



# STATE OF NEW YORK DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Dennis P. Whalen  
*Executive Deputy Commissioner*

November 16, 1998

## **CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Bradley C. Mohr, Esq.  
NYS Department of Health  
Corning Tower Room 2509  
Empire State Plaza  
Albany, New York 12237

Raul Aude, M.D.  
33 William Street-Suite 5  
Auburn, New York 13021

Michael J. Vavonese, Esq.  
Rossi & Vavonese  
108 West Jefferson Street-Suite 500  
Syracuse, New York 13202

### **RE: In the Matter of Raul Aude, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 98-266) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct  
New York State Department of Health  
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.

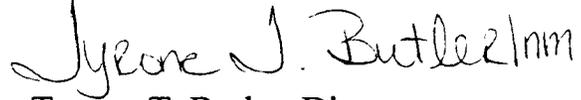
The notice of review served on the Administrative Review Board should be forwarded to:

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,

Handwritten signature of Tyrone T. Butler in cursive script, followed by the initials 'nm'.

Tyrone T. Butler, Director  
Bureau of Adjudication

TTB:nm  
Enclosure

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

COPY

-----X  
IN THE MATTER : DETERMINATION  
OF :  
RAUL AUDE, M.D. : ORDER  
-----X

BPMC-98-266

A Notice of Hearing and Statement of Charges, both dated April 2, 1998, were served upon the Respondent, Raul Aude, M.D. **STEVEN V. GRABIEC, M.D. (Chair), THERESE G. LYNCH, M.D., and NANCY J. MORRISON**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Bradley Mohr, Esq., Senior Attorney. The Respondent appeared by Rossi & Vavonese, Michael J. Vavonese, 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.

**STATEMENT OF CASE**

Petitioner has charged Respondent with seventeen specifications of professional misconduct. Sixteen of the specifications relate to Respondent's medical care and treatment of five patients. The allegations include gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, fraud, and moral

unfitness. A seventeenth specification concerns a prior administrative adjudication regarding violations of Article 33 of the New York Public Health Law.

Respondent filed an Answer in which he admitted the existence of the prior administrative adjudication, but denied all remaining charges. A copy of the Notice of Hearing and 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. Raul Aude, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State on March 7, 1975 by the issuance of license number 123010 by the New York State Education Department. (Exh. 2).<sup>1</sup>

2. Respondent was personally served with the Notice of Hearing, Statement of Charges and Summary of Department of Health Hearing Rules on April 20, 1998. (Exh. 1).

3. Lawrence N. Chessin, M.D. testified as an expert

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<sup>1</sup>T. \_\_ and Exh. \_\_ indicate a reference to the transcript of the hearing or an exhibit in evidence.

witness on behalf of Petitioner. Dr. Chessin is head of the Infectious Disease Division of the Genesee Hospital and has held this position for 28 years, from 1970 to the present. He is a senior attending physician at the hospital. Dr. Chessin has also been a clinical professor of medicine at the University of Rochester for the past eight years. Prior to that, he was a clinical associate professor for nine years and a clinical assistant professor for eleven years. Dr. Chessin has a full-time practice in internal medicine. (T. 48-49 Exh. 12).

**Patient A**

4. Patient A was a 41 year old white male who presented to Respondent on August 14, 1992. The patient was an investigator employed by the New York State Department of Health - Bureau of Controlled Substances (BCS), named Jay Hehn. Mr. Hehn used an assumed name (Patient A). He was conducting a covert investigation of Respondent's medical practice. He visited Respondent in the ordinary course of his duties as an investigator, and presented himself as a truck driver. (T. 20-21).

5. Investigator Hehn was wearing a body wire which is a small concealable transmitter that transmits a radio signal back to a unit in an unmarked vehicle that has a tape recorder. This was monitored on a speaker by BCS Investigators James Dore and Roberto Fonzi. Investigator Dore was in charge of the investigation. Each visit by Investigator Hehn, on August 14, 1992, September 15, 1992, November 30, 1992, February 5, 1993, and April 20, 1993, were monitored by Investigators Dore and

Fonzi. The conversations that came over the speaker were clearly audible. Investigator Dore testified on June 12, 1998. (T. 22,23,24).

6. Investigator Hehn presented himself as a patient who was a truck driver. He requested Plegine to assist him in staying awake while driving his truck. He made four subsequent visits, on September 15, 1992, November 30, 1992, February 5, 1993, and April 20, 1993. He received a prescription for Plegine on each of these occasions. (T. 21; Exh. 5).

7. On each of these four visits, August 14, 1992, September 15, 1992, November 30, 1992, February 5, 1993, and April 20, 1993, Investigator Hehn also requested Tylenol with Codeine. The reason he gave for requesting it was that he had previously had some and his girlfriend had consumed it. No medical reason was documented for its use nor did the patient have any medical condition which would cause him to have any legitimate medical need for it (T. 21, 25; Exh. 5).

8. Plegine is a Schedule III controlled substance (T. 25, 54). Plegine is phendimetrazine, a sympathomimetic drug that can act as an anorectic to assist in weight loss. It is a central nervous system stimulant which raises blood pressure and affects the gastrointestinal and urinary tracts (Exh. 20,21; T. 54). It is used as a short term (few weeks) treatment for weight reduction in conjunction with diet, exercise and a regimented program. (Exh. 20,21; T. 54, 55). It should not be used on a long term basis because it can be addictive (Exh. 21; T. 89). It can cause intense psychological dependence and social dysfunction

and over-stimulation, agitation, restlessness, psychotic states, blurring of vision, palpitation, tachycardia and stomach pain. It also should not be used on patients with a history of drug abuse (Exh. 20,21).

9. Patient A (Investigator Hehn) was 5'9" and 150 pounds when he presented on August 14, 1992. This patient's weight and height fell well within normal range (T. 105). Prescribing Plegine to this patient was below acceptable standards because patients within normal ranges of weight and height do not need to lose weight and therefore do not require an agent for weight loss (T. 25).

10. Tylenol with Codeine, No. 3 is a Schedule III Controlled Substance (T. 25). It is acetaminophen with codeine. Acetaminophen has many uses. It can be used to lower body temperature and for pain relief. When codeine is added, it is used for pain and discomfort. (T. 106). This is an addictive drug because it has codeine in it (T. 107). It is a central nervous system depressant. It can impair the ability to operate a motor vehicle. (Exh. 20, 21; T. 20,21).

11. Using an anorectic drug such as Plegine as a psychomotor stimulant and a central nervous system stimulant to keep a patient awake is inappropriate. Use of a stimulant to keep a patient awake should only be done if a patient has narcolepsy. Plegine is not the appropriate drug for this purpose. The drug of choice for that illness is Cycrin. (T. 126).

12. Prescribing Plegine for eight months for a patient

within a normal height and weight range would be for an inappropriate length of time (T. 133).

13. Respondent's prescribing of Tylenol with Codeine to Patient A was below acceptable standards because there was no documented indication for prescribing it or adequate medical justification (Exh. 5; T. 107, 128).

**Patient B**

14. Patient B was a 34 year old white male who presented to the Respondent on September 7, 1988. He was 5'8" and weighed 246 pounds (Exh. 4, 6; T. 142). He was overweight (T. 144).

15. The physical examination by Respondent of Patient B did not meet acceptable standards. (T. 143). The record does not show any physical examination was conducted when the patient first presented and Respondent began prescribing. (Exh. 6; T. 142, 143, 158).

16. The medical history that was recorded by Respondent when the patient first presented did not meet acceptable standards (T. 143). The patient's medical history should consist of a past medical history, social history (T. 143) and should be done at the onset of treatment, not 17 months later (T. 158). A medical history for a new patient should include a careful chief complaint, social and family history, review of systems, past surgical history, allergies, medications, behaviors, coffee intake, prior drug history, prior medications, marital status, sexual preference, and a careful physical examination (T. 164).

The usual medical practice is to date it when it is prepared (T. 166).

17. A medical history and physical was not taken until April 3, 1990, 17 months and seven visits after treatment of the patient first began. (Exh. 6; T. 145, 166).

18. Fastin was prescribed to Patient B on September 7, 1988 (Exh. 6; T. 142).

19. Fastin is used as an adjunct for weight loss and weight reduction (T. 142). Fastin is a phentermine. It is related to amphetamine and it is similar to Plegine (Exh. 24; T. 142).

20. Respondent first prescribed Plegine to Patient B on November 14, 1988. Plegine was prescribed a total of 20 times to Patient B, from November 14, 1988 through September 13, 1993. (Exh. 6).

21. Respondent's prescribing of Plegine to Patient B was below acceptable standards because it is indicated only for short term use (T. 146). Short term use is defined by the manufacturer as "a few weeks" (Exh. 20, 21). Beyond that period, there is the possibility of creating an addiction and/or dependence on the drug. (Exh. 20,21; T. 148).

22. Respondent first prescribed Tylenol with Codeine No. 3 to Patient B on July 9, 1991. Respondent also prescribed Tylenol with Codeine No. 3 on January 6, 1991, April 6, 1992, July 1, 1992, February 2, 1993, April 20, 1993, June 21, 1993, and September 13, 1993. (Exh. 6).

23. Respondent's prescribing of Tylenol with Codeine No. 3 was below acceptable standards because there is no indication that the patient had a chronic pain syndrome which would require use of a highly addictive narcotic (Exh. 22) on a regular basis over a two year period. In addition, Respondent failed to address the underlying pathology causing the pain or to refer the patient to an orthopedist or a pain clinic (T. 147-151). Respondent also failed to recognize that Plegine, which was also being prescribed by Respondent, might be intensifying the pain from the patient's orthopedic problem (T. 157,162).

**Patient C**

24. Patient C was a 35 year old white male. He was 5'9" and 226 pounds. He presented himself to Respondent on April 21, 1989. (Exh. 7).

25. The patient was prescribed Isuprel inhaler, a bronchodilator used by individuals who have asthma (Exh. 7; T. 168).

26. Isuprel is an adrenaline derivative and a sympathomimetic drug (T. 170). It is a heart stimulant (T. 172).

27. Plegine, an anorectic, was also prescribed (Exh. 7; T. 168). Plegine is a sympathomimetic drug. It should not be prescribed to an asthmatic on Isuprel because it could overstimulate a patient, causing rapid heartbeat, elevated blood pressure, tachycardia, and has been associated with sudden death. The patient was at a higher risk because of his family history of heart disease. (T. 173, 193).

28. Isuprel and Plegine are additive, thus increasing the danger from both of the drugs (T. 193-194) and placing the patient at risk for sudden death (T. 196).

29. No medical history was recorded when the patient initially presented on April 21, 1989. A medical history was not obtained until February 5, 1990, ten months and four visits later. (Exh. 7).

30. It is below acceptable standards to fail to take a patient's history on the first visit. (T. 170).

31. The patient's medical history that was recorded by Respondent of Patient C on February 5, 1990, did not meet acceptable standards (T. 171-172). Respondent failed to document what the patient's allergies were and whether he was allergic to medications, molds, grasses or other substances (T. 172). This is especially important in an asthmatic patient (T. 172). Respondent also failed to record a chief complaint to explain why the patient first presented (T. 170, 171). In addition, Respondent also failed to indicate an history of asthma which is important to consider prior to prescribing sympathomimetic drugs such as Plegine and Isuprel (T. 173).

32. Respondent failed to conduct a physical examination when Patient C first presented on April 21, 1989. (Exh. 7).

33. It was below acceptable standards to prescribe for a patient without performing a physical examination. Respondent only recorded the patient's age, height and weight when the patient first presented on April 21, 1989 (T. pp 169, 170-173). He failed to record blood pressure or whether or not the patient

was wheezing. At minimum, an accurate pulse record of a patient on Isuprel and Plegine was necessary because both drugs can cause rapid heartbeat, as well as a rise in blood pressure for a man of Patient C's age. An accurate blood pressure was also a minimum requirement for a patient being given a drug which can cause rapid heart rate and an increase in blood pressure. (T. 174).

34. On January 8, 1991, Respondent prescribed Visken. On this visit, Patient C's blood pressure was recorded as 160/90 (Exh. 7). This would be considered hypertensive in a 35 year old male (T. 175).

35. Visken is an antihypertensive drug (Exh. 29). It is contraindicated in bronchial asthma because it is a beta blocker. A beta blocker can cause serious side effects in an asthmatic because it can close the patient's airways down (T. 176).

36. Respondent continued to treat Patient C for two more years until September 17, 1993. During this time but never took or recorded the patient's blood pressure again (Exh. 7; T. 177).

37. Respondent's care and treatment of Patient C's hypertension was below acceptable standards (T. 177) because Respondent did not discontinue Plegine, despite the onset of hypertension in the patient. In addition, Respondent continued prescribing Isuprel which also raises blood pressure (T. 177, 182, 83). Furthermore, he subsequently failed to record any information regarding the patient's pulse and heart rate or the progress of the patient's asthma (T. 177, 184) or to determine if

the patient was experiencing tachycardia (T. 185). Respondent did not follow up at all with respect to the patient's hypertension (T. 187).

38. Long term abuse of amphetamines can cause hypertensive heart disease. Once a patient has hypertension, his blood pressure should be followed very carefully. In this case, it was not followed at all (Exh. 7; T. 195). If left untreated, hypertension can cause the heart to fail ;resulting in death (T. 185).

#### **Patient D**

39. Patient D was a 29 year old white male who presented to Respondent on September 13, 1988. His age, height (5'9"), weight (181 pounds), and blood pressure were the only facts recorded. No other physical examination or medical history was documented. (Exh. 8).

40. Respondent prescribed Plegine, an anorectic, to the patient despite the fact that the patient was not overweight (Exh. 8; T. 199).

41. On the next three visits, December 6, 1988, February 14, 1989, and May 12, 1989, Fastin was prescribed. On all subsequent visits (14 visits) until May 10, 1993, either Plegine or Fastin was prescribed to the patient (Exh. 8).

42. The initial physical examination of September 13, 1988, the date the patient first presented to Respondent, was below acceptable standards because it contains only a height, weight, and blood pressure (T. 201).

43. It is below acceptable standards to fail to take a

medical history. A full medical history is indicated prior to prescribing Plegine (T. 200).

44. The medical history that was documented on February 13, 1990 (Exh. 8) is below acceptable standards because it contains no family history or any other information regarding the patient's past medical history (T. 201).

45. Respondent's prescribing of Plegine and Fastin was below acceptable standards (T. 203, 203). Both of these drugs are for short term use in weight reduction. Respondent prescribed Plegine or Fastin 19 times over almost a five year period. Both of these drugs have the same effect on the body, producing an anorectic state which makes a patient feel less hungry (T. 203). This patient was not obese (T. 202,221), and did not need Plegine or Fastin (T. 213,214). Use of Plegine by a patient who is not in need of it unnecessarily subjects him to the risk of potential amphetamine addiction (T. 213-215). Respondent failed to recognizing the patient's growing dependence on Plegine based upon the correspondence he received from the patient (Exh. 8, p. 8, 9; T. 209, 210).

46. On March 23, 1990, Respondent prescribed Haldol to Patient D (Exh. 8; T. 203). Haldol is haloperidol (Exh. 25; T. 205). It is used to treat psychotic behavioral problems, inappropriate behavior, or for patients that are out of control or suffer from hallucinations or delusions (T. 203-205). It is often used with elderly patients. Its use can result in a patient developing irreversible tardive dyskinesia, which is a neurologic side effect (Exh. 25; 368).

47. Respondent's prescribing of Haldol to Patient D was below acceptable standards because there was no indication for prescribing this drug (Exh. 8; T. 204, 205).

48. On May 3, 1991, Respondent prescribed Butisol to Patient D. Butisol was also prescribed on August 28, 1991, December 11, 1991, and March 20, 1992 (Exh. 8; T. 206-209).

49. Butisol is a barbiturate drug. It is used as a sedative . It is a CNS depressant and should not be used in combination with alcohol (Exh. 26; T. 206, 209).

50. Respondent's prescribing of Butisol to Patient D was below acceptable standards because it was prescribed without any indication (Exh. 8; T. 206, 207). It was prescribed simply because the patient requested it (Exh. 8, p 10; T. 207). Respondent should have recognized the amphetamine-like effects of the Plegine, which is contraindicated for highly nervous or agitated patients, and discontinued it, rather than prescribing Butisol (T. 209, 210,211, 363.364).

51. When the patient informed Respondent that he had lost his drivers license for Driving While Ability Impaired (DWAI), an alcohol abuse related offense, Respondent should have made inquiries regarding the patient's alcohol consumption pattern, prior to prescribing Butisol, or continuing Plegine. Respondent made no inquiries concerning Patient D's use of alcohol (Exh. 8; T. 206-211).

**Patient E**

52. Patient E was a 48 year old white male who presented to Respondent on March 20, 1990. He was 5'8" and 248 pounds. A medical history and physical examination were documented. The patient's history showed no alcohol use. The patient was overweight. Plegine was prescribed to Patient E (Exh. 11; T. p 54).

53. Plegine was prescribed first on March 20, 1990 and again on June 26, 1990, October 8, 1990, February 19, 1991, and June 5, 1991. It was not prescribed on the next four visits until April 22, 1992, when it was resumed again and prescribed on August 11, 1992 and February 23, 1993 (Exh. 11).

54. Respondent's prescribing of Plegine to Patient E was below acceptable standards because it was prescribed over a period of three years (Exh. 20, 21; T. 89).

55. On October 20, 1991, the patient presented to Respondent with a back injury. The patient was prescribed Naprosyn and Soma (Exh. 11; T.55,56).

56. Naprosyn is contraindicated for patients with a drug allergy to aspirin. Patient E had a drug allergy to aspirin (Exh. 11, p 2; T. 55, 56).

57. Soma was also prescribed to Patient E on October 28, 1991 (Exh. 11; T. 55,56). On October 20, 1991, October 28, 1991, November 20, 1991, December 30, 1991, April 22, 1992, August 11, 1992, and February 23, 1993 Respondent prescribed Soma for the patient's musculoskeletal complaints. (Exh. 11).

58. Soma is a muscle relaxant used for musculoskeletal conditions (T. 56, 57). It is a sympathomimetic drug. It has an additive effect when combined with alcohol magnifying the effects of both Soma and alcohol. Taking both together can cause a Soma overdose, even when Soma is taken in the recommended doses (Exh. 28).

59. Alcohol is a neurotoxin which can produce a psychotic episode and cause intoxication, irrational and uncontrolled behavior, confusion and disorientation. (T. 60-61).

60. On October 20, 1991 Respondent prescribed Soma. On October 23, 1991, Patient E was admitted to Tompkins Community Hospital on voluntary status via the Emergency Room. He was discharged on October 24, 1991. He presented himself because he could not sleep for 5 days (Exh. 11, p.24) and began drinking in addition to taking Soma (Exh. 11, p.15). He felt acutely suicidal and devised a plan in which he wanted to call the police and await them with a loaded gun hoping they would kill him. He admitted to being an alcoholic with a long history of binge drinking since serving in the military in 1965-66 in Vietnam and a strong family history of alcoholism. He was living in a cabin in the woods (Exh. 11, pp.15,16; T. 57, 58).

61. Patient E was diagnosed with:

- a. Post traumatic stress disorder,
- b. Acute alcohol intoxication, BAL 0.17 on admission,
- c. Alcoholic dependence,
- d. Major depression (mild),

e. Panic disorder without agoraphobia

(Exh. 11, pp 15,16).

62. Respondent received a copy of the Record of Hospitalization at Tompkins Community Hospital, including the Discharge Summary, Discharge Instruction and Plan, Cumulative Summary (hospital laboratory report), Inpatient Admission Workup, Physical Examination, System Review, and Progress Notes and Consultations (Exh. 11, pp 15-28; T. 327).

63. The Tompkins Community Hospital records of Patient E's October 23-24, 1991 hospitalization were made a part of Respondent's medical records for Patient E (Exh. 11; T.57,327). These records would ordinarily be sent to a patient's physician within a period of a month or two after transcribing, which occurred on October 24, 1991 (T. 349). This would have been prior to the patient's visit of April 22, 1992 (T. 349) and would have been sent directly from the hospital (T. 328). The records do not contain any notations, such as Respondent's initials, indicating that it was read, reviewed and considered in prescribing and treating the patient (T. 349, 350).

64. Respondent prescribed Plegine, along with Soma to Patient E on April 22, 1992, August 11, 1992, and February 23, 1993 (Exh. 11, p 6).

65. Respondent's prescribing of Plegine to Patient E on those occasions was below acceptable standards because it is a psychoactive drug and was prescribed with Soma. Prescribing these two drugs could cause additive and synergistic behavior which heightens the effects of both of these drugs, including

their adverse effects. Both drugs are sympathomimetic, which means they work on the sympathetic nervous system, heightening awareness and responsiveness. If a patient is disturbed, they will make him more disturbed. The effects on the gastrointestinal system, cardiopulmonary effects and genitourinary effects are all intensified. They would also magnify the effects of alcohol, increasing the possibility of a psychotic episode, acute alcohol intoxication, irrational behavior, confusion, disorientation, and uncontrolled behavioral effects (T. 59-61, 338). Plegine is addictive and is also contraindicated for patients with a history of drug abuse (Exh. 20, 21; T.340), and alcohol is a drug (T. 58, 89-91, 94, 339). Respondent did not consider any of these effects on the patient even though he knew of the patient's problems with alcohol on these occasions (T. 90-92, 94) and knew the patient had a history of lying about his problems with alcohol (T.341).

66. Patient E was an admitted alcoholic with a pattern of binge drinking over 25 years and a very strong family history of alcoholism on both his maternal and paternal sides (Exh. 11, p. 15; T. 91, 101). Respondent should have requested further medical assistance in managing this patient for weight reduction instead of continuing him on Plegine (T. 67, 90).

67. On October 28, 1991, November 20, 1991, December 30, 1991, April 22, 1992, August 11, 1992, and February 23, 1993 Respondent saw the patient for musculo-skeletal problems. Respondent filed Worker's Compensation Board Attending Doctor's Reports for these visits (Exh. 11, pp 5, 6, 8-14).

68. Respondent's care and treatment of the patient's musculo-skeletal complaints were below acceptable standards. He made no physical findings to determine the patient's physical condition was but merely described the patient's symptoms; he conducted no appropriate tests; he failed to order an X ray of the back; he failed to refer the patient to an orthopedist or a neurosurgeon; he failed to make a definitive diagnosis and inappropriately prescribed Naprosyn, Soma and Plegine (T. 55, 56, 59-71, 61-64).

#### CONCLUSIONS OF LAW

Respondent is charged with seventeen 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 Henry M. Greenberg, Esq., 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:

Fraudulent Practice of Medicine is an intentional misrepresentation or concealment of a known fact. An

individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

**Negligence** is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

**Gross Negligence** is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

**Incompetence** is a lack of the skill or knowledge necessary to practice the profession.

**Gross Incompetence** is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of the profession.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that thirteen of the specifications of misconduct had been sustained. The Committee further concluded that the specifications alleging fraud and moral unfitness should be dismissed. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset, the Hearing Committee assessed the credibility of the witnesses presented by the parties. The Petitioner presented two witnesses - Lawrence N. Chessin, M.D.

and James Dore, an investigator employed by the Department's Bureau of Controlled Substances.

Dr. Chessin has had extensive clinical experience, serving as a staff physician and head of the infectious disease division at the Genesee Hospital for 28 years. He is also a clinical professor of medicine at the University of Rochester. He is a member of an active full time group practice where he practices as an internist. His practice encompasses primary care for neonatal through geriatric patients, and currently sees between 18 to 20 patients per day , four and one-half days per week. Dr. Chessin testified fairly and objectively as an expert for Petitioner, and has no stake in the outcome of this proceeding. The Hearing Committee found Dr. Chessin to be a credible witness and gave great weight to his testimony.

James Dore is a narcotics investigator for the Bureau of Controlled Substances. He oversaw the undercover investigation of Respondent which resulted in the allegations concerning Patient A (an undercover investigator posing as a patient). Mr. Dore testified as to the steps taken during the investigation and the results of various encounters between Patient A and Respondent. The encounters were relayed by radio to vehicle in which Mr. Dore tape-recorded the conversations.<sup>2</sup> The Hearing Committee found Mr. Dore to be a credible witness.

Respondent presented one witness - Robert M. Kalet,

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<sup>2</sup> The undercover investigator, Jay Hehn, is no longer employed by the Department of Health and was not available for testimony at the hearing.

D.O. Dr. Kalet is a colleague of Respondent's, practicing in Auburn, New York. Dr. Kalet provided virtually no information regarding his medical expertise nor the nature of his medical practice. His testimony was based on assumptions not supported by the records. (T. 298). It consisted primarily of stating what acceptable standards would require and stating that Respondent must have followed these standards, without citing any factual basis to support his opinions.

Dr. Kalet's "expert" analysis does not withstand an unbiased evaluation. He displayed a worrisome lack of pharmacological knowledge. He claimed familiarity with Fastin (an anorectic and CNS stimulant), yet did not know whether it was a stimulant or a depressant. Disturbingly, he considered this to be a "moot point". (T. 259-260, 277; Exh. 24).

Dr. Kalet's testimony that Patient A's medical record, devoid of any history at all, was consistent with a history of back pain was astonishing. (T. 313, 320). His suggestion that Respondent's treatment of Patient C's hypertension met acceptable standards, despite the clear absence of any follow-up on the patient's blood pressure, was incredible (T. 291). Despite evidence of Patient E's hospitalization for drug dependence, Dr. Kalet testified that Respondent's care of the patient met acceptable standards. He expressed this opinion even though the drugs which Respondent prescribed subjected the patient to serious risks with little discernable benefit.

Most disturbing of all was Respondent's blatant attempt to testify through Dr. Kalet without being subject to cross-

examination. The Hearing Committee unanimously concluded that Dr. Kalet's testimony should be rejected, except where his opinions were directly supported by the objective evidence.

The Hearing Committee was troubled by Respondent's failure to testify on his own behalf. As a result, the Hearing Committee was unable to fully ascertain the extent of Respondent's medical knowledge and the reasoning behind his treatment of the patients in question. The Committee inferred that his testimony, if truthfully given, would have proved to be unfavorable to his defense. Terra v. DOH, 604 NYS 2d 644, 199 AD 2d 577 (Third Dept., 1993).

#### **Patient A**

The Hearing Committee concluded that all factual allegations regarding Patient A were sustained. Respondent prescribed two controlled substances to Patient A (an undercover BCS investigator) at the patient's request. Plegine, a CNS stimulant used as a short term adjunct to a weight loss regimen, was given to this patient on four visits over a period of eight months. This patient was within normal height and weight range. He did not need to lose weight. The medication was given at the patient's request for use as a stimulant. This is not its stated purpose and is an inappropriate use for this drug. Giving this medication to help a truck driver stay awake is both inappropriate and dangerous since it could impair his ability to drive (T. 122,123).

Tylenol with Codeine No. 3 is a highly addictive drug. It was also given without medical indication. Codeine would also

impair the ability to operate a motor vehicle since it is a central nervous system depressant.

Respondent should have been suspicious of this patient since he was exhibiting drug seeking behavior. This was immediately apparent and recognized by Dr. Chessin (T. 125, 126, 129). Instead of recognizing this behavior and responding to it appropriately by investigating the causes of the patient's complaint, referring the patient to appropriate counseling, and declining to prescribe medications, Respondent prescribed highly addictive medications in excessive quantities (Exh. 4). The fact that this patient was an undercover investigator conducting a covert investigation and presenting himself as an obvious drug abuser hardly puts Respondent in a more favorable light.

Even if Respondent's claim, asserted second hand through his medical expert, Dr. Kalet, that the patient complained of back pain were taken at face value, no evidence whatsoever of this appears in the medical record. If such a complaint were made, a reasonably prudent and competent physician would want to investigate this complaint and document his findings in the record (T. 112). No such record was ever made.

The Hearing Committee concluded that Respondent's treatment of Patient A demonstrated gross negligence (First Specification), gross incompetence (Sixth Specification), as well as negligence (Eleventh Specification) and incompetence (Twelfth Specification), as defined above. The members of the Committee were concerned at the ease with which the undercover investigator was able to obtain controlled substances, without demonstrated

medical justification. However, the Committee concluded that this was more likely due to fundamental deficits in Respondent's basic knowledge of pharmacology, rather than an intent to sell prescriptions. Accordingly, the Hearing Committee dismissed the charges of fraud (Thirteenth and Fourteenth Specifications) and moral unfitness (Fifteenth and Sixteenth Specifications).

**Patient B**

The Hearing Committee voted to sustain all of the factual allegations raised concerning Patient B. This was a 34 year old white male patient that Respondent treated for obesity. Respondent began treating this patient with anorectics, beginning with Fastin on his first visit on September 7, 1988. He prescribed Plegine repeatedly during the period November 14, 1988 until September 13, 1993. The patient lost a total of 10 pounds over this period.

The anorectic medication was begun without a medical history or physical examination other than the patient's age, height, weight and drinking habits. No history or physical was done until seven visits and 19 months following the initial visit. Blood pressure was taken five times during a five year period comprising 21 visits. No caloric recommendation were given until 19 months and seven visits after the initiation of treatment. Laboratory tests were ordered on October 1, 1992, but no record exists of the results nor was an explanation offered as to what happened to them or whether they were ever performed.

The patient was seen on several visits for an orthopedic problem involving the left leg which was never clearly

defined. No record exists as to whether an orthopedic surgeon was treating this injury. Pain medication consisting of an addictive narcotic, Tylenol with Codeine No. 3, was given over a two year period, but it is unclear what condition was being treated nor did there appear to be any concern about creating a drug dependence in this patient. No attempt was made to identify or treat the underlying pathology.

The Hearing Committee concluded that Respondent's treatment of Patient B demonstrated gross negligence (Second Specification), incompetence (Eleventh Specification), gross incompetence (Seventh Specification), and incompetence (Twelfth Specification).

#### **Patient C**

The Hearing Committee voted to sustain all factual allegations raised concerning Patient C. This was a 35 year old white male patient, 5'9" at 226 pounds, who first presented himself to Respondent on April 21, 1989. This was an overweight individual. Respondent began prescribing Isuprel inhaler and Plegine, but failed to do an initial history or physical examination. He did not obtain a history and physical until some February 5, 1990 - ten months and four visits later. No reasons are noted in the record for prescribing Isuprel until February 5, 1990 when Respondent noted that the patient had asthma. Two different blood pressures were noted on the February 5, 1990 office visit. This is the first time blood pressures were noted in the record. On January 8, 1991 the patient's blood pressure was 160/90, showing the patient is hypertensive. Visken, an

anti-hypertensive medication was given. Visken is contraindicated for patients with asthma because it is a selective beta blocker and constricts the bronchial tubes (T. 190).

Both the Plegine and Isuprel are stimulants and could have caused or contributed to the patient's hypertension. They were both given to him over a four and a half year period. Respondent never considered the possibility that the hypertension might be caused by his drug therapy. Incredibly, no further blood pressures were ever taken again to follow the patient's hypertension.

Patient C suffered from multiple medical problems which were interrelated. Respondent's medical management of the patient was seriously deficient, and most probably contributed to his hypertension. The Hearing Committee concluded that Respondent's medical care and treatment of Patient C demonstrated gross negligence (Third Specification), negligence (Eleventh Specification), gross incompetence (Eighth Specification), and incompetence (Twelfth Specification).

#### Patient D

The Hearing Committee voted to sustain all factual allegations regarding Patient D. Patient D was a 29 year old white male, 5'10" and 181 pounds, who first presented to Respondent on September 13, 1988. Plegine was prescribed, although the patient was not overweight and had no medical need to lose weight. No history or physical examination was documented at the initial visit. A physical examination was not documented

until February 13, 1990 (seven visits and 17 months later). No medical history was ever recorded.

During the period September 1988 to May 1993, Respondent prescribed either Plegine or Fastin, another anorexiant, to Patient D on 18 occasions. During this period, the patient gained two pounds. On one occasion, March 23, 1990, Haldol, an antipsychotic medication was prescribed without any documented indication. Subsequently, on four occasions, from May 3, 1991 through March 20, 1992, Butisol, a barbiturate sedative, was prescribed without any indication, at the patient's request. No consideration was given to the effects of the Plegine, which is contraindicated in agitated or nervous patients, and yet continued at the same time as the Butisol. A DWAI conviction resulting in the loss of the patient's drivers license is documented in undated correspondence, but which appears to fall in the period around November 1990. No inquiries regarding the patient's alcohol consumption pattern were documented, despite the addictive potential of both Plegine and Butisol, and their additive effects with alcohol.

The Hearing Committee was very troubled by Respondent's medical care and treatment of Patient D. It appears as though the patient was controlling the drug therapy, rather than Respondent. Respondent either did not recognize or ignored clear warning signs of complications caused by the prolonged use of anorexants such as Plegine and Fastin. There is no indication that Respondent considered the possibility that overuse of anorexants might have been responsible for the agitation for

which he prescribed Haldol (an antipsychotic medication) and Butisol (a barbiturate).

Further, Respondent failed to take any appropriate steps upon being informed that Patient D had been convicted of DWAI. While this conviction was not in and of itself conclusive proof of addiction, it was incumbent upon Respondent to explore the possibility. Given the additive effects of alcohol, Plegine and Butisol, Respondent should have considered whether the controlled substances may have contributed to Patient D's driving while impaired.

The Hearing Committee unanimously concluded that Respondent's medical care and treatment of Patient D constituted gross negligence (Fourth Specification), negligence (Eleventh Specification), gross incompetence (Ninth Specification) and incompetence (Twelfth Specification).

#### **Patient E**

The Hearing Committee voted to sustain all factual allegations regarding Patient E. Patient E was a 48 year old white male seen by Respondent from March 20, 1990 through February 23, 1993. He presented at 5'8" and 248 pounds which was clinically overweight. He was given Plegine on eight occasions over this period of time resulting in a weight loss of seven pounds. The patient presented with a back injury on October 20, 1991 and was given Naprosyn and Soma. Naprosyn was contraindicated given the patient's aspirin allergy.

Patient E was hospitalized on a voluntary basis at Tompkins Community Hospital (Tompkins) on October 23-24, 1991,

for acute alcohol intoxication and suicidal ideation. He was diagnosed as being alcohol dependent with post-traumatic stress disorder and a major depressive illness. Although a copy of the patient's records from Tompkins were appended to Respondent's office record for the patient, there is absolutely no indication that he ever read them. Respondent continued to prescribe Soma and Plegine without any regard for the patient's background as an alcoholic with a depressive disorder. No consideration of the additive effects of these drugs on the patient was documented nor was any concern shown regarding the patient's misrepresentations regarding his history of alcohol abuse. Respondent failed to follow up to determine whether the patient entered a rehabilitation program.

Respondent subsequently treated the patient on six occasions, from October 28, 1991 through February 23, 1993. Worker's Compensation forms were completed for each of these visits. There were no significant physical findings relating to the patient's musculoskeletal complaints.

Again, Respondent inappropriately treated this patient with addictive drugs, without proper indication or monitoring. He ignored evidence of complications and failed to follow-up on evidence of serious substance abuse and mental illness. He failed to appropriately diagnose the patient's musculoskeletal complaints. The Hearing Committee unanimously concluded that Respondent's medical care and treatment of Patient E demonstrated gross negligence (Fifth Specification), negligence (Eleventh

Specification), gross incompetence (Tenth Specification), and incompetence (Twelfth Specification).

**Article 33 Violations**

Respondent entered into a Stipulation and Order violations of Article 33 of the Public Health Law for writing prescriptions for Plegine and Tylenol with Codeine No. 3 to patient A, an undercover BCS investigator. As noted previously, the Plegine was written not as an anorectic but to keep the patient awake and was prescribed at the patient's request. Similarly, there was no medical need for the Tylenol with Codeine. It too was prescribed at the patient's request. The prescription for Plegine issued on August 14, 1992 permitted four refills; The prescription issued on September 15, 1992 permitted three refills. On November 30, 1992, another prescription was written with four more refills, and the prescription for February 5, 1993 was issued with three refills). The Public Health Law (PHL §3335(3)) and the Department of Health regulations (10 NYCRR §80.69(a)) allow only a thirty (30) day supply to be prescribed.

Respondent is guilty of professional misconduct in violation of Educ. Law §6530(9)(e) by virtue of having been found by the Commissioner of Health to be in violation of Article 33 of the Public Health Law. Accordingly, the Hearing Committee voted to sustain the Seventeenth Specification 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 as a physician in New York State 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 established that all aspects of Respondent's medical practice are grossly substandard. His initial medical histories and physical examinations were virtually non-existent. He failed to address his patients' underlying pathologies. He prescribed drugs for excessive periods of time or in excessive quantities. He prescribed addictive drugs without medical need, merely because patients requested them. Respondent prescribed drugs contraindicated by the patients' condition and failed to recognize complications induced by his drug therapies. In addition, Respondent failed to coordinate with other health care professionals treating his patients.

Respondent's treatment of each of the named patients, considered alone, would be sufficient to warrant revocation of his medical license. The violations of Article 33 warrant a significant sanction. When considered together, they present a compelling argument for revocation.

Respondent failed to testify at the hearing. Consequently, there is no evidence to indicate that Respondent is a suitable candidate for re-training. The Hearing Committee was also troubled by Respondent's frequent outbursts during the hearing, raising concerns about his emotional stability. Under the totality of the circumstances, the Hearing Committee unanimously determined 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 and Seventeenth Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;
2. The Thirteenth through Sixteenth Specifications of professional misconduct are **DISMISSED**;
3. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order;

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**  
Nov. 9, 1998

  
**STEVEN V. GRABIEC, M.D. (CHAIR)**

THERESE G. LYNCH, M.D.  
NANCY J. MORRISON

TO: Bradley C. Mohr, Esq.  
Senior Attorney  
New York State Department of Health  
Corning Tower - Room 2509  
Empire State Plaza  
Albany, New York 12237

Raul Aude, M.D.  
33 William Street - Suite 5  
Auburn, New York 13021

Michael J. Vavonese, Esq.  
Rossi & Vavonese  
108 West Jefferson Street - Suite 500  
Syracuse, New York 13202

**APPENDIX I**

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



-----X  
IN THE MATTER : NOTICE  
OF : OF  
RAUL AUDE, M.D. : HEARING  
-----X

TO: RAUL AUDE, M.D.  
33 WILLIAM STREET  
SUITE 5  
AUBURN, N.Y. 13021

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
DEPT. ✓ RESPT. EXHIBIT 1  
ID ✓ EVD  
DATE.....INITIALS.....

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 28 day of MAY, 1998, at 10:00 in the forenoon of that day at the Alliance Building, 183 East Main Street, Rochester, 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  
April 2, 1998

  
PETER D. VAN BUREN  
Deputy Counsel

Inquiries should be directed to:

BRADLEY MOHR  
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) 473-4282

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

-----X

IN THE MATTER : STATEMENT  
OF : OF  
RAUL AUDE, M.D. : CHARGES

-----X

RAUL AUDE, M.D., the Respondent, was authorized to practice medicine in New York State on March 7, 1975 by the issuance of license number 123010 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

A. Respondent treated Patient A (patients are identified in the attached appendix) from on or about August 14, 1992, to on or about April 20, 1993, at his office, at 33 William Street, Suite 5, Auburn N.Y. 13021. Respondent's care and treatment of Patient A failed to meet acceptable standards of care, in that:

1. Respondent prescribed Plegine without adequate medical justification.
2. Respondent prescribed Plegine outside the course of medical treatment and for non-medical purposes.
3. Respondent prescribed Plegine for an inappropriately long period of time.
4. Respondent prescribed Tylenol with Codeine No.3, without adequate medical justification.

5. Respondent prescribed Tylenol with Codeine No.3, outside the course of medical treatment and for non-medical purposes.

B. Respondent treated Patient B from on or about September 7, 1988, to on or about September 13, 1993, at his office. Respondent's care and treatment of Patient B failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.
2. Respondent failed to perform and/or document an adequate initial physical examination.
3. Respondent prescribed Plegine for an inappropriately long period of time.
4. Respondent prescribed Tylenol with Codeine No.3, for an inappropriately long period of time.
5. Respondent prescribed Tylenol with Codeine No.3, without adequate medical justification.

C. Respondent treated Patient C from on or about April 21, 1989, to on or about June 29, 1993, at his office. Respondent's care and treatment of Patient C failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.
2. Respondent failed to perform and/or document an

adequate initial physical examination.

3. Respondent prescribed Plegine for an inappropriately long period of time.
4. Respondent failed to adequately monitor Patient C during the course of Plegine therapy.
6. Respondent failed to adequately evaluate, monitor and treat Patient C's hypertension.
7. Respondent prescribed Isuprel without adequate medical justification.
8. Respondent prescribed Plegine and Isuprel to the patient despite known hypertension.

D. Respondent treated Patient D from on or about September 13, 1988, to on or about May 10, 1993, at his office. Respondent's care and treatment of Patient D failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.
2. Respondent failed to perform and/or document an adequate initial physical examination.
3. Respondent prescribed Plegine and/or Fastin without adequate medical justification.
4. Respondent prescribed Plegine and Fastin for an inappropriately long period of time.
5. Respondent failed to adequately monitor Patient D during the course of Plegine and/or Fastin therapy.

6. Respondent prescribed Haldol without adequate medical justification.
7. Respondent prescribed Butisol without adequate medical justification.
8. Respondent inappropriately continued to prescribe Plegine and Butisol after the patient had been identified as having a history of alcohol abuse.

E. Respondent treated Patient E from on or about March 20, 1990, to on or about February 23, 1993, at his office. Respondent's care and treatment of Patient E failed to meet acceptable standards of care, in that:

- 1.. Respondent prescribed Plegine for an inappropriately long period of time.
2. Respondent failed to adequately monitor Patient E during the course of Plegine therapy.
3. Respondent inappropriately continued to prescribe Plegine after the patient had been diagnosed with major depressive disorder and chronic alcoholism.
4. Respondent failed to adequately monitor, evaluate, and/or treat the patient's musculoskeletal complaints.

F. On or about March 23, 1994, Respondent entered into Stipulation and Order CS-94-3, effective March 23, 1994, in which Respondent admitted and the Commissioner found violations of

Public Health Law Sections 3304 (1), 3335 (3) and 10 NYCRR 80.69(a). Respondent was assessed a civil penalty of \$10,000, of which \$5000 was suspended provided Respondent had no further violations of PHL Article 33 and 10 NYCRR Part 80 for one year.

### SPECIFICATIONS

#### FIRST THROUGH FIFTH SPECIFICATIONS

#### GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Law 6530(4) (McKinney Supp. 1998) 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.
2. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.
3. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, and/or C and C.8.
4. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7 and/or D and D.8.

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

**SIXTH THROUGH TENTH SPECIFICATIONS**

**GROSS INCOMPETENCE**

Respondent is charged with gross incompetence in violation of New York Education Law 6530 (6) (McKinney Supp. 1998) in that, Petitioner charges:

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

**ELEVENTH SPECIFICATION**

**NEGLIGENCE ON MORE THAN ONE OCCASION**

Respondent is charged with negligence on more than one occasion in violation of New York Education Law §6530(3) (McKinney Supp. 1998) in that, Petitioner charges two or more of the following:

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

**TWELFTH SPECIFICATION**

**INCOMPETENCE ON MORE THAN ONE OCCASION**

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5) (McKinney Supp. 1997) in that, Petitioner charges two or more of the following:

12. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5; B and B.1, B and B.2, B and B.3, B and B.4, B and B.5; C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and

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

**THIRTEENTH THROUGH FOURTEENTH SPECIFICATIONS**

**FRAUD**

Respondent is charged with practicing the profession fraudulently in violation of New York Education Law §6530(2) (McKinney Supp. 1998) in that, Petitioner charges:

13. The facts in Paragraphs A and A.2.
14. The facts in Paragraphs A and A.5.

**FIFTEENTH AND SIXTEENTH SPECIFICATIONS**

**MORAL UNFITNESS**

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20) (McKinney Supp. 1998) in that, Petitioner charges:

15. The facts in Paragraphs A and A.2.
16. The facts in Paragraphs A and A.5.

**SEVENTEENTH SPECIFICATION**

**VIOLATION OF ARTICLE 33**

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530(9)(e) by reason of having been found by the Commissioner of Health to be in violation of Article 33 of the Public Health Law, in that Petitioner charges:

17. The facts in Paragraph F.

DATED: April 2, 1998  
Albany, New York

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