



STATE OF NEW YORK DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 22, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

William J. Lynch, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237

James G. Eberz, Esq.
Richard C. Baker, Esq.
1311 Mamaroneck Avenue
P.O. Box 5057
White Plains, New York 10602

Steven Brett Astrachan, M.D.
130 North Front Street
Kingston, New York 12401

RE: In the Matter of Steven Brett Astrachan, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-75) 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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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.

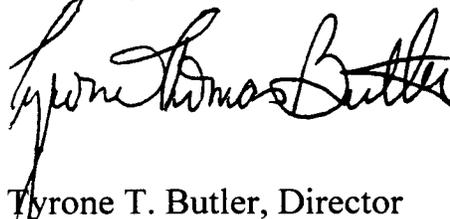
The notice of review served on the Administrative Review Board should be forwarded to:

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,

A handwritten signature in black ink, appearing to read "Tyrone T. Butler". The signature is written in a cursive style with a large initial "T".

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER
OF
STEVEN BRETT ASTRACHAN, M.D.

DETERMINATION

AND

ORDER

BPMC- 01-75

Jerry Waisman, M.D., Chairperson, **Edward C. Sinnott, M.D.** and **Karen Wolf, R.P.A.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(1)(e) and 230(12) of the Public Health Law. Attorney Susan F. Weber served as Administrative Officer for the Hearing Committee.

The Department of Health was represented by William J. Lynch, Senior Attorney. Respondent was represented by Richard C. Baker, Esq., and James G. Eberz, Esq., of Meiselman, Denlea, Packman, and Eberz, PC and Barry W. Agulnick, Esq., of Agulnick & Gogel, LLC.

Evidence was received, witnesses were sworn or affirmed and were heard, and transcripts were made of these proceedings. After consideration of the entire record, the Hearing Committee issues this Determination and Order.

STATEMENT OF CHARGES

The Department of Health (hereinafter "the Department" or the "Petitioner") has charged Steven B. Astrachan, M.D. (hereinafter "the Respondent" or Dr. Astrachan") with

professional misconduct by reason of having practiced the profession of medicine with negligence and incompetence, each on more than one occasion, one specification of exercising undue influence on a patient, one specification of engaging in conduct in the practice of medicine which evidenced moral unfitness, and five specifications of failure to maintain accurate records. The charges are more specifically set for in the Statement of Charges, a copy of which is attached hereto as Appendix 1 and made a part of this Determination and Order.

Along with their post-hearing submissions, counsel for Petitioner and Respondent submitted written Requests to Charge, and responded by electronic mail to each others' Requests to Charge. The Administrative Law Judge's Charge to the Hearing Committee is annexed hereto as Appendix 2. The Charge was given to the Hearing Committee in writing and was discussed and used during deliberations.

SUMMARY OF PROCEEDINGS

Commissioner's Order and Notice of Hearing Dated:	September 7, 2000
Answer Dated:	September 19, 2000
Amendment to Statement of Charges Dated:	October 12, 2000 ¹
Pre-hearing Conference:	September 28, 2000
Hearing Dates:	October 5, 6, and 12, 2000 November 2, 13, 14, and 30, 2000

¹ The Statement of Charges was amended to replace "opiates" with "opiate analgesics containing acetaminophen" in factual allegation E.1 (T. 10/12, 557)

Post-Hearing Submissions

Received:

December 22, 2000

Deliberation Date:

January 5, 2001

Place of Hearing:

Holiday Inn
503 Washington Avenue
Kingston, NY

Petitioner Appeared By:

Donald P. Berens, Jr., Esq.
General Counsel
NYS Department of Health
By: William J. Lynch, Senior Attorney

Respondent Appeared By:

Richard C. Baker and James G. Eberz, Esqs.
Meiselman, Denlea, Packman, and Eberz,
PC and Barry W. Agulnick, Esq.
Agulnick & Gogel, LLC

WITNESSES

For the Petitioner:

Carole W. Agin, MD, Expert
Patient A's Father
Patient A's Mother
Junious Harris
Patient D
Patient F

For the Respondent:

Steven B. Astrachan, MD
Patient C
Patient C's Wife
Jeffrey Altomari
Jacques Delphin, MD
Hyung Yeon, MD
Kathleen Watska
Emile Hiesiger, MD Expert

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Steven Brett Astrachan, MD, the Respondent, was licensed to practice medicine in the State of New York on December 5, 1983, by issuance of license number 156866 by the New York State Education Department. (Ex 3)²

2. Respondent was personally served with the Notice of Hearing and Statement of Charges on September 13, 2000. (Ex 2) Respondent interposed an answer denying each allegation. (Ex A)

² Characters in parentheses refer to transcript page and line, or to the exhibit number (for petitioner's exhibits) or exhibit letter (for respondent's exhibits). The reporting service in error repeated the pagination from October 12 again in the November 2nd transcript, so transcript pages 414 through 549 also reference the date of the hearing day.

3. An appropriate initial evaluation should contain chief complaints from the patient, history of current illness or complaint, past medical history, family history, social history, current medications, any allergies, physical exam including vital signs, pertinent positives with respect to the patient's complaint, an assessment as to what the physician feels is going on, and a treatment plan. (T. 17)

4. The minimum standard of care would require making an initial evaluation and documenting the initial evaluation, containing chief complaints, history of current illness or complaint, past medical history, family and social history, current medications, any allergies, physical exam including vital signs, and any pertinent positive findings with respect to the patient's complaint. (T. 16-17)

5. A patient who is seen at a chronic pain management office should have physical examinations and vital signs taken and recorded periodically, although not necessarily at each visit. A patient consulting a pain management specialist will generally be followed by an internist or primary care physician as well, who will take vital signs and follow the general health of the patient. (T. 82, 831, 852-855)

6. The minimum standard of care in pain management would require assessing the adequacy of the therapy on every visit and documenting that assessment. (T. 93-94)

7. Since chronic pain often brings with it depression and anxiety, appropriate therapeutic intervention in pain management includes an assessment of the emotional and psychological well-being of the patient. The physician must take time to evaluate these aspects

of the patient's condition and must develop a bond of mutual trust with the patient in order to be able to make such an evaluation. (T. 838-844)

8. To meet an acceptable standard of care, a physician should document a rationale when changing the dosage of a patient's medication. (T. 20)

9. To meet an acceptable standard of care, a physician should document a rationale when changing a patient's medication. Rationales for changing medications would include new complaints, a change in the patient's complaints, or that the patient has experienced side effects. (T. 21-22) Pain medications should be changed if the patient is getting inadequate analgesia or there are side effects. (T. 57) It is not standard practice to change back and forth between benzodiazepines. (T. 84)

10. Maintaining an adequate medical record is important because there is an additive effect between opiates and benzodiazepines. (T. 31) Maintaining a record of benzodiazepine medications is important because they have a potential for abuse. (T. 23)

11. When prescribing multiple opiate medications (with different actions) for different purposes, the patient should be carefully instructed as to how each medication is supposed to be taken and why each medication is being given. (T. 30) Instructions given to a patient concerning the combining of opiates should be part of the patient's medical record. (T.43)

12. There is no maximum amount of a pure opiate analgesic which may be given for pain. (T. 57, 91) Toxicity is not a concern with pure opiates. Patients who are on long term opiates accommodate to gradually increasing doses and side effects such as respiratory

depression. Withdrawal causes clamminess, GI upset, jitteriness, anxiety, yawning. But with tolerance of opiates, a patient is perfectly fine, functional, but not getting the same pain relief. (T. 90-92)

13. Hoarding medications, requesting new prescriptions sooner than appropriate, frequently losing prescriptions and escalating doses are activities that a patient may start to exhibit if becoming tolerant of or addicted to a medication (T. 24- 25). A physician must look for these aberrant behaviors in a patient. (T. 249)

14. A patient can be both addicted to pain medication -- taking medication for psychological purposes --and suffering from pain which requires treatment by the physician. (T. 846-847)

FINDINGS CONCERNING PATIENT A

15. Patient A was 37 years old when he began to be treated by Respondent on November 18, 1996. Respondent's diagnostic impression was that of post cervical residual pain/failed cervical laminectomy and spinal fusion. Respondent's plan was to continue the current regimen of Methadone and implement a trial course of cervical epidural steroid injections. (Ex. 4 at 1)

16. Respondent failed to document adequately his initial assessment of Patient A. In this initial assessment, Respondent failed to list vital signs and failed to address adequately Patient A's prior medication use. (Ex. 4 at 1; T. 17) Respondent failed to consistently document physical findings of Patient A, such as range of motion. (T. 95) Respondent failed to make a notation in his office medical records describing the cervical epidural injections that he had

allegedly performed on Patient A. (T. -11/2- 488) When Respondent saw Patient A September 23, 1998 on an emergency basis for pain secondary to a motor vehicle accident, he failed to indicate in the record that any physical examination was performed. (T. 110)

17. Respondent failed to document a rationale when increasing or changing Patient A's medication on multiple occasions. Respondent increased Patient A's dosage of a medication on January 8, 1997. (Ex. 4 at 2) Respondent failed to state a rationale when changing Patient A's medication. (T. 22, T. 26, T. 29-30). On October 8, 1997, Respondent added a prescription of morphine sulfate immediate release tablets and a prescription for Valium without documenting a rationale for this additional medication. Respondent prescribed methadone, morphine and Valium without documenting a rationale. (T. 31) On October 20, 1997, Respondent prescribed 240 morphine tablets without a rationale. (T. 32) One week later on October 27, 1997, Respondent changed his prescription back to 240 methadone tablets and 60 Valium tablets without indicating a rationale. On November 19, 1997, Respondent changed Patient A's medication to a different benzodiazepine, Xanax, without documenting a rationale. (T. 35-36)

18. On December 5, 1997, less than one week after receiving a check for \$12,500.00 from Patient A for investment purposes, Respondent prescribed 240 morphine tablets and 90 Valium tablets. If taken as prescribed, the morphine should have lasted one month (T. 36-37); however, on December 10, 1997, only five days later, Respondent prescribed 240 methadone tablets and 90 Xanax tablets (T. 37).

19. On December 17, 1997, Respondent prescribed a thirty day supply of transdermal fentanyl patches to Patient A. Only 21 days later on January 5, 1998, Respondent

again prescribed fentanyl to Patient A, making no mention in the record of the patient's excessive use. (Ex. 4 at 6; T. 38-39) Only nine days later on January 14, 1998, Respondent again prescribed a thirty day supply of fentanyl to Patient A with no mention of the patient's excessive use. (Ex. 4 at 7; T. 39) On January 24, 1998, Respondent gave Patient A another prescription of fentanyl without any mention of the fact that the patient had been prescribed a thirty day supply only ten days earlier. (Ex. 4 at 7; T. 40)

20. Respondent changed his prescribing for Patient A between various opiates and benzodiazepines on March 2, March 10, March 17, March 24, and March 29, 1998, without documenting an explanation for these changes. Respondent increased the dosage of MS Contin with no explanation. (T. 42-24) Respondent prescribed a month's supply of Valium on March 24, 1998, and five days later prescribed a month's supply of Xanax. Both of these medications are benzodiazepines, and there is no discussion in the medical record as to why both were needed. (T. 44-45) On March 29, 1998, Respondent prescribed 240 methadone tablets, and he prescribed an additional 60 methadone tablets as well as an increase to 120 MS Contin tablets on April 8, 1998.

21. On April 14, 1998, Respondent prescribed a month's supply of Valium and another 240 methadone tablets in spite of the fact that he had been prescribed a month's supply only six days earlier, without documenting a rationale. On May 4, 1998, Respondent prescribed 240 methadone tablets in spite of the fact that he had prescribed Patient A a month's supply only 13 days earlier. (Ex. 4 at 9; T. 46-47)

22. Respondent failed to document any instruction given to Patient A with respect to the combining of opiates. (T. 43)

23. Respondent's prescribing to Patient A from November 18, 1996 through November 23, 1998 did not meet minimally acceptable standards of care in that he failed to document a rationale for changing analgesic medications or the prescribed doses of such medications. The patient sometimes received concurrent prescriptions for three different benzodiazepines without explanation, and the dose changes between short acting and long acting medications were not equivalent, according to the expert's reading of the analgesic charts. (T. 51)

24. Respondent's medical record of Patient A failed to contain reports of diagnostic tests such as MRI results and CT scan results. (T. 79) Respondent's medical record of Patient A did not contain a history of prior drug abuse which would be an important part of the record. (Ex. 4; T. 80) A physician's record should indicate when there are signs of a patient's addiction and what measures the physician is taking to address that issue. It is important to document when a patient has been hospitalized, and Respondent failed to include in his record that Patient A had been hospitalized. (Ex. 4; T. 86)

DISCUSSION REGARDING PATIENT A UNDUE INFLUENCE AND MORAL UNFITNESS

The Hearing Committee was instructed that, in order to sustain the Third Specification of exercising undue influence on a patient, it would be necessary to find that the patient had diminished capacity to make financial decisions, and that Respondent used his position as

physician to take advantage of that diminished capacity, intending to gain a financial benefit from his position of trust as the physician.

The Hearing Committee carefully considered the testimony of Patient A's parents, the Respondent, Junious Harris, an investigator for the Ulster County District Attorney's Office, and Jeffrey Altomari, Patient A's financial consultant at E.G. Edwards, concerning the investment of \$25,000 of Patient A's money in a private investment vehicle allegedly offered only to physicians. Credible evidence supports the conclusion that the decision to make the investment was solely Patient A's. Respondent testified credibly that he did not recommend the investment in any way. (T.11/2 428) Patient A's mother testified that her son was not induced by Respondent to invest. (T. 293) Jeffrey Altomari testified patient A consulted him about the investment. It seems clear that Patient A exercised independent judgment in making the decision to invest.

The only evidence that Respondent intended to benefit from Patient A's investment is that the certificates bear his name and that they remain in Respondent's possession as of the date of the Hearing. Respondent did not attempt to hide the financial arrangement he made with Patient A. He readily admitted the arrangement and cooperated with both Patient A's parents and the District Attorney's investigation, which did not result in any charges. Both Respondent and Patient A's father testified that the estate's attorney, Mr. Palmer, was now involved in the matter, and that Respondent had been so informed. Respondent testified that he has been waiting for that attorney to contact him regarding transfer of title to the investment.(T. 426) None of this supports, by a preponderance of the evidence, that Respondent has yet benefited from this investment.

That said, the Hearing Committee found that Respondent exercised exceedingly poor judgment in acting as the intermediary in this investment and in failing to memorialize the

agreement with Patient A. The Hearing Committee found it inappropriate and exceeding the bounds of ethical behavior for Respondent to facilitate his patient's investment. At the very least, he should have taken the initiative to transfer his interest to Patient A's estate immediately upon Patient A's death. The Hearing Committee did not find that the Respondent has benefited financially from the investment, nor did he induce Patient A to make the investment. Consequently, the Third and Fourth Specifications of undue influence and moral unfitness are not sustained.

GENERAL DISCUSSION
MEDICAL EXPERT WITNESSES

The Petitioner presented Carole W. Agin, MD as its medical expert witness. Dr. Agin is certified by the American Board of Anesthesiologists with added qualifications in pain management. She is the Director of Long Island Pain Management in Port Jefferson, New York. She previously served as the director of the Pain Management Program at Montefiore Medical Center of the Albert Einstein College of Medicine, where she has taught courses in the Department of Anesthesiology. Dr. Agin's credentials in the area of pain management are impressive, and her testimony was extremely credible, informative, and straight-forward.

The Respondent's medical expert, Emile M. Hiesiger, MD, who is board certified in Neurology and Psychiatry, is an attending physician in the Departments of Neurology and Radiology at Beth Israel Medical Center, New York. Dr. Hiesiger is also a Clinical Associate Professor in the Departments of Radiology and Neurology at New York University School of Medicine in New York. Dr. Hiesiger's testimony regarding the practice of pain management in

general, and about addiction and substance abuse, was informative and credible. His testimony concerning the facts at issue in this case was often evasive and not forthcoming.

NEGLIGENCE AND INCOMPETENCE

Respondent admits that he often failed to document³ adequately his interactions with his patients. Although there was credible testimony that Respondent gave physical examinations periodically, instructed patients regarding the proper dosing of medications, discussed the patients' response to medications they were taking, assessed the patients' ability to function in activities of daily life, considered rationales for changing medications or dosages, and tested range of motion, where appropriate, in most instances these important interactions are not recorded in the patients' charts.

Respondent used the office visits to keep current with his patients and to develop the relationship of trust and confidence so necessary in a pain management practice. (T. 841) "Small talk", as characterized by Patient F (T.401), and conversations about investments with Patient A (T. 418) was the method Respondent used to assess his patients' emotional well-being, their ability to function, and the effectiveness of their medication. The Hearing Committee determined that he did attempt to rein in patients whose use of medications appeared to approach the boundaries of excessiveness. He made them sign notations in their charts documenting lost prescriptions or medication. He required Patient F to sign a contract for controlled substance prescriptions promising, among other things, not to obtain pain medication from any other source. (Ex. 17 p. 44-5, p.50)

³ Chart notes were not easily decipherable, making it difficult to assess the records.

Thorough and accurate record keeping allows the physician to keep track of medication usage and alerts him or her to the need to change medications or dosage. Of special benefit would be contact between the pain management specialist and other physicians treating the patient, to prevent situations, such as those which arose with Patients A and F, where patients obtain opiates and benzodiazepines from several physicians. Respondent received a print-out from Patient F's insurer listing the medications she had obtained from eight different pharmacies over a year's time. (Ex. 17 p.28-9) The Hearing Committee believed this was clear warning sign of possible substance abuse and should have alerted the Respondent.

The Hearing Committee recognizes that treating individuals with chronic pain is a difficult medical practice. Persons with chronic pain must be able to receive appropriate treatment. Patients are completely dependent upon the physician to maintain an acceptable quality of life. This dependence may lead to drug-seeking and drug hoarding behavior, and addiction. Patients who become addicted will hide that addiction, to the point where they will go to great lengths to keep their hospitalizations for detoxification from their doctor. The Committee agrees with Dr. Hiesiger that a person with a history of addiction may nevertheless still have pain that must be treated. (T.897) However, the physician must make sure to maintain standards of care necessary to protect this vulnerable patient population. This includes adequate documentation of all medication and periodic assessment of the patients' underlying condition and the need for medication.

The Hearing Committee finds that the Respondent failed to maintain such minimum standards in documenting due to negligence, not incompetence. Dr. Astrachan testified credibly about the care and treatment he gave these patients, including his rationale for medication dosage and changes. His testimony illustrated his professional and personal concern for his patients'

well-being. The Committee believes that Respondent was not attentive to the signs of substance abuse and, by giving them multiple prescription refills, he facilitated their abuse problems. This was negligent. In the case of Patient E, the Respondent and his attorney stipulated to all charges including those of incompetence.

FINDINGS CONCERNING PATIENT B

25. Respondent administered an excessive number of epidural steroid injections to Patient B over a ten week period.

26. Respondent initially administered four cervical epidural injections of 120 milligrams of DepoMedrol with approximately a two week interval between each administration. (T. 533) Respondent administered five lumbar epidurals to Patient B. (T. 533-534)

27. These steroid injections are usually done in a series of three. If the patient has not received relief after three injections, further injections will probably not improve the chances of relief. The patient is placed at risk because of the repeated steroid dosing. (T. 112, 133)

28. Important side effects of DepoMedrol include increasing the patient's blood sugar and retention of bodily fluids. Long term steroid use also can weaken bones. (T.134)

29. Respondent's administration of a total of nine epidural steroid injections to Patient B in a ten week period was excessive. (T.111)

30. Respondent's administration of five lumbar epidural injections to Patient B in a five week period was excessive. (T. 112)

31. Respondent's administration of 200 milligrams of DepoMedrol in a lumbar epidural to Patient B was not within accepted standards of care. (T. 113, 133) The side effects of DepoMedrol are dose-related; as the dose increases, so does the patient's risk for side effects. (T. 114)

DISCUSSION REGARDING PATIENT B

Respondent's chart for Patient B fails to document the rationale for the unusually high doses of DepoMedrol administered epidurally or for the frequency and unusually large number of such treatments. Respondent testified that he was trained to administer a 200 milligram dose of steroids epidurally. His medical expert was unable to credibly support a rationale for such a high dose, testifying that he himself had not used more than sixty or eighty milligrams. Although Dr. Hiesiger, who does not have personal experience with epidural steroid injection, made the argument that such high doses are frequently given by mouth or by vein (T. 819), the Hearing Committee did not find this argument persuasive. Epidural and oral doses of these medications are not analogous. Dr. Agin, whose credentials in the field of pain management are excellent, testified convincingly that 200 milligrams of DepoMedrol administered epidurally to the lumbar region is excessive, that the number of such injections was excessive, and that such treatment constitutes a deviation from the usual standard of care.

FINDINGS CONCERNING PATIENT C

32. Respondent failed to maintain a complete medical record of the office visits of Patient C. A minimal standard of care requires that the patient's reason for an office visit, ongoing medical problems, medications, vital signs when taken, and changes in the patient's condition be documented for each office visit. (T. 140) Respondent's medical record for Patient C fails to note any medical information for several office visits. (Ex. 13, 11/6/96, 12/22/97 at 4-6)

DISCUSSION REGARDING PATIENT C

Respondent admitted that his office records for Patient C are incomplete, partly because a disagreement with the landlord resulted in his office records prior to April, 1994 being lost to him. (T. -10/12- 420-422). Respondent testified that he had spoken with an attorney but never took legal action to retrieve patient records that he alleged had been held by his former landlord and were later destroyed. (T. -10/12- 452-453)

Respondent did not offer an explanation for the fact that his billing records showed office visits on May 8, 1996, June 12, 1996, June 26, 1996, and October 30, 1996, but there was no corresponding documentation whatsoever regarding these visits in Patient C's medical record. (T.-10/12- 461,462) The records frequently fail to provide a rationale for prescribing certain medications or for increasing or decreasing dosages. (Ex.13)

Respondent admitted that the records he did have for Patient C evidenced "a severe lack of documentation" (T. -10/12- 448), but testified that he typically discussed the patient's current

condition, changes in his life, where the pain was and how it was affecting the patient's lifestyle, and whether the patient needed additional help with the pain. Respondent testified that he examined their range of motion, discussed daily activities and any limitations on daily activities, sought to determine the patient's mental health status, and whether the medication and other treatment he was providing was working. (T. 10/12 430-432) This was generally corroborated by Patient C. (T.650-2)

The Hearing Committee found that Respondent's and Patient C's testimony regarding their interactions was credible. They felt that Respondent did have a reason for prescribing as he did. They believed that Respondent was concerned with doing the best he could for this patient and that, while he admittedly did not properly document examinations he did perform, he probably did, in fact, adequately examine this patient as he described (T. 10/12 430-432)

Both Respondent and Patient C testified that Patient C had been receiving methadone for pain control prescribed by Respondent and administered through a federally funded mental health clinic, referred to in his chart as "on methadone maintenance". Both Respondent and Patient C testified that Patient C's pain is now adequately controlled without opiates by a spinal cord stimulator implanted and adjusted from time to time by Respondent.

Respondent prescribed Lortabs to Patient C subsequent to Patient C's hospitalization for addiction to Lortabs. Respondent admitted that he had no documentation that he attempted to treat Patient C with other modalities such as physical therapy before prescribing Lortabs again. (T. 469-470) The Hearing Committee determined that it was not a deviation from the minimum standard of care for a physician to prescribe Lortabs for a patient who had once been addicted to that medication. Opiate analgesics all work on the same receptors, so if a patient is susceptible to

addiction to one opiate, any opiate could create a risk. Dr. Hiesiger testified that it would be inappropriate not to use a drug that had been effective, just because the patient has a history of addiction.(T. 888) Unfortunately, people can both have pain and be addicted. (T. 847) The clinician must be aware of the potential for opiate abuse and carefully monitor the patient for signs of addiction.

FINDINGS CONCERNING PATIENT D

32. Patient D came to Respondent for epidural anesthesia for elective ankle arthroscopic surgery with debridement and repair of a ruptured ligament in July of 1997.

33. The operative record shows that Patient D was given versed, a pre-anesthesia sedative, at 10:40 a.m., and was taken into the operating room at 10:45 a.m..(Ex.15 p.7)_

34. Respondent administered a test dose of anesthesia containing epinephrine. Respondent failed to document the timing of the test dose. (Ex. 15 at 16, T. 158) The timing of any medication given in an operating room should be documented to meet acceptable standard of care. (T. 159-160)

35. Epinephrine is put into an epidural test dose to help determine if the medication is inadvertently being administered intravascularly. If so, the epinephrine would cause an immediate increase in pulse rate. Intravascular placement of an epidural injection is a known complication of the procedure. (T. 162)

36. After receiving the anesthesia, Patient D experienced perioral numbness and anxiety. (T. 341, 344, 360) Facial or perioral numbness is a known side effect of intravascular injection of an anesthetic agent. (T. 161, 170, 180-181) When this occurs, the catheter must be repositioned or replaced and retested to meet accepted standard of care. (T. 162)

DISCUSSION REGARDING PATIENT D

Patient D, Respondent, and Nurse Kathleen Watska⁴ testified concerning the administration of anesthesia to Patient D for elective ankle surgery. Patient D's description of the events was considerably different from that given by Respondent and Nurse Watska, and substantiated by the operative record (Ex. 15). The Hearing Committee found Patient D credible, but believed that she, as the patient receiving anesthesia, was in a poor position to appreciate accurately at the time or to recollect with reliability after the fact, the details of the events that occurred during the procedure. It is clear that the administration of anesthesia did not proceed smoothly, and that the patient became alarmed. Neither the record of the procedure nor the testimony of Nurse Watska, who participated, corroborated Patient D's recollection of "flat-lining".

