STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

September 26, 2008

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Courtney Berry, Esq.
NYS Department of Health
90 Church Street, 4th Floor
New York, New York 10007-2919

Robert Hauben, M.D.

Redacted Address

Anthony Z. Scher, Esq.
Wood & Scher
222 Bloomingdale Road
White Plains, New York 10605

RE: In the Matter of Robert Hauben, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 08-187) 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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:nm

Enclosure

COPY

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

IN THE MATTER	:	DETERMINATION
	:	
OF	:	AND
	:	
ROBERT HAUBEN, M.D.	:	ORDER

BPMC-08-187

A Notice of Hearing and Statement of Charges, both dated February 21, 2008, were served upon the Respondent, Robert Hauben, M.D. **WALTER M. FARKAS, M.D., (CHAIR), MITCHELL S. STRAND, M.D., AND LOIS A. JORDAN,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Courtney Berry, Esq., Associate Counsel. The Respondent appeared by Wood & Scher, Anthony Z. Scher, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	February 21, 2008
Answer Filed:	February 26, 2008
Pre-Hearing Conference:	March 12, 2008
Hearing Dates:	March 19, 2008 May 6, 2008 May 20, 2008 June 2, 2008 June 10, 2008 July 1, 2008
Deliberations Held:	August 4, 2008

STATEMENT OF CASE

Petitioner has charged Respondent, a psychiatrist, with twenty-two specifications of professional misconduct. The charges relate to Respondent's medical care and treatment of ten patients. The charges include allegations of negligence on more than one occasion, incompetence on more than one occasion, and the failure to maintain accurate medical records, as well as violations of the terms of probation imposed by a prior Board Order. Respondent denied the allegations.

A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in

parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Robert Hauben, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 095463 on September 30, 1965. (Ex. #2).

2. Pursuant to BPMC Order No. 04-203, Respondent's license to practice medicine in the State of New York was suspended (stayed) and Respondent was subject to a three year term of Probation, which commenced in September, 2004. (Ex. B).

3. Respondent submitted two sets of medical records to OPMC for Patients A-J. Respondent certified both sets as "complete, true and exact" copies of the records for each patient. (Ex. 3, 3A, 4, 4A, 5, 5A, 6, 6A, 7, 7A, 8, 8A, 9, 9A, 10, 10A, 11, 11A, 12, 12A). During the course of the Hearing, Respondent admitted that several of these records were incomplete and offered additional pages of records into evidence. (Ex. E, G, P, Q; T. 608-609, 901-902, 959, 965, 974-975, 1142-1144).

4. Respondent made additions and changes to his medical records without giving any indication that the alteration took place. (T. 568, 627-631, 729-731, 777-782, 849-851, 853-856, 858-859, 902-905, 932-933).

5. As a matter of course, Respondent does not record a diagnosis or treatment plan in his records. (T. 563-565, 571, 588-589, 594-596, 619-620).

6. A mental status examination is the psychiatric equivalent of a physical examination. The psychiatrist notes the patient's appearance, attitude and behavior. It includes a description of the patient's emotional response, affect and emotion, speech patterns, specific delusions and a review of the patient's cognitive abilities, attention, memory and judgment. The mental status examination should be done at the beginning of treatment. During the course of treatment changes should be noted in the medical record. (190-192, 783-784; Ex. 3 and 3A).

7. A mental status examination is time-specific and should be dated. (T. 190-192, 783-784, 1048, 1052-1053; Ex. 3, 3A).

8. Respondent considered mental status examinations and histories to be "works in progress". He testified that he completed them during several visits, and did not date the

records. (T. 566-568, 653-655, 682-684, 728-732; Ex. 3 - 12A).

9. Respondent frequently ordered lithium for "augmentation purposes" for some of his patients. He did not order medical work-ups or test lithium levels for these patients. (T. 154-155, 634-636, 670-676, 858, 933-937).

10. A medical record is intended to be a means of communication to other physicians about the care that has been rendered. It has to be comprehensive and comprehensible. The initial assessment should include a history of present illness, past psychiatric history, medical history, family history, mental status examination, and a diagnosis. Following the initial assessment, there should be a treatment plan, including medications prescribed, doses, increases, rationale for medication shifts, a review of side effects, and drug interactions. (T. 186-187).

Patient A

11. Respondent treated Patient A at his office in Southampton, New York from on or about December 23, 2002 through at least October 24, 2006. (T. 20-21, 53-54, 312; Ex. 3 and 3A).

12. Patient A's chief complaint at the first visit was obsessive compulsive disorder (OCD). There is no

diagnosis or treatment plan documented in the medical record. (Ex. 3 and 3A).

13. Respondent inappropriately prescribed multiple short acting and long-acting benzodiazepines to Patient A. Respondent did not explain his rationale for medication changes in the records. (T. 35-37, 52-53, 197-199, 251-252, 261-264; Ex. 3 and 3A).

14. Respondent noted that Patient A was drinking "a few beers daily", while taking benzodiazepines and antidepressants. All sedative drugs are cross-tolerant and additive. There is no indication that Respondent addressed this issue with Patient A or followed up on the patient's alcohol consumption. (T. 208-210, 655-657).

15. Respondent testified that he did not recall a conversation with patient, but that he gives a standard warning to his patients regarding alcohol use with antidepressants. While he usually does not give this warning to patients who are taking benzodiazepines, he always gives it to patients taking antidepressants. Respondent failed to record any discussion regarding mixing substances in the medical record. (T. 614-617, 646-657, 690-691).

16. Respondent noted in the record that Patient A "shared a joint". There was no follow-up regarding the

patient's illegal drug use recorded in the chart. (T. 264-267; Ex. #3A).

17. The mental status examination in Patient A's chart is undated. (Ex. 3, 3A; T. 191).

18. On January 17, 2007, Respondent was interviewed by Melvin Steinhart, M.D., a medical coordinator from the Office of Professional Medical Conduct (OPMC). The interview concerned Patients A-J. Respondent had access to the medical records during the interview. (T. 25-172).

19. Respondent told Dr. Steinhart that his rationale for medication changes was based on patient response and whether the medication was being tolerated. He stated that he usually documents this, but did not for Patient A because he never thought it was relevant. (T. 35-36).

20. When asked why he prescribed both long-acting and short-acting benzodiazepines for Patient A, Respondent stated that he usually starts out with several at the same time. Respondent prescribed Xanax for breakthrough anxiety. Respondent did not know the difference between using benzodiazepines on a p.r.n. (as needed) basis, versus on a regular basis. (T. 36-37).

Patient B

21. Respondent treated Patient B at his office in Southampton, New York from on or about October 13, 2004 through at least on or about October 24, 2006. (Ex. 4 and 4A).

22. Patient B was an alcoholic, yet Respondent prescribed long and short acting benzodiazepines to her, at times simultaneously. (T. 71-72, 88-90, 303, 749-752; Ex. 4 and 4A).

23. When a drug is prescribed, the dose should be increased until there is either a therapeutic response, or bad side effect. This was not done. Instead, Respondent prescribed multiple antidepressants, tranquilizers, and medications for alcohol abuse, with frequent changes. (T. 88-90, 314-315).

24. On at least one occasion, Patient B reported that she consumed both Xanax and wine, yet Respondent continued to prescribe benzodiazepines to the patient. (T. 333-335, 733, 747-751; Ex. 4 and 4A).

25. The June 1, 2005 medication note states "Order liver functions. Prescribe Naltrexone, 50 mg q.d." (Ex. 4 and 4A). Naltrexone is an anti-opiate used for the treatment of cravings. (T. 305-306). The corresponding progress note

merely states "Life is still very chaotic", without mention of either the liver function tests or Naltrexone. There are no laboratory results in the chart. (T. 73-74, 340, 725-727, 742-744; Ex. 4 and 4A).

26. Respondent testified that he discussed AA, rehabilitation and hospitalization with Patient B. None of this is reflected in the medical record. (T. 308-309, 714-715, 719-720; Ex. 4 and 4A).

27. Patient B suffered from Cushing's disease, which was treated by an endocrinologist. Her illness could have contributed to the psychiatric symptoms, but there was no follow-up documented in the record. (T. 339-344).

28. When asked about his treatment plan for Patient B, Respondent stated that the patient rejected all of the medications he tried. This is not documented in the medical record. (T. 69-70; 302-303; Ex. 4 and 4A).

29. Respondent told Dr. Steinhart that he did not know the difference between a resting tremor and an intentional tremor. (T. 72073, 80).

Patient C

30. Respondent treated Patient C at his office in Southampton, New York from on or about May 21, 2004 through at least on or about October 24, 2006. (Ex. 5 and 5A).

31. The initial progress note lists the patient's chief complaint as "Depression", followed by "Has been on medications since 1998". There is no description of the depression, or its history, nor a listing of medications. There is no diagnosis recorded. (Ex. 5 and 5A).

32. The phrase "15 yrs sobriety" is listed under "Summary of Treatment", and family history information is listed under "Present Medications". The family psychiatric and medical history conflict with information contained in the patient's "Psychiatric Record". (T 348-350, 357-359, 361-370, 785; Ex. 5 and 5A).

33. There is no treatment plan recorded in the chart.(T. 94, 346; Ex. 5 and 5A).

34. The mental status examination is undated. Respondent made undated additions to the mental status exam sometime between submitting Exhibit 5 and 5A to the Department. (T. 349-350, 779-784; Ex. 5 and 5A).

Patient D

35. Respondent treated Patient D at his office in Southampton, New York from on or about April 13, 2005 through at least on or about October 24, 2006. (Ex. 6 and 6A).

36. There is no diagnosis or treatment plan noted in the record. (T. 111; Ex. 6 and 6A).

37. Patient D presented with a history of mania, having been discharged from a hospital in approximately one month prior to beginning treatment with Respondent. (Ex. 6 and 6A).

38. Respondent prescribed both Ritalin and Provigil for Patient D. Both drugs can exacerbate mania. (T. 111-112, 117-118, 122, 372-375, 380, 385-386, 800, 816-820; Ex. 6 and 6A).

39. Twice in the medical record Respondent mentioned ADD (attention deficit disorder). During his interview with Dr. Steinhart, Respondent said that ADD was a chronic problem with this patient. There is no support for an ADD diagnosis in the medical record. (T. 111-112, 115, 121-122, 375-377, 380-381, 385, 810-813; Ex. 6 and 6A).

40. The medical record refers to "severe" delusions without a description other than "Santa Claus delusions". (T. 119-120, 377-379, 810; Ex. 6 and 6A).

Patient E

41. Respondent treated Patient E at his office in Southampton, New York from on or about March 4, 1999 through at least on or about October 24, 2006. (Ex. 7 and 7A).

42. No diagnosis or treatment plan is documented in the medical record. (Ex. 7 and 7A).

43. Patient E was abusing Valium and required detoxification. Patient E also abused alcohol. Nevertheless, Respondent continued prescribing Valium as well as other benzodiazepines to the patient. (T. 422-426, 846-848; Ex. 7 and 7A).

44. Respondent prescribed multiple benzodiazepines for Patient E. He simultaneously prescribed Ativan and Xanax. When the patient abruptly discontinued the drugs, he then complained of agitation. (T. 128-131, 394-396, 848-849; Ex. 7 and 7A).

45. Abruptly stopping benzodiazepines can cause agitation. However, Respondent blamed the agitation on the patient's use of asthma medication. (T. 128-131, 394-396, 848-849).

46. Patient E had abnormal lab results, such as bacteria and ketones in his urine. There is no notation or discussion of the abnormal results in the chart. On the very last day of the hearing, Respondent submitted additional laboratory results, which were "missing" from the charts. (T. 130-132, 397-399, 402-404; Ex. 7 and 7A; Ex. P).

47. Respondent noted that Patient E had experienced suicidal ideation. Respondent prescribed Nembutal for Patient E. Nembutal is a barbiturate, and causes profound sedation.

It would be easy to attempt suicide using Nembutal. (T. 136-137, 391-392, 413-419, 836-837; Ex. 7 and 7A).

48. Respondent also noted that Patient E had experienced an auditory hallucination. He failed to note any description or follow-up in the medical record. (T. 421, 845-846; Ex. 7 and 7A).

49. Respondent altered Patient E's medical record, sometime between March, 2006 and October, 2006. Aside from adding information to individual progress notes, one complete page of progress notes was re-written. Respondent had no explanation for why he did this. (T. 853-855, 858-859; Ex. 7 and 7A).

Patient F

50. Respondent treated Patient F at his office in Southampton, New York from on or about January 21, 2003 through at least on or abut October 24, 2006. (Ex. 8 and 8A).

51. The medical record does not contain an initial intake or treatment plan. There is no documentation in the record for the period between January, 2003 and February, 2004. Respondent was unable to explain this gap. (T. 139-141, 435-436, 874-875, 880-887, 898-899; Ex 8 and 8A).

52. Progress notes dated March 18, 2004, May 5, 2004 and May 18, 2004 state that Patient F is "still delusional".

There is no prior mention or description of the delusions. (T. 151-152, 437-438, 445, 454-455; Ex. 8 and 8A).

53. Respondent prescribed, at various times, Ritalin, Provigil and Dexedrine for Patient F. These drugs could have exacerbated the patient's delusions. (T. 144-145, 149-150, 446-448; Ex. 8 and 8A).

54. During the course of the hearing Respondent produced a page of progress notes not found in either record submitted to the Department. (T. 457; Ex. E).

Patient G

55. Respondent treated Patient G at his office in Southampton, New York from on or about July 29, 1999 through at least on or about October 24, 2006. (Ex. 9 and 9A).

56. The medical history portion of the record states "essentially negative at age 72". However, in the medication list provided by the patient, Procardia (a drug given for heart disease) is listed. (T. 466-468; Ex. 9 and 9A).

57. In an October 10, 2002 medication note, Respondent prescribed lithium. There is no corresponding progress note. (T. 469, 929; Ex. 9 and 9A).

58. Prior to prescribing lithium, Respondent failed to order a medical work-up, despite the patient's urological

problems. Respondent did not test Patient G's lithium levels. (T. 154-157, 469-470, 473-478, 481-489, 925-927).

59. Patient G was noted to be stumbling and falling. Respondent failed to link these signs of ataxia to use of lithium. (T. 155, 470-471, 932-937; Ex. 9 and 9A).

Patient H

60. Respondent treated Patient H at his office in Southampton, New York from on or about July 27, 2003 through at least on or about October 24, 2006. (Ex. 10 and 10A).

61. The record does not contain a diagnosis or treatment plan. (Ex. 10 and 10A).

62. The first progress note is dated April 20, 2004. (Ex. 10 and 10A).

63. Ex. 10 contains 3 Outpatient Treatment Records (OTRs) which are not found in Exhibit 10A. (T. 158; Ex. 10 and 10A).

64. The first OTR is dated July 27, 2003. (T. 495; Ex. 10).

65. The three OTRs state that Patient H is on Prozac, 20 mg. q.d. Prozac is an anti-depressant. (T. 498; Ex. 10).

66. The medical record does not contain a medication chart. The record states that Patient H is opposed to the idea of taking anti-depressants. (Ex. 10 and 10A).

Patient I

67. Respondent treated Patient I at his office in Southampton, New York from on or about December 14, 1998 through at least on or about October 24, 2006. (Ex. 11 and 11A).

68. The first progress note is dated October 19, 1999. The first medication note is dated December 14, 1998. (T. 503-505; Ex. 11 and 11A).

69. Respondent did not know where the progress notes were for the intervening dates. (T. 162-163).

70. There is no diagnosis or treatment plan in the record. (T. 163, 503, 965-966; Ex. 11 and 11A).

71. Respondent noted that Patient I was having suicidal thoughts, but there is no description or follow-up in the notes. (T. 505-506; Ex. 11 and 11A).

72. Respondent submitted billing records for Patient I. There are numerous dates billed that are not reflected in the progress or medication notes. Respondent had no explanation for the discrepancies. (T. 967-969; Ex. 11, 11A and N).

Patient J

73. Respondent treated Patient J at his office in Southampton, New York from on or about March 4, 1998 through at least on or about October 24, 2006. (Ex. 12 and 12A).

74. There is no diagnosis or treatment plan in the records. The mental status exam which is contained in Exhibit 12A is missing from Exhibit 12. (T. 511-512; Ex. 12 and 12A).

75. The record notes "several diverse hospitalizations", with no further information. (T. 511-512; Ex. 12 and 12A).

76. Respondent noted that Patient J was hearing voices, which were often accusatory. No further elaboration is noted. (T. 512-513; Ex. 12A).

77. A MICA program "Psychiatric Update" form dated March 21, 2002 refers to a "recent slip". The progress note for that date indicates that the patient was stable and sober. There is nothing in the progress note explaining the "recent slip". (T. 170, 514-515; Ex. 12 and 12A).

78. In the same MICA form, Respondent only records Depakote under Patient J's medications. However, Patient J had been on several medications including Librium, Xanax, Ativan, Lithium, Zyprexa and Axid. (T. 170, 515-516, 989-991Ex. 12 and 12A).

79. Patient J was noted to be an alcoholic. Nevertheless, Respondent prescribed multiple benzodiazepines for the patient. (T. 171, 516-517, 528-530; Ex. 12 and 12A).

80. Patient J had an elevated TSH level. This was not reflected in the progress notes. (T. 171, 1002-1011; Ex. 12 and 12A).

81. Respondent prescribed a six month supply of lithium to Patient J. (T. 1002-1011; Ex. 12 and 12A).

82. At the last day of the hearing, Respondent submitted numerous laboratory reports and notes that were not part of either of the records previously submitted to the Department. (T. 1137-1141; Ex. Q; Ex. 12 and 12A).

CONCLUSIONS OF LAW

Respondent is charged with twenty-two specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled

"Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

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

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the purpose of which is solely to protect the welfare of patients dealing with State-licensed practitioners. Id.

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

For the remaining specifications of professional misconduct, the Hearing Committee interpreted the statutory language in light of the usual and commonly understood meaning of the language. (*See*, New York Statutes, §232).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. Melvin J. Steinhart, M.D. is a practicing psychiatrist, employed by OPMC as a medical coordinator. (T. 22-25). Dr. Steinhart testified regarding statements made by Respondent during an interview conducted on January 17, 2007. The Committee found Dr. Steinhart to be a credible witness.

The Department also presented expert testimony by William A. Frosch, M.D. Dr. Frosch is board certified in psychiatry, and is an emeritus professor at the Cornell University Medical College and an attending psychiatrist at the New York Presbyterian Hospital. Dr. Frosch has extensive experience in the field. (T. 179-184; Ex. 14). Dr. Frosch's testimony was comprehensive and dispassionate. There was no evidence of bias or malice towards Respondent. The Hearing Committee found Dr. Frosch to be an extremely credible witness.

Respondent presented testimony by Spencer Eth, M.D. Dr. Eth is board certified in psychiatry, child psychiatry, geriatric psychiatry, addiction psychiatry and forensic psychiatry. He is a professor and vice chair of psychiatry at New York Medical College and Medical Director of Behavioral Health Services at St. Vincent's Catholic Medical Centers. (T. 1021-1022). Dr. Eth's credentials are excellent, and the Committee has no doubt that he is a very skilled and competent psychiatrist. However, his testimony was ultimately not given strong weight. Dr. Eth primarily testified as to his opinion of the adequacy of Respondent's medical records. His testimony was focused mostly on Patient A, and he only testified in brief about some of the other nine patients. However, this case is about more than the adequacy of Respondent's record-keeping practices. Dr. Eth did not testify in depth about the quality of medical care rendered to Patients A through J. Accordingly, his testimony was of limited value to the Hearing Committee.

Additionally, Respondent testified on his own behalf. Naturally, he has a vested interest in the outcome of the case, and the Committee evaluated his testimony accordingly. There are several aspects of Respondent's testimony which were troubling. The first has to do with the submissions of more than one "complete" medical record for each of the ten patients.

Respondent first provided medical records, certified to be complete, on March 13, 2006. He claimed that he mistakenly thought that he was only supposed to send in records from the same time frame as the appointment logs provided to the OPMC, so the records he sent were not complete. Thereafter, he sent another "complete" set of records in October, 2006. However, this explanation does not square with the facts.

OPMC initially requested logs covering a six month period from July 2005 through January 2006. All ten records submitted in March 2006 dated back well ***before*** July 2005. Second, the records Respondent submitted in October 2006 were themselves incomplete. During the course of the hearing, Respondent submitted a "missing page of progress notes" for two patients, a large volume of lab reports and notes for two more patients. He further testified that for two additional patients, a page "must" be missing from the record.

Of even greater concern is the fact that Respondent altered the medical records sometime between March 2006 and October 2006. He filled in blanks. He re-wrote progress notes. He added information to already completed progress notes. He added descriptions and checked new categories in mental status examinations. In one case, he re-wrote an entire page of progress notes. Not once did he indicate that these were

alterations. When asked why he re-wrote an entire page of progress notes he answered "I can't—I can't explain it… I don't understand. I can't clarify". (T. 858-859).

In addition, Respondent offered into evidence Patient Face Sheets and billing records for nine of the ten patients in this case. (Ex. F, H, I, J, K, L, M, N and O). The billing records for Patient I (Ex. N) indicate bills for far more visits than were recorded in the patient's chart. Again, Respondent had no explanation for the discrepancies. (T. 967-969). Based on the foregoing, the Hearing Committee concluded that Respondent's testimony, and his medical records, were unreliable.

It is well settled that a medical record that fails to convey objectively meaningful medical information concerning the patient treated to other physicians is inadequate. Matter of Schwarz v. Board of Regents, 89 A.D.2d 711, 712 (3rd Dept. 1982), *lv* denied 57 N.Y. 2d 604. Given all of the problems with Respondent's medical records described above, the Hearing Committee unanimously concluded that Respondent failed to maintain medical records which accurately reflected the care and treatment of Patients A through J. Accordingly, the Committee sustained the Third through Twelfth Specifications of professional misconduct.

Moreover, where there is a relationship between inadequate record-keeping and patient treatment, the failure to keep accurate records may itself constitute negligence. Bogdan v. Med. Conduct Bd., 195 A.D.2d 86, 89 (3rd Dept. 1993). The absence of important information about patient status, laboratory studies, etc. as discussed above, clearly can impact patient treatment. Consequently, a finding of negligence on more than one occasion is amply supported by the inadequacy of the medical records alone.

However, the deficiencies in Respondent's treatment of the ten named patients goes beyond the problems noted regarding the records. Respondent's medication management for the ten patients was seriously deficient. He frequently prescribed both short and long-acting benzodiazepines simultaneously for his patients. This is problematic because one cannot know which medication is causing either a response or side effect in the patient.

Several of the patients were abusing alcohol and other substances. For example, Respondent prescribed benzodiazepines and anti-depressants for Patient A despite a history of alcohol use. There is no evidence Respondent addressed the additive potential of these drugs when combined with alcohol. When the patient acknowledged using marijuana, Respondent failed to

appropriately follow up. Patient E abused benzodiazepines and alcohol. He eventually underwent hospitalization and detoxification. Nevertheless, Respondent continued to prescribe benzodiazepines for the patient.

Patient E also expressed suicidal ideation and experienced auditory hallucinations. Respondent failed to appropriately follow up on these symptoms. In addition, he prescribed Nembutal, a barbiturate, for the patient. Barbiturates are strong sedatives which could easily be used in a suicide attempt.

Patient D presented with a history of mania, having been discharged from a hospital in Ireland one month prior to beginning treatment with Respondent. He prescribed both Ritalin and Provigil for the patient. These drugs are strong stimulants, with the potential to exacerbate the patient's mania. Respondent's use of these drugs for Patient D was inexplicable and inexcusable.

The Hearing Committee was also concerned with Respondent's treatment of patients with lithium. He initiated treatment with low doses of lithium without doing the necessary laboratory workups in advance, or during therapy. Even Dr. Eth acknowledged that while he doesn't prescribe sub therapeutic

doses of lithium, it would be prudent to get lithium levels. (T. 1107-1111). We agree.

The Hearing Committee concluded that Respondent repeatedly failed to exercise the care that a reasonably prudent physician would under the circumstances in treating Patients A through J. As a result, the Committee voted to sustain the First Specification of professional misconduct (negligence on more than one occasion).

Based upon Respondent's testimony and the records, we further conclude that Respondent displayed a lack of the necessary knowledge and skills needed to adequately practice psychiatry. There is little evidence that he actually understands the medications which he prescribes for his patients. This is reflected in his use of stimulants for manic patients, as well as in the simultaneous prescription of multiple benzodiazepines for patients. In addition, he failed to appreciate the possible connection between a patient's psychiatric symptoms and co-morbid conditions (as in the case of Patient B, who suffered from Cushing's disease). Respondent's failure to adequately address his patients' hallucinations and suicidal ideations also bespeaks a lack of knowledge and skill.

As a result, the Hearing Committee voted to sustain the Second Specification of professional misconduct (incompetence on more than one occasion).

The Department also charged Respondent with misconduct through a violation of the terms of his probation. We decline to sustain these charges. The care rendered to Patients A through J spans a period of time both prior to and during the term of probation. Moreover, the Department never specified the term or terms of probation which Respondent is alleged to have violated. Accordingly, we dismiss the Thirteenth through Twenty-Second Specifications of professional misconduct.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The evidence clearly established that Respondent repeatedly prescribed combinations of psychotropic drugs to his

patients, despite a lack of understanding concerning their mechanisms of function, or the risks involved. The Hearing Committee was also particularly troubled by the fact that Respondent repeatedly altered his medical records, going so far as to re-writing an entire page of progress notes. Almost all of the mental status examinations which were recorded were undated, rendering them nearly useless. Respondent acknowledged that his medical records were disorganized. (T. 1143).

Unfortunately, we are left with the inescapable conclusion that his medical treatment of the ten patients at issue was equally disorganized. Respondent demonstrated no insight into his shortcomings as a practitioner. He has already been subjected to one term of probation, which did nothing to improve his practice. Under the circumstances, the Hearing Committee unanimously concluded that revocation is the only sanction which will adequately protect the public.

ORDER

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

1. The First through Twelfth Specifications of professional misconduct, as set forth in the Statement of Charges, (Department's Exhibit #1) are **SUSTAINED**;

2. The Thirteenth through Twenty-Second Specifications of professional misconduct, as set forth in the Statement of Charges are **DISMISSED**;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED**;

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Troy, New York
September 25, 2008

Redacted Signature

WALTER M. FARKAS, M.D. (CHAIR)

MITCHELL S. STRAND, M.D.
LOIS JORDAN

TO: Courtney Berry, Esq.
Associate Counsel
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Robert Hauben, M.D.

Redacted Address

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APPENDIX I

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

IN THE MATTER

OF

Robert Hauben, M.D.

STATEMENT

OF

CHARGES

Robert Hauben, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 30, 1965, by the issuance of license number 095463 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, a psychiatrist, treated Patient A at his office in South Hampton, N.Y. from in or about December 23, 2002 through at least on or about October 24, 2006 .

1. Respondent failed to appropriately evaluate, diagnose and treat Patient A.
2. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent, a psychiatrist, treated Patient B at his office in South Hampton, N.Y. from on or about October 13, 2004 through at least on or about October 24, 2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient B.
2. Respondent failed to maintain an adequate medical record for Patient B.

C. Respondent, a psychiatrist, treated Patient C at his office in South Hampton, N.Y. from on or about May 21, 2004 through at least on or about October 24,

2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient C.
2. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent, a psychiatrist, treated Patient D at his office in South Hampton, N.Y. from on or about April 13, 2005 through at least on or about October 24, 2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient D.
2. Respondent failed to maintain an adequate medical record for Patient D.

E. Respondent, a psychiatrist, treated Patient E at his office in South Hampton, N.Y. from on or about March 4, 1999 through at least on or about October 24, 2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient E.
2. Respondent failed to maintain an adequate medical record for Patient E.

F. Respondent, a psychiatrist, treated Patient F at his office in South Hampton, N.Y. from on or about January 21, 2003 through at least on or about October 24, 2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient F.
2. Respondent failed to maintain an adequate medical record for Patient F.

G. Respondent, a psychiatrist, treated Patient G at his office in South Hampton,

N.Y. from on or about July 29, 1999 through at least on or about October 24, 2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient G.
2. Respondent failed to maintain an adequate medical record for Patient G.

H. Respondent, a psychiatrist, treated Patient H at his office in South Hampton, N.Y. from on or about July 27, 2003 through at least on or about October 24, 2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient H.
2. Respondent failed to maintain an adequate medical record for Patient H.

I. Respondent, a psychiatrist, treated Patient I at his office in South Hampton, N.Y. from on or about December 14, 1998 through at least on or about October 24, 2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient I.
2. Respondent failed to maintain an adequate medical record for Patient I.

J. Respondent, a psychiatrist, treated Patient J at his office in South Hampton, N.Y. from on or about March 4, 1998 through at least on or about October 24, 2006.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient J.
2. Respondent failed to maintain an adequate medical record for Patient J.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraphs A through J and their subparagraphs.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. Paragraphs A through J and their subparagraphs.

THIRD THROUGH TWELFTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

3. Paragraphs A and A2, B and B2, C and C2, D and D2, E and E2, F and F2, G and G2, H and H2, I and I2, and J and J2.

THIRTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS

VIOLATING ANY TERM OF PROBATION OR CONDITION OR LIMITATION

Respondent is charged with committing professional misconduct as defined

in N.Y. Educ. Law § 6530(29) by violating any term of probation or condition or limitation imposed on the licensee pursuant to section two hundred thirty of the public health law, as alleged in the facts of the following:

4. Paragraphs A through J and their subparagraphs.

DATED: February 21, 2008
New York, New York

Redacted Signature

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct