STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
HEALTHCARE SYSTEMS BRANCH
CONNECTICUT MEDICAL EXAMINING BOARD

In re: Gerson Sternstein, M.D.
Petition No. 2009-200921 (2009-0115-001-009)

SUMMARY SUSPENSION ORDER

WHEREAS, the affidavits, duly verified, allege facts which show violations of §20-13c of the Connecticut General Statutes, as amended, and which imperatively require emergency action in that the public health, safety or welfare of the citizens of the State of Connecticut is in clear and immediate danger; and,

Pursuant to the authority of §4-182(c) and §19a-17(c), pending the hearing set for the 27th and 31st day of AUGUST, 2010, at 9:30 a.m.

It is hereby ORDERED, by vote of the Connecticut Medical Examining Board (hereinafter "the Board") that license number 022391 of Gerson Sternstein, M.D. to practice as a physician and surgeon in the State of Connecticut is summarily suspended pending a final determination by the Board regarding the allegations contained in the Statement of Charges.

Dated at Hartford, Connecticut this 17th day of AUGUST 2010.

Anne C. Doremus, Chair
Connecticut Medical examining Board

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

PUBLIC HEALTH HEARING SECTION

September 22, 2011

Richard C. Tynan, Esq.
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VIA EMAIL
Certified Mail RRR #7004-1160-0000-8837-0227

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VIA EMAIL

RE: Gerson Sternstein, M.D. - Petition No. 2009-200921

Dear Attorney Tynan and Attorney Antonetti:

Enclosed please find a copy of the Memorandum of Decision issued by the **Connecticut Medical Examining Board** in the above-referenced matter.

Sincerely,

Jeffrey A. Kardys
Administrative Hearings Specialist/Board Liaison
Public Health Hearing Section

c: Jewel Mullen, MD, MPH, MPA, Commissioner, Department of Public Health
Daniel Shapiro, Assistant Attorney General
Wendy Furniss, Branch Chief, Healthcare Systems
Jennifer Filippone, Section Chief, Practitioner Licensing and Investigations
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STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

Gerson Sternstein, M.D.
License No.: 022391

Petition No. 2009-200921

MEMORANDUM OF DECISION

Procedural Background

On August 10, 2010, the Department of Public Health ("the Department") presented a Statement of Charges ("the Charges") and Motion for Summary Suspension to the Connecticut Medical Examining Board ("the Board") against Connecticut medical license number 022391 of Gerson Sternstein ("respondent"). Board Exh. 1.

The Charges allege that respondent's license is subject to disciplinary action pursuant to the Connecticut General Statutes ("the Statutes") §§ 20-13c(4) and/or 20-13c(5). The Motion for Summary Suspension was based on the Department's information and belief that respondent's continued practice represented a clear and immediate danger to the public health and safety. Board Exh. 1.

Pursuant to the authority of §§ 4-182(c) and 19a-17(c) of the Statutes, on August 17, 2010, the Board granted the Department's motion and summarily suspended respondent's license pending the Board's final determination on the allegations contained in the Charges. The Board set the hearing date for August 27 and 31, 2010. Board Exh. 1

The Department served the Motion for Summary Suspension, Charges, Summary Suspension Order and Notice of Hearing via certified mail, return receipt requested and via electronic mail on August 17, 2010. Board Exh. 1. The Notice of Hearing directed respondent to appear before a duly authorized panel of the Board on August 27, 2010 and August 31, 2010, for a formal hearing on the allegations contained in the Charges. The original panel consisted of Richard Bridburg, MD; Velandy Manohar, MD; and Anne C. Doremus. Board Exh. 1. On August 23, 2010, a Notice of Change in Panel Composition designated Henry Jacobs, MD as a Hearing Panelist and removed Velandy Manohar, MD. (Board Exh. 2). Respondent filed an Answer to the Charges on August 26, 2010. (Board Exh. 3.)

The Board, through its duly authorized panel, held an administrative hearing to adjudicate respondent's case on August 27, August 31, October 1, October 15, November 5, and November 12, 2010. Attorney Richard C. Tynan represented respondent, and Attorney David Tilles represented the Department.

The Panel conducted the hearing in accordance with Chapter 54 (the Uniform Administrative Procedure Act) of the Statutes. Both parties had the opportunity to present evidence, conduct cross-examination, and provide argument on all issues.

All Panel members involved in this decision received copies of the entire record and attest that they either heard the case or read the record in its entirety. The Board reviewed the panel's proposed final decision in accordance with the provisions of § 4-179 of the Statutes. The Board considered whether respondent poses a threat in the practice of medicine to the health and safety of any person. This decision is based entirely on the record and the specialized professional knowledge of the Board in evaluating the evidence. To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. SAS Inst., Inc., v. S & H Computer Systems, Inc., 605 F.Supp. 816 (Md. Tenn. 1985).

Allegations

1. In paragraph 1 of the Charges, the Department alleges that respondent is, and has been at all times referenced in the Charges, the holder of Connecticut medicine and surgery license number 022391.

2. In paragraph 2 of the Charges, the Department alleges that at various times in 2009 and preceding years, respondent prescribed opioids, benzodiazepines, and/or other controlled substances to patients K.R., T.P., R.O., P.P., M.D., D.T-W., L.W., K.O'C., P.B., and S.B. Respondent's care for one or more of these patients deviates from the standard of care in one or more of the following ways:

    a. his documentation was inadequate;
    b. he made inadequate examinations and/or assessments initially and/or at appropriate interim intervals;
    c. he failed to monitor response to treatment and/or compliance with medication regimens, or monitored inadequately;
    d. he initiated and/or continued prescriptions of controlled substances in spite of contraindicating laboratory studies;
    e. he failed to inform, or adequately inform, said patient(s) of risks inherent in the prescribed controlled substances;

f. he prescribed dangerous combinations of drugs;
g. he prescribed inappropriate combinations of drugs;
h. he prescribed excessive doses of opioids;
i. he initiated, continued, and/or increased dosing of opioids despite signs of abuse or criminal behavior by the patient relating to the prescriptions; and/or,
j. he failed to coordinate prescribing with other providers, including, but not limited to dentists, orthopedists, and primary care physicians.

