the factual allegations relating to the Respondent's medical

The two medical witnesses – Samuel Pauker, M.D. and Jesse Schomer, M.D. – provided medical testimony in favor of the Respondent.

Dr. Pauker is an assistant clinical professor of psychiatry at Cornell University Medical College, an assistant attending physician at New York Presbyterian Hospital and Pain Clinic, and on the faculty of the Columbia Analytic Center (Tr. 1316). Although he has impressive medical credentials, the Hearing Committee noted that the scope of his testimony was quite limited. He testified about a study group that he and the Respondent belong to (Tr. 1317) and the Respondent's treatment of Patient E, a patient that was referred to him by the Respondent after the Respondent's medical license had been suspended (Tr. 1330-1331). However, he admitted that he never reviewed the Respondent's medical records for Patient E and he was unaware that the Respondent had prescribed Oxycodone for Patient E (Tr. 1332-1334). Therefore, the Hearing Committee did not find his testimony very helpful.

Dr. Schomer, the Respondent's second medical witness, is Board Certified in Psychiatry and Child Psychiatry and has an excellent medical background (Tr. 1385-1387). Although he too has impressive medical credentials (Tr. 1385-1387), his testimony was also very limited. He testified about his professional relationship with the Respondent (Tr. 1387-1390) and the purpose and type of patient records that a psychiatrist should keep (Tr. 1392-1396). However, he admitted that he knows very little about the Respondent's practice (Tr. 1401). Consequently, he was unable to provide any insight into the Respondent's medical care and treatment of any of the patients listed in the Statement of Charges.

The Hearing Committee unanimously agreed that the testimony of Drs. Pauker and Schomer was unconvincing and of limited value to the resolution of the medical issues presented at this hearing.

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treatment of Patient F were withdrawn by the Petitioner on April 3, 2000. See note 5, *infra*.