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., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

October 9, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anthony M. Benigno, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237

Michael J. Teplitsky, M.D.
415 Oceanview Avenue
Brooklyn, New York 11235

Alan Lambert, Esq.
McAloon & Friedman, P.C.
123 William Street
New York, New York 10038

RE: In the Matter of Michael J. Teplitsky, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-269) 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.

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.

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,

Sean D. O'Brien/cah

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah
Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
	:	
OF	:	AND
	:	
MICHAEL J. TEPLITSKY, M.D.	:	ORDER
		BPMC #03-269

A Notice of Hearing, dated September 17, 2001 and a Statement of Charges, dated February 9, 2001, were served upon the Respondent, Michael J. Teplitsky, M.D. **WILLIAM J. MAHER, J.D. (CHAIR), RAVINDER MAMTANI, M.D., AND ELEANOR KANE, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Anthony M. Benigno, Esq., Associate Counsel. The Respondent appeared by McAloon & Friedman, P.C., Alan Lambert, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice Of Hearing:	September 17, 2001
Answer Filed:	September 21, 2001
Pre-Hearing Conference:	October 9, 2001
Hearing Dates:	October 18, 2001 November 21, 2001 January 25, 2002 February 15, 2002 February 22, 2002 March 1, 2002 March 15, 2002 May 2, 2002 July 24, 2002 July 25, 2002 August 14, 2002 September 13, 2002 September 27, 2002 October 4, 2002 November 15, 2002 November 22, 2002 December 13, 2002 January 17, 2003 January 24, 2003 February 28, 2003 March 7, 2003 March 14, 2003 May 16, 2003 May 23, 2003
Witnesses for Petitioner:	Robert Busch, M.D. Benjamin Kligler, M.D. Robert Shimm, M.D. George Harrington, M.D.
Witnesses for Respondent:	Michael J. Teplitsky, M.D. Eugene R. Shippen, III, M.D. Michael Schachter, M.D.
Deliberations Date:	July 10-11, 2003

STATEMENT OF CASE

Petitioner has charged Respondent with thirty-eight specifications of professional misconduct. The charges relate to Respondent's medical care and treatment of eight patients. The charges include allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, failure to maintain accurate records, and ordering excessive tests not warranted by the patients' conditions. Respondent denied the allegations.

A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

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

1. Michael J. Teplitsky, M.D. (hereinafter "Respondent"), was licensed to practice medicine in New York

State on July 15, 1986, by the issuance of license number 166986 by the New York State Education Department. (Ex. 3).

Patient A

2. Respondent treated Patient A, a male born on March 1, 1926 from approximately August 5,1997 through March 2, 1999 at Respondent's medical office. Patient A presented with a chief complaint of sexual dysfunction. (Ex. 4).

3. Respondent's differential diagnosis included hypothyroidism. In taking the patient's initial medical history, Respondent failed to document whether or not Patient A suffered from weight gain, constipation or joint aches and pains. (Ex. 4; T. 15).

4. An adequate medical history focuses a reasonably prudent physician's examination of the patient, and also focuses the physician's decisions regarding appropriate laboratory tests. (T. 15).

5. Respondent's failure to document whether or not Patient A suffered from weight gain, constipation or joint aches and pains (all possible symptoms of hypothyroidism) fell below generally accepted standards of medical practice. (T. 15).

6. A physician practicing complementary and alternative medicine (hereinafter "CAM"), has the same responsibilities as a

conventional practitioner regarding record keeping, history taking and physical examinations. (T. 747).

7. Respondent failed to examine Patient A's testicles despite a history of erectile dysfunction and the initiation of testosterone replacement therapy. A reasonably prudent physician must examine a patient's testicles to determine whether or not the testicles have atrophied, or been subjected to trauma. Respondent's failure to examine Patient A's testicles fell below generally accepted standards of medical practice. (T. 16, 18, 2491).

8. Respondent's failure to perform a follow-up digital rectal examination for seventeen months after initiating testosterone therapy fell below generally accepted standards of medical practice. (T. 2655-2656).

9. Respondent's failure to record Patient A's weight on a regular basis fell below generally accepted standards of medical practice. (T. 2514).

10. Respondent failed to record an accurate description of the condition of Patient A's thyroid gland, such as whether it was enlarged or had any nodules. (T. 16).

11. Respondent failed to record medication names and dosages. (T. 20; Ex. #4, p. 12).

12. At page 3 of Patient A's medical record, Respondent wrote the word "blood". He failed to indicate which blood tests were ordered. A subsequent treating physician would not know which tests had been ordered. (T. 21; Ex. #4, p. 3).

13. At page 19 of the medical record, Respondent indicated "discussed diet". A reasonably prudent physician must indicate the type of diet discussed, i.e., whether he prescribed a low calorie, high calorie, low-cholesterol, low fat or high fat diet. (T. 24; Ex. #4, p. 19).

14. Patient A had a testosterone level of 396 on August 5, 1997. This was well within the normal range of 240 to 1800 for a male of the same age. (T. 27; Ex. #4, p. 6).

15. Respondent inappropriately prescribed Androderm 5 mg. for Patient A despite his normal testosterone levels. Patient A had a history of benign prostatic hypertrophy, with a surgical history of a transurethral resection of the prostate (TURP). Respondent's prescription of Androderm for Patient A risked increasing the size of his prostate. (T. 26-30, 33-34, 748).

16. Respondent prescribed human growth hormone (Hgh) for Patient A. Patient A's level of insulin-like growth factor-1 (IGF-1) was 196. This level is at the upper end of the normal range for a male in his 70s. (T. 40; Ex. #4, p. 14).

17. Patient A did not have a condition approved by the United States Food and Drug Administration (FDA) for the use of human growth hormone, such as AIDS wasting, growth hormone deficiency, or a pituitary tumor. (T. 40, 750; Ex. #4, p. 14).

18. Respondent's prescription of Hgh for Patient A represented an "off label" use of the hormone. Generally accepted standards of medical practice required Respondent to record his reasons for using the hormone in this fashion, including the symptoms signs or laboratory values which prompted its use. Generally accepted standards of medical practice also required Respondent to document the patient's informed consent to the therapy. (T. 38-39, 823).

19. Respondent ordered vitamin B12 and folate assays despite the fact that the patient was not anemic. He ordered a series of vitamin levels, although there was no evidence of a suspected vitamin deficiency in the medical record. (T. 49).

20. Respondent ordered gastrin levels despite the absence of Zollinger-Ellison syndrome (a severe ulcer condition). (T. 51, 751).

21. Respondent ordered an Epstein-Barr virus capsid antigen study, as well as a Candida antigen study. These tests

were unnecessarily repeated in January, 1999. (T. 49, 752; Ex. #4, p. 32).

22. On August 5, 1997, Respondent obtained a series of thyroid function tests for Patient A. All thyroid values, including thyroid stimulating hormone (TSH) were within the normal range. TSH is the most sensitive indicator of the amount of thyroid hormone available in the body. (T. 52-53,754, 793-794; Ex. #4, p. 6; Ex. #27).

23. Despite the patient's normal thyroid levels, Respondent began treating Patient A with thyroid hormone on August 19, 1997. Two months after beginning treatment, the patient's thyroid levels were elevated, and the TSH level was low, indicating that the patient was hyperthyroid. Nevertheless, Respondent continued to inappropriately prescribe thyroid hormone for Patient A. (T. 54-56, 755; Ex. #4, p. 25).

Patient B

24. Respondent treated Patient B, a male born on August 29, 1951, from approximately August 26, 1997 through December 1, 1998, at Respondent's medical office. Patient B presented with a history including, but not limited to: occasional hypertension, stomach pains, frequent diarrhea, decreased libido, and decreased energy. (Ex. #5).

25. Respondent failed to record a chief complaint for Patient B. (Ex. #5, p. 2).

26. Respondent failed to record an adequate history regarding the patient's hypertension. He failed to obtain and record any history regarding chest pains and headaches. Respondent failed to record sufficient history concerning the diagnosis of hypothyroidism. Given the patient's history of decreased libido, Respondent should have noted the presence or absence of morning erections. He failed to do so. (T. 606-611).

27. At page 3 of the medical record, Respondent failed to indicate the status of any of the systems listed under the heading "review of systems". He failed to record the patient's height. (Ex. #5).

28. Respondent failed to examine Patient B's testicles and conduct a rectal examination, despite the history of decreased libido. (T. 2719-2720).

29. Respondent failed to document whether the patient's thyroid gland was enlarged. Merely noting "no nodules" does not provide sufficient information regarding the thyroid. (T. 611-613).

30. At page 3 of Patient B's medical record, Respondent wrote the word "blood". He failed to indicate which

blood tests were ordered. Respondent also noted "Disc. Diet" without any further information regarding the type of diet. (Ex. #5).

31. Patient B was not growth hormone deficient. His IGF-1 level was 280 on November 18, 1997 and 352 on March 3, 1998. These are at the upper end of the normal range for a 46 year old male. (T. 842; Ex. #5, pp. 14, 18).

32. On July 7, 1998, Respondent initiated treatment with Hgh for Patient B. Respondent's prescription of Hgh for Patient B represented an "off label" use of the hormone. Generally accepted standards of medical practice required Respondent to record his reasons for using the hormone in this fashion, including the symptoms signs or laboratory values which prompted its use. Generally accepted standards of medical practice also required Respondent to document the patient's informed consent to the therapy. Respondent failed to record his reasons for administering Hgh to Patient B, nor to record the patient's informed consent. (T. 38-39, 823).

33. Respondent prescribed testosterone to Patient B despite elevated liver enzymes. A reasonably prudent physician would have repeated the liver function tests. Instead, Respondent prescribed testosterone for Patient B on February 3, 1998, March 17, 1998 (at an increased dosage), May 12, 1998 and

July 7, 1998. Respondent failed to repeat the liver function tests until July 21, 1998. (T. 836-839; Ex. #5, pp. 4, 21-23).

34. On September 24, 1998, Patient B reported to Respondent that he had stopped taking human growth hormone because it was too expensive. However, on December 1, 1998, Respondent ordered another IGF-1 test. There was no medical justification for ordering this test. (T. 841, 2699, 2761; Ex. #5).

35. Patient B's cholesterol level on August 26, 1997 was 257 - an elevated value. On October 7, 1997, the patient's LDL level was 186 - also an elevated value. His cholesterol/LDL ratio was 7.06 on October 7, 1997. The ratio was 8.64 on November 18, 1997, and 9.44 on January 5, 1998. These ratios, coupled with the patient's other risk factors (obese male over 45, hypertensive, with a sedentary lifestyle), placed Patient B at an above average risk for coronary disease. (T. 851; Ex. #5, pp. 2-3, 12, 14, 16).

36. Generally accepted standards of medical practice in 1998 required Respondent to offer Patient B a three to six month trial of lifestyle approaches (diet and exercise) to reduce the LDL. If these lifestyle changes were not sufficient to lower the LDL to 160, a reasonably prudent physician would offer medication to treat the condition. On July 21, 1998,

Patient B's LDL cholesterol level was 164. At no point did Respondent place Patient B on cholesterol-lowering medication. (T. 854-855; Ex. #5, p. 23).

Patient C

37. Respondent treated Patient C, a 65 year old female at his medical office, beginning on November 14, 1991. Patient C presented with a chief complaint of "Heart-Arthritis". She had a history of frequent bouts of paroxysmal atrial tachycardia (PAT), chest pain/angina, arthritis, diabetes, lupus, and constipation. (Ex. #6, p. 2).

38. Given the patient's reported medical history of heart disease, generally accepted standards of medical practice required Respondent to inquire and document the nature and frequency of her chest pain. Similarly, generally accepted standards of medical practice required Respondent to inquire whether Patient C was currently suffering from palpitations, and when they first began. Respondent should also have obtained further history regarding the patient's diabetes, and whether she was suffering from rheumatoid arthritis or osteoarthritis. Respondent should have determined the dosage of Calan SR which the patient reported taking. No such inquiries are reflected in the patient's medical record for the initial history obtained by Respondent. The history taken by Respondent fell below

generally accepted standards of medical practice. (T. 462-467, 3005-3010; Ex. #6).

39. Respondent's initial physical examination of Patient C fell below generally accepted standards of medical practice. He failed to examine the patient's heart, and also failed to examine her extremities and joints despite a history of arthritis. (T. 467-470).

40. At page 3 of Patient C's medical record, Respondent wrote the word "blood". He failed to indicate which blood tests were ordered. (Ex. #6).

41. On September 17, 1997, Respondent noted "Diet. Trial of HGH", without any further information regarding the type of diet and dosage of Hgh. (T. 3025; Ex. #6, p. 15). This fell below generally accepted standards of medical practice. (T. 473).

42. Respondent's prescription of Hgh for Patient C represented an "off label" use of the hormone. Generally accepted standards of medical practice required Respondent to record his reasons for using the hormone in this fashion, including the symptoms signs or laboratory values which prompted its use. Generally accepted standards of medical practice also required Respondent to document the patient's informed consent to the therapy. Respondent failed to record his reasons for

administering Hgh to Patient C, nor to record the patient's informed consent. (T. 38-39; Ex. #6).

43. Patient C's cholesterol level on November 14, 1991 was 383. This is a very high total cholesterol level in light of the patient's history of heart disease and diabetes. (T. 473).

44. Based upon the medical record, it appears that Patient C was also being treated by a cardiologist. The cardiologist would be expected to monitor and treat Patient C's lipid levels. (T. 905-906, 911; Ex. #6).

45. Patient C presented with a history of arthritis and diabetes. Her initial IGF-1 level was 382. This is 92 points above the reference range for a female of her age. A reasonably prudent physician should have considered a diagnosis of acromegaly. (T. 480, 892; Ex. #6).

46. Instead of attempting to rule out acromegaly, Respondent initiated treatment with Hgh. Hgh was contraindicated for Patient C. (T. 483, 922-923; Ex. #6).

47. Respondent ordered a prostate-specific antigen (PSA) test for Patient C. Since the patient is a female, this test was ordered without medical justification. (T. 487-488; Ex. #6).

48. Respondent ordered Epstein-Barr Virus (EBV) levels on July 30, 1997. Despite normal values, Respondent repeated the test on March 30, 1998, without medical justification. Respondent ordered Estradiol levels in this post-menopausal woman, which could yield no meaningful information. He then repeated the test, without medical justification. Respondent ordered Anti-Candida testing without medical justification. (T. 488-491, 894-895, 2863; Ex. #6).

49. Despite normal thyroid levels, Respondent prescribed thyroid hormone for Patient C. This was contraindicated for a patient with a history of cardiac arrhythmia. (T. 496-498, 896-897, 920-922; Ex. #6).

Patient D

50. Respondent treated Patient D, a female, from approximately January 3, 1996 through March 31, 1999. Patient D presented with a history of thyroidectomy, osteoporosis and hypothyroidism. (Ex. #7).

51. Respondent failed to record the patient's age and sex, or to note a chief complaint. Respondent noted a history of headaches, but failed to elicit further history regarding the quality or frequency of the headaches. He noted a history of bowel problems without obtaining any further information as to the nature of the problems. (T. 656-666; Ex. #7, pp. 2-3).

52. Respondent examined the patient's blood pressure, pulse, thyroid, heart and abdomen at the initial visit on January 3, 1996. The patient was not seen by Respondent again until January 7, 1997. At that time, he conducted another physical examination. The examinations performed by Respondent did meet generally accepted standards of medical practice. (T. 704, 708, 710; Ex. #7, 3-4).

53. At pages 3 and 4 of Patient D's medical record, Respondent wrote the word "blood". He failed to indicate which blood tests were ordered. (Ex. #7).

54. During the January 3, 1996 office visit, Respondent wrote "Diet" under the heading "Plans". He failed to indicate the type of diet prescribed. (Ex. #7).

55. Patient D presented to Respondent with a pre-existing diagnosis of osteoporosis. She was taking a calcium supplement, DHEA, estrogen, progesterone and testosterone, all of which were prescribed for her by the physician managing this condition. (T. 1755-1756; Ex. #7, pp. 2-3, 14, 18).

56. When Patient D presented to Respondent, she was already taking Synthroid. It is common for patients with a history of thyroidectomy to need thyroid hormone supplementation. (T. 718; Ex. #7).

57. The thyroid levels reported to Respondent on January 22, 1997 indicated that the patient was taking too much thyroid. On April 23, 1997, Respondent appropriately recommended that the patient decrease the dosage of thyroid supplement that she was taking. The patient refused. Respondent appropriately recommended an endocrinology consultation. (T. 719-724; Ex. #7).

58. When the patient presented to Respondent on April 2, 1998, she was taking Armour thyroid supplement, 4 grains, as prescribed by another physician. Laboratory studies performed at that visit demonstrated that the patient was still taking too much thyroid hormone. Respondent appropriately recommended decreasing the dose to 3 grains. (T. 724-725; Ex. #7, pp.14, 16).

59. Patient C's IGF-1 levels on January 8, 1997 and April 2, 1998 were 174 and 175, respectively. These values are well within the normal reference range for a female of her age. Patient C was not growth hormone deficient. (T. 682-683; Ex. #7).

60. On April 9, 1998, Respondent prescribed Hgh, 4 units per week for Patient D. Respondent's prescription of Hgh for Patient D represented an "off label" use of the hormone. Generally accepted standards of medical practice required

Respondent to record his reasons for using the hormone in this fashion, including the symptoms signs or laboratory values which prompted its use. Generally accepted standards of medical practice also required Respondent to document the patient's informed consent to the therapy. Respondent failed to record his reasons for administering Hgh to Patient D, nor to record the patient's informed consent. (T. 38-39; Ex. #7).

61. Patient D was taking testosterone, as prescribed by another physician. Respondent tested the patient's testosterone levels, unnecessarily, since he was not prescribing the hormone for the patient. (Ex. #7).

Patient E

62. Patient E, a male born on December 10, 1926, presented for treatment at Respondent's medical office from September 8, 1997 through November 4,1998. He presented with a history of arteriosclerosis, hypertension, TIAs, myocardial infarction, congestive heart failure and an irregular heartbeat. (Ex. #8).

63. The list of medications which Patient E described for Respondent at the initial visit demonstrated that he was being treated by a cardiologist for his various cardiac conditions. (T. 807; Ex. #8).

64. Respondent testified that Patient E was under the care of a cardiologist and other physicians, and came to him to find out if there were any alternatives in terms of nutrition, lifestyle modification, and vitamin/mineral supplementation which might improve his condition. (T. 1858).

65. Given that the patient came to see Respondent for another opinion in his capacity as a CAM physician, the history taken by Respondent was adequate. (T.811, 1858, 3138-3139).

66. Respondent did not perform a physical examination at the initial visit on September 8, 1997, although he did order and perform a number of laboratory studies. (Ex. #8).

67. Respondent did perform an adequate physical examination at the next office visit on September 24, 1997, at which time the laboratory results were also reviewed with the patient. Respondent did not make any treatment recommendations prior to the performance of the physical examination on September 24. (T. 820, 1863-1865, 3140-3141; Ex. #8).

68. On occasion, physicians obtain an initial medical history and bring the patient back to the office for an extensive physical examination because of time constraints. (T. 3140).

69. Respondent's treatment plan for Patient E included "Diet". He failed to indicate the type of diet prescribed. (Ex. #8).

70. Respondent ordered laboratory studies without any documentation in the progress notes as to the nature of tests ordered. (Ex. #8).

71. Respondent's treatment plan for Patient E included Hgh, 4 units per week. Respondent's prescription of Hgh for Patient E represented an "off label" use of the hormone. Generally accepted standards of medical practice required Respondent to record his reasons for using the hormone in this fashion, including the symptoms signs or laboratory values which prompted its use. Generally accepted standards of medical practice also required Respondent to document the patient's informed consent to the therapy. Respondent failed to record his reasons for administering Hgh to Patient E, nor to record the patient's informed consent. (T. 38-39; Ex. #8).

72. Respondent ordered several laboratory studies, including Epstein-Barr virus titers, anti-Candida, and Estradiol levels, without adequate medical justification in the medical record. (T. 2891-2892, 2895-2996; Ex. #8).

Patient F

73. Patient F, a female born on October 27,1961, presented to Respondent's medical office with a history of hypothyroidism, fatigue and headaches. Her chief complaints were hypothyroidism, weight gain and fatigue. She reported that she was taking Synthroid, .325 mg. (Ex. #9, p. 2).

74. Patient F was taking a very high dose of Synthroid. Respondent should have obtained a more detailed history of her thyroid-related symptoms. Merely checking boxes for palpitations, fatigue, dizziness and headache on a pre-printed history form does not provide sufficient information. The medical history which Respondent obtained for Patient F did not meet generally accepted standards of medical practice. (T. 860-862; Ex. #9, p. 2).

75. Respondent performed and documented a physical examination of the patient on her initial visit. He obtained the patient's height, weight, blood pressure, pulse and temperature. He examined her skin, thyroid gland, heart, lungs, and abdomen. He examined her extremities, and tested her Achilles reflexes. The physical examination met generally accepted standards of medical practice. (T. 891, 892, 894, 3198; Ex. #9).

76. Respondent's treatment plan for Patient F included "Blood" and "Diet". He failed to document the blood tests ordered, or the type of diet prescribed for the patient. (E. #9).

77. During the entire course of Respondent's treatment of Patient F, her TSH levels were extremely low (0.08<), indicating a hyperthyroid condition. (Ex. #9).

78. Patient F reported symptoms of fatigue and weight gain. On physical examination, Respondent noted that she had dry skin and decreased deep tendon reflexes. These findings are suggestive of hypothyroidism. (T. 880, 2020; Ex. #9).

79. Respondent referred Patient F to an endocrinologist, but failed to make any attempt to follow up with the consultant regarding the management of this patient. Instead, Respondent continued to treat Patient F with Armour thyroid, 6 grains. Respondent's management of Patient F's thyroid condition fell below generally accepted standards of medical practice. (T. 865-875; Ex. #9).

80. On July 29, 1997, Patient F's IGF-1 level was 299 - well within the normal range for a 35 year old female. The patient was not growth hormone deficient. On August 12, 1997, Respondent prescribed Hgh for Patient F. Respondent's prescription of Hgh for Patient F represented an "off label" use

of the hormone. Generally accepted standards of medical practice required Respondent to record his reasons for using the hormone in this fashion, including the symptoms signs or laboratory values which prompted its use. Generally accepted standards of medical practice also required Respondent to document the patient's informed consent to the therapy. Respondent failed to record his reasons for administering Hgh to Patient F, nor to record the patient's informed consent. (T. 38-39, 875; Ex. #9).

81. Respondent ordered a number of laboratory studies during Patient F's initial visit on July 29, 1997. The tests included testosterone, vitamin B1 and B2, EBV titers, red cell magnesium, vitamin C, DHEA, FSH, LH, gastrin, and anti-Candida titers. (Ex. #9).

82. Despite receiving essentially normal results on the July 29, 1997 tests, Respondent repeated the testosterone, DHEA, FSH, and LH levels on September 9, 1997. On November 25, 1997, Respondent repeated the FSH, LH and DHEA tests. On January 13, 1998, Respondent repeated the FSH, LH, vitamin assays, ferritin, EBV and anti-Candida titers. There was no medical justification cited in the record for any of these repeated tests. (T. 876-879; Ex. #9).

Patient G

83. Patient G, a female born on March 9, 1931, presented for treatment at Respondent's medical office from approximately July 8, 1997 through April 15, 1999. She presented with a history of fibrocystic breasts, fatigue and intestinal pain. (Ex. #10).

84. Respondent included hypothyroidism and chronic fatigue syndrome ("CFS") under his impressions at the initial office visit. Respondent failed to obtain any additional history regarding these possible diagnoses. Respondent also listed chronic obstructive pulmonary disease ("COPD") under his impressions. He failed to obtain any history regarding shortness of breath which might support such a diagnosis. The initial history obtained by Respondent did not meet generally accepted standards of medical practice. (T. 931-933, 3276; Ex. #10).

85. At the initial visit, Respondent failed to determine the patient's height, weight, pulse and blood pressure. He failed to adequately examine the patient's thyroid gland. Respondent's initial physical examination of Patient G did not meet generally accepted standards of medical practice. (T. 933-935, 3252, 3276; Ex. #10).

86. Respondent's treatment plan for Patient G included "Blood" and "Diet". He failed to document the blood tests ordered, or the type of diet prescribed for the patient. (Ex. #10).

87. On July 8, 1997, Patient G's IGF-1 level was 124. This was well within the normal reference range (71-290) for a 61 year old female. The patient did not have symptoms of growth hormone deficiency. On July 22, 1997, Respondent prescribed Hgh for Patient G. (T. 935; Ex. #10, pp. 7, 14).

88. Respondent's prescription of Hgh for Patient G represented an "off label" use of the hormone. Generally accepted standards of medical practice required Respondent to record his reasons for using the hormone in this fashion, including the symptoms signs or laboratory values which prompted its use. Generally accepted standards of medical practice also required Respondent to document the patient's informed consent to the therapy. Respondent failed to record his reasons for administering Hgh to Patient G, nor to record the patient's informed consent. (T. 38-39; Ex. #10).

89. On December 16, 1997, Patient G reported that she had stopped taking all of her prescribed medications. On February 17, 1998, she reported that she was interested in Hgh. The record does not indicate that Respondent prescribed Hgh for

her. However, on October 20, 1998 Patient G reported that she discontinued the Hgh therapy again. Respondent failed to record the re-initiation of the Hgh therapy. (T. 935-938; Ex. #10, pp. 15, 21, 23).

90. Respondent ordered a DHEA sulfate level for Patient G without medical indication, as the patient was not being treated with either DHEA or testosterone. (T. 3266-3267).

91. Respondent ordered EBV and anti-Candida titers on January 15, 1998, October 20, 1998 and April 15, 1998 without medical indication. (T. 2921-2922).

92. Respondent ordered testosterone levels for Patient G on July 8, 1997, August 26, 1997 and April 15, 1999 without medical indication. (T. 942-944).

93. Respondent ordered FSH and LH levels for Patient G on July 8, 1997, August 26, 1997, January 25, 1998, October 20, 1998, and April 15, 1999. These tests were unnecessary as a reasonably prudent physician would not order FSH and LH levels for a postmenopausal woman in her sixties. (T. 3259, 3265; Ex. #10).

Patient H

94. Patient H, a male born on October 29, 1955, presented at Respondent's medical office from August 13, 1997 through September 13, 1997. He presented with a history of

possible decreased libido, headaches and previous anabolic steroid use. (Ex. #11; Ex. #29).

95. The history obtained by Respondent included information regarding his past medical history, drug allergies, current medications, family history of hypertension, sleep cycle and history of insomnia, drinking and smoking history, and drug history. (T. 992, 994-995, 1003-1004 3300; Ex. #11).

96. Respondent failed to determine and record the patient's height and weight. (Ex. #11).

97. Respondent failed to examine Patient H's testicles and his thyroid gland, despite his complaints of decreased libido and possible hormonal imbalance. This failed to meet generally accepted standards of medical practice. (T. 983-984; Ex. #11).

98. Respondent's treatment plan for Patient H included "Blood". He failed to document the laboratory tests which were ordered. (Ex. #11).

99. Patient H expressed an interest in trying Hgh. His IGF-1 level on August 13, 1997 was 240. This was well within the reference range (90-360) for a 41 year old male. (Ex. #11, pp. 5, 8-9).

100. On August 26, 1997, Respondent prescribed Hgh, 4 units per week for Patient H. Respondent's prescription of Hgh

CONCLUSIONS OF LAW

Respondent is charged with thirty-eight specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the

purpose of which is sole to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). Gross negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave

consequences to the patient. Post, *supra*, at 986; Minielly, *supra*, at 751.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. The Petitioner presented two expert witnesses. Robert Busch, M.D. is board certified in endocrinology. Dr. Busch gave concise, reasoned and objective testimony throughout the hearing, even during protracted and exhaustive cross-examination. Dr. Busch acknowledged that he has no direct expertise in the field of complementary and alternative medicine, and that he gave opinions based on his expertise in endocrinology. He has no stake in the outcome of the case, and no evidence of bias against Respondent was presented. The Hearing Committee found Dr. Busch to be a highly credible witness.

Petitioner also presented testimony by Benjamin Kligler, M.D. Dr. Kligler is the associate medical director of the Beth Israel Continuum Center for Health and Healing, and is

co-director of Beth Israel's fellowship program in integrative medicine. He also serves as associate editor of the Journal of Alternative Therapies in Health and Medicine, a peer reviewed journal of integrative medicine. Dr. Kligler is an expert in CAM. His testimony was objective, reasoned and fair. Based on his testimony that Respondent's treatment of Patient B's thyroid condition met acceptable standards of practice for a CAM physician, Petitioner withdrew the charges relating to that treatment. The Hearing Committee found Dr. Kligler to be a highly credible witness.

Petitioner also presented the testimony of Robert Shimm, M.D. and George Harrington, M.D. Their testimony was limited to the facts and circumstances of their investigative interviews with Respondent. The Committee found both doctors to be credible witnesses. However, their testimony was extremely limited in scope, and had no significant bearing on the outcome of this Committee's deliberations.

Respondent presented two expert witnesses, and also testified on his own behalf. Eugene R. Shippen, III, M.D. was presented as an expert on CAM use of hormones and hormonal therapies, particularly testosterone and human growth hormone. He also testified regarding Respondent's overall care of the named patients. Although Dr. Shippen claimed to be an expert in

the management of hormones, he is not board certified in endocrinology. In fact, he is not currently board certified in any medical specialty. Dr. Shippen's certification in family practice lapsed in 1985. There were several troubling issues raised by Dr. Shippen's testimony.

Dr. Shippen was habitually unable to give direct and concise answers to the questions posed by either counsel, as well as the Hearing Committee. Of greatest concern to the Committee is the fact that Dr. Shippen repeatedly stated that there were no written standards of acceptable medical practice. As a result, he was unable to identify appropriate standards by which to judge Respondent. Even so, on several occasions, Dr. Shippen testified that Respondent failed to take and record appropriate medical histories, or conduct adequate physical examinations. On balance, the Hearing Committee did not find Dr. Shippen to be a particularly credible witness.

Michael Schachter, M.D. also testified on Respondent's behalf. Dr. Schachter is board certified in psychiatry and neurology. He is a former president of the American College of Advancement in Medicine ("ACAM") and the Foundation for the Advancement of Innovative Medicine ("FAIM"). Dr. Schachter's testimony focused on the laboratory testing practices of CAM practitioners. Although he testified as a witness for

Respondent, on several occasions he questioned the appropriateness of the laboratory studies ordered by Respondent. Although he was not a very strong witness, the Hearing Committee gave some weight to Dr. Schachter's testimony.

Respondent also testified on his own behalf. He has an obvious stake in the outcome of this hearing. Although he claims to be a CAM practitioner, Respondent has no formal training in complementary and alternative medicine. He was extremely evasive when answering questions, even by his own counsel. He repeatedly made long, convoluted statements on the physiologic mechanisms of hormones without actually answering the questions. He spoke very glibly, almost as if he were making a presentation to a lay audience, rather than testifying at a disciplinary proceeding.

Respondent repeatedly testified in detail about physical examination findings and conversations with patients that were not documented in the medical records, particularly concerning the area of informed consent. The Hearing Committee did not find this testimony to be believable. For all of the reasons cited above, the Hearing Committee unanimously concluded that Respondent was not a credible witness, and gave little weight to his testimony.

Respondent has sought to portray himself as a CAM practitioner. Certainly, the New York State Education Law contemplates the practice of non-conventional, or complementary, medicine. *See*, Education Law §6527(4)(e). However, any licensed physician, whether a conventional or CAM practitioner, must adhere to the same standards of care applicable to all physicians practicing in this state. *See*, Matter of Gonzalez v. New York State Department of Health, 232 A.D.2d 886 (3rd Dept. 1996); *See also*, Gant v. Novello, 302 A.D.2d (3rd Dept. 2003). Based on the totality of the record, the Hearing Committee unanimously concluded that Respondent failed to meet the minimum standards of care for each of the named patients.

Much time and effort was expended during the proceedings regarding Respondent's use of low doses of human growth hormone. Respondent virtually flooded the record with journal articles purporting to show the benefits of such treatment. However, all of the articles submitted dealt with the possible benefits of significantly *higher* doses of growth hormone, when administered to growth hormone-deficient patients under controlled laboratory conditions.

None of the patients at issue in this case were growth hormone-deficient, as established by credible laboratory testing. Respondent produced no credible clinical research

demonstrating the benefit of low dose treatment of human growth hormone to non-hormone deficient patients. Respondent claimed that his use of human growth hormone, in an "off label" manner, was consistent with a CAM approach seeking to "optimize" a patient's condition.

Generally accepted standards of medical practice required Respondent to obtain informed consent from his patients before treating them with Hgh in this manner. Such informed consent can be obtained only after discussing the possible benefits as well as the possible risks of the treatment. The informed consent must then be clearly documented in the medical record. Contrary to Respondent's assertions, this need not necessarily entail a formal consent form, as might be used for a surgical procedure.

None of the patient records reviewed contained any indication that informed consent was obtained from any of the patients. Respondent claimed to have discussed the risks as well as benefits of treatment with each patient. However, the Hearing Committee frankly found this testimony not credible.

Documentation prepared by Respondent for his patients (Exhibits #31 and #32) extol the supposed virtues of human growth hormone. For example, Exhibit #32, which is entitled "Anti-Aging Therapy", states, in pertinent part, "Growth hormone

may well be the proverbial fountain of youth, the magic bullet of aging. Thousands of studies confirm that it can prevent and even reverse the aging process." Nowhere in either of these documents does Respondent disclose any of the potential side effects of growth hormone, or the fact that the results claimed were only obtained by individuals taking much higher doses of hormone than offered by Respondent. The Hearing Committee unanimously concluded that Respondent's failure to obtain and document informed consent from his patients constituted negligence, incompetence, and a failure to maintain records which adequately reflected the care and treatment rendered to each patient.

Respondent essentially took the position that the purpose of medical records was to refresh his own recollection of the patients' history and treatment. However, the purpose of medical records is, "at least in part, to provide meaningful medical information to other practitioners should the patient transfer to a new physician, or should the treating physician be unavailable for any reason". Schwarz v. Board of Regents, 89 A.D.2d 711 (3rd Dept. 1982). An objective review of Respondent's medical records revealed that they are seriously deficient. As previously, discussed, there is no documentation in any of the patient records indicating that informed consent was obtained by

Respondent prior to initiating treatment with human growth hormone. Further, in each of the records, Respondent made vague notations such as "blood" and "diet. There is no description of which blood tests were ordered, or what diet recommendations were made for each patient. Additionally, Respondent frequently failed to record weight and height measurements for his patients, as well as medication names and dosages.

The deficiencies in Respondent's medical care for each of Patients A through H will next be examined in greater detail.

Patient A

This 71 year-old male presented with a complaint of sexual dysfunction. Respondent instituted treatment with testosterone despite normal testosterone levels. He failed to examine the patient's testicles to rule out any organic pathology before starting the treatment. Respondent failed to elicit any history of possible psychological causes for the dysfunction. He also failed to perform a follow-up digital rectal examination for seventeen months following the commencement of treatment, despite the patient's history of benign prostatic hypertrophy.

Respondent diagnosed Patient A as being hypothyroid. He made this diagnosis without eliciting any history of possible symptoms of hypothyroidism, such as weight gain, constipation or

joint aches or pains. Respondent also failed to examine and record an accurate description of the patient's thyroid gland. Despite normal levels of thyroid hormone at the patient's initial visit, Respondent initiated treatment with thyroid hormone.

Respondent obtained an IGF-1 level for Patient A. The result (196) was at the upper end of the normal range for a patient of Patient A's age. Respondent failed to obtain and document informed consent before beginning treatment with Hgh. Respondent ordered repeat Epstein-Barr and Candida antigen studies for Patient A without adequate justification.

As was noted previously, Respondent noted "blood" and "diet discussed" in the medical record without any elaboration as to what blood studies were ordered or the type of diet to be followed. The Hearing Committee concluded that Factual Allegations A through A.7, as set forth in the Statement of Charges, should be sustained. The Committee further concluded that the allegations of negligence, incompetence, inadequate records, and unnecessary testing regarding this patient should also be sustained. The Committee further concluded that Respondent's misconduct did not rise to the level of either gross negligence or gross incompetence, as defined above.

Patient B

Patient B presented with a history of occasional hypertension, stomach pains, frequent diarrhea, decreased libido and decreased energy. Respondent failed to obtain an adequate initial history regarding these complaints. When performing his initial physical examination of the patient, Respondent failed to examine Patient B's testicles and perform a rectal examination, despite the complaint of decreased libido. In the absence of such an examination, it was inappropriate to treat the patient with testosterone.

Respondent also failed to document an adequate examination of the patient's thyroid gland, and did not record the patient's height. Despite the absence of demonstrated growth hormone deficiency, Respondent treated Patient B with Hgh. He failed to obtain and document informed consent for the treatment. After the patient discontinued the treatment, Respondent performed an IGF-1 study. This test was unnecessary, since the patient was no longer taking the growth hormone.

Patient B's initial cholesterol level on August 26, 1997 was significantly elevated (257). In October, 1997, his LDL level was elevated at 186. Throughout Respondent's treatment of Patient B, his LDL levels remained elevated. Respondent failed to offer any cholesterol lowering medication,

such as statins, to Patient B. Respondent claimed that he was not primarily treating the patient's cholesterol. However, having performed the cholesterol studies, it was incumbent upon Respondent to either offer medication, after a six month trial of lifestyle modification and diet, or offer to refer Patient B to another physician to manage his cholesterol.

The Hearing Committee concluded that Factual Allegations B.1 through B.8 (with the exception of B.7, which was withdrawn by Petitioner) should be sustained. The Committee further concluded that the specifications of negligence, incompetence, unnecessary testing, and failure to maintain records should also be sustained.

Patient C

Patient C reported an initial history of numerous significant health problems. Respondent's initial history failed to obtain adequate information about the patient's conditions, and her current situation. He failed to examine Patient C's heart or her joints during his initial examination.

Patient C's initial IGF-1 level was 92 points above the reference range for a patient of her age. This should have prompted Respondent to rule out acromegaly. Instead, he began treatment with Hgh. This was directly contraindicated for

Patient C. Moreover, as in Patients A and B, Respondent failed to obtain and document informed consent for the treatment.

Respondent prescribed thyroid hormone for Patient C, despite normal levels, and a history of cardiac arrhythmias. The use of thyroid hormone was contraindicated for this patient.

Respondent also ordered numerous tests for Patient C, that were without any medical justification. He ordered a prostate-specific antigen test for this female patient. He also ordered Estradiol levels, which could yield no meaningful information in a post-menopausal women. He repeated an Epstein-Barr virus test, despite normal results on an earlier study, and ordered anti-Candida testing without justification.

The Hearing Committee concluded that all of the factual allegations regarding Patient C should be sustained, with the exception of Allegation C.4. The medical record established that Patient C was also being followed by a cardiologist. Respondent could have reasonably expected the cardiologist to manage Patient C's cholesterol levels. Nevertheless, the Committee concluded that, based upon the remaining allegations, the specifications of negligence, incompetence, unnecessary testing, and failure to maintain records were sustained.

Patient D

The primary problems with Respondent's initial history for Patient D involve a lack of sufficient information regarding the patient's history of headaches and bowel problems. Additionally, Respondent failed to note such basic information as the patient's age and sex. The physical examinations conducted by Respondent did meet the minimum standard of care. Respondent's medical record for Patient D failed to meet minimum standards, because of the lack of documented informed consent for the use of Hgh, as well as the lack of specificity regarding diet and laboratory studies, as previously cited. Based on the above, the Hearing Committee concluded that Factual Allegations D.1, D.3, and D.6 were sustained, and that Allegation D.2 was not sustained.

Petitioner alleged that Respondent failed to appropriately manage Patient D's osteoporosis. However, the record established that this condition was being managed by another physician. Therefore, this allegation (D.4) was not sustained. Petitioner further alleged that Respondent failed to appropriately manage Patient D's pre-existing thyroid condition.

This condition was initially managed by another physician. Upon receiving a report of abnormal thyroid levels, Respondent appropriately recommended a decrease in the dosage of

thyroid hormone. The patient rejected this recommendation. Based on a review of the medical records, it appears that Respondent did not actually take over the management of Patient D's thyroid condition until April 2, 1998. The laboratory studies performed at that time showed that the patient was still taking too much thyroid hormone, as prescribed by another physician. Respondent again appropriately recommended a decreased dose. As a result, the Hearing Committee concluded that this factual allegation (D.5) was not sustained.

Respondent ordered a testosterone level for Patient D. Since he was not prescribing testosterone for the patient, the Committee concluded that the test was unnecessary, and sustained factual allegation D.7. The Committee further concluded that the factual allegations sustained regarding Patient D demonstrated both negligence and incompetence, as defined previously. The Committee also sustained the specifications of failure to maintain records and ordering of unnecessary tests.

Patient E

Patient E was under the care of other physicians, and came to Respondent in his capacity as a CAM physician, in order to explore alternative therapies for his multiple problems. Under those circumstances, the Hearing Committee found that the initial history taken by Respondent met minimum standards.

Respondent did not perform a physical examination at the first visit. He ordered various, albeit unspecified, laboratory studies. He deferred the physical examination, as well as any treatment recommendations, until the second visit. At this time, Respondent performed an adequate physical examination, and reviewed the laboratory results with the patient. The Committee concluded that Factual Allegations E.1 and E.2 were not sustained.

Patient E was not growth hormone deficient. Nevertheless, Respondent initiated treatment with Hgh, without first obtaining and documenting informed consent. This constituted a deviation from accepted standards of practice. In addition, Respondent failed to document the nature of laboratory studies ordered, and the type of diet recommended for this patient. As a result, the Hearing Committee sustained Factual Allegations E.3 and E.5.

Respondent failed to confer with Patient E's cardiologist before beginning treatment with Hgh. However, the low doses of Hgh administered were unlikely to have any negative impact on the patient's cardiac status. Accordingly, the Committee concluded that the failure to confer with the cardiologist did not constitute a deviation from minimum standards of care, and did not sustain Allegation E.4.

Respondent ordered Epstein-Barr virus and Candida studies for Patient E. Even his own expert, Dr. Schachter, questioned the need for these tests. The Committee concluded that these tests were unwarranted by the patient's condition, and sustained Factual Allegation E.6. The Committee further concluded that the specifications of negligence, incompetence, unnecessary testing, and failure to maintain records were sustained.

Patient F

When Patient F first presented to Respondent's office, she was already taking a very high dose of Synthroid. Given the symptoms which she reported, i.e., palpitations, fatigue, dizziness and headache, it was incumbent upon Respondent to obtain a more detailed history regarding these complaints. His failure to do so was a deviation from generally accepted standards of medical practice. The physical examination which Respondent conducted did, however, meet minimum standards.

This was admittedly a very complex situation. The patient's reported symptoms were indicative of a hypothyroid condition. However, her laboratory studies strongly suggested that she was *hyper*thyroid. Respondent appropriately referred Patient F to an endocrinologist, but made no attempt to follow-up directly with the consultant. Given the complexity of the

situation, this failure to coordinate Patient F's care with her other physicians was a significant deviation from the standard of care.

Respondent also failed to specify the laboratory studies ordered, or the diet prescribed for this patient. In addition, he prescribed Hgh for Patient F despite a lack of demonstrated growth hormone deficiency. As in the previous cases, Respondent failed to obtain and document informed consent before beginning the Hgh therapy.

Respondent ordered a number of laboratory studies for Patient F at her initial visit. It may have been appropriate, from a CAM perspective, to order these tests. However, despite receiving essentially normal results from these various studies, Respondent repeated them. In some instances, the tests were repeated more than once. There was no medical justification for repeating these tests. Thus, the Committee concluded that Respondent ordered these tests without adequate medical justification.

The Hearing Committee concluded that all Factual Allegations (with the exception of F.2) were sustained. The Committee further concluded that Respondent's treatment of Patient F demonstrated both negligence and incompetence, although it did not rise to the level of either gross negligence

or gross incompetence. In addition, Respondent failed to maintain an accurate record for this patient, and ordered unnecessary tests.

Patient G

Respondent listed a number of possible diagnoses for Patient G at the initial visit, including hypothyroidism, chronic fatigue syndrome and chronic obstructive pulmonary disease. However, he failed to elicit information from the patient to support these diagnoses. His initial examination of the patient was deficient, as well. Despite the impression of hypothyroidism, Respondent failed to adequately examine the patient's thyroid gland. He also failed to determine the patient's height, weight, pulse and blood pressure.

Patient G was not growth hormone deficient. Nevertheless, Respondent prescribed Hgh for her. As was seen in the previous patients, Respondent failed to obtain informed consent from the patient prior to initiating the therapy. The medical record was also deficient in that Respondent failed to document the type of laboratory studies ordered, or the diet prescribed for the patient.

The record also established that Respondent ordered numerous tests, such as FSH and LH levels, DHEA sulfate,

testosterone, Epstein-Barr virus and anti-Candida titers, which were not warranted by the patient's condition.

The Committee concluded that Factual Allegations G.1 through G.5 were sustained, and that Respondent's treatment of Patient G demonstrated that the specifications of negligence, incompetence, unnecessary testing, and failure to maintain records should also be sustained.

Patient H

Respondent's contact with Patient H was much more limited than that with the other patients at issue in this case. Patient H was treated by Respondent for a one month period in 1997. The history taken by Respondent was adequate. Therefore, Factual Allegation H.1 was not sustained. The physical examination, however, was deficient. Respondent failed to record the patient's height and weight. Despite the patient's complaints of decreased libido and possible hormonal imbalance, Respondent failed to examine the patient's testicles and thyroid. As was seen in the previous seven cases, Respondent failed to accurately record the blood work ordered, diet recommendations, and informed consent for Hgh therapy.

Respondent ordered a number of laboratory studies which, from a CAM perspective, were warranted by the patient's symptoms. The tests were only ordered once, and Respondent did

make treatment recommendations based on the results (i.e., changes in vitamin supplements). Therefore, Factual Allegation H.5 was not sustained. The remaining Allegations (H.2, H.3 and H.4) were sustained.

The Hearing Committee concluded that Respondent's treatment of Patient H demonstrated negligence, incompetence, and a failure to maintain an accurate record.

Specifications

The First Specification charged Respondent with negligence on more than one occasion, in violation of New York Education Law §6530(3). The Hearing Committee found that certain aspects of Respondent's treatment of each of the eight patients demonstrated negligence, as described previously. The Committee therefore voted to sustain the First Specification.

The Second Specification charged Respondent with incompetence on more than one occasion, in violation of New York Education Law §6530(5). The Hearing Committee found that Respondent's conduct with respect to each of the patients also demonstrated incompetence, and voted to sustain the Second Specification.

The Third through Twelfth Specifications charged Respondent with gross negligence, in violation of New York

Education Law §6530(4). The Committee carefully considered these allegations, in light of the definition of gross negligence. The Committee unanimously concluded that Respondent's conduct, though serious, did not demonstrate the severity necessary to sustain findings of gross negligence. Accordingly, the Committee voted to dismiss the Third through Twelfth Specifications.

The Thirteenth through Twenty-Second Specifications charged Respondent with gross incompetence, in violation of New York Education Law §6530(6). The Committee concluded that Respondent did not demonstrate an unmitigated lack of the basic skill and knowledge necessary to practice the profession. Therefore, the Committee voted to dismiss the Thirteenth through Twenty-Second Specifications.

The Twenty-Third through Thirtieth Specifications charged Respondent with ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, in violation of New York Education Law §6530(35). The Hearing Committee found that in seven of the cases presented (Patients A through G), Respondent ordered unnecessary tests, or repeated tests despite normal values on the initial studies. Accordingly, the Committee sustained the Twenty-Third through

Twenty-Ninth Specifications (Patients A through G), and dismissed the Thirtieth Specification (Patient H).

The Thirty-First through Thirty-Eighth Specifications charged Respondent with failure to maintain a record for each patient which accurately reflects the care and treatment of the patient, in violation of New York Education Law §6530(32). The evidence demonstrated that Respondent failed to accurately record the laboratory studies ordered for each patient, as well as the diet recommendations which he gave. In addition, Respondent failed to obtain and document informed consent from each of the patients prior to initiating Hgh therapy. The Committee unanimously voted to sustain the Thirty-First through Thirty-Eighth Specifications.

DETERMINATION AS TO PENALTY

Following the Committee's votes on each of the Specifications, and prior to the Committee's discussion of sanction, the Administrative Law Judge disclosed Respondent's prior disciplinary history to the Committee. ALJ Exhibits # 1 and #2 document the fact that Respondent was previously disciplined by the Board in relation to a criminal conviction for sexual abuse in the third degree. Respondent's medical license was suspended for three years, with the suspension stayed. A three year period of probation was also imposed.

In accordance with a pre-hearing ruling, the Administrative Law Judge also provided the Committee with copies of supplemental briefs on the issue of sanction, submitted by counsel for both parties. The Hearing Committee reviewed all of these documents, and based its determination on the totality of the record.

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be suspended for a period of one year from the effective date of this Determination and Order. Following successful completion of the period of suspension, Respondent shall be placed on probation for a period of four years. During this probationary period, Respondent's practice shall be monitored by a board-certified physician, acceptable to the Director of the Office of Professional Medical Conduct ('OPMC"). The monitoring physician must practice in the discrete department or section of complementary and alternative medicine in an academic institution or an affiliate institution. The complete terms of probation are attached to this Determination and Order in Appendix II, and incorporated herein. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute,

including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee carefully considered the possibility of revoking Respondent's medical license. Respondent is guilty of serious misconduct. However, the record did not demonstrate that Respondent's medical care placed his patients in any immediate danger or that his patient's were harmed by his treatment. For that matter, there was little evidence that they benefited from his medical care, either. The Committee unanimously determined that revocation was not warranted, because of the lack of immediate danger presented by Respondent's medical practice.

However, the Hearing Committee was very concerned about Respondent's non-caring, cavalier attitude towards his patients. This attitude was very apparent to the Committee throughout Respondent's own testimony. Further, Respondent's prior discipline for sexual abuse of a patient showed a lack of respect and concern for his patient's welfare. In that regard, the Committee considered the prior discipline to be an aggravating factor.

Respondent's medical records do not reveal a coherent thought process behind his treatment decisions. Patients come in, often seeking specific therapies. He orders panels of

laboratory tests, without regard for the actual needs of the individual patients. This results in absurd situations, such as obtaining PSA levels for a female patient. When the laboratory tests came in, Respondent frequently failed to follow up on the results.

The Hearing Committee unanimously determined that Respondent's medical license should be suspended for a full year as a result of his misconduct. Following the suspension, Respondent should be placed on probation for four years. Since Respondent holds himself out as a CAM practitioner, it is essential that his practice be monitored by a physician familiar with CAM standards and practices. Therefore, while on probation, Respondent's medical practice and records should be monitored by a board-certified physician, practicing in the discrete department or section of complementary or alternative medicine in an academic institution or an affiliate institution.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First, Second, Twenty-Third through Twenty-Ninth, and Thirty-First through Thirty-Eighth Specifications of professional misconduct, as set forth in the Statement of Charges are **SUSTAINED;**

2. The Third through Twenty-Second, and the Thirtieth Specifications of professional misconduct are **DISMISSED;**

3. Respondent's license to practice medicine in the State of New York shall be **SUSPENDED** for a period of **ONE (1) YEAR** from the effective date of this Determination and Order. Thereafter, Respondent shall be placed on probation for a period of **FOUR(4) YEARS** following completion of the one year suspension. The complete terms of probation are attached to this Determination and Order in Appendix II and incorporated herein;

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by

certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Troy, New York
October 8 **,2003**

William L Maher
WILLIAM L. MAHER, J.D. (CHAIR)

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APPENDIX I

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

IN THE MATTER

OF

MICHAEL J. TEPLITSKY, M.D.

STATEMENT

OF

CHARGES

Michael J. Teplitsky, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 15, 1986, by the issuance of license number 166986 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a male born on March 1, 1926, (Patient names are listed in Appendix A) from approximately August 5, 1997 through March 2, 1999, at Respondent's medical office. Patient A presented with a chief complaint of sexual dysfunction. Respondent's medical care of Patient A failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of Patient A.
2. Respondent failed to perform and/or document an adequate physical examination of Patient A.
3. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient A.
4. Respondent inappropriately treated Patient A with testosterone therapy despite his history of benign prostatic hypertrophy and normal testosterone levels.
5. Respondent inappropriately treated Patient A with human growth

hormone.

6. Respondent ordered tests not warranted by the condition of the patient.
7. Respondent inappropriately managed Patient A's thyroid hormonal levels.

B. Respondent treated Patient B, a male born on August 29, 1951, from approximately August 26, 1997 through December 1, 1998, at Respondent's medical office. Patient B presented with a history including, but not limited to: occasional hypertension; stomach pains; frequent diarrhea; decreased libido; and decreased energy. Respondent's medical care of Patient B failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of Patient B.
2. Respondent failed to perform and/or document an adequate physical examination of Patient B.
3. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient B.
4. Respondent inappropriately treated Patient B with testosterone therapy despite the fact that Patient B had normal testosterone levels.
5. Respondent ordered tests not warranted by the condition of the patient.
6. Respondent inappropriately treated Patient B with human growth hormone.
7. ~~Respondent inappropriately managed Patient B's thyroid hormonal levels.~~ withdrawn by Petitioner 09/27/02 JHB
8. Respondent failed to adequately treat and/or manage Patient B's high cholesterol levels.

C. Respondent treated Patient C, a female born on May 25, 1926, from approximately November 14, 1991 through August 31, 1998, at Respondent's medical office. Patient C presented with a history including, but not limited to: hypertension; heart palpitations; chest pain/angina; arrhythmia; diabetes; arthritis; and obesity. Respondent's medical care of Patient C failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of Patient C.
2. Respondent failed to perform and/or document an adequate physical examination of Patient C.
3. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient C.
4. Respondent failed to adequately treat and/or manage Patient C's high cholesterol levels.
5. Respondent inappropriately treated Patient C with human growth hormone.
6. Respondent ordered tests not warranted by the condition of the patient.
7. Respondent inappropriately managed Patient C's thyroid hormonal levels.

amended by Petitioner 07/24/2002 JCB

D. Respondent treated Patient D, a female, from approximately January 3 1997 6 through March 31, 1999, at Respondent's medical office. The record fails to indicate Patient D's date of birth. Patient D presented with a history including, but not limited to: thyroidectomy; osteoporosis; and hypothyroidism. Respondent's medical care of Patient D failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of Patient D.
2. Respondent failed to perform and/or document an adequate physical examination of Patient D.
3. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient D.
4. Respondent failed to adequately treat and/or manage Patient D's osteoporosis.
5. Respondent failed to adequately treat and/or manage Patient D's thyroid hormonal levels.
6. Respondent inappropriately treated Patient D with human growth hormone.
7. Respondent ordered tests not warranted by the condition of the patient.

E. Respondent treated Patient E, a male born on December 10, 1926, from approximately September 8, 1997 through November 4, 1998, at Respondent's medical office. Patient E presented with a history including, but not limited to: arteriosclerosis; hypertension; TIAs; myocardial infarction; congestive heart failure; and an irregular heartbeat. Respondent's medical care of patient E failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of Patient E.
2. Respondent failed to perform and/or document an adequate physical examination of Patient E.
3. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient E.

4. Respondent failed to confer with Patient E's treating cardiologist and failed to follow up on other consultations.
5. Respondent inappropriately treated Patient E with human growth hormone.
6. Respondent ordered tests not warranted by the condition of the patient.

F. Respondent treated Patient F, a female, born on October 27, 1961, from approximately July 29, 1997 through January 27, 1998, at Respondent's medical office. Patient F presented with a history including, but not limited to: hypothyroidism; fatigue; and headaches. Respondent's medical care of Patient F failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of Patient F.
2. Respondent failed to perform and/or document an adequate physical examination of Patient F.
3. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient F.
4. Respondent failed to adequately treat and/or manage Patient F's thyroid hormonal levels.
5. Respondent inappropriately treated Patient F with human growth hormone.
6. Respondent ordered tests not warranted by the condition of the patient.

G. Respondent treated Patient G, a female, born on March 9, 1931, from approximately July 8, 1997 through April 15, 1999, at Respondent's medical office. Patient G presented with a history including, but not limited to: heart

palpitations; fibrocystic breasts; fatigue and intestinal pain. Respondent's medical care of Patient G failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of Patient G.
2. Respondent failed to perform and/or document an adequate physical examination of Patient G.
3. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient G.
4. Respondent inappropriately treated Patient G with human growth hormone.
5. Respondent ordered tests not warranted by the condition of the patient.

H. Respondent treated Patient H, a male, from approximately August 13, 1997 through September 13, 1997, at Respondent's medical office. The record fails to indicate Patient H's date of birth. Patient H presented with a history including, but not limited to: headaches; and possible endocrine disease. Respondent's medical care of Patient H failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or document an adequate history of Patient H.
2. Respondent failed to perform and/or document an adequate physical examination of Patient H.
3. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient H.
4. Respondent inappropriately treated Patient H with human growth hormone.

5. Respondent ordered tests not warranted by the condition of the patient.

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) 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. The facts in paragraphs A and A1, A and A2, A and A4, A and A5, A and A7, B and B1, B and B2, B and B4, B and B6, B and B7, B and B8, C and C1, C and C2, C and C4, C and C5, C and C7, D and D1, D and D2, D and D4, D and D5, D and D6, E and E1, E and E2, E and E4, E and E5, F and F1, F and F2, F and F4, F and F5, G and G1, G and Ge, G and G4, H and H1, H and H2, H and/or H4.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) 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. The facts in paragraphs A and A1, A and A2, A and A4, A and A5, A and A7, B and B1, B and B2, B and B4, B and B6, B and B7, B and B8, C and C1, C and C2, C and C4, C and C5, C and C7, D and D1, D and D2, D and D4, D and D5, D and D6, E and E1, E and E2, E and E4, E and E5, F and F1, F and F2, F

and F4, F and F5, G and G1, G and Ge, G and G4, H and H1, H and H2, H and/or H4.

THIRD THROUGH TWELFTH SPECIFICATIONS

GROSS NEGLIGENCE

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

3. The facts in paragraphs A and A4.
4. The facts in paragraphs A and A5.
5. The facts in paragraphs B and B6.
6. The facts in paragraphs C and C5.
7. The facts in paragraphs D and D6.
8. The facts in paragraphs E and E5.
9. The facts in paragraphs F and F4.
10. The facts in paragraphs F and F5.
11. The facts in paragraphs G and G5.
12. The facts in paragraphs H and H4.

THIRTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

13. The facts in paragraphs A and A4.
14. The facts in paragraphs A and A5.
15. The facts in paragraphs B and B6.

16. The facts in paragraphs C and C5.

17. The facts in paragraphs D and D6.

18. The facts in paragraphs E and E5.

19. The facts in paragraphs F and F4.

20. The facts in paragraphs F and F5.

21. The facts in paragraphs G and G5.

22. The facts in paragraphs H and H4.

TWENTY-THIRD THROUGH THIRTIETH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35) 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:

23. The facts in paragraphs A and A6.

24. The facts in paragraphs B and B5.

25. The facts in paragraphs C and C6.

26. The facts in paragraphs D and D7.

27. The facts in paragraphs E and E6.

28. The facts in paragraphs F and F6.

29. The facts in paragraphs G and G5.

30. The facts in paragraphs H and H5.

THIRTY-FIRST THROUGH THIRTY-EIGHTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) 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:

31. The facts in paragraphs A and A3.
32. The facts in paragraphs B and B3.
33. The facts in paragraphs C and C3.
34. The facts in paragraphs D and D3.
35. The facts in paragraphs E and E3.
36. The facts in paragraphs F and F3.
37. The facts in paragraphs G and G3.
38. The facts in paragraphs H and H3.

DATED: February 9, 2001
Albany, New York

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

APPENDIX II

Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession. Respondent acknowledges that if he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law §171(27)]; State Finance Law § 18; CPLR § 5001; Executive Law §32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall practice medicine only when monitored by a licensed, board-certified physician, practicing in the discrete department or section of complementary or alternative medicine in an academic institution or an affiliate institution. The monitor shall be proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly, and shall examine a selection of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation from accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.
b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.
c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.
d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with § 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

9. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.