These charges are only allegations which may be contested by the licensee in an administrative hearing.

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

IN THE MATTER

OF

SETH FIELDING, M.D.

STATEMENT

OF

CHARGES

SETH FIELDING, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 11, 1969 by the issuance of license number 104414 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (each patient is identified in the attached Appendix A), then a 26-year-old male, at various times from on or about March 27, 2018 to on or about April 8, 2021. Respondent's medical care of Patient A deviated from accepted standards of care as follows:

1. Respondent, on one or more occasions, failed to conduct and/or document adequate psychiatric examinations of Patient A.
2. Respondent failed to appropriately diagnose Patient A, including but not limited to, ruling out other conditions, including substance use disorder.
3. Respondent failed to develop, implement, and revise as necessary, an appropriate treatment plan for Patient A, and/or document the same.
4. Respondent, on one or more occasions, prescribed medications to Patient A without adequate medical indication and/or without documenting adequate medical indication.

5. Respondent failed to appropriately monitor Patient A while maintained on controlled substances and/or failed to document the same.
6. Respondent failed to maintain a record for Patient A that accurately reflects the evaluation and treatment rendered.

B. Respondent provided medical care to Patient B, then a 26-year-old male, from on or about March 16, 2018 to on or about April 8, 2021. Respondent's medical care of Patient B deviated from accepted standards of care as follows:

1. Respondent on one or more occasions, failed to conduct and/or document adequate psychiatric examinations of Patient B.
2. Respondent failed to appropriately diagnose Patient B, including but not limited to, ruling out other conditions, including substance use disorder.
3. Respondent failed to develop, implement, and revise as necessary, an appropriate treatment plan for Patient B, and/or document the same.
4. Respondent, on one or more occasions, prescribed medications to Patient B without adequate medical indication and/or without documenting adequate medical indication.
5. Respondent failed to appropriately monitor Patient B while maintained on controlled substances and/or failed to document the same.
6. Respondent failed to maintain a record for Patient B that accurately reflects the evaluation and treatment rendered.

C. Respondent provided medical care to Patient C, then a 21-year-old female, from on or about July 16, 2012 to on or about December 2, 2021. During the period from on or about August 31, 2020 to on or about December 2, 2021, Respondent's medical care of Patient C deviated from accepted standards of care as follows:

1. Respondent, on one or more occasions, failed to conduct and/or document adequate psychiatric examinations of Patient C.
2. Respondent, on one or more occasions, prescribed medications to Patient C without adequate medical indication and/or without documenting adequate medical indication.
3. Respondent failed to appropriately monitor Patient C while maintained on controlled substances and/or failed to document the same.
4. Respondent failed to maintain a record for Patient C that accurately reflects the evaluation and treatment rendered.

D. Respondent provided medical care to Patient D, then a 25-year-old female from on or about February 7, 2013 to on or about December 3, 2021. During the period from on or about September 1, 2020 to on or about December 3, 2021, Respondent's medical care of Patient D deviated from accepted standards of care as follows

1. Respondent, on one or more occasions, failed to conduct and/or document adequate psychiatric examinations of Patient D.
2. Respondent, on one or more occasions, prescribed medications to Patient D without adequate medical indication and/or without documenting adequate medical indication.
3. Respondent failed to appropriately monitor Patient D while maintained on controlled substances and/or failed to document the same.
4. Respondent failed to maintain a record for Patient D that accurately reflects the evaluation and treatment rendered.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

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

1. Paragraph A and A.2
2. Paragraph A and A.4
3. Paragraph A and A.5

FOURTH THROUGH SEVENTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

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

4. Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A.6
5. Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, and/or B and B.6
6. Paragraphs C and C.1, C and C.2, C and C.3, and/or C and C.4
7. Paragraphs D and D.1, D and D.2, D and D.3, and/or D and D.4.

EIGHTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS[1]

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

8. A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, and/or D and D.4.

DATE: September 4, 2026
New York, New York

[redacted]
HENRY WEINTRAUB, ESQ.
Chief Counsel
Bureau of Professional Medical Conduct