Page 7 of Ex 15, the operative record for 7/10/97, shows that Patient D was brought to the operating room at 10:45, after receiving a pre-anesthesia dose of versed at 10:40. Nurse Watska testified that monitoring devices⁵ and IV's were connected to Patient D at 11:00 a.m. Respondent testified that he administered IV sedation, placed the patient in a sitting position and

⁴ Kathleen Watska, Hurley Avenue Surgical Center employee since 1986, was present throughout the procedure and brought the patient to the recovery room.(T 782-799)

⁵ A blood pressure cuff, EKG leads, a pulse oximeter. (T. 520)

prepared her back for administration of the epidural anesthetic. He then administered local anesthetic to the area where the epidural injections would be given.

All three witnesses agreed that Respondent made more than one attempt to establish the epidural, but had conflicting recollections of how many attempts were made. (T. 784) Nurse Watska and Respondent testified that more than one attempt was made to establish the epidural but that eight separate punctures, as Patient D had alleged, were not made. Respondent testified that two punctures were made, and that he also made several attempts to locate the epidural space without withdrawing the needle. He testified that the patient “did not feel good. She said she felt faint.”(T. 522) After positioning the needle into the epidural space and inserting the catheter for delivery of the anesthetic, Respondent testified, he administered a test dose of anesthetic containing epinephrine through the catheter. Respondent made no record of the timing of the test dose.

The test dose is given to determine whether the catheter is properly positioned in the epidural space or whether it was placed in such a manner as to deliver the medication into the vascular space. Vascular delivery of epinephrine should cause an immediate rise in heart rate. Respondent testified that no increase in Patient D’s heart rate occurred.

Thereafter, the patient was placed in a supine position with her arms secured to arm boards, and a subsequent dose of local anesthetic was administered in two stages, one to two minutes apart. Respondent testified that after the second dose was administered, Patient D told him that she had some tingling around her lips and numbness in her face. Respondent said he continued to monitor and observe the patient as she became increasingly “excited”. He testified that the surgeon was in the room, the leg had been tested with a pin, and the team was ready to prep the ankle for surgery. At that point, about 11:30 a.m., when Patient D complained of perioral tingling, Respondent testified, he assumed there had been some inadvertent absorption of the anesthetic. (T. 525)

Both Nurse Watska and Respondent testified that Patient D appeared very anxious after experiencing perioral numbness, but did not flail her arms about nor at anytime lose consciousness or “flat-line”, as Patient D had testified. (T.527, 786-787) Credible evidence indicates that because Patient D was anxious and agitated, after observing her until 12:00 pm, the team decided not to proceed with this elective surgery and moved the patient to the recovery room. (T. 526, 796-799)

Petitioner’s expert, Dr. Carole Agin, testified that Patient D’s perioral numbness was caused by the test dose of epinephrine entering the bloodstream through the incorrectly positioned catheter. Respondent testified that the Patient’s pulse rate did not go up immediately when he administered the test dose containing epinephrine which would have indicated this. (T.523) Instead, he testified, the increase in pulse rate was a response to anxiety following her experiencing perioral numbness. (T. 528)

The inability to determine when the pulse rate increased is because of the Respondent’s own failure to record the time when he administered the test dose of epinephrine, which is in violation of the standard of care. (T. -10/12- 534-535)

FINDINGS CONCERNING PATIENT E

37. Respondent failed to adequately document his assessment of Patient E. Respondent’s documentation of the April 2, 1996 initial assessment lacks a basic medical history, physical examination, and vital signs. (Ex.16 at 1; T. 188) Respondent failed to document the efficacy of the medication he prescribed to Patient E. (T. 191, 192)

38. Respondent failed to document a rationale when increasing or changing Patient E's medications. (T. 200) During the office visits of April 17, 24, and May 8, 1996, Patient E was given injectable Demerol as well as oral Dilaudid without recording any rationale. (Ex.16 at 1; T.189) Since Patient E was being treated for an abscess and skin infection, injectable intramuscular medications placed her at additional risk for infection. No explanation was given for this choice. (T.190)

39. In addition to the Demerol and Dilaudid, Respondent prescribed morphine for Patient E on May 22, 1996, without documenting any rationale. (T.190) On June 26, 1996, Respondent prescribed injectable Demerol, Dilaudid and methadone without documenting any rationale. (T.191)

40. Respondent prescribed excessive quantities of high dose opiates and benzodiazepines for Patient E on several occasions. On February 24, 1997 alone, Respondent prescribed 200 tablets of morphine sulfate immediate release, 30 milligrams; 120 tablets of MS Contin, 100 milligrams; 480 tablets of methadone, 10 milligrams; and 100 milligrams of injectable Demerol, 100 milligrams per ml. (Ex. 16 at 5) Respondent's pattern of prescribing to Patient E was excessive and violated minimally acceptable standards of care. (T. 192-194, 198, 199)

DISCUSSION REGARDING PATIENT E

At the hearing, Respondent did not contest any of the charges related to Patient E. He offered no testimony from either himself or his expert witness to refute the allegations contained

in the Statement of Charges or the testimony of the Department's expert witness. The Hearing Committee notes that on February 24, 1997, Respondent prescribed one long acting, one medium-to-long acting and two short acting opiates (or "rescue" analgesics), all without documenting a rationale. Whereas it is appropriate to prescribe a long-acting analgesic to maintain pain relief as well as a short-acting analgesic as a "rescue" dose for instances where the patient has increased or "break-through" pain, Dr. Agin testified that Respondent's pattern of prescribing for Patient E was excessive. (T. 193)

On 9/23/96, Respondent's notes for Patient E indicate that she had not filled the prescriptions she'd received on 9/18, but lost them. (Ex. 16, p.4) Again on 3/10/97, Respondent's chart notes record that Patient E admitted to lying about having destroyed approximately 300 tablets of Dilaudid, that such an account of medication will not be tolerated, and that any lost, stolen or destroyed medications will not be replaced. (Ex. 16 p.5) Respondent had the patient sign the office note on both occasions. This indicates Respondent's attempts to help the patient control medication usage. Dr. Agin testified that this patient was a difficult case -- "a chronic pain patient with high dose opiate requirements." (T. 202)

The lack of adequate documentation throughout makes it impossible to follow Respondent's rationales; however, the Hearing Committee was especially concerned about Respondent's judgment in prescribing injectable analgesics to a patient being treated with antibiotics for a skin abscess.

FINDINGS CONCERNING PATIENT F

41. Respondent failed to adequately document his assessment of Patient F.

Respondent failed to document the efficacy of the medications that he prescribed to Patient F. (T. 218) Respondent's prescribing escalating doses of opiates was excessive and inappropriate. (T. 229)

42. It is within the standard of care to give a chronic pain management patient a one month supply of medication, calculated by the prescribed maximum daily dose times 30 days. (T. 53)

43. Respondent failed to document a rationale when increasing or changing Patient F's medications. On May 14, 1997, Respondent prescribed Esgic without documenting any rationale. (Ex. 17 at 23; T. 217) On June 23 and July 9, 1997, Respondent increased the dosage of Lortabs prescribed to Patient F without documenting any rationale. (Ex. 17 at 23; T. 219-220) Respondent prescribed Ambien to Patient F without documenting a rationale. (T. 221)

44. Respondent prescribed excessive quantities of opiate analgesics containing acetaminophen for Patient F on several occasions. On her initial visit, Respondent prescribed Patient F, 50 tablets of Lortabs with 5 refills, which would amount to an availability of 300 tablets. This prescribing was excessive. (T.217) On another occasion, only sixteen days after having prescribed Patient F 400 Lortabs, Respondent issued an additional prescription of Lortabs. If Patient F had consumed 400 tablets in 16 days, she was averaging 25 tablets per day which is excessive. (T. 219)

45. Each Lortab contains 500 milligrams of acetaminophen. The maximum daily dose of acetaminophen is 4000 milligrams. (T.219) If Patient F consumed 25 Lortabs in one day, she would be receiving over 12,000 milligrams of acetaminophen, which far exceeds

the recommended daily dose. (T. 219) The risks associated with exceeding the maximum daily dose of acetaminophen are liver failure, renal failure, respiratory depression and death. (T.220)

DISCUSSION REGARDING PATIENT F

Evidence in the record establishes that Patient F had been obtaining treatment for an alleged recurrent urinary tract infection (UTI) and chronic pelvic pain resulting from interstitial cystitis. However, the record does not provide that definitive a diagnosis.⁶ By her own admission, Patient F was a chronic abuser of pain medications, which she obtained from several physicians, without one knowing that she was being treated by others. She testified that she knew what to say in order to obtain the Lortabs from emergency rooms and other physicians, and at the time of her last hospital admission for drug abuse, she had Lortab and hydrocodone “prescriptions from all over.” (T.386) She underwent detox on several occasions without informing the Respondent. She apparently told the Respondent (and testified at the hearing) that she was in constant pain, but hospital records report she described having spikes of pain interspersed among pain-free periods. Her testimony establishes that she was able to obtain Lortabs and other opiates from physicians who had knowledge of her substance abuse after leaving Respondent’s care. (T.587-592)

Dr. Agin was critical of Respondent for not prescribing long-acting analgesics for Patient

⁶ The cause or causes of chronic interstitial cystitis and non-bacterial cystitis are unknown. Interstitial cystitis is a diagnosis of exclusion, capable of producing pain; but the Hearing Committee notes that, despite numerous urological and gynecological work-ups, the record fails to establish that there was a documented infection at any time during Patient A’s treatment by urologists, by the Respondent or during her hospitalizations. Likewise, the diagnosis of interstitial cystitis was excluded by appropriate examination by a urologist.

F. Patient F testified that she was not interested in long-acting medication, that she was addicted to Lortabs and did not want to change.(T. 407-8) Respondent testified, and his progress notes support, that he recommended other options for pain control such as an epidural block (Ex. 17 p.18 - Aug. 12, 1998) and alternative treatment modalities including counseling (Ex. 17 p.18, 17 - May 18, Sept 16, 1998; T. 396) in an effort to better control Patient F's pain.

Patient F candidly admitted that she became addicted to Lortabs, for which she apparently blames the Respondent, and that she had given false information to Respondent and other health care practitioners to obtain medication when she was addicted. Respondent supplied her with escalating amounts of Lortabs, which contain acetaminophen, risking liver damage. Dr. Hiesiger testified that the complexities of obtaining pain relief for an individual patient may force the clinician to use more acetaminophen than he or she would want to, but four grams (4,000 mg.) is considered an upper dose. When prescribing that level of acetaminophen long-term, he testified, the patient's liver function should be evaluated on a regular basis. (T. 901) This was not done by Respondent, and failure to do such testing, while continuing to supply high quantities of Lortabs, is a breach of the standard of care.

Respondent's prescribing to Patient F placed her at risk for liver and renal failure and death. Assuming Respondent felt that this was the only medication that would relieve her pain, he failed to monitor the effect that this substance was having on Patient F's kidneys and liver. Although acetaminophen is readily available without a prescription, the Lortabs that Respondent prescribed were a dangerous combination. It is likely that Patient F took excessive amounts of Lortabs because her addiction craved the opiate, but the addition of acetaminophen was the substance that placed her at greatest risk.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Hearing Committee makes the following Conclusions of Law with regard to the Specifications. All votes as to the Specifications were unanimous:

1. The First Specification charges Respondent with professional misconduct under NY Educ. Law Section 6530 (3) by reason of his practicing with negligence on more than one occasion. The First Specification is **SUSTAINED**, based upon the facts contained in Paragraphs A and A.1, A and A.3, B and B.1, B and B.2, B and B.3, c and C.1, D and D.2, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.5.

2. The Second Specification charges Respondent with professional misconduct under N.Y. Educ. Law Section 6530(5) by reason of his practicing the profession of medicine with incompetence on more than one occasion. The Second Specification is **SUSTAINED** based upon facts contained in paragraphs E and E-1, E and E-2, E and E-3, and E and E-4.

3. The Third Specification charges Respondent with exercising undue influence on a patient to exploit the patient for financial gain in violation of N.Y. Educ. Law Section 6530 (17). The Third Specification is **NOT SUSTAINED**.

4. The Fourth Specification charges Respondent with conduct in the practice of medicine which evidences moral unfitness to practice medicine within the meaning of N.Y. Educ. Law Section 6530(20). The Fourth Specification is **NOT SUSTAINED**.

5. The Fifth through Ninth Specifications charge Respondent with failing to maintain a record which accurately reflects the treatment of a patient in violation of N.Y. Educ. Law Section 6530(32). The Fifth through Ninth Specifications are **SUSTAINED** based upon the facts in Paragraphs A, A.1, A.2, and A.3; Paragraphs C and C.1; Paragraphs D, D.2, and D.4; Paragraphs E and E.1, E.2, and E.3; and Paragraphs F and F.1, F.2, and F.3.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee voted as follows:

Paragraphs A, A.1, A.2, and A.3

Paragraphs B and B1, B.2, and B.3

Paragraphs C. and C.1

Paragraphs D and D.2, and D.4

Paragraphs E and E.1, E.2, E.3, and E.4

Paragraphs F and F.1, F.2, F.3 and F.5

ARE SUSTAINED.

Paragraphs A.4 and A.5

Paragraphs C.2 and C.3

Paragraphs D.1 and D.3

Paragraphs F. 4 and F.6

ARE NOT SUSTAINED.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee does not find fault with prescribing opiates for the long-term control of chronic pain in persons with non-terminal conditions. Persons in pain, such as those treated by Respondent in this case, deserve to have their pain alleviated. This is so even when they become psychologically or physically addicted to the medications they require for managing their pain. The Hearing Committee wishes to make the point that chronic pain patients deserve to be treated by practitioners who respect their condition and their needs but who recognize their obligation not to place patients in further jeopardy.

In determining a penalty, the Hearing Committee was cognizant of the fact that the practice of pain management is a difficult, yet important area of medical specialization, fraught with dynamics found in few other areas of medicine. Patients often require high doses of addictive substances to control pain resulting from a myriad of conditions. For successful treatment, the patient and physician must develop a relationship of trust. The patient must trust the physician to provide appropriate pain relief, and the physician must trust the patient's reports about the severity of the pain and the efficacy of treatment. If the patient feels the physician is overly suspicious or skeptical of his or her reports, the necessary trust will be destroyed. However, the physician must maintain an accurate record complete with rationales for prescribing and for changing medications and dosages and must be vigilant for signs that patients are misusing prescribed medication. For patients on high dose acetaminophen-opiate combinations, monitoring is crucial to prevent the risk to kidneys and liver posed by long-term high dose therapy. Such monitoring was not done for several patients in this case.

Of great concern to the Hearing Committee was Respondent's lack of judgment, evidenced by egregious record-keeping deficiencies, his involvement with Patient A's investments, prescribing of injectable analgesics for Patient E, and prescribing multiple refills of opiates without proper oversight. This pattern of poor judgment constitutes an imminent danger to the public, in the eyes of the Hearing Committee. The record establishes that Respondent has knowledge deficits regarding chemical dependence and addictive behavior, which he did not appear to recognize or admit, in spite of several periods of post graduate training at respected institutions. (Ex. D). Lacking motivation and insight, Respondent would not benefit significantly from retraining, the Hearing Committee felt.

In assessing a penalty, the Hearing Committee was of the opinion that Respondent should not be allowed to practice medicine without supervision. Periodic record audits, the Committee believed, would not provide sufficient oversight for patient safety. Given the medical specialty involved and the geographical area in which Respondent practices, restricting his practice to a mandated hospital setting or with a practice monitor were, the Committee believed, impractical and unworkable options. Therefore, the Hearing Committee unanimously determined there was no acceptable alternative to revocation.

ORDER

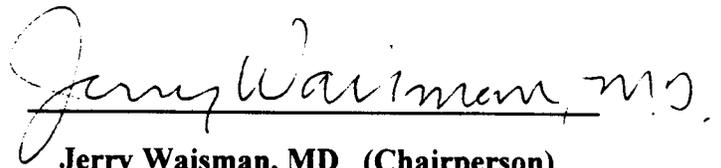
Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The license to practice medicine of Respondent **STEVEN B. ASTRACHAN** is hereby **REVOKED**, and that

This Order shall take effect **IMMEDIATELY**.

Dated: New York, New York

March 19 ,2001

A handwritten signature in cursive script that reads "Jerry Waisman, MD". The signature is written in black ink and is positioned above the printed name of the signatory.

Jerry Waisman, MD (Chairperson)

Edward C. Sinnott, MD

Karen Wolf, RPA

APPENDIX I



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

-----X

IN THE MATTER : NOTICE
OF : OF
STEVEN BRETT ASTRACHAN, M.D. : HEARING

-----X

TO: STEVEN BRETT ASTRACHAN, M.D.
130 North Front Street
Kingston, New York 12401

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 4th and 5th days of October, 2000, at 10:00 in the forenoon at the Holiday Inn Gathers Annex on Washington Avenue in Kingston, New York 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 Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180, (518-402-0748), 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(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy 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.
YOU ARE URGED TO OBTAIN AN ATTORNEY TO
REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
September 7, 2000

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to: William J. Lynch
Senior Attorney
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 486-1841

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

-----X
IN THE MATTER : STATEMENT
OF : OF
STEVEN BRETT ASTRACHAN, M.D. : CHARGES
-----X

STEVEN BRETT ASTRACHAN, M.D., the Respondent, was authorized to practice medicine in New York State on December 5, 1983 by the issuance of license number 156866 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine through November 30, 2000 with a registration address of 130 Front Street, Kingston, New York 12401.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A [all patients are identified in Appendix] at his office located at 130 North Front Street in Kingston, New York (hereafter Respondent's office) and at Benedictine Hospital in Kingston, New York between approximately November 18, 1996 through November 23, 1998. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care in that:

1. Respondent failed to adequately assess and/or document his assessment of Patient A.

2. Respondent failed to consider and/or document a rationale when increasing Patient A's dose of medications on various occasions.

3. Respondent failed to consider and/or document a rationale for changing Patient A's medication on various occasions.

4. Respondent prescribed excessive quantities of opiates and benzodiazepines for Patient A on various occasions.

5. On approximately September 8, 1997 and approximately November 29, 1997, Respondent induced Patient A to give him two checks in the amount \$12,500, totaling \$25,000, by representing that he would invest it for him in a corporation that was producing a patch to lose weight and/or a patch for pain management.

B. Respondent provided medical care to Patient B at his office and at Kingston Hospital between approximately December 7, 1994 through August 16, 1995. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care in that:

1. Respondent administered an excessive number of epidural steroid injections to Patient B over a period of ten weeks.

2. Respondent administered an excessive number of lumbar spinal injections to Patient B over a five week period.
 3. Respondent prescribed an excessive dose of Depomedrol to Patient B on various occasions.
- C. Respondent provided medical care to Patient C at his office and at Kingston Hospital between approximately April 8, 1994 through October 15, 1998. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care in that:
1. Respondent failed to maintain a complete record of the office visits of Patient C.
 2. Respondent prescribed opiates to Patient C, in spite of the fact that Patient C had been hospitalized previously for detoxification from opiates on approximately March 1994.
 3. Respondent again prescribed Lortabs for Patient C on November 6, 1996, in spite of the fact that Patient C was hospitalized for detoxification from opiates specifically Lortabs on August 7, 1995.
- D. Respondent provided medical care to Patient D at Hurley Avenue Surgical Center in Kingston, New York on

approximately July 10, 1997. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care in that:

1. Respondent made eight attempts to place and/or position the epidural catheter.

2. Respondent failed to adequately document his treatment of Patient D.

3. Respondent failed to adequately monitor Patient D for potential adverse effects after the test dose was given and/or adequately document monitoring of Patient D.

4. Respondent failed to provide adequate timing between the test dose and the subsequent doses given to Patient D and/or failed to document the timing of these doses.

E. Respondent provided medical care to Patient E at his office and at Kingston Hospital between approximately April 2, 1996 through September 28, 1998. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care in that:

1. Respondent failed to adequately assess and/or document his assessment of Patient E.

2. Respondent failed to consider and/or document a rationale when increasing Patient E's dose of medications on several occasions.
 3. Respondent failed to consider and/or document a rationale for changing Patient E's medication on several occasions.
 4. Respondent prescribed excessive quantities of opiates and benzodiazepines for Patient E on several occasions.
- F. Respondent provided medical care to Patient F at his office and at Benedictine Hospital between approximately April 7, 1997 through January 5, 2000. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care in that:
1. Respondent failed to adequately assess and/or document his assessment of Patient F.
 2. Respondent failed to consider and/or document a rationale when increasing Patient F's dose of medications on several occasions.
 3. Respondent failed to consider and/or document a rationale for changing Patient F's medication on several occasions.

4. Respondent failed to attempt the use of long acting analgesic medication for Patient F's alleged chronic pain.

5. Respondent prescribed excessive quantities of ~~opiates~~ ^{opiate analgesics containing acetaminophen} for Patient F on several occasions.

6. Respondent prescribed opiates to Patient F in September 1998, in spite of the fact that Patient F had been hospitalized for detoxification from opiates in approximately August 1998.

SPECIFICATIONS

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, and/or F and F.6.

SECOND SPECIFICATION
**PRACTICING WITH INCOMPETENCE ON
MORE THAN ONE OCCASION**

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

2. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, and/or F and F.6.

THIRD SPECIFICATION
EXERCISING UNDUE INFLUENCE ON A PATIENT

Respondent is charged with exercising undue influence on a patient to exploit the patient for financial gain in violation of New York Education Law §6530(17), in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4 and/or A and A.5.

FOURTH SPECIFICATION

CONDUCT WHICH EVIDENCES MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine within the meaning of New York State Education Law §6530(20), in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4 and/or A and A.5.

FIFTH THROUGH NINTH SPECIFICATION

FAILURE TO MAINTAIN ACCURATE RECORD

Respondent is charged with failing to maintain a record which accurately reflects the treatment of a patient in violation of New York Education Law §6530(32), in that Petitioner charges:

5. The facts in Paragraphs A and A.1, A and A.2, and/or A and A.3.
6. The facts in Paragraphs C and C.1.
7. The facts in Paragraphs D and D.2, D and D.3, and/or D and D.4.
8. The facts in Paragraphs E and E.1, E and E.2, and/or E and E.3.
9. The facts in Paragraphs F and F.1, F and F.2, and/or F and F.3.

DATED:

September 7, 2000
Albany, New York

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

Charges to the Hearing Panel
Matter of Steven B. Astrachan
by Susan F. Weber, ALJ

1. **Undue Influence:** To find undue influence you must find that Patient A had **diminished capacity** to make financial decisions, and that the Respondent took **advantage of that diminished capacity, intending to gain a personal benefit** from his position of trust as Patient A's physician.

Evidence of the patient's diminished capacity and of Respondent's intent to gain a personal benefit must be based upon a preponderance of the evidence. Knowledge and intent may be inferred, but such inferences must be stated. The facts upon which an inference is based must also be stated.

2. **Moral Unfitness:** To sustain an allegation of moral unfitness, the State must show that Respondent committed acts which evidence moral unfitness. There is a difference between a finding that an act "evidences moral unfitness" and a finding that a person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Panel is asked to decide if certain alleged conduct is suggestive of, or would tend to prove, moral unfitness. The Panel is not called upon to make an overall judgment of respondent's moral character. It is noteworthy that an otherwise moral individual may commit an act "evidencing moral unfitness" due to a lapse in judgment or other temporary aberration.

The standard for moral unfitness in the practice of medicine is twofold: First, there may be a finding that the accused has violated the public trust bestowed upon that person by reason of licensure as a physician. Physicians have privileges available solely due to their licensure as physicians. The public places great trust in physicians solely due to their licensure as physicians. Examples include physicians' access to controlled substances and billing privileges, as well as the fact that patients willingly place themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment, and when they reveal intimate facts about themselves and their families. Hence, it is expected that a physician will not violate the trust the public has bestowed through professional licensure. This leads to the second aspect of the standard: Moral unfitness can be seen as a violation of the moral standards of the medical community which the Panel, as delegated members of that community, represent.

3. **Record keeping (failure to perform and/or document):** The fact that something is not recorded in the chart does not mean that it did not occur. While the failure to keep a record may be an independent basis for a finding against Respondent, the absence of a

record does not mean that a conversation did not occur or that an event did not take place. However, you may evaluate the credible evidence before you -- the testimony and credibility of witnesses, the medical records themselves -- to determine whether or not something occurred.

4. While there was discussion on the record regarding performance of an intrathecal administration of medication in Patient B, there are no charges related to this procedure. Therefore, this procedure cannot be the basis of discipline. Further, where there is no specific charge pending regarding a subject, discussion of that subject as a basis for discipline of Respondent would be improper.

5. Concerning the autopsy report of Patient A's death, I caution the panel that there is no charge against Respondent concerning the death of Patient A. As to the report's relevance to the charge of excessive opiate prescribing, the statement contained in the autopsy report that "there were excessive quantities of opiates" must be evaluated in the context of other evidence in the record; for example, evidence concerning Patient A's chronic pain, dosages and duration of his opiate use, as well as evidence concerning other sources and types of drugs Patient A may have used. Panel is instructed that the probative value of the report's contents is diminished by the fact that opinions stated therein cannot be tested through cross examination.

astrachan/panel