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HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

April 21, 2014

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jeffrey J. Conklin, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2505
Albany, New York 12237

Melvin Pisetzner, M.D.
c/o Thomas C. Burke, Esq.
Osborn, Reed & Burke, LLP
45 Exchange Boulevard
Rochester, New York 14614

RE: In the Matter of Melvin Pisetzner, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 14-98) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2013) and §230-c subdivisions 1 through 5, (McKinney Supp. 2013), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

REDACTED

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah
Enclosure

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

In the matter of **Melvin Pisetzner, M.D.** regarding charges of violations of NYS Ed.L 6530	**Determination and Order** BPMC #14-98

COPY

Before a committee on professional conduct:

Charles J. Vacanti, M.D., Chair
Suwarna A. Naik, M.D.
Heidi B. Miller, M.P.H., R.P.A.-C

John Harris Terepka, Administrative Law Judge

Held at: New York State Department of Health
259 Monroe Avenue
Rochester, New York 14607
January 9, 10, 14, 17, 24, 2014
Briefs: February 28, 2014
Deliberations: March 14, 2014

Parties: New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2505
Empire State Plaza
Albany, New York 12237
By: Jeffrey J. Conklin, Esq.

Melvin Pisetzner, M.D.
By: Thomas C. Burke, Esq.
Osborn, Reed & Burke, LLP
45 Exchange Boulevard
Rochester, New York 14614

JURISDICTION

As is set forth in Public Health Law 230(1)&(7) and Education Law 6530, the legislature created the State Board for Professional Medical Conduct (the Petitioner) in the Department of Health, and authorized it to conduct disciplinary proceedings in matters of professional medical conduct.

A notice of hearing and statement of charges, both dated December 11, 2013, were served on Melvin Pisetzner, M.D. (The Respondent). A hearing before a committee on professional conduct (the Hearing Committee) was scheduled pursuant to PHL 230(10) and hearing procedures set forth in Department of Health regulations at 10 NYCRR Part 51. The burden of proof is on the Petitioner. 10 NYCRR 51.11(d)(6).

SUMMARY

The charges arise from the Respondent's actions in connection with five patients under his psychiatric care between the mid 1970s and 2012 in the Rochester, New York area. The statement of charges made forty-eight "factual allegations" in support of seven charges of misconduct. (Exhibit 1.) The Petitioner charged negligence on more than one occasion, incompetence on more than one occasion, and failure to maintain records with regard to all five patients (Patients A-E.) The Petitioner also charged gross negligence, gross incompetence, fraudulent practice and moral unfitness with regard to Patient A.

The Respondent conceded that the Department's criticisms of his recordkeeping practices, including failure to document medications, dosages and rationales, re-prescribing for long periods of time without office visits, and preparation of summaries of multiple visits rather than documenting each visit, are legitimate. (Respondent brief, pages 14-15; Transcript, pages 491-92.) He offered no explanation for the eighteen years of missing

records for his patients, except to acknowledge, without further explanation, that "his practice cleared out thousands of old records." (Respondent brief, page 2.) He acknowledged he prescribed high doses of controlled substances, including amphetamines, benzodiazepines and opiates, and asserted these were matters of professional judgment he was entitled to make. He admitted making three payments to Patient A in 2008 in the total amount of $1,700, but denied it was for any inappropriate reason. He denied that he had a sexual relationship with Patient A.

The Respondent argued that he is essentially guilty of little more than "sloppy recordkeeping." (Transcript, page 25.) He claimed changes in his practices, in particular the adoption of a computerized record keeping program, have addressed any problems. He claimed that the care he provided was good and that he should be able to continue to practice.

In this decision, the Hearing Committee unanimously sustains all factual allegations in the statement of charges with the exception of factual allegations A4, A6, B4, C4 and C5. The Hearing Committee unanimously sustains all charges of misconduct with the exception of fraudulent practice. The Hearing Committee determined that the appropriate penalty is revocation of the Respondent's license to practice medicine.

EVIDENCE

A pre-hearing conference pursuant to 10 NYCRR 51.9(c)(9) was held on January 2, 2014.

Witnesses for the Petitioner:	Dean B. Harlam, M.D. Amy Nixon Telva Olivares, M.D. Margaret O'Keefe Anne Fugle, M.D.
Petitioner exhibits:	Exhibits 1-3, 4A-E, 5A-G, 7A, 7A1, 7B-D, 8A-B, 9A-E, 10A-C, 11, 13A-C, 15A-B, 21, 22A-B, 23
Witnesses for the Respondent:	Melvin Pisetzner, M.D.

Respondent exhibits: Exhibits A-B

A transcript of the proceedings was made. (Prehearing conference transcript, pages 1-36; Intrahearing transcript, pages 1-9; Hearing transcript, pages 1-648.) Each side submitted one post hearing brief.

FINDINGS OF FACT

All findings were made upon unanimous vote of the Hearing Committee.

1. Respondent Melvin Pisetzner, M.D. was authorized to practice medicine by the New York State Education Department on February 9, 1973 under license number 114914. (Exhibit 3.) The Respondent maintained a private practice in psychiatry in Pittsford, New York.

Patient A (Exhibits 4A, 5A-G, 22A, 22B, 23.)

2. The Respondent provided psychiatric care to Patient A at various times from the late 1970s through September 21, 2010.

3. Patient A, born in September 15, 1962, was diagnosed by the Respondent with bipolar disorder and antisocial personality disorder. (Transcript, pages 475-76.) He was a heavy drug user, including heroin and cannabis, a substance abuser, and dependent on diazepam prescribed by the Respondent. (Exhibit 5A; Transcript, pages 545-47.) Patient A was also HIV positive and had pain as a result of broken bones from motorcycle accidents. (Exhibit 5A, page 62; Transcript, page 546.)

4. The Respondent failed to take appropriate steps to recommend treatment for chemical dependence and failed to document recommendations that Patient A receive treatment for chemical dependence. (Exhibit 5A.)

5. The Respondent failed to take appropriate steps to refer Patient A to a specialist for pain treatment.

6. During the years 2000 to 2008, the Respondent regularly prescribed diazepam 60mg/day and Percodan 180 tablets/month for Patient A with no adequate documented or apparent medical basis. (Exhibits 4A, 5A, 5D, 5E.)

7. In 2007, and twice in 2009, Patient A was hospitalized for suicidal overdoses of diazepam and was weaned off of it. After each discharge, and without documenting a medical basis, the Respondent continued his prescription of diazepam 60mg/day without seeing Patient A first. (Exhibits 5A, 5E.)

8. Over the years 2004 through 2010, the Respondent wrote dozens of prescriptions for medications that are nowhere documented in his medical records. (Exhibit 5D.)

9. The Respondent failed to maintain any medical records of his treatment of Patient A from the late 1970s through 2000. (Transcript, pages 567-68.)

10. The Respondent made three payments in the form of personal checks to Patient A, in July, September and November 2008, in the total amount of $1,700. (Exhibit 23; Transcript, page 434.)

11. The Respondent failed to document any reason for the payments or even to document that he made them, even though the Respondent knew Patient A had made allegations that a sexual relationship had existed between them and that he had been paid with money and drugs to keep quiet about it. (Exhibits 5B, 5C, 5F, 5G, 23; Testimony of Nixon, Olivares, O'Keefe, Fugle; Transcript, pages 480, 483, 538, 564.)

12. When interviewed by the Petitioner in April 2012, the Respondent falsely claimed that the payments were made pursuant to provisions in his wife's will. (Transcript, pages 539-41; Exhibit 13A, page 5; Exhibits 13C, 22A, 22B.)

13. Since at least 1985, Patient A has claimed to hospital providers that as a teenaged patient he had a sexual relationship with the Respondent that went on until his early 20's. Patient A repeated these allegations during several hospitalizations in 2010 and 2011. (Exhibits 5B, 5C, 5F, 5G, 23; Testimony of Nixon, Olivares, O'Keefe, Fugle.)

14. The Respondent engaged in sexual activity with Patient A during the early years of Patient A's treatment. (Exhibits 5B, 5C, 5F, 5G, 23; Testimony of Nixon, Olivares, O'Keefe, Fugle.)

Patient B (Exhibits 4B, 7A-D.)

15. The Respondent provided psychiatric care to Patient B at various times from the late 1990s through November 23, 2011. (Exhibit 7A.)

16. The Respondent failed to maintain any medical records of his treatment of Patient B during the 1990s. (Exhibit 7A.)

17. In his treatment of Patient B after 2000, the Respondent routinely documented multiple office visits, over periods as long as eighteen months, by combining them into one brief summary note. (Exhibit 7A, pages 3-10.)

18. In his treatment of Patient B after 2000, the Respondent routinely failed to document medications, doses, changes in medications, and rationales for medications he prescribed, including high doses of clonazepam, alprazolam, and dextroamphetamine. (Exhibits 7A-D.)

Patient C (Exhibits 4C, 8A-B.)

19. The Respondent provided psychiatric care to Patient C for bipolar disorder at various times from August 20, 2002 through October 21, 2011. (Exhibit 8A.)

20. In his treatment of Patient C, the Respondent routinely failed to document medications, doses, changes in medications, and rationales for medications he prescribed, including high doses of clonazepam and alprazolam. (Exhibits 4C, 8A-B.)

21. The Respondent regularly prescribed medications, including controlled substances, between January 2004 and July 2005, and again between November 2008 and December 2010, without seeing Patient C. (Exhibits 4C, 8A, 8B; Transcript, page 579.)

22. The Respondent failed to document any basis for an opinion he gave on January 8, 2007 in support of a disability claim that Patient C was unable to work. (Exhibit 8A, page 74.)

Patient D (Exhibits 4D, 9A-E.)

23. The Respondent provided psychiatric care to Patient D at various times from April 22, 2002 through December 1, 2011. (Exhibit 9A.)

24. In his treatment of Patient D, the Respondent routinely documented multiple office visits by combining them into one brief summary note. (Exhibit 9A, pages 15-20.)

25. In his treatment of Patient D, the Respondent routinely failed to document medications, doses, changes in medications, and rationales for medications he prescribed, including high doses of clonazepam and amphetamine. (Exhibits 4D, 9A-E.)

26. The Respondent prescribed medications, including controlled substances, from October 10, 2010 through September 2011 without seeing Patient D. (Exhibits 4D, 9A.)

27. The Respondent prescribed extremely high doses of clonazepam for Patient D without documenting the doses or rationale or even that the medication was being prescribed. (Exhibits 4D, 9A.)

Patient E (Exhibits 4E, 10A-C.)

28. The Respondent provided psychiatric care to Patient E for bipolar disorder and substance abuse at various times from November 7, 2005 through October 24, 2011. (Exhibit 10A.)

29. In his treatment of Patient E, the Respondent routinely documented multiple office visits by combining them into one brief summary note. (Exhibit 10A, pages 4-21.)

30. In his treatment of Patient E, the Respondent routinely failed to document medications, doses, changes in medications, and rationales for medications, including controlled substances he prescribed. (Exhibits 4E, 10A-C.)

DISCUSSION OF FACTUAL ALLEGATIONS

Credibility of witnesses

The demonstrably untrue stories the Respondent told the Petitioner's investigators (PMC investigators) about his wife's will in his initial attempt to explain his payments to Patient A exemplify his lack of credibility. The Respondent consistently admitted only what he had to and then ignored or misrepresented the rest.

Confronted with the awkward fact that he had paid substantial sums of money to a patient who alleged a sexual relationship with him, the Respondent came up with a story that they were made pursuant to a provision in his wife's will. (Exhibit 13A, pages 4-5; Transcript, pages 539-40.) Asked to produce the will, he instead deepened the misrepresentation by presenting a fictional "further statement" of the specific language he claimed was in it. (Exhibit 13C; Transcript, pages 540-41.) Through his attorney, he attempted to put the Petitioner off any further inquiry:

> If the existence and/or contents of this will are really important *perhaps* I can make application to the Monroe County Surrogate Court *if* the will was probated there... (Exhibit 13C) (italics in original).

The Petitioner, apparently undeterred by the Respondent's efforts to dissemble, obtained a copy of the will from the court. (Exhibit 22A.) There was no provision "to help indigent patients with needed food and shelter." The Respondent also turned out to be the named executor. At the hearing he denied that he had the will filed in Monroe County by quibbling "I assume the estate lawyer did." (Transcript, pages 541-42.)

After his story about the will unraveled the Respondent's explanations about the claimed fund "to help indigent patients with needed food and shelter" became increasingly vague, ending up with inconsistent stories about conversations with relatives who were lawyers, or confusion about an earlier will that he also failed to produce. (Transcript, pages 483-84, 540-41.)

As he attempted to explain the payments to Patient A, the Respondent's claims became vague as the evidence disproved them. The same phenomenon, only in reverse, was exhibited in his claims about Patient A's age. On that issue, his claims became definite as it became clear that evidence would not disprove him. Patient A reported that the sexual relationship began when he was 14. (Exhibit 5C, page 431.) When initially interviewed, the Respondent told the PMC investigators he began treating Patient A at "maybe age 15 or 16." (Exhibit 13A, page 2.) By the time of this hearing, he had become sure that it was in 1979 and that Patient A was "about 17." (Transcript, pages 435-36.) It is not clear how, with his records prior to 2000 all lost, the Respondent became so much more sure by the time of this hearing that Patient A was 17 and first treated in 1979, especially since Patient A did not even turn 17 until September 15, 1979. (Transcript, page 435-36.)

The Respondent's credibility was further undermined by his history as a tax cheat. In 1998 he pleaded guilty to and was convicted of a repeated failure to file his income taxes. (Exhibit 21; Transcript, pages 496, 534.) His medical license was suspended because of the conviction. (Exhibit 15A.) The Respondent was also convicted in 2010 of disorderly conduct after being charged with and admitting to soliciting for prostitution. (Transcript, pages 496-97, 537.) There is, then, ample evidence of the Respondent's willingness to violate, purely out of self-interest, laws applicable to everyone, including criminal laws regarding sexual behavior.

The Respondent's untruths, half truths, evasions and distortions at the hearing were numerous. He acknowledged Patient A was a substance abuser, "had an issue" with cannabis, and that hospital records document marijuana dependence. Asked if there was any mention of the cannabis dependence in his records, he said "I think there is" without pointing out where. (Transcript, pages 545-47.) The Hearing Committee was unable to find any such mention. The Respondent claimed on cross examination that for Patient A he prescribed ibuprofen before turning to Percodan (Transcript, page 551.) Percodan was prescribed for years before he prescribed the high dose ibuprofen that he was being asked to explain.

The Respondent claimed that he put Patient A back on Valium in September 2007 without knowing about his recent hospitalization for a Valium overdose until three weeks after his August 27, 2007 discharge. (Transcript, pages 559-60.) The Respondent's own chart documents that the hospital record was faxed to him on August 28, 2007. (Exhibit 5A, page 43.)

The Respondent claimed Patient A "would be forced, usually by judge's order in the hospital, to take medication" for his bipolar disorder. (Transcript, page 597.) He presented

no evidence of any such forcing or of any judge's orders. Hospital records document, to the contrary, that all that was needed was "a brief amount of time and encouragement" to persuade Patient A to take medications for his bipolar condition. (Exhibit 5A, page 78.)

The Respondent claimed Dr. Guttmacher "concurred" in his treatment of Patient B with high doses of clonazepam. (Respondent brief, page 13; Transcript, pages 511-12.) Dr. Guttmacher's actual opinion was "My vote would be to drastically reduce or eliminate the clonazepam." (Exhibit 7A, page 168.) As Dr. Harlam pointed out, Dr. Guttmacher did not agree with the way the Respondent was treating this patient. (Transcript, pages 154-56, 161; Exhibit 7A, pages 168-69.)

When interviewed by PMC investigators in April 2012 about his 2007 opinion supporting a disability claim for Patient C, which was not consistent with the patient's condition documented in his own chart, Respondent offered the excuse that he was distracted and distressed over his wife's death at the time. (Exhibit 13A, pages 8, 9.) She had died three years earlier, in 2004. (Transcript, page 439.) Confronted with the discrepancy at the hearing, he used the same tactic, this time claiming that at the April 2012 interview he was distressed about his second wife who had just been diagnosed with cancer. (Transcript, pages 542-43, 581.) He used the tactic a third time to explain another dating error made during his PMC interview. (Transcript, page 540.) These personal tragedies do not explain or justify his fabrication of excuses.

At the hearing the Respondent claimed for the first time that his opinion supporting the disability claim, which was completely inconsistent with his own chart, was based on a telephone conversation with a psychologist, Dr. Greene. There is no evidence of such a conversation. (Transcript, page 580.) He did not mention any such conversation, or Dr.

Greene, as the source for his disability determination when both the disability determination and Dr. Greene were extensively discussed in his April 2012 interview with PMC investigators. (Exhibit 13A, pages 8-9.)

Regarding his denial of a sexual relationship with Patient A, the Respondent acknowledged his bisexuality but made a point of explaining that he discussed it with his first wife and made a commitment to be faithful to her during their marriage, a commitment that he claimed he kept until she was bedridden for the last three years before her 2004 death. (Transcript, pages 440-41.) He did not mention what if any arrangement he had with the second wife he married in 2008, whose illness he discovered in 2012 (Transcript, page 581), that found him admitting to soliciting a young male prostitute in February 2010. (Exhibit 20C; Transcript, pages 496-97, 540.)

The consistent and obvious pattern of self serving bias and dishonesty, and of making up and then changing stories to excuse himself, severely undermined the Respondent's credibility. The Respondent seemed unable to resist embellishing by exaggeration even on such a minor point as the length of his military service. (Transcript, pages 443-44, 604-605.)

The Hearing Committee found Dr. Harlam, on the other hand, who had no stake in the outcome of this proceeding, entirely credible and completely convincing in his facts and in his opinions. Dr. Harlam was generous where he could be, commenting with regard Patient B that "it's admirable to work with a difficult patient" (Transcript, page 157) and acknowledging where he could that the Respondent provided some good care for some of these patients.

The Department's other witnesses, all medical providers who reported what Patient A told them, were also credible. The Respondent suggests that their credibility is not a central

issue because they did not claim to know for certain the truth of Patient A's allegations, they simply reported them. The Hearing Committee, however, found little reason to question the accuracy of their reports of what Patient A told them, or the sincerity and honesty of the opinions they expressed about it. The Hearing Committee also gave significant weight to these witnesses' professional experience and expertise in assessing when a psychiatric patient is delusional and not to be taken seriously and when he is not.

Patient A (Exhibits 4A, 5A-G.)

The Respondent began treating Patient A, who is now in his early fifties, in the mid to late 1970's when he was a teenager. Although treatment continued through September 2010, the Respondent failed to produce any records for the more than twenty year period before 2000. Dr. Harlam testified, and the Hearing Committee agreed, that the standard of care required the Respondent to retain all records for a patient under active continuing treatment. (Transcript, page 72.) The Respondent offered no reasonable explanation for his failure to maintain and produce any records of his treatment of Patient A in his private practice for the eighteen years from 1982 through 2000. He claimed he was storing records with other doctors and that "our group, which had at that point 43,000 individual records, had decided to clear out records before 2000." (Transcript, page 567.) He offered no evidence to substantiate his story that a group of physicians, of which he was just one, collectively decided upon the wholesale destruction of 43,000 medical records. In any event, "we threw them away" is hardly an adequate answer or excuse for failing to maintain records required to be kept.

Patient A's diagnosis was bipolar disorder, antisocial personality. He was a heavy drug user, including of heroin, and had many psychiatric hospitalizations over the years

related to his bipolar disorder and substance dependence. He was at Rochester Psychiatric Center in 1981, 1985, 1986 and 2010, and he had at least 20 to 30 other inpatient admissions in various states over the years. (Exhibit 5B, page 34; Transcript, page 77.)

For the entire period 2000-2008, the Respondent prescribed high doses of both diazepam (Valium) and Percodan (oxycodone and aspirin) for Patient A. As Dr. Harlam pointed out, and the Respondent agreed, these are not the appropriate medications to treat the patient's actual condition, bipolar disorder. (Transcript, pages 41, 54, 549.) The appropriate medications for bipolar disorder were not prescribed. (Transcript, page 102.) The Respondent said:

> To this day, he believes he does not have bipolar disorder, so I never – except when he was in the hospital, when I first started treating him, I've never treated him for bipolar disorder. (Transcript, page 597.)

The Respondent's response to Dr. Harlam's criticism was that he gave these inappropriate medications because the patient refused to take the appropriate medication for bipolar disorder and asked for these other medications instead. This was not a medically appropriate way of handling the problem. As Dr. Harlam pointed out, what was needed, and the Respondent's duty, was to push the patient to get the care he actually needed instead of the drugs he obviously wanted.

Instead, diazepam, in a very high dose, was prescribed for years. From January 2000, when the first available records start, until 2010, Patient A was prescribed 60 mg. of diazepam daily. (Exhibit 4A; Exhibit 5A, pages 38-42; Exhibit 5E.) Dr. Harlam, associate medical director responsible for supervising all of the psychiatrists at St. Vincent's Hospital, Westchester, for twenty years, had never in his career seen any of the psychiatrists he supervises prescribe such a high dose. (Transcript, pages 27, 39.) This was especially

inappropriate for a patient with serious substance abuse problems, because benzodiazepines are themselves addictive. (Transcript, pages 36-37, 40.)

As Dr. Harlam pointed out, treating substance dependence with addictive benzodiazepines is just going to prolong the substance dependence. Furthermore, in combination with other drugs they can be dangerous, even lethal in a patient like Patient A, who had a demonstrated propensity to overdose on them. (Transcript, pages 37, 55.) Patient A's alleged complaint of "anxiety," which the Respondent never actually diagnosed, and his expressed desire for the medication were not appropriate rationales for prescribing it. (Transcript, pages 55-56.)

