BEFORE THE DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE

RE: ALAN M. SELTZER, M.D.	)	
	)	**Case No.: 10-219-13**
	)	**10-02-14**
	)	**10-65-14**
	)	
LICENSE NO.: C1-0003084	)	**FINAL BOARD ORDER**

ORDER

Pursuant to 29 *Del. C.* § 8735(v)(1)d a properly noticed hearing was conducted before a hearing officer to consider the above referenced complaints filed by the State of Delaware against Alan M. Seltzer, M.D. with the Board of Medical Licensure and Discipline. The hearing officer has submitted the attached recommendation in which the hearing officer found as a matter of fact that the above-captioned case numbers 10-219-13, 10-02-14, and 10-65-14 have been shown by a preponderance of the evidence presented to establish Dr. Seltzer, a licensee of the Delaware Board of Medical Licensure and Discipline, entered into a consent agreement that was adopted by the Board as an order in November of 2010. In that consent, Dr. Seltzer conceded that he had not restricted patient access to the building that was both his office and his home. He agreed that he was unable to supervise waiting patients while he consulted with others. Dr. Seltzer conceded that he had not properly secured areas in the building where he stored controlled substances, medications, patient records, and his prescription pads. Dr. Seltzer admitted in 2010 that he had not referred patients seeking controlled substances to other health care providers such as pain specialists to evaluate medical, psychological, or addition issues and conceded that he lacked the training and expertise to effectively engage in pain management. Dr. Seltzer admitted he had prescribed Ambien for personal use in non-emergency situations and conceded that physical problems caused him difficulties in writing and deciphering his own

patient notes. In the 2010 agreement, Dr. Seltzer agreed, in pertinent part, to use a tape recorder to memorialize patient notes and then arrange for their transcription and to keep full and complete files for each patient. Dr. Seltzer's license was placed on probation for one year, but the conditions on his license were to remain unless withdrawn by the Board in writing. The hearing officer further found as a matter of fact that in March of 2011, Dr. Seltzer agreed to the suspension of his controlled substance registration for one month, agreed to properly secure patient records, restrict patient access to certain areas in his home office, refrain from storing controlled substances in his building, secure prescription pads, refrain from engaging in pain management, provide copies of prescriptions to the Director of the Office of Controlled Substances on a monthly basis for two years, and to permanently refrain from prescribing, administering, dispensing, or distributing all controlled substances except nine articulated medications.

With regard to the instant complaints, the hearing officer found as a matter of fact that Dr. Seltzer was not making an audio recording of patient notes for later transcription in every case and "had largely ignored this Board requirement – one to which he had agreed in the consent." Indeed, the hearing officer found as a matter of fact that Dr. Seltzer acknowledged that patient files were incomplete. Further, the hearing officer found as a matter of fact that Dr. Seltzer rarely, if ever, secured prior medical records generated by other health care providers and his patient files are lacking in Dr. Seltzer's rationale at the time he started or stopped controlled substance prescriptions or other medications, or chose to amend dosages. With regard to patient Daniel, the hearing officer found as a matter of fact that Daniel received multiple Xanax scripts from Dr. Seltzer in early 2014 and thereafter presented to the Wilmington Hospital with "possible benzodiazepine abuse and overdose as well as possible heroin overdose," while Dr.

Seltzer's chart on Daniel contained no documentary evidence that Dr. Seltzer sought out medical records of other providers or ordered toxicology tests to screen for illegal drug use, even though Dr. Seltzer admitted that Daniel's overdose may have resulted in part from his prescriptions. The hearing officer found as a matter of fact that Dr. Seltzer's patient notes starting in January 2014 are devoid of prescription profiles which would have been readily available to him had he registered by the DPMP, and that some forms included in patient files captioned "progress notes" were blank and some "new patient forms" have no recorded data pertaining to patients' medical histories.

By January 1, 2014 all prescribers such as Dr. Seltzer were to have registered with the Delaware Prescription Monitoring Program (DPMP). 16 *Del C.* § 4798(u). The DPMP is a database that prescribers of controlled substances, such as Dr. Seltzer, are to check before issuing any new controlled substance prescription to ensure that patients are not seeking multiple prescriptions from multiple sources. According to Dr. Seltzer, he refused to comply with the law and register with the DPMP until the day before his evidentiary hearing – September 23, 2014.

As a result of these findings of fact, the hearing officer recommended the Board find that Dr. Seltzer violated 24 *Del. C.* § 1731(b)(3) and Bd. Reg. 8.1.13 in that it is dishonorable or unethical to fail to adequately maintain and properly document patient records especially where, as here, Dr. Seltzer acknowledged the incompleteness of his records and conceded that in many instances it would be helpful in providing appropriate treatment to have more records and information than he saw fit to collect and "red flags" were evident in Dr. Seltzer's records, including a new patient report that indicates the chief patient complaint as "want to go back to Adderall and Xanax" or "get my Rx's back." The hearing officer further recommended that the Board find that Dr. Seltzer violated 24 *Del. C* § 1731(b)(11) in that he acted unprofessionally by

engaging in a pattern of negligence in the practice of medicine. Finally, the hearing officer recommended the Board find that Dr. Seltzer violated 24 *Del. C* § 1731(b)(17) in that he is in violation of an order of the Board.

The Board is bound by the findings of fact made by the hearing officer. 29 *Del. C.* § 8735(v)(1)d. However, the Board may affirm or modify the hearing officer's conclusions of law and recommended discipline. The parties were given twenty days from the date of the hearing officer's proposed order to submit written exceptions, comments and arguments concerning the conclusions of law and recommended penalty. Dr. Seltzer, through his attorney, provided written exceptions and oral arguments. Specifically, Dr. Seltzer took exception to the recommendation that the Board find a violation of 24 *Del. C.* § 1731(b)(3) (defining a disciplinable offense, in part, as "any dishonorable, unethical, or other conduct likely to deceive, defraud, or harm the public) because the complaint sought a finding that Dr. Seltzer violated 24 *Del. C.* § 1731(b)(13) (defining a disciplinable offense, in part, as the "failure to report to the Board as required by § 1730(a) of this title"). The Board is not persuaded by this argument. Dr. Seltzer was given the relevant facts that formed the basis of the complaint, all of which related to his record keeping practices and his past disciplinary history. Adequate notice of the nature of the charges was given such that Dr. Seltzer had adequate time to prepare his defense. There was no mention of any failure to report another licensed practitioner in the complaint, and the hearing officer's conclusion that this was a typographical error was reasonable, and should have been apparent to Dr. Seltzer himself.[1]

Dr. Seltzer next argues that there was no expert testimony of the standards for keeping medical records, nor are there any regulatory provisions which define such standard, and that the

[1] Indeed, Dr. Seltzer's exception indicates that the hearing officer unilaterally amended this to "4 *Del. C.* ¶ 1731(b)(3)" rather than the correct citation "24 *Del. C.* § 1731(b)(3)."

hearing officer's findings of facts do not support a legal inference of "negligence." The Board rejects this argument as well. This Board is the sole entity in the state of Delaware vested with the authority to regulate the practice of medicine within this state to protect the citizenry. To that end, the legislature has empowered this Board to discipline licensees who engage in unprofessional conduct. Unprofessional conduct has been defined by the legislature and this Board, utilizing its own expertise, has evaluated the finding of facts of the hearing officer and determined that the recommended conclusions of law are all accepted as a final order of this Board. Expert testimony on the standards for keeping medical records is not required in order for this Board to find a violation of 24 *Del. C.* Ch. 17. Finally, Dr. Seltzer has taken exception to the recommended finding that he violated 24 *Del. C.* § 1731(b)(17) by having failed to adhere to a Board order with respect to "recordkeeping, building security, transcription of charts, and other violations" in that the hearing officer's use of the term "other violations" is indefinite and unsupported by the findings of fact. The Board accepts this argument and modifies the hearing officer's recommended conclusion of law to be a finding that Dr. Seltzer failed to adhere to the Board's prior order with respect to recordkeeping, building security, and transcription of charts.

In addition to his written exceptions, Dr. Seltzer and his counsel presented to the Board's January 6, 2015 meeting and provided further verbal exceptions. Robert D. Goldberg, Esquire addressed the Board on behalf of Dr. Seltzer. Mr. Goldberg argued that his client, Dr. Seltzer, may not have taken this matter as seriously as he should have. Mr. Goldberg explained that he came into the case late but his understanding is that Dr. Seltzer did not give a good enough explanation for why his files were in the shape that they were in, but that the representative files were not, in fact, representative of Dr. Seltzer's practice. Here, the investigator noted that all of things Dr. Seltzer was supposed to do, for the most part, he did. That is, his prescription pads

and files were locked up. What Dr. Seltzer admittedly did not do was have his notes typed up. An investigation would have shown, and a decent explanation of what happened would have made clear, that Dr. Seltzer's secretary was out for an extended period of time and things got out of hand. The record is silent on the fact that Dr. Seltzer is a psychiatrist and this is where his passion lies. If you look at the report, you may get one impression of Dr. Seltzer, but if you pull out and look at all of his files, you will get a different impression. Dr. Seltzer's patients like him and they trust him.

The State also presented to the Board's January 6, 2015 meeting and presented verbal comments. The State indicated that the hearing officer's summation of the State's position is clear, but it is important to understand the level of concern that the State has regarding Dr. Seltzer's practice. The State highlighted portions of Dr. Seltzer's testimony at the hearing, including his admission that he does not always secure records from his patients' other providers. Dr. Seltzer testified that some of his patients are seeking Adderall and Xanax for selling on the street and that he believes he needs to "wake up" and change his practices. Dr. Seltzer testified that he has been co-dependent in that he has participated in the addiction of some of his patients to controlled substances. All of these excerpts of the hearing transcript were noted by the Board.

In determining the appropriate discipline, the Board cannot ignore that Dr. Seltzer has a history of problematic record keeping and the Board has significant concerns that there is a pattern of significant shortcomings in records. Dr. Seltzer offered no explanation for these serious short-comings. Doctors create a great risk of harm to patients when they do not obtain records from other providers before prescribing serious medications. More disturbing is Dr. Seltzer's complete refusal to register with the DPMP, which would have provided him with important information about his patients' other providers even in the absence of his requesting

records or information. Over time, Dr. Seltzer has been required to take many continuing education courses in an attempt to address his unsafe record keeping practices. Dr. Seltzer has received intense coaching in the proper methods of record keeping and has been afforded many opportunities to rehabilitate himself. However, taken in light of his disciplinary history, the most recent findings indicate there is an on-going inability or refusal to improve his practice to ensure that he is practicing in a safe and competent manner. Therefore, the Board finds that the appropriate discipline, necessary to protect the public, is revocation.

IT IS SO ORDERED this 3rd day of February, 2015.

DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE

Joseph M. Parise, D.O., President
Pursuant to 29 *Del. C.* § 10128(g)

Date Mailed: 2/4/15

BEFORE THE DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE

In the Matter of:	)	
	)	Case Nos. 10-219-13
Alan M. Seltzer, M.D.	)	10-02-14
Lic. No. C1-0003084	)	10-65-14

RECOMMENDATION OF CHIEF HEARING OFFICER

Nature of the Proceedings

The State of Delaware, by and through the Department of Justice, has filed a complaint and amended complaint in the above professional licensure cases against Alan Seltzer, M.D., an active physician licensee of the Board of Medical Licensure and Discipline.

The amended complaint alleges that in June 2010 the Board suspended Dr. Seltzer's medical license on an emergency basis as a result of allegations that Dr. Seltzer had failed to control access to medical records and medications stored in his office, had failed to ensure proper security for the storage of controlled substances, failed to properly prescribe, dispense and maintain proper records regarding the prescription of controlled substances, and failed to conduct proper medical examinations before prescribing controlled and non-controlled substances. In addition, the State alleged in its 2010 complaint that Dr. Seltzer possessed certain physical limitations which called into question his ability to practice medicine with reasonable skill and safety.

The amended complaint further alleges that in November 2010 the Board accepted a consent agreement signed by Dr. Seltzer continuing the license suspension until November 10, 2010, and then imposing upon his license a one-year period of probation. The State alleges that in the 2010 consent agreement Dr. Seltzer agreed to a number of practice restrictions, including referring out pain management patients, refraining from pain management, restricting his

practice to psychiatry, controlling patient movement within the building which is both his home and the location of his practice, refraining from storing controlled substances in that building, securing medical records and prescription pads, making audio recordings of patient notes to be transcribed and maintained by a secretary in separate patient files, having the secretary monitor patient movements within the building where Dr. Seltzer practices, installing a working security system there, refraining from self-prescribing, and refusing the return of medications to him for any reason. In addition, in the consent agreement Dr. Seltzer agreed not to violate either the Delaware Medical Practice Act or the Controlled Substances Act and agreed to cooperate with random inspections of his office by the Division of Professional Regulation.

The State further alleges that Dr. Seltzer's Controlled Substances Registration (CSR) was suspended on an emergency basis in July 2010 pursuant to complaints which resulted in the consensual suspension of Dr. Seltzer's medical license. Dr. Seltzer's CSR suspension ended in April 2011 after Dr. Seltzer had entered into an additional consent agreement with the State. In the CSR agreement Dr. Seltzer agreed to limit his prescription practice to ten controlled substances.

The State alleges that the probationary period for Dr. Seltzer's medical license ended in May 2012. The State further alleges that in July 2013 Dr. Seltzer saw a patient diagnosed with anxiety and prescribed Xanax without having performed a comprehensive evaluation and without having first accessed the Delaware Prescription Monitoring Program. A further visit with the same patient was not documented by Dr. Seltzer. Several months later the patient presented at a hospital following a heroin and benzodiazepine overdose.

The State further alleges that later in 2013 Dr. Seltzer prescribed Amphetamine tablets for a patient with a history of opioid addiction and without having documented the visit. That

same month the State alleges that Dr. Seltzer saw another new patient who observed that Dr. Seltzer's office was dirty and "in disarray". Dr. Seltzer prescribed Wellbutrin and Adderall for the patient and later directed him to cut dosing of the latter by half when the patient reported certain side effects. The State alleges that visits with this patient were not documented by Dr. Seltzer.

The State next alleges that in April 2014 an investigator from the Division of Professional Regulation conducted a random inspection of Dr. Seltzer's office. The investigator noted certain violations of the earlier consent agreement. The State now alleges multiple violations of the agreement. The State alleges that Dr. Seltzer, by his actions in this case, has violated three provisions of the Medical Practice Act and a regulation adopted by the Board.

An open hearing was convened on due notice at 9:15 a.m. on September 24, 2014 in the State Office Building, 820 N. French St., Wilmington DE. The State was represented by Stacey Stewart, Deputy Attorney General. Dr. Seltzer attended the hearing without legal counsel. Seated with him during the hearing was Ms. Carolyn Hughes, the office manager for Dr. Seltzer's practice. All witnesses testified under oath or affirmation. A registered court reporter was present who made a stenographic record of the proceedings. This is the recommendation of the undersigned hearing officer after due consideration of all relevant evidence.

Summary of the Evidence

At the outset Ms. Stewart offered a 440-page binder of exhibits which was admitted without objection as State Exhibit 1 ("SX 1").

Ms. Stewart made an opening statement. The State has included in SX 1 certain documents related to earlier complaints against Dr. Seltzer. She summarized practice limitations to which Dr. Seltzer agreed in 2010, which are found at SX 1 at 13 *et seq.* She also referred to

Dr. Seltzer's signed consent agreement concerning his CSR. She added that restrictions imposed in both proceedings are relevant to these pending cases.

In his opening Dr. Seltzer stated that he is now age 56. He is divorced with three children. He has practiced psychiatry since 1989. He stated that, unlike others in the profession, he has learned how to be a therapist. He enjoys both therapy and prescribing medications. In his practice he stresses a "shit happens" philosophy. Patients must learn to cope. He stays calm. He has prescribed controlled substances in the past, but has reduced prescribing. He follows the admonition "do unto others..." He practices approximately 30-35 hours per week. He accepts referrals. He acknowledged that some patients seek out Adderall and Xanax to resell the drugs on the street.

The State first called Anthony Kemmerlin, Sr., a Division licensing investigator. He specializes in medical investigations, and has done so for 11 years. He is a Diplomate of the American College of Forensic Examiners. He listed other affiliations. He investigated the earlier 2010 complaints against Dr. Seltzer, and investigated the pending cases.

Mr. Kemmerlin identified the complaint which generated Case No. 10-65-14. SX 1 at 33. A patient reported on May 12, 2014 that Dr. Seltzer had prescribed certain medications without "due diligence". The patient went to an emergency room after having overdosed. The complaint was filed by emergency room personnel. In the narrative portion of the complaint, the hospital employee reported that the relevant patient claimed he had paid cash to Dr. Seltzer and received multiple Xanax scripts in February 2014. The patient stated that Dr. Seltzer did not review any medical records and asked him what drug he wanted. The patient mentioned Xanax, and a prescription was written. In May 2014 the patient was admitted to the Wilmington Hospital ER with a possible heroin/benzodiazepine overdose. He was found unresponsive at

home and was revived by paramedics. The complainant confirmed the patient's prescription history electronically. The complainant stated that it was "possible" that unprofessional conduct by Dr. Seltzer contributed to these adverse outcomes. SX 1 at 34-35. Mr. Kemmerlin contacted the complainant, ascertained witnesses and prepared subpoenas for records. He interviewed ER staff and Dr. Seltzer, and subpoenaed records from both.

Dr. Seltzer's written response to this complaint is found in a letter dated June 13, 2014 at SX 1 at 36-38. In July 2013 the patient in Case 10-65-14 (Daniel) reported "severe anxiety issues" and claimed prior use of Xanax 2mg QID as needed. He had stopped using Xanax six months before. Daniel claimed "severe panic attacks" since he stopped using Xanax. His brother had committed suicide recently. His speech and behavior were normal. Daniel denied prior substance abuse. Dr. Seltzer diagnosed anxiety disorder and prescribed Xanax 1mg 1 and ½ TID and 2 at bedtime. 100 tablets were prescribed. The "cash" reference in the complaint was to Daniel's mode of payment for Dr. Seltzer's services. Alprazolam was prescribed because Daniel claimed it provided relief.

Daniel's last visit prior to February 2014 was in July 2013. The February 2014 visit was his first follow-up. At that visit Dr. Seltzer increased the Alprazolam dosage to 2mg with one tablet BID to TID. He was given 90 tabs with two refill scripts for 90 tabs each. Dr. Seltzer concedes in his response that his prescriptions were "at least partly responsible for (Daniel's) episode." SX 1 at 37. He adds that he has "never given a refill for any medication as part of my initial evaluation. I am truly disheartened as to why I would have done this." *Id.* In closing his letter, Dr. Seltzer states that in no other past case has he prescribed refills at the time of initial psychiatric evaluation, nor will it happen again. SX 1 at 38.

Mr. Kemmerlin identified Daniel's medical records as maintained by Dr. Seltzer at SX 1 at 40-49. On a patient information form, Daniel stated that he was unemployed and that the referring party was the "phone book". He paid $250 for the July 17, 2013 visit.

Mr. Kemmerlin stated that a psychiatrist uses the Diagnostic and Statistical Manual (DSM) as the "bible" to assign psychiatric diagnoses. Axis I is the clinical diagnosis; Axis II refers to personality disorders and retardation; Axis III sets forth a patient's major medical conditions; Axis IV refers to psychosocial wellbeing and coping mechanisms; and Axis V refers to global functioning. Axes are usually established at the time of the initial full evaluation. In Mr. Kemmerlin's experience, the initial visit and evaluation is longer, i.e. 2-4 hours.

Dr. Seltzer's handwriting at SX 1 at 44-46 is generally illegible. That had been a problem in the past. If a patient chart contains no entry, Dr. Seltzer tries to rely on his memory. Dr. Seltzer was little help in deciphering his own writing. He does not maintain typewritten records. Under "Past Medical History" (SX 1 at 45), Mr. Kemmerlin can not interpret the entry "5 years". Usually a physician addresses weight issues if appropriate. Daniel's blood pressure is high (160/100), but was apparently not addressed.

In fact Dr. Seltzer has told Mr. Kemmerlin that he does not perform physical exams. There was no scale in his office. Nor does he have a blood pressure cuff. Dr. Seltzer stated that he would perform physicals if required to do so. He gets physical condition information from the patient. There was no indication that Dr. Seltzer had secured the patient's prior medical records. Patients are not asked to sign releases to arrange for the transfer of records. Mr. Kemmerlin has never seen other physicians' records in Dr. Seltzer's office.

The only documentation of the February 18, 2014 med management visit by Daniel is the professional invoice at SX 1 at 48. There is no explanation why his medications (90 Xanax tabs)

were continued. Pursuant to a request from Mr. Kemmerlin, a PMP prescription history for Daniel was received. SX 1 at 52. Dr. Seltzer told Mr. Kemmerlin that he does not use the PMP, but that he would "follow up" and do so. There are "red flags" in Daniel's drug profile.

Case No. 10-219-13 was initiated after an anonymous complaint to the Division. SX 1 at 53-57. In that complaint it was alleged that patient Joseph was being prescribed Methadone daily by ATS, a Claymont DE clinic. At the same time Dr. Seltzer was prescribing for Joseph Klonopin, Adderall and Ambien while allegedly aware of Joseph's visits to ATS. The complainant alleged that the combined medications could be "deadly". It was also alleged that Joseph was paying cash for his scripts. Mr. Kemmerlin interviewed the complainant, who insisted on anonymity.

Dr. Seltzer's written response to the complaint regarding Joseph (written after he was interviewed by Mr. Kemmerlin) is at SX 1 at 58-59. In it Dr. Seltzer states that he first saw Joseph on November 18, 2013 and diagnosed Attention Deficit Hyperactivity Disorder and anxiety. He prescribed Adderall, Alprazolam and Tamazepam. Joseph returned for a follow-up visit in December 2013, and reported that "everything was going well". He received another set of the same scripts. In his response Dr. Seltzer writes that Joseph had not disclosed "Methasone" (sic) maintenance. He adds that he asks "every patient seen" about substance abuse. Dr. Seltzer did not produce any records about Joseph which were authored by him. Nonetheless, he was able to include details about Joseph in his letter response because the scripts inform Dr. Seltzer about what Joseph "would have said". Mr. Kemmerlin testified that he found that explanation not credible.

Complaint No. 10-02-14 stemmed from a complaint filed with the Division on December 27, 2013. SX 1 at 64-69. Complainant George was a patient of Dr. Seltzer. He found Dr.

Seltzer on the Internet and was able to schedule an appointment with him on the date when he called, December 3, 2013. He found Dr. Seltzer's office a dirty "pig sty". He described his depression to Dr. Seltzer and his belief that he was "worthless" and unattractive to his spouse. Dr. Seltzer allegedly responded, "so you're ugly and stupid". Dr. Seltzer prescribed Wellbutrin 200mg daily for depression.

George returned later in December and reported that he was feeling better. The office was cleaner because inspectors had told him to "clean up". According to George, and unlike the first visit, Dr. Seltzer did not take notes during the second visit. Though George did not believe the medication would treat his anxiety, Dr. Seltzer prescribed Adderall (60mg daily). George took the Adderall and was allegedly awake for a period of 48 hours with "hard heart beat". He could not concentrate and his depression increased.

He reported these effects to Dr. Seltzer and was told to reduce the daily dosage by half. When he told Dr. Seltzer he was fearful that his depression and "hard heart beat" would continue, Dr. Seltzer allegedly said, "that's crap-o". George then disposed of the Adderall and associated with another physician. That individual told George the Adderall should not have been prescribed, and that he should have been returned to Zoloft, which was prescribed for him when he was younger. George reported to the Division that research disclosed Dr. Seltzer's disciplinary past, and that he was "on probation due to prescribing Adderall" to a patient. SX 1 at 69. George's final allegation is that Dr. Seltzer "seems to just throw medicine out at you without doing an evaluation."

Mr. Kemmerlin interviewed George and sought Dr. Seltzer's records. Dr. Seltzer apologized that he had no records pertaining to George. Pharmacy records confirmed Dr. Seltzer's prescribing for George. SX 1 at 73-78. Dr. Seltzer told Mr. Kemmerlin that he did not

recall George. He admitted he "must do better", and asked if this would be a problem for the Board.

Dr. Seltzer's written response to George's complaint is found at SX 1 at 70-71. He apologizes for the appearance of his office. If he made the "ugly and stupid" remark, he was "probably joking in order to obtain his (George's) attention." The Wellbutrin was prescribed because Dr. Seltzer had diagnosed "low energy". His records are secured by a lock on the door and a lock on a cabinet. In his letter he repeats or summarizes a number of statements made by George in the professional complaint. George did not see him take notes during the second session because most notes are taken during the first. Dr. Seltzer determined that George "deserved a trial of Adderall". His response to the drug was "no doubt due to" adrenergic effects. When Dr. Seltzer used the word "crap-o", that was his way of saying he would respond well to the Adderall. SX 1 at 71. He apologizes if he was "unprofessional". He has "never behaved in any way but professional." *Id.*

Mr. Kemmerlin again notes that Dr. Seltzer had maintained no medical records concerning George. But Dr. Seltzer "knew" why he would have prescribed the Adderall. He now knows what he "would have done". Dr. Seltzer relied on George's complaint to reconstruct certain facts.

After this second case of absence of medical records, Mr. Kemmerlin decided to review some of Dr. Seltzer's patient files. In that process Dr. Seltzer was "very accommodating". In order to demonstrate his "due diligence", Dr. Seltzer stated that he had discharged some drug-seekers from his practice. Mr. Kemmerlin performed an unannounced audit of Dr. Seltzer's records after receiving the complaint from George. He found problematic records which lacked much content. Dr. Seltzer selected approximately 15 patient files for Mr. Kemmerlin to review.

Mr. Kemmerlin summarized practice restrictions imposed earlier by the Board. The restrictions are found at para. 18 of the adopted consent agreement. SX 1 at 13-14. In reviewing Dr. Seltzer's produced files, Mr. Kemmerlin found no active pain management patients. The ordered consent required that Dr. Seltzer secure his files in a locked cabinet. Mr. Kemmerlin found the files to be reviewed on a counter in the office, but conceded there was a lock on the cabinet where they were stored. The ordered consent required that Dr. Seltzer orally dictate his patient notes and that they be transcribed by his secretary and kept in patient files. Dr. Seltzer was out of compliance with this requirement. Though some patient notes were typed, most were not.

In addition, the ordered consent required that Dr. Seltzer maintain "full and complete" patient files. Mr. Kemmerlin testified that, in his opinion, Dr. Seltzer was also out of compliance with this requirement in that some files could not be produced by him, and others lacked substantial information. Another non-compliance with the ordered was consent was the fact that the outside door to his office and home was unlocked. Further, Mr. Kemmerlin did not observe a required security system for the building.

With regard to the requirement that Dr. Seltzer act in compliance with the Medical Practice Act and Controlled Substances Act, Dr. Seltzer had prescribed Adderall without an adequate patient assessment of Attention Deficit Hyperactivity Disorder (ADHD).

Mr. Kemmerlin testified further that Dr. Seltzer generally failed to demonstrate that he had failed to take comprehensive family, social and medical histories from patients. There was "no depth" in his records. Nor was there evidence that Dr. Seltzer had performed physical examinations regarding certain conditions which complicated treatment. Dr. Seltzer had failed to collect child records regarding his ADHD diagnoses, though he routinely placed patients in the

52-55 range, a serious rating. Dr. Seltzer was able to produce few office notes. He did not record information regarding whether prescribed medications were effective. Though Dr. Seltzer billed patients for psychotherapy sessions, he maintained few, if any, notes of those sessions. Dr. Seltzer often wrote prescriptions with few progress notes. Examples of lack of entries regarding the effectiveness of meds or the substance of psychotherapy sessions are found in Lauren's chart at SX 1 at 99, 106.

Dr. Seltzer then cross-examined Mr. Kemmerlin. Mr. Kemmerlin stated that Dr. Seltzer's office hours are 10 a.m.-5:30 p.m. Mr. Kemmerlin denied that Dr. Seltzer had provided adequate treatment for all of his patients. Mr. Kemmerlin was not aware of Dr. Seltzer stating that he was unaware of a patient's substance abuse problem. Dr. Seltzer's office was presentable when he visited. In Mr. Kemmerlin's opinion, Dr. Seltzer's documentation fails to substantiate the writing of certain prescriptions. Mr. Kemmerlin does not know whether Dr. Seltzer's staff had begun to type his patient notes since July 2014. Based on Mr. Kemmerlin's earlier findings and his review of Dr. Seltzer's records, the documentation does not contain sufficient required information to make Axis I-V entries. The American Psychiatric Association requires more substantial patient notes.

The State next called Dr. Seltzer. He presently sees 6-8 patients daily in a former bedroom in his house. Up to four of the patients are provided therapy, while the remainder are med checks. Appointments are approximately 30 minutes in length. If he provides therapy at the time of a med check, the patient is not billed for the therapy, specially "if there is no insurance." He now has approximately 150 active patients. After approximately 5-6 months of monthly med checks, patients are seen quarterly if Dr. Seltzer is comfortable with that schedule. Though he formerly gave some patients 10-12 scripts for up to a year, the Board has directed him

to cease that practice. He treated with one patient bimonthly for financial reasons, but she improved in a year. Some patients improve in less time.

Dr. Seltzer is a solo practitioner. He can refer patients to psychologists and social workers. He acknowledged it is "crucial' to collect background information on patients. He now "routinely" checks the PMP. He uses a three-page patient evaluation form. Without patient history, he can not diagnose and provide good treatment. His initial evaluations usually last 1 to 1.5 hours. That is when he collects family history. It is good to know drug allergies on patients, but that is not "super important". He instructs patients to call him if there are drug "sensitivities." He uses the evaluation form to collect individual characteristics. Wilmington Hospital now uses his form.

It is "absolutely important" to know the medications patients are taking, as well as drug and alcohol histories. For instance, if a patient is currently maintained on Methadone, Xanax would affect heart function. He can not tell when a patient is lying to him. Other than the PMP and other information, he must "rely on their smile". He now secures records from other providers. He agrees that at the time of the complaints, he was not securing histories. Nor was he confirming information from patients on current drug use.

He agrees that it is necessary to check with family members if there is a serious psychiatric disorder. Though not earlier concerned with drug abuse, he agrees he must now "wake up". He has been fooled in the past. To ignore the issue is a "naïve way of treating people". He has been fooled, and has been naïve. Both a patient and his mother have told him he is naïve. The word is "out on the street" that Dr. Seltzer "does not take any baloney now".

Dr. Seltzer does not know why he is permanently barred from prescribing pain medications. In the past he had tried to help patients with "horrible pain". Dr. Seltzer is a

"social person". He has been a co-dependent to the extent that he has assisted some addicts in getting worse. He can not say that is consistent with his medical license. When asked why he has waited until mid-2014 to discharge some patients, Dr. Seltzer stated, "good question". He was being "defensive" and "didn't want to see it." A Claymont resident whom he respects has told him that he can hurt patients.

At this point Dr. Seltzer offered three exhibits, which were admitted without objection. A September 20, 2014 letter to Mr. F from Dr. Seltzer informs the patient that he is being "eliminated" from Dr. Seltzer's practice because a change in his practice has caused him to discharge patients being prescribed a combination of Adderall and Xanax. Respondent Exhibit 1 ("RX 1"). A second unidentified patient is notified in an August 18, 2014 letter that, after reevaluation, Dr. Seltzer does not feel he can help the patient. RX 2. Another letter to an unidentified patient dated May 20, 2014 informs the individual that Dr. Seltzer sees "no healthy purpose" to refill the patient's prescriptions. Dr. Seltzer invites the patient to contact him if he or she is having "psychiatric problems". The stated purpose for stopping the prescriptions is to keep medications from being "abused or sold" and to "promote your better health." RX 3.

RX 1 was mailed to Mr. F four days prior to the hearing because Adderall and Xanax are highly abused. He had learned that Mr. F had been jailed for a drug conviction. Mr. F had been a patient for 6-8 months. Dr. Seltzer admitted that he had no medical records that he had attempted to wean Mr. F from the meds.

Since the copy of RX 1 appeared to be an original, Dr. Seltzer was asked if it had even been sent to Mr. F yet. Dr. Seltzer stated that it had not. He did not know if RX 3 had been sent yet. When asked why the documents were placed in evidence, Dr. Seltzer stated that he wanted to show that "it's on his mind" to discharge some patients. RX 2 is not addressed to any specific

patient. Dr. Seltzer admitted that it had not yet been sent to any patient. Rather, it is an "example" of a letter which he is "thinking of sending". If a patient simply wants medications, Dr. Seltzer asks why, and what help they hope to gain from the meds.

Dr. Seltzer was asked questions about the "new patient form" found at SX 1 at 44. A space on the form refers to "current psychiatric medications." Dr. Seltzer admitted that he does not regularly request records from other physicians concerning his patients. He conceded that some of his patients may be drug-seekers. He stated that he now has PMP access. When asked, he stated that he had registered with PMP the day before the hearing. He realized he need to register. He did not register earlier, or when shown a PMP profile by Mr. Kemmerlin. He has not "gotten on the computer" to train to use PMP.

The new patient form also inquires as to "current non-psychiatric medications." He needs to know if such medications will interact with medications he would prescribe. If he is unaware of interactions, he contacts a pharmacist. He does that approximately once a week. He admitted he does not document those contacts. Nor does he document prior patient drug use in his medical records.

The new patient form has a blank to record "past psychiatric history". SX 1 at 45. According to Dr. Seltzer, it is important to know about a bipolar history or a history of manic episodes. Such a patient may need to be seen more often. In some cases Dr. Seltzer may secure hospital records.

SX 87 is a "Psychiatric Evaluation" of patient Richard. Though he had previously seen two other psychiatrists, Dr. Seltzer did not request copies of their records. The State's attorney noted that there were no hospital records in the entire 440-page binder of State's exhibits. Dr.

Seltzer stated that he does not typically request them unless there is a "question". Nor does he typically ask for other prior medical records. He may have made such a request three years ago.

The "Psychiatric Evaluation" form has a blank to record "family psychiatric history". SX 1 at 88. Dr. Seltzer testified that it is important to have that information, which can lead to a diagnosis. The family history he secures is from the patient. "Social history highlights" on the evaluation form records information about boyfriends and what they do, whether a personality disorder is keeping a patient from holding on to friends, disability issues and work. Social history is important in treating patients.

The evaluation form allows him to record "mental status examination". *Id.* Dr. Seltzer identified the traits or characteristics he records. On the final page of the form Dr. Seltzer enters his Axis I-V psychiatric impressions. Combined, the axes allow for diagnosis and preparation of a treatment plan.

With regard to complainant George, Dr. Seltzer agreed that he did not have any medical records regarding that patient. As to patient Joseph, be only maintained some biographical information but no patient notes. He could not locate records for either patient. Since he prescribed controlled substances for them, he thinks the records are somewhere in his office. He agreed that another physician acting in the future could not evaluate his care of a patient in the absence of records.

Dr. Seltzer acknowledged writing the response to the complaint regarding Daniel. SX 1 at 36. At the time he wrote the letter (June 2014), he was prescribing Xanax for Daniel. Dr. Seltzer can not presently state why he increased dosages for Daniel. He speculated that there "may have been other concerns", though he did not document them. It is possible he did not

know how to word those concerns. He "should have made up words", even if they were not exact.

Dr. Seltzer acknowledged that he rarely documents "progress notes" for patients. Dr. Seltzer is "used to being spoiled" when patients get better. He is remiss in failing to write progress notes, but does not believe that is inconsistent with his medical license and professional standards. He agreed with Ms. Stewart that he should not be remiss in failing to document changes or the lack of change. He agrees that it is important to document the information should a patient move on to another provider.

Patient Richard's documents are found at SX 1 at 84-92. Dr. Seltzer admitted that he had failed to secure Richard's signature on some forms.

Patient Lauren's records are found at SX 1 at 94-119. She requested a change in medications. SX 1 at 95. Under Axis I, Dr. Seltzer entered ADHD. SX 1 at 97. No entry was made by Dr. Seltzer for Axes III-V. Dr. Seltzer prescribed Xanax and Adderall. He agreed that Lauren's chart contains no progress notes, though he claims to have dictated one on March 16, 2014. SX 1 at 102.. He reiterated that all of his notes are typed now. He thought that Lauren's note had been typed and put in her chart. The individual who was to do the typing has left his employ. A "progress note" form at SX 1 at 107 is blank for April 10, 2014, the date of a therapy visit. Dr. Seltzer could not explain that.

Patient Megan's chart is found at SX 1 at 121-147. A letter in the file from a pharmacist compliments Megan for the responsible way in which she deals with her medications. Dr. Seltzer does not know why the letter is in the file. Her "new patient" form is missing substantial information such as patient histories. Dr. Seltzer was "surprised" because he sees her "regularly". On October 24, 2013 Dr. Seltzer wrote prescriptions for her for Xanax, Lamictal

and Trazedon, but without having previously diagnosed her condition(s) in the chart. SX 1 at 131. In January 2014 Dr. Seltzer is informed that the State had requested a new psychiatric evaluation in conjunction with Megan's eligibility for Medicaid benefits. Dr. Seltzer stated that no new evaluation had been performed.

Patient Craig's chart is found at SX 1 at 149-161. Craig's "chief complaint" at the time of evaluation was "get my Rx's back". Dr. Seltzer prescribed Xanax and Adderall for him. At this time Dr. Seltzer addressed Ms. Stewart and told her she need not point out what is missing from charts. He diagnoses ADHD based on how a patient speaks. His impressions are "just about always right". Perhaps one patient in 10,000 is a problem, Dr. Seltzer testified.

Patient Valerie's chart is found at SX 1 at 163-220. In a letter dated December 17, 2013 Dr. Seltzer notes that Valerie's "unstability" is due to a brain tumor. Dr. Seltzer testified that the information regarding the tumor came from the patient. He had no medical evidence of that condition. Nor did he attempt to confirm it by requesting records. He agreed with the State's attorney that he should not make assumptions but seek out records. To Ms. Stewart he said, "I hear ya." A lengthy three-page typed progress note is in Valerie's chart. SX 1 at 165-167. He conceded that the adopted consent requires typed notes. When asked why he was not having notes typed consistently, he stated that he thought someone else was doing that. Though he has been dictating his notes, the tapes have now been lost. The responsible employee left eight months ago. Since 2011 he has had four employees. Some notes were not typed because employees were not told to do so. He understands the need to do so, but was not thinking of it.

A letter from Dr. Seltzer to Mr. Kemmerlin and dated June 21, 2014 is found at SX 1 at 79-81. The letter was apparently in response to correspondence informing him that efforts were underway to schedule this hearing. In the letter he notes his "discontent" with the way the

consent agreement was handled in 2010. He states that he wants the new complaints dealt with in a different way. He describes his efforts to comply with the terms of the adopted consent agreement. He does not believe he is guilty of the pending alleged violations, and is hopeful that additional discipline will not be imposed. He sets forth his treatment strategies for different disorders.

Dr. Seltzer acknowledged his handwriting is poor and that his notes will be typed. He is afflicted with multiple sclerosis. When the condition subsides, his handwriting improves. He conceded that the Board has not withdrawn the requirements that he document care and that he have his notes typed.

Patient Stephen's records are found at SX 1 at 391-403. Stephen's "psychiatric evaluation form" is blank but for the "chief complaint" of anxiety. Stephen was prescribed Xanax, Adderall and Restoril at the initial visit. Dr. Seltzer agrees that the second visit was not memorialized in a progress note. Nor was the next visit, though the Xanax prescription was continued. A typed letter (presumably to Stephen) dated April 7, 2014 from Dr. Seltzer is found at SX 1 at 397. In the letter Dr. Seltzer notes that an ER physician had telephoned Dr. Seltzer to inform him that Stephen had overdosed on Xanax and heroin. Dr. Seltzer informs Stephen that since he did not provide a history of heroin use and because of the "nature of the overdose", Stephen was discharged from Dr. Seltzer's care. Dr. Seltzer testified that in the past he has ordered pill counts and urine toxicology to detect abuse. He agreed that none of the patients whose files are in SX 1 were so tested.

Patient Angel's records are found at SX 1 at 405-431. Though it is nearly illegible, Dr. Seltzer appears to write her "chief complaint" as "annoyed". SX 1 at 406. A February 28, 2014 note regarding contact from a "Case Manager with NHS" indicates that Angel was going out of

state to seek out Adderall, and that her prescription medications were causing "severe psychosis" ("bipolar with psychotic features"). SX 1 at 413. Dr. Seltzer agreed that this was a "red flag", and discharged Angel. However, he saw Angel in March 2014 for medication management. SX 1 at 414. Dr. Seltzer testified that he was concerned for her well-being. He did not discuss the NHS note with her. He did not want to "scare her away". He kept her on her medications because she was a patient. He did not order that she provide a urine sample for toxicology screening.

In response to the hearing officer, Dr. Seltzer conceded that all of the files which the State included in SX 1 are complete. He also stated that he believed the files constituted an "unfair" sampling of his charts. (Mr. Kemmerlin had stated earlier that Dr. Seltzer selected those files.)

Dr. Seltzer further stated that he can not defend the fact that he must rely on his memory to reconstruct his care for patients. He did base some of his responses to questions on considering what he "would have done" under the circumstances. He added that he would not knowingly give Xanax to a patient on a Methadone regimen. At this point the State rested.

Dr. Seltzer then continued his testimony. He offered a series of patient discharge letters to Ms. Stewart for her review. After reviewing them, Ms. Stewart stated that the State would stipulate that the six files presented to her by Dr. Seltzer each contain a discharge letter dated September 20, 2014.

Dr. Seltzer then provided three charts to Ms. Stewart for her review. Each contains a typed evaluation or evaluations. Ms. Stewart stated that she agreed that the files show that typing was done in those three charts. Dr. Seltzer offered Ms. Stewart eight more charts which she reviewed. Ms. Stewart stated that she was willing to stipulate that each of the eight files

contains one or more typed progress notes. She added that the State would not stipulate to the accuracy or the substance of the typing.

After a brief break, Ms. Stewart stated on the record that most of the files provided to her during the hearing are new files. They do not address the lack of typed documents after the 2010 consent agreement was accepted by the Board.

Dr. Seltzer then testified that he intends to make his office "totally electronic". He wants to be able to sign scripts electronically so that they are more legible for pharmacists. He wants to make his practice better, safe and neat. Dr. Seltzer offered an email from Verizon describing ways in which that company can assist a practitioner in "streamlining" workflow. The email was admitted as RX 4. A document setting forth Dr. Seltzer's office hours (10 a.m. to 5 p.m. on weekdays) was admitted as RX 5. He added that his office remains in his home. He understands that he is to keep doors locked. He admitted that the building was unlocked during one of Mr. Kemmerlin's visits. He added that one evening he found a drug seeker in his house at 3:30 a.m. At this point Dr. Seltzer rested.

In rebuttal the State then recalled Mr. Kemmerlin. He stated that the Board had required that exterior doors to his building be locked. One door was unlocked during a visit he made. The Board ruling does not change simply because Dr. Seltzer's practice is in his home.

In response to Dr. Seltzer, Mr. Kemmerlin stated that Dr. Seltzer's front door was unlocked on two occasions with free access to the area were medical records were stored. Dr. Seltzer replied that this will not happen again. He now uses an "alert" system.

In her closing argument Ms. Stewart asked that the hearing officer take notice of Dr. Seltzer's disciplinary history with the Board. When new complaints were filed with the Division, the existing adopted consent agreement was reviewed and Dr. Seltzer was found out of

compliance. He had failed to have office notes typed. Dr. Seltzer agrees that his handwriting is poor. At some point after the consent order was adopted by the Board in 2010, Dr. Seltzer decided not to comply with that provision. In a letter in June 2014 Dr. Seltzer contended that the typing requirement was not necessary. The Board has disagreed.

There were no documents in Dr. Seltzer's files for two of the three complainants here. Dr. Seltzer has admitted that he can not recall the care provided for 150 patients. He has therefore tried to guess what he "would have done". He has failed to keep complete files. In this case two files are completely missing. Of the 15 files pulled in this case, they are inadequately documented. They are missing information which Dr. Seltzer has conceded is important. Patterns in his charting include writing scripts at the time of initial evaluation without entering diagnoses and treatment plans. During medication management visits no notes are entered to support the continuation or adjustment of medications. No records contain evidence of pill counts, urine screens or other techniques to determine abuse. Dr. Seltzer simply says he will change his ways.

With regard to Case No. 10-65-14 (Daniel), he came from a hospitalization caused by a benzo/heroin overdose. Some of Dr. Seltzer's prescriptions endangered his patients. He made no effort to determine whether they were in fact drug-seeking.

Dr. Seltzer selected the patient files which are in SX 1. It is dangerous to prescribe Xanax and Adderall without having secured records from other treating physicians or drug profiles. Ms. Stewart asked, rhetorically, why Dr. Seltzer waited until the day before this hearing to register with the PMP. He has still not trained to access the PMP.

The State contends that Dr. Seltzer can not safely and competently practice. He is a danger to the public. He prescribes without assessments and has no checks on his patients. It is

impossible to review his records to determine what care he is providing. Dr. Seltzer's June 21, 2014 letter to Mr. Kemmerlin is telling. The files which he produced show little or no psychotherapy was conducted. Even if therapy was billed for, there is no documentary proof that it was provided. There are few, if any, progress notes in the file. Even if they are in the files, they are non-compliant because not typed. Dr. Seltzer has admitted simply relying on memory and does not defend that practice. As recently as June 2014, he still did not believe he had to have notes typed. That is inconsistent with the Board's order.

In some files Dr. Seltzer does not document all psychiatric axes. The typed files he presented to Ms. Stewart during the hearing related to very recent care. Again, Ms. Stewart asked why it took him so long to comply with the typing requirement.

Ms. Stewart argued that in this case the State has proven a failure to properly document care or to comply with the Board's orders. There is a pattern of negligence in this case. Some records demonstrate gross negligence. The State asks that this hearing officer recommend to the Board that Dr. Seltzer's medical license be revoked. He can not and will not comply with the orders of the Board. The evidence here is "alarming". The State is concerned with the quality of treatment provided by Dr. Seltzer. He can not continue to practice safely.

In his closing Dr. Seltzer stated that Ms. Stewart's arguments are "all true". However, he argued that if his license is revoked, all or most of his patients will see their conditions worsen. He added that "if it's the Board's goal to revoke my license, so be it". He added that he is capable of practicing with good intent and under the restrictions of the Board's order. It is not difficult to lock doors and to secure medical records from others, and that will be done.

After the hearing Dr. Seltzer sought to supplement the factual record in this case with two letters dated October 2 and 7, 2014. Since the factual assertions in those letters were not made

during the hearing so that they could be subject to cross-examination by the State, they have not been considered in preparing this recommendation.

Findings of Fact

The notice of this hearing provided Dr. Seltzer with the date, time, place and subject matter of the proceedings. It enclosed a copy of the State's amended complaint. Dr. Seltzer in fact received the notice, and attended the hearing without counsel.

The following facts have been proven in this case by a preponderance of the evidence. The Board of Medical Licensure and Discipline has considered disciplinary complaints in the past which have a direct bearing on the disposition of the pending cases. In my view the Board may and should consider these new cases in the light of prior disciplinary action taken against Dr. Seltzer. According to the State's new allegations against him, the prior actions against Dr. Seltzer's medical license provided clear guidance as to how he should conduct his psychiatric practice during the foreseeable future immediately following entry of a Board order dated November 9, 2010.

In 2010 the State filed a complaint in Board Case Nos. 10-48-10 and 10-82-10. In the complaint the State alleged that Dr. Seltzer had failed to control access to patient records and medications in his office, failed to secure controlled substances stored there, committed professional violations with regard to prescribing and dispensing medications as well as patient record-keeping, failed to perform proper examinations to support his prescriptive decisions, and admitted physical limitations which called into questions his ability to practice with reasonable skill and safety. Based primarily or solely on the State's allegations in the two 2010 cases, at least seven members of the Board found that Dr. Seltzer's continued medical practice presented a

clear and immediate danger to the public health and suspended his medical license on an emergency basis on June 16, 2010. SX 1 at 8.

Thereafter negotiations between Dr. Seltzer and the State resulted in his execution on November 8, 2010 of both a personal affidavit as well as a consent agreement which was intended to resolve the then-pending complaints. A copy of the 2010 consent agreement is found at SX 1 at 11-16. In that agreement Dr. Seltzer (at para. nos. 4-16) conceded that he had not restricted patient access to the building which was both his office and his home. He agreed that he was unable to supervise waiting patients while he consulted with others. He conceded that he had not properly secured areas in the building where he stored controlled and other medications as well as patient records and prescription pads. He agreed that while he had represented to the Board in March 2010 that he is not a neurologist and should not be "treating sciatica", nonetheless he continued to prescribe Vicodin and Oxycodone.

Dr. Seltzer further admitted in the consent agreement that he had not referred patients receiving scripts for controlled substances to other health care providers such as pain specialists to evaluate medical, psychological or addiction issues. He conceded that he lacked the training and expertise to effectively engage in pain management. He agreed that all of these conceded shortcomings constituted misconduct and incompetence and constituted violations of 24 *Del C.* §1731(b)(11). Dr. Seltzer further admitted that he had prescribed Ambien for personal use in non-emergency situations in violation of an opinion set forth in the Medical Ethics Code of the American Medical Association as well as 24 *Del C.* §1731(b)(1). He conceded that physical problems caused difficulties in writing and in deciphering his own patient notes.

Because of these cited concessions in the consent agreement, Dr. Seltzer signed a personal affidavit on the same date that he executed the consent agreement. SX 1 at 16A-16B.

Under oath, Dr. Seltzer made the following relevant averments in his affidavit which were, by their terms, effective immediately:

1. He will permanently refrain from pain management and restrict his practice to psychiatry only.

2. He will restrict patient access in his home to a waiting room and office only.

3. He will keep no controlled substances in his home or office.

4. He will maintain patient files and prescription pads in a locked cabinet in his office.

5. A secretary will be present at all times when he is seeing patients.

6. He will use a tape recorder to memorialize patient notes and then arrange for a secretary to transcribe the notes and maintain them in patient files.

7. He will "keep full and complete files for each patient".

8. He will keep outside doors to his home and office locked.

9. The premises will be protected by a security system.

10. He will refrain from prescribing medications for self-use.

11. He will prohibit patients from returning medications to him for any reason.

12. He will not violate any provision of the Delaware Medical Practice Act or the Controlled Substance Act.

13. He will fully cooperate with random inspections of his home and office by the Executive Director of the Board, her designee, or investigators employed by the Division of Professional Regulation.

The affidavit closed with Dr. Seltzer's understanding that future violations of the Medical

Practice Act or Controlled Substance Act could result in additional discipline, including revocation of his medical license. The affidavit was notarized by an attorney who it appears represented Dr. Seltzer in the prior proceedings.

The personal averments of Dr. Seltzer were then incorporated in a consent agreement submitted by him and the State to the Board and became conditions of a Board order signed on November 9, 2010. SX 1 at 10. The adopted agreement further ordered that the suspension of Dr. Seltzer's medical license would terminate on November 10, 2010, followed by a period of one year's license probation. During that probationary period Dr. Seltzer was to provide quarterly reports to the Executive Director of the Board confirming his compliance with the stated conditions. Even if Dr. Seltzer successfully petitioned the Board to end the license probation after one year, the Board order directed that the conditions listed above would be permanent unless withdrawn by the Board in writing. SX 1 at 15. In its order adopting the consent agreement, the Board cautioned that violations of the agreement may lead to further professional discipline up to and including license revocation.

In addition to seeking discipline of Dr. Seltzer's medical license, the State also filed a complaint in 2010 seeking discipline of his Controlled Substance Registration (CSR). Finding that the suspension of a practitioner's medical license is an independent basis on which to discipline a CSR, on July 2, 2010 the Delaware Secretary of State issued an order suspending Dr. Seltzer's CSR pending a full hearing before the Controlled Substance Advisory Committee.

The "CSR complaint" eventually resulted in the execution by Dr. Seltzer of another consent agreement on March 23, 2011. SX 1 at 24. In that consent Dr. Seltzer repeated some of the admissions which he had made in the consent submitted to the Board. Dr. Seltzer agreed to the suspension of his CSR through April 18, 2011, unless the Secretary of State were to end the

suspension sooner. He further agreed to a permanent prohibition against prescribing, administering, dispensing or distributing all controlled substances without the specific permission of the Secretary of State except for the following medications, either under generic or brand names:

1. Adderall
2. Alprazolam (Xanax)
3. Clonazepam (Klonopin)
4. Diazepam (Valium)
5. Flurazepam (Dalmane)
6. Methylphenidate (Ritalin)
7. Temazepam (Restoril)
8. Triazolam (Halcion)
9. Zolpidem (Ambien)

Dr. Seltzer further agreed to properly secure patient records, restrict patient access to certain areas in his home/office, refrain from storing controlled substances in his building, secure prescription pads, refrain from engaging in pain management, and provide copies of prescriptions to the Director of the Office of Controlled Substances on a monthly basis for two years.

The Committee on Controlled Substances accepted the CSR consent agreement and recommended its adoption by the Secretary as an order. SX 1 at 23. The Secretary of State then entered the terms of the consent as an order on March 30, 2011. SX 1 at 22.

The Board should be informed by the above procedural history with regard to Dr. Seltzer's licensure. In brief, the affidavit of Dr. Seltzer and the adopted consent agreements signed by him to resolve complaints concerning both his medical license and his CSR essentially established a specific set of rules and restrictions which would govern his practice of psychiatry after November 2011. By the terms of its 2011 order, the Board determined that the conditions which it accepted and imposed at that time were to be permanent in nature, at least until the

Board affirmatively withdrew or modified them. There is no evidence in this record that those conditions have been changed by action of the Board.

After two of the three pending professional complaints had been filed against Dr. Seltzer, Mr. Kemmerlin conducted an unannounced visit to and inspection of his office and files on December 19, 2013. Based on Mr. Kemmerlin's observations during that visit and his subsequent review of medical records produced by Dr. Seltzer, Mr. Kemmerlin came to certain conclusions concerning whether or not Dr. Seltzer had acted in compliance with the terms of the 2010 ordered consent. Since Dr. Seltzer did not effectively contradict Mr. Kemmerlin's findings, and since those observations are largely based on direct observation, they have essentially been proven in the record of this case.

Based on Mr. Kemmerlin's investigation, Dr. Seltzer has ceased engaging in pain management and has restricted his practice to psychiatry. He has either discharged or referred pain management patients out to other practitioners. Patient access has been restricted to the waiting room and the office within the structure which has served as both Dr. Seltzer's home and office. Dr. Seltzser does not store controlled substances in his home or his office.

Para. 18(h) of the ordered consent agreement states that "patient files are and will be kept in a locked file cabinet in his secretary's office". SX 1 at 13. When Mr. Kemmerlin arrived on December 19, he testified that he found several patient files to be reviewed on a counter. He did acknowledge that locks had been installed on cabinets which housed medical records. Based on this record I can not find as a matter of fact that Dr. Seltzer had failed to secure his files as ordered by the Board in 2010. A fair inference from these facts is that Dr. Seltzer had removed the loose files from a secure cabinet to facilitate Mr. Kemmerlin's access to them. There was no evidence that anyone else had accessed them.

Mr. Kemmerlin had secured his prescription pads in a locked cabinet. Since no patients were present in the building at the time of his visit, Mr. Kemmerlin could not determine whether the presence of a secretary was required.

However, after a review of the patient files which Dr. Seltzer had produced, Mr. Kemmerlin did find that Dr. Seltzer had acted in violation of the Board's requirement that he make an audio recording of patient notes for later transcription. Though he did find some patient notes typed out, for the most part patient notes allegedly made since November 2010 had not been transcribed. Based on this record, I find as a matter of fact that Mr. Kemmerlin was in clear violation of this requirement. Dr. Seltzer all but conceded this violation. He stated that he "thought" that transcribing was occurring. He also stated that employees responsible to type the notes had left his employ. At another point he testified that tapes from which transcriptions were to be made had been "lost". Based on my assessment of the evidence, I find it more likely so than not so that Dr. Seltzer had largely ignored this Board requirement – one to which he had agreed in the consent. I also find that while some physicians are perhaps notorious for their poor handwriting, Dr. Seltzer's handwritten notes in some produced files are particularly illegible and difficult to read.

The consent order directs that patient files will be "full and complete". SX 1 at 14 at para. 1. Mr. Kemmerlin reviewed the files Dr. Seltzer produced and found him out of compliance with this requirement. Some initial evaluation forms and subsequent patient notes were missing information which Dr. Seltzer deemed important to collect. Others were only partially filled in by him. For instance, physicians typically enter data on "axes" which provides a uniform means of psychiatric diagnosis. Some of Dr. Seltzer's charts contain partial or no information corresponding to those axes. During the hearing Dr. Seltzer acknowledged that patient files were

incomplete. When asked how he was able to now reconstruct notes about specific patients, Dr. Seltzer testified that he was able to do so from memory because scripts he wrote during visits triggered his ability to say what he "would have done" and what he "would have been told" based on medication needs of those patients. I do not believe that such imperfect reliance on memory constitutes "standard of care" patient charting.

Mr. Kemmerlin also testified that Dr. Seltzer rarely, if ever, secured prior medical records generated by other health care providers. He concluded, for instance, that records for some patients who had been prescribed Adderall were wholly lacking the sort of detailed patient assessments and records which would permit the reasonable psychiatrist to diagnose Attention Deficiit Hyperactivy Disorder and other psychiatric conditions. I have independently reviewed the patient records in SX 1 and find them lacking such patient histories while many lacked detailed evaluations. Dr. Seltzer had chosen not to be informed by the histories of patients most of whom had likely been the subject of treatments by others. Nor would his records inform in any meaningful way the care of other physicians who inherited his patients after their discharge, or after they had chosen to go elsewhere for treatment. (For a subsequent provider to gain any insight from some of Dr. Seltzer's charting, he would need to accompany the charts so that he could supplement the paucity of information in them with his memory of what he "would have done".) His patient files are also mostly lacking in Dr. Seltzer's rationale at the time when he started or stopped controlled and other medications, or chose to amend their dosages.

I find as a matter of fact that Dr. Seltzer had failed or refused to "keep full and complete files for each patient". Dr. Seltzer (and not Mr. Kemmerlin) chose the files which Mr. Kemmerlin would review after his unannounced visit in December 2013. If by doing so Dr. Seltzer was representing those files as his "best" or most representative exemplars, then I further

find that insufficient record keeping admitted by him in 2010 continued up until the time of Mr. Kemmerlin's audit in late 2013, and beyond.

Adequate record-keeping is not simply something which is a "good idea". Rather, inadequate record keeping can result in harm to patients. For instance, patient Daniel received multiple Xanax scripts from Dr. Seltzer in early 2014. Thereafter, he presented at Wilmington Hospital after "possible benzodiazepine abuse and overdose as well as possible heroin overdose." SX 1 at 35. A review of Daniel's chart as maintained by Dr. Seltzer contains no documentary evidence that Dr. Seltzer had sought out the medical records of other providers. Nor had Daniel been toxicologically screened for illegal drug abuse. In his letter to Mr. Kemmerlin, Dr. Seltzer admitted that he knew Daniel had previously been prescribed Xanax. Daniel denied prior drug abuse and denied Methadone treatment, and Dr. Seltzer accepted those representations. SX 1 at 37. Daniel was unemployed, found Dr. Seltzer in the phone book, and paid cash for his visits. Dr. Seltzer admits that Daniel's episode may have resulted in part from Dr. Seltzer's prescriptions. However, he adds that Daniel's overdose "would only be due to (Daniel's) own behaviors/desires." *Id.*

Dr. Seltzer's choice to violate Delaware law further hampered his ability to compile complete medical records relating to some patients. By January 1, 2014 all prescribers such as Dr. Seltzer were to have registered with the Delaware Prescription Monitoring Program (DPMP). 16 *Del. C.* Sec. 4798(u). According to Dr. Seltzer, he finally registered to participate the day before the hearing – September 23, 2014. Although he testified that he now uses the DPMP to secure drug profiles and to gain other information on patients, in fact he had just registered, and had not yet had any training on the DPMP computer system as of the date of the hearing.

In the 2010 ordered consent, Dr. Seltzer was ordered to keep "outside doors to the premises locked." SX 1 at 14. When Mr. Kemmerlin arrived for his visit in December 2013, he found that at least one exterior door was unlocked. Mr. Kemmerlin stated that Dr. Seltzer claimed he was meeting the requirement that patients were greeted at the front door by a secretary and them monitored while on the premises. Mr. Kemmerlin offered no evidence to the contrary. Dr. Seltzer also told him the premises were alarmed with a security system. Though Mr. Kemmerlin did not inspect or see such a system, he did not offer evidence that Dr. Seltzer's representation was not true.

Mr. Kemmerlin stated that there is no evidence that Dr. Seltzer has prescribed medications for himself since the date of the 2010 consent order. Nor is there evidence that patients have returned medications to him for any reason.

The 2010 consent order further prohibits any future violations of the Medical Practice Act, 24 *Del C.* Ch. 17, or the Uniform Controlled Substances Act, 16 *Del. C.* Ch. 47. In my opinion, the State has proved violations of the Board's order by Dr. Seltzer since 2010 as a matter of fact. Those violations and the proven records deficiencies in this case will be discussed in more detail below.

Conclusions of Law

The notice of this hearing provided Dr. Seltzer with the date, time, place and subject matter of the proceedings. The notice otherwise comported with legal requirements for notices of hearings before the Board. The notice was in fact received by Dr. Seltzer, who attended the hearing with his office manager.

The legislature has determined that the practice of medicine in Delaware is a privilege and that the public health, safety and welfare is protected when the practice is properly regulated

so that the public is protected from unprofessional, improper or unqualified practice. 24 *Del C.* §1701. The Board of Medical Licensure and Discipline has been chartered to supervise and regulate the profession and to impose professional discipline when that is deemed just and proper. 24 *Del C.* §1710(a). The Board has been authorized to promulgate regulations designed to carry out its powers and duties under the Act. 24 *Del C.* §1713(a)(12). The Board is also vested with the authority to conduct hearings. 24 *Del C.* §1713(a)(11). These are all valid means and ends rationally related to the legitimate State purpose of protecting the public from those who would practice medicine incompetently or unprofessionally.

In its amended complaint the State contends that Dr. Seltzer has violated three provisions of the Medical Practice Act and a regulation of the Board. The State first contends that Dr. Seltzer has violated 24 *Del C.* §1731(b)(13) in that he has engaged in "dishonorable or unethical" conduct as that term has been defined in Board regulations. Amended Comp at para. 24(a). SX 1 at 6. It appears that the State has made a typographical error in drafting para. 24(a). Section 1731(b)(13) of the Act concerns willful failures to report to the Board unprofessional conduct and the inability of another person to practice medicine. Based on the clear allegations in para. 24(a) of the amended complaint, the State intended to allege a violation of Sec. 1731(b)(3). Since the allegation is immediately followed by reference to Bd. Reg. 8.1.13, it is or should be apparent to the reader that the correct reference is to (b)(3) rather than (b)(13).

Twenty-four *Del. C.* Sec. 1731(b)(3) deems it "unprofessional" medical conduct when a licensee engages in "dishonorable, unethical, or other conduct likely to deceive, defraud, or harm the public." The Board has undertaken to define or list instances of "dishonorable or unethical conduct" in Bd. Reg. 8.0 *et seq.* The State alleges that Dr. Seltzer has committed conduct

described in Bd. Reg. 8.1.13. That section deems it "dishonorable or unethical" to fail to "adequately maintain and properly document patient records."

I have already found above that, in my opinion, Dr. Seltzer's patient records are "inadequate" as a matter of fact. It remains to determine whether the files are *legally* inadequate. As an initial proposition, Bd. Reg. 8.1.13 the Board, in its discretion, has determined that inadequate records can be evidence of dishonorable or unethical conduct and thus a basis for discipline under 24 *Del C.* §1731(b)(3). Perhaps understandably, the Board has not undertaken to describe in detail what constitutes "adequate" medical documentation for most practitioners. An exception to that lack of specificity is in the Board's adoption of the "Model Policy for the Use of Controlled Substances for the Treatment of Pain." Bd. Reg. 18.0 *et seq.* That regulation provides substantial detail with regard to required record-keeping by pain management practitioners. The Board may be informed by that regulation in examining the sufficiency of medical records maintained by licensees other persons than pain management physicians. (No evidence was introduced suggesting that patients seeking treatment for chronic, non-cancer pain are more, or less, likely to abuse controlled substances or illegal drugs.) Nonetheless, by its terms Bd. Reg. 18.0 applies to pain managers and the State does not allege that Dr. Seltzer is presently engaged in that specialty.

The State did not call an "expert" witness to describe what is adequate or "standard of care" patient documentation and how, if at all, Dr. Seltzer's records fail to meet such a standard. Nor did Dr. Seltzer call an expert. Though a physician presumably may render an "expert" opinion on the adequacy of his own patient records, significantly Dr. Seltzer did not argue during this hearing that his records are adequate. He acknowledged the incompleteness of his records, and conceded that in many instances it would be helpful in providing appropriate treatment to

have more records and information than he saw fit to collect. Indeed, he stated that *in the future* he will do more to get medical histories on his patients from other providers.

In my opinion the Board should find that Dr. Seltzer's patient medical records clearly fail to satisfy even minimally adequate "standard of care" record-keeping for a physician situated such as Dr. Seltzer. Put another way, if the Board finds Dr. Seltzer's patient record-keeping adequate in this case, that would appear to eviscerate the meaning of Bd. Reg. 8.1.13. His records are devoid of any medical documentation requested from or provided by other physicians or health care providers who had treated Dr. Seltzer's patients. His records contain few progress notes which describe what his treatment and therapies have accomplished. Most, if not all, of his patients' past and current prescribed and illegal drug use histories were gleaned and accepted from patients and were not independently verified. Though Dr. Seltzer claimed that he had used certain techniques to determine whether patients were engaged in the abuse of prescription medications or illegal drugs, there was no evidence of any pill counts, toxicology screenings or the like. Some would argue that a "red flag" may be apparent when a new patient reports with the "chief complaint" of "want to go back to Adderall and Xanax" (SX 1 at 95), or with a chief complaint of "get my Rx's back" (SX 1 at 151).

His patient notes starting in January 2014 are devoid of prescription profiles which would have been readily accessible to him had he abided by the law and registered with and used the DPMP by that time. Some forms in the files captioned "progress notes" are blank. Some "new patient forms" have no recorded data pertaining to histories and the like. Dates on which patients or third parties were billed for services show that no corresponding notes about the patients were either hand-written or typed on those dates. Handwritten notes in most files are nearly illegible but have not been transcribed to facilitate their comprehensibility by others. To

recap, in my opinion the State has proven clear violations of Bd. Reg. 8.1.13 and, consequently, 24 *Del C.* §1731(b)(3).

The State next contends that Dr. Seltzer has violated 24 *Del C.* §1731(b)(11) by acting unprofessionally in engaging in "misconduct…incompetence, gross negligence or a pattern of negligence in the practice of medicine…." *Id.* These terms must be treated separately and then defined fairly to determine whether this section of the Act has been violated. The legislature has not defined the operative nouns in the quoted passage. Nor are the terms defined by the Board in its regulations. The reader of the Delaware Code is instructed to define words and phrases in statutes according to the common and approved usage of the English language. 1 *Del. C.* Sec. 303.

"Misconduct" has been defined as "intentional wrongdoing…deliberate violation of a law or standard." *Webster's Collegiate Dictionary* (10th ed. 1996) at 742. I listened carefully to Dr. Seltzer's testimony and observed his demeanor closely during the hearing. Accepting the quoted definition of "misconduct", I do not find that Dr. Seltzer acted with "intent" or a "deliberate" desire to ignore or thwart the Board's 2010 corrective order or the promises he made in his personal affidavit. No pre-2010 charts maintained by Dr. Seltzer were placed in evidence in SX 1. Hence, I can not make an assessment as to what, if any, changes he made in his practice after the 2010 proceedings were concluded. That said, my assessment is that Dr. Seltzer's conduct under the strictures of the Board's 2010 order was benign, and perhaps careless, but not defiant or driven by a desire to intentionally thwart the authority of the Board. Though I find it puzzling that Dr. Seltzer did not make more diligent efforts to comply with the 2010 order since its violation could result in additional discipline, I do not find that he engaged in "misconduct" as that word is commonly defined.

Nor is the word "incompetence" defined in Delaware law nor Board regulations in the context of its use in the Medical Practice Act. Similarly, it is not defined in the Delaware Health Care Medical Negligence Insurance and Litigation Act, 18 *Del. C.* Ch. 68. One is "incompetent" if "not legally qualified...inadequate to or unsuitable for a particular purpose...lacking the qualities needed for effective action...unable to function properly." *Webster's* at 588. As noted above, the State did not call an expert witness to opine on Dr. Seltzer's qualifications to engage in psychiatry, or his suitability for that sort of practice, or his ability to function professionally. Rather, the State's theme in this case is that Dr. Seltzer has failed or refused to comply with the provisions of the 2010 consent order.

Though it could be argued that the prescription of controlled substances to patients about whom Dr. Seltzer had collected and analyzed insufficient information demonstrated isolated acts of "incompetence" as to those patients, I do not believe that the State has proven a general case of "incompetence" in the this record. No patients or other physicians weighed in with opinions about Dr. Seltzer's "competence" to practice. (When a Wilmington Hospital official filed a professional complaint against Dr. Seltzer with regard to his care of Daniel, that reporter could only allude to a "possible" benzodiazepine overdose, a "possible" heroin overdose and the "possible...supposed" unprofessional actions of Dr. Seltzer. SX 1 at 35.) In my view Dr. Seltzer's failure to comply faithfully with all of the terms of the 2010 consent order does not establish professional incompetence *per se.* Though it could be concluded that his style and habit of practice is perhaps unique in Delaware and not consistent with current psychiatric "best practices", I can not make the leap in this record to a general conclusion that he is an "incompetent" psychiatrist.

Nonetheless, I do find that in the context of this case Dr. Seltzer has established a "pattern of negligence" *vis a vis* the 2010 consent order. "Negligence" is not specifically defined in the Act nor in Board regulations. The term has both a common definition and one developed in tort law. According to the dictionary "negligence is a "failure to exercise the care that a prudent person usually exercises". To be "negligent" is to be "culpably careless" or inattentive "to one's duty or business." *Webster's* at 777. Trial juries in Delaware are routinely instructed by judges that "negligence" is a "lack of ordinary care…the absence of the kind of care a reasonably prudent and careful person would exercise in similar circumstances." *Del. P.J.I. Civ.* Sec. 5.1.

The 2010 consent order of the Board set out a number of restrictions on and requirements for Dr. Seltzer's psychiatric practice. If the Board agrees with the factual findings in this recommendation that Dr. Seltzer routinely and for a prolonged period failed to abide by some of the terms of that order, then in my opinion the State has proven a pattern of negligence in the context of this case and as a matter of law. The reasonably prudent psychiatrist situated such as Dr. Seltzer during the period 2010-2014 should have conformed his conduct to the terms of the 2010 order which were tailored to ensure that he brought his practice into compliance with acceptable standards.. He was clearly inattentive to the legal duties imposed on his practice by that order, and routinely breached those duties. It is more likely so than not so that some of his patients may have suffered harm by virtue of his refusal to conform to the order. Since I have found a prolonged pattern of negligence in failing to conform to the clear terms of the Board's order, I therefore conclude that the State has proven a violation of 24 *Del C.* §1731(b)(11).

The State finally alleges in the amended complaint that Dr. Seltzer has violated 24 *Del C.* §1731(b)(17) in that he has violated an order of the Board. In 2010 the Board incorporated the

terms of the consent agreement between Dr. Seltzer and the State and incorporated the representations in Dr. Seltzer's affidavit into a final order of the Board which has the force and effect of law. I have found above that Dr. Seltzer has violated the terms of that order in record-keeping, building security, transcription of charts, and other violations for a prolonged period of time. Hence, the State has proven a violation of 24 *Del C.* §1731(b)(17).

The Board has developed a set of guidelines for the imposition of professional discipline based on the nature and extent of violations of the Act and Board regulations pursuant to 24 *Del C.* §1713(f). The guidelines are found at Bd. Reg. 17.0.

The Board has characterized a violation of 24 *Del C.* §1731(b)(3) as "general misconduct". The discipline which may be imposed by the Board for such a violation ranges from a $1,000 fine to six months' license suspension. Bd. Reg. 17.5.1. On proof of a "pattern of negligence" by a licensee under 24 *Del C.* §1731(b)(11), recommended discipline ranges from one year license probation to license suspension with reinstatement conditioned on a showing of "satisfactory improvement." Bd. Reg. 17.3.2. Finally, violation of an order of the Board under 24 *Del C.* §1731(b)(17) can result in discipline ranging from six months' probation to six months' license suspension. Bd. Reg. 17.5.3.

The Board may diverge from these "guidelines" in a given case on a showing of "mitigating" or "aggravating" factors. Mitigating factors are set out at Bd. Reg. 17.15 *et seq.* Of the mitigators listed in that regulation, I find the following to be present in this case: (a) absence of dishonest or selfish motive (Bd. Reg. 17.15.6); (b) no evidence of motivation of criminal, dishonest or personal gain (Bd. Reg. 17.15.16); (c) mental or physical health, weak health (Bd. Reg. 17.15.17); and (d) present fitness of the practitioner (Bd. Reg. 17.15.19).

"Aggravating" factors which may have a bearing on discipline are listed at Bd. Reg. 17.14 *et seq.* My assessment of this record leads to the conclusion that the following may be pertinent here: (a) prior disciplinary offenses (Bd. Reg. 17.14.1); (b) past disciplinary record (Bd. Reg. 17.14.2); (c) frequency of acts (Bd. Reg. 17.14.3); (d) false statements during disciplinary process (contentions by Dr. Seltzer that he was actively using DPMP and had arranged for all patient notes to be type-written) (Bd. Reg. 17.14.5); (e) different multiple offenses (Bd. Reg. 17.14.8); (f) failure to comply with Board order (Bd. Reg. 17.14.9); (f) vulnerability of victims of misconduct (Bd. Reg. 17.14.10); consensus about blameworthiness of conduct (Bd. Reg. 17.4.13); (g) potential for injury ensuing from acts (Bd. Reg. 17.4.17); and (h) ill repute upon profession (need for word to get out "on the street" that Dr. Seltzer does not take any "baloney") (Bd. Reg. 17.14.22).

On balance, the "aggravating" factors in Bd. Reg. 17 substantially outweigh the "mitigators" in this case as a matter of law. In my opinion the most significant of the aggravating factors is Dr. Seltzer's prolonged failure for almost four years to make diligent and effective efforts to fully comply with the Board's 2010 consent order. Had Dr. Seltzer made a credible effort to comply, the scope of this hearing would have been far more narrow, or there would not have been a need for these proceedings. The discipline recommended below is driven by the fact that there is no assurance that Dr. Seltzer has the means or the desire to implement some of the important terms of the 2010 order in the future, e.g. maintaining "full and complete" patient files. During this hearing he repeated some of the "promises" or representations which he made in his affidavit. SX 1 at 16A. But his words are not followed by deeds. In the opinion of the undersigned hearing officer, if Dr. Seltzer is to practice professional and standard of care psychiatry in the future, he needs to "reset" his practice.

Due process has been afforded in these proceedings.

Recommendation

Based on the relevant evidence in this case and the findings of fact and conclusions of law set forth above, the following is recommended to the Board:

1. That the medical license issued by the Board to Alan Seltzer M.D. be suspended for a period of one year commencing 45 days after the date of the entry of the final order of the Board;
2. That during the 45-day period prior to the commencement of his license suspension, Dr. Seltzer limit his professional activities to contacting all of his currently active patients and assisting them in securing their medical records and in establishing professional relationships with new psychiatrists or other appropriate health care providers should any active patient desire to enter into such new relationship;
3. That Dr. Seltzer document by typewritten notes all of his activities during said 45-day period in the charts of active patients and cooperate with investigators from the Division of Professional Regulation and designees of the Board at the close of said period in performing a random inspection of active patient files to determine whether and in what manner the patient transfer activities have been accomplished;
4. That during the period of his license suspension, and in order to successfully petition the Board for the termination of such suspension after the passage of one year, Dr. Seltzer perform and complete the following activities, document that he has completed them, and cooperate with Division investigators and Board designees in verifying that he has done so:
   (a) That all hand-written patient notes in the custody or control of Dr. Seltzer be audio-recorded by him and then transcribed by his secretary or other competent persons and inserted in patient files;
   (b) That he arrange for the installation of an effective and working security system which provides 24-hour security at all exterior openings to any building or structure where he intends to resume his psychiatric practice;
   (c) That Dr. Seltzer devise an effective release form compliant with all State and federal laws and then utilize said form when his license suspension ends in order to secure the pertinent records of other health care providers with respect to patients who return to his practice post-suspension and for all new patients;
   (d) That Dr. Seltzer receive effective training so as to become fully competent in the use and application of the Delaware Prescription Monitoring Program;
   (e) That Dr. Seltzer undertake and complete 15 acceptable continuing education hours or credits in the subject areas of maintaining full and complete patient files in the standard of care psychiatric practice (9 credits) and identifying and addressing drug addiction and abuse in the standard of care psychiatric practice (6 credits), which credits shall be in addition to and not in lieu of any continuing education requirements imposed upon his medical license at the time of its next renewal;

(f) That Dr. Seltzer develop and prepare to implement an electronic system or other system designed to make his written prescriptions fully legible to all pharmacists to whom they are presented;

(g) That Dr. Seltzer continue to comply or come into compliance with any and all other conditions set forth in the order of the Board dated November 9, 2010 in Board Case Nos. 10-48-10 and 10-82-10;

5. That the Board retain the right, in its sole discretion, to place any additional reasonable and necessary restrictions or requirements upon Dr. Seltzer's practice at such time as the Board sees fit to terminate his license suspension;
6. That the Board order that a monetary fine in the amount of $10,000 be paid by Dr. Seltzer within 30 days of the date of the final order of the Board in the form of a draft made payable to the "State of Delaware" and submitted to the Executive Secretary of the Board;
7. That the final order of the Board constitute public disciplinary action reportable to appropriate public practitioner data bases.

Roger A. Akin
Chief Hearing Officer

Dated: November 10, 2014