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

**IN THE MATTER**

**OF**

**ARISTIDE HENRI ESSER, M.D.**

MODIFICATION

ORDER

BPMC No. 01-253

Upon the proposed agreement of ARISTIDE HENRI ESSER, M.D. (Respondent) for Modification Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Modification Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 12/20/01

REDATED SIGNATURE

WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

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

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NEW YORK STATE DEPARTMENT OF HEALTH
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**IN THE MATTER**

**OF**

**ARISTIDE HENRI ESSER, M.D.**

MODIFICATION AGREEMENT AND ORDER

STATE OF NEW YORK )
ss.:
COUNTY OF )

ARISTIDE HENRI ESSER, M.D., (Respondent) being duly sworn, deposes and says:

That on or about September 20, 1967, I was licensed to practice as a physician in the State of New York, having been issued License No. 099943 by the New York State Education Department.

My current address is REDACTED ADDRESS and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

Following a full hearing before a Hearing Committee of the State Board for Professional Medical Conduct (hereinafter "Hearing Committee") a Decision and Order (BPMC #01–253, attached hereto, made part hereof, and marked as Exhibit "A") was issued by the Hearing Committee. The sanction imposed, *inter alia*, by the Hearing Committee included a requirement, denominated as a Term of Probation number 10, requiring that I not prescribe opiates during the period of probation.

I have been previously informed through my attorney that the Department of Health, Petitioner in this matter, was considering pursuing an appeal in this matter, addressed to the Administrative Review Board, for the purpose of

modifying this Term of Probation and recasting it as a Limitation pursuant to section 230-(a)(3) of the Public Health Law, to remain in place for as long as I retain my license to practice medicine in New York State or until the Office of Professional Medical Conduct and the State Board for Professional Meedical Conduct agree to further modification. As I wish to finally dispose of this matter without further litigation, and as I do not object to this Modification, I hereby make application to the State Board for Professional Medical Conduct for a Consent Order imposing such Modification.

I hereby request and agree to the Modification of Determination and Order BPMC #01-253 , so as to convert the substance of Term of Probation number 10, to be a Limitation upon my license, as set forth above. In all other respects, Determination and Order BPMC #01-253 shall remain unchanged.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Modification Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of further litigation on the merits, I knowingly waive any right I may have to contest the Modification Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

REDACTED SIGNATURE

ARISTIDE HENRI ESSER, M.D.
RESPONDENT

DATED Nov 30, 01

Sworn to before me
on this 20 day of
Nov 2001

NOTARY

G. Robert Clemenson
Notary Public, State of New York
No. 4614913
Residing in Rockland County
My Commission Expires Feb 1, 2002

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 11/28/01

REDACTED SIGNATURE

ANTHONY Z. SCHER, ESQ.
Attorney for Respondent

DATE: 12/7/01

REDACTED SIGNATURE

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

DATE: 12/19/01

REDACTED SIGNATURE

DENNIS J. GRAZIANO
Director
Office of Professional
Medical Conduct

EXHIBIT "A"

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

IN THE MATTER

OF

ARISTIDE HENRI ESSER, M.D.

DETERMINATION

AND

ORDER

BPMC #01-253

COPY

DAVID HARRIS, M.D., Chairperson, SHELDON GAYLIN, M.D., and MS. LOIS VOYTICKY, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law ["PHL"]. DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE, served as Administrative Officer for the Hearing Committee.

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

## STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by practicing the profession of medicine with gross negligence on a particular occasion (one specification), by practicing the profession of medicine with negligence on more than one occasion (one specification) and with incompetence on more than one occasion (one specification), and by failing to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient (five specifications).

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

## SUMMARY OF PROCEEDINGS

| | |
|---|---|
| Notice of Hearing and Statement of Charges Dated: | April 5, 2001[1] |
| Date of Service of Notice of Hearing and Statement of Charges: | April 5, 2001 |
| Answer to Charges Dated: | April 18, 2001 |
| Prehearing Conference Date: | April 19, 2001 |
| Hearing Dates: | May 1, 2001<br>May 30, 2001<br>June 4, 2001<br>June 5, 2001<br>June 12, 2001<br>June 13, 2001<br>June 19, 2001<br>June 26, 2001<br>June 29, 2001 |
| Deliberation Dates: | July 27, 2001<br>August 29, 2001 |
| Place of Hearing: | NYS Department of Health<br>5 Penn Plaza, 6th Floor<br>New York, New York |
| Petitioner Appeared By: | Leni S. Klaimitz, Esq.<br>Attorney<br>NYS Department of Health, Bureau of Professional Medical Conduct |

[1] On May 30, 2001 the original Statement of Charges dated April 5, 2001 (Ex. 1) was replaced by an amended Statement of Charges dated May 29, 2001 (Ex. 1A) upon the request of the Petitioner and without objection from the Respondent.

Respondent Appeared By:

Wood & Scher
14 Harwood Court – Suite 512
Scarsdale, N.Y. 10583
By: Anthony Z. Scher, Esq.

## WITNESSES

For the Petitioner:

William Rosenthal, M.D.
Patient A's Mother
Patient B's Husband

For the Respondent:

Aristide Henri Esser, M.D.
James W. Flax, M.D.
Richard S. Blum, M.D.
Patient F
Patient F's Husband

## FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

## GENERAL FINDINGS AS TO THE RESPONDENT

1. Aristide Henri Esser, M.D. ["the Respondent"] is a 71 year old board certified

psychiatrist (Tr. 560 and 609; Exs. 3 and B). He was authorized to practice medicine in New York State on September 20, 1967 by the issuance of license number 099943 by the New York State Education Department (Tr. 34-35; Ex. 3).

2. The Respondent received his medical education and training in the Netherlands, where he completed a general residency and a psychiatric residency (Tr. 551-552; Ex. B). In 1961 the Respondent came to the United States and then completed a one year research fellowship at the Department of Psychiatry at Yale University (Tr. 552-553; Ex. B). In 1970 he obtained board certification in psychiatry (Tr. 560; Ex. B).

3. From 1962 until 1989 the Respondent's psychiatric practice had been an institutional practice. During this period the Respondent held positions at various institutions, which included the following: Medical Director of a Research Ward at Rockland Research Institute (presently known as the Nathan Kline Institute for Psychiatric Research) in Orangeburg, N.Y. (1962-1969); Director of Psychiatric Research at Letchworth Village in Thiells, N.Y. (1969-1971 or 1973); Director of the Central Bergen Community Mental Health Center in Paramus, N.J. (1973-1977); Medical Director of Mission of the Immaculate Virgin in Staten Island, N.Y. (1977-1980); Director of Quality Assurance and then Acting Deputy Director of Inpatient Services at Bronx Psychiatric Center in Bronx, N.Y. (1980-1985); Chief of the Special Evaluation and Treatment Unit at the Nathan Kline Institute for Psychiatric Research (1985-1986); and, Chief of the Supportive Rehabilitation Unit at Rockland Psychiatric Center in Orangeburg, N.Y. (1985-1988). (Tr. 553-561 and 570-571; Ex. B).

4. In addition, the Respondent held several academic appointments which included the following: Assistant Attending Psychiatrist at Columbia University, College of

Physicians and Surgeons, in New York, N.Y. (1971-1980); Associate Clinical Professor of Psychiatry at Albert Einstein College of Medicine in Bronx, N.Y. (1980-1985); and, Research Professor of Psychiatry at New York University, School of Medicine, in New York, N.Y. (1985-1993). (Ex. B).

5. During his appointment at Albert Einstein College of Medicine the Respondent served as the psychiatric consultant for the three methadone clinics run by the medical school and he also served as a member of the medical school's Pain Management Committee (Tr. 559-560; Ex. B).

6. Since 1990, the Respondent has been primarily engaged in a private psychiatric practice in Rockland County (Tr. 570-572; Ex. B). The Respondent is presently on the medical staffs at Good Samaritan Hospital in Suffern, N.Y., and Rye Hospital Center in Rye, N.Y. (Tr. 560-561; Ex. B).

7. At present, the Respondent has approximately 800 active patients. Although the Respondent's practice is primarily psychopharmacology, the Respondent does perform some psychotherapy as well. (Tr. 587).

8. All of the outpatient treatment provided by the Respondent to the patients at issue in this matter (Patients A, B, C, E, F, G and H) was performed at either the Respondent's medical office at 337 North Main Street, New City, N.Y., or his prior office at 21-23 North Broadway, Nyack, N.Y. (Exs. 5, 7, 8, 10, 11, 12 and 13).

## GENERAL FINDINGS AS TO MEDICAL ISSUES

9. An initial psychiatric evaluation should include the following: a chief complaint; history

of the present complaint; an evaluation of the patient's symptoms; history of past treatment, including hospitalizations and medications; medical, social and family histories; and a mental status examination which is essential in determining the appropriate course of treatment. A mental status examination is an evaluation of the patient's present thinking and mood. (Tr. 52, 289, 393-394 and 995).

10. The formulation of a diagnosis and treatment plan, including therapeutic goals and methods, should be addressed during the initial evaluation (Tr. 91-92, 98-99, 373 and 995).

11. A psychiatrist in private practice should record all of the above in a record maintained for each patient (Tr. 70 and 995).

12. In order to formulate, carry out and modify a treatment plan, a psychiatrist must have a picture of the patient's life, including the patient's ability to function and the patient's relationships with others. The absence of such information in the medical record is a deviation from accepted medical standards. (Tr. 370-371).

13. The listing of prescribed medications does not, in and of itself, constitute a treatment plan (Tr. 126-128).

14. A patient claiming to be depressed does not necessarily have a diagnosis of depression as defined by the guidelines of the Diagnostic and Statistical Manual of Mental Disorders-IV (Tr. 1282).

15. A psychiatrist should ascertain the patient's medication history, history of compliance with medication, and whether the patient has a history of substance abuse (Tr. 54-55).

16. In the case of a patient who presents with a history of prior substance abuse, including alcohol abuse, a psychiatrist should obtain information on the particular treatment

provided to the patient for that problem and should attempt to obtain history from third parties. The psychiatrist should also inquire as to which physicians the patient has had contact with. (Tr. 68- 70).

17. Physicians must exercise caution in prescribing medications, which might be abused, to patients with histories of substance abuse. Care should be taken regarding the amount of medication being prescribed. (Tr. 55-56, 65, 70, 81-83 and 993).

18. Substance abusers are very difficult to manage. To maintain as much control as possible over a substance abuser, a physician should prescribe small quantities of drugs for short periods of time. (Tr. 1193-1194).

19. There are recognizable signs when patients are misusing their medication. The "red flags" are complaints of lost and/or stolen medication and requests for dose escalations. Family members can also provide relevant information. Psychiatrists in particular, by training and experience, should be alert to the manipulative behavior of patients who are abusing medication. (Tr. 218, 263-264, 642-643,1045, 1146-1147 and 1600-1601).

20. Once it becomes clear to a physician that a patient is abusing medication, the physician should re-evaluate treatment and initiate a plan to address the abuse (Tr. 219 and 1053-1054).

21. Lithium is a medication used in the treatment of mania. It is potentially quite toxic. It is necessary to monitor the level of lithium in the blood of a patient who is being treated with lithium in order to confirm that the lithium level is within the therapeutic range and has not reached a toxic level. Lithium levels need to be obtained at least weekly at the initiation of treatment. However, once a patient has been regulated, lithium levels should typically be obtained every three to four months. The dosage of lithium being prescribed

has no bearing on the frequency of testing. Since lithium can have serious side effects upon the kidneys, thyroid and heart, certain baseline laboratory values should be obtained before beginning lithium treatment. (Tr. 291-292, 297-299, 1328-1329 and 1338-1339).

22. Cylert and Ritalin are central nervous system stimulants used in the treatment of Attention Deficit Disorder ["ADD"] and Attention Deficit Hyperactivity Disorder ["ADHD"]. They are controlled substances and potentially addictive. These medications will improve the attention of people who do not have ADD or ADHD, as well as those who do. (Tr. 712, 720, 790-791 and 1432).

23. Attention can be impaired by depression and other illnesses or factors. A diagnosis of ADD or ADHD in adults is formulated from the patient's history of functioning in school, functioning in the more recent past and present, the observations by the physician, and sometimes neuro-psychological testing. The self-reported results of a self-administered questionnaire cannot form the sole basis for a diagnosis of ADD or ADHD. Should a questionnaire be utilized in making this diagnosis, the questionnaire should be made part of the patient's medical record. (Tr. 1382, 1396-1401 and 1427).

24. Benzodiazepines, a class of medications also known as minor tranquilizers, are controlled substances which are potentially addictive. Benzodiazepines are commonly utilized to alleviate anxiety. Included in this class of medications are Xanax, Valium, Klonopin, Ativan, Lorazepam, Diazepam and Tamazapam. When two benzodiazepines are prescribed in tandem the two medications deliver an increase in sedation and side effects and thereby place the patient at greater risk. Potential side effects include drowsiness, sluggishness, mood depression, and short-term memory loss. A physician should have clear justification if engaging in such tandem prescribing. (Tr. 56-58, 1135 and 1439-

1440).

25. The use of alcohol is contraindicated with the use of benzodiazepines because of the dangerous synergistic effect which occurs between the two. Patients should be informed of the dangers of combining benzodiazepines and alcohol. The fact that a patient may have been warned in the past about the dangers of combining these two substances does not alter, in any way, a physician's responsibility to specifically address this issue with the patient. Generally, benzodiazepines should not be prescribed in the case of a patient who is presently abusing alcohol or who has a history of alcohol abuse. If they are prescribed, very low doses of the medication and careful monitoring should be utilized. (Tr. 59, 326-327, 1145, and 1339-1340).

26. Opioids, also known as narcotics, are utilized for the alleviation of pain. They are highly addictive medications. Included in this class of medications are Percoset, Percodan, Vicodin, Vicoprofin, Roxicet, morphine, codeine, Hydrocodone, Oxycodone, Dilaudid and Lortab. (Tr. 63, 210, 267-268, 431, 1132-1133).

27. Opiods are not used in the practice of psychiatry because they do not address the symptoms of psychiatric disorders. They may be contraindicated because they may prevent the patient from dealing with those issues which motivate the patient to seek out opiods. A psychiatrist may treat a patient's acute physical pain on a temporary basis until the patient can be seen by an appropriate physician qualified to treat the patient's particular physical pain. (Tr. 60-61, 64-65 and 1028).

28. Percoset is a drug which is bought and sold on the street (Tr. 1072 and 1864).

29. Mental stress and pain should not be treated with medications that address physical pain. Those medications numb the patient, cloud the patient's cognition, and do not contribute

to the patient's ability to deal with the cause of the mental pain. (Tr. 400-401 and 708-709).

30. Psychiatrists are not trained in pain management unless they specifically take courses in that field. There are psychiatrists who have become expert in pain management and who are therefore able to manage patients who have dual diagnoses of psychiatric illnesses and pain disorders. (Tr. 60 and 977-978).

31. Patients with chronic pain and coexisting psychiatric disorders are very difficult, time-consuming and complicated to manage, particularly in a private practice where the need to communicate with other providers is required to properly coordinate the care of these patients. These patients require a team approach, whether the team is a formal one or a de facto one. (Tr. 979, 1032-1036, 1038-1040, 1151-1152 and 2051-2052).

32. The Respondent does not consider himself to be expert in the field of pain management nor does he consider himself to be highly qualified or expert in the treatment of patients with substance abuse or chemical dependency problems. (Tr. 566 and 576).

33. If a psychiatrist does undertake to treat chronic pain, the psychiatrist should ascertain directly or through a team member what the nature of the underlying condition is and what treatment has been given. The psychiatrist should have sufficient information to be satisfied that an appropriate and recent investigation of the patient's non-psychiatric complaint has been conducted. The psychiatrist's record should indicate the location, duration and intensity of the pain, and the specific conditions that affect the severity of the pain. In addition, the record should include a reevaluation of these factors over the course of treatment. (Tr. 110-112, 999-1002, 1008-1009, 1025-1026, 1029-1030 and 1238).

34. A physician treating a patient for pain should assess the efficacy of the treatment on an ongoing basis, including the patient's ability to function. This assessment should be noted in the medical record. (Tr. 252-253 and 1290-1291).

35. The complaint of headache is a nonspecific complaint, the specific cause of which must be understood in order that an appropriate treatment plan can be formulated and pursued (Tr. 704 and 1587-1589).

36. A medical record maintained by a psychiatrist in private practice should contain the patient's history, treatment plan, medication notes, and progress notes. Its purpose is to provide a record of what condition is being treated, how the patient is responding to treatment, and what adjustments are being made to treatment. The record is maintained for the benefit of both the physician and the patient. (Tr. 7–71).

37. In the case of a conflict between the number of patient visits authorized by a health plan and the number of visits thought appropriate by a physician, the physician is not relieved of responsibility for seeing the patient as frequently as is needed (Tr. 253).

## SPECIFIC FINDINGS AS TO EACH PATIENT

### Patient A

38. The Respondent first treated Patient A, a 26 year old female with a history of drug and alcohol abuse, on March 3, 1998. The Respondent treated her from March 3, 1998 through May 19, 1998 (Ex. 5).

39. When Patient A arrived at the Respondent's office for her initial consultation she was unsteady on her feet and her eyes were glazed over (Tr. 482).

40. The Respondent's initial evaluation of Patient A lasted approximately fifteen minutes. The usual length of an initial psychiatric evaluation is forty-five minutes to one hour. (Tr. 52 and 482).

41. The Respondent failed to obtain an adequate history and conduct an adequate evaluation of Patient A at the time of the initial visit. The Respondent did not record a chief complaint, history of present illness, or present signs or symptoms of the complaint. School and work histories were also omitted. The patient reported having been on medication since the age of seven, but no further information is noted regarding childhood illness and treatment. Although Patient A indicated a history of past drug abuse and hospitalization(s) for detoxification, the Respondent's record does not specify what substance or substances had been abused, nor does the Respondent recall having inquired as to when the abuse and hospitalization(s) had occurred. Furthermore, although the Respondent recorded that the patient had been incarcerated and had violated probation, these areas were left unexplored in the Respondent's record for the patient. Only a partial mental status exam is noted. Finally, the Respondent recorded a diagnosis of Major Depression. This diagnosis is not supported by the evaluation. (Tr. 122-126, 170, 174, 1059, 1065-1079 and 1091-1092; Ex. 5, pp. 1-2).

42. At the time of her initial visit Patient A reported that she had been in an accident in 1990, had slight scoliosis in her back, and was taking Valium for her back. The Respondent did not note who was prescribing the Valium for the patient, nor did he have any contact with the prescribing physician. (Tr. 1862; Ex. 5, pp. 1-2).

43. The Respondent failed to formulate an adequate treatment plan at the time of the initial consultation. The Respondent noted as his treatment plan for Patient A prescribing the

medications Xanax (a benzodiazepine), Ambien (a sleep medication), and Effexor (an anti-depressant). (Tr. 1862-1863; Ex. 5, p. 2; See finding 13, *supra*).

44. Patient A next saw the Respondent eleven days later, on March 14, 1998. The patient related that she had been arrested in New York City for having a "cracked windshield", that she had been "beaten", and that she had her "medication taken away". There is no information as to when these events took place. The Respondent wrote new prescriptions for Xanax and Effexor and, at the patient's specific request, wrote a prescription for 90 tablets of the narcotic Percoset, *daw* (dispense as written). Ninety tablets would constitute a three to four week supply of Percoset. The record does not indicate why the Percoset was prescribed. The Respondent admitted that he had prescribed the Percoset for pain although he had not noticed any bruising, may not have asked where the patient was feeling pain, and did not inquire of the patient whether she had consulted a non-psychiatrist physician for care. (Tr. 135-136, 184-185 and 1863-1864; Ex. 5, p. 2).

45. On March 23, 1998 the Respondent learned that Patient A was in a methadone maintenance program. At her next visit on April 2, 1998, the patient told the Respondent that she had been "kicked off" the methadone program. She also stated that her Klonopin had been "stolen from me". The Respondent issued a new prescription for 120 Klonopin. The patient's father later confirmed that his daughter had been terminated from the program due to non-compliance. (Ex. 5, p. 3).

46. During the six and one-half week period between April 2, 1998 and May 19, 1998, the Respondent saw the patient only once, on April 28, 1998. During this time period Patient A was hospitalized three times: first, at Stony Lodge Hospital, followed by two admissions to Yonkers General Hospital. The Respondent was in possession of the

patient's hospital record from Stony Lodge Hospital prior to her last consultation with him on May 19, 1998. This hospital record indicates that the patient was admitted to the hospital in a severely intoxicated state; that she admitted to having used two bags of heroin on the day of admission, and that she stated that she was under the influence of multiple medications. The patient reported that she had been in "every rehab (program) you can name" and that her violation of probation had been for possession of a controlled substance. The patient signed out of the hospital with the stated intention of attending a 28 day inpatient program at Arms Acres. It was recommended to Patient A that she also attend 12-step meetings. (Ex. 5, p. 3; Ex. 5A, pp. 8-9, 17 and 35).

47. At some point prior to Patient A's last consultation with the Respondent on May 19, 1998, the patient's mother telephoned the Respondent to inform him of her daughter's lengthy history of drug abuse, to advise him that the patient had been arrested and in a car accident, and to express her concern about the amount of medication he was prescribing. Patient A's mother had observed a deterioration in her daughter's condition during the course of her treatment by the Respondent. (Tr. 484-485 and 1893).

48. On May 19, 1998, Patient A saw the Respondent. The Respondent noted that the patient had been in Yonkers General Hospital since he had last seen her on April 28, 1998. He further noted that the patient plans to "go to college and work in the medical field". There is no indication in the patient's medical record that the Respondent discussed addiction treatment with the patient or recommended a structured program. No evaluation or mental status of the patient is noted in the patient's record. The Respondent wrote prescriptions for Valium # 120 and Percoset, *daw*, # 120. The Respondent had last prescribed Valium # 120 (a month's supply) to the patient twenty-one days earlier, during

the time in which the patient had been hospitalized. The record does not indicate why the medications were prescribed. (Ex. 5, p. 3).

49. At the end of June 1998 Patient A was in a serious car accident and ceased being treated by the Respondent (Tr. 487).

50. The Respondent failed to formulate and pursue an adequate treatment plan for Patient A, as evidenced by the lack of a treatment plan in the medical record, the course of treatment given by the Respondent, and the failure of the Respondent to re-evaluate the patient's treatment in light of the patient's termination from the methadone program, continued drug abuse, serial hospitalizations, and continued need for narcotics. (Tr. 152 and 1085; Ex. 5).

51. The Respondent's pharmacological treatment of Patient A deviated from acceptable medical standards in that he prescribed medications with a potential for abuse to a patient with a history of drug abuse without adequate monitoring; and, he continued to do so after learning that the patient had not been open about being in a methadone program, had been terminated from the methadone program for non-compliance, and was continuing to abuse heroin. (Tr. 151-152; Ex. 5).

52. The Respondent failed to maintain an adequate medical record for Patient A in that the record for the patient does not reflect an adequate initial diagnostic evaluation, a basis for diagnosis, reevaluations of the patient, rationales for the use of medications, and a treatment plan. (Tr. 152, 156, 184, 1068, 1092 and 1095; Ex. 5).

**Patient B**

53. Patient B, a thirty-eight year old female, initially consulted the Respondent on July 18,

1997 and continued in treatment with him through January 30, 2000.[2] (Exs. 7 and C).

54. At the time of the first visit Patient B described herself as an abuser of prescription drugs, stated that she was an attendee of Narcotics and Alcoholics Anonymous, gave a history of opiate and benzodiazepine abuse, and indicated that she had been detoxified from codeine two months earlier. She related that she had been in therapy since the age of fourteen, began treatment with benzodiazepines at twenty-one, and has been treated with anti-depressant medications. She also reported that she had undergone back surgery for two herniated disks in 1993. In the Case Review and Summary portion of the Patient Face Sheet of the patient's medical record the Respondent noted that the patient was "an overweight woman, depressed, concerned about her 'habit'." As a treatment plan the Respondent prescribed medications for anxiety and depression and wrote "try slowly to decrease painkillers". The Respondent did not prescribe any medications for the treatment of pain at this first visit. (Tr. 201-202 and 1901; Ex. 7, pp. 11-12).

55. The first time the Respondent prescribed medication for the treatment of Patient B's pain was on November 15, 1997, when he wrote a prescription for the narcotic Vicodin ES # 90. The Respondent next saw the patient nine days later, on November 24, 1997, when he noted "Has overused Vicodin ES, give # 90". At the next two appointments Patient B was again given prescriptions for Vicodin ES – a prescription for 75 given five days later on November 29, 1997 and a prescription for another 70 given six days after that on December 5, 1997. The Respondent next saw the patient one week later, on December 12, 1997, and wrote another prescription for Vicodin. This amounts to 325 tablets being prescribed for the twenty-seven day period between November 15, 1997 and December

[2] Although the Respondent treated Patient B through January 30, 2000, the instant charges concern the Respondent's actions through July 4, 1999.

12, 1997. The usual dose of Vicodin is three to four tablets a day. Patient B was prescribed enough medication to enable her to consume in excess of twelve tablets per day. This amount of medication is excessive and indicative of substance abuse. The Respondent's record for these dates does not reflect any discussions with the patient concerning her overuse of medication. None of the entries for the visits referred to above contains an explanation for the prescribing of the Vicodin. (Tr. 260-263; Ex. 7, p. 14).

56. The Respondent continued to prescribe narcotic medications to Patient B throughout the course of treatment. The medications included Percodan, Lortab, Vicoprofen, Percoset and Roxicet. The Respondent did so despite his own realization that shortly after he began prescribing narcotics to the patient she was "out of control", "out of hand" and that "she very frequently used so many that whatever I prescribed had to be replaced immediately". The Respondent was also aware that the patient was not functioning well during the course of treatment. There was a deterioration in her personal hygiene and appearance as well as in her ability to fulfill responsibilities at home and work. In addition, the Respondent continued to prescribe large quantities of narcotics to Patient B after he had learned that she had been obtaining similar prescriptions from other physicians – from March 25, 1999 through April 25, 1999 the Respondent gave her prescriptions for 450 tablets. The Respondent continued to issue prescriptions after Patient B claimed that medications had been left behind or stolen. (Tr. 524, 1907, 1909 and 1925-1926; Ex. 7, pp. 14-18).

57. The Respondent persisted in his prescribing practices despite concerns expressed by third parties. The Respondent noted that the patient's husband, who he knew was a substance abuse counselor, telephoned him on January 16, 1998 to complain about his wife's

prescriptions. Patient B's husband had called to inform the Respondent of his wife's history of addiction to pain medications and benzodiazepines, suicide attempts, and hospitalizations. Patient B's husband made a second call to the Respondent around March 1998 following his wife's release from an inpatient program at which she had undergone substance abuse detoxification from Vicodin and Klonopin. Patient B's husband expressed his surprise and indignation that the Respondent was continuing to prescribe the same or similar medications to his wife. Patient B's husband initiated a third telephone contact with the Respondent around May 1998, wherein he expressed his concern about his wife's well-being, her struggles with addiction, and the Respondent's continued prescribing practices. The Respondent's response was to "hang up" on him. (Tr. 520-523, 537, 1911 and 1943-1944; Ex. 7, pp. 11 and 14).

58. The Respondent was also made aware of Patient B's potential overuse of controlled substances by her insurer, Oxford Health Plans. In two letters, the first dated March 1998 and the second dated September 1998, Oxford alerted the Respondent to the number of prescriptions of narcotics being prescribed by multiple physicians within given time periods. The Respondent was asked to complete a physician evaluation form on both occasions, which he did. He responded both times that the patient was at risk for overuse of controlled substances, but that he would not be changing his prescribing habits. (Ex. 7, pp. 5-10).

59. The Respondent provided prescriptions for controlled substances in an effort to treat Patient B's physical pain without consultation with prior treating physicians or referrals to appropriate physicians for current evaluation and exploration of other treatment alternatives. (Tr. 221, 226-227 and 1925-1926; Ex. 7).

60. There is nothing in Patient B's medical record indicating that Patient B suffered from back pain (Tr. 1299; Ex. 7).

61. The Respondent failed to pursue an adequate treatment plan for Patient B. He did not follow his own plan to decrease the patient's use of painkillers by limiting her supply of medication. He did not adequately address overuse of narcotics. He did not make any modifications to his treatment of the patient in light of information he received. Finally, he did not seek outside consultations for the patient's complaint of back pain or her substance abuse problem. (Tr. 219-221; Ex. 7).

62. The Respondent's pharmacological treatment of Patient B deviated from acceptable medical standards in that the Respondent prescribed amounts of narcotic medication sufficient to enable the patient to overuse the medication without indication or justification for the need for such medication (Tr. 206-207; Ex. 7).

63. The Respondent failed to maintain a medical record for Patient B which adequately documents indications for pharmacological treatments and assessments of the patient (Tr. 1295-1297; Ex. 7).

**Patient C**

64. Patient C was a twenty-eight year old male when he first saw the Respondent on June 13, 1994. The Respondent treated him from June 13, 1994 through October 8, 1998. (Ex. 8).

65. At the initial consultation Patient C provided the Respondent with a long history of psychiatric hospitalizations, including one which had ended six days earlier, as well as inpatient treatment for alcoholism. The Respondent noted "alcoholism" as the precipitating factor in the patient's seeking treatment and that the patient "tries to go to AA". The patient further indicated that he had been disabled in 1989, could not leave his

home, and was paranoid. The Respondent recorded a diagnosis of Bi-polar Disorder, mixed, in partial remission, and noted as his treatment plan for Patient C a list of prescriptions – Risperdal (a major tranquilizer used for psychotic symptoms), Lithium and Klonopin. The Respondent did not order any baseline laboratory studies for the patient prior to prescribing the lithium. The Respondent did not address the patient's alcohol abuse, which constitutes a significant omission in his treatment plan. (Tr. 291-294, 1949 and 1965; Ex. 8, pp. 1-2).

66. Other than a notation on the Patient Face Sheet completed at the initial consultation and a progress note written when the patient called the Respondent from an alcohol detoxification program, there is no mention in the patient's medical record of attendance at AA meetings or of any treatment or help that the patient was receiving for his alcohol and substance abuse problem. (Tr. 358-360; Ex. 8).

67. The Respondent failed to formulate and pursue an adequate treatment plan for Patient C in that the Respondent 1) failed to address the patient's need for a highly structured program for his alcohol and substance abuse, 2) failed to establish therapeutic goals, 3) did not obtain information from other providers necessary for the formulation of an appropriate course of treatment, 4) failed to assess the patient's mental status and functioning which is necessary for the formulation of a treatment plan, and 5) did not modify the patient's treatment following hospitalizations and detoxification. (Tr. 329-332 and 370-377; Ex. 8).

68. The Respondent's pharmacological treatment of Patient C deviated from acceptable medical standards in that he prescribed potentially addictive medications to a patient who he knew to be an abuser of medication and alcohol. These medications were prescribed

without adequate controls and justifications and in combinations without discernible reason. (Tr. 304-305, 310-311, 313-314, 320, 325-332, 378-379, 1312-1313 and 1331; Ex. 8, pp. 3-12, 22-27; Ex. 17, pp. 4-5).

69. The Respondent's care also deviated from acceptable medical standards in that he failed to adequately monitor Patient C's blood lithium level and to obtain baseline laboratory values prior to prescribing the lithium. The Respondent obtained three blood lithium levels for Patient C during a course of treatment that lasted more than four years. This was not an adequate number of lithium blood levels to insure that the patient had not reached a toxic lithium level and to confirm that the patient's lithium level was within the therapeutic range. (Tr. 1318-1320 and 1328-1329; Ex. 8).

**Patient E**

70. Patient E was a forty-one year old male when he initially consulted the Respondent on July 3, 1997. The Respondent treated Patient E from July 3, 1997 through November 17, 2000.[3] (Exs. 10 and E).

71. The Respondent failed to formulate and pursue an adequate treatment plan for Patient E in that the Respondent 1) failed to establish therapeutic goals, 2) did not obtain information and consultations necessary for the formulation of a treatment plan for the patient's complaint of pain, 3) did not recommend psychotherapy to the patient prior to his hospitalization, and 4) failed to adequately address the patient's need for a structured program for his substance abuse problem. (Tr. 449, 462-463 and 1239-1240; Ex. 10).

72. The Respondent's pharmacological treatment of Patient E deviated from acceptable medical standards in that he prescribed narcotic medications to the patient without any

[3] Although the Respondent treated Patient E through November 17, 2000, the instant charges concern the Respondent's actions through July 9, 1999.

medical justification and he continued to do so even after he believed the patient to be an abuser of those medications. Furthermore, the Respondent prescribed both narcotics and benzodiazepines to the patient without adequate control, monitoring and assessments. (Tr. 398-402, 416, 419, 424-427, 432-436, 448-449, 1992-1993, 2004, 2007, 2015-2016, 2024, 2033 and 2042-2047; Ex. 10, pp. 2-5 and 9-14).

73. The Respondent failed to maintain a medical record for Patient E which adequately documents indications for pharmacological treatments and assessments of the patient. (Tr. 449, 1236 and 2035; Ex. 10).

74. The initial evaluation contains inadequate information concerning the patient's childhood, education, psychiatric history, history of substance and alcohol abuse, and treatment for back pain (including the omission of who was currently prescribing medication for the patient). No mental status evaluation is noted. (Tr. 389-398, 1997-1998; Ex. 10, pp. 1-2)

75. On February 27, 1999, Patient E was admitted to Rye Hospital Center as the Respondent's patient. Patient E provided a history of long-term abuse of street drugs, medications and alcohol. He remained in the hospital until March 8, 1999. During his hospitalization his use of narcotics was reduced. His prognosis was thought to be "good if patient remains compliant with the treatment plan and continues in psychodynamic psychotherapy with attendance in NA and/or AA". There is no indication in the Respondent's record that Patient E was attending NA and/or AA meetings following discharge from the hospital or that the Respondent even inquired as to his attendance at any such meetings. (Tr. 464-465; Ex. 10, pp. 6-8; Ex. E).

76. On one occasion the Respondent gave Patient E a prescription - Valium # 120 - for

Patient E's wife (Ex. 10, p. 9).

77. Delivering a prescription to one member of a family for the use of another member of the family, also a patient, is not uncommon and, in and of itself, does not deviate from acceptable medical standards (Tr. 1555-1558).

**Patient F**

78. Patient F was a forty-seven year old female when she initially consulted the Respondent on October 11, 1996. The Respondent treated Patient F from October 11, 1996 through at least April 19, 2001.[4] (Exs. 11 and F).

79. The Respondent diagnosed the patient as having anxiety, Panic Disorder without Agoraphobia, and Opioid Dependence. The Respondent noted as his treatment plan "Give Vicodin ES # 60, for one week". (Tr. 890, 1356, 1358 and 1461; Ex. 11, pp. 1-2).

80. The Respondent failed to formulate and pursue an adequate treatment plan for Patient F in that the Respondent 1) failed to adequately evaluate, or refer for evaluation, the patient's headaches, 2) failed to adequately evaluate the patient's psychiatric condition, including her possible ADD, 3) failed to indicate the basis for the treatments that were given, 4) failed to set treatment goals, and 5) failed to evaluate the patient's functioning as treatment proceeded. (Tr. 730-731 and 1367; Ex. 11).

81. The Respondent's pharmacological treatment of Patient F deviated from acceptable medical standards in that the Respondent continued for a period of years to prescribe narcotic medications without apparent justification to a patient who had sought treatment from him to stop her abuse of such medications. The Respondent did so without setting therapeutic goals and evaluating the patient's functioning as treatment progressed.

[4] Although the Respondent treated Patient F through at least April 19, 2001, the instant charges concern the Respondent's actions through July 30, 1999.

Furthermore, he prescribed additional medications which are subject to abuse. (Tr. 727-728, 730-731 and 760; Ex. 11).

82. The Respondent continued to prescribe Vicodin ES to Patient F with an immediate escalation in the amount of medication being prescribed. On October 29, 1996, four days after having received a prescription for Vicodin ES # 60, the patient came to the Respondent's office on an emergency basis, at which time the Respondent noted "during stress has used much more Vicodin". The Respondent prescribed another 60 tablets. On November 12, 1996, the Respondent noted "Overused Vicodin, is back on emergency basis". On December 6, 1996, the Respondent prescribed 120 tablets of Vicodin ES. Four days later, on December 10, 1996, the patient returned indicating that her daughter, Patient G, had taken her medication. The Respondent prescribed another 70 Vicodin tablets for Patient F. This was followed by prescriptions for 120 Vicodin tablets on December 17, 1996, 120 Vicodin tablets on January 2, 1997, and 100 Vicodin tablets on January 7, 1997. (Ex. 11, pp. 3-4).

83. The Respondent continued to prescribe Vicodin ES and/or other narcotics to Patient F throughout the course of treatment, seeing her mostly on a weekly basis and frequently for extra medication. Patient F often sought more Vicodin. On December 15, 1997, the Respondent prescribed both Vicodin ES and Hycodan syrup (a narcotic cough syrup) to Patient F who had "headache, sniffles, etc". The Respondent prescribed Hycodan on many other occasions when no cold or cough symptoms were noted. The Respondent also prescribed the narcotics Lortab and Percodan to Patient F. The Respondent's record for the patient rarely indicates why the narcotics were prescribed. Although there are a few references to headache, the Respondent did not address the headache pain with the

patient nor were referrals made or consultations sought in order to understand the etiology and explore possible alternate treatment of the headaches. Numerous notes appearing in the record relate to stress at home and work. Obscuring stress with narcotic medication does not help a patient in dealing with the stress. The patient record does not contain a plan for the reduction of the patient's use of narcotics and does not reveal an effort to control the patient's supply of medication. On April 5, 1999, the Respondent prescribed Hycodan # 180 and noted "will try to decrease after 15th". On each of the next three visits – April 19, 1999, April 26, 1999 and May 10, 1999 - prescriptions of 180 Hycodan tablets were given to the patient. (Tr. 708-709, 717, 729 and 887; Ex. 11, pp. 9-16).

84. On January 7, 1997, the Respondent added Cylert to Patient F's medication regimen. The medical record does not indicate why the Cylert was prescribed, although the Respondent added a diagnosis of ADHD, inattentive type, to the patient's Face Sheet. The Respondent based his diagnosis on Patient F's responses to a checklist of symptoms of ADHD contained in two news articles (Exs. I and J) which the Respondent had given her to review. The Respondent did not make any notes regarding the patient's self-reported symptoms, her history, or his observations which led him to consider this diagnosis. (Tr. 856-860; Ex. 11, pp. 1, 2 and 4).

85. On January 14, 1997, the Respondent prescribed Klonopin to Patient F. The Respondent continued to do so through much of the course of treatment, sometimes prescribing large quantities of the medication. A reasonably prudent physician would have been more cautious in prescribing a medication with a potential for abuse to a patient who was a known abuser of medication. (Tr. 720-724; Ex. 11, pp. 4-16).

86. On August 31, 1988, the Respondent wrote a prescription for Patient G, Patient F's daughter, which he gave to Patient F for delivery to Patient G. This prescription was for Klonopin, a medication which was also being prescribed for Patient F. (Tr. 711 and 730; Ex. 11, p. 15; See finding 77, *supra*).

87. The Respondent failed to maintain a medical record for Patient F which adequately documents indications for pharmacological treatments and assessments of the patient (Ex. 11).

88. Patient F was self-referred and gave the reason for her seeking treatment as "uses too much meds". On the Patient Face Sheet next to "Substance Abuse" the Respondent noted "Vicodin ES overuse!" which the patient had been taking for headaches for three years. Although Patient F testified that her headaches were related to sinus infections, the Respondent's patient record 1) does not mention sinus infections as a possible cause of the headaches and contains no medical history, 2) does not reflect who had been prescribing the medication to Patient F, and 3) what, if any, work-up had been done for the headaches. Furthermore, the record does not contain the patient's psychiatric history, even though the patient had been in treatment with at least one psychiatrist for several years in the early 1990's. Finally, the Respondent did not note a mental status examination. (Tr. 730-731 and 1367-1368; Ex. 11).

**Patient G**

89. Patient G, the daughter of Patient F, was almost 18 years old when she initially consulted the Respondent on December 6, 1996. The Respondent treated Patient G from December 6, 1996 through July 2, 1999. (Tr. 1782; Ex. 12).

90. The Respondent failed to formulate and pursue an adequate treatment plan for Patient G

in that the Respondent 1) failed to adequately evaluate Patient G, 2) failed to establish the basis for prescribing medications, 3) failed to set treatment goals and assess the patient's progress during the course of treatment, and 4) failed to address the patient's abuse of medication in a timely and effective manner. (Tr. 797-798; Ex. 12).

91. The Respondent's pharmacological treatment of Patient G deviated from acceptable medical standards.

92. On December 10, 1996, Patient F reported to the Respondent that her daughter, Patient G, had taken her (Patient F's) medications. Although the Respondent noted this information in Patient F's medical record, he did not record this information in Patient G's medical record nor did he address this accusation with Patient G when she appeared for an office visit on December 17, 1996. Four days later, on December 21, 1996, the Respondent noted that Patient G "has much headache" and he prescribed Vicodin # 60. Although the Patient Face Sheet mentions headaches twice a week, there is no mention of history of treatment, characteristics, or severity of the headaches which would justify the prescription for Vicodin. The Respondent testified that he did not believe it made sense to find out what kind of headache the patient had because she was so emotionally upset and depressed. He further testified that he had chosen Vicodin because he knew that the patient had taken her mother's and that she had "good reactions" to it. Given the patient's previous report that she had been on large doses of codeine in connection with a prior surgery and her possible use of her mother's medication, the Respondent should have been alert to the patient's potential overuse of pain medications and he should have noted his reasoning for the prescription. (Tr. 779-783, 1416-1417 and 1787-1789; Ex. 11, p. 4; Ex.12, p. 19).

93. On January 7, 1997, the Respondent noted in Patient G's record "looks like she overuses like mother". At Patient G's next visit, on January 14, 1997, the Respondent noted that "She likes to take her Vicodin, but should be weaned off it. She also takes Ambien 30 mg * and has to be weaned off." Despite these notations, the Respondent prescribed Vicodin # 60 for Patient G on January 14th. (Ex. 12, p. 20).

94. The Respondent continued to prescribe Vicodin to Patient G through February 26, 1998 without indicating why the medication was being prescribed and despite clear indications that it was being abused. By early February 1997, the Respondent was in receipt of a note from Patient F in which she expressed concern about her daughter's consumption of Vicodin. The note stated that her daughter "has good intentions with the Vicodin, but she was probably taking about 30 tablets a day and she does not have success with the 12." (Tr. 1418 and 1751-1752; Ex. 12, pp. 1 and 20-27)

95. 30 tablets a day is a very large quantity of Vicodin. Although by February 1997 the Respondent considered Patient G to be abusing narcotics, the Respondent did not note any efforts made or recommendations given to secure treatment addressing this abuse. (Tr. 1418 and 1751-1752; Ex. 12, pp. 20-21).

96. On February 6, 1997 the Respondent made arrangements for Patient G's father to supervise Patient G's medications. However, Patient G's overuse of medications continued, with the Respondent noting the patient's continued overuse of medications on March 11, 1997 and March 31, 1997. On April 7, 1997, Patient G came to the Respondent's office crying and screaming. She stated that she "can't control herself" and that her "mother gave me the pills". There is no indication in the patient's record that referrals to other providers or recommendations for hospitalization or detoxification were

considered at this juncture. (Ex. 12, pp. 21-22).

97. The Respondent prescribed potentially addictive medications to Patient G without justification, continued to prescribe narcotics to her after he was aware that she was abusing them, and did not make timely referrals for treatment of her medication abuse. (Tr. 798-799; Ex. 12).

98. On January 23, 1997 and January 30, 1997, the Respondent wrote prescriptions for Patient F, Patient G's mother, which the Respondent gave to Patient G for delivery to Patient F. These prescriptions were for Vicodin. Since the Respondent knew that Patient G had previously taken her mother's Vicodin and was overusing Vicodin herself, it was inappropriate for the Respondent to give the mother's Vicodin prescription to Patient G and constituted a deviation from acceptable medical standards. (Tr. 787-788, 1751-1752 and 1827-1831; Ex. 11, p. 4; Ex. 12, p. 20).

99. The Respondent failed to maintain a medical record for Patient G which adequately documents indications for pharmacological treatments and assessments of the patient (Tr. 799; Ex. 12).

100. The Respondent noted that the patient was seeking treatment for a repeat depression. The Respondent did not obtain an adequate history and mental status evaluation, which is needed for the formulation of a diagnosis and treatment plan. The Respondent also noted that for several months in 1999 the patient did not want to attend school, and that in August 1996 the patient underwent breast reduction surgery and was on massive doses of codeine. The Respondent recorded present symptoms, diagnosed the patient with depression and school phobia, and noted as his treatment plan prescriptions for the anti-depressant Paxil and Ambien, a sleep medication. (Tr. 773-778 and 1411; Ex. 12, pp. 17-

18).

101. On January 2, 1997, Patient G reported that she "took 'overdose' of Vicodin from her mother on New Year's Eve 'to sleep'." There is no indication that the Respondent altered his treatment plan and prescribing practices in the face of such significant information which a reasonably prudent psychiatrist would have done. (Tr. 783-784; Ex. 12, p. 19).

102. Although Patient G began therapy with Ms. Roberts, a social worker, at some point in time while under the Respondent's care, the Respondent did not note when the therapy commenced or how it was progressing. There is no indication in the Respondent's record for Patient G that there was a coordination of care by the Respondent with Ms. Roberts. (Tr. 1811-1814 and 1820-1821; Ex. 12).

103. The Respondent provided Patient G with two news articles (Exs. I and J) concerning ADD and asked her to think about these articles. After discussing these articles with Patient G, the Respondent began prescribing Cylert for her. The Respondent's record for Patient G does not contain any notes which indicate symptoms of ADD, the discussion conducted with the patient, or the reasons for the Cylert prescription. (Tr. 1770-1772; Ex. 12).

**Patient H**

104. Patient H, a male, was almost forty-four years old when he initially consulted the Respondent on December 18, 1999. The Respondent treated Patient H from December 18, 1999 through February 26, 2000. (Ex. 13).

105. Patient H was a self-referred patient. The Respondent noted that the patient had a long history of depression and was always thinking of suicide. The Respondent did not obtain

an adequate history of Patient H. Although the Respondent noted that the patient had been on disability for seven years, the Respondent failed to note the reason why the patient was on disability. In addition, the Respondent did not record a mental status evaluation, the patient's level of functioning, or the patient's relationships with others. Furthermore, the Respondent failed to adequately explore the patient's statement "I am better off dead" which was made during the initial consultation. While past psychiatric hospitalizations are noted in the patient's record, an adequate history of past illness and treatment is not. The Respondent did not note a medical history, but did, under Mental Status, write that the patient had "backaches, muscle pain (tense muscles!)". The Respondent noted as his treatment plan prescriptions for Trazodone, an anti-psychotic medication, Xanax and/or Valium and Dalmane, sedating benzodiazepines, and Ambien, a sleeping medication. (Ex. 13, pp. 2-3).

106. The Respondent failed to formulate and pursue an adequate treatment plan for Patient H in that the Respondent 1) failed to obtain an adequate history upon which an adequate treatment plan could be predicated, 2) failed to establish therapeutic goals, and 3) failed to assess the patient and the effectiveness of the treatment as the treatment progressed. (Tr. 825; Ex. 13).

107. The Respondent's pharmacological treatment of Patient H deviated from acceptable medical standards.

108. During the course of treatment the Respondent continued to prescribe multiple benzodiazepines for Patient H. Using multiple benzodiazepines is not typical and presents the risk of additive effects of sedation to the patient. The Respondent's record for the patient does not provide a rationale for the use of multiple benzodiazepines. If the

Respondent was attempting to treat the patient's back spasm, his failure to investigate or work-up the complaint would constitute a significant omission. (Tr. 826, 1438-1440 and 1442-1443; Ex. 13, p. 4).

109. The Respondent did not adequately evaluate the patient before prescribing medications, over-prescribed benzodiazepines without justification, and did not assess the patient's response to the medications prescribed. (Tr. 826; Ex. 13).

## CONCLUSIONS OF LAW

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

The Respondent did not practice medicine with gross negligence on a particular occasion. The Petitioner has failed to prove by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patient A, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, B, C, E, F, G and H, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

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

The Respondent did fail to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent in connection with the Respondent's treatment of Patients A, B, E, F and G, failed to maintain adequate records that accurately reflect the Respondent's evaluation and treatment of each of these patients.

## DISCUSSION

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

### Discussion of the Witnesses

The Petitioner relies primarily upon the medical testimony of William Rosenthal,

M.D., and the factual testimony of Patient A's Mother and Patient B's Husband, in its efforts to establish its case against the Respondent. While Dr. Rosenthal testified with regard to the Respondent's medical care and treatment of all the patients listed in the Statement of Charges, Patient A's Mother testified about the Respondent's treatment of Patient A and Patient B's Husband testified about the Respondent's treatment of Patient B.

As its first witness the Petitioner presented William Rosenthal, M.D., as an expert in the field of psychiatry. Dr. Rosenthal received his medical training at the Chicago Medical School (1955-1959). After completing his internship at King's County Hospital Center, Brooklyn, N.Y. (1959-1960), he did a Residency in Internal Medicine at the Veteran's Administration Hospital, Bronx, N.Y. (1960-1962), which was followed by a Chief Residency in Internal Medicine at Misericordia Hospital, Bronx, N.Y. (1965-1966). He then went to Westchester County Medical Center where he did a Residency in Psychiatry (1966-1968), followed by a Chief Residency in Psychiatry (1968-1969). He received his psychoanalytic training and certification at Columbia University Psychoanalytic Center for Training and Research (1969-1973). In 1977, he received Board Certification in Psychiatry and Neurology. (Tr. 38-39; Ex. 4).

Dr. Rosenthal served as an Adjunct Assistant Attending Physician at New York Hospital-Cornell Medical Center (1975-1981) and since 1973 he has been both an Instructor in Clinical Psychiatry and a Collaborating Psychoanalyst at the Psychoanalytic Center for Training and Research of Columbia University. He has also served as a Consultant Psychiatrist at Family Services of Westchester, White Plains, N.Y. (1975-1992). In addition, he belongs to various professional organizations and served as President of the Westchester Branch of the American Psychiatric Society (1997-1998). (Tr. 42-43; Ex. 4).

Dr. Rosenthal practiced internal medicine from 1964 through 1965 and has been practicing psychiatry in private practice since 1969. Although he practices general psychiatry, a major portion of his current practice involves psychopharmacology. (Tr. 39-41; Ex. 4).

The Hearing Committee found Dr. Rosenthal to be a highly credible witness with impressive qualifications and expertise. His training in internal medicine added extra weight to his expertise. He was straightforward, non-evasive, and extremely knowledgeable. His statements were backed up by persuasive reasoning. Although, at times, emphatic in his testimony, his bearing and deportment was professional and he appeared unbiased and objective.

Following the testimony of Dr. Rosenthal, the Petitioner presented Patient A's Mother. The Hearing Committee found Patient A's Mother to be honest, sincere, straightforward, non-evasive and without a motive to lie. The Hearing Committee believed her and found her testimony credible.

The Petitioner's final witness was Patient B's Husband. Patient B's Husband was passionate in his testimony against the Respondent and, at times, even angry. Inasmuch as he genuinely believed that his wife received poor treatment from the Respondent and that the Respondent contributed to his wife's decline, he did not appear to be either objective or unbiased. Consequently, the Hearing Committee has strong reservations about the credibility of Patient B's Husband in this particular matter.

The Respondent's case relies primarily upon the medical testimony of James W. Flax, M.D., and Richard S. Blum, M.D., the factual testimony of Patient F and Patient F's Husband, and the medical and factual testimony of the Respondent.

James W. Flax, M.D., the Respondent's first witness, was presented as an expert in the field of psychiatry. He also has a background in Pain Management.

Dr. Flax graduated from the University of Minnesota Medical School (1974), did an internship and a Residency in Psychiatry at the Mary Imogene Bassett Hospital (1974-1976), an affiliate of Columbia-Presbyterian Medical Center, and did a Senior Residency in Psychiatry at Columbia-Presbyterian Medical Center and the New York State Psychiatric Institute (1976-1977). He was a Robert Wood Johnson Clinical Scholar (1977-1979) and received a Masters Degree in Public Health from Columbia University (1980). In 1979, he received Board Certification in Psychiatry and he has added qualifications in Geriatric Psychiatry. (Tr. 962-963; Ex. G).

Dr. Flax served as an Instructor in Clinical Psychiatry at Columbia University College of Physician and Surgeons (1977-1979) and as a Clinical Assistant Professor of Clinical Psychiatry at New York University (1980-1984). Since 1979, he has been an Assistant Clinical Professor of Psychiatry at Columbia University College of Physicians and Surgeons. In addition, Dr. Flax is a member of various professional organizations, including the American Pain Society, and is the co-founder of the Hudson Valley Pain Society. (Ex.G).

At present, Dr. Flax has a private psychiatric practice in Rockland County and he also has a hospital practice at Helen Hayes Hospital, West Haverstraw, N.Y., where he renders the psychiatric treatment (particularly psychopharmacology) aspect of a team approach (Tr. 963-965, 985-986 and 1007-1009; Ex. G).

The Hearing Committee found Dr. Flax to be an impressive witness with an excellent background. He was credible and objective during most of his testimony, although at times he became vague and evasive. However, when pressed he did provide objective testimony, even when such testimony did not support the Respondent's position (Tr. 1416-1419).

Nevertheless, many of Dr. Flax's opinions were unpersuasive due to inherent

weaknesses in his reasoning. First, his opinions relating to the adequacy of the particular patient records maintained by the Respondent were based on the premise that the Respondent's records were acceptable because he, Dr. Flax, frequently sees incomplete and scanty records in the medical community in which he practices. The Hearing Committee does not accept this view and believes that the failure of some physicians in the medical community to maintain accurate and complete patient records does not excuse the Respondent, or for that matter any other physician, from the responsibility to maintain accurate and complete medical records for each patient. Secondly, his opinions relating to the appropriateness of the treatment rendered to each particular patient were based on the assumption that, where there is insufficient information in the patient record for the reviewing physician to formulate an opinion, the physician who originally rendered the treatment "knows what he is doing". (Tr. 1427-1432). Consequently, by assuming at the outset that the Respondent knew what he was doing, the opinion that the treatment was adequate becomes a foregone conclusion.

Richard S. Blum, M.D., the Respondent's second medical witness, was presented as an expert in the field of pharmacology, with a background in pain management and substance abuse. Dr. Blum attended Chicago Medical School (1959-1963) and did an internship (1963-1964), Assistant Residency in Internal Medicine (1966-1968), and Chief Residency in Internal Medicine (1968-1969) at Long Island Jewish Hospital, New Hyde Park, N.Y.. He also received postdoctoral training in pharmacology and toxicology at St. John's University School of Pharmacy (1972-1976). (Tr. 1109-1110; Ex. H).

Dr. Blum served as the Medical Director of the Methadone Maintenance Treatment Program at Long Island Jewish-Hillside Medical Center, Hyde Park, N.Y. (1970-1978). He also has served on numerous professional committees concerned with drug abuse

issues and he has written extensively in the area of drug use and abuse. (Tr. 1112-1116; Ex. H).

Up until 1998, Dr. Blum had a private medical practice in internal medicine, with an emphasis on pharmacology. Currently, he is working as the Medical Director of United Cerebral Palsy, Suffolk, County, N.Y., where he sees most of his patients. However, he occasionally sees a few private patients at his home office. (Tr. 1110-1111; Ex. H).

The Hearing Committee had various concerns about the credibility of Dr. Blum. The information listed in his Curriculum Vitae appears embellished and, at times, is at variance with his testimony. In addition, the Hearing Committee notes that although Dr. Blum was presented as an expert in pharmacology with additional expertise in pain management and substance abuse, he has no formal credentials in either pharmacology or psychiatry. (Ex. H). Furthermore, he readily offered opinions in areas where his expertise was not established. For example, he testified about the mechanism of death of Patient H while criticizing the Medical Examiner's Report. However, when questioned about his expertise in forensic pathology, he acknowledged that his expertise was based on an autopsy that he performed in medical school and another autopsy that he observed while a resident. (Tr. 1647-1648).

Additionally, many of Dr. Blum's opinions were weakened by the inadequacy of the patient records maintained by the Respondent. These records were reviewed by Dr. Blum prior to testifying and provided the foundation for many of his opinions. Since many of these records did not provide sufficient information about the patient and the care provided, Dr. Blum was unable to assess the Respondent's medical judgment in his treatment of these patients. (Tr. 1590-1594).

After the completion of the medical testimony of Drs. Flax and Blum, the Respondent presented two factual witnesses - Patient F, and then her husband. Patient F and her

husband, who are also the parents of Patient G, highly praised the Respondent and each provided favorable testimony regarding the Respondent's medical care and treatment of both Patient F and their daughter, Patient G.

The Hearing Committee found Patient F and her husband to be sincere witnesses, who were quite convincing in their description of the Respondent as being a caring and unselfish physician. However, their testimony, although complimentary, shed minimal light on the precise charges which are the subject of this hearing and was of limited value to the resolution of the medical issues upon which this matter is based.

The most important witness to testify in support of the Respondent's case, was the Respondent himself. The Respondent is a board certified psychiatrist, who maintains a private psychiatric practice in Rockland County and has an active caseload of approximately 800 patients. (See findings 1 through 8, *supra).* The Hearing Committee found the Respondent to be a presentable witness with an adequate background in psychiatry, but not in pain management.

However, the Hearing Committee was not impressed with the Respondent's testimony and had various concerns about his credibility. He did not maintain a consistent level of believability throughout his testimony. For example, at different times during his testimony, he willingly conceded obvious mistakes that he had made. However, at other times during his testimony, he made unconvincing attempts to justify or minimize other mistakes. Consequently, while he appeared sincere and certain portions of his testimony appeared forthright and truthful, other portions of his testimony appeared self-serving and questionable.

The Hearing Committee notes that the Respondent readily takes on complicated cases involving pain related to chronic illnesses and disorders, *i.e.* neurological and/or musculo-skeletal, without either the requisite training or expertise in the management of those disorders or

consultations with or referrals to those who have. The Respondent attempts to justify his handling of these cases by suggesting that when the primary diagnosis is major depression or anxiety state, it is proper for him to treat these patients without consultation with or referral to a physician with the requisite expertise. The Hearing Committee disagrees.

Finally, the Hearing Committee observed that the Respondent lacks the ability of self-criticism and knowledge of his own limitations.

**Discussion of the Charges**

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary incompetence, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients. An evaluation of the factual testimony concerning the Respondent's treatment of each of the particular patients was also required.

The resolution of the recordkeeping issues required an examination of the entries made by the Respondent in the medical records for each patient as well as an evaluation of the medical testimony relating to the adequacy of each of these medical records.

Finally, the Hearing Committee is sympathetic to the use of large quantities of pain medication, including opiates, when appropriate to the patient's needs. However, the physician must document the need for such medication. This documentation should include, at the very least, a recorded assessment of the pain and a continuing assessment in order to determine the effectiveness of the treatment. The Respondent's patient records which were in question did not meet an acceptable minimum standard and often left in doubt whether any assessment was performed at all.

## Discussion of the Treatment of the Patients

### Patient A

The Respondent deviated from acceptable medical standards 1) by failing to obtain an adequate history of the patient, 2) by failing to formulate an adequate treatment plan for the patient, and 3) by his pharmacological treatment of the patient. The Respondent inappropriately prescribed large quantities of controlled substances to a patient who 1) was known to the Respondent as a narcotics abuser, 2) was not forthcoming, and 3) showed signs of manipulative behavior which a psychiatrist would be expected to recognize. Furthermore, the Respondent did not adequately assess and document the patient's history or take into account other information regarding the patient which was relevant to treatment.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient A. However, the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence or constitutes incompetence. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment of Patient A.

Lastly, the Respondent's failure to adequately document the care and treatment that he provided to Patient A, although constituting a violation of § 6530(32) of the Education Law ["Ed Law"], did not constitute negligence since such failure did not adversely affect patient treatment.[5]

### Patient B

The Respondent failed to formulate an adequate treatment plan for the patient and his pharmacological treatment of the patient deviated from acceptable medical standards. The

[5] The determination that the recordkeeping violation relating to Patient A did not constitute negligence was not unanimous. This determination represents the view of a majority of the Hearing Committee.

Respondent inappropriately prescribed large quantities of controlled substances to a known narcotics abuser. In essence the Respondent was providing drugs on demand, since the patient was setting the dosage, not the Respondent (Tr. 1939-1941). This unacceptable situation continued, despite the Respondent being notified of the patient's potential overuse of controlled substances by both the patient's insurer and by the patient's husband (Ex. 8, pp. 6, 8 and 14). If the patient had an underlying physical problem, the Respondent made no effort to consult with prior treating physicians or refer the patient to an appropriate specialist for evaluation and treatment.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient B. However, the Hearing Committee does not believe that any of the proven allegations constitutes incompetence. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment of Patient B.

Lastly, the Respondent's failure to adequately document the care and treatment that he provided to Patient B, although constituting a violation of Ed Law § 6530(32), did not constitute negligence since such failure did not adversely affect patient treatment.

Patient C

The Respondent failed to formulate an adequate and inclusive treatment plan for a chronically ill patient with multiple secondary problems, *i.e.* alcoholism, major depression and drug abuse. In addition, the Respondent's pharmacological treatment of the patient deviated from acceptable medical standards. Consequently, the Respondent grievously failed in his roll as a primary mental health therapist for the patient.

Therefore, the Hearing Committee finds the Respondent negligent in connection

with the medical care that he provided to Patient C. However, the Hearing Committee does not believe that any of the proven allegations constitutes incompetence.

Patient E

The Respondent failed to 1) obtain an adequate history of the patient, 2) formulate an adequate treatment plan for the patient, and 3) address the patient's drug and alcohol problems. In addition, The Respondent's pharmacological treatment of Patient E was below acceptable medical standards in that he prescribed narcotic medications to the patient without any medical justification and he continued to do so even after he believed the patient to be an abuser of those medications. Moreover, the Respondent prescribed both narcotics and benzodiazepines to the patient without adequate control, monitoring and assessments.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient E. However, the Hearing Committee does not believe that any of the proven allegations constitutes incompetence. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment of Patient E.

Lastly, the Respondent's failure to adequately document the care and treatment that he provided to Patient E, although constituting a violation of Ed Law § 6530(32), did not constitute negligence since such failure did not adversely affect patient treatment.

Patient F

The Respondent failed to formulate an adequate treatment plan for the patient and his pharmacological treatment of the patient deviated from acceptable medical standards. Furthermore, the Respondent's pharmacological treatment of the patient demonstrated a lack of the basic skill or knowledge necessary to treat the patient. Although the Respondent originally

diagnosed the patient as having anxiety, Panic Disorder without Agoraphobia, and Opioid Dependence, he subsequently added an additional diagnosis of ADHD. This diagnosis was based on the patient's responses to a checklist of symptoms of ADHD contained in two news articles which the Respondent had given the patient to review.

The Respondent believes that if a patient reports that more than 50 percent of the symptoms appearing in the checklist apply, then it is likely that the patient has ADD or ADHD. The Respondent also believes that the best way to arrive at a definitive diagnosis of ADD or ADHD is with a trial of medication. (Tr. 1672-1682 and 1741; Exs. I and J).

Using lay material for patient education is acceptable. However, reliance upon such material as a primary basis for establishing a diagnosis of and treating ADD and/or ADHD demonstrates a lack of basic understanding of this disorder. (Tr. 759-760 and 1396-1406).

Therefore, the Hearing Committee finds the Respondent both negligent and incompetent in connection with the medical care that he provided to Patient F. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient F which accurately reflects the evaluation and treatment of Patient F.

Lastly, the Respondent's failure to adequately document the care and treatment that he provided to Patient F, although constituting a violation of Ed Law § 6530(32), did not constitute negligence since such failure did not adversely affect patient treatment.

Patient G

The Respondent deviated from acceptable medical standards 1) by failing to formulate an adequate treatment plan for the patient, 2) by his pharmacological treatment of the patient, and 3) by giving Patient G a prescription for her mother, Patient F. The Respondent's pharmacological treatment of the patient also demonstrated a lack of the basic skill or knowledge

necessary to treat the patient.

The Hearing Committee is aware that its determination of the charge that the Respondent gave a patient a prescription for the use of another member of the patient's family, is different for Patient G than it was for Patients E and F. There is a difference between the circumstances relating to Patients E and F and the circumstances relating to Patient G.

Delivering a prescription to one member of a family for the use of another member of the family, also a patient, is not uncommon and, in and of itself, does not deviate from acceptable medical standards. However, it is imprudent and unacceptable to give a patient, who is a known abuser of a specific drug, a prescription for that particular drug for the use of another family member. By doing so the physician puts into the hands of the abusing patient a prescription for the very drug that the patient abuses. Thus, the case of the mother, Patient F, being given a prescription for Klonopin for her daughter, Patient G, is significantly different from the daughter, Patient G, receiving her mother's, Patient F's, prescription for Vicodin. While the record does not show that the mother, Patient F, was an abuser of Klonopin, the Respondent knew that the daughter, Patient G, was abusing Vicodin. (Tr. 1828-1831). This is a significant distinction.

Therefore, the Hearing Committee finds the Respondent both negligent and incompetent in connection with the medical care that he provided to Patient G. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient G which accurately reflects the evaluation and treatment of Patient G.

Lastly, the Respondent's failure to adequately document the care and treatment that he provided to Patient G, although constituting a violation of Ed Law § 6530(32), did not constitute negligence since such failure did not adversely affect patient treatment.

Patient H

The Respondent failed to formulate an adequate treatment plan for a chronically ill patient who was depressed, expressed suicidal ideation, and was probably psychotic. In addition, the Respondent's pharmacological treatment of the patient deviated from acceptable medical standards.

The Respondent's evaluation of the patient was inadequate and failed to include a mental status, which may have indicated an active suicidal and psychotic process. Despite being notified that the patient was hallucinating, the Respondent failed to evaluate and adequately address and explore the patient's underlying condition.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient H. However, the Hearing Committee does not believe that any of the proven allegations constitutes incompetence.

## VOTE OF THE HEARING COMMITTEE

**(All votes were unanimous unless otherwise specified)**

### Factual Allegations

Factual Allegations relating to the treatment of Patient A

Sustained: A, A1, A2, A3 and A4

Factual Allegations relating to the treatment of Patient B

Sustained: B, B1, B2 and B3

Factual Allegations relating to the treatment of Patient C

Sustained: C, C1 and C2

Factual Allegations relating to the treatment of Patient E

Sustained: E, E1, E2 and E4

Not Sustained: E3

Factual Allegations relating to the treatment of Patient F

Sustained: F, F1, F2 and F4

Not Sustained: F3

Factual Allegations relating to the treatment of Patient G

Sustained: G, G1, G2, G3 and G4

Factual Allegations relating to the treatment of Patient H

Sustained: H, H1 and H2

**Specifications**

Gross Negligence

1st Specification (Treatment of Patient A) Not Sustained

Negligence on More than One Occasion

2nd Specification Sustained

Sustained Factual Allegations in Support of the 2nd Specification:

Treatment of Patient A: A, A1, A2 and A3

Treatment of Patient B: B, B1 and B2

Treatment of Patient C: C, C1 and C2

Treatment of Patient E: E, E1 and E2

Treatment of Patient F: F, F1 and F2

Treatment of Patient G: G, G1, G2 and G3

Treatment of Patient H: H, H1 and H2

Incompetence on More than One Occasion

3rd Specification Sustained

Sustained Factual Allegations in Support of the 3rd Specification:

Treatment of Patient F: F and F2

Treatment of Patient G: G and G2

Failure to Maintain a Patient Record

4th Specification (Medical Record of Patient A) Sustained

Sustained Factual Allegations in Support of the 4th Specification: A and A4

5th Specification (Medical Record of Patient B) Sustained

Sustained Factual Allegations in Support of the 5th Specification: B and B3

6th Specification (Medical Record of Patient E) Sustained

Sustained Factual Allegations in Support of the 6th Specification: E and E4

7th Specification (Medical Record of Patient F) Sustained

Sustained Factual Allegations in Support of the 7th Specification: F and F4

8th Specification (Medical Record of Patient G) Sustained

Sustained Factual Allegations in Support of the 8th Specification: G and G4

## DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that the Respondent's license to practice medicine in the State of New York should be suspended for a period of four years ["the suspension"], that the

suspension is to be stayed, and that the Respondent is to be placed on probation for the four year period of the suspension. In addition, the terms of probation shall include a requirement for a Practice Monitor, a requirement that the Respondent enroll in and complete a continuing medical education program in the area of medical recordkeeping, and a restriction prohibiting the Respondent from prescribing opiates. The complete terms of probation are attached to this Determination and Order as Appendix II.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough examination of the Respondent's testimony and demeanor during the hearing.

The Hearing Committee unanimously concluded that the Respondent's conduct was unacceptable and that the Respondent failed to fully appreciate the seriousness of his actions. The Hearing Committee believes that in view of all the circumstances, a four year stayed suspension, connected to probation, is an appropriate penalty. Furthermore, the Hearing Committee recognizes that its primary responsibility is to protect the public and it firmly believes that it is fulfilling this responsibility by imposing probation with provisions for a Practice Monitor, continuing medical education in medical recordkeeping, and a prohibition against prescribing opiates.

The Hearing Committee observed that, with respect to the particular patients who were the subject of this hearing, the Respondent's pattern of practice revealed 1). a flawed

approach to the prescribing of potentially addictive medications, 2) poor clinical judgment, and 3) an inability to recognize the limitations of his own expertise. Moreover, the Respondent did not conduct and record adequate mental status evaluations and present symptoms. This omission was exacerbated by the Respondent's failure to establish a treatment plan that includes therapeutic goals and functional benchmarks against which progress or lack of progress can be measured.

The Hearing Committee believes that the most effective way to address its primary concern – the manner in which the Respondent practices psychiatry – is to require some oversight of the Respondent's psychiatric practice. While probation provides continuing supervision over a period of time, straight probation, although useful, is not enough. It needs to be supplemented by a specialized form of oversight. A Practice Monitor would provide the necessary specialized oversight, thereby insuring the safety of the public.

In addition, the Hearing Committee noted that many of the sustained misconduct charges emanated from or were aggravated by inadequate recordkeeping. Since many of the Respondent's deficiencies are connected in one way or another to his failure to maintain adequate patient records, supplemental training in medical recordkeeping would enable the Respondent to overcome his shortcomings in recordkeeping. Furthermore, a Practice Monitor would have the responsibility to review the Respondent's patient records on an ongoing basis. Therefore, a Practice Monitor would serve as an additional measure in improving the quality of the patient records maintained by the Respondent.

Finally, the Hearing Committee was particularly concerned about the Respondent's prescribing practices relating to opiates. This concern is alleviated by the prohibition against prescribing opiates.

In addressing this concern regarding opiates, the Hearing Committee considered a broad restriction of the Respondent's right to prescribe controlled substances. Although a broad restriction prohibiting the Respondent from prescribing controlled substances would prevent the Respondent from prescribing opiates, it would also have the unfortunate consequences of limiting the Respondent's ability to prescribe various non-opiate medications that may be appropriate for the treatment of many patients suffering from serious psychiatric disorders. Therefore, the Hearing Committee believes that a narrower restriction – a restriction that only prohibits the Respondent from prescribing opiates – is a reasonable compromise and appropriate.

The Hearing Committee was impressed with the testimony of Patient F and her husband when they described the caring, empathetic, dedicated and unselfish manner in which the Respondent cared for Patient F and their daughter, Patient G. The Hearing Committee is also mindful that substance abusers are very difficult patients to treat and many psychiatrists in private practice are reluctant to take on the management of such patients. Additionally, it should be noted that the Statement of Charges contains only a single specification charging gross negligence and that particular specification was not sustained. Given the totality of the circumstances regarding this matter, the Hearing Committee believes that the revocation of the Respondent's medical license is not warranted.

The Hearing Committee does not wish to be misunderstood as to in any way condoning the Respondent's conduct. The penalty imposed herein is designed to affirm the Hearing Committee's disapproval of the Respondent's conduct while imposing a fair punishment and offering sufficient protection to the public.

The Hearing Committee believes that by allowing the Respondent to practice medicine under the strict conditions it is imposing, the public is sufficiently protected and the

Respondent can continue to provide an important service to the community.

## ORDER

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

1. The 2nd, 3rd, 4th, 5th, 6th, 7th and 8th Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I), are **SUSTAINED**; and

2. The 1st Specification of professional misconduct contained within the Statement of Charges (Appendix I) is **DISMISSED**; and

3. The Respondent's license to practice medicine in the State of New York is hereby **SUSPENDED** for a period of four years ["the suspension"], the suspension is to be **STAYED** and the Respondent is to be placed on **PROBATION** for the four year period of the suspension; and

4. The **TERMS OF PROBATION** shall include a requirement for a Practice Monitor, a requirement that the Respondent enroll in and complete a continuing medical education program in the area of medical recordkeeping, and a restriction prohibiting the Respondent from prescribing opiates; and

5. The Respondent shall comply with all **TERMS OF PROBATION** as set forth in Appendix II, which is attached hereto and made part of this Order; and

6. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

**Dated:** **New York, New York**
**October 30 , 2001**

REDACTED SIGNATURE

**DAVID HARRIS, M.D.**
**Chairperson**

**SHELDON GAYLIN, M.D.**
**LOIS VOYTICKY**

**TO:** **ARISTIDE HENRI ESSER, M.D.**
REDACTED ADDRESS

**ANTHONY Z. SCHER, ESQ.**
Wood & Scher
14 Harwood Court – Suite 512
Scarsdale, N.Y. 10583

**LENI S. KLAIMITZ, ESQ.**
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5 Penn Plaza, Suite 601
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# APPENDIX I

**APPENDIX I**

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

**AMENDED**

IN THE MATTER

OF

ARISTIDE HENRI ESSER, M.D.

STATEMENT

OF

CHARGES

ARISTIDE HENRI ESSER, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 20, 1967, by the issuance of license number 099943 by the New York State Education Department.

## FACTUAL ALLEGATIONS

A. Between on or about March 3, 1998, and on or about May 19, 1998, Respondent treated Patient A, a twenty-six year old woman, for psychiatric illness(es) on an outpatient basis at his medical office located at 337 North Main Street, New City, New York 10956 (hereinafter "medical office"). (The names of patients are contained in the attached Appendix.) Respondent's medical records indicate that as of the initial visit, Respondent was aware of Patient A's history of alcohol and drug abuse. On or about March 23, 1998, Respondent noted in the record that the patient was in a methadone program. During the course of Respondent's treatment of Patient A, the patient was discharged from the methadone program due to "non-compliance", requested a new prescription for reportedly stolen medication and was arrested.

1. Respondent failed to obtain an adequate history of Patient A's illness and to perform an adequate evaluation of her condition.
2. Respondent failed to formulate and pursue an adequate

treatment plan for Patient A.

3. Respondent's pharmacological treatment of Patient A deviated from acceptable medical standards.

4. Respondent failed to maintain a medical record for Patient A which adequately documents indications for pharmacological treatments and assessments of the patient.

B. Between on or about July 18, 1997 and on or about ~~June 3, 1999~~ July 4, 1999,* Respondent treated Patient B, a woman who was thirty-eight years old when treatment with the Respondent commenced, for psychiatric illness(es) on an out-patient basis at his medical office. Respondent's medical records indicate that at her initial visit Patient B described herself as an abuser of prescription drugs with a history of hospitalization for detoxification and an attendee of Narcotics Anonymous and Alcoholics Anonymous meetings. During his treatment of Patient B, Respondent was notified by the patient's insurer on two occasions of the potential overuse and/or high utilization of controlled substances by Patient B and received complaints about the patient's medications from her husband (an alcoholism counselor), who flushed her medications down the toilet.

* Amended on consent on 6/29/01 SEB ALJ

1. Respondent failed to pursue an adequate treatment plan for Patient B.

2. Respondent's pharmacological treatment of Patient B deviated from acceptable medical standards.

3. Respondent failed to maintain a medical record for Patient B which adequately documents indications for pharmacological treatments and assessments of the patient.

C. Between on or about June 13, 1994, and on or about October 8, 1998, Respondent treated Patient C, a man who was twenty-eight years old wher treatment with the Respondent began, for psychiatric illness(es) on an out-patient basis at his medical office and during a month-long hospitalization a Rye Hospital Center, Rye, New York 10580, from on or about June 14, 1995, through on or about July 15, 1995. Patient C presented with a histor of alcoholism, psychiatric illness and hospitalizations. During the aforementioned hospitalization, the patient was detoxified from Percocet an benzodiazepines. In an undated note in the medical record Respondent stated that "in 1995 became clear that the patient abuses alcohol and Rx medications."

1. Respondent failed to formulate and pursue an adequate treatment plan for Patient C.
2. Respondent's pharmacological treatment of Patient C deviated from acceptable medical standards.

E. Between on or about July 3, 1997 and on or about July 9, 1999, Responden treated Patient E, a man who was forty-four years old when treatment begar for chronic back pain and psychiatric illness(es) on an outpatient basis. Patient E presented with a history of alcohol abuse and back surgery. In ar undated note in 1998 Respondent added Opioid Dependence as an additional Axis I diagnosis for the patient. On multiple occasions during the course of treatment Patient E requested additional prescriptions stating tha

his wife had taken his medications or flushed his medications down the toile In October of 1995 Patient E threatened suicide and in February 1999 he was hospitalized for detoxification from pain medication. On at least one occasion Respondent gave a prescription for Patient E's wife to Patient E.

1. Respondent failed to formulate and pursue an adequate treatment plan for Patient E.
2. Respondent's pharmacological treatment of Patient E deviated from acceptable medical standards.
3. Respondent deviated from acceptable medical standards in giving Patient E a prescription for his wife.
4. Respondent failed to maintain a medical record for Patient E which adequately documents indications for pharmacological treatments and assessments of the patient.

F. Between on or about October 11, 1996 and on or about July 30, 1999, Respondent treated Patient F, a woman who was forty-seven when she an was initially seen by Respondent, for psychiatric illness(es) on an out-patient basis at his medical office. Patient F was a self-referred patient, who at the initial visit stated that she was using too much Vicodin and wanted to "get off medication. Respondent prescribed Vicodin on that date and continued to do so through most of the course of treatment. On at least one occasion Respondent provided Patient F with a prescription for her daughter, Patient G.

1. Respondent failed to formulate and pursue an adequate treatment pla for Patient F.
2. Respondent's pharmacological treatment of Patient F deviated from acceptable medical standards.
3. Respondent deviated form acceptable medical standards in giving Patient F a prescription for her daughter.
4. Respondent failed to maintain a medical record for Patient F which adequately documents indications for pharmacological treatments and assessments of the patient.

G. Between on or about December 6, 1996, and on or about July 2, 1999, Respondent treated Patient G, the daughter of Patient F, for psychiatric illness(es) on an out-patient basis at his medical office. The patient was almost eighteen when treatment commenced. In an undated entry in 1997 Respondent noted that Patient G had an Opioid co-dependency with her mother. In a note from Patient F to Respondent dated January 24, 1997, Patient F wrote that Patient G was taking thirty tablets of Vicadin, instead of the twelve per day which Respondent had prescribed. On several occasions Respondent gave Patient G prescriptions for her mother.

1. Respondent failed to formulate and pursue an adequate treatment plan for Patient G.
2. Respondent's pharmacological treatment of Patient G deviated from acceptable medical standards.
3. Respondent deviated from acceptable medical standards in giving prescriptions to Patient G for Patient F.
4. Respondent failed to maintain a medical record for Patient G

which adequately documents indications for pharmacological treatments and assessments of the patient.

H. Between on or about December 18, 1999, and on or about February 26, 2000, Respondent treated Patient H, a man who was forty-three years old at the commencement of treatment, for psychiatric illness(es) on an outpatient basis at his medical office. The patient presented with a history of hospitalizations, a long history of depression and was "always thinking of suicide". Patient H died on March 7, 2000. The cause of death was found to be multiple drug toxicity.

1. Respondent failed to formulate and pursue an adequate treatment plan for Patient H.
2. Respondent's pharmacological treatment of Patient H deviated form acceptable medical standards.

## SPECIFICATION OF CHARGES

## FIRST SPECIFICATION

## GROSS NEGLIGENCE

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

1. Paragraphs A and A(1) through A(4).

## SECOND SPECIFICATION

## NEGLIGENCE ON MORE THAN ONE OCCASION

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

2. Paragraph A and A(1) through A(4); Paragraph B and B(1) through B(3); Paragraph C and C(1) through C(2); Paragraph E and E(1) through E(4) ; Paragraph F and F(1) through F(4); Paragraph G and G(1) through G(4); Paragraph H and H(1) through H(2).

**THIRD SPECIFICATION**

**INCOMPETENCE ON MORE THAN ONE OCCASION**

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

3. Paragraph A and A(1) through A(4); Paragraph B and B(1) through B(3); Paragraph C and C(1) through C(2); Paragraph E and E(1) through E(4); Paragraph F and F(1) through F(4); Paragraph G and G(1) through G(4); Paragraph H and H(1) through H(2).

**FOURTH THROUGH EIGHTH SPECIFICATIONS**

## FAILURE TO MAINTAIN RECORDS

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

4. Paragraph A and A(4).
5. Paragraph B and B(3).
6. Paragraph E and E(4).
7. Paragraph F and F(4).
8. Paragraph G and G(4).

DATED: May 29, 2001
New York, New York

REDACTED SIGNATURE

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

# APPENDIX II

## APPENDIX II

## TERMS OF PROBATION

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

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

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

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

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

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

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

8. The Respondent shall practice medicine only when monitored by a licensed physician, board certified in psychiatry ("the Practice Monitor"), proposed by the Respondent and subject to the written approval of the Director of OPMC.

   a. The Respondent shall make available to the Practice Monitor any and all records or access to the practice requested by the Practice Monitor, including on-site observation. The Practice Monitor shall visit the Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of records maintained by the Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the Practice Monitor shall be reported within 24 hours to OPMC.

   b. The Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

   c. The Respondent shall cause the Practice Monitor to report quarterly, in writing, to the Director of OPMC.

   d. The Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to the Respondent's practice after the effective date of this Order.

9. The Respondent shall enroll in and complete a continuing medical education program in the area of medical recordkeeping. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within ninety (90) days of the effective date of this Order, unless the Director of OPMC approves an extension in writing.

10. The Respondent shall not prescribe opiates during the period of probation.

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