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

August 22, 2005

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Richard J. Lanham, M.D.
2156-a Sheridan Drive
Kenmore, New York 14223

Mark C. Farrell, Esq.
4455 Transit Road, Suite 2C
Williamsville, New York 14221

Kevin C. Roe, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
2509 Corning Tower, ESP
Albany, New York 12237

RE: In the Matter of Richard J. Lanham, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 05-180) 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, Director
Bureau of Adjudication

SDO:djh

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER OF RICHARD J. LANHAM, M.D.	DETERMINATION AND ORDER BPMC # 05- 180

A Notice of Hearing and Statement of Charges, each dated October 22, 2004 was served upon the Respondent, **RICHARD J. LANHAM, M.D. MARGARET H. McALOON, M.D.**, Chairperson, **ARTHUR HENGERER, M.D.**, and **WILLIAM W. WALENCE, Ph.D.**, duly designated members of the State Board for Professional Medical Conduct appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ESQ.** served as Administrative Law Judge for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Hearing Dates:	December 15, 2004, February 14, March 7, April 18, 2005
Department of Health appeared by:	**DONALD P. BERENS, JR., ESQ.**, General Counsel, NYS Department of Health 2509 Corning Tower Empire State Plaza Albany, New York 12237-0032 BY: **KEVIN C. ROE, ESQ.**
Respondent appeared by:	**MARK G. FARRELL, ESQ.** 4455 Transit Road, Suite 2C Williamsville, New York 14221
Witness for the Department of Health:	Thomas S. Scanlon, M.D.

Witnesses for Respondent: Eve Parment
Sandra Cemulini
Richard J. Hooper
Richard J. Lanham, M.D. (Respondent)

Deliberations held: June 20, 2005

Note: The extended time period for completion of this proceeding was caused by the unavailability at certain times of the attorneys representing each party and was not due to the unavailability of the members of the Hearing Committee.

Numbers in parenthesis refer to transcript pages or exhibits, and they 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 evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

Note: Petitioner's Exhibits are designated by Numbers.
Respondent's Exhibits are designated by Letters.
T. = Transcript

A copy of the Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix II.

FINDINGS RELATED TO PATIENT A

1. Respondent treated Patient A at his office from 1996 to July, 2002 for a variety of complaints primarily related to Respondent's diagnosis of Chronic Fatigue Immune Deficiency Syndrome. (Ex. 2A, 2B)

2. Between April 27, 2000, and July 1, 2002, the patient was seen by Respondent approximately forty times. Respondent prescribed numerous narcotic analgesics throughout this period of time to Patient A including Talacen, Lortab, Percocet, Hydrocodone and Dilaudid. (Ex. 2A)

3. Respondent's office records for Patient A did not contain sufficient information regarding initial and continuing medical justification for the prescribing of narcotic analgesics. The nature, location, duration and severity of pain was not described. Physical examinations were incomplete and non-specific. There was no documentation that Respondent monitored the efficacy, safety or tolerability of the medications prescribed. Respondent considered the patient's diagnosed condition of chronic fatigue syndrome to have been cured by 2000, yet continued to prescibe pain medications for her without explanation in the record. (Ex. 2A; T. 32-51, 269, 306-8)

4. On November 14, 2001, Patient A was seen in the Emergency Department at Mercy Hospital of Buffalo with complaints of having had a syncopal episode the previous evening and right foot pain status post fall. Laboratory studies showed a cholesterol level of 296 and hypercholesterolemia was diagnosed. Patient A was discharged to follow up with her primary care physician documented as being Respondent. (Ex. 2A, pp. 143 - 161; T. 28 - 30)

5. Patient A was seen by Respondent on December 4, 18 and 31, 2001 at his office. Repeat cholesterol studies were apparently ordered on December 4, 2001. No results are documented. There was no documentation in Respondent's medical record that Patient A was counseled regarding hypercholesterolemia, that further requests for cholesterol studies were made or that Patient A refused, declined or failed to have the laboratory studies performed. Laboratory studies requested by Respondent in May of 2002 did not include cholesterol determinations. (Ex. 2A, pp. 162 - 169, 227 - 232; T. 28 - 32)

Conclusions: Factual Allegations A.1. and A.2. were sustained. Respondent prescribed narcotics on a continual basis to Patient A as treatment for a non-acute and chronic condition. Although

Respondent testified that the patient's chronic fatigue syndrome was cured in 2000, he continued to prescribe narcotics without documenting the purpose for those medications. No specific trauma was indicated in the medical records. Respondent also failed to follow-up results of cholesterol studies that he ordered following an elevated cholesterol report in November, 2001. There was no documentation that the patient failed or refused to have a second test performed.

FINDINGS RELATED TO PATIENT B

6. Respondent treated Patient B from on or about May 31, 2001, to January 30, 2002. (Ex. 3)

7. Patient B was seen at Respondent's office on May 31, 2001 for complaints of erectile dysfunction. Respondent recorded the patient's history as including morbid obesity (5 foot, 10 inches, 420 lbs), hypertriglyceridemia and hypercholesterolemia, mild to moderate hypertension, tension headaches, upper respiratory infections, gangrenous large intestine, bilateral cataracts, heel spurs, and multiple skin tags. No history of cardiac problems or use of nitrates was documented. Respondent prescribed Viagra 100mgs, 1 per day orally with three refills. (Ex. 3, p. 1)

8. No physical examination was performed or documented at the initial office visit on May 31, 2001. Physical examination should have included vital signs, auscultation of the heart and lungs, clinical evaluation for evidence of left ventricular hypertrophy and examination for evidence of peripheral vascular disease. (Ex. 3, p. 1; T. 55 - 61)

9. The history obtained and recorded by Respondent was incomplete and should have included a more extensive review of systems to rule out or investigate diabetes, thyroid disease, vascular disease and/or neurological disease. There was also no indication in the medical record of the name of another primary care physician who may have been providing care and treatment to Patient B. (T. 56 - 57)

10. Respondent's medical records documented that Patient B called on August 26, 2001 requesting Fiorinal, a narcotic analgesic, and indicated that the patient would pick up the prescription. Fiorinal with Codeine, 180 tablets with three refills, was prescribed by Respondent. There was no office visit on this date and no history or physical examination were performed. (Ex. 3, p. 2)

Conclusions: All Factual Allegations related to this patient, except B.4., were sustained. The documentation of Patient B's history, taken at the initial office visit of May 31, 2001, was incomplete and inadequate. No physical examination was performed at that visit. A note in the medical record dated August 26, 2001 states "patient called...needs Fiorinal". Fiorinal with codeine, 180 tablets with three refills, was prescribed and there is no record of any justification for such medication or that a physical examination was performed as a basis for the prescription. There was no documentation of any other physician who may have also been providing medical care to Patient B and there was no record that Respondent had any contact with a primary care physician who may have seen the patient.Treatment of Patient B by another physician could not be assumed without some indication of such fact in the chart. Respondent made a note of the patient's hypertension, hyperlipidemia and obesity, but there was no evidence of any evalation or treatment of these conditions by him. The documentation by Respondent of erectile dysfunction was considered to be adequate justification for the prescription of Viagra and Allegation B.4. was not sustained.

FINDINGS RELATED TO PATIENT C

11. Respondent treated Patient C, Patient B's wife, from May, 1998 to February 4, 2002 for a variety of complaints, including lower back pain. (Ex. 4A, 4B)

12. Throughout the period of treatment in question, Respondent prescribed narcotic analgesics, including Fiorinal with codeine and hydrocodone and other analgesics containing barbiturates,

including Esgesic and Fiorinal to Patient C. (Ex. 4A, 4B)

13. Throughout the period of treatment in question, Patient C was seen on a regular basis and narcotic analgesics were prescribed or continued by Respondent. The medical record for Patient C did not document the location, nature or severity of the pain and contained inadequate follow up regarding efficacy and tolerability of the medications. (Ex. 4A; T. 108 - 111)

Conclusions: Factual Allegation C.1. was sustained. There was no explanation in the medical records for the purpose in prescribing narcotic analgesics on a regular and repeated basis to Patient C. No description of the nature of the patient's pain was documented and any evaluation of her back pain was inadequate. During the approximately three month period of June through September, 2001, Respondent prescribed about 1,500 doses of Darvocet, Fiorinal and Esgesic to Patient C while prescribing about 700 doses of the same or similar medications to her husband (Patient B).

FINDINGS RELATED TO PATIENT D

14. Respondent treated Patient D, his son, at his office beginning in March, 2001 and continuing through January, 2002. (Ex. 5)

15. Respondent's medical record for Patient D contained documentation of eight physician-patient interactions during the period of treatment. There was no indication whether the encounters were in-person or by telephone. At the initial encounter, Respondent documented that his 42 year old son, in excellent health, had gained 25 pounds over the past year and wanted help losing weight. An 1800 calorie a day diet was recommended and Fastin (Phentermine) 30mg was prescribed. No further history was obtained or recorded. No physical examination was performed or recorded. (Ex. 5)

16. Respondent prescribed Phentermine renewals without documenting Patient D's height and weight or findings of a physical examination. (Ex. 5)

17. Most authorities and medical societies discourage the treatment of family members because of the inherent conflict based on the pre-existing personal relationship and the corresponding lack of objectivity. Respondent should have referred Patient D to another physician for evaluation and treatment. (T. 89 - 91)

Conclusions: All Allegations related to Patient D were sustained. The fact that the patient was Respondent's son did not excuse him from maintaining acceptable records. There was no recorded physical examination. Despite a complaint of obesity, no findings of height or weight were documented. Fastin was prescribed on at least two occasions. Darvocet and Lortab was prescribed on several occasions for complaints of back pain. Respondent testified that his son travelled extensively for his work. It could not be determined when, or if, he was seen in person by Respondent. The Committee believed it would have been most appropriate for Respondent to have referred his son to another physician who could have personally examined Patient D.

FINDINGS RELATED TO PATIENT E

18. Respondent treated Patient E from May 26, 2000, to on or about November 26, 2001. During such period, the patient was seen by Respondent approximately twenty-two times. (Ex. 6)

19. Respondent prescribed numerous narcotic analgesics and muscle relaxants throughout this period of time to Patient A including Darvocet, Lortab, Baclofen and Soma without documenting an adequate history or findings of physical examinations to justify such medications. (Ex. 6)

20. Patient E was first seen by Respondent on May 26, 2000, with complaints of back pain and a need to lose weight. No further history was obtained or documented. Vital signs were blood

pressure 116/66, pulse 82, temperature 97.9 and weight 175. No further physical examination was performed or recorded. Fastin 30mg with one refill and Darvocet (90 units) with one refill were prescribed. (Ex. 6, pp. 1 - 6)

21. Respondent prescribed Fastin and Adipex, weight loss medications, on a continuous basis to Patient E. Fastin and Adipex are appetite suppressants used as a short term adjunct to diet and exercise to promote weight loss. These medications lose their efficacy after two or three weeks. However, side effects, primarily agitation and nervousness persist. (Ex. 6; T. 120 - 122)

22. Baclofen and Soma are known to be used by drug abusers to increase the euphoric sensation derived from narcotics. Neither complaints nor physical findings of muscle spasm are documented in Respondent's office medical records for Patient E. (Ex. 6; T. 125 – 126, 128)

23. In August, 2000, Respondent ordered lipid testing for the patient. There was no evidence the testing was ever performed or that she refused to undergo lipid testing. In July, 2001, Respondent ordered blood work testing for Patient E without ordering lipid testing. (Ex. 6, pp. 21, 93-4)

24. Patient E was a 29 year old female when first seen by Respondent in May 2000. No evidence that the patient was being seen by a gynecologist was documented by Respondent. Routine preventative health maintenance measures should have been ordered for her, including a pap smear, other gynecological services and lipid determinations. (Ex. 6; T. 129 – 136)

Conclusions: All Allegations related to Patient E were sustained. Respondent prescribed 180 Lortab for Patient E on a monthly basis without documenting the need for such continuous treatment or the monitoring of any effects of such medication. There was no documentation of an exam of the patient's back, the ostensive basis for the presciption of narcotic treatment. Respondent ordered lipid testing for the patient, but failed to follow up to ensure that the test was performed, or, in the

alternative, failed to document that the patient refused to undergo such testing. There was no documentation that the patient was being provided gynecologic services by another physician. In the absence of another treating physician, the Committee determined that Respondent should have provided routine healthcare services , such as pap smears or mammograms, to Patient E.

FINDINGS RELATED TO PATIENT F

25. Respondent treated Patient F on November 13 and December 13, 2001. (Ex. 7)

26. On November 13, 2001, Patient F was seen at Respondent's office with complaints of an ear infection, back and leg pain. No further medical history was obtained or recorded. A social history form was filled out by the patient. No physical examination was performed or recorded. Lortab was prescribed by Respondent. (Ex. 7, pp. 1 - 15; T. 487)

27. Patient F returned to Respondent's office on December 13, 2001, with a complaint of an ear infection. Physical examination relative to the ear infection was performed and recorded. A one centimeter globular mass was excised and sent for pathology. Respondent noted that lumbrosancral spine syndrome still hurt. No further history was obtained or recorded and no further physical examination was performed or recorded. Baclofen and Lortab (10/500, 180 doses) were prescribed. (Ex. 7, pp. 16 - 18)

28. Respondent's medical evaluation and assessment of Patient F was inadequate and incomplete. Further history and a physical examination should have been obtained and recorded. The prescription of hydrocodone based on a current complaint of back pain without history or physical examination was inappropriate and without adequate medical justification. (T. 166 - 177)

Conclusions: Factual Allegations F.1., F.2. and F.4. were sustained. Respondent admitted in his testimony that he did not perform a physical examination of the patient before prescribing Lortab.

There was no description of a complaint of back pain documented. The complaint of an ear infection was recorded and appropriately treated. Factual Allegation F.3. was not sustained.

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. Unless otherwise noted, all conclusions resulted from a unanimous vote of the Hearing Committee. The Hearing Committee concluded that the following Factual Allegations should be **SUSTAINED**. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraphs A. and A. 1., A. 2. :	(1-5);
Paragraphs B. and B. 1., B. 2., B. 3., B.5., B.6., and B.7. :	(6-10);
Paragraphs C. and C. 1. :	(11-13);
Paragraphs D. and D. 1. through and including D. 4. :	(14-17);
Paragraphs E. and E. 1. through and including E. 4. :	(18-24);
Paragraphs F. and F.1., F.2., and F.4. :	(25-28).

The Hearing Committee determined that all other Factual Allegations should **NOT** be sustained.

The Hearing Committee concluded that the following Specifications of Professional Misconduct should be **SUSTAINED** based on the Factual Allegations which were sustained as set out above:

First through and including Sixth Specifications;

Thirteenth and Fourteenth Specifications.

The Hearing Committee determined that all other Specifications of Professional Misconduct should **NOT BE SUSTAINED.**

DISCUSSION

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories 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 certain types of professional misconduct.

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

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

The Committee relied upon these definitions in considering the Specifications of professional misconduct.

DISCUSSION

The Department's case was solely based on the testimony of it's expert witness. The Committee found Dr. Thomas Scanlon to be an experienced solo practitioner and considered his testimony to be very credible and objective. He was direct in his answers and honestly stated he did not know an answer when he was, in fact, uncertain. His testimony was accorded great weight by the members of the Committee. In contrast, Respondent was seen as lacking a grasp of basic fundamentals of medical treatment and record keeping. He attempted to rationalize his failings as merely poor documentation techniques. The Committee strongly believed that meeting accepted standards of record keeping is an essential part of medical care and treatment and not an item that is separate and apart from overall acceptable levels of care. An adequate medical record requires that each act of treatment be written; there is no other manner to confirm that such an act was actually performed.

Respondent's care and compassion for his patients were duly noted; however, those qualities could not be accepted as a substitute for basic competence. His witnesses testified of his genuine concern, but not of his actual medical competence. A disconnect was noted between the medical literature he distributed to his patients and the actual manner of his practice. Ultimately, the Committee was given the impression that Respondent failed to grasp how to meet accepted standards of practice.

Specifications that Respondent practiced medicine with negligence and with incompetence on more than one occasion were sustained. The Committee considered the continuous and cumulative failures to meet acceptable standards of practice to constitute the practice of the profession with gross negligence. Respondent's practices did not demonstrate a complete absence of skill or knowledge that was so egregious as to constitute gross incompetence.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set out above, unanimously determined that Respondent's license to practice medicine in New York State

should be limited in accordance with the Terms of Probation set out in Attachment I. 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.

Respondent testified that he had already been "mentored" by another physician concerning how to change his record keeping practices to meet acceptable standards. In actuality, Respondent developed a template and met on a few occasions with another physician to obtain a favorable opinion as to the acceptability of that template and to discuss charting issues. The Committee did not consider that action to be the equivalent of a true mentoring program and had no confidence in Respondent's ability to effectively implement use of his revised forms.

The Committee concluded that Respondent lacked any insight into his own deficiencies. The members believed his perception of his level of skill was not realistic and that Respondent rationalized his deficiencies by placing the blame solely on poor record keeping skills. This lack of insight led the Committee to believe that a requirement that Respondent participate in continuing medical education relating to record keeping practices would not be effective. In addition, there was a basis in the hearing record to indicate that Respondent's curriculum vitae was not fully accurate. Respondent's testimony related to the 1990 termination of his employment at Willard Psychiatric Center and the surrender of his Ohio license to practice medicine suggested that his deficiencies were longstanding. Participation in continuing medical education was not viewed as an activity that would be helpful to Respondent.

Respondent testified that he currently performs some occupational health services activities. The Committee believed Respondent to be capable of conducting physical examinations and documenting findings of those examinations on a preprinted, standardized form such as which he currently utilizes. The Committee determined that the public would be adequately protected if Respondent's medical practice in the future is limited exclusively to those activities and not include medical treatment or the prescribing of any medications..

ORDER

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

1. The following Specifications of professional misconduct as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED:**

   a. First through and including Sixth Specifications;

   b. Thirteenth and Fourteenth Specifications.

2. Respondent's license to practice medicine shall be **SUSPENDED** for a period of **TEN YEARS**, said period of suspension to be **STAYED**, and Respondent shall be placed on **PROBATION** and shall comply during the period of the stayed suspension of his license with all Terms of Probation as set forth in Appendix I, attached hereto and made a part of this Determination and Order; and

3. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Troy, New York

Aug 17, **2005**

Margaret McAloon MD

MARGARET H. McALOON, M.D., CHAIRPERSON

ARTHUR HENGERER, M.D.
WILLIAM W. WALENCE, Ph. D.

TO:

Kevin C. Roe, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
2509 Corning Tower
Albany, New York 12237

Mark G. Farrell, Esq.
4455 Transit Road, Suite 2C
Williamsville, New York 14221

Richard J. Lanham, M.D.
2156-a Sheridan Drive
Kenmore, New York 14223

APPENDIX I

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.

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. 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.

5. 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.

6. 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.

7. Respondent's practice of medicine shall be restricted to performing only activities related to occupational medicine evaluations. Such activities shall not consist of evaluations related to claims for Worker's Compensation. Respondent is expressly prohibited from providing medical treatment of any kind including the prescribing of any medications including, but not limited to, controlled substances.

8. Respondent shall attest to compliance with the prescribed practice restrictions, set out above in Paragraph 7, by signing and submitting to the Director of OPMC a Practice Restriction Declaration, as directed by the Director.

9. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to this 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.

APPENDIX II

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

IN THE MATTER OF RICHARD J. LANHAM, M.D.	STATEMENT OF CHARGES

Richard J. Lanham, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 2, 1973, by the issuance of license number 116317 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the attached Appendix) at his office 2156-A Sheridan Drive, Kenmore, New York beginning in March of 1998. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed narcotic analgesics without adequate medical justification.

2. Respondent failed to provide adequate follow-up to a markedly elevated cholesterol determination in November of 2001.

B. Respondent treated Patient B at his office beginning in May of 2001. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent prescribed narcotic analgesics without adequate medical justification.

4. Respondent prescribed Viagara without adequate medical justification.

5. Respondent failed to adequately evaluate and/or treat hypertension.

6. Respondent failed to adequately evaluate and/or treat hyperlipidemia.

7. Respondent failed to adequately evaluate and/or treat obesity.

C. Respondent treated Patient C at his office beginning in May of 1998. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed narcotic analgesics without adequate medical justification.

D. Respondent treated Patient D at his office beginning in March of 2001. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent prescribed Phentermine without adequate medical justification.

4. Respondent failed to refer Patient D to another physician.

E. Respondent treated Patient E at his office beginning in May of 2000. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent prescribed weight loss medications for a prolonged period of time without adequate medical justification.

2. Respondent prescribed narcotic analgesics without adequate medical justification.

3. Respondent prescribed muscle relaxants without adequate medical justification.

4. Respondent failed to provide routine preventative healthcare including, but not limited to, pap smears, mammograms and/or lipid determinations.

F. Respondent treated Patient F at his office beginning in November of 2001. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent failed to adequately assess Patient F and/or formulate an adequate plan of treatment.

4. Respondent prescribed narcotic analgesics without adequate medical justification.

SPECIFICATIONS

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Laws §6530(4) in that, Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A.2.
2. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, and/or B.7.
3. The facts in Paragraphs C and C.1.
4. The facts in Paragraphs D and D.1, D.2, D.3, and/or D.4.
5. The facts in Paragraphs E and E.1, E.2, E.3, and/or E.4.
6. The facts in Paragraphs F and F.1, F.2, F.3, and/or F.4.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law §6530(6) in that, Petitioner charges:

7. The facts in Paragraphs A and A.1 and/or A.2.
8. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, and/or B.7.
9. The facts in Paragraphs C and C.1.
10. The facts in Paragraphs D and D.1, D.2, D.3, and/or D.4.
11. The facts in Paragraphs E and E.1, E.2, E.3, and/or E.4.
12. The facts in Paragraphs F and F.1, F.2, F.3, and/or F.4.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Education Law §6530(3) in that, Petitioner charges two or more of the following:

13. The facts in Paragraphs A and A.1, A.2; B and B.1, B.2, B.3, B.4, B.5, B.6, B.7; C and C.1; D and D.1, D.2, D.3, D.4; E and E.1, E.2, E.3, E.4; and or F and F.1, F.2, F.3, and/or F.4.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5) in that, Petitioner charges two or more of the following:

14. The facts in Paragraphs A and A.1, A.2; B and B.1, B.2, B.3, B.4, B.5, B.6, B.7; C and C.1; D and D.1, D.2, D.3, D.4; E and E.1, E.2, E.3, E.4; and or F and F.1, F.2, F.3, and/or F.4.

DATED: October 22, 2004
Albany, New York

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