3. In paragraph 3 of the Charges, the Department alleges that the above described facts constitute grounds for disciplinary action pursuant to § 20-13c of the Statutes, including, but not limited to § 20-13c(4); and/or § 20-13c(5).

Findings of Fact

1. Respondent is the holder of Connecticut physician and surgeon license number 022391. See, Respondent's Answer, Board Exh. 3.

2. At all relevant times, respondent practiced psychiatry as a member of Paragon Behavioral Health. Tr. 10/15/10, p. 45.

3. Respondent provided care to K.R. from January 2006 through September 2009. K.R. entered respondent's practice seeking pain medication. K.R. was diagnosed with depression, anxiety, hepatitis C, head injury, cervical neck pain and right knee pain. K.R. had a history of substance abuse. Dept. Exh. 2; Dept. Exhs. 6-9 (sealed); Tr. 8/31/10, pp. 59, 60-65 (sealed); Tr. 10/1/10, pp. 40-77 (sealed); Tr. 10/15/10, pp. 161-248 (sealed).

4. Respondent prescribed K.R. increasingly high doses of oxycodone without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 6- 9 (sealed); Tr. 8/31/10, pp. 59, 60-65 (sealed); Tr. 10/1/10, pp. 40-77 (sealed); Respondent's written record for K.R. is below the standard of care as its notations are barely legible, extremely brief and there are no objective assessments noted. Dept. Exh. 2, Consultant Review by Dr. Ducate and Dept. Exh. 7. Respondent prescribed an inappropriate combination of drugs and a dangerous combination of drugs to K.R. Id. Respondent prescribed an excessive amount of opioids (oxycodone) to K.R. Id. Respondent failed to inform, or adequately inform K.R. of risks inherent to his prescribe controlled substances intake. Id. Respondent initiated, continued and/or increased dosing of opioids in spite of clear signs of abuse or criminal behavior by the patient relating to the prescriptions. Id. Respondent practiced below the standard of care in prescribing controlled substances because the plan of care was completely based upon patient self report and it occurred without an examination of the patient by respondent. Id. Respondent practiced below the standard of care when he prescribed K.R. controlled substances without an assessment that demonstrated objective evidence for the need to prescribe controlled substances. Id. With respect to patient K.R., respondent failed to coordinate the prescribing of controlled substances with other providers. Id. Respondent failed to inform K.R. of the risks inherent in his taking of the controlled substances that were prescribed to him by respondent. Id.

5. Respondent provided care to T.P. from August 2008 through June 2009. Dept. Exhs. 2 and 11. T.P. entered respondent's practice seeking Suboxone for opiate dependence and pain medication. Id. T.P had a history of polysubstance abuse and treatment with prescription opiate medication. Dept. Exh. 2; Dept. Exhs. 10-12 (sealed); Tr. 10/1/10, pp. 77-96, 157, 158, 166-170 (sealed); Tr. 10/15/10, pp. 248-284 (sealed). Respondent's written record for T.P. is below the standard of care as its notations are barely legible, extremely brief and they do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exh. 2, Consultant Review by Dr. Ducate and Dept. Exh. 11. Respondent failed to adequately assess patient T.P. Id. Respondent prescribed an inappropriate combination of drugs and a dangerous combination of drugs to T.P. Id. Respondent prescribed an excessive amount of opioids to T.P. Id. Respondent practiced below the standard of care in prescribing controlled substances because the plan of care was almost exclusively based upon patient self report and it occurred without an examination of the patient by respondent. Id. With respect to patient T.P., respondent failed to coordinate the prescribing of controlled substances with other providers, including the patient's dentist. Id.

6. Respondent prescribed T.P. high doses of opioids and Suboxone without addressing tolerance and potential lethal toxicity or documenting the need for the medication. Respondent also prescribed T.P. a benzodiazepine without any documented reason. Dept. Exh. 2; Dept. Exhs. 10-12 (sealed); Tr. 8/31/10, pp. 65-75 (sealed); Tr. 10/1/10, pp. 77-96, 134, 166-170 (sealed), 134, 166-170.

7. Respondent provided care to R.O. from January 2007 through May 2009. R.O. entered respondent's practice seeking to ease back and neck pain. R.O. had Major Depression and Pain Disorder with Psychological factors. R.O. had a history of drug and alcohol addiction. Dept. Exh. 2; Dept. Exhs. 13-15 (sealed); Tr. 8/31/10, pp. 75-89 (sealed); 10/1/10, pp. 134, 159-164; Tr. 11/5/10, pp. 181-222 (sealed).

8. Respondent prescribed R.O. excessively high doses of opioid medication that R.O. used in combination with antidepressants. Respondent prescribed medication without addressing R.O.'s tolerance or potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 13-15 (sealed); Tr. 8/31/10, pp. 75-89 (sealed); Tr. 10/1/10, pp. 134, 159-164; Tr. 11/5/10, pp. 181-222 (sealed). In May of 2007, respondent prescribed Oxycontin and Percocet to R.O. without seeing and/or examining the patient. Dept. Exhs. 2 and 14. Respondent's patient records for R.O. were inadequate as they lacked detail and did not contain objective evidence for a need for the high doses of Schedule II medicine prescribed by respondent. Id. The clinical notes for patient R.O. are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exh. 2. The assessment of patient R.O. was inadequate and below the standard of care as there is no evidence in R.O.'s record that a response to treatment is assessed through standard measures used to monitor the response of the chronic pain to the treatment. Id. Respondent initiated, continued and/or increased dosing of opioids to R.O. despite the fact that the patient had a history of drug and alcohol addiction and despite the fact that the urine drugs screens for R.O. indicated that

the patient was also using other opiates that were not prescribed by respondent. Id. This conduct is below the standard of care for physicians in Connecticut.

9. Respondent provided care to P.P. from February 2002 through September 2009. When P.P. entered respondent's practice, she sought help for addiction and admitted to using heroin, cocaine, crack, and prescription opioids. P.P. had Opiate Dependence, cervical disc disease, traumatic injury and Chronic Obstructive Pulmonary Disease ("COPD"). Dept. Exh. 2; Dept. Exhs. 16-19 (sealed); Tr. 8/31/10, pp. 89-94 (sealed); Tr. 11/5/10, pp. 178-181 (sealed).

10. Respondent prescribed P.P. excessively high doses of opioid medication in combination with other addictive medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 16-19 (sealed); Tr. 8/31/10, pp. 89-94 (sealed); Tr. 11/5/10, pp. 178-181 (sealed). The clinical notes for patient P.P. are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exhs. 2 and 17. The assessment of patient P.P. was inadequate and below the standard of care as there is no evidence in the P.P.'s record that a response to treatment is assessed through standard measures used to monitor the response of the chronic pain to the treatment. Id. Respondent failed to inform this patient of the risks inherent in the prescribed controlled substances. Id. Respondent failed to coordinate prescribing with P.P.'s other providers. Id. Respondent initiated, continued and/or increased dosing of opioids to P.P. despite the fact that the patient had a history of drug and alcohol addiction and despite the fact that the patient was using cocaine. Id.

11. Respondent provided care to M.D. from January 2002 through September 2009. M.D. entered respondent's practice seeking help for depression and arm and neck pain. M.D. had a history of polysubstance abuse and treatment with prescription opiate medication. Dept. Exh. 2; Dept. Exhs. 20-22 (sealed); Tr. 8/31/10, p. 106; Tr. 11/5/10, pp. 170-178 (sealed).

12. Respondent prescribed M.D. excessively high doses of opioid medication without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 20-22 (sealed); Tr. 8/31/10, pp. 116-119, 124-125; Tr. 10/1/10, pp. 191-197; Tr. 11/5/10, pp. 170-178 (sealed). Respondent's documentation and treatment were inadequate in that there were no objective assessments noted in the record, and the plan of care was only based upon the patient's self report. Dept. Exhs. 2 and 21. In addition, the documentation lacked sufficient detail and the notes were barely legible, extremely brief and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Risks, benefits and the alternatives to treatment were not explained to M.D. Id. Respondent initiated, continued and/or increased dosing of opioids to M.D. despite the fact that the patient had a history of drug and alcohol addiction and despite the fact that the urine drugs screens for M.D. indicated that the patient was also using other opiates that were not prescribed by respondent. Id.

13. Respondent provided care to D.T-W. from January 2008 through September 2009. D.W. entered respondent's practice seeking to ease back pain and lack of sleep. D.T-W.'s urine

toxicology screens revealed the presence of cocaine and methadone, but no Suboxone. Dept. Exh. 2; Dept. Exhs. 23-26 (sealed); Tr. 8/31/10, pp. 130-152 (sealed); Tr. 11/5/10, pp. 152-170 (sealed). The patient's medical record indicated that she was crushing and snorting 70-120 mg of Percocet per day. Dept. Exh. 24. The records for D.T.-W. are inadequate in that there are not notes of physical examinations and very few objective observations. Dept. Exh. 2. Respondent practiced below the standard of care for patient D.T-W. in that he prescribed controlled substances for this patient despite clear evidence that this patient was engaged in criminal activity and/or abusive behavior with respect to the prescriptions and other drugs. Dept. Exh. 2.

14. Respondent prescribed D.T-W. a combination of opioids and Suboxone without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 23-26 (sealed); Tr. 10/1/10, pp. 195, 196; Tr. 8/31/10, pp. 130-152 (sealed); Tr. 11/5/10, pp. 152-170 (sealed). The patient records are inadequate in that they are barely legible, extremely brief and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exhs. 2 and 24. Respondent failed to inform the patient of risks inherent in the prescribed controlled substances. Id. Respondent prescribed a dangerous and or inappropriate combination of drugs in that he prescribed Suboxone to this patient despite the fact that the patient is dependent on opiate agonists. It is below the standard of care to prescribe opiates with Suboxone as drug interactions are a risk, and it lowers the effectiveness of both drugs. Also, serious withdrawal symptoms can emerge as well as an increased risk of opiate abuse if these drugs are combined in this manner. Id.

15. Respondent provided care to L.W. from July 2002 through February 2009. L.W. entered respondent's practice seeking to ease severe pain. L.W. had a history or depression and schizoaffective disorder, as well as multiple medical conditions. Dept. Exh. 2; Dept. Exhs. 27- 29 (sealed); 11/5/10, pp. 222-259 (sealed).

16. Respondent prescribed L.W. excessively high doses of opioid medication in combination with other addictive medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 27- 29 (sealed); 11/5/10, pp. 222-259 (sealed); 11/12/10, pp. 106-118 (sealed), 101-105. The documentation for patient L.W. was inadequate as there are no objective assessments are noted, the plan of care is based only on the patient's self report and the records lacked sufficient detail. Dept. Exhs. 2 and 28. Respondent failure to communicate with the patient's dentist who may have been prescribing pain medication as well was below the standard of care for physicians in Connecticut. Dept. Exh. 2. Respondent prescribed a dangerous and inappropriate combination of drugs for L.W. during August of 2008 and January of 2009. Respondent also failed to appropriately and adequately assess the patient during treatment. Id.

17. Respondent provided care to K.O'C. from June 2000 through June 2009. K.O. entered respondent's practice seeking to ease pain and was in treatment for depression and anxiety. K.O. had a history of drug and alcohol addiction. The patient's records also indicated that there was narcotic analgesic abuse evident and that the patient had engaged in drug seeking behavior for Vicodin. Dept. Exh. 2; Dept. Exhs. 31-33 (sealed); Tr. 8/31/10, pp. 152-160 (sealed). Respondent prescribed excessive doses of drugs to this

patient despite the fact that the patient's orthopedic evaluation did not find objective evidence to support the patient's report of debilitating pain. Dept. Exhs. 2, 31-33. On January 15, 2007, respondent prescribed "Oxycontin 80 mg, 17 tablets per day, #240 total tablets, Xanax 1 mg, 4 tablets per day and #60 tablets, with 2 refills, and 40 mg Oxycontin, 8 tablets per day and #120 tablets." Id. The Board finds that these prescriptions at these doses in one visit without any objective evidence is a violation of the standard of care. Respondent initiated, continued and/or increased dosing of opioids to K.O-C. despite the fact that the patient had a history of drug and alcohol addiction and despite the fact that the urine drugs screens for K.O'C. indicated that the patient was also using other drugs that were not prescribed by respondent. Id.

18. Respondent prescribed K.O'C. excessively high doses of opioid medication in combination with other addictive medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 31-33 (sealed); Tr. 8/31/10, pp. 152-160 (sealed); Tr. 10/1/10, p. 196. The clinical notes for this patient are inadequate in that they are barely legible, extremely brief, and do not indicate a patient's condition and behavior. Dept. Exhs. 2 and 32.

19. Respondent provided care to P.B. from October 2001 through November 2008. P.B. entered respondent's practice for insurance purposes and wanted to continue on her then-current medication regimen. P.B. was taking pain medication and psychotropic medication for depression and anxiety. Dept. Exh. 2; Dept. Exhs. 34, 35a, 35b, 36-41 (sealed); Tr. 8/31/10, pp. 162-170, 185-199 (sealed); Tr. 10/1/10, pp. 170-171, 175-182, 197-199 (sealed); Tr. 11/5/10, p. 103.

20. As early as March 2003, P.B. was documented by New Britain General Hospital for abusing prescription medication. Dept. Exh. 2; Dept. Exhs. 34, 35a, 35b, 36- 41 (sealed); Tr. 8/31/10, pp. 186, 187 (sealed).

21. Respondent prescribed P.B. excessively high doses of opioid medication in combination with other addictive medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 34, 35a, 35b, 36-41 (sealed); Tr. 8/31/10, pp. 162-170, 185-199 (sealed); Tr. 10/1/10, pp. 170-171, 175-182, 197-199 (sealed); Tr. 11/5/10, pp. 101- 150 (sealed). Respondent prescribed an inappropriate combination of drugs to P.B. Dept. Exhs. 2 and 35-36. The Board agrees with Dr. Ducate's assessment that the "practice of prescribing massive doses of Schedule II controlled substances, as well as other sedating medication is well below the community standard of care, especially with [the patient's] history of hospitalizations due to opioid toxicity and her history of unreliable reporting of her medication use." Id. The clinical notes for this patient are inadequate in that they are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Id. Respondent made inadequate examinations and assessments. Id. Respondent failed to inform this patient of the risks inherent in the prescribed controlled substances. Id. Respondent initiated, continued and/or increased dosing of controlled substances despite clear evidence that the patient was misusing and abusing the medication. Id.

22. In January 2009, P.B. died due to opiate toxicity. Dept. Exh. 2; Dept. Exhs. 34, 35a, 35b, 36-41; Tr. 10/1/10, pp. 170-171, 175-182 (sealed); Tr. 11/5/10, pp. 138-150 (sealed).

23. Respondent provided care to S.B. from September 2001 through September 2009. S.B. entered respondent's practice for depression, sleep and pain problems. S.B. had a history of drug abuse that discontinued in 1977, Hepatitis B, Hepatitis C, chronic narcotic addiction, hypertension and depression. Dept. Exh. 2; Dept. Exhs. 42-51 (sealed); Tr. 8/31/10, pp. 170-185, 199-209 (sealed); Tr. 10/1/10, pp. 170-171, 183-191 (sealed); Tr. 11/5/10, pp. 10-101 (sealed).

24. Respondent prescribed S.B. excessively high doses of opioid medication in combination with other addictive and sedative medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 42-51 (sealed); Tr. 8/31/10, pp. 170-185, 199-209 (sealed); Tr. 10/1/10, pp. 170, 171, 183-191 (sealed); Tr. 11/5/10, pp. 10-101 (sealed). The clinical notes for this patient are inadequate in that they are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exhs. 2, 43, and 46. Respondent failed to inform the patient of risks inherent in the prescribed controlled substances. Id. Respondent initiated, continued and/or increased dosing of controlled substances despite clear evidence that the patient was misusing and abusing the medication and despite evidence that the patient was addicted to controlled substances. Id.

25. In February 2009, S.B. died due to hypertrophic dilated cardiomyopathy. The toxicology report revealed the presence of prescribed medication. Dept. Exh. 2; Dept. Exhs. 42-51 (sealed); Tr. 8/31/10, pp. 170-185, 199-209 (sealed); Tr. 10/1/10, pp. 170, 171, 183-191 (sealed).

26. Generally, and as specifically noted throughout this Memorandum of Decision, respondent's documentation was inadequate. Respondent's clinical notes were illegible and he failed to document medical justification or objective observations for his elected plan of treatment for each patient. Dept. Exh. 2; Tr. 8/31/10, pp. 56-59; Tr. 10/1/10, pp. 34-35, 43-46, 73, 74; Tr. 10/15/10, p. 196.

27. Generally, and as specifically noted throughout this Memorandum of Decision, respondent made inadequate examinations and/or assessments initially and/or at appropriate interim intervals. Dept. Exhs. 2, 3; Tr. 8/31/10, pp. 59, 60-206 (sealed); Tr. 10/1/10, pp. 37, 40-96.

28. Generally, and as specifically noted throughout this Memorandum of Decision, respondent failed to monitor his patients' response to treatment and/or compliance with medication regimens, or monitored inadequately. Dept. Exhs. 2, 3; Dept. Exhs. 6- 29, 31-51 (sealed); Tr. 8/31/10, pp. 59, 60-206 (sealed); Tr. 10/1/10, pp. 37, 40-96; Tr. 11/5/10, pp. 10-259 (sealed).

29. Generally, and as specifically noted throughout this Memorandum of Decision, respondent initiated and/or continued prescriptions of controlled substances in spite of contraindicating laboratory studies. Dept. Exhs. 2, 3; Tr. 10/1/10, pp. 37, 40-96; Tr. 10/15/10, pp. 99-103, 108-118; Tr. 11/5/10, pp. 10-101, 160-163 (sealed).

30. Generally, and as specifically noted throughout this Memorandum of Decision, respondent failed to inform, or adequately inform, patient(s) of risks inherent in the prescribed controlled substances. Dept. Exhs. 2, 3; Dept. Exhs. 6- 29, 31-51 (sealed); Tr. 10/1/10, pp. 72-74 (sealed). There is no evidence in the ten patient records which demonstrates that respondent informed patients of the risks inherent in the controlled substances he was prescribing. Dept. Exhs. 2, 7, 11, 14, 17, 21, 24, 28, 31-33, 35-36, 43 and 46.

31. Generally, and as specifically noted throughout this Memorandum of Decision, respondent prescribed dangerous combinations of drugs. Dept. Exhs. 2, 3; Dept. Exhs. 6-29, 31-51 (sealed); Tr. 8/31/10, pp. 40-46; Tr. 10/1/10, pp. 40-96 (sealed); 165-166, 190, 191.

32. Generally, and as specifically noted throughout this Memorandum of Decision, respondent prescribed inappropriate combinations of drugs. Dept. Exhs. 2, 3; Dept. Exhs. 6- 29, 31-51 (sealed); Tr. 8/31/10, pp. 40-46; Tr. 10/1/10, pp. 40-96 (sealed), 19-26, 74-76, 190, 191.

33. Generally, and as specifically noted throughout this Memorandum of Decision, respondent initiated, continued, and/or increased dosing of opioids in spite of signs of abuse or criminal behavior by patients relating to the prescriptions. Dept. Exhs. 2, 3; Dept. Exhs. 6- 29, 31-51 (sealed); Tr. 10/1/10, pp. 90-95 (sealed), 132-134, 137-144, 192-197.

34. Generally, and as specifically noted throughout this Memorandum of Decision, respondent failed to coordinate prescribing with other providers, including, but not limited to dentists, orthopedists, and primary care physicians. Dept. Exh. 2; Dept. Exhs. 6-12, 16-19, 27-29 (sealed); Tr. 10/1/10, pp. 70-77; Tr. 11/5/10, pp. 100, 101, 149, 150 (sealed).

35. Dr. Sternstein's testimony is wholly unreliable and not credible.

36. Dr. Ducate's written opinions and oral testimony are reliable and credible.

Discussion and Conclusions of Law

The Department bears the burden of proof by a preponderance of the evidence in this matter. Goldstar Medical Services, Inc., et al. v. Department of Social Services, 288 Conn. 790, 820-21 (2008). Although the burden of proof is a preponderance of evidence, the Board finds

that the Department provided overwhelming credible evidence that respondent practiced medicine significantly below the standard of care for physicians in Connecticut. The respondent's testimony was not reliable or credible, and specifically it was not reliable or credible regarding his explanations for his treatment and prescribing of controlled substances to his patients. The Department presented reliable and credible evidence that clearly demonstrated that respondent's treatment of his patients, as more fully described below, was significantly below the standard of care for physicians in Connecticut. The Board agrees with Dr. Ducate's opinion that there is "**a clear pattern of substandard medical care provided by Dr. Gerson Sternstein that is grossly below**" the standard of care. (emphasis supplied). Exh. 2, p. 2.

After reviewing all of the evidence in this matter, the Board finds that respondent poses a serious threat in his practice of medicine to the health and safety his patients. The Board finds that respondent's practice of medicine is far below the standard of care and is dangerous. Respondent's conduct, as described in this Memorandum of Decision, constitutes illegal, incompetent or negligent conduct in the practice of medicine in violation of Conn. Gen. Stat. § 20-13c(4).

Section 19a-10 of the Statutes provides in pertinent part, "[Boards] may conduct hearings on any matter within their statutory jurisdiction. Such hearings shall be conducted in accordance with Chapter 54 and the regulations established by the Commissioner of Public Health."

Pursuant to § 20-13c(4) of the Statutes "the board is authorized to restrict, suspend, or revoke the license or limit the right to practice of a physician or take any other action in accordance with section 19a-17, for . . . illegal, incompetent or negligent conduct in the practice of medicine." The board finds that the Department met its burden of proof with respect to the Charges.

With respect to paragraphs 1 of the Charges, the evidence establishes that respondent is a licensed physician in the State of Connecticut who practices psychiatry. Respondent admitted to this Charge in his Answer. See, Board Exh. 3.

With respect to paragraph 2a of the Charges, the Department proved by a preponderance of the evidence that respondent's documentation was inadequate, in violation of the standard of care. See, Findings of Fact ("FF") 4, 5, 8, 10, 12, 13, 14, 16, 18, 21, 24 and 26. There is clear evidence of poor documentation throughout the ten charts at issue. Id. Due to illegibility, it was impossible to read a vast number of entries. In fact, in testimony, respondent states, "I'm not

sure what even I wrote, I can't read my writing Tr. 11/5/10, p. 120, and that he used block letters to obtain a motorized wheelchair because, "they need to be able to read my writing." Tr. 11/5/10, p. 121. Generally, the clinical notes for the patients are inadequate in that they are barely legible, extremely brief, and do not indicate the results of a physical exam and rarely contain mental status exam or an observation of the patient's condition and behavior. Dept. Exhs. 2.

With respect to paragraph 2b of the Charges, the Department met its burden of proof that respondent made inadequate examinations and/or assessments initially and/or at appropriate interim intervals. See, FF 4, 5, 8, 10, 12, 13, 14, 16, 18, 21, 24, and 27. In reviewing the 10 patient records, there may be chronic pain diagnoses and in some cases the underlying pathology can be inferred, but there is no evidence of any physical examination at the initial interview or thereafter even with patients in treatment for many years. Id. In prescribing increasing doses of narcotics for a particular problem, the standard of care requires that there be clear documentation of an exacerbation in the patient's condition evidenced by reports from a physiatrist, orthopedist, or rheumatologist caring for the patient, or the prescriber must personally examine and document reasons for changing the prescribing pattern. Dept. Exh. 2.

Instead, respondent placed heavy, and in many cases, exclusive reliance upon the patients' statements about pain. Dept. Exh. 2 and Tr. 8/31/10, p. 181. There is little or no documentation of any examination of patients. Dept. Exh. 2.

With respect to paragraph 2c of the Charges, a preponderance of the evidence establishes that respondent failed to monitor the patient's responses to treatment and/or compliance with medication regimens, or monitored inadequately in violation of the standard of care. FF 4, 6, 8, 10, 24 and 28. Respondent agreed with the Connecticut State Guidelines and with Dr. Ducate, the Department's expert, that response to treatment and compliance with medications must be monitored. Tr. 10/15/10, p. 282 (sealed). Yet, the record is replete with examples of patients' probable abuse of controlled substances that respondent failed to monitor.

With respect to paragraphs 2c, 2f, 2g, 2h and/or 2i, of the Charges, the Department sustained its burden of proof that respondent violated the standard of care when he failed to monitor or inadequately monitored his patients' response to treatment and/or compliance with medication regimens, and initiated, continued, and/or increased dosing of opioids in spite of

signs of abuse or criminal behavior by the patient relating to the prescriptions. FF 4, 6, 8, 10, 12, 13, 14, 17, 21, 24, 28, 29 and 33.

P.B. was prescribed high doses of Duragesic, Dilaudid, Fentora, methadone and Norco, Klonopin, Valium, Seroquel, Flexeril, Xanax, and was on Soma. Dept Exhs. 34-41 (sealed). P.B.'s records show that P.B. had liver dysfunction. Yet respondent did not conduct any liver testing before or after the liver dysfunction was discovered in the hospital. Dept. Exhs. 34-41 (sealed).

P.B. was under respondent's care from October 2001 through November 2008. As early as March 2003, New Britain General Hospital documented that P.B. had bizarre behavior, organic mental syndrome and opiate withdrawal. FF. 19. Respondent prescribed P.B. Fentora, Methadone, Xanax, Soma, Dilaudid and Duragesic, bringing P.B.'s dosage back up without any explanation. In February 2007, P.B. was admitted to New Britain General Hospital due to lethargy and mental status changes due to opioid abuse. From April 2007 through June 2007, P.B.'s liver function tests were abnormal and her opioid levels were increased. In May and June of 2007, P.B. was again hospitalized. P.B.'s hospital records indicated that P.B. had a primary problem of opiate toxicity during her May and June 2007 admissions. Despite hospital admissions indicating P.B.'s opiate toxicity and addiction, respondent continued to prescribe P.B. high doses of opiate medication in addition to other medications that resulted in sedation and respiratory depression. FF. 21. On December 2, 2008, P.B. died of opiate toxicity at age 52, as stated in the hospital records.

Respondent began treating SB in September 2001. Dept. Exh. 43 and 46, FF. 23-25. Throughout SB's treatment respondent prescribed high doses of Vicodin, Soma, Effexor, Triazadone, Valium, Ritalin, Flomax, Duragesic, Oxycontin and Seroquel to SB who suffered from liver disease, depression, hypertension, and chronic back pain. Id. Beginning on or about July 16, 2008 through August of 2009, SB had several episodes in which SB experienced confusion and disorientation from opiate abuse or narcotic overdoses, sometimes causing SB to fall and require hospitalization. Dept. Exh. 44-49 (sealed). Hospital records indicate that in March 2009, the Valium and Soma were stopped and SB improved, and by August 2009, all of SB's medications were tapered or discontinued, including methadone or other narcotics. Dept. Exh. 44-49 (sealed). Despite SB's hospital history regarding drug overdoses and addictions and marked improvements once those medication were reduced or stopped, respondent resumed

prescribing narcotics to SB. Dept. Exh. 44-49 (sealed). On June 3, 2009, SB was prescribed 20 mg of methadone four times a day. On June 10, 2009, SB was prescribed 40 mg. four times a day of methadone. Respondent's last prescription to SB was on June 18, 2009, but only because SB was no longer available to respondent.

Additionally, as noted by Dr. Ducate, several of respondent's patients tested positive for illicit drugs. Specifically, substances such as heroin, cocaine, and morphine were found in urine screens of respondent's patients, providing respondent significant reason to believe his patients were engaging in drug abuse. Moreover, respondent had patients who were receiving Medicaid for their prescription, but they would pay cash in the thousands of dollars for name brand prescriptions, a red flag for possible diversion of drugs. Despite serious signs of abuse or criminal behavior, respondent continued to prescribe high, and sometimes lethal doses of opiates to his patients.

For example, respondent provided care for P.P. from February 2002 through September 2009. FF 9. P.P. had a history of detoxification from crack cocaine, heroin and opioids. P.P. used heroin on the day of admission into respondent's practice. Tr. 8/31/10, p. 91 (sealed). P.P. had a diagnosis of COPD. Tr. 11/5/10, p. 179 (sealed). Given this diagnosis, coordinating care with a pulmonologist was important due to the potential respiratory depression with large doses of opioids that the patient received by respondent's prescription. There is no evidence that this was done. Additionally, P.P. had a conviction for assault and possession of drug paraphernalia, multiple urine reports with cocaine present and diluted urine specimens. Tr. 11/5/10, p. 179 (sealed). Essentially, all of these are red flags for risk of diversion and/or addiction. Yet, respondent took no action.

M.D. was under respondent's care from January 30, 2002 through September 16, 2009. M.D. had urine toxicology screens for cocaine and marijuana, and many negatives screens for methadone and fentanyl, which were his prescribed medications. Tr. 10/1/10, p. 133; Tr. 11/5/10, pp. 153-163 (sealed). M.D. informed respondent that he got "old morphine from a friend." Despite these red flags, they did not appear to raise any concerns for respondent about potential diversion and addiction.

Between 2008 and 2009, D.T-W. had positive urine tests for cocaine and methadone, yet D.T-W. tested negative for Suboxone, which was prescribed for him. D.T-W. was opiate-dependent for two years and took 70 to 120 mg. of Percocet, which D.T-W. crushed and snorted.

D.T-W. bought medications from patients in pain clinics in Bristol and Meriden. Yet, there is no evidence of any action taken by respondent regarding potential diversion or abuse by D.T-W.

L.W. had a medical history of asthma and sleep apnea. Dept. Exh. 28 (sealed). Yet there was no pulmonologist involved in the coordination of care for L.W. at any time during L.W.'s treatment for prescription of opioids that can cause pulmonary depression.

Respondent provided care to K.O'C. from June 27, 2000 through June 18, 2009. FF. 17. K.O. was being weaned off of narcotics as of the initial visit on June 27, 2000. The Connecticut Department of Social Services required K.O. to be in a drug-lock program to avoid insurance abuse. Dept. Exh. 32 (sealed). So K.O'C. paid cash for Xanax for about a year at Wal-Mart to avoid detection. Further, K.O'C. was buying Oxycontin on a monthly basis for $1,600.00 or more, while living on disability payments. Dept. Exh. 33 (sealed). Respondent appealed to Humana Clinical Pharmacy twice on K.O'C's behalf because Humana refused coverage for K.O. Respondent stated that K.O. needed brand name Oxycontin, and that he was doing regular tests to rule out any diversion by K.O. Dept. Exh. 32 (sealed). The evidence establishes, however, that respondent only did one serum test on August 2, 2005, and one on December 17, 2003. Respondent's appeal to Humana was denied twice.

With respect to paragraph 2d of the Charges, the Department sustained its burden of proof that respondent deviated from the standard of care when he initiated and/or continued prescriptions of controlled substances in spite of contraindicating laboratory studies. FF 8, 12, 17 and 29. Dept. Exhs. 2, 14, 21, 24, 31-33. In the cases of R.O., M.D., D.T.W., and K.O'C., although their urine testing was not consistent with respondent's prescriptions, respondent continued to give them prescriptions. Tr. 10/1/10, p. 196. FF 8, 12, 17 and 29. Dept. Exhs. 2, 14, 21, 24, 31-33.

With respect to paragraph 2e of the Charges, the Department met its burden of proof that respondent deviated from the standard of care when he failed to inform, or adequately inform, patients of risks inherent in the prescribed controlled substances. Dept. Exh. 2, 7, 11, 14, 17, 21, 24, 28, 31-33, 35-36, 43 and 46; FF 4, 10, 12, 14 21, 24 and 30. There is no evidence in any of the ten cases that respondent talked with his patients about the potential risks and benefits of his treatment or alternative treatment, or that respondent made a written treatment plan regarding their care. Id. Respondent stated that he discusses risks and benefits of treatment in pain group, stating, "if they are getting pain medications from me, they're coming." However, at best, only

half of the ten patients attended the pain group. Tr. 10/15/10, pp. 66-70 (sealed). Respondent's testimony that some of the patients received counseling about the risks of the controlled substances is not sufficient or credible.

With respect to paragraphs 2f, 2g and/or 2i, a preponderance of the evidence establishes that respondent deviated from the standard of care when he prescribed dangerous and inappropriate combinations of drugs. FF 4, 5, 8, 10, 12, 14, 16, 17, 18, 21, 24, 31 and 32. Respondent used extremely high doses of opiates, often with benzodiazepines, sometimes with Suboxone, and often with several other drugs. He stated he only knew one other physician in the state who prescribed opiates like he did. Tr. 11/12/10, p. 45. Medications with serious side effects need to be clearly monitored and reasons for changing medications and dosages should be clearly documented. Dept. Exh. 2. In this case, respondent repeatedly failed to meet the standard of care. FF 4, 5, 8, 10, 12, 14, 16, 17, 18, 21, 24, 31 and 32, and Dept. Exh. 2. Some examples regarding this finding are as follows:

T.P. was prescribed Lyrica, Ativan, Percocet, Oxycontin, and Suboxone. Dept. Exh. 11 Yet, the combination of short-acting pain relievers makes it difficult to know which medications are effective and which ones are not. Dept. Exhs. 10-12 (sealed). Further, Percocet should not be used in conjunction with Soma because the acetaminophen in the Percocet can cause liver toxicity. R.O. was prescribed the same combination of Percocet and Soma, which in addition to liver toxicity, can also cause hallucinations and death. Dept. Exhs. 13-15 (sealed). Respondent failed to conduct any liver function studies as required by the standard of care when prescribing these combinations of medications, and there is no explanation in the charts as to why he prescribed T.P. and R.O. this combination of drugs. Dept. Exhs. 10-15 (sealed).

P.P. was prescribed high doses of Oxycontin, methadone, Roxycontin, and Xanax. Dept. Exhs. 16-19. The record is unclear as to why respondent prescribed both Oxycontin and Roxycontin when they are essentially the same thing. There is no documented rationale or explanation in the records of this patient. Dept. Exh. 2.

M.D. was prescribed high doses of Oxycontin, methadone, Roxycontin, Xanaflex, and fentanyl. M.D. tested negative 24 times for methadone and Fentanyl, although prescribed, and also ran out of the prescription early, yet M.D.'s prescriptions were refilled several times. Dept. Exhs. 20-22 (sealed).

D.W. was prescribed high doses of Suboxone, Oxycontin, Dilaudid, Opana, Soma and Percocet containing 5.2 mg. of acetaminophen per day. No liver function tests were ordered on D.W. The combination of benzodiazepines found in the urine, but not prescribed, plus Oxycontin, Percocet, and Opana in high doses is dangerous. Dept. Exh. 23-26 (sealed). Respondent's explanation for continuing to fill DTW's prescriptions is that another doctor prescribed D.W. the Opana and the benzodiazepines. Tr. 11/5/10, p. 157 (sealed). The board finds respondent's claim not to be credible because the other doctors' records do not show such prescriptions. Moreover, even when D.W.'s urine tested positive for cocaine and methadone, respondent continued to prescribe to D.W. Dept. Exh. 23-26 (sealed).

Respondent prescribed L.W. Fentora and Actiq, which are two forms of fentanyl: lozenge and tablet. Dept. Exhs. 27-30 (sealed). Respondent also prescribed to LW, Roxycodone and oxycodone, which are also the same drug. Dept. Exhs. 27-29. The Board finds that respondent did not adequately justify his prescription of the same drugs in two different forms, and instead created circumstances that heighten the risk for diversion.

With respect to paragraph 2h of the Charges, the Department sustained its burden of proof that respondent prescribed excessive doses of opiates in violation of the standard of care. Respondent failed to provide sufficient medical justification or an objective need for prescribing high doses of opiates and placed each patient at high risk of overdose or dependency. FF. 4, 8, 10, 12, 13, 17, 21, 24, 28, 29 and 33. Dept. Exhs. 2, 7, 11, 14, 17, 21, 24, 28, 31-33, 35-36, 43 and 46.

With respect to paragraph 2j of the Charges, a preponderance of the evidence establishes that respondent failed to coordinate prescribing with other providers, including, but not limited to dentists, orthopedists, and primary care physicians. FF. 4, 5, 10, 16. Communication with a patient's treating provider is necessary to avoid duplication and disruption of treatment, and negative drug interactions. Respondent's records indicate that L.W., P.P. and T.P. were each prescribed pain medication secondary to dental procedures, and that K.R. was provided multiple prescriptions from more than one doctor. Dept. Exhs. 6-12, 16-18, 27-29 (sealed). Despite the known existence of other treating providers, there is no evidence that respondent coordinated with these patients' other providers to ensure the safety and efficacy of respondent's treatment plan.

In reviewing the record in its entirety, it is the opinion of the Board that the expert for the Department is reliable and credible. Respondent, on the other hand, was not credible in his testimony. When pressed to explain his rationale for prescribing in specific cases, he repeatedly deflected and reverted to theories.[1] His explanation of the use of multiple pharmacies was not credible.

While respondent claims that it is safe to give very large doses of opiates "so long as they are titrated upward properly," he did not always comply with this approach. He stated, " I tell people that they have to assume that I'm giving them a prescription for a gun with bullets. (Tr. 10/15/10, p. 82)." He also stated, "I think if someone were to do this [his kind of pain management] they'd have to be part of a group or part of a hospital or part of a university. This is tertiary [sic] care medicine . . . . (Tr. 11/12/10, p. 77)."

Respondent engages in a practice of prescribing medications that is significantly below the standard of care. His patient records are void or scant of information relating to testing, assessments, practitioner collaboration, informed risks and alternatives, or medical justification. Dept. Exh. 2. Instead, in many cases he simply has allowed patients to self-report their pain to acquire a prescription. The Board believes respondent has failed to demonstrate that he is able to practice medicine with reasonable skill and safety. Respondent's failure to recognize the inadequacies and dangers posed by his practice is extremely concerning to this Board. The Board finds that respondent presents a significant and real danger to patients in Connecticut.

Order

Based upon the record in this case, the above findings of fact and the conclusions of law, and pursuant to the authority vested in it by §§ 19a-17 and 20-13c of the Statutes, the Board finds that the misconduct alleged and proven is severable and warrants the disciplinary action imposed by this order.

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[1] Respondent also testified that he teaches patients how to carry their medications in case they are pulled over by the police, and if a pharmacy refuses to fill a script to "swallow hard" and say "well, ok. I guess I'll take my business elsewhere." He tells the patients that they might hear from pharmacists that there is a problem with "Me." At the same time the respondent admits to using several pharmacies for the same patient and the same drug. He states that this is because he prescribes so much that he is being considerate to other customers of the pharmacies in case they run out of opiates. He also states that usually three pharmacies are involved and the pharmacists know and are part of the treatment team. Respondent also stated that he has no documentation of this. At another point in his testimony, when he was asked if Walgreens knew that the same patient was getting more of the same drug from another pharmacy, respondent stated, "I can't speak exactly of what other people know." Tr. 11/12/10, p. 15. This testimony is not credible. The practice of pharmacies is to have all drugs for a patient dispensed in one place. There is no problem for pharmacies to get opiates in any amount. Further, this teaches patients some of whom are addicts of illicit drugs, to go to multiple pharmacies which is anti-therapeutic and against federal and state guidelines for prescribing. See Tr. 11/5/10, pp. 185, 201.

The Board orders that in Petition No. 2009-200921:

1. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient K. R., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
2. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient T.P., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
3. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient R.O., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
4. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient P.P., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
5. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient M.D. , and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
6. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient D.T.-W., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
7. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient L.W., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
8. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of

patient K.O.'C ., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,

9. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient P.B., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,

10. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient S.B., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,

11. Respondent shall pay the civil penalties described above which equal a total of fifty thousand dollars ($50,000.00) by certified or cashier's check payable to "Treasurer, State of Connecticut." The check shall reference the Petition Number on the face of the check, and shall be payable within thirty days of the effective date of this Decision.

12. All correspondence related to this Memorandum of Decision and payment of the civil penalty must be mailed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

13. This Memorandum of Decision is effective on September 20, 2011.

September 20, 2011

Anne C. Doremus

By: Anne C. Doremus, Chairperson
Connecticut Medical Examining Board

CERTIFICATION

I hereby certify that, pursuant to Connecticut General Statutes § 4-180(c), a copy of the foregoing Memorandum of Decision was sent this 21st day of September 2011, by certified mail, return receipt requested to:

Richard C. Tynan, Esq.
Halloran & Sage
One Goodwin Square
225 Asylum Street
Hartford, CT 06103-4303

Certified Mail RRR #7004-1160-0000-8837-0227

and via email to:

Matthew Antonetti, Principal Attorney
Legal Office
Department of Public Health
410 Capitol Avenue, MS #12LEG
Hartford, CT 06134-0308

Jeffrey A. Kardys
Administrative Hearings Specialist/Board Liaison
Department of Public Health
Public Health Hearing Office