



STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Dennis P. Whalen
Executive Deputy Commissioner

May 24, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lillian Gross, M.D.
55 Bluebird Drive
Great Neck, NY 11023

Lani Klamitz, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, NY 10001

T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy & Schoppmann, P.C.
420 Lakeville Road
Lake Success, NY 11042

RE: In the Matter of Lillian Gross, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-104) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

COPY

DECISION

AND

ORDER

Order #99-104

**IN THE MATTER
OF
LILLIAN GROSS, M.D.**

DETERMINATION AND ORDER OF THE HEARING COMMITTEE

The undersigned Hearing Committee consisting of **RICHARD MILONE, M.D.**, chairperson, **NORTON SPRITZ, M.D.** and **LUIS OSORIO**, were duly designated and appointed by the state Board for Professional Medical Conduct. **MARY NOE** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Section 230 (10) of the New York Public Health Law and sections 301-307 of the New York State Administrative Procedure Act of receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **LILLIAN GROSS M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charge of medical misconduct.

SUMMARY OF PROCEEDINGS

Pre-Hearing Conferences: December 11, 1998

Hearing Dates: December 17, 1998
December 30, 1998
January 14, 1999
February 3, 1999
February 12, 1999
March 3, 1999
March 10, 1999

Date of Deliberation: April 8, 1999

Petitioner appeared by: Kern Augustine Conroy & Schoppman
By: T. Lawrence Tabak, Esq.
Wendy A. Stimpfel, Esq.
420 Lakeville Road
Lake Success, New York 11042

WITNESSES

For the Petitioner Sigurd Ackerman, M.D.

For the Respondent: [REDACTED] (Patient E)
Sanford Herman, M.D.
Lillian Gross, M.D.

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with acceptable standards of medical practice in this State. Gross negligence was defined as single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious means a conspicuously bad act or severe deviation from standards.

Gross incompetence was defined as a complete lack of ability necessary to perform an act in connection with the practice of the profession. Gross incompetence involves a total and flagrant lack of necessary knowledge or ability to practice. Incompetence was defined as the lack of the requisite skill or knowledge to practice medicine, the ability to discharge the physician's required duty to the physician's patients because of a want of skill or knowledge.

With regard to the expert testimony herein, including Respondent's the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

Inaccurate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

PATIENT A

1. Respondent treated Patient A from on or about May 9, 1994 through of about June 29, 1996. (Pet. Exh. 4) The Statement of Charges refers to the period of treatment through on or about May 31, 1996. (Pet. Exh. 1, 4)
2. At the time of Patient's A's first appointment, Dr. Gross was made aware of various salient features of the patient's past history including history of drug overdose, therapy for eleven years and history relating to "multiple personality disorder." The patient also indicated that she had been consuming two quarts of alcohol per day. (Pet. Exh. 4 p. 193-194; T. 29-30)
3. The medical record maintained by Dr. Gross for Patient A contains a letter dated June 24, 1994 and records, including hospital records, forwarded by the patient's prior treating psychiatrist, W. Glenn Jamison, M.D. Dr. Jamison treated Patient A for almost eleven years and reported to Dr. Gross aspects of Patient A's psychiatric history including: alcohol and prescription medication abuse, suicide attempts, self-injury, reports of alters, multiple drug overdoses and resultant hospitalizations, and detoxification. (Pet. Exh. 4 p. 166) Hospital records reflect, among other diagnoses, benzodiazepine dependance, chloral hydrate dependance, alcohol abuse, major depression and Fiorinal abuse. On May 27, 1994 Patient A herself report to that in the previous year she had three overdoses. (Pet. Exh. 4 pp. 108, 115, 117 and 199)
4. At the time of her first consultation with Dr. Gross, Patient A reported that she was presently using the medication Zoloft and Trilafon. There is no indication in the medical record as whether the respondent continued or discontinued their use. Dr. Gross prescribed Librium, 10 mg. 120 tablets, four times per day at the time of the first visit and scheduled the next visit for one week later. (Pet. Exh. 4 193-194)

5. Librium may be utilized as part of a detoxification treatment plan for a patient who is abusing alcohol. (T. 39-40)
6. Dr. Gross failed to adequately ascertain the parameters of Patient A's use of alcohol and did not formulate a plan for detoxification from alcohol with appropriate instruction. (T. 38-42)
7. The Respondent testified she prescribed Librium for Patient's A alcohol problem (T. 719) and then testified she prescribed Librium to substitute for alcohol (T. 785) and the medical records for December 1994 reflect Librium prescribed for severe anxiety (Exh. 4 p. 206)
8. The Respondent issued a prescription for an increased dosage of Librium to 10 mg., 120 tablets, 2 Q.I.D. on Patient A's next visit, May 16, 1994, and continued to prescribe Librium through February 20, 1995, by which time the Respondent was writing prescription for 25 mg., 224 tablets, 2 Q.I.D. Dr. Gross did not provide or document the rationale for the long term use of Librium of this patient. Respondent discontinued the Librium as of February 21, 1995, after Patient A reported that it depressed her. Valium was prescribed in place of the Librium (Pet. 4 p. 86, 94, 210)
9. Dr. Gross continued to prescribe Valium to Patient A from February 2, 1995 through May 24, 1996, approximately one week before the patient's hospitalization at Kings Park Psychiatric Center. The initial prescription for the Valium was to 10 mg., 120 tablets, Q.I.D. The dosage was ultimately increased to 10 mg., 2 Q.I.D. or 80 mg. per day. (Pet. Exh. 4 p. 210, 222; Pet. Exh. 4 A p. 3)
10. Eighty (80) mg. of Valium per day constitutes a high dose of medication. Dr. Gross, through her prescribing practices gave access of large quantities of medication, which suggests the patient is consuming that amount. (T. 91)

11. On March 3, 1996 a prescription was issued for what should have constituted a thirty day supply of medication; however nineteen days later, on March 22, 1996, a prescription for 320 tablets of Valium was given to Patient A, a forty day supply at 2 Q.I.D. This prescription was followed by others, each for a forty day supply on April 5, 1996 and May 24, 1996. (T. 89, 91; Pet. Exh. 4 p. 220-222)
12. Respondent failed to limit Patient A's access to large numbers of Valium tablets even when she knew that the patient was abusing the Valium. (T. 221; Pet. Exh. 4 p. 173, 219, 221)
13. A reasonably prudent psychiatrist would not have prescribed Valium in this manner to Patient A given her history of substance abuse, the other potentially addictive substances she was using and the clear indication of Valium abuse. (T. 212; Pet. Exh. 4 p. 221-222)
14. The Respondent inappropriately prescribed Valium in combination with another benzodiazepine, Restoril. This manner of prescribing was inappropriate given Patient A's history of prescription medication abuse and alcohol abuse. (T.194; Pet. Exh. 4 p. 210-222)
15. The Respondent inappropriately prescribed Fioricet, which contains a barbiturate, to Patient A for the treatment of headaches, the nature of which was unspecified in the medical record. These prescriptions were inappropriate given this patient's substance abuse history. (T68-69, 197, 222; Pet. Exh. 4 p. 203, 210)
16. The respondent inappropriately prescribed Lomotil, which has a narcotic base, to Patient A for the long-term treatment of diarrhea. Lomotil, when used for longer periods of time, is almost exclusively used by gastroenterologists under controlled circumstances for the treatment of specific disorders. In this case, there was no indication as to a specific disorder being treated, other than diarrhea. A responsible

prudent psychiatrist would not have prescribed this narcotic to Patient A in this manner. (T. 72, 99-100, 222-223; Pet. Exh. 4 p. 200, 209, 211, 215, 218-220)

17. Respondent prescribed Ritalin inappropriately to Patient a without Justification. There is no diagnosis written in the Record. (T. 223-224; Pet. Exh. 4 p. 209)
18. On Jun 30, 1995 Patient A was in a car accident in which she drove into a telephone pole and "totaled" her vehicle. At the time of the accident Patient A was receiving prescriptions for Valium and Restoril from Respondent, among other medications. No substantial assessment, reevaluation or change in medication strategy occurred following this accident, other than the addition to the patient's regiment of Tylenol with codeine for unspecified reasons, without indication of physical examination, without coordination of medication with other physicians and without the extreme care in monitoring the patient that was required in this case. (Pet. Exh. 4 p. 212-217, T. 1244)
19. On November 3, 1995, less than five months later, Patient A was in a second accident in which her care was "Totaled." (Pet. Exh 4 p. 216)
20. Respondent failed to act as a reasonably prudent psychiatrist following these accident in that she failed to consider that Patient A was in an intoxicated state when the accidents occurred, failed to do a through mental status examination following the accidents, filed to corroborate the patient's use of medications and behavior at home and continued to prescribed multiple medications which might cause the patient to be in intoxicated state. (T. 93-96, 1284-1285; Pet. Exh. 4 p. 212-223)
21. On June 1, 1996 Patient A was admitted to Kings Park Psychiatric Center. The patient at the time of admission was taking the following prescription medication: Valium (80-120 mg./day); Tylenol with Codeine (3-4 tablets/day), Restoril (90 mg./day), Prozac, Soma and Lomotil. Patient A's diagnoses on discharge was

Substance-Induced Mood Disorder and Polysubstance Abuse. It was noted that the patient had been abusing prescription drugs and that Dr. Gross reported that the patient took medication according to the patient's wishes. The patient was discharged without any psychiatric medication. (Pet. Exh. 4 p. 3-7)

22. The Respondent was the source of the prescription medications the patient was using/abusing as the time of Patient as admission to Kings Park Psychiatric Center. (T. 108-109; Pet. Exh. 4 and 4A)
23. The Respondent failed to adequately evaluated Patient A as evidenced by the lack of a mental status examination in the record, the lack of information on which to base a diagnosis and the manner in which Respondent's treatment of Patient A proceeded. (T. 165-176, 186-187, 212-213)
24. The Respondent failed to formulate and pursue an adequate treatment plan for Patient A because the treatment did not properly address the major diagnoses which Dr. Gross was treating, no reasons are given to prescribing medication and no target symptoms or benchmarks for measuring the efficacy of medications are noted. Dr. Gross could not have formulated an adequate treatment plan because, as she testified from her other physicians. Furthermore, nowhere in the record is a treatment plan recorded. (T. 176, 184, 217-218, 813, 1293-1994; Pet. Exh 4)
25. Respondent failed to maintain an adequate medical record for Patient A in that the record does not contain necessary information pertaining to the evaluation and treatment of Patient A. (T. 1271)
26. The respondent inappropriately prescribed the aforementioned medications in that there was almost no chance that the medications, in the quantities and for the

durations reflected in the medical record, would have helped Patient in light of her history of drug abuse, and suicide attempts. (Pet. Exh. 4, T 230-231)

PATIENT B

27. Respondent treated Patient B from November 4, 1983 through November 24, 1998. The charges are for the Respondent's treatment of Patient B through March 23, 1998. (Pet. Exh 1; Pet. 5)
28. At the time of her initial visit, Patient B provided Dr. Gross with a prior psychiatric history of at least two suicide attempts by overdose resulting in hospitalizations, long-term psychotherapy and agoraphobia. The patient reported that she had been using alcohol for the past six months to get away from her nervousness and her family and that on October 31, 1998 (four days before the consultation) she had been arrested for driving while intoxicated after having been in a car accident. Patient B reported that she had been feeling suicidal prior to the accident. (Pet. Exh. 5 p. 18-21)
29. Patient B's chief complaint as noted by Dr. Gross was "Feeling of great anxiety and concern re: shaking under pressure." It is unclear from the record as to whether these feelings began one year earlier or were being experienced currently. The notes for that first visit do not contain a history of the patient's present illness, an evaluation of the patient's suicide risk or potential, depression, alcoholism or an anxiety disorder. (T. 249-250; Pet. Exh. 5 p. 18-21)
30. The Respondent inappropriately prescribed Xanax (2 mg./day, 60 tablets) at the time of Patient B's initial consultation. It was inappropriate for Respondent to prescribe Xanax without an evaluation which would support the need for medication as a treatment. The patient was an alcoholic who had four days previously had an accident while intoxicated. Xanax is potentiated by alcohol. The patient reported

feeling suicidal and access to large quantities of Xanax at one time could harmful.
(Pet. Exh. 5 p. 18-21; T. 250-253, 301, 1332-1332)

31. There is no indication that Respondent alerted Patient B to the possible toxic affects of Xanax and to the dangers of using alcohol while on this medication (Pet. Exh. 5 p. 18-21)
32. Respondent did not act as a responsibly prudent psychiatrist when she continued to prescribe Xanax to Patient B after the initial visit and provided Patient B with amounts of Xanax which were in excess of the dose Dr. Gross was instructing her consume. From November 11, 1983 through January 6, 1984, Respondent provided Patient B with 390 1 mg. T.I.D. tablets of Xanax. This represented an almost 100 day supply given within a 57 day period. Dr. Gross gave this patient access large amounts of drugs despite a history of drug abuse. (T. 253-255; Pet. Exh. 5 p. 22-23)
33. Respondent indicated that she was "considering reducing "Xanax" in note of March 6, 1984. Yet after reducing the dosage to 5 mg. 1 Q.I.D. on May 15, 1984, Respondent without explanation, on May 29, 1984, wrote a prescription for Xanax 1 mg. #100, 1 Q.I.D. (renew one time) and continued to prescribe amounts of Xanax to Patient B in excess of what she advised the patient to take. This prescription gave the patient an opportunity to consume more medication the Dr. Gross was instructing her to take. (Pet. Exh. 5 p. 24, 27, 35; T. 258)
34. Respondent prescribed these large amounts of Xanax to Patient B, even though her notes reflect that the patient was least periodically using alcohol. (Pet. Exh. 5 p. 29, 34, 39)
35. On November 12, 1987, Patient B consumed an entire bottle of her husband's Dalmane, a Benzodiazepine, resulting in her hospitalization Dr. Gross characterized this act as the patient's fourth suicide attempt. Respondent saw Patient B the next day

but did not note an evaluation of the patient's suicide risk or a mental status examination. (Pet. Exh. 5 p. 40, 41; T. 261-262)

36. Respondent did not act as reasonably prudent psychiatrist when she continued prescribing Xanax to Patient B after the suicide attempt in amounts large enough to pose a danger to the patient, sometimes even giving the patient renewable prescriptions, and despite indications that Patient B was drinking at least occasionally. (T. 262-263, 266-277; Pet. Exh. 5 40-44)
37. On October 24, 1989, Patient B was hospitalized at South Oaks Hospital. The patient reported that she had been using alcohol on and off for the past year and had recently been consuming about one pint of vodka every two days. The patient also reported that she was taking Xanax 8 mg./day, twice the dosage Dr. Gross had instructed her to consume. Patient B remained at South Oaks Hospital until November 29, 1989 during which time she was detoxed down to Xanax 3 mg. day. Patient B's diagnoses on discharge were: alcohol dependence, benzodiazepine dependence and major affective disorder depressive. (Pet. Exh. 5 p. 54, 107-18; T.271)
38. Although the Respondent knew of Patient B's hospitalization and was sent copy of the patient's clinical summary by South Oaks on or about December 28, 1989, her medical record does not reflect any evaluation of the implications of the hospitalization on future treatment. (Pet. Exh 5 p. 4, 57, 106-108)
39. Respondent maintained Patient B on Xanax through April 11, 1990, when she began prescribing Klonopin, another benzodiazepines, in addition to the Xanax. Respondent continued to prescribe both benzodiazepines to the patient through the course of treatment. (Pet. Exh. 5 p. 54-93; T 274-275)
40. On each the following dates Dr. Gross issued prescription for 540 tablets of Klonopin to Patient B; April 19, 1993, September 14, 1993, November 23, 1993, February 23,

1994 and June 20, 1994. On September 14, 1993 when patient B reported that she had lost a prescription, another was given to her. Each of the aforementioned prescription represents a potentially lethal dose of Klonopin given to patient who had a history of suicide attempts via overdose and alcohol abuse. (Pet. Exh. 5 p. 64-65; T. 279-283)

41. The Respondent failed to adequately evaluate Patient B as evidenced by the lack of any diagnostic evaluations in the medical record she maintained, the lack of a diagnosis or diagnosis in the medical record, and the course of treatment which was pursued, especially following the patient's suicide attempt and hospitalization. (Pet. Exh. 5; T. 316, 1327, 1349-1350)
42. The Respondent failed to formulate and pursue an adequate treatment plan for Patient B as evidenced by the lack of a written treatment plan in the medical record, the absence of evaluations of the efficacy of treatment, and the manner in which medication was prescribed for the patient. (Pet. Exh. 5; T. 259-260, 283-284, 315)
43. Respondent failed to maintain adequate medical records in that the records do not support a diagnosis, do not contain mental status evaluations and indications for the pharmacological treatment which was pursued and do not contain assessments of the patient or treatment on a periodic basis. (Pet. Exh. 5; T. 283, 1349)

PATIENT C

44. Patient C was treated by respondent from April 15, 1985 through July 22, 1985 and then from April 15, 1993 through February 2, 1996. (Pet. Exh. 6)
45. At Patient C's initial consultation of April 15, 1985 she reported to Dr. Gross that she had been experiencing a burning of the vulva for nineteen months. He sought treatment from other health care providers, had been treated with a number of medications and was fearful and couldn't sleep. Although Dr. Gross noted a family

and social history, she did not note a history of present illness. (Pet. Exh. 6 p. 40-44; T. 332-333)

46. Patient C's next appointment was for the following day. No further information concerning a history of the current illness was elicited. Dr. Gross was aware that the patient was taking medications prescribed by other (she noted "to bring all meds taking"). Dr. Gross prescribed Xanax 1 mg. #100. There is no indication as to why Dr. Gross prescribed this medication. (Pet. Exh. 5 p. 40)
47. During the three months of treatment in 1985, Dr. Gross prescribed for Patient C the following medications at various times; the benzodiazepines Tranxene, Valium and Ativan; as well as Desyrel, Stelazine, Eskalith, Norpramine, Mellaril, Chloral Hyrate and Nardil. (Pet. Exh. 6 p. 35-41)
48. Respondent prescribed these medications despite the fact that on April 23, 1985 Respondent noted that the patient "hasn't taken any medicine as prescribed" and continued to prescribe additional medications after the patient reported that she was feeling drugged on may 17, 1985, without evaluating whether the medications were causing this feeling. (Pet. Exh. 6 p. 35-41; T. 248-345, 1427)
49. Dr. Gross's prescribing practices during this first period of treatment deviated from minimally accepted medical standards in that she prescribed the above medications without conducting a diagnostic evaluation, formulating a treatment plan, and systematically evaluating the efficacy of the medications. (T. 339-347)
50. Patient C began her second period of treatment by Dr. Gross on May 18, 1994. The patient complained that her skin was hurting and that she was experiencing burning and feeling as though she was being stuck with needles. At her second appointment two days later, the patient reported that she was drinking for relief of pain. The medical records do no contain a diagnostic evaluation or formulate a treatment plan

nor note any history of present illness; however, Respondent did prescribe the narcotic Dilaudid to Patient C on the later visit. (Pet. Exh. 6 p. 33)

51. Respondent noted on June 15, 1994 that she had requested of Patient C a list of all medications she was taking. She indicated in the next note that the patient had failed to provide such a list. Respondent nevertheless prescribed the benzodiazepine Ativan, the sedative/hypnotic Placidyl and the barbiturate Seconal to Patient C. (Pet. Exh. 6 p. 32)
52. Respondent indicated on June 24, 1994 patient "is a drug addict." Respondent subsequent prescribing to Patient C, especially in light of the patient's refusal to bring in a list of medications which she was taking and her past history with Dr. Gross of not taking medication as prescribed. (Pet. Exh. 6 p 32, 40; T. 351-358, 956-957, 1433-1434)
53. Despite the above, and in the absence of a diagnostic evaluation, diagnosis, treatment plan and system for evaluating the efficacy of treatment, Respondent prescribed the following medications to Patient C during this second phase of treatment: the benzodiazepine Klonopin, Valium, Ativan; the sedative/hypnotic chloral hydrate. Seconal and Placidyl and the narcotics Demoral, Percocet, Codeine and Methadone. (Pet. Exh. 6 p. 7-32; T. 352-353)
54. Based on Patient's C prior history, there was no appropriate rationale to exposing Patient C to the risks of abuse of benzodiazepines and addiction to narcotics and the attendant risks of intoxication's. (T. 352-353)
55. The Respondent was not influenced by Gae Rodlee, M.D., a Gynecologist who advised the Respondent that she wanted the patient "off tranquilizer and pain killers" and continued to prescribed medications. (Pet. Exh. 6 p. 7-16)

56. The Respondent failed to adequately evaluate Patient C following the patient's report of feeling helpless and hopeless in December 1994, January 1995 and March 1995 and failed to consider the possibility that the patient was suffering from substance-induced depression. These failings resulted in a lack of appropriate treatment. (Pet. Exh. 6 p. 10-13; T. 366-367)
57. Although Respondent noted on July 7, 1995, the Patient C was to be detoxified at Psych Systems of Nassau and, according to Dr. Gross's testimony, the patient was not detoxified and was not during this time following medication schedules "at all", Respondent continued to prescribe Valium, Dilaudid, Percocet, and chloral hydrate to Patient C with no indication (by the testimony of Respondent's own expert Dr. Herman) that Respondent was tapering the patient's use of these medications. (Pet. Exh. 6 p. 7-8; T. 961-962, 1437-1439)
58. Respondent failed to adequately evaluate Patient C's conditions and to formulate and pursue an adequate treatment plan as evidenced by Respondent's course of treatment of Patient C as indicated above, and Respondent's failure to address the patient's symptoms of depression and signs of drug addiction. (Pet. Exh 6; T. 595-596, 599-601, 604, 611-614, 956-958, 1437-1439)
59. Respondent failed to maintain adequate medical records for Patient C in that the records do not reflect an adequate diagnostic evaluation, diagnosis, rationales for the use of medications and a treatment plan. (Pet. Exh. 6; T. 365, 1445)

PATIENT D AND PATIENT D'S WIFE

60. Patient D initially consulted Respondent on March 13, 1992 and had appointments with her through November 27, 1998. The charges before the Panel concern Respondent's actions through February 17, 1998. (Pet. Exh. 7 p. 26-41; Pet Exh. 1)
61. At the time of his first visit, Patient D reported that he was HIV positive and had been on Valium and Xanax. Respondent did not note a chief complaint, history of present illness (other than a reference to HIV), or diagnostic evaluation. Respondent prescribe Xanax 1 mg. #90, 1 Q.I.D. (Pet. Exh. 7 p. 26; T. 398)
62. On April 3, 1992, Patient D reported that 1 mg. T.I.D. of Xanax was insufficient. Another prescription for Xanax was issued by Respondent for an unspecified number of tablets and at an unspecified dosage. Respondent increased the dosage to 1 mg. Q.I.D. with a prescription for 120 tablets at the time of Patient D's third visit on May 1, 1992. (Pet. Exh. 7 p. 26)
63. Respondent continued to prescribe Xanax to Patient D throughout his more than six years of treatment. By September 21, 1992 the prescriptions were being written for 1 mg. T.I.D. by July 13, 1993, the prescriptions were for 1 mg. 2 T.I.D. and 1 H.S. (Pet. Exh. 7 p. 26-41)
64. Respondent at times during the course of treatment issued prescriptions for more Xanax than she was instructing Patient D to consume. For example, on January 5, 1995 a prescription for a thirty day supply of 210 tables was written, followed by another prescription for a thirty day supply on January 25, 1995, followed by a prescription for another thirty day supply of Xanax on February 16, 1995. (Pet. Exh. 7 p. 30-31)

65. On November 11, 1994, Patient D reported that he had fallen from a ladder at work. The record fails to state that Dr. Gross examined the patient. Dr. Gross prescribed Dilaudid to the patient. She wrote this prescription even though she believed that Patient D had been treated at Kings County Hospital for the injury. (Pet. Exh 7 p. 30; T. 1016-1020, 1053-1055)
66. Respondent continued to prescribed Dilaudid to Patient D through March 13, 1995, without ever examining the patient or obtaining treatment records from Kings County Hospital. (Pet. Exh. 7 p. 30-31; T. 1016-1023, 1053-1055)
67. In May 1996, Respondent again began prescribing narcotics to Patient D prescribing either Dilaudid or Dolophine at almost every visit thereafter. Prescriptions for narcotics were issued on May 17, 1996, July 2, 1996, August 27, 1996 (two prescriptions for Dilaudid were written on that date), October 6, 1996, November 22, 1996, December 13, 1996, January 17, 1997, February 3, 1997, February 14, 1997, March 7, 1997, April 1, 1997, April 28, 1997, May 12, 1997, July 18, 1997, August 15, 1997, September 5, 1997, September 12, 1997, October 2, 1997, December 1, 1997, December 16, 1997, December 28, 1997, January 20, 1998 and February 17, 1998. (Pet. Exh. 7 p. 33-39)
68. These prescriptions were not issued pursuant to a treatment plan. Only occasionally did Respondent note a physical complaint which accompanied the prescription (i.e. July 2, 1996; hurt back lifting mother, December 28, 1997: needed Dolophine early because in accident helping uncle with floods) and Respondent never undertook a physical examination of the patient. Furthermore, Respondent never communicated with the out patient physicians who were treating Patient D for his HIV. (Pet. Exh. 7 p. 33-39; T. 1021-1022, 1048-1054, 1062-1063)

69. Patient D reported severe pain in his liver from hepatitis on November 28, 1996. He continued to complain of liver pain (February 14, 1997) and reported that he was having a work-up for liver cancer (3/7/97) had radiation for a liver cyst (9/5/97) and that he was to have liver surgery for a cancerous liver tumor (9/30/97). Although Respondent has stated that the liver pain was also a basis for the narcotics prescriptions, she never undertook a physical examination of the patient. Furthermore, Respondent was informed via a letter dated September 1, 1997 from a Oncologist who evaluated Patient D, that a CT scan had not detected an hepatic mass and that, contrary to the claim of the patient, no liver biopsy had ever been performed on him at Nassau County Medical Center. (Pet. Exh. 7 p. 1, 7-8, 34-37; T. 991-992)
70. Respondent continued prescribing narcotics to Patient D despite a lack of verification of the liver mass or confirmation of any of his physical injuries. (Pet. Exh. 33-39, 7-8)
71. Patient D successfully obtained addition medication from Respondent by reporting that medication/prescriptions had been lost or stolen on March 14, 1993; January 5, 1995; April 1, 1996 and September 12, 1997. Patient D obtained an "early" prescription for Dolophine on December 28, 1997 because of an "accident." (Pet. Exh. 7 p. 27, 30, 33, 37, 38)
72. Respondent persisted in supplying Patient D with medication with potential for abuse and addiction throughout his course of treatment in the face of evidence contained in her own record that he was likely abusing and/or addicted to drugs.
- a. On June 16, 1995 Respondent noted that she had discussed tapering his Xanax with Patient D;

- b. On July 2, 1996 the patient reported that he had tried a friend's methadone;
- c. On October 15, 1999 the patient and/or his wife reported that he was abusing drugs and that the wife had flushed them down the toilet;
- d. On February 14, 1997 Respondent reported that she had given prescription to Patient D's brother-in-law because "I don't quite believe patient 100% truthful re: dosages;
- e. Dr. D'Alessandro report in her letter of September 1, 1997, that she had referred the patient to the Methadone Treatment Facility "because of a questionable history of drug-seeking behavior, as related by his pharmacist."

(Pet. Exh. 7 p. 31, 33, 34, 35, 7-8; T. 1013)

- 73. Patient D did not obtain treatment for his substance abuse and Dr. Gross continued to prescribe tranquilizer narcotics to him following these clear indications of a drug problem (T. 1044-1045)
- 74. Respondent's treatment of Patient d over the course of six years could not be viewed as palliative care or treatment of terminal illness. (T. 500, 502-505, 511)
- 75. Although Respondent states in her cover letter accompanying the medical record that when Patient D "is in the hospital they give him generous amounts of methadone because of his pain. I have continued his management on an outpatient basis" there is no information concerning hospitalizations in the record to substantiate this claim. (Pet. Exh. 7)
- 76. Respondent's prescribing practices did not meet minimally accepted standards of care for the reasons indicated above. (T. 405-408)

77. Respondent failed to adequately evaluate Patient D and to formulate and pursue an adequate treatment plan for him as evidenced by a lack of a diagnostic evaluation, history of past and present illness, treatment plan and evaluation of the efficacy of treatment in the medical record and as evidenced by the course of treatment itself which resulted in the patient's drug addiction. (Pet. Exh. 7; T. 398-400, 407-408, 494, 507)
78. Respondent failed to maintain an adequate medical record for Patient D as she herself has acknowledged. (T 507, 1065)
79. From February 1994 through November 27, 1998 Respondent issued prescriptions for Mrs. D, the wife of Patient D. (Pet. Exh. 7 p. 28-41)
80. Respondent indicates certain appointments at which Mrs. D was present. On many of the occasions at which prescriptions for Mrs. D were issued, her presence is not noted. (Pet. Exh 7)
81. Respondent inappropriately issued prescriptions for Xanax for Mrs. D when Respondent gave those prescriptions to Patient D outside of the presence of Mrs. D in that a reasonably prudent physician needs to evaluate the patient in order to provide prescriptions. (T. 442-443; Pet. Exh. 7)
82. Respondent failed to maintain an adequate medical record for Patient D's wife in that she did not maintain one for her.

PATIENT E

83. Patient E initially consulted Dr. gross on September 29, 1995 and remained in treatment with her through March 7, 1998. The charge before the Panel concern Respondent's treatment of Patient E through March 7, 1998. (Pet. Exh. 1-5; Pet. Exh. 8 p. 3-8)

84. At the time of her first appointment with Respondent, Patient E reported that she had been addicted to cocaine for twelve year period which had ended two years earlier. The patient also report that she had been on Eskalith (Lithium), Depakote, and Ambien. She complained that she "has difficulty focusing." Respondent prescribed Tegretol, an anti-seizure medication, also commonly used in the treatment of bipolar disorder. (Pet. Exh. 8 p. 3; T. 516)
85. At the time of Patient E's second visit, Respondent prescribed the sedative/hypnotic Ambien to her. (Pet. Exh. 8 p. 4)
86. Commencing with Patient E's third visit on October 13, 1995, Respondent began prescribing medication used in the treatment of ADHD for her; Ritalin was prescribed on the following two visits and was discontinued when Dr. Gross began prescribing Cylert on December 22, 1995. Respondent continued to prescribe Cylert on a fairly regular basis through March 7, 1998. (Pet. Exh. 8 p. 4-7; T. 520-523)
87. In December of 1996, Respondent began prescribing the benzodiazepine Ativan to Patient E. (Pet. Exh. 8 p. 5)
88. Respondent had progress notes concerning Patient E from Project Transition in her record for Patient E. These notes had been faxed to Respondent on October 6, 1995 and indicated at least a possible previous diagnosis of bipolar disorder. The medications which Patient E reported having taken in the past included those used in the treatment of bipolar disorder, as well. (Pet. Exh. 8 p. 26-27; T. 515)
89. The symptoms of bipolar disorder and ADHD can be similar, but making a clear differential diagnosis has important treatment implications. (T. 525-526)
90. Respondent failed to perform an adequate diagnostic assessment prior to prescribing medications for the treatment of ADHD to Patient E. The only indication contained

in Patient E's medical record which supports that diagnosis is the statement "has difficulty focusing" noted on the first visit. (Pet. Exh. 8; T. 520-522, 1332)

91. Respondent's failure to make a clear differential diagnosis prior to beginning treatment of Patient E for ADHD unnecessarily exposed the patient to the risk of a medication-provoked manic episode. (T. 524-526, 551)
92. Respondent inappropriately prescribed Ativan and Ambien, both drugs of potential abuse, to Patient E given her long history of prior substance abuse and the lack of an indication for their need. (T. 524-526, 528-529)
93. Respondent failed to adequately evaluate Patient E's condition and to formulate and pursue an adequate treatment plan for Patient E in that she began a course of treatment for Patient E prior to obtaining the necessary history and without conducting a diagnostic evaluation which exposed the patient to unnecessary risks. (T. 522, 524, 526, 538-539, 548, 551)
94. Respondent failed to maintain adequate medical records for patient E in that the records do not contain a diagnostic evaluation, treatment plan and assessments of the patient's response to treatment. (Pet. Exh. 8; T. 532-533, 1097-1098)

PATIENT F

95. Patient F had two periods of treatment by Respondent, separated by an almost nine-year span. She initially consulted Respondent from November 13, 1983 through June 26, 1984. Treatment resumed on February 12, 1993 and ended on April 14, 1998 with the patient's hospitalization. (Pet. Exh. 9)
96. At the time of her first visit, on November 12, 1983, Patient F related some family and social history and described her course following a diagnosis and treatment of breast cancer. The patient reported that she had experienced an anxiety attack seven

or eight years previously and felt another coming. Respondent prescribed Xanax 0.5 mg./100/2 Q.I.D. at the first visit. (Pet. Exh. 9 p. 6; T. 618)

97. On November 18, 1983 Respondent noted that she had received a call from the patient's former therapist who reported to her that Patient F "tends to abuse drugs." (Pet. Exh. 9 p. 7)
98. Respondent continued to prescribed Xanax to Patient F throughout the first period of treatment. She also prescribed Desyrel, Norpramine and Nortriptylene (Aventyl) all anti-depressants, to Patient F. (Pet. Exh. 9 p. 7-14; T. 630-632)
99. Respondent inappropriately prescribed Norpramine (Aventyl) to Patient F in that Respondent discontinued the medication after a thirteen day trail, at a relatively low dose, noting that the patient had no results. This medication requires a longer trial before its efficacy can be evaluated. (T. 636-638, 678-680, 1573-2576)
100. Respondent inappropriately prescribed Xanax to Patient F in that prescribing a drug of potential abuse to a patient who is reported to abuse drugs requires clear indications and thoughtful analysis, neither of which is indicated; the record for this first period of treatment is devoid of a diagnostic assessment and treatment plan (T. 628-629, 665-666; Pet. Exh. 9)
101. The second period of Respondent's treatment of Patient F commenced on February 12, 1993. Patient F reported that she had been diagnosed with colon cancer and had an recurrence of breast cancer. She indicated that she wanted to utilize hypnosis in order to stop smoking. (Pet. Exh. 9 p.14-15)
102. Respondent inappropriately prescribed a number of medications to Patient F during this second phase of treatment, including the benzodiazepines Halcion, Valium, Xanax, Klonopin and Damane; the barbiturate Seconal; Ritalin, the neuroleptic Mellaril, and the anti-depressants Zoloft and Wellbutrin. (Pet. Exh. 9 p. 15-31)

103. Respondent inappropriately prescribed these medications in the absence of a diagnostic evaluation, diagnosis and treatment plan. (Pet. Exh. 9 p. 14-31; T. 638-642)
104. Although Respondent had been warned of Patient F's tendency to abuse medication and absent clear indications for their use, Dr. Gross proceeded to prescribe multiple benzodiazepines to Patient F. The effects of these benzodiazepines would be additive because all benzodiazepines have similar effects. Furthermore, it would be difficult to evaluate which effect would be attributable to which medication. (T. 642-645; Pet. Exh. 9 p. 6, 14-31)
105. Respondent continued to prescribe benzodiazepines in light of evidence that Patient F was abusing them:
 - a. Patient F's friend called Respondent expressing her concern over the patient's multiple addictions;
 - b. Patient F reported that her housekeeper had thrown away her medications;
 - c. The patient exhibited signs of the toxic effects of benzodiazepines which are associated with addiction: confusion, deteriorating mental status and ability to function. (T. 645-649; Pet. Exh. 9 p. 18-29)
106. On April 1, 1997, Respondent reported that the patient wanted to "get off" Valium. Respondent had not prescribed this medication to Patient F in over two months, so it is likely that the patient had been receiving this medication elsewhere. Respondent nonetheless prescribed Valium 2 mg./120/1 Q.I.D. to the patient. No adequate plan for achieving the taper was made. Eight days later, when the patient reported that she was experiencing withdrawal symptoms, Respondent prescribed Valium 5 mg/120/1 Q.I.D. In providing this amount of Valium to Patient F, Respondent made it possible

- for the patient to take a higher dose than was being advised, to not taper her use of the Valium and to continue her dependence on the drug. (T. 650-653, 658, 673-674)
109. Respondent failed to adequately control Patient F's access to Valium, to assess her deteriorating mental status and to take appropriate action for the benefit of the patient. Respondent failed to consider the possibility that Patient F's deterioration may have been caused by the medications she was taking. (T. 657-658, 682-683)
110. On March 23, 1998, Respondent saw Patient F for the first time that year. Nevertheless, she prescribed Valium 5 mg/60/1 B.I.D. without indication. On April 14, 1998, Respondent arranged for Patient F's hospitalization noting that the patient was completely disoriented and was exhibiting bizarre behavior. (Pet. Exh. 9 p. 30-31)
111. Respondent failed to adequately evaluate Patient F's condition and to formulate and pursue an adequate treatment plan as evidenced by Respondent's course of treatment of Patient F as indicated above.
112. Respondent failed to maintain an adequate record for Patient F as evidenced by the lack of a diagnostic assessment, treatment plan or evaluation of treatment in the record. (Pet. Exh. 9; T. 658, 1556)

DISCUSSION

The Panel, after listening to the testimony of all the witnesses examining all the evidence found the following:

Dr. Ackerman's testimony was unbiased and credible. Wherever possible, Dr. Ackerman seemed to give the Respondent the benefit of any doubt. Dr. Ackerman recognized that Respondent's records were totally deficient often lacking in the most

basic important information such as a repeated failure to diagnose (. 73, 74), failure to form a treatment plan (T. 50, 52, 56), and a failure prescribed medications (T. 67). Notwithstanding the Respondent's poor recordkeeping, based on the medications prescribed that were recorded in the medical reports, Dr. Ackerman testified that these medicines posed a serious risk to patients and therefore could not justified. (T. 554) The Respondent failed to recognize the risk at the time of treatment over and over again, (T. 42, 46, Exh. 5, T. 881, 333, 334, 339, 406) and at the time of this hearing. The Respondent continued to prescribe medications despite other physician's information stating the patients were addicts. (T. 441)

The Panel found Dr. Herman's testimony not valid. He failed to recognized his role as an expert. He failed to review the records and substituted his own conclusions based on his own investigation of interviewing the Respondent and patients. His testimony was based on information not in the record and never testified to by the Respondent. Despite this, even he at times, could not justify the Respondent's actions. (T. 1514, 1552)

The Panel noted that the Respondent provided care over long periods of time to difficult and complex patients who may have been rejected by other care-givers. Unfortunately, the care provided often led only to exaggerated and prolonging of the problems of drug abuse and did not provide for the patients very much needed consultations, alternative forms of management, or hospitalization or other restrictions.

The Respondent's judgment in prescribing drugs was so faulty, she placed her patients at unnecessary, extreme risk. (Exh. 5, p. 40, Exh. 6 p. 35-41, T. 248-345, 1427; T. 339-347, T. 576) She repeatedly failed to coordinate treatment with other treating physician. (T. 477, 671, 1320) The Respondent's testimony that she called other treating physicians who never returned her call is implausible. (T. 1049-1050) The Respondent often prescribed one drug and another, without justification, in an attempt to relieve the patient's symptoms. (T. 334, 339, 965) The Respondent failed to assimilate as part of her treatment patient's prior diagnosis of addictive

behavior (T. 441, 543, 648). The Respondent's practices of prescribing drugs to the patients were often out of control (T. 798, 811, 813, 831) not just a matter of poor recordkeeping. (494, 554)

The Respondent, both at the time of the Patient's A automobile accidents as well as at the hearing, failed to connect the serious car accident with the drugs she prescribed. Such a failure placed Patient A at risk again when she was involved in a second car accident.

The Respondent repeatedly exposed patients with prior history of drug/alcohol abuse, or suicide attempts to excessive quantities of medications which could pose an imminent threat to life. (T. 91) Hospital records during and after the Respondent's treatment document patient's drug abuse, (T. 880, Exh. 5 107A) yet Respondent continued to prescribe large quantities of additive drugs. Respondent either ignored or refused to follow other physician's advice in letter stating patients were drug addicts.

Respondent often "accommodated" patients by writing new prescriptions when patients claimed the prescriptions were lost (Exh. 7 p. 27-37) stolen or before the prior prescription was exhausted (T. 80)

The Respondent prescribed drugs to the patients in a thoughtless, unreasonable way without taking care of the patient's disorder. (T. 132-134, 984, 1384-1385, 889, 258, 38, 41, 366, 971, Exh. 6. 33, 10-13, 595-596) The Respondent often prescribed one drug after another, without justification, in an attempt to relieve the patient's symptom. (T. 334, 339, 965) Throughout the patient's medical records, there was no organized treatment plan (T. 60, 67, 72, 1349, Exh. 6, Exh. 7) substantiating a basis of prescribing large quantities of medicines to patients and placing them at risk. (T. 80)

The Respondent had failed to set parameters with the patients which caused an inability to control her patients and led to the patients controlling her prescribing practices. (T. 58) Often the Respondent would "accommodate" her patients by prescribing medicines.

Additionally, she would allow the patients to violate boundaries by permitting them to call into her bedroom.

Panel found the Respondent's testimony, at times, was less than credible and an attempt to construct an explanation for her actions for the purposes of this hearing. The Respondent's testimony as to the lack of information in the medical records was implausible.

PANEL'S DETERMINATION ON CHARGES

Paragraphs A, A(1), A(2 a-h,1), a(3), A(4), is sustained

Paragraphs B, B(1) – B(4) is sustained

Paragraphs C, C(1) – C(93) is sustained

Charges D, D(1) – D(6) is sustained

Charge E, E(1) – E(4) is sustained

Charge F, F(1) – F(4) is sustained

PANEL'S DETERMINATION ON SPECIFICATION

1. First Specification of Gross Negligence for Paragraphs
A through Paragraphs F in their entirety is guilty
2. Second Specification on Negligence for Paragraphs
A through Paragraphs F in their entirety is guilty
3. Third Specification of Gross Incompetence for Paragraphs
A through Paragraphs F in their entirety is guilty
4. Fourth Specification of Incompetence for Paragraphs
A through Paragraphs F in their entirety is guilty

5. Fifth Specification of Failure to Maintain Records Eighth
For Paragraphs A through Paragraphs F in their entirety is guilty

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The hearing Committee, in a unanimous vote, after giving due consideration of all the penalties available have determine that the Respondent's license to practice medicine in the state of New York be **REVOKED**.

ORDERED

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

1. Respondent's license to practice medicine in the State of New York is **REVOKED**.

DATED: New York, New York

May 19, 1999



Richard Milone, M.D., Chairman

Norman Spritz, M.D.

Luis Osorio

Appendix 1

IN THE MATTER
OF
LILLIAN GROSS, M.D.

STATEMENT
OF
CHARGES

LILLIAN GROSS, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 16, 1961, by the issuance of license number 85979 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Between on or about May 9, 1994 and on or about May 31, 1996, Respondent treated Patient A for psychiatric illness(es) on an outpatient basis. Respondent's medical records indicate that Patient A had a past history of substance abuse and suicide attempts by overdose. Respondent's medical records further indicate that Patient A abused alcohol during the course of her treatment by Respondent.
1. Respondent failed to adequately evaluate Patient A's condition.
 2. Respondent inappropriately prescribed medications to Patient A including, but not limited to, the following:
 - a. Chlordiazepoxide (Librium)
 - b. Flurazepam (Dalmane)
 - c. Temazepam (Restoril)
 - d. Diazepam (Valium)
 - e. Fioricet
 - f. Tylenol with Codeine

- g. Lomotil
- h. Methamphetamine (Ritalin)
- i. Soma
- j. Sertraline
- k. Fluoxetine
- l. Valproex sodium
- m. Hydrazine
- n. Perphenazine.

- 3. Respondent failed to formulate and pursue an adequate treatment plan for Patient A.
- 4. Respondent failed to maintain an adequate medical record documenting the evaluation and treatment of Patient A.

B. Between on or about November 1983 and on or about March 23, 1998, Respondent treated Patient B for psychiatric illness(es) on an outpatient basis. Respondent's medical records indicate that Patient B had a past history of suicide attempts and alcohol abuse. Respondent's medical records indicate that Patient B continued to abuse alcohol during the course of treatment by Respondent. In or about November 1987, Patient B attempted suicide by overdose with her spouse's medication. In or about October 1989, Patient B was hospitalized at a psychiatric facility for treatment of alcohol dependence, benzodiazepine dependence and major depression.

- 1. Respondent failed to adequately evaluate Patient B.
- 2. Respondent inappropriately prescribed medications to Patient B including, but not limited to, the following:

- a. Alprazolam (Xanax)
- b. Clonazepam (Klonopin)
- c. Diazepam (Valium)

3. Respondent failed to formulate and pursue an adequate treatment plan for Patient B.
4. Respondent failed to maintain an adequate medical record documenting the evaluation and treatment of Patient B.

C. Between on or about April 15, 1985 and on or about July 22, 1985; on or about February 8, 1991 and April 15, 1993; and between on or about May 18, 1994 and on or about February 2, 1996, Respondent treated Patient C on an outpatient basis. Patient C presented with the complaint of a burning sensation of her vagina which proved to be chronic and without discernible medical etiology. Respondent's medical records indicate that as of on or about June 24, 1994, Patient C was a "drug addict".

1. Respondent inappropriately prescribed medications to Patient C including but not limited to, the following.

- a. Alprazolam
- b. Lorazepam
- c. Oxazepam
- d. Clorazepate
- e. Diazepam
- f. Trazadone
- g. Desipramine
- h. Nomifensine

- i. Phenezine
- j. Stelazine
- k. Mellaril
- l. Atenolol
- m. Chloral hydrate
- n. Synthroid
- o. Ethchlorvynol (Placidyl)
- p. Clonazepam
- q. Meperidine (Demerol)
- r. Oxycodone (Percoset)
- s. Codeine
- t. Methadone

- 2. Respondent failed to formulate and pursue an adequate treatment plan for Patient C.
- 3. Respondent failed to maintain an adequate medical record documenting the evaluation and treatment of Patient C.

D. Between on or about March 13, 1992 and February 17, 1998, Respondent treated Patient D on an outpatient basis. From on or about February 1994 through February 1998 Respondent occasionally saw Patient D's Wife (see appendix) with Patient D and more frequently issued prescriptions in her name. Respondent's medical records for Patient D indicate that in 1996 Respondent became aware of Patient D's possible substance abuse.

- 1. Respondent failed to adequately evaluate Patient D's condition.
- 2. Respondent inappropriately prescribed medications to Patient D including, but not limited to, the following:

- a. Alprazolam (Xanax)
- b. Hydromorphone (Dilaudid)

- 3. Respondent failed to formulate and pursue an adequate treatment plan for Patient D.
- 4. Respondent failed to maintain an adequate medical record documenting the evaluation and treatment of Patient D.
- 5. Respondent inappropriately issued prescriptions for Alprazolam in the name of Patient D's Wife outside of the presence of Patient D's Wife and provided said prescriptions to Patient D.
- 6. Respondent failed to maintain an adequate medical record documenting the evaluation and treatment of Patient D's Wife.

E. Between on or about September 29, 1995 and on or about March 7, 1998, Respondent treated Patient E on an outpatient basis. Respondent's medical records indicate that Patient E had a past history of cocaine abuse.

- 1. Respondent failed to adequately evaluate Patient E's condition.
- 2. Respondent inappropriately prescribed medications to Patient E including, but not limited to, the following:

- a. Methylphenidate (Ritalin)
- b. Pemoline (Cylert)
- c. Zolpidem (Ambien)
- d. Lorazepam (Ativan)

- 3. Respondent failed to formulate and pursue an adequate treatment for Patient E.



4. Respondent failed to maintain an adequate medical record documenting the evaluation and treatment of Patient E.

F. Between on or about November 15, 1983 and on or about June 26 1984; and between on or about February 12, 1993 and April 14, 1998, Respondent treated Patient F on an outpatient basis. Respondent's medical records for Patient F indicate that in or about November 1983 Patient F's former therapist informed Respondent that Patient F "tends to abuse drugs".

1. Respondent failed to adequately evaluate Patient F's condition.
2. Respondent inappropriately prescribed medication to Patient F including, but not limited to, the following:

- a. Alprazolam (Xanax)
- b. Desipramine (Norpramine)
- c. Nortriptyline (Aventyl)
- d. Secobarbital (Seconal)
- e. Flurazepam (Dalmane)
- f. Fluoxetine (Prozac)
- g. Sertraline (Zoloft)
- h. Paroxetine
- i. Busperone (Buspar)
- j. Bupropion (Wellbutrin)
- k. Methylphenidate (Ritalin)
- l. Thioridazine (Mellaril)
- m. Hydroxyzine (Atarax)
- n. Diazepam (Valium)
- o. Clonazepam (Klonopin)

- p. Triazolam (Halcion)
3. Respondent failed to formulate and pursue an adequate treatment plan for Patient F.
 4. Respondent failed to maintain an adequate medical record documenting the evaluation and treatment of Patient F.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A(1) through A(4), and each and every subparagraph thereof.
2. Paragraph B and B(1) through B(4), and each and every subparagraph thereof.
3. Paragraph C and C(1) and C(3) and each and every subparagraph thereof.
4. Paragraph D and D(1) through D(6) and each and every subparagraph thereof.
5. Paragraph E and E(1) through E(4) and each and every subparagraph thereof.
6. Paragraph F and F(1) through F(4) and each and every subparagraph thereof.

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N. Y. Educ. Law §6530(3)(McKinney Supp. 1998) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

7. Paragraph A and A(1) through A(4) and each and every subparagraph thereof; Paragraph B and B(1) through B(4) and each and every subparagraph thereof; Paragraph C and C(1) through C(3) and each and every subparagraph thereof; Paragraph D and D(1) through D(6) and each and every subparagraph thereof; Paragraph E and E(1) through E(4) and each and every subparagraph thereof; and Paragraph F(1) through F(4) and each and every subparagraph thereof.

EIGHT THROUGH THIRTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N. Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

8. Paragraphs A and A(1) through A(4), and each and every subparagraph thereof.
9. Paragraph B and B(1) through B(4), and each and every subparagraph thereof.
10. Paragraph C and C(1) and C(3) and each and every subparagraph thereof.
11. Paragraph D and D(1) through D(6) and each and every subparagraph

thereof.

12. Paragraph E and E(1) through E(4) and each and every subparagraph thereof.
13. Paragraph F and F(1) through F(4) and each and every subparagraph thereof.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N. Y. Educ. Law §6530(5)(McKinney Supp. 1998) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

14. Paragraph A and A(1) through A(4) and each and every subparagraph thereof; Paragraph B and B(1) through B(4) and each and every subparagraph thereof; Paragraph C and C(1) through C(3) and each and every subparagraph thereof; Paragraph D and D(1) through D(6) and each and every subparagraph thereof; Paragraph E and E(1) through E(4) and each and every subparagraph thereof; and Paragraph F(1) through F(4) and each and every subparagraph thereof.

FIFTEENTH THROUGH TWENTIETH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N. Y. Educ. Law §6530(32)(McKinney Supp. 1998) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

15. Paragraph A and A(4).
16. Paragraph B and B(4).

17. Paragraph C and C(3).
18. Paragraph D and D(4) and D(6).
19. Paragraph E and E(4).
20. Paragraph F and F(4).

DATED: November 24, 1998
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct