STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

Ljudmil Kljusev, M.D.
License No. 039302

Petition Nos. 2010-49 and 2010-5464

MEMORDANDUM OF DECISION

Procedural Background

On April 19, 2012, the Connecticut Department of Public Health (the "Department") presented the Connecticut Medical Examining Board (the "Board") with a Statement of Charges (the "Charges") brought against license number 039302 of Ljudmil Kljusev, M.D. ("Respondent") in Petition Nos. 2010-49 and 2010-5164. The Charges allege that Respondent violated § 20-13c(4) of the General Statutes of Connecticut (the "Statutes"). Board Exhibit ("Bd. Ex.") 2.

On July 24, 2012, a Notice of Hearing was sent via certified mail to Respondent, scheduling a hearing for September 7 and 21, 2012. Bd. Ex. 1.

On August 13, 2012, Respondent filed an Answer to the Charges. Bd. Ex. 3

On August 13, 2012, Respondent filed a Motion for Continuance of the September 7, 2012 hearing. Bd. Ex. 4. The Motion was granted.

On September 19, 2012, Respondent filed a Motion to Recuse/Motion to Exclude Dr. Richard Bridburg from the Medical Panel. Bd. Ex. 5. During the hearing on September 21, 2012, Respondent withdrew the Motion. Transcript ("Tr.") 9/21/12, pp. 12-14.

A hearing was held on September 21, and December 7, 2012, and January 29, 2013, regarding the allegations contained in the Charges. The hearing was held before a duly authorized panel of the Board comprised of Richard Bridburg, M.D.; Anne Doremus; and Joseph Kaplowe, P.A. (the "Panel"). Bd. Ex. 6.

The Panel conducted the hearing in accordance with Chapter 54 of the Statutes and §§ 19a-9a-1 *et seq.* of the Regulations of Connecticut State Agencies (the "Regulations"). Respondent was represented by Attorney Trudie Hamilton; Attorney Diane Wilan represented the Department. Both parties had the opportunity to present evidence, conduct cross-examination, and provide argument on all issues.

All Panel members involved in this decision attest that they have 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. Department alleges that, "Respondent is, and has been, at all times referenced in the [Charges], the holder of Connecticut license number 039302 to practice medicine and surgery." Charges, ¶ 1 and 5; Bd. Ex. 2.

Count One

2. Department alleges that, "[o]n or about November 16, 2009[1], Respondent, a specialist in psychiatry, failed to maintain a professional office environment at his Milford, Connecticut office. Charges, ¶ 2; Bd. Ex. 2.

3. Department alleges that, "Respondent failed to maintain proper medical documentation when on or about November 16, 2009, he failed to document an incident with patient L.S. who arrived for a scheduled appointment, but became upset and left before the professional session took place." Charges, ¶ 3; Bd. Ex. 2.

4. Department alleges that, "[t]he above facts constitute grounds for disciplinary action pursuant to §20-13c, including, but not limited to §20-13c(4) of the Statutes." Charges, ¶ 4; Bd. Ex. 2.

Count Two

5. Department alleges that, "Respondent failed to maintain professional boundaries when, during approximately 2007:

    a. He disclosed personal information about himself to patient D.L. and conducted person telephone calls in her presence;

[1] The Department made a Motion for a Technical Amendment to change the date in Count One, allegations numbered 2 and 3, from November 11, 2009 to November 16, 2009. Respondent stipulated to the November 16, 2009 date. The Board granted the Motion to Amend. Tr., 9/21/12, p. 18.

b. He invited patient D.L. to meet him socially outside the clinical framework;

c. He sent text messages to patient D.L. which were unrelated to treatment; and/or,

d. He took Provigil during D.L.'s treatment sessions and provided Provigil to D.L. for use during the session without a prescription.

e. He made sexual advances toward patient D.L. during treatment sessions, including kissing and/or inappropriately touching her." [2] Charges, ¶ 6; Bd. Ex. 2.

6. Department alleges that, "Respondent failed to maintain proper medical documentation when:

a. Between approximately April 2003 and December 2007, his records failed to adequately justify his prescribing of medication to treat patient D.L.; and/or

b. Between approximately April 2003 and December 2007, he failed to adequately document ongoing substance abuse assessments for patient D.L." Charges, ¶ 7; Bd. Ex. 2.

7. Department alleges that, "[t]he above facts constitute grounds for disciplinary action pursuant to §20-13c, including, but not limited to §20-13c(4) of the Statutes." Charges, ¶ 8; Bd. Ex. 2.

Findings of Fact

1. Respondent, of Bridgeport, Connecticut is, and has been at all times referenced in the Charges, the holder of Connecticut physician license number 039302. Bd. Ex. 3.

2. On November 16, 2009, patient L.S. ran out of her medication. She called Respondent and was instructed to meet him at his office in Milford at 7:30 p.m. Respondent Exhibit ("Resp. Ex.") A (sealed); Tr. 9/21/12, pp. 43, 44, 153, 156 169, 170, 180, 194, 195; Tr. 9/21/12, pp. 84, 107, 112, 117, 118 (sealed); Tr., 12/7/12, pp. 16, 17.

3. When L.S. arrived for her appointment with Respondent in Milford on November 16, 2009, it was about 7:15 p.m. and Respondent had candles lit, there was a strong scent of cologne, the room was dark, there was an animal print rug on the floor, a computer on the desk, and Respondent had a beer in his hand and lit a cigar. There were boxes behind the receptionist desk with no receptionist present. Department Exhibit ("Dept. Ex.") 1-3; Resp. Exs. B, C; Tr., 9/21/12, p. 158; Tr. 9/21/12, pp. 48-51, 59-62, 68, 69, 85, 87, 88-100, 110, 111 (sealed).

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[2] During the hearing on January 29, 2013, and after the Department rested its case, Dr. Bridburg made a Motion to the Dismiss the allegation contained in 6e of the Charges based on the Department's failure to meet its burden of proof. The Motion was seconded by Anne Doremus and unanimously accepted by the Panel. Therefore, Allegation 6e of the Charges was dismissed on the record, and it is dismissed pursuant to this Memorandum of Decision.

4. On March 9, 2010, Diane Cybulski, supervising nurse consultant for the Department, and Lavita Sookram, nurse consultant for the Department, made a site visit to Respondent's Milford office. On that date, no one else was present, there were two leather chairs, some animal print rugs, and candles. There was overhead lighting in the reception area and tabletop lighting in the office that gave a softer appearance to the room. Respondent explained to Ms. Cybulski that the cigar and beer were brought to the office on November 16, 2009 from friends who were visiting from out-of-the country and the candles were used to get rid of the residual smoke smell. Dept. Exs. 4, 8; Resp. Ex. B; Resp. Exs. I, J (sealed); Tr., 9/21/12, pp., 148, 153-158, 160, 161, 163, 168-179, 182-189; Tr., 12/7/12, pp., 17, 18, 25, 38, 39, 41, 42, 45, 46, 55, 56; Tr., 1/29/13, pp. 200, 201.

5. Respondent failed to maintain proper medical documentation when on or about November 16, 2009, he failed to document an incident with patient L.S. who arrived for a scheduled appointment, but became upset and left before the professional session took place. Bd. Ex. 3; Dept. Exs. 10, 12; Resp. Ex. A; Tr. 9/21/12, pp. 43, 44, 158, 159, 164, 189-191, 199, 205, 206, 212, 214, 216, 217, 221, 224, 225; Tr. 9/21/12, pp. 49-53, 59, 62, 63, 65, 107, 108 (sealed); Tr., 12/7/12, p. 16.

6. While providing treatment to D.L., Respondent made limited personal disclosures to D.L., in D.L.'s presence in response to D.L's inquiries about routine personal information, and while taking a telephone calls from his wife. Bd. Ex. 3; Dept. Ex. 19 (sealed); Tr. 12/7/12, pp. 117-119, 122, 123.

7. On November 29, 2007, Respondent invited D.L. to meet him at a restaurant in Southport, Connecticut where he attended a pharmaceutical meeting. Bd. Ex. 3; Dept. Ex. 19 (sealed); Resp. Ex. H; Tr. 12/7/13, p. 105 (sealed); Tr., 1/29/13, pp. 203- 209.

8. Respondent failed to maintain professional boundaries in 2007 when he sent text messages to patient D.L., which were unrelated to treatment. Dept. Ex. 1; Dept. Exs. 19, 21 (sealed); Tr. 12/7/2012, pp. 92-113 (sealed).

9. In 2007, Respondent gave D.L. Provigil during a treatment session. Dept. Ex. 19 (sealed); Tr. 12/7/12, pp. 90, 91 (sealed); Tr., 1/29/13, pp. 70-72, 191, 192.

10. Respondent's records adequately justified his prescribing of medication to treat patient D.L between April 2003 and December 2007. Resp. Ex. A, pp. 50, 51; Dept. Ex. 12; Dept. Exs. 15, 19 (sealed); Tr. 1/29/12, pp. 73-75, 99, 100-130.

11. Between April 2003 and December 2007, Respondent adequately documented ongoing substance abuse assessments for patient D.L. Resp. Ex. A, pp. 50, 51; Dept. Ex. 12; Dept. Exs. 15, 19 (sealed); Tr. 1/29/12, pp. 74, 75, 99, 100-130.

12. Neither L.S. nor D.L. are deemed credible on all issues, but their testimonies are credible in part, and due weight is given with respect to each issue. Tr., 9/21/12, pp. 41-44; Tr., 9/21/12, pp. 48-127 (sealed); Tr., 12/7/12, pp. 70-270 (sealed).

Discussion and Conclusions of Law

The Department bears the burden of proof by a preponderance of the evidence. *Charles Ray Jones v. Connecticut Medical Examining Board*, SC #18843 (2013); *Goldstar Medical Services, Inc., et al. v. Department of Social Services,* 288 Conn. 790 (2008).

Section 19a-10 of the Connecticut General 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 the Statutes § 20-13c(4) "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 for allegations 1, 3, 5 6b, 6c and 8 of the Charges.

With respect to allegations 1 and 5 of the Charges, Respondent agrees that he is the holder of Connecticut physician and surgeon license number 039302. Bd. Ex. 3. Thus, allegations 1 and 5 are proven.

Count One

With respect to allegation 2 of the Charges, the Department failed to sustain its burden of proof that on or about November 16, 2009, Respondent failed to maintain a professional office environment at his Milford, Connecticut office. Dept. Exs. 1-3, p. 7; Tr. 9/21/12, pp. 48-51, 59-62, 68, 69, 85, 87, 88-100, 110, 111 (sealed). L.S. testified that when she arrived at Respondent's Milford office around 7:15 p.m. on November 16, 2009, the office was dark, smelled of strong cologne, had lit candles, and animal print rugs. When she arrived, Respondent had a beer in his hand and later lit a cigar. Department Exhibit ("Dept. Ex.") 1, p. 7; "Resp. Ex." B; Tr., 9/21/12, p. 158; Tr. 9/21/12, pp. 48-51, 59-62, 68, 69, 85, 87, 88-100, 110, 111 (sealed). L.S. also testified that she was concerned that the computer and wires in his office was an indication that she was being "camcorded." Tr., p. 88 (sealed).

On March 9, 2010, pursuant to L.S.'s complaint, the Department's investigators, Ms. Cybulski and Ms. Sookram conducted an inspection of Respondent's Milford office and what they found was mainly consistent with L.S.'s description. Respondent, however, explained his computer was set up for electronic medical records , and that he lit candles to remove the residual smoke smell from a cigar smoked during his friends' visit just minutes prior to L.S.'s appointment, and he was putting away the beer when L.S. arrived early. Dept. Ex. 4; Resp. Exs. B, C; Resp. Exs. I, J (sealed); Tr., 9/21/12, pp., 148, 153-158, 160, 161, 163, 168-179, 182-189; Tr., 12/7/12, pp., 17, 18, 25, 38, 39, 41, 42, 45, 46; Tr., 1/29/13, pp. 200, 201.

Dr. John Santopietro, the Department's expert, opined that it is not a breach of the standard of care to use a professional office for a social visit at a time when patients are not being seen, (Dept. Ex. 12; Tr. 9/21/12, pp. 244-246), and the Board finds that although some of the items seem uncommon for a professional office, the existence of such items does not deem it inappropriate. As Dr. Santopietro testified, an office that is lit by tabletop lamps and candles is not inappropriate. Tr. 9/21/12, pp. 233, 238-241. The Board also finds that while Respondent may have been holding a beer to put away, there is insufficient evidence to establish that Respondent's office environment was unprofessional and fell below the standard of care.

With respect to allegation 3 of the Charges, the Department satisfied its burden of proof that Respondent failed to maintain proper medical documentation when on or about November 16, 2009, he failed to document an incident with patient L.S. who arrived for a scheduled appointment, but became upset and left before the professional session took place. Respondent claims that L.S.'s appointment was unscheduled, but the facts establish otherwise. Tr. 9/21/12, pp. 43, 44. Respondent received a phone call from L.S. and told her to come into his Milford office at 7:30 p.m. At that point, the session was scheduled. Tr. 9/21/12, pp. 43, 44, 153, 156 169, 170, 180, 194, 195; Tr. 9/21/12, pp. 84, 107, 112, 117, 118 (sealed). Anytime a patient attends a session, scheduled or not, such session requires documentation, and documentation becomes all the more important when the patient leaves abruptly, as L.S. did in this matter. Dr. Santopietro testified that any patient encounter is important to document in the patient's record. Tr. 9/21/12, p. 214. L.S.'s November 16, 2009 appointment was not documented nor were there any records of a termination of L.S.'s treatment with Respondent. Tr. 9/21/12, p. 225. Not only was the record devoid of any notes by Respondent of the November 16, 2009 session, Respondent also agreed in his Answer and through his testimony that he failed to document the

incident. Bd. Ex. 3; Resp. Ex. A, p. 53. As such, Respondent breached the standard of care when he negligently failed to document the November 16, 2009 session with L.S., in violation of § 20-13c(4) of the Statutes.

Count Two

With respect to allegation 6a of the Charges, the evidence fails to establish that Respondent failed to maintain professional boundaries during approximately 2007, when he disclosed personal information about himself to patient D.L. and conducted personal telephone calls in her presence. The Department presented D.L. as a witness to support its position. D.L. suffers from a cocaine addiction, which continued throughout her treatment with Respondent, Dept. Exs. 17, 20 (sealed), and made several claims regarding Respondent's conduct, including a claim that he gave her a gold coin worth $17,000. Tr., 12/7/12, pp. 225, 228-231(sealed). The Board finds that D.L.'s testimony on this issue is not credible and is unreliable. Respondent acknowledges that he disclosed limited personal information, Bd. Ex. 3, but the Department presented insufficient credible evidence that there were disclosures by Respondent in violation of the standard of care and § 20-13c(4) of the Statutes.

The Department sustained its burden of proof for allegation 6b of the Charges that Respondent failed to maintain professional boundaries when, on November 29, 2007, Respondent invited patient D.L. to meet him socially outside the clinical framework. Respondent claims that he was attending a professional psychiatric meeting held at Paci's on said date, and agreed to have D.L. meet him there. Bd. Ex. 3; Resp. Ex. H; Tr. 1/29/13, pp. 203-206. He testified that D.L. may have seen a flyer for the event and wanted to attend, but this claim is not credible. Tr. 1/29/13, pp. 200, 208, 209. Text messages to D.L. indicate that he invited D.L. Specifically, Respondent texted, "Am at pacci in southport . . .You want to join?? . . . Me alone! . . . In 10 min outside. ..." [*sic*] Dept. Ex. 11. The Board finds D.L.'s data regarding Respondent's text messages to be reliable. Respondent's attempted meeting with D.L. was outside of the office and was social in nature. As such, Respondent failed to maintain professional boundaries in violation of § 20-13c(4) of the Statutes when he acted negligently and invited D.L. to meet him socially, outside of his office.

The Department sustained its burden of proof for allegation 6c of the Charges that Respondent failed to maintain professional boundaries when he sent text messages to patient

D.L, which were unrelated to treatment. D.L. testified that Respondent sent her numerous text messages of a personal nature. Tr., 12/7/12, pp. 93-113. D.L's testimony, pertaining to this allegation is deemed credible as it is further supported by Respondent's testimony, as well as the Department's submission of D.L.'s cell phone records, which revealed messages sent from Respondent to D.L. that were clearly inappropriate, particularly his reference to her as "Sweety." Bd. Ex. 3; Dept. Ex. 11; Dept. Ex. 21 (sealed); Tr. 1/29/13, pp. 195-200. Respondent testified that D.L. wanted to be called "Sweety." Tr. 1/29/13, p. 196. However, Respondent's claim is troubling to the Board, highlighting his failure to understand the inappropriateness of the use of such a term with a patient, and his conduct thereby violates § 20-13c(4) of the Statutes.

With respect to allegation 6d of the Charges, the Department provided insufficient credible evidence that Respondent took and provided D.L. Provigil without a prescription during D.L.'s treatment sessions. Respondent denies he ever took Provigil and claims he provided D.L. samples of Provigil that were in his office to help D.L. with symptoms of cocaine withdrawal that she was exhibiting during her session. Bd. Ex. 3; Tr. 1/29/13, pp. 191, 192. D.L. claims the Provigil was taken from Respondent's desk and he gave her half and he took the other half. Tr. 12/7/12, pp. 90, 91 (sealed). While Dr. Santopietro testified that it may be appropriate at times to provide a patient a sample medication when a patient is experiencing symptoms, (Tr., 1/29/13, pp. 70-72), the Department presented no additional evidence to sustain its burden of proof that Respondent took the Provigil or that the Provigil given to D.L. during her session was given in violation of § 20-13c(4) of the Statutes.

The Department failed to sustain its burden of proof with respect to allegation 7a of the Charges, that Respondent failed to maintain proper medical documentation when between approximately April 2003 and December 2007, his records failed to adequately justify his prescribing of medication to treat patient D.L. As a private practitioner, Respondent's notes are proper. The Department's expert, Dr. Santopietro testified that Respondent's documentation failed to meet the standard of care. Tr. 1/29/12, pp. 99, 100-124. However, the Board finds Dr. Santopietro's testimony did not apply to Respondent's practice, as Dr. Santopietro's testimony was consistent with the requirements for institutional documentation of services for payment versus the type documentation required in private practices with private insurers. Dept. Ex. 12; Dept. Ex. 15 (sealed); Tr. 1/29/13, pp. 75, 76, 125-130. Although the Board would have

preferred to have seen more detailed records, there is insufficient evidence that the records fail to meet the standard of care in violation of § 20-13c(4) of the Statutes.

With respect allegation 7b of the Charges, the Board finds that there is insufficient evidence to establish that Respondent failed to adequately document ongoing substance abuse assessments for patient D.L. between April 2003 and December 2007. In fact, the Board finds amongst the exhibits submitted by both parties that Respondent maintained documentation of D.L.'s substance abuse, her diagnosis and prescriptions. Resp. Ex. A., pp. 50, 51; Dept. Ex. 12; Dept. Ex. 15 (sealed), p. 8. Additionally, Dr. Santopietro agreed from his review of Respondent's records that Respondent's treatment notes contained: 1) diagnoses; 2) brief assessments of D.L.; 3) adequate reference to D.L.'s substance abuse, drug craving and dependence; 4) notes for relapse prevention; and 5) therapist and intensive outpatient treatment recommendations. Tr. 1/29/13, pp. 126-130. The Board finds such records meet the professional standard of care and are deemed adequate documentation of ongoing substance abuse assessment for D.L.

Although the Department met its burden of proof, the Board finds that Respondent's failure to document L.S.'s November 16, 2009 session, as alleged in allegation 3 of the Charges, does not rise to the level of warranting disciplinary action against the Respondent's license. The Board does, however, find that Respondent's boundary violations, as alleged in allegations 6b and 6c of the Charges, constitute violations of § 20-13c(4) of the Statutes, warranting disciplinary action as stated below.

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 hereby finds that the misconduct found by the Board warrants the disciplinary action imposed by this Order. The Board hereby orders the following concerning Ljudmil Kljusev, holder of Connecticut physician and surgeon license no. 039302:

1. Respondent shall pay a civil penalty of fifteen thousand dollars ($15,000.00) by certified or cashier's check payable to "Treasurer, State of Connecticut." The check shall reference the Petition Numbers on the face of the check, and shall be payable within thirty days of the effective date of this Decision.

2. Respondent's license number 039302 to practice as a physician and surgeon in the State of Connecticut is hereby REPRIMANDED.

3. 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 Regulations
410 Capitol Avenue, MS#12HSR
P.O. Box 340308
Hartford, CT 06134-0308

4. The Board reserves the right to take additional disciplinary action pursuant to §§ 19a-17 and 20-13c of the Statutes should Respondent fail to comply with this Order.

5. This Memorandum of Decision is effective upon signature of the Board.

Connecticut Medical Examining Board

September 17, 2013
Date

By: Kathryn Emmett, Esq.
Chairperson

CERTIFICATION

I hereby certify that, pursuant to Connecticut General Statutes § 4-180(c), a copy of the foregoing Memorandum of Decision was sent this 19th day of September 2013, by certified mail, return receipt requested to:

Trudie Hamilton, Esq.
Carmody & Torrance
50 Leavenworth Street
PO BOX 1110
Waterbury, CT 06721-1110

Certified Mail RRR #91-7199-9991-7033-0326-2716

and via email to:

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