Patient A's medical history while on this medication regimen amply illustrates its dangers and the Respondent's lack of concern about them. Patient A was admitted to Rochester General Hospital on August 1, 2007 after taking an overdose of diazepam. (Exhibit 5A, page 63.) Rochester General Hospital tapered him completely off of it before discharge on August 27, 2007. (Exhibit 5A, page 44.) Prescription records show that within the next month, the Respondent put him back on it at the same high dose of 60mg per day. (Exhibit 5A, page 40; Exhibit 5E, page 4; Transcript, pages 44-45.) The Respondent did this without even seeing him. When an office visit did subsequently take place, in October 2007, there is no mention of the overdose in the note. (Exhibit 5A, page 20; Transcript, pages 45-47.)

The Respondent claimed he was not informed of Patient A's admission to Rochester General hospital or of his discharge until three weeks after discharge. (Transcript, page 559.) His chart shows the discharge summary was faxed to him on August 28, 2007, one day after discharge. (Exhibit 5A, page 43.)

The Respondent's justification for putting Patient A back on Valium on September 20, right after he had overdosed and then been weaned off of it in the hospital, was "just because someone overdoses on a medication doesn't mean that the medication is not helpful for them." (Transcript, pages 487, 557.) What is missing from this explanation is how or why the medication was helpful to Patient A in these circumstances. Dr. Harlam testified, and the Hearing Committee agreed:

> Well, when a patient tries to kill himself with a very high dose of a medication that you are prescribing, most likely you're not going to prescribe it at all. But if you're going to prescribe it, your [sic] certainly going to prescribe it at a much lower dose so that he won't make a lethal overdose of it....
>
> And to prescribe it before seeing the patient would be a very serious deviation from the standard of care. (Transcript, page 58.)

On April 6, 2009 the patient was hospitalized at Strong Memorial Hospital for dependence on benzodiazepines and another diazepam overdose. (Transcript, pages 47-50; Exhibit 5A, pages 77-79.) He was again tapered completely off the diazepam and all benzodiazepines and placed on Depakote, an appropriate medication for his bipolar disorder. He was discharged on April 9, 2009. (Exhibit 5A, pages 77-79; Transcript, pages 47-50.)

On April 10, 2009, one day after his discharge from Strong Memorial Hospital, Patient A was hospitalized at Rochester General Hospital for yet another diazepam overdose. (Exhibit 5A, page 85; Transcript, pages 50-51.) He was again weaned off of diazepam, and upon discharge on April 20 was given a lower dose of clonazepam, as needed only, compared to the high daily dose of diazepam he was getting from the Respondent before hospitalization. (Exhibit 5A, page 84; Transcript, pages 51-52.)

In spite of this experience of hospitalization for two suicide attempts by overdosing on diazepam, during both of which he was tapered off of the inappropriate benzodiazepine

and placed on the appropriate medication for his actual condition, pharmacy records show that on April 23, 2009, the Respondent again, and without seeing him, put Patient A right back on the high dose of diazepam. The Respondent did not see Patient A until April 28. (Exhibit 5E, page 4; Exhibit 5A, page 24; Transcript, page 52.) The Respondent's explanation at the hearing was:

> Well, it is certainly not the definitive treatment for bipolar, but he would always, underline that, with maybe one exception, always stop his bipolar medication on discharge from the hospital, which would leave him extraordinarily anxious, restless, difficulty sitting still, sweaty palms, moving around, worrying about things all the time. So I gave him benzodiazepine, Valium, which seemed to take care of the anxiety component of his illness. And I strongly urged him – and on occasion, he did take appropriate treatment, medication for bipolar disorder. (Transcript, page 486.)

According to the hospital records, Patient A had been completely tapered off of diazepam. The Respondent did not explain how he could have been aware of all these physical symptoms of anxiety when he put Patient A back on it without seeing him. The reason he documented in his April 28 chart entry was:

> Willing to take meds now, although prefers [diazepam] to Clonazepam, 'provides more relief.' (Exhibit 5A, page 24.)

The Respondent offered no evidence to support his bare claim that Patient A took his bipolar medications in the hospital only because "[h]e would be forced, usually by judge's order in the hospital, to take medication." (Respondent brief, page 10; Transcript, page 597.) The hospital records do not support this claim. The April 9, 2009 hospital discharge summary, for example, saying nothing about any court order, reports:

> ... the patient was completely tapered off of all benzodiazepines... He appeared to respond well to the medication regime, cleared in his thinking, and denied suicidality... it is questionable that the patient had been taking [his Depakote] consistently prior to his hospitalization. The patient will need to follow with his outpatient psychiatrist for his next Depakote level. Of note, the patient initially refused to take his medications; however, with a brief amount of time and encouragement, he began to take all of his medications as prescribed... It was

reinforced with the patient the importance of taking his medications as prescribed. (Exhibit 5A, page 78.)

The Respondent's medical records do not document any adequate rationale for prescribing diazepam after these hospitalizations in August 2007 and April 2009 (twice) and weaning off of it. The patient repeatedly attempted suicide with medication the Respondent had been prescribing, and yet the Respondent repeatedly put him right back on it at the same high dose, without even seeing him, because the patient said he preferred it to the appropriate medication for his diagnosed condition.

The Respondent's attempts to justify this treatment went in incoherent and irrelevant circles:

Dr. Naik: So even after the first time that he claimed to have taken an overdose, you prescribed the same amount. And then this happened again and you prescribed the same large amounts of Valium; is that correct?

Respondent: If a patient responds to a medication, they should be on it. A patient can kill themselves again much or [sic] easily with aspirin, much more easily with Tylenol than with over-the-counter medications than they can with Valium.

Dr. Naik: But what are you calling a response, if he were already responding, then he would not be overdosing or being admitted?

Respondent: Well, he wasn't responding. I wasn't – he would not let allow me to treat his bipolar disorder. (Transcript, pages 596-97.)

The Respondent also prescribed 180 Percodan tablets (oxycodone and aspirin) per month continuously from January 28, 2000 through December 19, 2008. (Exhibit 5A, page 41; Transcript, page 548.) Percodan, an opiate, is for pain. Dr. Harlam testified, and the Hearing Committee agreed, that a psychiatrist should not be managing pain like this over such a long term. (Transcript, pages 38-39, 60-62.) Continuously prescribing high doses of Percodan, an addictive pain killer, for a substance abuser was, according to Dr. Harlam, a

"serious" deviation from the acceptable standard of care. (Transcript, pages 68-69.) In combination with other controlled substances Percodan could be lethal. Furthermore, it was giving the patient an excuse not to get the medical care he really needed from the appropriate specialists for, among other things, his HIV status and history of numerous motorcycle accidents with broken bones. (Transcript, pages 68-69.)

The Respondent acknowledged he was prescribing a very high dose of Percodan. (Transcript, pages 488, 548-49.) His notes document that he was in a dilemma about this situation because the patient did not want to seek other treatment for the pain, and yet was in pain. However, as Dr. Harlam pointed out:

> It isn't really much of a dilemma. Psychiatrists face it all the time. You know, it's not in the patient's interest for you to be prescribing it.
>
> You're not doing the patient any favors. You're very possibly not realizing the medical condition that the patient has that the patient should be treated for. In this case, you know that the patient is HIV positive. And, if anything, you're really giving him an excuse to not get HIV treatments.
>
> So you really may be contributing to that patient's death by continuing to give him the pain medication. (Transcript, pages 63-64.)

The simple solution to the so-called "dilemma" is that if a patient is refusing to see a specialist for pain, the psychiatrist should set a date on which he will stop prescribing pain medications. (Transcript, page 62.)

The Respondent took credit at the hearing for convincing Patient A to finally go to an HIV clinic in 2003 "which I convinced him to go to after three years." (Transcript, pages 508, 553; Exhibit 5A, pages 13-14.) He did not address the question whether his routine prescription of high doses of painkillers and anxiety medications, for years, might have contributed to the patient's failure to seek this treatment that the Respondent himself agrees he needed all along.

Even after Patient A apparently did visit an HIV clinic, the Respondent continued to prescribe Percodan at the same high dose for another five years. (Exhibit 5A, pages 39-41.) The Respondent claimed that he talked to a doctor at the HIV clinic who asked him to do this because the doctor was concerned about criticism if the clinic prescribed it. (Transcript, pages 553-54.) None of this is documented in the Respondent's medical record. The Respondent's story is an attempt to dress up the obvious: the HIV clinic, like Dr. Harlam and the Hearing Committee, did not consider it to be appropriate or necessary to prescribe Percodan in such high doses and would not do so for that reason.

The Respondent claimed a background in treating psychiatric patients for pain. He suggested the views of Dr. Harlam about his excessive and unnecessary use of pain medications were a matter of changed attitudes in the profession. His answer to the criticism of his administering admittedly "higher than usual" doses of Percodan was "I naively believed that as a physician, I could prescribe any medication." He showed no sign that he acknowledged any problem with what he was doing, and said he stopped prescribing pain medications in 2009 only because he was told to stop by an insurer and by the Petitioner. (Transcript, pages 446-47, 488-89, 594-95.)

The Respondent repeatedly mischaracterized Dr. Harlam's criticisms as being about minor recordkeeping issues, but Dr. Harlam made it very clear this was not the main concern. On cross examination he was asked:

> Q: Beyond the allegations of sexual misconduct with the patient, which we've agreed is something that you don't have personal knowledge of, your criticisms of Dr. Pisetzner boil down to his failure to document both his therapeutic visits with the patient and prescribing practices?
>
> Dr. Harlam: No. That's not my – my main concern is that this patient who has had a severe substance abuse problem from the time he was a teenager was being prescribed two controlled substances that he should not have been prescribed. So the

> fact that the rational wasn't document [sic], that's a problem, also. But it's hard to imagine any rational [sic] for treating that individual with that – those two drugs. (Transcript, pages 95-96.)

In 2005 and 2006, at the same time as he was prescribing 60mg/day diazepam and 180/month Percodan, the Respondent also regularly prescribed what Dr. Harlam characterized as "huge... that would be like taking 24 Motrin a day" doses of ibruprofen. (Exhibit 5D; Transcript, pages 64-66.) Respondent's chart does not contain any mention at all of these prescriptions, let alone any sort of rationale for them, nor did the Respondent offer any explanation or even address them in his testimony. Asked about the matter on cross examination, he said "I believe I started the ibuprofen before I tried the Percodan." (Transcript, page 551.) The records show this answer to be disingenuous at best. The question was about his prescription of very high doses of ibuprofen in 2005 and 2006, at which time the patient had been on Percodan for at least five years. There is no evidence he prescribed ibuprofen at all before August 2004. (Exhibit 5D.)

The Respondent also prescribed many other medications about which Dr. Harlam pointed out:

> Well, none of them are documented. Most of them aren't controlled, even though there is Ambien, for example, which is controlled. But a lot of them are – they have medical – I don't even know what some of them are.
>
> I mean, there are things that various medical specialists would prescribe. None of them are in any of the progress notes or on the medication log. (Transcript, page 68.)

Pharmacy records show that the Respondent wrote dozens of prescriptions for medications over the years 2004-2010 that are nowhere documented in his medical record. (Exhibit 5D; Transcript, pages 67-68.)

The Respondent knew that Patient A used cannabis and had used heroin, among other drugs, and acknowledged that Patient A was dependent on cannabis. (Transcript, pages 545-

47.) As Dr. Harlam pointed out, the Respondent's records fail to document any attempt to talk to the patient about or evaluate this issue, or refer him for treatment. (Transcript, pages 70-71.) The Respondent brushed this criticism off by expressing the view that "being dependent on cannabis was less of the problem than his bipolar disorder" (Transcript, page 547), as if that were the choice for this patient. He acknowledged, however, that he failed to document this view, or any attempt to talk to the patient about or evaluate the issue, or to refer him for treatment. (Transcript, pages 547-48.)

The Respondent admits he wrote three personal checks to Patient A in July, September and November 2008, in the total amount of $1,700. (Exhibit 23.) Dr. Harlam testified, and the Hearing Committee agreed, that it is not appropriate for a psychiatrist to give money to a patient without some very good documented reason:

> The standard of care is that psychiatrists don't give money to patients... there could be a very unusual circumstance in which a psychiatrist would give a patient money. It could be a loan if the patient were in a bad jam. But the standard of care would be that you would document the rationale for giving or lending the patient that amount of money. (Transcript, pages 80-81.)

> I have never in my practice heard of a psychiatrist writing out a check to a patient. It is extremely rare. It's not good for the treatment. But, yes, I'll accept the idea that in a very unusual circumstance, a psychiatrist might do it. In that case, it would be extremely important to document the rational [sic], especially in a patient who has been accusing you over time of having a sexual relationship. (Transcript, page 94.)

The Respondent admits knowing Patient A had claimed that he received drugs and money to keep quiet about a sexual relationship between them. (Transcript, pages 480, 564.) Even with that background the Respondent failed to document these payments or any reason for them in the patient's record or anywhere else. (Transcript, pages 483, 538.)

The Respondent claimed at the hearing that the $1,700 was to help Patient A get an apartment and get on his feet. (Transcript, page 482-83.) He claimed that, like the purchases

of small items such as shoes that he claimed he and his wife had made years before for hospital patients, these payments were not "clinically relevant" to the patient's care. (Transcript, pages 456, 483.) It was obvious to the Hearing Committee that buying a pair of shoes for a hospital patient is not at all the same as writing $1,700 in personal checks to a private patient who has made accusations about a sexual relationship.

The Respondent was apparently conscious of this difference, as he concocted a story to explain the payments when he was first interviewed by PMC investigators, claiming they were made pursuant to a provision in his wife's will that set aside $5,000 "to help indigent patients with needed food and shelter." (Transcript, pages 539-40; Exhibit 13A, page 5; Exhibit 22B.) By the time of this hearing the specific and detailed written provisions the Respondent gave to the PMC investigators, which proved to be fabricated, had become vague "discussions" with relatives of his wife who happened to be lawyers, but were not the lawyers who prepared her will, which discussions were occasioned by her terminal illness. (Transcript, page 484.) Or, in yet another alternative he offered, they had become provisions in an earlier will that she had written with a previous attorney, of which he produced no evidence. (Transcript, page 541.)

There is no evidence, other than his own story, of the claimed generous attitude the Respondent's wife supposedly had about his patients that led him to assume a philanthropic role that is not only unusual but directly contrary to the appropriate psychiatrist-patient standard of care. (Transcript, pages 455-56.) Although he never abandoned his basic claim that his payments to Patient A reflected some philanthropic history inspired by his first wife and a special fund available for that purpose, the Respondent admitted that he never made any payments to anyone else in accordance with it. The one and only example of his claimed

philanthropy to patients of which there is any evidence, the giving of $1,700 to Patient A, is not even consistent with the claimed history of making small donations of needed items.

The Hearing Committee concluded that none of the Respondent's evidence or attempts to explain these payments puts his actions in an understandable or acceptable light. There was something seriously wrong in giving, to a private patient he knew had claimed a sexual relationship with him, this amount of money for no clear reason, without making any record of it, and lying about it. The Respondent offered no credible or convincing explanation for his actions. The Hearing Committee consequently infers both that it was an inappropriate act and that it evidences an inappropriate relationship.

The nature of that relationship is the most contentious issue in this case. The Petitioner's theory of why the Respondent prescribed excessive amounts of narcotics, and gave Patient A large sums of money, is that it was to keep Patient A quiet about the sexual relationship they had in the first years of treatment. That was apparently how Patient A understood it. The prescriptions alone do not necessarily suggest a sexual relationship for the simple reason that the Respondent is also demonstrated to have had similar prescription practices with other patients, such as Patients B and D. The unexplained payments of money, however, are far more suggestive of something inappropriate in the background.

The Petitioner's direct evidence consists primarily of the disclosures Patient A made to numerous hospital personnel. As the Respondent acknowledged in his interview with PMC investigators, Patient A told the same story at numerous hospitalizations over the years. (Exhibit 13A, page 5.) Hospital records in evidence confirm that Patient A consistently reported he exchanged sex for money and drugs. (Exhibit 5F, page 32; Exhibit 5C, page 431;

Exhibit 5B, page 34.) Several of the hospital personnel he made these disclosures to testified at this hearing.

Amy Nixon was an inpatient social worker at Strong Memorial Hospital who treated Patient A when he was hospitalized in November and December 2010. He disclosed to her that he had been sexually abused by the Respondent when he was a teenager, and said he had been paid with money and prescriptions to keep quiet about it. (Exhibit 5C, pages 91-95; page 167; Transcript, pages 296-97.) Ms. Nixon also received emails from and had discussions about this with Patient A's representative, who is now deceased. (Exhibit 5C, pages 91-95; Transcript, pages 297-300.) Ms. Nixon pointed out that Patient A's disclosures to her were repeated and consistent, and that he did not make such accusations about anyone else. She concluded that "something inappropriate had happened." (Transcript, pages 296, 298, 311.)

Anne Fugle, M.D. was a psychiatrist who treated Patient A at Strong Memorial Hospital in November 2010. (Transcript, page 366.) Patient A told her a sexual relationship with the Respondent began when he was around 14 years old and continued until he was diagnosed with HIV in his early 20s. Patient A told her he was a prostitute for the Respondent, and continued to get drugs and money afterwards, but now wanted to "come clean" about the drugs and abuse. (Exhibit 5C, pages 85, 289, 299, 431; Transcript, pages 368-75.)

Dr. Fugle gave several reasons why she found Patient A believable. He showed no signs he was delusional about it, or psychotic. His accusations were consistent over time, and made at an actual or perceived risk to himself, so he had no incentive to make them. (Transcript, pages 377-80.) His history of not connecting to care was also consistent with a

history of betrayal by caregivers. (Exhibit 5C, pages 157, 312.) Dr. Fugle assessed Patient A to be truthful. (Transcript, page 377.)

Telva Olivares, the psychiatrist who oversaw Patient A's medical care at Strong in 2010, was notified by Dr. Fugle of Patient A's allegations. (Transcript, pages 316-18.) Dr. Olivares evaluated Patient A herself, and he again told her essentially the same story and said he believed the checks and prescriptions to be inducements not to say anything. (Transcript, pages 319-20.) Dr. Olivares never had another patient make this accusation. (Transcript, page 340.)

Margaret O'Keefe, a social worker at Rochester Psychiatric Center, was Patient A's primary therapist social worker when he was admitted in December 2010. (Transcript, page 345.) On discharge planning Patient A brought up concerns that he did not want to go back to the Respondent because of the sex and drugs, and so she respected that request in discharge planning. (Exhibit 5B, pages 20-25, 35, 40; Transcript, page 346.)

The 2010 disclosures about which these witnesses testified were supported by Rochester Psychiatric Center records showing that in 1985 Patient A had made the same allegations. (Exhibit 5F, pages 31-32; Transcript, page 348.)

The Hearing Committee understands that the direct evidence in support of this charge is hearsay. The Hearing Committee is entitled, however, to base its conclusion entirely on hearsay in an appropriate case. The real issue is the reliability of the hearsay. The Hearing Committee also recognizes, as the Petitioner points out, that the hospital witnesses were unable to conclusively say that Patient A was telling the truth. The Committee notes, however, that it was and is not the witnesses' responsibility to do so. It is the responsibility

of this Hearing Committee to do so in accordance with the applicable standard of proof, which is a preponderance of the evidence. PHL 230(10)(f).

The Hearing Committee was impressed with these witnesses' ability and experience in recognizing whether someone like Patient A is making claims that should be taken seriously. Patient A undoubtedly had serious psychiatric issues, but these witnesses gave good and persuasive reasons for taking his accusations seriously. Circumstantial evidence, such as the Respondent's unexplained payments to Patient A and demonstrated history of a willingness to violate legal boundaries for reasons that include his own sexual gratification, provide additional reason to take the accusations seriously.

Although the Respondent concedes he was aware that Patient A was making extremely serious accusations over the years, he never addressed the matter in his documented treatment of the patient, and never took the obvious precaution of carefully documenting that and why he was giving this patient large amounts of money. Instead, he concealed the payments and then lied about them. The Respondent failed again at this hearing to give any credible explanation for the payments. If he was not engaged in some inappropriate way with Patient A, it is difficult to understand why he concealed matters that he had every reason to be so careful to document.

In evaluating this evidence, the Hearing Committee also considered the Respondent's poor credibility and the evidence regarding his propensity to engage in such activity. The Respondent has a demonstrated history of criminal dishonesty. The Respondent has also demonstrated a propensity to inappropriately engage in sexual relations with young men. He acknowledges being bisexual (Transcript, page 439) and acknowledges he was arrested for

and admitted to soliciting a 19 year old male prostitute in 2010 by arranging to meet the prostitute at his office and pay for sex. (Transcript, pages 496-97, 537.)

The Respondent denies any sexual activity with Patient A and claims the consistency of his accusations over the years is explainable as a "fixed delusion." (Transcript, pages 505-506.) He did not show where any support for this theory is found in his or any of the other voluminous medical records in evidence. The Respondent's dismissal of the accusations with this explanation, considering his poor credibility, demonstrated propensity to concoct excuses, obvious motive to deny the charge, and all the circumstances surrounding his transactions with Patient A, was less convincing than the Department's evidence. The Hearing Committee accordingly concluded, by unanimous vote, that the Petitioner did meet its burden of proving by a fair preponderance of the evidence that the Respondent engaged in sexual activity with Patient A.

The Hearing Committee's unanimous determination on the factual allegations set forth in the statement of charges is as follows:

Factual allegation A1. Sustained. The Petitioner met its burden of proving by a preponderance of the evidence that the Respondent engaged in a sexual relationship with Patient A during the early years of his treatment.

Factual allegation A2. Sustained. The Respondent's unexplained and inappropriate payments to Patient A, and prescription of opiates and benzodiazepines in excessive amounts under inappropriate circumstances for many years establishes that there was an inappropriate relationship.

Factual allegations A3, A5. Sustained. The Respondent issued personal checks to Patient A without any apparent reason and without documenting that or why he did.

Factual allegation A4. Not sustained. The Petitioner did not meet its burden of proving that the checks were issued because of a prior inappropriate relationship. The checks clearly were part of an inappropriate relationship, but such a simple and direct cause and effect between them was not established.

Factual allegation A6. Not sustained. The Petitioner did not meet its burden of proving the Respondent prescribed controlled substances because of a prior inappropriate relationship. The prescriptions were evidence of inappropriate care, and may have been part of an inappropriate relationship, but they were not proved to have been written because of a prior inappropriate relationship. The evidence that the Respondent also prescribed inappropriately for other patients supports this conclusion.

Factual allegations A7a&b. Sustained. The Respondent made a false statement to PMC investigators about the source of and reason for the payments he gave to Patient A. The Respondent made the statement "knowing it to be false and/or with a reckless disregard for the truth thereof." He also gave false information about the contents of his wife's will in a subsequent written statement. The Respondent made the statement "knowing it to be false and/or with a reckless disregard for the truth thereof."

Factual allegation A8. Sustained. The Respondent failed to provide appropriate psychiatric care and treatment for Patient A's chemical dependency. The Respondent's prescription of high doses of diazepam right after Patient A had been hospitalized for overdoses and tapered off of it, without even seeing him, were the most egregious but not the only examples of this.

Factual allegation A9. Sustained. The Respondent failed to produce any records for his treatment of Patient A from the 1970s until 2000, and failed to establish any good reason for that failure.

Factual allegation A10. Sustained. The Respondent failed to document recommendations for needed chemical dependency treatment and failed to recommend such treatment.

Factual allegation A11. Sustained. The Respondent inappropriately maintained Patient A on a high dose of opiate pain medication for at least ten years.

Factual allegation A12. Sustained. The Respondent failed to document a recommendation to stop cannabis use and failed to make such a recommendation.

Factual allegation A13. Sustained. Patient A, maintained by the Respondent on a high dose of Percodan for many years, should have been but was not referred to a pain specialist.

Factual allegations A14, A15. Sustained. The Respondent prescribed high doses of addictive, controlled substances, including diazepam, with no connection to the patient's diagnosis, in unexplained and dangerous combinations and with little monitoring.

Factual allegation A16. Sustained. The Respondent failed to document any rationale for prescribing high doses of diazepam.

Factual allegations A17, A19. Sustained. The Respondent failed to adequately document any evaluation of the risks to Patient A of prescribing a large quantity of the narcotics on which he had repeatedly overdosed, and failed to document reasons for represcribing diazepam after he had been weaned of it during each of two psychiatric hospitalizations.

Factual allegation A18. Sustained. The Respondent exacerbated Patient A's substance abuse problem by maintaining him on high doses of diazepam and Percodan.

Factual allegation A20. Sustained. The Respondent failed to maintain appropriate psychiatric records for Patient A. He produced no records for his eighteen years of treatment of the patient from 1982 until 2000. His later records establish, and he admitted, that he prescribed medications and changed doses without documenting rationales for the prescriptions or dose changes.

Patient B (Exhibits 4B, 7A-D.)

Patient B was in his early twenties when the Respondent began treating him for "major depression, recurrent, severe and obsessive compulsive disorder" in the 1990s. Patient B was jailed for a time, and treatment resumed in 2000. (Transcript, page 511; Exhibit 7A, page 2.) The Respondent produced no records of his six years of treatment during the 1990s. The evidence regarding the failure to produce records was the same as for Patient A.

The Respondent routinely combined his documentation of multiple visits, over periods as long as eighteen months, into one brief summary note. (Exhibit 7A, pages 3-10.) He claimed, when interviewed by OPMC investigators, that combined notes were used because visits for Patient B were similar and the patient was stable. (Exhibit 13A, page 6.) At the hearing, he said "I did not think it was necessary to rewrite the same thing over and over again." (Transcript, page 575.)

Dr. Harlam said that it might conceivably be adequate to combine summaries for several visits for psychotherapy alone, if the patient is not being medicated. (Transcript, page 158.) This patient, however, was receiving treatment with multiple controlled

substances in high doses, and changes of the treatments were also being made, all over very long periods of time. Although he said Patient B was "very seriously ill" the Respondent admitted that he did not document the many medications prescribed, the doses for those medications, changes in the doses, or rationales for the medications. (Transcript, pages 513, 571-72.) He agreed that another physician looking at his records would not be able to tell what medications had been prescribed. (Transcript, page 573.)

The Respondent testified on cross examination that his policy was to keep a medication log, but then said:

> I did not keep one for Patient B because he basically had been on every medication and there were no substantive changes with the exception of occasional use of the latest antidepressant on the market and he didn't change in 20 years. (Transcript, page 572.)

This is not an explanation of anything, nor does the evidence even support it as a statement of fact.

Records obtained from the pharmacies that filled them show many changes in the prescriptions the Respondent wrote for Patient B. (Exhibit 7B-D.) He failed to document any rationales for or even that he was making changes, as the standard of care requires. (Transcript, pages 127-128.) The Respondent admitted even he could not say why he made the dosage changes for the clonazepam. (Transcript, pages 575-76; Exhibit 13A, page 7.)

The Respondent treated Patient B, who had a history of substance abuse, with clonazepam (Klonopin) and alprazolam (Xanax), both benzodiazepines, both in high doses, both addictive. He increased the clonazepam dosage from 4mg/day on August 5, 2009 to 6mg/day on October 27, 2009 to 8mg/day on March 24, 2010 without documenting any of these changes. (Transcript, page 575.) The alprazolam varied from 3-6mg/day. (Exhibit 7B.)

The Respondent also prescribed high doses of dextroamphetamine (Dexedrine), generally 160mg/day. (Exhibit 7B.) His chart consistently misidentified the dextroamphetamine he was prescribing as Adderall, a different medication (Transcript, pages 122, 573-74), a misidentification he brushed off on the grounds that "they are virtually identical drugs." (Transcript, page 574.)

Dr. Harlam characterized all these dosages as high. (Transcript, page 120.) The Respondent agreed they were high, but claimed that another physician he consulted, Dr. Guttmacher, "concurred" with his treatment and with the high dose of clonazepam. (Transcript, pages 511-12: Respondent brief, page 13.) Dr. Guttmacher clearly did not concur. His opinion, consistent with Dr. Harlam's, was that the patient should not have been treated with high doses of clonazepam. (Transcript, pages 154-57, 161.) His written report in the Respondent's medical record lists six "untried approaches" to treatment and states "My vote would be to drastically reduce or eliminate the clonazepam." (Exhibit 7A, pages 168-69.)

Several years went by while dextroamphetamine and clonazepam were prescribed without mention of the doses. The Respondent did not ever document the dosage of clonazepam. Although prescription records show he also continuously prescribed alprazolam for years - he was still prescribing it in 2010 - his chart does not even mention alprazolam after the year 2000. (Transcript, page 125; Exhibit 7A, page 3; Exhibits 7B, 7C.)

Even after getting a February 11, 2010 letter from the Department about his overuse of dextroamphetamine (Exhibit 7A, page 73), the Respondent still did not bother to document in his chart what he was doing. His next chart entry after receiving this letter was a summary for five office visits between August 5, 2009 and July 22, 2010 that did not even

mention dosages of dextroamphetamine or indeed any of the medications he prescribed over that nearly one year period. (Exhibit 7A, page 9.)

Because the Respondent's records were so inadequate in so many ways, Dr. Harlam was unable to understand the care being given to this patient. (Transcript, page 162.)

The Hearing Committee's unanimous determination on the factual allegations set forth in the statement of charges is as follows:

Factual allegations B1, B2, B3, B8. Sustained. The Respondent prescribed medications, including high doses of dextroamphetamine, clonazepam and alprazolam, and changed doses without documenting rationales for the prescriptions or the dose changes.

Factual allegation B4. Not sustained. Allegation B4 is not sustained because the Petitioner failed to provide specific details in support of the allegation that a medication was started or changed without an office visit or was prescribed without office visits at adequate intervals. Dr. Harlam testified that it is inappropriate to start or change medication without an office visit. (Transcript, pages 137-38.) He did not testify that the Respondent started or changed a medication without an office visit, as the Petitioner claims in its brief (Petitioner brief, page 44, citing Transcript, pages 146-47.) The Petitioner failed to identify where the evidence establishes that the Respondent did. The Petitioner also failed to identify what intervals between office visits, during which prescriptions were written, are alleged to have been inadequate.*

Factual allegations B5, B6, B8. Sustained. The Respondent failed to prepare contemporaneous progress notes for patient visits, relying instead upon inadequate and

* The Petitioner did identify such intervals in connection with allegation C2, and that factual allegation is accordingly sustained.

inappropriate summary progress notes purporting to document multiple visits in one brief note.

Factual allegation B7. Sustained. The Respondent failed to produce any records for several years of treatment he gave to Patient B in the 1990s.

Patient C (Exhibits 4C, 8A-B.)

The Respondent began treating Patient C for bipolar disorder in 2002, when she was thirty one. (Exhibit 8A, pages 3-4; Transcript, page 187.) After years of prescribing alprazolam (Xanax), he changed to clonazepam, another benzodiazepine, on December 17, 2010 without documenting any indication of a reason or even documenting that the change was made. (Exhibit 8B, page 4; Transcript, pages 188-89.) The chart entry for December 17, 2010 notes "as before." (Exhibit 8A, page 11.) Clonazepam is not even mentioned anywhere in the Respondent's medical record. (Transcript, page 189.)

On January 24, 2007, the Respondent prescribed Abilify. (Exhibit 8A, medication log, page 13.) Abilify is an antipsychotic medication that can be used when a bipolar patient is having an acute episode, as was apparently its use in this instance. (Transcript, page 190.) The Respondent acknowledged, however, that the chart entries for office visits on either side of the prescription contain no mention of Abilify or of any reason to even consider prescribing it. The entry before the prescription was written says Patient C is doing well, as does the entry after it was written. (Exhibit 8A, page 9.)

There was apparently some kind of crisis, but Dr. Harlam was only able to tell that because he found in the record a letter written by a psychologist, Dr. Greene. (Transcript, page 191; Exhibit 8A, page 85.) Dr. Greene's January 24, 2007 letter mentions that the Respondent had started Patient C on Abilify in early January, and the Respondent himself

told PMC investigators he started the medication on January 7, 2007. (Exhibit 8A, page 85; Exhibit 13A, page 9.) There is, however, no documentation in the Respondent's records that he prescribed Abilify in early January 2007, nor is any reason to do so documented.

On November 19, 2006, the Respondent's medical record notes Patient C's status as "doing well." The next entry, on February 13, 2007 is "still doing well." (Exhibit 8A, page 9.) Yet in between, on January 8, 2007, in addition to prescribing the Abilify, the Respondent signed a disability claim attesting that Patient C was unable to work as of December 18, 2006 because of her bipolar disorder. (Exhibit 8A, page 74.) There is no mention in the Respondent's record of any disability from working, other than the claim form itself.

Dr. Greene's January 24, 2007 letter does state that Patient C had "relapsed into manic symptoms with psychotic features." (Exhibit 8A, page 85.) The Respondent, however, signed the disability claim form on January 8, 2007, at which time the psychologist's January 24, 2007 letter did not exist. (Exhibit 8A, pages 74, 85.) At the hearing, the Respondent claimed he had a telephone conversation with Dr. Greene which he did not document. (Transcript, page 580.) He did not mention any such conversation, or Dr. Greene as the source for his disability determination, when both the disability determination and Dr. Greene were discussed in his April 2012 interview with PMC investigators. (Exhibit 13A, pages 8-9.)

The assessment the Respondent gave on the disability claim form stands in sharp contrast to the Respondent's own records documenting that the patient was "doing well" during this period. Dr. Harlam pointed out, and the Hearing Committee agreed, that the physician who provides the disability information must make his own determination, not

simply rely on another, non-physician therapist's opinion. (Transcript, page 208.) The Respondent failed to document the basis for the opinion he gave on the disability claim form. Furthermore, the documentation he did maintain is inconsistent with that opinion.

The excuse the Respondent offered to PMC investigators for not documenting any basis for the disability assessment was that his wife had just died. (Exhibit 13A, page 8.) The assessment was done in 2007, and she died in 2004. When that was pointed out to him at the hearing, the Respondent then offered, as an excuse for his first false excuse, that he said it at a time when his second wife had just been diagnosed with cancer. (Transcript, page 581.)

The Respondent continued to prescribe medications between January 2004 and July 2005, although he did not see Patient C at all over these 18 months. (Exhibit 8A, pages 8, 12; Transcript, page 579.) His notes show awareness of the problem and his need to demand that she come in, and yet he later allowed two more years to pass, from 2008-2010, in which he again continued to prescribe controlled substances without seeing her. (Exhibit 8A, pages 10-11; Exhibit 4C; Transcript, page 579.)

Dr. Harlam testified, and the Hearing Committee agreed with him, that when a patient is being prescribed controlled substances, as was the case here, the outside limit for renewing without an office visit might be six months. (Transcript, page 200.) The Respondent himself testified that visits for medication management should be at least every three months. (Transcript, pages 520-22.) In this case, the Respondent repeatedly allowed one to two years to pass while he wrote prescriptions for Patient C without seeing her.

The medication log stops on May 16, 2007 (Exhibit 8A, page 13), but the Respondent continued to treat Patient C well into 2011. Pharmacy records show that he continued to

prescribe medications over those years and that there were numerous changes in both the medications and the dosages including changes of alprazolam doses and switching with clonazepam. (Exhibit 8B.) After November 20, 2007 and at least until 2011, the Respondent failed to document any of the medications or changes in medications he was prescribing.

At the hearing, the Respondent claimed he talked with Patient C on the telephone and that her phone messages document the changes in dosage. (Transcript, page 578.) His record does contain phone messages from Patient C indicating that she called to request prescriptions. (Transcript, page 195; Exhibit 8A, pages 149-54.) None of these telephone messages, however, is from the period in question. The last one is dated May 15, 2007. In any event, the messages do not document that the Respondent talked with Patient C or what, if any, action he took. As Dr. Harlam pointed out, all these phone messages record is:

> ...the secretary takes phone calls. And the patient evidently says, I need this or I need that. And so each of these little memo pieces has different doses and different medications... (Transcript, pages 195-96.)

As Dr. Harlam pointed out, it is not possible to tell from review of the medical record what medications Patient C is on during the years 2007 to 2011.

The Hearing Committee's unanimous determination on the factual allegations set forth in the statement of charges is as follows:

Factual allegations C1, C7, C8. Sustained. The Respondent prescribed medications and changed doses without documenting the changes or the rationales for the prescriptions or dose changes.

Factual allegation C2. Sustained. The Respondent prescribed medications, including controlled substances, for as long as two years without seeing Patient C.

Factual allegation C3. Sustained. The Respondent failed to document any support for the opinion he gave in support of a disability claim that the patient was unable to work.

Factual allegations C4, C5. Not sustained. The Petitioner failed to present evidence to establish that the Respondent's progress notes were not contemporaneous with the office visits they document. The Petitioner failed to identify any summary progress notes for multiple visits in the Respondent's record for Patient C and there do not appear to be any. (Exhibit 8A, pages 4-11.) The Petitioner failed to address these allegations in its brief.[†]

Factual allegation C6. Sustained. While the Petitioner did establish that the Respondent prescribed alprazolam and changed the dosage without documenting the changes or any rationale for them, the Petitioner did not present evidence to establish that it was inappropriate to prescribe alprazolam at all. Factual allegation C6 is sustained to the extent it alleges that the Respondent inappropriately prescribed alprazolam because he failed to document the rationale for the prescriptions.

Patient D (Exhibits 4D, 9A-E.)

The Respondent began treating Patient D in 2002, when she was twenty one, for anxiety disorder and a history of eating disorder and mood fluctuations. (Exhibit 9A, pages 5-6.) Patient D initially denied substance abuse. (Exhibit 9A, page 5.) The Respondent's ongoing suspicion of it, however, is evident in his progress notes. During the period 2009-2011 he prescribed, among other things, the controlled substances clonazepam and amphetamine. (Exhibits 4D, 9B-D.)

[†] The Petitioner's seventy five page brief discussed each of the forty eight factual allegations individually except for C4 & C5, which it misnumbered and left out. (Petitioner's brief, pages 49-54.) It is unquestionable that allegation C5, at the very least, should have been withdrawn. The government should have no interest in prevailing by mistake, and should not adopt a strategy of hoping a hearing committee will not notice.

After the first few office visits, the Respondent began combining multiple office visits into one note rather than documenting each visit. Dr. Harlam made it very clear, in spite of the Respondent's attempts to suggest he was inconsistent about the matter, that when a psychiatrist is treating a patient with medications, including making changes in the medications and doses over a long period of time, it is not appropriate to combine several office visits into one recorded note. (Transcript, pages 226-29.) The Respondent admitted the criticism of his summary notes was fair, as was the criticism of his failure to document medications, dosages, and rationales for them. (Transcript, pages 526, 581.)

In 2006, the Respondent prescribed clonazepam with notations "limit to 4mg" and "watch for signs of drug use." In 2007 he made an entry "will not go above 6mg clonazepam." (Exhibit 9A, pages 17-18.) After April 4, 2008, there is no further mention of clonazepam in his medical record.

Prescription records, however, show that the Respondent continued to prescribe clonazepam. Dr. Harlam testified: "4 milligrams is a high dose, 6 milligrams is a very high dose. I've never in my career seen a dose of clonazepam above 6 milligrams." (Transcript, page 237.) The Respondent, who began with the notation "limit to 4mg" in 2006, increased the dose to 12 milligrams by 2009. (Exhibit 4D.) These levels are especially alarming when given to a substance abuser who is also being given amphetamine. (Transcript, page 237.) No rationale was documented, and indeed clonazepam was not even mentioned in the medical record after April 4, 2008, when the Respondent wrote "will not go above 6mg." (Exhibit 9A, page 17.)

The Respondent acknowledged he was prescribing a "very high dose" of clonazepam for Patient D. (Transcript, page 524.) He acknowledged that as he was raising Patient D's

clonazepam dose to 12 milligrams, he failed to document either that he was doing so or why. (Transcript, pages 583-84.) His testimony at the hearing was that in 2009, when he increased the dose to 12mg:

> She was functionless, in a fetal position, agitated, wouldn't talk to anybody. She had been a prostitute. She had been beaten by her pimp and was basically out of control... At the time I gave the very high dose of clonazepam, she was functionless, agitated, anxious. Had been seen in an emergency room in Syracuse, where she lived, three or four times in three or four days. Had not been admitted and was not sleeping, was not eating, was not functioning in any meaningful way. (Transcript, pages 524-25.)

The Respondent's actual records of this period fail to document anything like this. From 2008 through 2010 they are in his usual form of summary notes for multiple visits, repeatedly recording such things as "doing well," "mood stable," "continues stable," "remarkably stable," "doing well on current regimen," "doing well. Working as a nurse in Syracuse. Pleased with progress." (Exhibit 9A, pages 17-20.) There is no mention of any emergency room, being functionless or being in a fetal position, nor is there even any mention of clonazepam after the note from April 2008 that he "will not go above 6mg."

Respondent's lack of concern about what he was doing was exemplified by his treatment of this patient. After documenting that he would not go above clonazepam 6mg because of concerns about her drug use, he thereafter did not document that he was even prescribing clonazepam (Exhibit 9A, pages 20-21), yet prescription records show he actually increased the dose to the extremely high level of 12 mg by 2009. (Exhibit 4D.) By early 2009, another doctor was prescribing suboxone, which is a treatment for opiate addiction, for Patient D. (Exhibit 9B, page 2.)

Patient D's last office visit was October 10, 2010, but the Respondent continued to write monthly prescriptions for both amphetamine and clonazepam until September 2011.

((Exhibit 9A, page 19; Exhibit 4D.) None of these prescriptions is documented in the medical record that the Respondent provided to the Department on November 21, 2011. (Exhibit 9A.) Dr. Harlam again testified, and the Hearing Committee agreed, that it was a violation of the standard of care to prescribe controlled substances over such an extended period of time without seeing the patient. (Transcript, pages 248-49.)

The Hearing Committee's unanimous determination on the factual allegations set forth in the statement of charges is as follows:

Factual allegations D1, D4, D7. Sustained. The Respondent prescribed medications and changed doses without documenting rationales for the prescriptions or dose changes. No doses are recorded for any of the medications prescribed after April 4, 2008.

Factual allegations D2, D3. D7. Sustained. The Respondent failed to prepare contemporaneous progress notes, relying instead upon inadequate and inappropriate summary progress notes for multiple visits.

Factual allegation D5. Sustained. The Respondent prescribed extremely high doses of clonazepam without documenting why or even that he was doing so.

Factual allegation D6. Sustained. The Respondent prescribed medications, including controlled substances, from October 10, 2010 through September 2011 without seeing Patient D.

Patient E (Exhibits 4E, 10A-C.)

Patient E was a 38 year old man, HIV positive, first seen by the Respondent in 2005 for bipolar disorder and substance abuse. (Exhibit 10A, pages 2-3.) The Respondent prescribed numerous medications over the years, including clonazepam, lithium, trazodone, Adderall, nortriptyline, amphetamine and dextroamphetamine. (Exhibits 4E, 10B&C.)

Dr. Harlam agreed that the Respondent "did good things with this patient" and that the treatment was within acceptable standards. (Transcript, pages 262-63.) There were some good notes at the outset. (Transcript, page 258.) However, the Respondent soon began to rely on brief summaries for multiple visits over several months, which are not acceptable, and, as with the other patients reviewed, changes to medication doses were not documented. These were deviations from the appropriate standard of care. (Transcript, page 258-59.)

The Respondent admitted that his use of summaries for multiple visits and his failure to document any rationales for his medication decisions was inappropriate. (Transcript, page 529.) As with all of these patients, he tried to characterize this matter as simply one of sloppy or inadequate recordkeeping, and claimed that his new computerized recordkeeping system would solve the problems. (Transcript, pages 529-30.)

The Hearing Committee's unanimous determination on the factual allegations set forth in the statement of charges is as follows:

Factual allegations E1, E2, E3, E4. Sustained. The Respondent prescribed medications and changed doses without documenting rationales for the prescriptions or dose changes. He failed to prepare contemporaneous progress notes, relying instead upon inadequate and inappropriate summary progress notes for multiple visits.

DETERMINATION ON SPECIFICATIONS OF CHARGES

The statement of charges included seven charges of misconduct as defined in various subsections of Ed.L 6530. (Exhibit 1.) The charges of misconduct are:

1. Gross negligence. The Petitioner charges that the Respondent violated Ed.L 6530(4) by practicing with gross negligence with regard to the sexual relationship, his payments to Patient A and his misrepresentations about those payments. (Factual allegations

A1-A7.) The Hearing Committee unanimously sustained the charge on the basis of allegations A1, A2, A3 and A5. Gross negligence was established by the Respondent's egregious conduct in both the sexual relationship with Patient A and the undocumented and unexplained payments made in violation of appropriate psychiatrist-patient standards. Factual allegations A4 and A6 were not upheld. Factual allegations A7a&b did not support this charge because the Respondent's misrepresentations to the Petitioner's investigators were acts of dishonesty, not negligence.

2. **Gross incompetence**. The Petitioner charges that the Respondent violated Ed.L 6530(6) by practicing with gross incompetence with regard to Patient A because of the sexual relationship, payments of money, and misrepresentations about it. (Factual allegations A1-A7.) The Hearing Committee unanimously sustained the charge on the basis of allegations A1, A2, A3 and A5. The Respondent's sexual relationship with a vulnerable young man in his psychiatric care was an act of gross incompetence, as was his unexplained and undocumented payment of large sums of money to a drug addicted patient who had alleged a sexual relationship with him. Factual allegations A7a&b did not support this charge because the Respondent's misrepresentations to the Petitioner's investigators were acts of dishonesty, not incompetence.

3. **Fraudulent practice**. The Petitioner charges that the Respondent violated Ed.L 6530(2) by practicing medicine fraudulently with regard to Patient A in his misrepresentations to the Petitioner about his wife's will. (Factual allegations A7a&b.) The Hearing Committee agreed to sustain both allegations that "Respondent made such statement knowing it to be false and/or with a reckless disregard for the truth thereof." Even as fully sustained, however, the factual allegations fail to establish fraudulent practice. The Hearing

Committee did not find the Respondent to be honest or credible, but something more than a propensity to be untruthful is required to sustain a charge of practicing medicine fraudulently.

The Petitioner's own brief accurately sets forth the three elements of fraudulent practice: (1) a false representation by the licensee (2) the licensee knew the representation was false, (3) the licensee intended to mislead through the false representation. (Petitioner's brief, page 5.) The Petitioner failed to allege the third element, intent to mislead. Indeed, factual allegations that statements were made "and/or with a reckless disregard for the truth thereof" are inconsistent with a finding of intent to mislead. The Petitioner's brief (pages 22, 38-39, 73) failed to address or correct this deficiency in the charge. The charge of fraudulent practice is not sustained.

4. **Moral unfitness**. The Petitioner charges that the Respondent violated Ed.L 6530(20) by conduct with regard to Patient A that evidences moral unfitness to practice medicine. (Factual allegations A1-A7.) The Hearing Committee unanimously concluded that engaging in a sexual relationship with Patient A, giving him substantial sums of money for no clear or documented reason, and fabricating a story to explain it, evidenced moral unfitness.

5. **Negligence on more than one occasion**. The Petitioner charges that the Respondent violated Ed.L 6530(3) by practicing with negligence on more than one occasion with regard to all five patients. The Respondent failed to keep anything remotely like adequate records for these patients. His failure to document what he was doing as he prescribed high doses of addictive and controlled substances demonstrates inattention and a lack of concern for his patient's medical needs. The Hearing Committee unanimously agreed

that the Respondent's years of egregious recordkeeping and prescription practices with all these patients constituted negligence on more than one occasion.

6. **Incompetence on more than one occasion**. The Petitioner charges that the Respondent violated Ed.L 6530(5) by practicing with incompetence on more than one occasion with regard to all five patients. The Respondent failed to keep anything remotely like adequate records for these patients, and his prescription practices included prescribing high doses of addictive, controlled substances with no connection to the diagnoses of the patient, over many years, in unexplained and dangerous combinations and with little monitoring. In addition to being negligent care, this constituted incompetent care. The Hearing Committee unanimously agreed that the Respondent's years of egregious recordkeeping and prescription practices with all these patients evidenced incompetence on more than one occasion.

7. **Failure to maintain records**. The Petitioner charges that the Respondent violated Ed.L 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient. The Hearing Committee unanimously agreed that the Respondent's egregious recordkeeping practices for all these patients, including missing records, summary progress notes, inaccurate and incomplete records of patient encounters, patient care and patient prescriptions, constituted a failure to maintain records that accurately reflect the evaluation and treatment of the patient.

The Respondent's claim in his post hearing brief (pages 2, 18) that the Petitioner's failure to also allege or charge "physical contact of a sexual nature" and charge misconduct in violation of Ed.L 6530(44) compromises the validity of its charges of misconduct in violation of Ed.L 6530(2)-(6),(20)&(32) is without merit and is rejected.

PENALTY DETERMINATION

The Hearing Committee reviewed the penalties available to it under PHL 230-a.

The Respondent wants these charges to be about two things: the charge that he had sex with a patient, which he adamantly denies, and the inadequacy of his record keeping. His discussion in his brief about any proposed penalty passes directly from the sexual allegations, which he flatly denies, to the recordkeeping issues, without even acknowledging the issues raised in the charges, with which Dr. Harlam was most concerned, about his prescribing practices. (Respondent brief, pages 27-28.)

Dr. Harlam agreed that improvements in the Respondent's record keeping practices would address many of the criticisms he made, but he made it very clear that this was not the most important issue. (Transcript, page 266.) The Respondent offered no significant or credible response to what Dr. Harlam clearly stated was the most serious concern, which was his prescribing practices with all these patients: the repeated prescription, for year after year, of very high doses of benzodiazepines and opiates, addictive and narcotic medications, with no documented or apparent justification and indeed in alarming circumstances. Patients with bipolar illnesses resisted the appropriate medication, and doses for medications that are not even appropriate for the conditions they had were raised to excessive levels. (Transcript, pages 267-68.) Four of the five patients under review (Patients A, C, D & E) were diagnosed by the Respondent as having bipolar disorder. (Transcript, pages 468, 524.) The Respondent acknowledged knowing what the appropriate treatment for bipolar disorder was, yet he did not prescribe it for any of them. Patients were instead given amphetamines, benzodiazepines and opiates.

The doses of these medications are not matters of minor difference of opinion among physicians. They are far beyond what is reasonable. As Dr. Harlam said:

> I think that it's fair to say that there is – there are differences of opinion, but in the 25 psychiatrists that I'm supervising now, I have never seen a dose of 12 milligrams of clonazepam. I've never seen a dose of 60 milligrams of diazepam. I mean, these are just not – we're not talking about a minor difference of opinion.
>
> We're talking about things that are so far out of the realm of what doctors prescribe, I think you would be hard pressed to find a physician who would prescribe those levels of those drugs. And 160 of the Adderall is another one is higher than I've seen before. (Transcript, page 269.)

The Hearing Committee fully agreed with Dr. Harlam's view of these matters.

The Respondent acknowledged the documentation criticisms without acknowledging the charges amount to anything more than that or that there is anything substantively wrong with his practice. He ignored the prescribing and patient care issues, offering no discussion or acknowledgement of his own practices in allowing these egregious treatment issues to go on for years, even decades. He showed no indication he has any interest in changing the way he thinks about his patient care, or understands there was anything wrong with it.

The Respondent instead made much of his purchase of a computerized record keeping program. In his view, with his purchase of this program, the problems are now solved. (Transcript, pages 492-93, 495-96, 513, 520, 526, 529-30.) According to the Respondent, the new record keeping system will ensure that patients do not receive prescriptions for long periods without visits, and that a record is made for each visit, not just summary notes. Although he also claimed his manner of keeping records was not a problem because he has a good memory, he went on to say his new recordkeeping system will also remind him to do things. (Transcript, page 588.)

The Respondent's claim that because he has a machine he will now do what he is supposed to do as a matter of good medical judgment and was supposed to be doing all along, is not persuasive. It is not the computer that makes the decisions, it is the physician when he writes the note of the visit or the prescription. The Respondent's impatience with the computer system was already evident at the hearing:

> I – despite the fact that those records meet the standards of now... The ICA records, I'm sorry, meet the current standards. I still have problems with them, because they require physician to have computer working with patient and typing away while you're trying to establish or maintain a relationship with the patient. I don't think it's quite the same as a cardiologist asking, do you have chest pain, yes or no. (Transcript, page 493.)

The Respondent's history has given him ample reason to be aware of and take seriously his professional responsibilities, including among other things his prescription practices. He served as a consultant to the Petitioner in the 1990s. (Transcript, page 462; Exhibit B.) He faced disciplinary proceedings before the Petitioner in 1999 and his medical license was suspended. (Exhibit 15A.) In 2009 he had problems with Blue Cross after the parents of yet another patient complained about his prescription of pain medications. He also acknowledged "The OPMC -- a few years ago, the same issues came up in terms of prescribing these medications, especially the pain medications," and said that he was told by the Petitioner not to prescribe any pain medications. (Transcript, pages 594-95.) In 2010 his prescribing of amphetamine for Patient B was excessive enough to prompt a letter of concern from the Department of Health. (Exhibit 7A, page 73.) He showed no sign at this hearing that he thinks there was anything wrong in simply throwing away thousands of medical records that he knew he was under a legal obligation to maintain. His lack of concern for or even recognition of his documentation responsibilities is even more egregious in that he

trains residents in those very things. (Transcript, pages 585-86.) These experiences appear to have had little effect on him.

In this context and with this background the Respondent's recordkeeping and documentation failures are far more than what he calls "sloppy recordkeeping." (Transcript, page 25.) Falling back on the old and inadequate truisms "you treat the patient not the chart" and "anyone can treat a chart and anyone can make a chart look good" (Transcript, page 587) does not answer the charges. It is not just that he was not adequately documenting the care he was giving. It is the care that he was not adequately documenting that is alarming.

The Respondent himself agrees revocation is the appropriate penalty if he had a sexual relationship with a patient. He denies that he did have such a relationship. The Hearing Committee concluded that the preponderance of the evidence establishes otherwise. If it were true that he did not, and if this case were just a matter of what the Respondent tries to characterize as "sloppy recordkeeping," some penalty short of revocation might be considered. But it is not just a matter of recordkeeping. The Hearing Committee determined that even if factual allegation A1 were not sustained, revocation would still be the appropriate penalty.

The Hearing Committee, like Dr. Harlam, was appalled by the Respondent's prescribing practices and the circumstances under which they were carried on for years if not decades. The Hearing Committee was appalled by the Respondent's apparent unwillingness to acknowledge or inability to recognize how serious they were. The Hearing Committee unanimously concluded that those practices, in the context of his egregiously irresponsible documentation and recordkeeping, his inappropriate and unexplained transactions with

Patient A and his dishonesty to the Petitioner about them, justify the revocation of the Respondent's license.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following charges of misconduct under Ed.L 6530 are sustained:

   Ed.L 6530(4). Gross negligence
   Ed.L 6530(6). Gross incompetence
   Ed.L 6530(20). Moral unfitness to practice medicine
   Ed.L 6530(3). Negligence on more than one occasion
   Ed.L 6530(5). Incompetence on more than one occasion
   Ed.L 6530(32). Failure to maintain records

2. The Respondent's license to practice medicine is hereby revoked.

3. This order shall be effective upon service on the Respondent by personal service or by registered or certified mail as required under PHL 230(10)(h).

Dated: Pittsford, New York
18 April 2014

By: REDACTED
Charles J. Vacanti, M.D., Chair

Suwarna A. Naik, M.D
Heidi B. Miller, M.P.H., R.P.A.-C

EXHIBIT I

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

IN THE MATTER OF MELVIN PISETZNER, M.D.	STATEMENT OF CHARGES

MELVIN PISETZNER, M.D., the Respondent, was authorized to practice medicine in New York State on or about February 9, 1973, by the issuance of license number 114914 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric care to Patient A (hereinafter identified in the attached Appendix A) at Respondent's office, located at 1000 Pittsford-Victor Road, Pittsford, New York 14534, from on or about the late 1970's through on or about September 21, 2010. Respondent has not provided Patient A's medical records for the period of time prior to January 28, 2000. Respondent's psychiatric care of Patient A deviated from accepted standards of care as follows:

1. Respondent engaged in an inappropriate sexual relationship with Patient A;
2. Respondent engaged in an inappropriate relationship with Patient A;
3. Respondent inappropriately issued checks made payable to Patient A;
4. Respondent because of a prior inappropriate relationship with Patient A inappropriately issued checks made payable to Patient A;
5. Respondent inappropriately failed to document any rationale for issuing checks made payable to Patient A;
6. Respondent because of a prior inappropriate relationship with Patient A inappropriately prescribed controlled substances for Patient A;
7. a. Respondent was interviewed by representatives of the New York State Department of Health, Office of Professional Medical Conduct (OPMC) on or about April 2, 2012. On such occasion Respondent was asked questions about and gave information relating to payments made to Patient A and the

(4)

source of said funds. Respondent stated that his wife, who had died, left $5,000 in her will for any of his patients that needed financial help. Respondent made such statement knowing it to be false and/or with a reckless disregard for the truth thereof.

b. On May 9, 2012, Respondent provided supplemental materials to OPMC as a follow-up to the interview. Subsequently, Respondent advised OPMC that his wife's will stated that "Because of my husband's devotion to his profession and his frequent care of indigent patients, $5,000 of my estate will be available to use as he pleases to help indigent patients with needed food and shelter". Respondent made such statement knowing it to be false and/or with a reckless disregard for the truth thereof.

8. Respondent failed to provide appropriate psychiatric care and treatment of Patient A's chemical dependency;
9. Respondent failed to properly maintain and preserve Patient A's medical records from on or about the late 1970s through January 28, 2000, including the initial psychiatric care assessment;
10. Respondent failed to recommend that Patient A receive treatment for chemical dependency and/or Respondent failed to document such recommendation;
11. Respondent inappropriately maintained Patient A on a high dose of an opiate pain medication for over a ten year period;
12. Respondent failed to recommend that Patient A stop using cannabis, and/or failed to document such recommendation;
13. Respondent failed to refer Patient A to an appropriate medical specialist to address said patient's pain;
14. Respondent inappropriately prescribed medications for Patient A;
15. Respondent inappropriately prescribed Diazepam and/or prescribed Diazepam at an inappropriately high dose for Patient A;
16. Respondent failed to document any rationale for prescribing high doses of Diazepam;

17. Respondent failed to properly document any evaluation of the risks to Patient A of prescribing a large quantity of narcotics to said patient, in light of taking overdoses of said medication on two occasions;
18. Respondent exacerbated Patient A's substance abuse problem by maintaining said patient on high doses of Diazepam and/or Percodan;
19. Respondent, after Patient A had been weaned off Diazepam during each of two separate psychiatric hospitalizations, failed to document the reasons for represcribing Diazepam to Patient A; and
20. Respondent failed to maintain appropriate psychiatric records for Patient A.

B. Respondent provided psychiatric care to Patient B (hereinafter identified in the attached Appendix A) from on or about the late 1990s and continued through on or about November 23, 2011. Respondent has not provided Patient B's medical records for the period of time prior to April 21, 2000. Respondent's psychiatric care of Patient B deviated from accepted standards of care as follows:

1. Respondent inappropriately prescribed high doses of dextroamphetamines for Patient B, and/or failed to properly monitor said patient and failed to document the rationale for such high dose prescriptions;
2. Respondent prescribed a combination of Clonazepam and Alprazolam for Patient B, and failed to appropriately document the rationale for such prescriptions;
3. Respondent inappropriately changed the doses of medications prescribed for Patient B, and/or failed to document the rationale for such changes and/or any changes in said patient's symptomatology that necessitated dose changes;
4. Respondent inappropriately prescribed medications for Patient B without having in-person office visits with Patient B at adequate intervals and/or without adequate in-person assessments of said patient;
5. Respondent failed to prepare appropriate medical records, including progress notes, for Patient B contemporaneously with office visits;
6. Respondent prepared inadequate and inappropriate summary progress notes regarding Patient B's office visits;

7. Respondent failed to properly maintain and preserve Patient B's medical records from on or about the late 1990s through April 21, 2000; and
8. Respondent failed to maintain appropriate psychiatric records for Patient B.

C. Respondent provided psychiatric care to Patient C (hereinafter identified in the attached Appendix A) from on or about August 20, 2002, through on or about October 21, 2011. Respondent's psychiatric care of Patient C deviated from accepted standards of care as follows:

1. Respondent inappropriately failed to document the medications, doses, or changes in medications/doses for Patient C;
2. Respondent inappropriately prescribed medications for Patient C without having in-person office visits with Patient C at adequate intervals and/or without adequate in-person assessments of said patient;
3. Respondent inappropriately failed to document the reason for his statement that Patient C was disabled and unable to work;
4. Respondent failed to prepare appropriate medical records, including progress notes, contemporaneously with office visits;
5. Respondent prepared inadequate and inappropriate summary progress notes regarding Patient C's office visits;
6. Respondent inappropriately prescribed Alprazolam for Patient C, and/or failed to document the rationale for such prescriptions;
7. Respondent inappropriately prescribed medications for Patient C and changed the doses of such medications without documenting the rationales for the prescriptions and dose changes; and
8. Respondent failed to maintain appropriate psychiatric records for Patient C.

D. Respondent provided psychiatric care to Patient D (hereinafter identified in the attached Appendix A) from on or about April 22, 2002, through on or about December 1, 2011. Respondent's psychiatric care of Patient D deviated from accepted standards of care as follows:

1. Respondent prescribed medications for Patient D and changed the doses for such medications without documenting the rationales for such prescriptions and/or dose changes;
2. Respondent failed to prepare appropriate medical records, including progress notes, contemporaneously with office visits;
3. Respondent prepared inadequate and inappropriate summary progress notes regarding Patient D's office visits;
4. Respondent failed to document medication dosages for Patient D from on or about April 4, 2008 through 2010;
5. Respondent inappropriately prescribed a high dose of Clonazepam for Patient D and inappropriately changed the dose of such medication, and/or failed to document the rationales for such high dose prescriptions and/or changes in the dose;
6. Respondent inappropriately prescribed medications, and/or changed the dose of such medications, for periods of time during which there were inadequate office visits and/or insufficient communications between the Respondent and said patient; and
7. Respondent failed to maintain appropriate psychiatric records for Patient D.

E. Respondent provided psychiatric care to Patient E (hereinafter identified in the attached Appendix A) from on or about November 7, 2005, through on or about October 24, 2011. Respondent's psychiatric care of Patient E deviated from accepted standards of care as follows:

1. Respondent prescribed medications for Patient E and changed the doses for such medications without documenting the rationales for the prescriptions and dose changes;
2. Respondent failed to prepare appropriate medical records, including progress notes, contemporaneously with office visits;
3. Respondent prepared inadequate and inappropriate summary progress notes regarding Patient E's office visits; and
4. Respondent failed to maintain appropriate psychiatric records for Patient E.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in New York Education 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. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7a, and A and A.7b.

SECOND SPECIFICATION

GROSS INCOMPETENCE

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

2. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7a, and A and A.7b.

THIRD SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. The facts of Paragraphs A and A.7a, and A and A.7b.

FOURTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

4. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7a, and/or A and A.7b.

FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of the following:

5. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7a, A and A.7b, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, A and A.13, A and A.14, A and A.15, A and A.16, A and A.17, A and A.18, A and A.19, and A and A.20; B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, and B and B.8; C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, and C and C.8; D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, and D and D.7; and E and E.1, E and E.2, E and E.3, and/or E and E.4.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of the following:

6. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7a, A and A.7b, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, A and A.13, A and A.14, A and A.15, A and A.16, A and A.17, A and A.18, A and A.19, and A and A.20; B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, and B and B.8; C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6; C and C.7 and C and C.8; D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, and D and D.7; and E and E.1, E and E.2, E and E.3, E and E.4, and/or E and E.5.

SEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of the following:

7. The facts of Paragraphs A and A.5, A and A.9, A and A.10, A and A.12, A and A.16, A and A.17 A and A.19, and A and A.20; B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, and B and B.8; C and C.1, C

and C.3, C and C.4, C and C.5, C and C.6, C and C.7, and C and C.8; D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, and D and D.7; and E and E.1, E and E.2, E and E.3, and/or E and E.4.

DATE: December 11, 2013
Albany, New York

REDACTED

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct