STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

February 3, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Sylvia Finkelstein, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

David P. Schiebel, M.D.
40 East 89th Street
Apt. 15E
New York, New York 10028

Seth Stein, Esq.
Stein & Schonfeld
100 Quentin Roosevelt Blvd.
Garden City, New York 11530

RE: In the Matter of David P. Schiebel, M.D.

Dear Ms. Finkelstein, Dr. Schiebel and Mr. Stein:

Enclosed please find the Determination and Order (No. BPMC-94-10) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 than 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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he 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 all action 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., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0030

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.

Very truly yours,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER OF DAVID P. SCHIEBEL, M.D.	DETERMINATION AND ORDER NO. BPMC-94-10

The Hearing Committee, composed of Alvin Rudorfer, D.O., Chairperson, Anthony Santiago and S. Mouchly Small, M.D., was duly designated and appointed by the Commissioner of Health of the State of New York pursuant to New York Public Health Law § 230, subd. 10(e). Eugene A. Gaer, Esq., Administrative Law Judge, served as Hearing Officer for the Committee.

The Committee, each member of which has considered the entire record in this matter, hereby renders its decision with regard to the charges of medical misconduct filed against David P. Schiebel, M.D. (the "Respondent").

STATEMENT OF CHARGES

Respondent is charged by Petitioner Department of Health (the "Petitioner") with three types of professional misconduct, as defined in New York Education Law § 6530, subds. 4, 3 and 32, respectively. The charges are that he practiced the profession with gross negligence (first specification), that he practiced the profession with negligence on more than one occasion (second specification) and that he failed to maintain a record which

accurately reflects the evaluation and treatment of the patient (third specification).

These allegations relate to Respondent's treatment of a single patient between May 1987 and January 1991. The charges are more particularly set forth in the Statement of Charges, a copy of which is attached hereto as Appendix 1.

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	July 13, 1993
Pre-hearing Conference:	July 23, 1993
Hearing dates:	August 4, 1993 August 18, 1993 September 22, 1993 September 29, 1993 October 13, 1993 October 20, 1993 November 17, 1993
Closing briefs submitted on:	December 3, 1993
Deliberation date:	December 8, 1993
Place of Hearing:	New York State Department of Health 5 Penn Plaza New York, New York 10001
Petitioner represented by:	Silvia P. Finkelstein, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York 10001
Respondent represented by:	Seth Stein, Esq. Stein & Schonfeld 100 Quentin Roosevelt Blvd. Garden City, New York 11530

WITNESSES

Petitioner called these witnesses:

Patient A	Fact Witness
Ruth Dowling Bruun, M.D.	Expert Witness

Respondent testified in his own behalf and also called these witnesses:

Paul Kaiser, C.S.W.	Fact Witness
Jane Simon, M.D.	Fact Witness
Michael R. Liebowitz, M.D.	Expert Witness
Sidney Malitz, M.D.	Character Witness

FINDINGS OF FACT

The following findings of fact were made after review of the entire record by the Committee. Citations indicate evidence found persuasive by the Committee in arriving at the finding. "Tr." citations are to the transcript of the hearing. "P.Ex." and "R.Ex." citations are to the exhibits introduced by Petitioner and Respondent. Evidence which conflicted with any finding of the Committee was considered and rejected.

General Findings

1. Respondent was authorized to practice medicine in the State of New York on August 27, 1976, by the issuance of License No. 128205 by the Department of Education. P.Ex. 2, p. 3. He

has been continuously licensed to practice medicine in the State since that time. See P.Ex. 2, p. 2; Tr. 526.

2. Respondent has completed residency training in psychiatry and is board-certified in that specialty. Tr. 526-28, 572. At all times relevant to this proceeding his office has been located at 40 East 89th Street, New York, New York. Tr. 526.

Findings as to Patient A: Treatment

3. Respondent treated Patient A from May or June 1987 to January 1991. Tr. 113-14, 116, 153-55, 547, 666-69. Patient A was 40 years old when Respondent first treated her. See Tr. 163.

4. Beginning in or about April 1987 Patient A was undergoing psychotherapy with Paul D. Kaiser, C.S.W. Tr. 114-15, 395, 431; see, also, P. Ex. 5. In therapy, Patient A was dealing with issues related to being a single mother raising a teenage son, inability to write, unhappiness, difficulties in work and social relationships, and feelings of isolation. Tr. 114-15, 395.

5. Patient A told Mr. Kaiser that members of her family had been alcoholics and that she was familiar with support groups for individuals with alcoholic family members. Tr. 409-10, 426-27; P.Ex. 5. Patient A did not present symptoms of alcohol abuse to

Mr. Kaiser and she denied to him that she might be drinking too much. Tr. 409, 411-13, 426, 455, 464.

6. Mr. Kaiser referred Patient A to Respondent for the prescription of medication to facilitate Patient A's treatment by Mr. Kaiser. Tr. 400-02, 537; cf. Tr. 14-15. After Mr. Kaiser and Respondent discussed Patient A's condition over the telephone, there was one initial consultation between Respondent and Patient A in May or June 1987. Tr. 116, 537-38, 544-47.

7. During the initial visit Patient A described her difficulties and history to Respondent, who prescribed Xanax and meprobamate for her.[1] Tr. 402, 448, 547-48, 550-69; cf. Tr. 120-21, 259-60, 287. Because it was anticipated that Patient A's treatment by Mr. Kaiser might last several years, Respondent discussed with Patient A the likelihood that these medications might continue to be prescribed over an extended period, that she might become dependent on them and that she might have withdrawal symptoms when they were discontinued. Tr. 567-68.

8. Following the initial consultation with Patient A, Respondent and Mr. Kaiser discussed Respondent's prescriptions for her. Tr. 444-45. Thereafter Respondent and Mr. Kaiser periodically spoke (primarily by telephone) about Patient A's

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[1]Meprobamate is also known as Miltown and Equanil. Tr. 54, 351, 1079.

condition and Respondent's prescriptions. Tr. 404-05, 573, 579-81, 588-89.

9. From in or about June 1987 through July 1989, Respondent mailed prescriptions for Xanax and meprobamate to Patient A, without intervening work-ups or follow-up evaluations. There were no additional visits between Patient A and Respondent within this period. Tr. 842, 845-48.

10. In April 1989, Respondent began to prescribe Librium for Patient A in addition to Xanax and meprobamate. Tr. 582-87, 847-48.[2]

11. During the period June 1987 - July 1989, Patient A's use of medication was monitored over the telephone by Respondent. Patient A would call him when she exhausted her prescriptions, and Respondent would routinely ask her a standard set of five questions concerning amount of medication taken, date and quantity stated on the medicine bottle, effectiveness of the medication, possible side-effects, and changes in life-style, including use of alcohol and other drugs. Tr. 126, 574-75, 581-82, 814, 842-44.

12. In 1988 Patient A enrolled in a graduate social work

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[2]Xanax and Librium are classified as benzodiazepines; meprobamate is not. Tr. 54.

program. Problems concerning the program and the related field-placements became issues in Patient A's psychotherapy. Tr. 127-29, 132-33, 142-43, 197, 582-83, 600-05.

13. In or about July 1989 Patient A terminated treatment with Mr. Kaiser. Tr. 135-36, 407, 590-91; P.Ex. 5. Respondent then began to provide her psychotherapy, consisting of several visits per week. Tr. 138-39, 140-41, 148-49, 597, 605-07. Respondent also continued to prescribe Xanax, Librium and meprobamate on a regular basis. Tr. 599-60, 607-08.

14. Xanax, Librium and meprobamate are generally indicated for the treatment of anxiety. Tr. 54; cf. Tr. 884. Patient A presented symptoms of anxiety. See, e.g., Tr. 395, 397-99, 404, 545, 548, 562, 582-83, 684-85, 871-73; cf. Tr. 367-68.

15. At the time Patient A commenced psychotherapy with Respondent, he knew of her history of alcohol and Valium abuse while in her 20's. Tr. 544-45, 553-55. During the time Respondent was treating her, Patient A did not present symptoms of alcohol or drug abuse. Tr. 557-59, 613-16, 685-89.

16. Between April 21, 1989, and January 24, 1991, Respondent simultaneously prescribed controlled substances to Patient A, including Librium (in two different dosages), Xanax and meprobamate. Tr. 599-60, 607-08, 626-27, 632-33, 639-48, 673,

676-78; P.Ex. 3. On two occasions he also prescribed Dexedrine. Tr. 620-21. P. Ex. 3.[3]

17. In 1990 Patient A completed her Master of Social Work degree with honors and began work as a hospital social worker. Tr. 151, 622, 634-35, 650-51; see, also, Tr. 157.

18. In January 1991 Patient A terminated her treatment with Respondent. Tr. 153-55, 666-69. Respondent advised her that it would be necessary for her to withdraw gradually from her medications. Tr. 673, 675-78.

Findings As To Patient A: Recordkeeping

19. A medical record kept by a psychiatrist should contain an initial evaluation and history. Entries should be dated. As treatment continues, the record should contain progress notes and notes about the prescription of medications and any changes in those prescriptions. Tr. 56-57, 976.

20. Respondent's records contain no initial evaluation of Patient A or any record of their initial consultation in May or June 1987. See P.Ex. 4; see, also, Tr. 734, 738, 823-24.

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[3]The details of the prescriptions are set forth in Appendix B to the Statement of Charges (P.Ex. 1). Certain of these entries were amended by stipulation during the course of the hearing. See Tr. 13-14, 73-74.

21. Respondent's records of Patient A consist of process notes taken during psychotherapy sessions. P.Ex. 4, pp. 305-427; Tr. 697-700, 824-25, 832-35. Also in the records are numerous letters and other writings composed by Patient A and sent to Respondent during the course of her psychotherapy, intermixed with papers relating to problems in her social work training. P.Ex. 4, pp. 2, 6-304; Tr. 181-83, 705.

22. Respondent did not maintain records which accurately reflect the evaluation, diagnosis and treatment of, and prescription of controlled substances for, Patient A. See, Tr. 87-91, 971, 976-77, 980-82, 988-89, 991-94, 1064-65, 1093-94.

Findings As To Patient A: Aftermath

23. By February 1991 Patient A was beginning to suffer withdrawal from the medications prescribed by Respondent. Tr. 236. In March 1991 Patient A sought help from Jane Simon, M.D., in withdrawing from her dependency on Xanax, Librium and meprobamate. Tr. 236-40, 479-80. Dr. Simon attempted to help Patient A taper off from these drugs by prescribing Compazine and Librium (in two different dosages). Tr. 480-84. She later prescribed tapering dosages of Xanax and meprobamate. Tr. 484-87.

24. Dr. Simon saw Patient A four times between March 8 and

June 6, 1991. Tr. 482-87. Dr. Simon did not detect symptoms of alcohol abuse in Patient A. Tr. 488-89, 500, 507, 510-11, 518.

25. Between June 12 and July 3, 1991, Patient A was hospitalized at Conifer Park, a treatment facility in Scotia, New York, where she underwent detoxification and rehabilitation for drug dependence. P.Ex. 7, p. 1; Id., "History and Physical Examination."[4]

26. On September 16, 1993, Patient A commenced an action against Respondent alleging medical malpractice, lack of informed consent and intentional infliction of emotional distress. R.Ex. G.

CONCLUSIONS AS TO FACTUAL ALLEGATIONS

General Conclusions

Respondent was a psychiatrist practicing in New York City, who treated Patient A over an extended period from May or June 1987 to January 1991.[5] As part of that treatment, Respondent

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[4]An extract from Patient A's Conifer Park record was introduced at the hearing as P.Ex. 7. The full record was later reviewed by the Committee pursuant to stipulation of the parties.

[5]**Paragraph A** of the Statement of Charges accurately summarizes this treatment and is therefore **SUSTAINED**.

prescribed multiple controlled substances for the patient. The State charges that those prescriptions were inappropriate and inadequately documented.

In considering the charges, the Committee reviewed Respondent's prescription practices in the light of his treatment objectives and of recognized professional standards, as presented through the testimony of Respondent and of expert witnesses.[6]

The Committee has also had to determine whether the prescriptions were appropriate for someone with Patient A's actual physical and psychiatric condition. Because the patient and the physician were often diametrically opposed in their description of that condition, it was necessary for the Committee to evaluate their relative credibility.

The Committee was aided in doing so by the testimony of two other practitioners who treated Patient A. One of these, Paul D. Kaiser, C.S.W., provided her psychotherapy conjointly with Respondent during the period May 1987 - July 1989. The other, Jane Simon, M.D., attempted to help Patient A withdraw from medication for approximately four months after the patient terminated her treatment with Respondent in January 1991. In addition the Committee had available the records of Patient A's

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[6]Citations to the record in the Findings of Fact which are applicable to the corresponding Conclusions are not repeated.

hospitalization at Conifer Park, a treatment facility she entered in June 1991.

Viewing the evidence as a whole, the Committee finds that Respondent was more credible than Patient A with respect to significant disputed issues. This conclusion seriously undermines Petitioner's allegations that Respondent's treatment of Patient A was inadequate, inappropriate or negligent.

Finally, and as an independent matter, the Committee has reviewed the records maintained by Respondent while he was treating Patient A. Recordkeeping is an especially sensitive matter when, as here, there has been extensive use of controlled substances in the course of treatment. Despite its voluminous size, the file which Respondent maintained for Patient A (P.Ex. 4) had undeniably troubling gaps in documentation.

Conclusions as to the Period of Conjoint Treatment

Paragraph A.1 of the Statement of Charges relates to the period when Patient A was being treated conjointly by Respondent and Mr. Kaiser. At that time Patient A was receiving psychotherapy from Mr. Kaiser and was seen only once by Respondent, in May or June 1987, to enable him to prescribe controlled substances to facilitate her therapy with Mr. Kaiser. There is, in the main, no dispute that during this period

Respondent was prescribing multiple drugs for Patient A simultaneously, including Xanax and meprobamate.[7]

Beyond this is a significant dispute about the nature and characterization of Respondent's practices. Paragraph A.1 charges that the prescriptions were made "without adequate work-up and/or follow-up evaluations" and that "Respondent failed to monitor or follow-up Patient A's clinical condition while prescribing these drugs." The Committee finds that the evidence does not support these charges.

Respondent did examine and evaluate Patient A at the time of the initial interview; he also conferred by telephone with her psychotherapist shortly thereafter. There were a number of further telephone consultations (and one in-person discussion) between Respondent and Mr. Kaiser about Patient A. Tr. 404-05, 579-81. Although there were no further office visits to Respondent while Patient A's treatment with Mr. Kaiser continued,

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[7]It is not disputed that after April 1989 Librium was also being prescribed. However, Paragraph A.1 of the Statement of Charges suggests that Respondent prescribed Librium from the outset. There is no documentary evidence concerning any prescription prior to April 1989 (see P.Ex. 3), and the witnesses' testimony on this issue was in conflict. Respondent testified that he first began to prescribe Librium in April 1989 in an attempt to alleviate Patient A's anxiety while reducing her dependence on meprobamate. Tr. 583-87. This finds support in Mr. Kaiser's testimony that he only knew Respondent was prescribing two drugs, and that he did not recall that either was Librium. Tr. 402, 448. In contrast Patient A testified that all three drugs were prescribed from her first visit to Respondent. Tr. 117, 120-21, 129-30, 259.

the Committee finds convincing Respondent's testimony concerning his procedure for checking her usage by telephone before issuing new prescriptions. The weight of the credible evidence establishes that Respondent monitored Patient A's drug usage by telephone.[8]

The Committee does not find the prescription of multiple drugs inappropriate in the light of Patient A's specific condition. Respondent testified that he selected these medications and determined their dosage after careful consideration of Patient A's symptoms and prior history of drug usage, and, in part, to forestall dependency on any particular one. Tr. 563-66, 569-70, 583-88. The expert testimony also points toward the conclusion that for this patient Respondent's decision to prescribe this combination of medications was appropriate. See Tr. 883-91, 936, 961-65; cf. Tr. 55-56, 86, 91-95, 509-10, 1078-79. The Committee concludes that at no time was the amount of medication excessive in the light of Patient A's symptoms or psychiatric condition.

Thus, while Paragraph A.1 is correct in stating when Patient A's sole office visit occurred within the period of conjoint treatment and in describing the fact that prescriptions were

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[8]The testimony of Respondent's expert witness that this kind of monitoring procedure was consistent with acceptable professional standards (Tr. 874-75) was not controverted by Petitioner. See Tr. 943-44.

mailed to Patient A, its overbroad identification of the prescribed medications, its allegations that there was no adequate evaluation, follow-up or monitoring of Patient A, and its characterization of the prescriptions as inappropriate, are not supported by the evidence.

Accordingly **Paragraph A.1** is **NOT SUSTAINED.**

Conclusions as to the Period of Psychotherapy

Paragraph A.2 relates to the period from July 1989 to January 1991, when Patient A was receiving psychotherapy directly from Respondent at several sessions per week. Respondent continued prescribing essentially the same medications as before, although the dosages were varied as Patient A's condition changed. This Paragraph correctly states the dates of Patient A's psychotherapy with Respondent and, as amended, properly references the details of the prescriptions during this period. See Footnote 3, supra.

The core allegations of this Paragraph are that

> Although Respondent knew that Patient A had a history of alcohol abuse and was a habitual user of controlled substances,... Respondent inappropriately prescribed multiple controlled substances to Patient A, including but not limited to: Librium,
>
> Meprobamate, Xanax, Equanil,

and [Dexedrine][9].

Any evaluation of Respondent's prescriptions must take account of whether they were issued at a time when Patient A was indeed abusing alcohol. See, e.g., Tr. 55, 57, 86, 93-95. There is no question that Patient A was sensitive to issues relating to alcoholism, based on her experiences with alcoholic family members, on her own involvement as a young woman with alcohol and Valium abuse, on her participation in codependency support groups and on her training as a social worker. But it is questionable whether Patient A was herself abusing alcohol while being treated by Respondent.

Patient A testified that during the time of her treatment by Mr. Kaiser (i.e., before her psychotherapy with Respondent) she was "drinking too much", i.e., "four or five margaritas, three or four times a week", and that this practice continued throughout her therapy with Respondent and until about the time she began seeing Dr. Simon. Tr. 115-16, 131, 152, 159, 172-73, 212, 244-46. Respondent denied that she reported heavy alcohol use to him, or that there were signs of it at her office visits. Tr. 557-59, 613-16, 685-89.

Respondent's denial is corroborated by the testimony of

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[9]This listing, although accurate, may create a misimpression. Meprobamate and Equanil are the same drug. See Footnote 1, supra. Dexedrine was only prescribed on two occasions for particular reasons. Tr. 620-21.

both Mr. Kaiser and Dr. Simon -- two disinterested and wholly independent practitioners who treated Patient A at or about the same time as Respondent. Mr. Kaiser testified that he did ask Patient A if she might be using alcohol excessively and that Patient A replied that she occasionally drank wine and that she definitely did not abuse alcohol. In his view she did not present symptoms of alcohol abuse. Tr. 409-13, 455.

Dr. Simon, who treated Patient A after she terminated her therapy with Respondent, also detected no signs of alcohol abuse. This physician was consulted by Patient A for the specific purpose of aiding her withdrawal from the medications prescribed by Respondent. In that context it was a matter of importance for the treating physician to know whether the patient had a problem with alcohol abuse. Yet Dr. Simon testified that Patient A neither reported nor presented symptoms of alcohol abuse during the time she was treating her. Tr. 488-89, 500, 507, 510-11, 518.[10]

The evidence from Patient A's record of treatment at Conifer Park also undermines her claim that she presented symptoms of alcohol abuse. For example, the "Medical Discharge Summary" lists "Alcohol dependence continuous, severe" (together with

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[10]Patient A testified that she last drank alcohol in March 1991 (Tr. 159), around the time of her first visit to Dr. Simon. But the Conifer Park form recording her "Past History of Drinking/Drugs" reports her "Last Drink" as "6/5".

"Sedative Hynotic dependence severe" and "Benzodiazepine dependence severe") in the "Final Primary Diagnosis". But the form recording her "Past History of Drinking/Drugs" lists as "Length of present habit" "1-2 glasses wine 2-3 x wk".

Patient A's credibility on this issue is called into question by her testimony on related issues. She testified that her Conifer Park admission in June 1991 directly followed a "seizure" or convulsion" induced either by overuse or withdrawal from drugs. Tr. 157-58; 271-73. However, the Conifer Park record does not state that she reported such a seizure when she was admitted. Dr. Simon, who had been treating her with respect to withdrawal down to a few days before this admission, was unaware that Patient A had suffered seizures (Tr. 505-07, 518-19), and, on the basis of a review of the record, it was found doubtful by Respondent's expert witness. Tr. 984-87.[11]

Patient A did evince symptoms of dependence on the controlled substances which Respondent was prescribing. However these medications were selected with a view to minimizing the known risks of such dependence in the light of Patient A's history and psychological condition. The evidence does not show that over the course of Patient A's treatment her dosages exceeded recognized standards. Nor, in view of the progress made

[11]There are also significant variances between Patient A's testimony at the hearing and the allegations in her malpractice complaint against Respondent. See R.Ex. G.

by Patient A in her personal life during the course of her treatment (including completion of her Master of Social Work degree with honors and commencement of appropriate employment), can it be said that her treatment by Respondent was ineffective.

When the above facts are considered together, it does not appear that Respondent's prescriptions were written at a time when Patient A was abusing alcohol or that they were excessive or inappropriate for a patient with her specific condition.

Accordingly the allegations of **Paragraph A.2** are **NOT SUSTAINED**.

Conclusions as to Recordkeeping

Paragraph A.3 states that

> Respondent failed to maintain records which accurately reflect the evaluation, diagnosis, treatment and prescriptions of controlled substances for Patient A.

An integral part of all patient care is the maintenance by the physician of an accurate record detailing the patient's history, and initial and subsequent evaluation, symptoms, treatment and progress. Where controlled substances are prescribed, the physician should record the rationale for their use, as well as the dosage and other pertinent details. Besides aiding the treating physician's care of the patient, the record

should be in such a format as to apprise a subsequent physician of the relevant facts concerning the patient's treatment.

In the present case Respondent's recordkeeping failed to meet these standards. No satisfactory explanation was given for the total absence of any record of the initial office visit of May or June 1987 or of the prescriptions thereafter issued until April 1989.

A sizable office file does exist for the period when Patient A was receiving psychotherapy from Respondent. P.Ex. 4. But (aside from the patient's letters, writings and school-related records), this file consists exclusively of undated and unstructured process notes written down by Respondent during psychotherapy sessions. There was no recorded evaluation of Patient A's condition or progress, and there would have been no way for a consulting or succeeding practitioner to evaluate the patient's status.

The fact that this patient's treatment involved substantial prescription medications only serves to enhance the problem. Although Respondent retained (separately from Patient A's office file) required copies of her prescriptions during the period April 1989 - January 1991, he nowhere recorded the rationale for the use, combination or dosage of these drugs, a lapse which

could have had serious consequences if any of the practitioners who subsequently helped her withdrawal had found it necessary to review her treatment and medication history.

The defective character of Respondent's recordkeeping with respect to this patient, which he ultimately conceded, cannot be overlooked. The allegations of **Paragraph A.3** are **SUSTAINED**.

DISPOSITION OF SPECIFICATIONS

Having entered the foregoing Findings of Fact and Conclusions as to the Allegations, the Committee has, by unanimous vote, determined that the charges that Respondent practiced the profession with gross negligence and with negligence on more than one occasion are not sustained by the evidence. The Committee also has determined by unanimous vote that the charge that Respondent failed to maintain a record which accurately reflects the evaluation and treatment of the patient is sustained by the evidence. The Committee has entered the following Dispositions of the Specifications of Charges:

FIRST SPECIFICATION (gross negligence):

NOT SUSTAINED

SECOND SPECIFICATION (negligence on more than one occasion):

NOT SUSTAINED

THIRD SPECIFICATION (inaccurate recordkeeping):

SUSTAINED

ORDER

The Committee, by unanimous vote, has determined that the following penalty should be, and it hereby is,

ORDERED that Respondent **DAVID P. SCHIEBEL, M.D.**, shall be **CENSURED** and **REPRIMANDED** for failing to maintain a record which accurately reflects the evaluation and treatment of a patient.

Dated: New York, New York
January , 1994

By: _____
ALVIN RUDORFER, D.O.
(Chairperson)

ANTHONY SANTIAGO
S. MOUCHLY SMALL, M.D.

APPENDIX 1

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

IN THE MATTER

OF

DAVID P. SCHIEBEL, M.D.

NOTICE

OF

HEARING

TO: DAVID P. SCHIEBEL, M.D.
40 East 89th Street, Apt. 15E
New York, New York 10028

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1993). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 4th day of August, 1993 at 10:00 in the forenoon of that day at 5 Penn Plaza, Sixth Floor, New York, NY 10016 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas

issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1993). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
July 13, 1993

CHRIS STERN HYMAN
Counsel

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

IN THE MATTER	**STATEMENT**
OF	**OF**
DAVID P. SCHIEBEL, M.D.	**CHARGES**

DAVID P. SCHIEBEL, M.D., the Respondent, was authorized to practice medicine in New York State on August 27, 1976 by the issuance of license number 128205 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994, from 40 East 89th Street, Apt. 15E, New York, New York 10028.

FACTUAL ALLEGATIONS

A. Respondent, a psychiatrist, treated Patient A from in or about May, 1987 to January, 1991. Respondent's office is located at 40 East 89th Street, Apt. 15 E, New York, New York 10028. (Patient A is identified in the annexed Appendix A).

1. From in or about May, 1987 to in or about July, 1989 on numerous occasions, Respondent inappropriately prescribed controlled substances

to Patient A, including but not limited to Librium, Miltown and Xanax, without adequate work-up and/or follow-up evaluations. Respondent had one initial consultation in May 1987 with Patient A. Thereafter, Respondent mailed prescriptions to Patient A. There were no additional visits within this period of time. Respondent failed to monitor or follow-up Patient A's clinical condition while prescribing these drugs.

2. From in or about July 1989 through in or about January 1991, Respondent rendered medical care to Patient A consisting of several psychotherapy visits per week and prescribing controlled substances. Although Respondent knew that Patient A had a history of alcohol abuse and was a habitual user of controlled substances, including Valium, Librium, and Miltown, on numerous occasions, between on or about April 21, 1989 and January 24, 1991, Respondent inappropriately prescribed multiple controlled substances to Patient A, including but not limited to: Librium, Meprobamate, Xanax, Equanil, and Dexadrine. (Prescriptions are detailed in the annexed Appendix B).

3. Respondent failed to maintain records which accurately reflect the evaluation, diagnosis, treatment and prescriptions of controlled substances for Patient A.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law section 6530(4), (McKinney Supp. 1993), by practicing the profession with gross negligence, in that Petitioner charges:

1. The facts in Paragraphs A, A.1, and/or A.2.

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law section 6530(3), (McKinney Supp. 1993), in that he practiced the profession with negligence on more than one occasion, specifically, Petitioner charges two or more of the following:

2. The facts in Paragraphs A, A.1, and/or A.2.

THIRD SPECIFICATION

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law section 6530(32), (McKinney Supp. 1993), by failing to maintain a record which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

3. The facts in Paragraphs A and A.3.

DATED: New York, New York
July 13, 1993

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct

APPENDIX B

DATE	DRUG	AMT.	SIG.	NUMBER
04/21/89	Librium 10 mg.	60	2/day	3248337
06/08/89	Meprobamate 400 mg.	100	4/day	
06/07/89	Librium 10 mg.	120	4/day	3248317
06/07/89	Xanax 0.5 mg.	120	4/day	3248318
07/24/89	Librium 10 mg.	120	4/day	1429598
09/06/89	Librium 10 mg.	120	4/day	5078805
10/20/89	Librium 10 mg.	120	4/day	5078868
11/03/89	Equanil 400 mg.	120	4/day	5599535
11/30/89	Dexadrine 5 mg.	5	half/day	5599555
01/19/90	Librium 10 mg.	120	4/day	5599574
01/19/90	Equanil 400 mg.	120	4/day	
02/21/90	Librium 10 mg.	100	4/day	5599577
03/16/90	Dexedrine Inst. rel. 5 mg.	10	1 prn/day	7924252
03/16/90	Librium 10 mg.	120	4/day	7924253
04/09/90	Xanax .5 mg.	60	2/day	7924268
04/09/90	Meprobamate 400 mg.	60	2/day	
04/09/90	~~X~~anax 15 mg.	60	2/day	7924268
04/09/90	Librium 10 mg.	60	2/day	7924267
04/09/90	Librium 25 mg.	60	2/day	7924266
05/30/90	Librium 10 mg.	120	4/day	7924337

07/03/90	Meprobamate 400 mg.	100	4/day	6101445
07/03/90	Librium 25 mg.	100	4/day	6101442
07/03/90	Xanax 0.5 mg.	60	2/day	6101444
07/03/90	Librium 10 mg.	120	4/day	6101443
08/01/90	Meprobamate 400 mg.	100	4/day	6101501
08/01/90	Xanax 0.5 mg.	60	2/day	6101475
08/01/90	Librium 10 mg.	100	4/day	6101474
08/01/90	Librium 25 mg.	100	4/day	6101473
09/20/90	Meprobamate 400 mg.	100	4/day	
09/20/90	Librium 25 mg.	100	4/day	5078838
09/20/90	Librium 10 mg.	100	4/day	5078837
09/20/90	Xanax 0.5 mg.	100	4/day	5078839
11/02/90	Librium 10 mg.	120	4/day	6101499
12/12/90	Xanax 0.5 mg.	60	2/day	0668763
12/12/90	Librium 10 mg.	120	4/day	0668759
12/12/90	Meprobamate 400 mg.	60	2/day	
12/12/90	Librium 25 mg.	60	2/day	0688760
01/24/91	Xanax 0.5 mg.	60	2/day	0668782
01/24/91	Librium 25 mg.	120	4/day	0668781
01/24/91	Librium 10 mg.	120	4/day	0668780
01/27/91	Meprobamate 400 mg.	100	1/day	