VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: MARTIN STEIN, M.D.
License No.: 0101-030679

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Martin Stein, M.D., on January 31, 2008, in Richmond, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Karen Ransone, M.D., Chair; Claudette Dalton, M.D.; and General Clara Adams-Ender, R.N. Dr. Stein appeared personally and was represented by Michael L. Goodman, Esquire. Julia K. Bennett, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions. The purpose of the informal conference was to consider Dr. Stein's Application for the Reinstatement of his License to Practice Medicine and Surgery in Virginia, and to receive and act upon evidence that grounds may exist to deny said application, as set forth in an Amended Notice of Informal Conference dated September 14, 2007.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee adopts the following Findings of Fact and Conclusions of Law in this matter:

1. Martin Stein, M.D., was issued license number 0101-030679 by the Board to practice medicine and surgery in the Commonwealth of Virginia on April 2, 1979. Said license was surrendered for suspension of not less than one year on October 11, 2002.

2. Dr. Stein is in violation of Section 54.1-2915.A(4) and (14) of the Code, in that he is impaired to practice medicine with skill and safety due to mental and/or physical illness.

3. Dr. Stein is in violation of Section 54.1-2915.A(4) of the Code, in that he is incompetent to practice medicine safely because he has not practiced since October 2002.

4. Dr. Stein violated Section 54.1-2915.A(13) of the Code, when, on several different occasions, he simultaneously treated members of the same family, failing to recognize the inherent conflict of interest and potential harm arising from such treatment. Specifically:

a. Dr. Stein provided individual treatment and therapy to members of the same family consisting of Patients B (husband/father), C (wife/mother), D and E (minor children of Patients B and C) from approximately 1994 to 1996. The clear conflict of interest present in this situation resulted in detrimental consequences to these patients, especially Patient B, whom Dr. Stein dismissed from his practice upon belatedly recognizing the conflict of interest present in treating both Patient B and his spouse, Patient C.

b. Dr. Stein provided individual treatment and therapy to members of the same family consisting of Patients I (wife/mother), J and K (minor sons of Patients I and L), and L (husband/father) from approximately March 1996 to October 2002.

c. Dr. Stein provided individual treatment and therapy to members of the same family consisting of Patients N (wife/mother), O (minor child of Patients N and P), and P (husband/father) from approximately March 1997 to October 2002.

5. Dr. Stein violated Section 54.1-2915.A(13) of the Code, in that, without performing an adequate physical examination or assessment, obtaining a relevant medical history, or consulting with or referring to other appropriate healthcare providers, he treated Patients A, D, I, J, K, L, O, and P for the following conditions:

a. Dr. Stein provided psychiatric care to minor patients D, J, K and O, instead of referring them to specialists in child psychiatry.

b. On or about December 29, 1997, Dr. Stein treated Patient I for pain and trauma associated with a finger amputation; Dr. Stein prescribed birth control pills for Patient I on numerous occasions; and Dr. Stein treated Patient I for a bad cough and viral throat infection on or about February 12, 1999.

c. Commencing on or about April 8, 1999, and continuing for approximately six months, Dr. Stein diagnosed and treated, including writing prescriptions for, Patient K for enuresis.

d. Dr. Stein prescribed Viagra to Patients A and L on or about June 24, 2002, and June 20, 2002, respectively.

e. On or about April 29, 1998, Dr. Stein began treating Patient O, a minor child, for migraines, to include prescribing Inderal.

f. On several occasions, Dr. Stein wrote prescriptions for Atenolol to treat Patient P's high blood pressure.

6. Dr. Stein violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003*, (13), and (16) of the Code, in that he engaged in conduct that was potentially harmful to Patients B, C, I, N, and P when he failed to maintain appropriate boundaries during their treatment.

Specifically:

a. Dr. Stein failed to respect appropriate boundaries and did not act in the best interest of Patient B when, on or about May 5, 1995, he referred Patient C to an attorney for legal advice regarding a separation from Patient B.

b. Dr. Stein warned a prior boyfriend of Patient I to leave her alone via an e-mail message and also communicated with his supervisor regarding his behavior towards Patient I. Further, Dr. Stein sought legal advice and counsel for Patient I regarding a possible product liability lawsuit.

c. By Dr. Stein's own admission, he became "over involved" in decisions concerning how Patients N and P should handle the pregnancy of their teenage daughter, who was not Dr. Stein's patient. Further, Dr. Stein failed to maintain appropriate boundaries when he hugged Patient N on more than one occasion.

7. Dr. Stein violated Section 54.1-2915.A(13) of the Code, in that he frequently failed to properly assess and diagnose, and consequently, to treat, manage, and monitor the care of his patients. Specifically, Dr. Stein formulated diagnoses for Patients B-D, G-K, and N-P that were not supported by objective or subjective findings, diagnostic testing, or other medical indication, as set forth in more detail below:

a. On or about March 6, 1996, Dr. Stein diagnosed Patient I with, among other things, organic affective disorder, a diagnosis that does not exist under the Diagnostic and Statistical Manual of Mental Disorders - IV ("DSM - IV"), and with partial epilepsy, notwithstanding the fact that an EEG performed on or about April 30, 1996 was normal. Further, Dr. Stein's diagnoses of Patient I with left bundle branch

hemiblock and post-concussive syndrome were not supported by diagnostic testing or any other clinical data or findings.

b. Dr. Stein admits that there was no support for his diagnosis of anxiety for Patient K. Dr. Stein's diagnosis of intermittent explosive disorder at Patient K's initial visit was also unsupported. Further, on or about May 19, 1999, Dr. Stein began to treat Patient K for, and diagnosed him with, possible attention deficit disorder, based on the documented rationale that the patient felt good when he drank caffeine beverages.

c. By Dr. Stein's own admission, he misdiagnosed the conditions of Patient N, whom he treated from approximately January 1997 to October 2002 for, among other things, major depression affective disorder, restless leg syndrome, rule-out hypersomnia with sleep apnea, migraine, bipolar affective disorder, obsessive-compulsive disorder, and pre-senile dementia. Dr. Stein did not have adequate objective or subjective findings to support his diagnoses of obsessive-compulsive disorder or pre-senile dementia. Dr. Stein continued to prescribe medications for Patient N for restless leg syndrome, even though her sleep study did not confirm the presence of that syndrome. Further, Dr. Stein never documented confirmation or negation of the rule-out diagnosis of hypersomnia with sleep apnea during his treatment of Patient N, even though Patient N's sleep study indicated that she had significant depression with hypersomnolence or suffered from idiopathic hypersomnolence.

d. Dr. Stein treated Patient O from approximately January 1997 to October 2002, for, among other things, attention deficit disorder/child without hyperactivity, major

depressive disorder, and obsessive compulsive disorder. However, Dr. Stein did not have objective or subjective findings to support his diagnosis of obsessive-compulsive disorder, and Dr. Stein admits that he did not consider that Patient O's reported inattention at his initial visit could have been the result of his depression, rather than attention deficit disorder. Further, on or about February 7, 1997, Dr. Stein diagnosed Patient O with Gilles de la Tourette's syndrome ("Tourette's syndrome"), even though Dr. Stein admits that Patient O did not fit the DSM-IV criteria for that syndrome, and in the absence of adequate clinical findings to substantiate that diagnosis.

e. Dr. Stein treated Patient P from approximately January 1997 to October 2002 for, among other things, attention deficit disorder/child without hyperactivity, and major depressive affective disorder. However, Dr. Stein admits that he arrived at the diagnosis of attention deficit disorder at Patient P's initial visit without reviewing all of the features of that condition. Further, on or about April 12, 1999, Dr. Stein diagnosed Patient P with Tourette's syndrome with no reasonable objective or subjective findings to justify that diagnosis.

f. Dr. Stein misdiagnosed or diagnosed without reasonable objective or subjective findings the following conditions in the following patients:

Patient	Diagnosis	Date
B	Tourette's syndrome	December 2, 1994
D	Partial epilepsy	August 18, 1994
G	Partial epilepsy	August 18, 1994
H	Obsessive-compulsive disorder	October 19, 2000
J	Obsessive-compulsive disorder	April 8, 1999

8. Dr. Stein violated Section 54.1-2915.A(4), *as codified prior to July 1, 2003*, of the Code, in that he did not see patients frequently enough to adequately monitor and manage their care. Specifically:

a. By his own admission, Dr. Stein did not see Patients A, M, and N frequently enough to provide them with appropriate care.

b. Dr. Stein did not attempt to schedule Patient B for an emergency visit to assess his condition after Dr. Stein learned from his wife on or about December 8, 1994, that he was suicidal subsequent to Dr. Stein diagnosing him with Tourette's syndrome.

c. Dr. Stein failed to exercise sound medical judgment when he accepted Patient F as a patient and continued to treat him knowing that he was commuting to see Dr. Stein from Maine and then New York. Patient F, a very unstable patient, was not able to see Dr. Stein with the frequency necessitated for reasonable observation and management of his conditions, and Dr. Stein was unable to respond in a timely fashion to the frequent episodes of mania that Patient F experienced.

d. On or about January 19, 2000, Dr. Stein responded to a desperate phone call from Patient Q by telephonically prescribing her a higher dose of Klonopin; however, Dr. Stein did not require Patient Q to come in immediately for an office visit to assess her condition nor did he see her for approximately nine more months.

9. Dr. Stein violated Sections 54.1-2915.A(13) and (17), 54.1-3303.A, and 54.1-3408.A of the Code, in that he failed to prescribe appropriate medications, prescribed medications in excessive quantities and doses, and failed to properly manage and monitor medications prescribed for Patients A-Q. Specifically:

a. Dr. Stein endangered the health and welfare of minor patients J, K and O when he repeatedly prescribed medications that were not recommended for children or for which the safety and/or efficacy of use in children had not been adequately tested.

b. Dr. Stein repeatedly endangered the health and welfare of patients when he regularly prescribed medications in excess of their maximum safe recommended dosages or in dosages exceeding that which had been adequately tested, as set forth below:

Patient	Medication	Dose Prescribed	Max. Safe Dose At time of Prescription
F	Prozac Zyprexa Provigil Lamictal	Up to 400 mg/day 40 mg/day 600 mg/day 800mg-1600 mg/day	80 mg/day 20 mg/day 400 mg/day 400 mg/day
H	Prozac	Dose sufficient to "clear head"	80 mg/day
I	Neurontin Celexa Remeron	Up to 10,000 mg/day Up to 200 mg/day Up to 90 mg/day	3600 mg/day 40 mg/day 45 mg/day
J	Celexa Prozac	Up to 60 mg/day No. of pills necessary to "clear head"	40 mg/day 80 mg/day
K	Celexa	Up to 80 mg/day	40 mg/day
L	Adderall Celexa Prozac	Up to 120 mg/day Up to 100/mg day Up to 120/mg day	40 mg/day 40 mg/day 80 mg/day
M	Prozac	Up to 240/mg day	80 mg/day
N	Prozac	Up to 120 mg/day	80 mg/day
P	Paxil	80 mg/day	60 mg/day
Q	Prozac	Up to 200/mg day	80/mg day

c. Dr. Stein jeopardized his patients' health and welfare when he overprescribed medications, prescribed unwarranted medications, or prescribed medications or combinations thereof that were contraindicated. Specifically:

i. On or about January 17, 1997, Dr. Stein prescribed Patient F vigabatrin (Sabril), an experimental drug for patients unresponsive to other anti-epileptic medication available in Canada, without a diagnosis of epilepsy or any other medical indication for prescribing such medication. Further, on or about April 6, 2000, Dr. Stein added Depakote to Patient F's medication regimen, but he did not appropriately lower the dose of Lamictal prescribed to take into account the fact that Depakote may increase the blood level of Lamictal.

ii. Dr. Stein over prescribed multiple medications for Patient G, to include Ativan, Klonopin, Tegretol, Prozac, Tofranil, Paxil, Depakote, Dilantin, Neurontin, Topamax, and Xanax, which adversely affected Patient G mentally, emotionally, and physically, to include excessive sleepiness, muscle spasms, and confusion and mental disorientation.

iii. Dr. Stein's prescription of multiple and conflicting medications, including Provigil, Prozac, Lamictal, Lithobid, Parnate, Procardia, Amitriptyline, Effexor, Remeron, Zyprexa, Wellbutrin, Klonopin, Nortriptyline, Aricept, Risperdal, Clonidine, Xanax, Trazodone, Prometrium, Baclofen, Adderall, and Clozaril, contributed to the deterioration of Patient H's health under his care. Dr. Stein prescribed Patient H MAOI antidepressants, tricyclic antidepressants, and lithium, a combination of medications that is potentially dangerous and requires close monitoring. Dr. Stein also continued to prescribe MAOI antidepressants after Patient H informed him she was not complying with dietary restrictions necessary for the safe utilization of this medication.

Further, on or about April 10, 2001, Dr. Stein added Adderall to Patient H's medication regimen, without a medical indication for doing so.

iv. In prescribing Celexa, Ambien, Zyprexa, Tegretol XR, Verapamil, Buspar, Paxil, Klonopin, Zoloft, Xanax, Neurontin, Ativan, Ritalin, Sinemet, Percocet, Motrin, Lamictal, Prozac, Trazodone, Imitrex, Remeron, Carbatrol, Topamax, Effexor, Lithobid, Risperdal, Seroquel, and Norinyl, Dr. Stein overmedicated Patient I, resulting in adverse consequences to her health. Dr. Stein continued to prescribe excessive amounts of medication to Patient I even after he noted the need to decrease her medications and after other physicians expressed concern about the amount and combinations of medications Patient I was taking. Further, on or about November 6, 1997, Dr. Stein prescribed Zyprexa for Patient I with no documented medical rationale for doing so; on or about March 3, 1998, Dr. Stein prescribed Sinemet to Patient I, even though he had discontinued that prescription on January 8, 1997, based on his assessment that it was not working for Patient I; on or about February 24, 2000, Dr. Stein added a third antidepressant, Effexor, to Patient I's medication regimen, without documenting a medical rationale therefore and notwithstanding the fact that Patient I was already taking two other antidepressants; on or about February 27, 2001, Dr. Stein prescribed Topamax for Patient I, after it had been previously discontinued, for purposes of weight loss, an inadequate rationale for such prescription; on or about February 22, 2002, Dr. Stein began

prescribing Effexor to Patient I again after he had previously discontinued that medication based on Patient I's report that it made her feel bad.

v. On or about April 17, 2001, Dr. Stein prescribed Adderall to Patient L despite the presence of a high blood pressure reading and information from his family physician that Patient L had been noncompliant in the control and management of his blood pressure, a requirement Dr. Stein previously had established as a precondition for prescribing amphetamines for him. Further, Dr. Stein prescribed Wellbutrin and Risperdal to Patient L without an adequate medical indication or rationale for doing so.

vi. Dr. Stein overmedicated Patient N when he prescribed multiple medications, to include Luvox, Ativan, Tegretol, Prozac, Eskalith, Ritalin, Dexedrine, Lamictal, Provigil, Klonopin, Inderal, Effexor, Exelon, Concerta, Risperdal, Wellbutrin, Sinemet, Topamax, Trazodone, Sonata, Zyprexa, and Lithobid. Further, on or about December 29, 1997, Dr. Stein prescribed Zyprexa for Patient N with inadequate medical rationale for doing so; on or about May 2, 1997, Dr. Stein began prescribing Prozac for Patient N, who was diagnosed as bipolar, without taking into consideration the fact that Prozac can initiate rapid cycling and mania, and even though Patient N had previously informed him that she experienced akathisia when taking Prozac; on or about March 15, 2000, Dr. Stein added Risperdal to Patient N's medication regimen without an adequate medical rationale for doing so; on or about June 9, 2000, Dr. Stein added Sonata to Patient N's medication regimen, even though he was already

prescribing her 3 mg Klonopin to help with her sleep; and on or about May 31, 2002, Dr. Stein began prescribing Patient N Exelon, a medication for Alzheimer's, even though he did not believe Patient N had Alzheimer's and her diagnostic tests were inconsistent with that condition.

vii. By Dr. Stein's own admission, medications that he prescribed to Patient O prevented him from being able to determine what behaviors of Patient O were due to medication versus other causes. For example, Dr. Stein began prescribing Dexedrine for Patient O at his initial visit. However, as Patient O's behavior worsened, Dr. Stein failed to consider that this medication could have been causing or contributing to the deteriorating behavior. Subsequently, Patient O's treating psychiatrist at the day treatment facility to which he was admitted in April 1997 discontinued the Dexedrine. Nevertheless, Dr. Stein restarted Patient O on Dexedrine on or about October 9, 1997, subsequent to Patient O asking to be put back on that medication after taking Dexedrine on his own, without prior consultation with or approval from Dr. Stein. On or about September 21, 1999, Dr. Stein wrote Patient O's school a letter asking that he be permitted to chew nicotine gum in school, allegedly to provide therapeutic benefit for his Tourette's syndrome. However, there is insufficient medical basis for using such gum in the treatment of that condition, and, in light of Patient O's behavioral problems and indications of substance abuse, such treatment was not advisable. Further, Dr. Stein prescribed Risperdal, Wellbutrin, and Topamax for Patient O without an adequate medical indication

or rationale for dosing so, and, on or about March 14, 2000, Dr. Stein restarted Patient O on lithium after he had recently stopped that medication because it was not helping him.

viii. Starting on or about April 16, 1998, Dr. Stein added Flexeril and Sinemet to Patient P's medication regimen and continued to prescribe those medications, even though the patient did not note any improvement in his symptoms. Subsequently, on or about January 30, 2001, Dr. Stein again prescribed Sinemet for Patient P, even though he previously had discontinued that medication based on its ineffectiveness. Further, Dr. Stein prescribed the following medications to Patient P without an adequate medical indication or rationale for doing so: Risperdal, Buspar, Ritalin, Lithobid, Cytomel, Provigil, and Adderall XR.

ix. Dr. Stein prescribed medications for patients without having or documenting any reasonable medical indication or rationale for doing so, as set forth below:

Patient	Medication	Date	Diagnoses
A	Risperdal	January 1, 2001	Social phobia, anxiety, OCD
B	Catapres Patches Risperdal	Dec. 2 & 4, 1994 April 3, 1995	Tourette's syndrome
J	Paxil Celexa Clonidine	January 29, 2001 October 29, 2001 May 16, 2002	ADD and OCD
K	Risperdal Wellbutrin	March 4, 1999 July 22, 2002	OCD, anxiety, intermittent explosive disorder, ADD

M	Prozac Concerta Lithobid	January 7, 2000 December 31, 2001 August 28, 2002	No formal diagnosis documented in record
Q	Ambien Topamax Provigil Naltrexone Axert	February 8, 1999 December 15, 1999 August 23, 2001 July 3, 2002 July 5, 2002	Kleptomania, OCD, PMS, body dysmorphic disorder, restless leg syndrome, bipolar

d. Dr. Stein ignored medication side effects and/or prescribed additional medication(s) to counteract reported side effects, rather than identifying and reducing or eliminating the medications causing such side effects or taking other appropriate action to ameliorate such side effects. Specifically:

i. Dr. Stein continued to prescribe Dexedrine and Ritalin for Patient B after he was informed that Dexedrine made Patient B more obsessive and Ritalin made him suicidal.

ii. On or about October 10, 1994, Dr. Stein prescribed Ritalin to Patient D in order to provide a stimulant to offset the tiredness produced by the Depakote he was prescribing for Patient D.

iii. Dr. Stein continued to prescribe Prozac for Patient F in excessive doses after he noted that the patient's hypomanic behavior might be Prozac-induced, and Dr. Stein continued to prescribe Lamictal to Patient F in excessive dosages after Patient F informed him that he was experiencing diplopia, a side effect of Lamictal. Dr. Stein admitted to the Committee that he should not have been treating Patient F because he was too sick and lived too far away.

iv. Dr. Stein continued to prescribe Neurontin in excessive doses to Patient I, even though she complained to him of extreme fatigue, a side-effect of Neurontin. On or about November 6, 1997, Dr. Stein prescribed Ambien for Patient I, even though he had discontinued that medication at her last visit based on concerns that Patient I was experiencing amnesia as a side-effect thereof.

v. On or about March 30, 2001, Dr. Stein prescribed Depakote to Patient K for mood stabilization in order to offset the mood swings he noted Patient K to have begun experiencing after he prescribed him Celexa.

vi. On or about August 29, 2001, Dr. Stein failed to consider that excessive doses of Adderall prescribed to Patient L may have been causing his complaints of sleeplessness and too much energy at bedtime, and instead prescribed Celexa and Klonopin.

vii. On or about August 28, 2002, Dr. Stein observed Patient M to exhibit elements of hypomania, but, instead of considering that such symptoms may have been triggered by the excessively high doses of Prozac he was prescribing Patient M, Dr. Stein conjectured that she was bipolar and treated her for that condition.

viii. On or about April 12, 1999, Dr. Stein added Provigil to Patient N's medication regimen in order to treat her reported symptoms of daytime somnolence without determining the cause of those symptoms. When Patient N complained that she was having anxiety and word-finding problems, Dr.

Stein did not consider that these symptoms may have been caused by the excessive dosage of Prozac he was prescribing her. Dr. Stein acknowledged that, on several occasions, he should have stopped all of Patient N's medications after she complained to him of increasing lack of coordination and balance problems, confusion, problems with handwriting, lack of focus, excessive tiredness, slurring of speech, memory loss, and inability to function effectively at home or at work, as well as the fact that several individuals thought she was overmedicated. Although Dr. Stein suspected that Topamax may have been causing Patient N's cognitive difficulties, he did not discontinue or lower the dose prescribed because Patient N wanted to continue the medication without change. Further, on or about March 5, 2002, Dr. Stein began prescribing Inderal to treat tremors that Patient N was experiencing, although he subsequently stated that he suspected these tremors were induced by the lithium he was prescribing for Patient N.

ix. On or about March 18, 1997, Dr. Stein began prescribing Patient O Cogentin as an antidote for Risperdal, notwithstanding the fact that Patient O had not reported any symptoms of akathisia from Risperdal. Further, Dr. Stein continued to prescribe Haldol to Patient O after his mother reported that he was experiencing twitching in his legs and back since starting that medication. Dr. Stein's response was to prescribe Cogentin to control those symptoms. In addition, on or about May 5, 1999, Dr. Stein continued to prescribe Haldol after Patient O reported constant fatigue and falling asleep in school. Dr. Stein's

response to these complaints was to add Provigil to Patient O's medication regimen.

e. Dr. Stein routinely initiated medications for patients at high doses, rather than starting at a low dose and increasing as necessary, and often started multiple new medications at or near the same time, thereby making it difficult to ascertain the effectiveness of each. Specifically:

i. Although Dr. Stein prescribed 100 tablets of Ritalin for Patient B's attention deficit disorder on or about November 11, 1994, he prescribed another stimulant, Dexedrine, 100 tablets, on or about December 4, 1994.

ii. On or about May 10, 1996, Dr. Stein added Ritalin to Patient I's medication regimen and doubled her dose of Paxil with no documented medical rationale for these actions.

iii. On or about April 24, 1997, Dr. Stein prescribed Tegretol and Lithobid to treat Patient N's bipolar disorder, instead of adding one drug at a time to ascertain the efficacy of one drug before adding another. Further, on or about September 2 and 11, 1997, Dr. Stein prescribed Patient N two new medications, Wellbutrin and Lamictal, over the telephone without a patient visit and without documenting the medical rationale for these prescriptions. On or about June 19, 2002, Dr. Stein started Patient N on Concerta at the maximum approved dosage, which was too strong for the patient and had to be reduced.

iv. On or about June 5, 1998, Dr. Stein made several simultaneous changes in Patient O's medications. Dr. Stein added Eskalith 450 mg, a new medication,

at a high dose, on the suspicion that Patient O had a lithium-responsive condition, based only on the fact that the patient's mother was taking lithium. At the same time, Dr. Stein discontinued Patient O's Wellbutrin, and increased Paxil to 60 mg.

v. On or about July 21, 2000, Dr. Stein added Effexor to Patient P's medication regimen, even though he was already prescribing Paxil in excess of the maximum recommended safe dosage for Patient P's depression.

f. Dr. Stein regularly allowed patients, to include Patients F, L, N, and P, to experiment with and/or adjust their medication dosages, without first consulting with him or obtaining his approval. Frequently, Dr. Stein simply increased the dosage prescribed at the next visit when the patient reported to him the medication changes he/she had unilaterally implemented.

g. Dr. Stein prescribed new medications and/or authorized refills of medications for Patients A, F, G, J, K, L, M, N, O, P, and Q over the telephone or by mail without seeing them on a sufficiently regular basis to monitor the effect the medications were having on the patients' conditions, including after they had missed appointments or failed to present for office visits subsequent to being informed that such visits were necessary before additional prescriptions would be written.

10. Dr. Stein violated Section 54.1-2915.A(13) of the Code, in that, in the case of Patients A, G, and O, he failed to note signs of, and therefore did not treat or refer for treatment of, substance abuse. Specifically:

a. Dr. Stein did not consider alcohol or substance abuse as a possible diagnosis for Patient A in a timely fashion, despite information from Patient A that should have caused him to consider such diagnosis prior to his arrest for Driving Under the Influence on or about May 2001. Even after Dr. Stein became aware of this arrest and the fact that Patient A had misused Klonopin that he had prescribed, Dr. Stein did not add a diagnosis with respect to substance abuse or dependence. Further, Dr. Stein continued to prescribe Klonopin, Ativan, and Ambien, drugs with high potential for abuse and addiction, despite the fact that he noted in his January 23, 2002 progress notes that Patient A "is starting to use too many benzodiazepines to deal with his anxiety disease." Dr. Stein ignored other signs of drug-seeking behavior, to include Patient A's repeated requests for early refills of medication.

b. Dr. Stein failed to recognize signs that Patient G was abusing and had become addicted to the Xanax he was prescribing for her, to include several patient reports of lost or spilled pills and requests for early refills. Further, Dr. Stein continued to prescribe substances with high potential for abuse and addiction, including Xanax and Dexedrine, after he became aware on or about November 11, 1994, that Patient G had been hospitalized for a suicide attempt by drug overdose.

c. Dr. Stein failed to consider substance abuse as a cause of Patient O's behaviors, notwithstanding reports that Patient O, a troubled teen-ager, had tried marijuana, used inhalants, smoked cigarettes, and drank alcohol.

11. Dr. Stein violated Section 54.1-2915.A(16) of the Code, in that, on several occasions, he diagnosed patients with conditions that did not exist in order to obtain

insurance coverage for the prescribed medications or otherwise provided false information in his treatment of patients. Specifically:

a. On or about April 16, 2001, Dr. Stein falsely notified Patient H's insurance company that Patient H was being prescribed Adderall for attention deficit disorder in order for insurance to cover the prescriptions, when in fact he had not made such a diagnosis of Patient H.

b. On or about January 1, 1997, Dr. Stein prescribed Motrin 800 mg for Patient I, even though he admits he did not prescribe this for any medical condition he was treating, but instead prescribed it so the medication would be covered by Patient I's insurance. Further, on or about April 30, 1996, Dr. Stein wrote a letter for Patient I to present to her pharmacist claiming that he was a consultant for the manufacturer of Neurontin, when in fact he was not.

c. On or about May 3, 2002, Dr. Stein authored a letter stating that Patient M was unable to return to work until May 8, 2002, because she was on medical leave. However, Patient M's medical record contains no indication of the medical necessity for such leave.

d. On or about January 17, 2000, Dr. Stein admits that he diagnosed Patient O with narcolepsy so that insurance would pay for his prescriptions of Provigil. Further, on or about February 21, 2002, Dr. Stein increased the dosage of Provigil prescribed to Patient O, not for a clinical reason, but to allow the patient to accumulate extra medication in case the insurance company stopped covering it in the future.

e. On or about June 22 and July 23, 1998, Dr. Stein wrote letters on Patient Q's behalf stating that he was treating her for prolonged post-traumatic stress disorder, among other things, even though Patient Q's medical record contains no documented diagnosis of prolonged post-traumatic stress disorder.

12. Dr. Stein's treating psychiatrist stated to the Committee that he had been seeing Dr. Stein since 1999 to address his health issues and that his condition is stable with appropriate medication and therapy. Further, he gave his opinion that Dr. Stein was safe to return to the practice in a limited setting to treat the general psychiatric population, with the exception of substance abuse patients and victims of sexual/physical abuse.

14. Drs. Patricia Pade and Yaacov Pushkin, of the Virginia Health Practitioners' Intervention Program, stated that Dr. Stein was in full compliance with his Recovery Monitoring Contract executed June 6, 2005. They both felt that Dr. Stein was not ready to return to clinical practice with patient contact. They were of the opinion that Dr. Stein's standard of care issues before the Committee could not be fully explained by his health issues.

15. Dr. Stein said he realized that it was difficult to demonstrate to the Committee in the course of the Informal Conference that he was safe and competent to return to the practice of medicine; however, he felt he could demonstrate his ability if given the opportunity to practice under any terms the Board might impose on his license.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ORDERED that Dr. Stein's Application for the Reinstatement of his License to Practice Medicine and Surgery in Virginia be, and hereby is, DENIED.

Pursuant to Section 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Sections 54.1-2400(10) of the Code, Dr. Stein may, not later than 5:00 p.m., on March 10, 2008, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on March 10, 2008; unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 2/7/08

COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

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December 6, 2007

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CERTIFIED MAIL
7160 3901 9845 1842 4132

RE: Martin H. Stein, M.D.
License No.: 0101-030679
Rescheduling of Informal Conference

Dear Mr. Goodman:

This is official notification that Dr. Stein's informal conference scheduled for December 4, 2007, and continued upon your request, has been rescheduled for **Thursday, January 31, 2008, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Richmond, Virginia**. I enclose a copy of the Amended Notice of Informal Conference dated September 14, 2007, and a map for your convenience.

You and Dr. Stein should arrive at least thirty (30) minutes in advance of the appointed time. Materials relating to Dr. Stein's informal conference were forwarded to him by certified mail with the original notice. These documents will be distributed to the members of the Special Conference Committee and will be considered by the Committee when deliberating on this case.

Should you wish to submit additional information for consideration by the Committee, you must submit eight (8) copies to the attention of Renée S. Dixson, Discipline Case Manager, Virginia Board of Medicine, Perimeter Center, 9960 Mayland Drive, 3rd Floor, Richmond, Virginia 23233 by **January 14, 2008.**

If you have any questions regarding this matter, please contact Adjudication Specialist Julia K. Bennett at (804) 367-4427.

Sincerely,

Jennifer L. Deschenes
Deputy Executive Director, Discipline
Virginia Board of Medicine

JLD:fd1206L1.reschifcnot.stein.07

Enclosures:
Amended Notice of Informal Conference, dated September 14, 2007
Map

cc: Renée S. Dixson, Discipline Case Manager, Board of Medicine
Julia K. Bennett, Adjudication Specialist [108718/108734]
Marilyn Dundon, Discipline Support Specialist
Martin H. Stein, M.D.

COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

www.dhp.virginia.gov
TEL (804) 367- 4400
FAX (804) 527- 4475

November 29, 2007

Michael L. Goodman, Esquire
Goodman, Allen, & Filetti, PLLC
4501 Highwoods Parkway, Suite 210
Glen Allen, Virginia 23060

BY FACSIMILE
(804) 346-5954

RE: **Martin H. Stein, M.D.**
License No.: 0101-030679
Continuance of Informal Conference

Dear Mr. Goodman:

This letter is official notification that Dr. Stein's informal conference scheduled to convene on December 4, 2007, has been continued due to exigent circumstances regarding board member availability. The informal conference will be rescheduled for a date mutually agreeable to all parties.

The Board of Medicine apologizes for any inconvenience this change may cause and should you have any questions, please contact Renée Dixson, Discipline Case Manager, at (804) 367-4513.

Sincerely,

Jennifer L. Deschenes
Deputy Executive Director, Discipline
Virginia Board of Medicine

cc: Renée S. Dixson, Discipline Case Manager, Board of Medicine
Julia Bennett, Adjudication Specialist, APD [108718, 108734]
Martin H. Stein, M.D.

COMMONWEALTH of VIRGINIA

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October 17, 2007

Michael L. Goodman, Esquire
Goodman, Allen & Filetti, PLLC
4501 Highwoods Parkway, Suite 210
Glen Allen, Virginia 23060

CERTIFIED MAIL
7160 3901 9845 1842 3784

RE: Martin H. Stein, M.D.
License No.: 0101-030679
Rescheduling of Informal Conference

Dear Mr. Goodman:

This is official notification that Dr. Stein's informal conference scheduled for October 20, 2007, and continued upon request, has been rescheduled for **Tuesday, December 4, 2007, at 9:30 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Richmond, Virginia.** I enclose a copy of the Amended Notice of Informal Conference dated September 14, 2007, and a map for your convenience.

You and Dr. Stein should arrive at least thirty (30) minutes in advance of the appointed time. Materials relating to Dr. Stein's informal conference were forwarded to him by certified mail with the original notice. These documents will be distributed to the members of the Special Conference Committee and will be considered by the Committee when deliberating on this case.

Should you wish to submit additional information for consideration by the Committee, you must submit eight (8) copies to the attention of Renée S. Dixson, Discipline Case Manager, Virginia Board of Medicine, Perimeter Center, 9960 Mayland Drive, 3rd Floor, Richmond, Virginia 23233 by **November 16, 2007.**

If you have any questions regarding this matter, please contact Adjudication Specialist Julia Bennett, at (804) 367-4427.

Sincerely,

Jennifer L. Deschenes
Deputy Executive Director, Discipline
Virginia Board of Medicine

JLD:fd1017L1.reschifcnot.stein.07

Enclosures:
Amended Notice of Informal Conference, dated 9/14/07
Map

cc: Renée S. Dixson, Discipline Case Manager, Board of Medicine
Julia K. Bennett, Adjudication Specialist [108718, 108734][93172, 93027, 92962, 88627, 88626]
Marilyn Dundon, Discipline Support Specialist
Martin H. Stein, M.D.

COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

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October 2, 2007

Anisa P. Kelley, Esquire
Hancock, Daniel, Johnson & Nagle, P.C.
The Flint Hill Centre
3050 Chain Bridge Road, Suite #300
Fairfax, Virginia 22030

BY FACSIMILE
(703) 591-7646

RE: **Martin H. Stein, M.D.**
License No.: 0101-030679
Continuance of Informal Conference

Dear Ms. Kelley:

The Board of Medicine is in receipt of your letter dated September 20, 2007, regarding your request for a continuance of the informal conference for Dr. Stein scheduled to convene on October 20, 2007, in Richmond.

After careful consideration, it has been determined that your request should be granted since it demonstrates good cause. Therefore, the matter has been removed from the Board's docket for October 20, 2007. Dr. Stein's informal conference will be rescheduled for December 4, 2007, in Richmond, as agreed to by the parties.

Sincerely,

Jennifer L. Deschenes
Deputy Executive Director, Discipline
Virginia Board of Medicine

JLD/fd1002L1.congranted.ltrstein.07

cc: Renée S. Dixson, Discipline Case Manager, Board of Medicine
Julia Bennett, Adjudication Specialist [108718, 108734][93172,93027,92962,88627,88626]
Martin H. Stein, M.D.

COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

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September 14, 2007

AMENDED NOTICE OF INFORMAL CONFERENCE

Martin Stein, M.D.
3543 Winfield Lane, NW
Washington, D.C. 20007

CERTIFIED MAIL
7160 3901 9848 8721 0589

RE: License No.: 0101-030679

Dear Dr. Stein:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Saturday, October 20, 2007, at 9:30 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Richmond, Virginia**. The conference will be conducted pursuant to Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

The Amended Notice of Informal Conference supersedes the Notice dated September 11, 2007, and further clarifies the authority of the Special Conference Committee in acting on your application for reinstatement. The Notice dated September 11, 2007, has been vacated and is no longer considered a public document.

A Special Conference Committee ("Committee") will convene to consider your petition for the reinstatement of your license to practice medicine and surgery in the Commonwealth of Virginia, which was surrendered for suspension by Consent Order of the Board of Medicine, entered October 11, 2002 ("Consent Order"). As petitioner, you have the burden of proving your competency and fitness to practice medicine in the Commonwealth of Virginia. Please be advised that upon the introduction of evidence relating to your competency and fitness to practice medicine, the Board will also consider evidence that you may be in violation of certain laws and regulations governing the practice of medicine in Virginia. Specifically:

1. You may be in violation of Section 54.1-2915.A(4) and (14) of the Code, in that you may be impaired to practice medicine with skill and safety due to mental and/or physical illness.

2. You may be in violation of Section 54.1-2915.A(4) of the Code, in that you may be incompetent to practice medicine safely because you have not practiced since October 2002.

3. You may have violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003,* (13), and (16) of the Code, when, on several different occasions, you simultaneously treated members of the same family, failing to recognize the inherent conflict of interest and potential harm arising from such treatment. Specifically:

a. You provided individual treatment and therapy to members of the same family consisting of Patients B (husband/father), C (wife/mother), D and E (minor children of Patients B and C) from approximately 1994 to 1996. The clear conflict of interest present in this situation resulted in detrimental consequences to these patients, especially Patient B, whom you dismissed from your practice upon belatedly recognizing the conflict of interest present in treating both Patient B and his spouse, Patient C.

b. You provided individual treatment and therapy to members of the same family consisting of Patients I (wife/mother), J and K (minor sons of Patients I and L), and L (husband/father) from approximately March 1996 to October 2002.

c. You provided individual treatment and therapy to members of the same family consisting of Patients N (wife/mother), O (minor child of Patients N and P), and P (husband/father) from approximately March 1997 to October 2002.

4. You may have violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003,* (13), and (16), of the Code, in that, without performing an adequate physical examination or assessment, obtaining a relevant medical history, or consulting with or referring to other appropriate healthcare providers, you treated Patients A, D, E, I, J, K, L, O, and P for the following conditions:

a. You provided psychiatric care to the following minor patients, instead of referring them to specialists in child psychiatry:

Patient	Diagnosis
D	Subclinical seizure disorder and partial epilepsy
J	Attention deficit hyperactivity disorder and obsessive-compulsive disorder
K	Obsessive compulsive disorder, anxiety, intermittent explosive disorder, attention deficit disorder
O	Attention deficit disorder, major depressive affective disorder, obsessive compulsive disorder, Tourette's syndrome

b. On or about December 29, 1997, you treated Patient I for pain and trauma associated with a finger amputation; you prescribed birth control pills for Patient I on numerous occasions; and you treated Patient I for a bad cough and viral throat infection on or about February 12, 1999.

c. Commencing on or about April 8, 1999, and continuing for approximately six months, you diagnosed and treated, including writing prescriptions for, Patient K for enuresis.

d. You prescribed Viagra to Patients A and L on or about June 24, 2002, and June 20, 2002, respectively.

e. On or about April 29, 1998, you began treating Patient O, a minor child, for migraines, to include prescribing Inderal.

f. On several occasions, you wrote prescriptions for Atenolol to treat Patient P's high blood pressure.

5. You may have violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003*, (13), and (16) of the Code, in that you engaged in conduct that was potentially harmful to Patients B, C, I, N, and P when you failed to maintain appropriate boundaries during their treatment. Specifically:

a. You failed to respect appropriate boundaries and did not act in the best interest of Patient B when, on or about May 5, 1995, you referred Patient C to an attorney for legal advice regarding a separation from Patient B.

b. You warned a prior boyfriend of Patient I to leave her alone via an e-mail message and also communicated with his supervisor regarding his behavior towards Patient I. Further, you sought legal advice and counsel for Patient I regarding a possible product liability lawsuit.

c. By your own admission, you became "over involved" in decisions concerning how Patients N and P should handle the pregnancy of their teenage daughter, who was not your patient. Further, you failed to maintain appropriate boundaries when you hugged Patient N on more than one occasion.

6. You may have violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003*, (13), and (16) of the Code, in that you frequently failed to properly assess and diagnose, and consequently, to treat, manage, and monitor the care of your patients. Specifically, you formulated diagnoses for Patients B-D, G-K, and N-P that were not supported by objective or subjective findings, diagnostic testing, or other medical indication, as set forth in more detail below:

a. By your own admission, on or about June 28, 1994, you diagnosed Patient C with hypersomnia with sleep apnea, and cataplexy and narcolepsy, even though you had no medical confirmation of these conditions via a sleep study or other diagnostic tests, nor were there other clinical data or findings to substantiate these diagnoses.

b. On or about March 6, 1996, you diagnosed Patient I with, among other things, organic affective disorder, a diagnosis that does not exist under the Diagnostic and Statistical Manual of Mental Disorders - IV ("DSM - IV"), and with partial epilepsy, notwithstanding the fact that an EEG performed on or about April 30, 1996 was normal. Further, your diagnoses of Patient I with left bundle branch hemiblock and post-concussive syndrome were not supported by diagnostic testing or any other clinical data or findings.

c. You admit that there was no support for your diagnosis of anxiety for Patient K. Your diagnosis of intermittent explosive disorder at Patient K's initial visit was also unsupported. Further, on or about May 19, 1999, you began to treat Patient K for, and diagnosed him with, possible attention deficit disorder, based on the documented rationale that the patient felt good when he drank caffeine beverages.

d. By your own admission, you misdiagnosed the conditions of Patient N, whom you treated from approximately January 1997 to October 2002 for, among other things, major depression affective disorder, restless leg syndrome, rule-out hypersomnia with sleep apnea, migraine, bipolar affective disorder, obsessive-compulsive disorder, and pre-senile dementia. You did not have adequate objective or subjective findings to support your diagnoses of obsessive-compulsive disorder or pre-senile dementia. You continued to prescribe medications for Patient N for restless leg syndrome, even though her sleep study did not confirm the presence of that syndrome. Further, you never documented confirmation or negation of the rule-out diagnosis of hypersomnia with sleep apnea during your treatment of Patient N, even though Patient N's sleep study indicated that she had significant depression with hypersomnolence or suffered from idiopathic hypersomnolence.

e. You treated Patient O from approximately January 1997 to October 2002, for, among other things, attention deficit disorder/child without hyperactivity, major depressive disorder, and obsessive compulsive disorder. However, you did not have objective or subjective findings to support your diagnosis of obsessive-compulsive disorder, and you admit that you did not consider that Patient O's reported inattention at his initial visit could have been the result of his depression, rather than attention deficit disorder. Further, on or about February 7, 1997, you diagnosed Patient O with Gilles de la Tourette's syndrome ("Tourette's syndrome"), even though you admit that Patient O did not fit the DSM-IV criteria for that syndrome, and in the absence of adequate clinical findings to substantiate that diagnosis.

f. You treated Patient P from approximately January 1997 to October 2002 for, among other things, attention deficit disorder/child without hyperactivity, and major depressive affective disorder. However, you admit that you arrived at the diagnosis of attention deficit disorder at Patient P's initial visit without reviewing all of the features of that condition. Further, on or about April 12, 1999, you diagnosed Patient P with Tourette's syndrome with no reasonable objective or subjective findings to justify that diagnosis.

g. You misdiagnosed or diagnosed without reasonable objective or subjective findings the following conditions in the following patients:

Patient	Diagnosis	Date
B	Tourette's syndrome	December 2, 1994
D	Partial epilepsy	August 18, 1994
G	Partial epilepsy	August 18, 1994
H	Obsessive-compulsive disorder	October 19, 2000
J	Obsessive-compulsive disorder	April 8, 1999

7. You may have violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003,* (13), and (16) of the Code, in that you did not see patients frequently enough to adequately monitor and manage their care. Specifically:

a. By your own admission, you did not see Patients A, M, and N frequently enough to provide them with appropriate care.

b. You did not attempt to schedule Patient B for an emergency visit to assess his condition after you learned from his wife on or about December 8, 1994, that he was suicidal subsequent to your diagnosing him with Tourette's syndrome.

c. You failed to exercise sound medical judgment when you accepted Patient F as a patient and continued to treat him knowing that he was commuting to see you from Maine and then New York. Patient F, a very unstable patient, was not able to see you with the frequency necessitated for reasonable observation and management of his conditions, and you were unable to respond in a timely fashion to the frequent episodes of mania that Patient F experienced.

d. On or about January 19, 2000, you responded to a desperate phone call from Patient Q by telephonically prescribing her a higher dose of Klonopin; however, you did not require Patient Q to come in immediately for an office visit to assess her condition nor did you see her for approximately nine more months.

8. You may have violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003,* (13), and (16) of the Code, in that you failed to appropriately consult, communicate, or

otherwise to coordinate your care with other healthcare providers treating Patients A, G, N, and O.

9. You may have violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003,* (13), (16), and (17), 54.1-3303.A, and 54.1-3408.A of the Code, in that you failed to prescribe appropriate medications, prescribed medications in excessive quantities and doses, and failed to properly manage and monitor medications prescribed for Patients A-Q. Specifically:

a. You endangered the health and welfare of several minor patients when you repeatedly prescribed medications that were not recommended for children or for which the safety and/or efficacy of use in children had not been adequately tested, as set forth below:

Minor Patient	Medication	Date	Age at time of Prescription
J	Paxil Celexa	January 29, 2001 October 29, 2001	10 11
K	Celexa	March 4, 1999	13
O	Paxil Wellbutrin Provigil Prozac Sinemet	January 6, 1997 April 21, 1998 May 5, 1999 May 5, 1999 Dec. 28, 2000	11 12 13 13 15

b. You repeatedly endangered the health and welfare of patients when you regularly prescribed medications in excess of their maximum safe recommended dosages or in dosages exceeding that which had been adequately tested, as set forth below:

Patient	Medication	Dose Prescribed	Max. Safe Dose At time of Prescription
F	Prozac Zyprexa Provigil Lamictal	Up to 400 mg/day 40 mg/day 600 mg/day 800mg-1600 mg/day	80 mg/day 20 mg/day 400 mg/day 400 mg/day
H	Prozac	Dose sufficient to "clear head"	80 mg/day
I	Neurontin Celexa Remeron	Up to 10,000 mg/day Up to 200 mg/day Up to 90 mg/day	3600 mg/day 40 mg/day 45 mg/day
J	Celexa Prozac	Up to 60 mg/day No. of pills necessary to "clear head"	40 mg/day 80 mg/day
K	Celexa	Up to 80 mg/day	40 mg/day
L	Adderall Celexa Prozac	Up to 120 mg/day Up to 100/mg day Up to 120/mg day	40 mg/day 40 mg/day 80 mg/day
M	Prozac	Up to 240/mg day	80 mg/day
N	Prozac	Up to 120 mg/day	80 mg/day

P	Paxil	80 mg/day	60 mg/day
Q	Prozac	Up to 200/mg day	80/mg day

c. You jeopardized your patients' health and welfare when you overprescribed medications, prescribed unwarranted medications, or prescribed medications or combinations thereof that were contraindicated. Specifically:

i. On or about January 17, 1997, you prescribed Patient F vigabatrin (Sabril), an experimental drug for patients unresponsive to other anti-epileptic medication available in Canada, without a diagnosis of epilepsy or any other medical indication for prescribing such medication. Further, on or about April 6, 2000, you added Depakote to Patient F's medication regimen, but you did not appropriately lower the dose of Lamictal prescribed to take into account the fact that Depakote may increase the blood level of Lamictal.

ii. You over prescribed multiple medications for Patient G, to include Ativan, Klonopin, Tegretol, Prozac, Tofranil, Paxil, Depakote, Dilantin, Neurontin, Topamax, and Xanax, which adversely affected Patient G mentally, emotionally, and physically, to include excessive sleepiness, muscle spasms, and confusion and mental disorientation.

iii. Your prescription of multiple and conflicting medications, including Provigil, Prozac, Lamictal, Lithobid, Parnate, Procardia, Amitriptyline, Effexor, Remeron, Zyprexa, Wellbutrin, Klonopin, Nortriptyline, Aricept, Risperdal, Clonidine, Xanax, Trazodone, Prometrium, Baclofen, Adderall, and Clozaril, contributed to the deterioration of Patient H's health under your care. You prescribed Patient H MAOI antidepressants, tricyclic antidepressants, and lithium, a combination of medications that is contraindicated and potentially dangerous. You also continued to prescribe MAOI antidepressants after Patient H informed you she was not complying with dietary restrictions necessary for the safe utilization of this medication. Further, on or about April 10, 2001, you added Adderall to Patient H's medication regimen, without a medical indication for doing so.

iv. In prescribing Celexa, Ambien, Zyprexa, Tegretol XR, Verapamil, Buspar, Paxil, Klonopin, Zoloft, Xanax, Neurontin, Ativan, Ritalin, Sinemet, Percocet, Motrin, Lamictal, Prozac, Trazodone, Imitrex, Remeron, Carbatrol, Topamax, Effexor, Lithobid, Risperdal, Seroquel, and Norinyl, you overmedicated Patient I, resulting in adverse consequences to her health. You continued to prescribe excessive amounts of medication to Patient I even after you noted the need to decrease her medications and after other physicians expressed concern about the amount and combinations of medications Patient I was taking. Further, on or about November 6, 1997, you prescribed Zyprexa for Patient I with no documented medical rationale for doing so; on or about

March 3, 1998, you prescribed Sinemet to Patient I, even though you had discontinued that prescription on January 8, 1997, based on your assessment that it was not working for Patient I; on or about February 24, 2000, you added a third antidepressant, Effexor, to Patient I's medication regimen, without documenting a medical rationale therefore and notwithstanding the fact that Patient I was already taking two other antidepressants; on or about February 27, 2001, you prescribed Topamax for Patient I, after it had been previously discontinued, for purposes of weight loss, an inadequate rationale for such prescription; on or about February 22, 2002, you began prescribing Effexor to Patient I again after you had previously discontinued that medication based on Patient I's report that it made her feel bad; and on or about October 2, 2002, you started Patient I on a new medication, Seroquel, even though you knew you would not be able to monitor her on this medication due to the impending suspension of your license.

v. On or about April 17, 2001, you prescribed Adderall to Patient L despite the presence of a high blood pressure reading and information from his family physician that Patient L had been noncompliant in the control and management of his blood pressure, a requirement you previously had established as a precondition for prescribing amphetamines for him. Further, you prescribed Wellbutrin and Risperdal to Patient L without an adequate medical indication or rationale for doing so.

vi. You overmedicated Patient N when you prescribed a plethora of medications, to include Luvox, Ativan, Tegretol, Prozac, Eskalith, Ritalin, Dexedrine, Lamictal, Provigil, Klonopin, Inderal, Effexor, Exelon, Concerta, Risperdal, Wellbutrin, Sinemet, Topamax, Trazodone, Sonata, Zyprexa, and Lithobid. Further, on or about December 29, 1997, you prescribed Zyprexa for Patient N with inadequate medical rationale for doing so; on or about May 2, 1997, you began prescribing Prozac for Patient N, who was diagnosed as bipolar, without taking into consideration the fact that Prozac can initiate rapid cycling and mania, and even though Patient N had previously informed you that she experienced akathisia when taking Prozac; on or about March 15, 2000, you added Risperdal to Patient N's medication regimen without an adequate medical rationale for doing so; on or about June 9, 2000, you added Sonata to Patient N's medication regimen, even though you were already prescribing her 3 mg Klonopin to help with her sleep; and on or about May 31, 2002, you began prescribing Patient N Exelon, a medication for Alzheimer's, even though you did not believe Patient N had Alzheimer's and her diagnostic tests were inconsistent with that condition.

vii. By your own admission, the plethora of medications that you prescribed to Patient O prevented you from being able to determine what behaviors of Patient O were due to medication versus other causes. For example, you began

prescribing Dexedrine for Patient O at his initial visit. However, as Patient O's behavior worsened, you failed to consider that this medication could have been causing or contributing to the deteriorating behavior. Subsequently, Patient O's treating psychiatrist at the day treatment facility to which he was admitted in April 1997 discontinued the Dexedrine. Nevertheless, you restarted Patient O on Dexedrine on or about October 9, 1997, subsequent to Patient O asking to be put back on that medication after taking Dexedrine on his own, without prior consultation with or approval from you. On or about September 21, 1999, you wrote Patient O's school a letter asking that he be permitted to chew nicotine gum in school, allegedly to provide therapeutic benefit for his Tourette's syndrome. However, there is insufficient medical basis for using such gum in the treatment of that condition, and, in light of Patient O's behavioral problems and indications of substance abuse, such treatment was not advisable. Further, you prescribed Risperdal, Wellbutrin, and Topamax for Patient O without an adequate medical indication or rationale for dosing so, and, on or about March 14, 2000, you restarted Patient O on lithium after you had recently stopped that medication because it was not helping him.

viii. Starting on or about April 16, 1998, you added Flexeril and Sinemet to Patient P's medication regimen and continued to prescribe those medications, even though the patient did not note any improvement in his symptoms. Subsequently, on or about January 30, 2001, you again prescribed Sinemet for Patient P, even though you previously had discontinued that medication based on its ineffectiveness. Further you prescribed the following medications to Patient P without an adequate medical indication or rationale for doing so: Risperdal, Buspar, Ritalin, Lithobid, Cytomel, Provigil, and Adderall XR.

ix. You prescribed medications for patients without having or documenting any reasonable medical indication or rationale for doing so, as set forth below:

Patient	Medication	Date	Diagnoses
A	Risperdal	January 1, 2001	Social phobia, anxiety, OCD
B	Catapres Patches Risperdal	Dec. 2 & 4, 1994 April 3, 1995	Tourette's syndrome
J	Paxil Celexa Clonidine	January 29, 2001 October 29, 2001 May 16, 2002	ADD and OCD
K	Risperdal Wellbutrin	March 4, 1999 July 22, 2002	OCD, anxiety, intermittent explosive disorder, ADD
M	Prozac Concerta Lithobid	January 7, 2000 December 31, 2001 August 28, 2002	No formal diagnosis documented in record

Q	Ambien Topamax Provigil Naltrexone Axert	February 8, 1999 December 15, 1999 August 23, 2001 July 3, 2002 July 5, 2002	Kleptomania, OCD, PMS, body dysmorphic disorder, restless leg syndrome, bipolar

d. You ignored medication side effects and/or prescribed additional medication(s) to counteract reported side effects, rather than identifying and reducing or eliminating the medications causing such side effects or taking other appropriate action to ameliorate such side effects. Specifically:

i. You continued to prescribe Dexedrine and Ritalin for Patient B after you were informed that Dexedrine made Patient B more obsessive and Ritalin made him suicidal.

ii. On or about October 10, 1994, you prescribed Ritalin to Patient D in order to provide a stimulant to offset the tiredness produced by the Depakote you were prescribing for Patient D.

iii. You continued to prescribe Prozac for Patient F in excessive doses after you noted that his hypomanic behavior might be Prozac-induced, and you continued to prescribe Lamictal to Patient F in excessive dosages after Patient F informed you that he was experiencing diplopia, a side effect of Lamictal.

iv. You continued to prescribe Neurontin in excessive doses to Patient I, even though she complained to you of extreme fatigue, a side-effect of Neurontin. On or about November 6, 1997, you prescribed Ambien for Patient I, even though you had discontinued that medication at her last visit based on concerns that Patient I was experiencing amnesia as a side-effect thereof.

v. On or about March 30, 2001, you prescribed Depakote to Patient K for mood stabilization in order to offset the mood swings you noted Patient K to have begun experiencing after you prescribed him Celexa.

vi. On or about August 29, 2001, you failed to consider that excessive doses of Adderall prescribed to Patient L may have been causing his complaints of sleeplessness and too much energy at bedtime, and instead prescribed Celexa and Klonopin.

vii. On or about August 28, 2002, you observed Patient M to exhibit elements of hypomania, but, instead of considering that such symptoms may have been triggered by the excessively high doses of Prozac you were prescribing Patient M, you conjectured that she was bipolar and treated her for that condition.

viii. On or about April 12, 1999, you added Provigil to Patient N's medication regimen in order to treat her reported symptoms of daytime somnolence without determining the cause of those symptoms. When Patient N complained that she was having anxiety and word-finding problems, you did not consider that these symptoms may have been caused by the excessive dosage of Prozac you were prescribing her. You acknowledge that, on several occasions, you should have stopped all of Patient N's medications after she complained to you of increasing lack of coordination and balance problems, confusion, problems with handwriting, lack of focus, excessive tiredness, slurring of speech, memory loss, and inability to function effectively at home or at work, as well as the fact that several individuals thought she was overmedicated. Although you suspected that Topamax may have been causing Patient N's cognitive difficulties, you did not discontinue or lower the dose prescribed because Patient N wanted to continue the medication without change. Further, on or about March 5, 2002, you began prescribing Inderal to treat tremors that Patient N was experiencing, although you subsequently stated that you suspected these tremors were induced by the lithium you were prescribing for Patient N.

ix. On or about March 18, 1997, you began prescribing patient O Cogentin as an antidote for Risperdal, notwithstanding the fact that Patient O had not reported any symptoms of akathisia from Risperdal. Further, you continued to prescribe Haldol to Patient O after his mother reported that he was experiencing twitching in his legs and back since starting that medication. Your response was to prescribe Cogentin to control those symptoms. In addition, on or about May 5, 1999, you continued to prescribe Haldol after Patient O reported constant fatigue and falling asleep in school. Your response to these complaints was to add Provigil to Patient O's medication regimen.

e. You routinely initiated medications for patients at high doses, rather than starting at a low dose and increasing as necessary, and often started multiple new medications at or near the same time, thereby making it difficult to ascertain the effectiveness of each. Specifically:

i. Although you prescribed 100 tablets of Ritalin for Patient B's attention deficit disorder on or about November 11, 1994, you prescribed another stimulant, Dexedrine, 100 tablets, on or about December 4, 1994.

ii. On or about May 10, 1996, you added Ritalin to Patient I's medication regimen and doubled her dose of Paxil with no documented medical rationale for these actions.

iii. On or about March 31, 2000, you changed Patient J from Dexedrine to Dexostrat, and, without explanation, added another stimulant, Adderall, to Patient J's medication regimen.

iv. On or about May 19, 1999, you began prescribing two medications, Adderall and Dexedrine, to Patient K, and without explanation, wrote six (6) prescriptions for Dexedrine and two for Adderall on that date.

v. On or about April 24, 1997, you prescribed Tegretol and Lithobid to treat Patient N's bipolar disorder, instead of adding one drug at a time to ascertain the efficacy of one drug before adding another. Further, on or about September 2 and 11, 1997, you prescribed Patient N two new medications, Wellbutrin and Lamictal, over the telephone without a patient visit and without documenting the medical rationale for these prescriptions. On or about June 19, 2002, you started Patient N on Concerta at the maximum approved dosage, which was too strong for the patient and had to be reduced.

vi. On or about June 5, 1998, you made several simultaneous changes in Patient O's medications. You added a new medication at a high dose, i.e., Eskalith 450 mg, on the suspicion that Patient O had a lithium-responsive condition, based only on the fact that his mother was taking lithium. At the same time, you discontinued Patient O's Wellbutrin, and increased Paxil to 60 mg.

vii. On or about July 21, 2000, you added Effexor to Patient P's medication regimen, even though you were already prescribing Paxil in excess of the maximum recommended safe dosage for Patient P's depression.

f. You regularly allowed patients, to include Patients F, L, N, and P, to experiment with and/or adjust their medication dosages, without first consulting with you or obtaining your approval. Frequently, you simply increased the dosage prescribed at the next visit when the patient reported to you the medication changes he/she had unilaterally implemented.

g. You prescribed new medications and/or authorized refills of medications for Patients A, F, G, J, K, L, M, N, O, P, and Q over the telephone or by mail without seeing them on a sufficiently regular basis to monitor the effect the medications were having on the patients' conditions, including after they had missed appointments or failed to present for office visits subsequent to being informed that such visits were necessary before additional prescriptions would be written.

h. In the case of Patients B, J, and L, you refilled prescriptions before they should have run out, and wrote multiple prescriptions for the same medication on the same day.

10. You may have violated Sections 54.1-2915.A(4), *as codified prior to July 1, 2003,* (13), (16), and (17), 54.1-3303.A, and 54.1-3408.A of the Code, in that, in the case of Patients A, G, and O, you failed to note signs of, and therefore did not treat or refer for treatment of, substance abuse. Specifically:

a. You did not consider alcohol or substance abuse as a possible diagnosis for Patient A in a timely fashion, despite information from Patient A that should have caused you to consider such diagnosis prior to his arrest for Driving Under the Influence on or about May 2001. Even after you became aware of this arrest and the fact that Patient A had misused Klonopin that you had prescribed, you did not add a diagnosis with respect to substance abuse or dependence. Further, you continued to prescribe Klonopin, Ativan, and Ambien, drugs with high potential for abuse and addiction, despite the fact that you noted in your January 23, 2002 progress notes that Patient A "is starting to use too many benzodiazepines to deal with his anxiety disease." You ignored other signs of drug-seeking behavior, to include Patient A's repeated requests for early refills of medication.

b. You failed to recognize signs that Patient G was abusing and had become addicted to the Xanax you were prescribing for her, to include several patient reports of lost or spilled pills and requests for early refills. Further, you continued to prescribe substances with high potential for abuse and addiction, including Xanax and Dexedrine, after you became aware on or about November 11, 1994, that Patient G had been hospitalized for a suicide attempt by drug overdose.

c. You failed to consider substance abuse as a cause of Patient O's behaviors, notwithstanding reports that Patient O, a troubled teen-ager, had tried marijuana, used inhalants, smoked cigarettes, and drank alcohol.

11. You may have violated former Section 54.1-2915.A(4), *as codified prior to July 1, 2003;* (13), and (16) of the Code, in that, contrary to acceptable standards of care, you did not properly manage patient records or maintain adequate, legible, and complete records for Patients A, C, F, L, and N. Specifically:

a. You failed to document palmar hyperhidrosis as a diagnosis in Patient A's medical record, even though you treated him for that condition.

b. You failed to document Patient F's last office visit in his medical record, when he became violent and you decided to terminate the practitioner-patient relationship.

c. By your own admission, the record for Patient L's initial visit is inexplicably missing, and consequently there is no documented assessment, medical history, diagnosis, or treatment plan. Further, you admit that you saw Patient M for only about 10 minutes at her initial visit on or about January 7, 2000, and hence failed to

perform or document an adequate assessment, history, diagnosis or treatment plan. Notwithstanding this lack of information, you prescribed and refilled medications for both Patients L and M.

12. You may have violated Section 54.1-2915.A(1), (16), and (17) of the Code, in that, on several occasions, you diagnosed patients with conditions that did not exist in order to obtain insurance coverage for the prescribed medications or otherwise provided false information in your treatment of patients. Specifically:

a. On or about April 16, 2001, you falsely notified Patient H's insurance company that Patient H was being prescribed Adderall for attention deficit disorder in order for insurance to cover the prescriptions, when in fact you had not made such a diagnosis of Patient H.

b. On or about January 1, 1997, you prescribed 800 mg Motrin for Patient I, even though you admit you did not prescribe this for any medical condition you were treating, but instead prescribed it so the medication would be covered by Patient I's insurance. Further, on or about April 30, 1996, you wrote a letter for Patient I to present to her pharmacist claiming that you were a consultant for the manufacturer of Neurontin, when in fact you were not.

c. On or about May 3, 2002, you authored a letter stating that Patient M was unable to return to work until May 8, 2002, because she was on medical leave. However, Patient M's medical record contains no indication of the medical necessity for such leave.

d. On or about January 17, 2000, you admit that you diagnosed Patient O with narcolepsy so that insurance would pay for his prescriptions of Provigil. Further, on or about February 21, 2002, you increased the dosage of Provigil prescribed to Patient O, not for a clinical reason, but to allow the patient to accumulate extra medication in case the insurance company stopped covering it in the future.

e. On or about June 22 and July 23, 1998, you wrote letters on Patient Q's behalf stating that you were treating her for prolonged post-traumatic stress disorder, among other things, even though Patient Q's medical record contains no documented diagnosis of prolonged post-traumatic stress disorder.

Please see Attachment I for the name of the patient referenced above.

After consideration of all information, the Committee may:

1. Deny your application;
2. Reinstate you;
3. Place you on probation with such terms as it deems appropriate.

4. Reprimand you;
5. Modify a previous Order; and
6. Impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

You have the right to information that will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the Committee for its consideration when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. These materials have been provided this date to your counsel, Anisa P. Kelley, Esquire.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Reneé S. Dixson, Discipline Case Manager, Virginia Board of Medicine, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Richmond, Virginia 23233-1463, by **September 28, 2007**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Julia K. Bennett wish to submit any documents for the Committee's consideration after **September 28, 2007**, such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by **September 21, 2007**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **September 21, 2007**, will not be considered

Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia cited in this notice can be found on the Internet at **http://leg1.state.va.us**. To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

Please advise the Board, in writing, of your intention to be present. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions.

If you have any questions regarding this notice, please contact Julia K. Bennett, Adjudication Specialist, at (804) 367-4427.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

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Enclosures:
Attachment I
Informal Conference Package
Map

cc: Stephen E. Heretick, J.D., President, Virginia Board of Medicine
Sandra Whitley Ryals, Director, Department of Health Professions
Reneé S. Dixson, Discipline Case Manager, Board of Medicine
Julia K. Bennett, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
Anisa P. Kelley, Esquire *[w/enclosures]*
Vicky Fox, Senior Investigator (108718, 108734, 93172, 93027, 92963 & 88626, 88627)

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: MARTIN H. STEIN, M.D.
License No.: 0101-030679

CONSENT ORDER

By letter dated August 16, 2002, the Board of Medicine ("Board") noticed Dr. Stein for an informal conference is to inquire into allegations that Dr. Stein may have violated certain laws governing the practice of psychiatry in Virginia.

In lieu of further proceedings, the Board and Dr. Stein, as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting the license of Dr. Stein to practice medicine in Virginia.

FINDINGS OF FACT

The Board adopts the following findings in this matter:

1. Dr. Stein holds license 0101-030679 to practice medicine in the Commonwealth of Virginia.

2. From on or about January 29, 1999, through on or about July 28, 1999, Dr. Stein treated Patient A for major depression and obsessive-compulsive disorder.

a. Dr. Stein's treatment of Patient A was contrary to sound medical judgment in that he prescribed Oxycontin, a Schedule II controlled substance of high abuse potential, to treat Patient A's severe depression, when he knew she had used heroin five or six times in the past. Dr. Stein failed to closely monitor the frequency of the Oxycontin prescriptions written for Patient A, who became addicted to Oxycontin. She was subsequently hospitalized on or about August 15, 1999, as a result of her intravenous use of Oxycontin.

b. Dr. Stein failed to properly maintain the medical record of Patient A, in that:

i. He began treating Patient A in late January or early February 1999, but there is no initial intake treatment note in the chart. The first documented office visit for Patient A is February 24, 1999.

ii. A review of Dr. Stein's medications log for Patient A reveals that he prescribed Xanax (Schedule IV) for Patient A on January 29, 1999; however, there is no documentation of a January 29, 1999 encounter or phone note in Patient A's medical records. Similarly, on or about March 13, 1999, Dr. Stein authorized a refill of Cogentin (Schedule VI); however, there is no documentation as to when he first prescribed Cogentin for Patient A.

3. From on or about September 10, 1998, through on or about January 22, 1999, Dr. Stein treated Patient B, a person he knew to have a history of drug abuse, for post-concussion syndrome, restless leg syndrome ("RLS"), obsessive-compulsive disorder, major depressive disorder, and attention deficit disorder. His treatment of Patient B was contrary to sound medical judgment, in that:

a. Dr. Stein prescribed Percocet, a Schedule II controlled substance of high abuse potential, "for sleep," after Patient B related that he had slept well when he was using heroin. Further, a review of Patient B's medical records reveal that on or about October 8, 1998, Dr. Stein prescribed additional oxycodone to treat Patient B's RLS.

b. Dr. Stein continued to prescribe Oxycontin and Oxy-IR for Patient B after he relapsed into the use of heroin. In a letter dated November 16, 1998, Dr. Stein told Patient B that he would no longer prescribe any of the "abusable medications...such as oxycodone, klonopin nor dexedrine." However, after an office visit on or about November 24, 1998, Dr. Stein resumed prescribing Oxycontin, Oxy-IR, Klonopin and Dexedrine for Patient B.

4. From on or about September 19, 1997 through on or about December 20, 1999, Dr. Stein treated Patient C for attention deficit hyperactivity disorder, post-traumatic stress disorder, anxiety, depression, obsessive-compulsive disorder, anorexia, bipolar disorder and possible cyclothymia. His treatment of Patient C was contrary to sound medical judgment, to include his failure to maintain proper

professional boundaries with Patient C and his engagement in an inappropriate and unethical social relationship with her. Specifically:

a. Dr. Stein engaged in sexually intimate behavior with Patient C that frequently occurred during the early morning and evening hours.

b. Dr. Stein used hypnosis, suggestion, massage and psychotropic medicines to evoke memories of childhood abuse. Said memories are not corroborated and have, in at least one instance, been disproved by objective evidence.

c. In March and June 1998, while Dr. Stein was away, Patient C over-medicated herself into a state of semi-consciousness. Further, Dr. Stein failed to direct her to go to a hospital for a psychiatric emergency, despite her suicidal state and discouraged her from seeking an independent second opinion from another psychiatrist, when she and her family indicated they thought it was warranted.

d. Dr. Stein failed to seek a second, independent medical opinion or to change his treatment plan, when he witnessed Patient C's deterioration under his care, which included extended periods of time during which she stopped eating, showed a marked decrease in her Global Assessment of Functioning ("GAF") from 70 to 20 and made repeated threats of suicide.

e. Dr. Stein talked to Patient C about his past and personal life, at times crying and allowing her to hold him and also had Patient C meet and talk with his sister about abuse. Further, Dr. Stein discussed aspects of another patient's treatment with Patient C and on one occasion, showed Patient C a video of said patient.

f. Dr. Stein visited Patient C at her home several times (and charged her $200 per hour for doing so), went shopping with her (and charged her $200 per hour for doing so), took her for rides

in his car, went for walks with her, accepted gifts from and gave gifts to her, let her bring him meals, allowed her to try on clothes in his office, went out to dinner with her, permitted her to "hang out" in his waiting room for hours prior to her appointments "just to be near him" and allowed her to rent a room in his office suite for $100.00 a day. Further, in June 1998, Dr. Stein traveled with Patient C, at her expense, to her hometown and childhood homes in Danville, Illinois.

g. Dr. Stein influenced Patient C to limit and/or terminate communication with her family members by instructing Patient C not to discuss her therapy with her family and aiding her with the initiation of legal action against them. Specifically:

i. His treatment contributed to Patient C's inability to take care of her children whom she frequently neglected to spend time with Dr. Stein. Said neglect resulted in Child Protective Services removing the children from Patient C's custody.

ii. Dr. Stein encouraged Patient C's divorce from her husband and actively participated by referring her to an attorney, with whom he was friends, to represent her in the matter. Dr. Stein at times sought to consult with said attorney in regards to Patient C's legal matters without her knowledge or consent.

iii. Subsequent to Patient C's divorce, Dr. Stein attempted to disrupt her relationship with her boyfriend through the use of threats.

h. Dr. Stein became inappropriately involved with Patient C's personal finances. Specifically:

i. Despite Patient C's indication to Dr. Stein that she needed help learning to control her compulsive spending he encouraged her spending behavior by advising her that extravagant spending of her inheritance from her father would be therapeutic.

Simultaneously, Dr. Stein advised her not to "blow [her] money away...to conserve [her] resources" and remarked that money was useful "for some decent therapy."

ii. Dr. Stein encouraged Patient C to sell her home and buy a condominium so that she could spend her money "elsewhere" and had referred Patient C to a bookkeeper who also provided him with bookkeeping services to help Patient C with her finances and payment of her bills. Dr. Stein also had Patient C bring her financial statements in for his review and personally appraised her valuables for sale.

i. Dr. Stein failed to keep complete and accurate records of his therapy sessions with Patient C, frequently documenting only the date and time span of the therapy sessions and omitted from her medical records approximately 40-50 pages of e-mailed letters sent between him and Patient C within the context of his treatment of her. Further, on or about April 2, 1998, Dr. Stein had an appointment with Patient C's husband, but failed to document this meeting in the patient's record.

j. Dr. Stein failed to provide proper medication management to Patient C, in that Dr. Stein prescribed various medications, to include: Ritalin; Zyprexa; cyclobenzaprine; Risperdal; Neurontin; Klonopin; Ecotrin; Ambien; Lamictal; Buspar; Paxil; Elavil; Flexeril; Tylenol with Codeine; Lithonate; Lithium; Lithobid; Carbitrol; Cytomel; Prozac; Tegretol; Ativan; Xanax; Bentyl; Celexa; Eskalith; Toradol; Cogentin; Dexedrine and Klonopin. Specifically:

i. Dr. Stein failed to properly monitor the dosage of and interactions among Patient C's medications despite receiving reports from several individuals, including Patient C, that she was experiencing side effects from the medications including: memory impairment; syncope; exhaustion; an inability to focus and uncontrollable shaking.

ii. Dr. Stein gave Patient C prescriptions for her heart, stomach, hormones,

arthritis and irritable bowel syndrome, rather than referring her to appropriate specialists for treatment.

5. From on or about January 2, 1999 until on or about May 24, 1999, Dr. Stein treated Patients D and E, the minor children of Patient C, against the express written objections of their father. His treatment of Patients D and E during this time was contrary to sound judgment, in that:

a. Dr. Stein failed to refer Patients D and E to an appropriately trained specialist in child psychiatry. Further, his simultaneous treatment of Patient D, E and their mother created a clear conflict of interest.

b. Dr. Stein erroneously used adult psychiatric criteria to diagnose Patient D, a four (4) year old child, contributing to his misdiagnoses of suffering from major depression, tourette's syndrome, obsessive compulsive disorder, attention deficit hyperactivity disorder, dissociative identity disorder, bipolar disorder and anxiety. Subsequent treating professionals diagnosed Patient D as suffering primarily from depression.

c. On or about February 27, 1999, after receiving a phone call from Patient C that Patient D was "out of control" and had attempted to "jump out of the car", Dr. Stein advised Patient C to bring Patient D into his office for a consultation at which Dr. Stein bound his ankles and feet with electrical tape in front of Patients C and E.

d. Following the conclusion of his therapeutic relationship with Patient D, Dr. Stein interfered with the treatment by a subsequent therapist through his failure to communicate truthfully and completely with the subsequent therapist regarding his knowledge of possible causes of Patient D's depression, to include his relationship with Patient C. Consequently, said therapist was not able to immediately provide adequate treatment to Patient D. Further, Dr. Stein repeatedly consulted and

communicated with Patient D's other treating physicians. Dr. Stein convinced Patient C to discharge Patient D's and E's treating physicians in favor of one Dr. Stein recommended despite the issuance of a court decree, entered September 29, 1999, forbidding his involvement in the children's treatment and receiving written notice from their father that he was not to be involved.

e. Dr. Stein failed to provide proper medication management to Patients D and E, to include the prescribing of medications that could have been harmful to children of their age. Specifically:

i. With inadequate clinical rationale, Dr. Stein prescribed multiple medications for Patient D, including Lithium, , Paxil, Zoloft, Buspar, Cogentin, Risperdal, Clonidine, Ritalin and Dexedrine. Buspar, Risperdal and Lithium are not approved for children under the ages of eighteen (18), twelve (12) and six (6), respectively. Dr. Stein also prescribed medications not recommended for use by children to Patient E, including Prozac.

ii. Dr. Stein failed to properly monitor the interactions of Patient D's medications and continued to dispense medication to Patient D after he was the patient of another psychiatrist.

6. From on or about July 18, 1997 to on or about July 27, 2001, Dr. Stein treated Patient F for attention deficit disorder, anxiety, migraines, restless legs syndrome, narcolepsy, obsessive-compulsive disorder, cataplexy, and complex partial seizures/generalized convulsive epilepsy. His treatment of Patient F during this time was contrary to sound medical judgment, in that:

a. Dr. Stein ignored scientific evidence and medical opinion that directly conflicted with his diagnoses of Patient F. This failure to recognize possible alternative diagnoses and treatments resulted in Patient F receiving long term care that was both ineffective and harmful. Specifically:

i. Dr. Stein treated Patient F for epilepsy and narcolepsy despite results of an EEG, brain MRI, cerebral perfusion SPECT exam and sleep study that were all within normal limits. Dr. Stein failed to order a follow-up EEG and stated in his written response to the investigator from the Department of Health Professions ("Department") that "whether it was normal or not...would not have changed my treatment approach." Further, Dr. Stein insisted that Patient F's symptoms were biologically based despite neuropsychological testing which revealed that Patient F's chief symptoms (difficulty concentrating, anxiety, depression, and fatigue) were of psychological etiology. Subsequently, Dr. Stein indicated in his written response to the Departments investigator that, "his neuropsychological test...supported my opinion that there were...organic factors causing a significant part of his chief complaint."

ii. Dr. Stein disregarded the opinions of previous physicians that Patient F probably did not suffer from narcolepsy and did not need anti-epileptic therapy, and that his solitary seizure was related to Wellbutrin. In reinitiating Patient F's anti-epileptic therapy, Dr. Stein wrote that his seizures were of "unknown origin." A neurologist who examined Patient F subsequent to Dr. Stein's treatment of him found that Patient F did not have narcolepsy or epilepsy and diagnosed him with chronic depression, an alerting disorder, and a sleep disorder.

iii. Dr. Stein failed to properly pursue a diagnosis of depression for Patient F, despite the Patient's statement that he had "a long-standing depression." Further, Dr. Stein discontinued Patient F's previously prescribed antidepressant without determining whether it needed to be replaced. Patient F's subsequent physician treated his depression successfully with Effexor.

b. Dr. Stein prescribed inappropriate and contraindicated medications for Patient F, including Ritalin, Risperdal, Dexedrine, Desoxyn, Neurontin, Methamphetamine, Lamictal, Luvox,

Klonopin, Xanax, Concerta, Aricept, and Gingko Biloba. The manner in which said medications were prescribed resulted in a delay in Patient F receiving appropriate treatment and unnecessarily exposed him to the risk of serious side effects. Patient F reported being confused by taking so many medications at once and suffered tremors, which he attributed to "interactions of medications." Additionally, Dr. Stein prescribed Patient F Lamictal, an anti-epileptic medication, for "mood control," despite having listed it among the medications to which he was allergic.

7. From on or about November 14, 1991 to on or about April 2, 1997, Dr. Stein treated Patient G, a fifteen (15) year-old female referred to Dr. Stein by her school for depression and drug and alcohol use. At various times during the course of his treatment of Patient G, Dr. Stein diagnosed her with major/atypical depression, seasonal affective disorder, epilepsy, organic affective disorder, obsessive-compulsive disorder, attention deficit disorder and post concussion syndrome. His treatment of Patient G during that time was contrary to sound medical judgment, in that:

a. Dr. Stein disregarded scientific evidence and other medical opinion that directly conflicted with his diagnoses of Patient G, his diagnosis of epilepsy in particular. This failure to recognize possible alternative diagnoses and treatments resulted in Patient G receiving long term care that was both ineffective and harmful. Specifically:

i. A telemetry report stated that, "patient was stimulated but a seizure could not be provoked" and the patient has no history of seizures; however, in his written response to the Department's investigator Dr. Stein stated that "a minimal amount of electrical stimulation led to an electrical seizure." Patient G had normal MRI's, EEG's and SPECT scans.

ii. Dr. Stein stated in his written response to the Department's investigator that "the telemetry [confirmed] the diagnosis of temporal lobe epilepsy;" however, Patient G's

PET scan revealed only "slight" deviation from normal. Additionally, a Georgetown University nuclear medicine specialist wrote, "normal cerebral perfusion study [with] no abnormalities in temporal lobes." Further, a George Washington University neurophysiologist wrote, "there were no EEG changes...to support [a diagnosis of] seizures." A consulting neuropsychiatrist noted that "she has no evidence of characteristic seizure events" and that "there is no family history of paroxysmal disorders such as epilepsy." He believed that "her mood instability may be...related to her excessive dependence on a variety of drugs and the frequent changing of drugs prescribed."

iii. Dr. Stein's records indicate that he presented Patient G to the George Washington University epilepsy conference as a candidate to undergo invasive "intracerebral electrode monitoring [to include] depth electrodes in both amygdala/hippocampi and electrode strips around both temporal lobes." Dr. Stein encouraged Patient G to undergo said procedure despite his own written admissions that, "[she does] not have a positive EEG, MRI, or SPECT, and [her] PET is not fully diagnostic...and does not have the weight to justify the surgery," and that the proposed surgery was justified only by "the clinical experience that we have developed working together..."

iv. On or about December 19, 1994, Dr. Stein diagnosed Patient G with Attention Deficit Disorder, however, Dr. Stein failed to document medical indication or subjective and objective findings to substantiate said diagnosis.

v. Although Dr. Stein had history from the patient that she abused cocaine and marijuana, Dr. Stein did not include substance abuse in his list of working diagnoses. Additionally, Dr. Stein failed to address any Axis II issues with this patient.

b. Dr. Stein failed to properly manage multiple medications he prescribed for Patient G, to include: Ritalin, Neurontin, Valium, Luvox, Dexedrine, Lamictal, Ludiomil, Elavil, Desoxyn, Xanax, Vigabatrin, Risperdal, Cylert, Felbatol, Dilantin, Topamax, Ativan, Loestrin, Prozac, Ultram, Anafranil, Tranxene, Tegretol, Tylenol with Codeine, Imipramine, Procardia, Parnate, Buspar, Mesantoin, Paxil, Klonopin, Wellbutrin and Zoloft. Specifically:

i. Dr. Stein prescribed Vigabatrin, an experimental drug for patients unresponsive to other anti-epileptic medications, without having properly diagnosed Patient G with epilepsy.

ii. Dr. Stein prescribed Dilantin and Prozac for Patient G despite being advised by a consulting neuropsychiatrist that Patient G was allergic to Dilantin and that Prozac had a paradoxical effect on her. Further, Dr. Stein prescribed Xanax and Klonopin for Patient G despite having documented that neither had worked for her previously.

iii. On or about November 8, 1994, Dr. Stein prescribed Dexedrine for Patient G without medical indication and failed to document an office visit on that date. At the time said prescription was written, Dr. Stein had not examined or personally consulted with Patient G since January 18, 1993.

iv. Despite having knowledge of Patient G's history of drug abuse (including the use of cocaine), Dr. Stein prescribed for her controlled substances, including large doses of benzodiazepines and amphetamines without properly monitoring her use of medication.

c. Dr. Stein failed to send Patient G for proper consultations regarding medical complaints outside his scope of practice. Specifically:

i. Dr. Stein failed to order a proper consultation for evaluation of her chronic

stomach problems, despite her having suffered from esophagitis as a child. Dr. Stein inappropriately assumed that her stomach problems were of neuropsychiatric etiology, without pursuing adequate differential diagnosis.

ii. After documenting his belief that Patient G was "in need of a hospital setting for detox," Dr. Stein instructed her to enter the hospital, but failed to make certain that she was actually admitted before he left for a vacation. She did not enter the hospital.

8. From on or about February 16, 1998, through on or about May 11, 2000, Dr. Stein treated Patient H, a 46 year-old chemical engineer, for obsessive-compulsive disorder, major depression, bipolar affective disorder, acute stress and anxiety. Dr. Stein's treatment of Patient H during that time was contrary to sound medical judgment, in that he prescribed inappropriate and conflicting medications for Patient H including: Paxil; Xanax; Zyprexa; Celexa; Lamictal; Eskalith; Wellbutrin; Effexor and Provigil, which resulted in Patient H suffering serious side effects and permanent injury. Specifically:

a. Despite the following occurrences, Dr. Stein failed to appropriately respond to evidence that Patient H was abusing his medication as well as experiencing extreme side effects from his usage of it.

i. Dr. Stein was informed by Patient H that he was suffering from dizziness, confusion, loss of equilibrium and that he was "losing time." Further, Patient H was involved in three (3) car accidents while on his medication; two (2) of which resulted from Patient H blacking out at the wheel while driving.

ii. On or about September 15, 1998, Patient H underwent a urine screen. Patient H tested positive for opioids and tricyclic antidepressants, which were not prescribed by Dr. Stein, and a level of benzodiazepenes disproportionately high for the dosage that he was being

prescribed. In response Dr. Stein documented "there is an abuse here" and that "patient may need to be detoxified and may have to be treated without medication;" however, Dr. Stein never had Patient H admitted to any treatment program or modified his medications.

iii. On or about January 7, 1999 Patient H's wife informed Dr. Stein that Patient H was taking twice the amount of Celexa that was being prescribed for him. In response Dr. Stein ordered a refill for Patient H. Further, Patient H's wife informed Dr. Stein that on different occasions, Patient H was blacking out, had fallen head first down the stairs; and that she had called paramedics to her home on two separate occasions, in one instance she had been unable to awaken Patient H.

b. Dr. Stein failed to properly manage the multiple medications that he prescribed for Patient H. Specifically:

i. On or about September 1, 1998, Dr. Stein documented that Patient H "clearly cannot take Xanax" due to the fact that it disoriented him; however, on or about September 25, 1998, he prescribed Xanax for Patient H without regard to his reported side effects. Further, Dr. Stein prescribed Eskalith for Patient H after documenting his unwillingness to prescribe Lithium for Patient H because of the possible seratonin syndrome that could result from the interaction of Lithium and Celexa.

ii. Dr. Stein prescribed Lamictal and Provigil for Patient H without documenting a medical indication or indicating when said prescriptions were initiated.

iii. Patient H's wife, who was being treated by Dr. Stein for chronic pain, was allowed to monitor and adjust Patient H's medication without consultation with Dr. Stein.

c. Dr. Stein mismanaged Patient H's treatment by failing to recognize and properly respond

to evidence that Patient H's condition was severely deteriorating under his care. Further, Dr. Stein failed to explore any possible alternative diagnoses and treatments or obtain a second opinion for Patient H despite receiving medical opinions that his symptoms were caused by medication.

i. Dr. Stein failed to list alcohol and substance abuse among Patient H's diagnoses despite being notified by Patient H's wife on May 5, 1998, that he abused medications and alcohol. Further, during a January 4, 1999 neuropsychological evaluation, Patient H admitted an increased use of alcohol and his diversion of Prozac prescribed for his son.

ii. On or about January 12, 1999, Dr. Stein diagnosed Patient H with bipolar affective disorder; however, he failed to document a medical indication or subjective and objective findings to substantiate said diagnosis.

iii. Dr. Stein failed to thoroughly assess Patient H's lethality upon hearing his threats of suicide despite documenting on January 27, 1999 that "he has plans about suicide... one was sodium cyanide, he does not like pain too much and he has sodium cyanide at home." The results of the January 4, 1999 neuropsychological evaluation concluded, "personality testing is consistent with the presence of a significant level of ...suicidal ideation. Continued psychiatric consultation, and follow-up regarding the details of his suicidal thought and the potential for suicidal behavior is warranted..."

iv. During the period of approximately one (1) year prior to March 23, 2000, Patient H's GAF showed a marked decrease from 70 to 35.

v. On or about January 27, 2000, Dr. Stein received a letter from a neurologist that, having performed an evaluation of Patient H, wrote, "I am more impressed than ever that

his symptoms of lethargy, encephalopathy and occasional syncope may in large part be due to medication related side effects." Said physician also recommended that Patient H's medications be "further modified and reduced."

d. As a direct result of Dr. Stein's treatment, Patient H has suffered irreparable brain damage and is unable to work due to permanent disability. In an interview with the Department of Health Professions' ("DHP") investigator, Patient H's subsequent treating physician indicated that on his first encounter with Patient H on or about March 23, 2000, Patient H was "incredibly overmedicated" and as a result "had to be sent to the emergency room." He further stated that Patient H "had deteriorated from a high functioning engineer scientist to being unable to function." Said physician diagnosed Patient H with adjustment reaction mixed with anxiety and depression and persistent amnesia related to his psychotropic drug use.

9. From on or about August 8, 1996 until her death on March 19, 2000, Dr. Stein treated Patient I, a 46 year-old female and the wife of Patient H, for classic migraines and pain "in joint involving pelvic region and thigh," nocturnal eating disorder and sciatica, resulting from injuries suffered in car accidents. Dr. Stein's treatment of Patient I was contrary to sound medical judgment in that:

a. On or about July 19, 1999, Dr. Stein authored a letter in support of Patient I's application for disability in which he stated that she suffered from sciatica; however Patient I's medical records indicate that she was not diagnosed with sciatica until on or about July 26, 1999. Further, Dr. Stein failed to document medical indication or subjective and objective findings to substantiate said diagnosis.

b. Dr. Stein failed to provide proper medication management to Patient I, in that he prescribed various medications, to include: Imitrex; Oxycontin; Lorcet; Elavil; Prempro; Lorocet w/

Methycellulose; Percocet; Dilaudid; Clariton; MS Contin; Neurontin; Amitriptyline and Aricept. Specifically:

i. Dr. Stein failed to conduct any physical examination, document an adequate treatment plan and utilize appropriate testing, to include urine/serum screens to monitor the number and frequency of prescriptions for controlled substances.

ii. During the period between September 25, 1996 through June 6, 1998 and November 30, 1998 through April 15, 1999, Dr. Stein prescribed medication, including Schedule II opioid analgesics, for Patient I without documenting the occurrence of any office visits. Further, Dr. Stein was aware that Patient I was at that time seeing another physician who was also prescribing Schedule II opioid analgesics for her.

iii. Dr. Stein failed to appropriately respond to evidence that Patient I may have been misusing her medication and either prescribed medication for her or increased the prescribed dosage when she ran out of medicine prematurely.

c. Dr. Stein failed to refer Patient I for a second opinion despite documenting on July 19, 1999, that her "current dose is the highest of anyone in my practice and is still not adequate to relieve her pain." Further, on July 26, 1999, Dr. Stein documented his intent to have Patient I undergo a confirmatory consultation with another physician, with whom he had consulted over the telephone regarding her condition. Dr. Stein never scheduled the consultation.

d. On or about March 19, 2000, Patient I collapsed and died while in her bed. At the time of her death Patient I was taking Dilaudid, MS Contin, Neurontin, Effexor, Imitrex and Lipitor. On or about March 21, 2000, Dr. Stein signed Patient I's death certificate, indicating that the immediate cause of death merely as cardiac arrest, without documenting the cause of the cardiac arrest. At the

time of Patient I's death, Dr. Stein had not documented an office visit with her since July 26, 1999, yet he failed to perform any examination of Patient I's body or order an autopsy. On or about August 1, 2002, in a deposition taken in relation to a claim filed by the administrator of Patient I's estate, Dr. Stein indicated that he was unaware of Patient I having any history of heart problems and stated, "I don't know why she died."

10. From on or about November 20, 1995 through on or about May 11, 2000, Dr. Stein treated Patient J, the seven-year-old minor son of Patients H and I, for obsessive compulsive disorder, attention deficit disorder without hyperactivity and Gilles de la Tourette's disorder. Dr. Stein's treatment of Patient J was contrary to sound medical judgment in that:

a. Dr. Stein undertook treatment of Patient J without having adequate training in child psychiatry despite his acknowledgement that Patient J suffered from myriad problems on Axis I. Further, Dr. Stein failed to arrive at an intergrated diagnosis for Patient J, instead diagnosing him with several Axis I disorders and prescribing several medications for treatment at his initial meeting with Patient J.

b. Dr. Stein mismanaged Patient J's treatment by failing to recognize and properly respond to evidence that Patient J's condition was severely deteriorating under his care. Further, Dr. Stein failed to explore any possible alternative diagnoses and treatments or obtain a second psychiatric opinion for Patient H despite receiving medical opinions that his symptoms were being caused by his medication.

i. On or about June 14, 1996, Dr. Stein documented a consultation with a neurologist who had a long-standing clinical relationship with Patient J. Said neurologist indicated her feelings that "dexedrine or prozac is making him more irritable." Dr. Stein

further documented, "she wishes to lower one of the medications however I do not want to lose the antiobsessional changes even though it is possible that prozac has lowered the seizure threshold. Therefore I will raise the dose of neurontin to see if I can get more control."

ii. On or about September 9, 1997, the previously mentioned neurologist, who began evaluating Patient J "when he was a preschooler," performed a Developmental Cognitive Neurology Evaluation of Patient J. In response to said evaluation she concluded, "we believe that the medication is not working for him and that there is no way to put more medication into his system in order to try to achieve or desired effects. We believe that he needs to have a second opinion, possibly involving hospitalization...and preferably with a consultant who has worked for many years with the psychiatric problems of children with severe language disorders." "...perhaps we are depending too much on medication to solve too much of the behavioral problems." Said physician contacted Dr. Stein regarding her findings on or about September 29, 1997.

c. Dr. Stein failed to provide proper medication management to Patient J, in that he prescribed various medications, to include: Dexedrine; Tegretol; Prozac; Clonodine; Risperdal; Anafranil; Neurontin; Klonopin; Valium; Bactroban Ointment; Paxil; Zyprexa, Kemadrin; Cogentin; Haldol; Depakote; Lamictal; Adderall; Luvox; Trazodone; Lithium; Restoril; Sinemet; Specifically:

i. Dr. Stein prescribed Prozac, which is not recommended for children, for Patient J in the amount of 160 mg. per day, twice the maximum amount recommended for adult usage.

ii. Dr. Stein prescribed Rispideral, Anafranil, Bacotran Ointment and Haldol for Patient J without documenting a medical indication for said medications.

iii. Dr. Stein allowed Patient J's mother, whom he was treating for chronic pain, to monitor and adjust Patient J's medication without consultation with Dr. Stein, to include her administration of Uncle VA1, a mixture of herbs that she had obtained from a neighbor with Multiple Sclerosis.

iv. On or about December 7, 1995, Dr. Stein documented that Patient J had a rash caused by a reaction to Tegretol. On or about May 7, 1996, Dr. Stein documented that Patient J "cannot tolerate Tegretol..." On or about August 9, 1996, he prescribed Tegretol for Patient J without regard to his reported side effects.

d. On or about February 11, 1998, Patient J was admitted to Dominion Hospital, Falls Church, Virginia, on an emergent basis. Patient J remained at Dominion Hospital until on or about April 23, 1998, when he was admitted to Cumberland Hospital, New Kent, Virginia, for inpatient treatment. On or about June 15, 1998, Patient J was admitted to Bridges Treatment Center at Virginia Baptist Hospital, Lynchburg, Virginia ("Bridges") for residential treatment under the care of a practitioner other than Dr.Stein. On or about June 11, 1999, Patient J was discharged from Bridges with the following diagnoses:

Axis I:	Pervasive Development Disorder, Not Otherwise Specified Learning Disorder, Not Otherwise Specified
Axis II:	None
Axis III:	History of functional heart murmur
Axis IV:	Primary support group, social and educational problems
Axis V:	GAF 55

Patient J's medication upon being discharged from Bridges consisted of Luvox 75 mg. twice a day and Riperidone 2 mg. at bedtime and 1 mg. in the morning.

11. Dr. Stein's simultaneous treatment of Patient H, I and J created a clear conflict of interest.

12. In approximately January 2000, Dr. Stein entered into psychiatric treatment.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that Dr. Stein is in violation of Sections 54.1-2915A(4), (5) and (3), as further defined by Sections 54.1-2914(3), (7), (8), (11), (12), (13) and (14) [*formerly Sections 54.1-2914A(3), (9), (10), (13), (14), (15) and (16)*] of the Code and Section 18 VAC 85-20-100 [*effective February 3, 1999*] of the Regulations Relating to Medicine and Other Healing Arts.

CONSENT

I, Martin H. Stein, M.D., by affixing my signature hereto, acknowledge that:

1. I have been advised specifically to seek the advice of counsel prior to signing this document;

2. I am fully aware that without my consent, no legal action can be taken against me, except pursuant to the Virginia Administrative Process Act, § 2.2-4000 A et seq. of the Code of Virginia;

3. I have the following rights, among others:

   a. the right to a formal fact-finding hearing before the Board;

   b. the right to representation by counsel; and

   c. the right to cross-examine witnesses against me.

4. I waive all rights to a formal hearing;

5. I do not admit the truth of the above Findings of Fact, but agree not to contest these findings in any future proceeding before the Board and;

6. I consent to the following Order affecting my license to practice medicine in the Commonwealth of Virginia.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ORDERED that the Board accept the VOLUNTARY SURRENDER FOR SUSPENSION for not less than

one year of the license of Martin H. Stein, M.D., with the suspension STAYED for ten days following the entry of this Order, at which time the stay will be lifted and the license of Dr. Stein will be SUSPENDED.

During the ten-day period of time following the entry of this Order, Dr. Stein shall effect the closure of his practice and transfer all remaining patients to appropriate practitioners to ensure continuity of care for his patients. This transfer shall also encompass the transfer of medical records to the subsequent practitioners.

During the ten-day period of time following the entry of this Order, Dr. Stein shall not accept new patients, nor initiate new treatment for existing patients, except in the case of a life-threatening emergency.

In the event that Dr. Stein seeks reinstatement of his license to practice medicine, he shall be noticed to appear before the Board in accordance with the Administrative Process Act, and present evidence that he is capable of resuming the practice of medicine in a safe and competent manner.

Pursuant to Section 54.1-2920 of the Code, Dr. Stein shall give notice, by certified mail, of the suspension of his license to practice medicine to all patients to whom he is currently providing services. Dr. Stein shall cooperate with other practitioners to ensure continuation of treatment in conformity with the wishes of the patient. Dr. Stein shall also notify any hospitals or other facilities where he is currently granted privileges, and any health insurance administrators or health maintenance organizations currently reimbursing him for any of the healing arts.

Violation of this Order constitutes grounds for the revocation of the license of Dr. Stein. In the event Dr. Stein violates the terms of this Order, an administrative proceeding will be convened to determine whether the license of Dr. Stein shall be revoked.

The license of Dr. Stein will be recorded as suspended and no longer current. Consistent with the terms of this Order, in the event that Dr. Stein seeks reinstatement of his license, he shall be responsible for

any fees that may be required for the reinstatement and renewal of his license prior to issuance of his license to resume practice.

Pursuant to Section 2.2-4023 of the Code, the signed original of this Consent Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

FOR THE BOARD:

William L. Harp, M.D. 10/18/02
Executive Director
Virginia Board of Medicine

10/11/02
ENTERED

SEEN AND AGREED TO:

Martin H. Stein, M.D.

COMMONWEALTH OF VIRGINIA
~~COUNTY~~/CITY OF Alexandria, TO WIT:

10th Subscribed and sworn to before me, the undersigned Notary Public, in and for the Commonwealth of Virginia, at large, this day of October, 2002, by Martin H. Stein, M.D.

Notary Public

My commission expires: 8/31/2004

COMMONWEALTH of VIRGINIA

Robert A. Nebiker
Director of the Department

William L. Harp, M.D.
Executive Director of the Board

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August 16, 2002

Martin H. Stein, M.D.
1911 North Fort Myer Drive
Suite 907
Arlington, VA 22209

CERTIFIED MAIL
7160 3901 9844 7518 9341

RE: License No.: 0101-030679

Dear Dr. Stein:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Thursday, November 14, 2002, at 9:00 a.m., at the Holiday Inn Select, 2801 Plank Road, Fredericksburg, Virginia**. The conference will be conducted pursuant to Sections 54.1-2919, 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

An Informal Conference Committee ("Committee"), composed of three members of the Board, will inquire into allegations that you may have violated certain laws governing the practice of psychiatry in Virginia. Specifically, you may have violated Sections 54.1-2915A(4), (5) and (3), as further defined by Sections 54.1-2914(3), (7), (8), (11), (12), (13) and (14) [*formerly Sections 54.1-2914A(3), (9), (10), (13), (14), (15) and (16)*] and Section 54.1-2910.1 of the Code; Sections 18 VAC 85-20-100 and 18 VAC 110-20-340 [*effective February 3, 1999*] and Section 18 VAC 85-20-290 of the Regulations Relating to Medicine and Other Healing Arts; and Section 18 VAC 110-20-340 of the Regulations Governing the Practice of Pharmacy in that:

1. From on or about January 29, 1999, through on or about July 28, 1999, you treated Patient A for major depression and obsessive-compulsive disorder.

   a. Your treatment of Patient A was contrary to sound medical judgment in that you prescribed Oxycontin, a Schedule II controlled substance of high abuse potential, to treat Patient A's severe depression. Said treatment was undertaken despite Patient A's having related to you that she had used heroin five or six times in the past. You failed to closely monitor the frequency of the Oxycontin prescriptions written for Patient A, who became addicted to Oxycontin. She was subsequently hospitalized on or about August 15, 1999, as a result of her intravenous use of Oxycontin.

   b. You failed to properly maintain the medical record of Patient A, in that:

i. You began treating Patient A in late January or early February 1999, but there is no initial intake treatment note in the chart. The first documented office visit for Patient A is February 24, 1999.

ii. A review of your medications log for Patient A reveals that you prescribed Xanax (Schedule IV) for Patient A on January 29, 1999; however, there is no documentation of a January 29, 1999 encounter or phone note in Patient A's medical records. Similarly, on or about March 13, 1999, you authorized a refill of Cogentin (Schedule VI); however, there is no documentation as to when you first prescribed Cogentin for Patient A.

2. From on or about September 10, 1998, through on or about January 22, 1999, you treated Patient B, a person you knew to have a history of drug abuse, for post-concussion syndrome, restless leg syndrome ("RLS"), obsessive-compulsive disorder, major depressive disorder, and attention deficit disorder. Your treatment of Patient B was contrary to sound medical judgment, in that:

a. You prescribed Percocet, a Schedule II controlled substance of high abuse potential, "for sleep," after Patient B related that he had slept well when he was using heroin. Further, a review of Patient B's medical records reveal that on or about October 8, 1998, you prescribed additional oxycodone to treat Patient B's RLS.

b. You continued to prescribe Oxycontin and Oxy-IR for Patient B after he relapsed into the use of heroin. In a letter dated November 16, 1998, you told Patient B that you would no longer prescribe any of the "abusable medications...such as oxycodone, klonopin nor dexedrine." However, after an office visit on or about November 24, 1998, you resumed prescribing Oxycontin, Oxy-IR, Klonopin and Dexedrine for Patient B.

3. From on or about September 19, 1997 through on or about December 20, 1999, you treated Patient C for attention deficit hyperactivity disorder, post-traumatic stress disorder, anxiety, depression, obsessive-compulsive disorder, anorexia, bipolar disorder and possible cyclothymia. Your treatment of Patient C was contrary to sound medical judgment, to include your failure to maintain proper professional boundaries with Patient C and your engagement in an inappropriate and unethical social relationship with her. Specifically:

a. You engaged in sexually intimate behavior with Patient C that frequently occurred during the early morning and evening hours.

b. You used hypnosis, suggestion, massage and psychotropic medicines, to evoke memories of childhood abuse. Said memories are not corroborated and have, in at least one instance, been disproved by objective evidence. Following the recovery of these memories you were often unavailable to Patient C for periods of several days and you failed to secure an alternative therapist for her.

c. In March and June 1998, despite the request of Patient C and her family, you failed to provide a back-up psychiatrist for Patient C when you were away on vacation. During that time Patient C over-medicated herself into a state of semi-consciousness. Further, you failed to direct her to go to a hospital for a psychiatric emergency, despite her suicidal state and discouraged her from seeking an independent second opinion from another psychiatrist, when she and her family indicated they thought it was warranted.

d. You failed to seek a second, independent medical opinion or to change your treatment plan, when you witnessed Patient C's deterioration under your care, which included extended periods of time during which she stopped eating, showed a marked decrease in her Global Assessment of Functioning ("GAF") from 70 to 20 and made repeated threats of suicide.

e. You talked to Patient C about your past and personal life, at times crying and allowing her to hold you and also had Patient C meet and talk with your sister about abuse. Further, you frequently discussed aspects of another patient's treatment with Patient C and on one occasion, showed Patient C a video of said patient.

f. You visited Patient C at her home several times (and charged her $200 per hour for doing so), went shopping with her (and charged her $200 per hour for doing so), took her for rides in your car, went for walks with her, accepted gifts from and gave gifts to her, let her bring you meals, allowed her to try on clothes in your office, went out to dinner with her, permitted her to "hang out" in your waiting room for hours prior to her appointments "just to be near you" and allowed her to rent a room in your office suite for $100.00 a day. Further, in June 1998, you traveled with Patient C. at her expense, to her hometown and childhood homes in Danville, Illinois.

g. You influenced Patient C to limit and/or terminate communication with her family members by instructing Patient C not to discuss her therapy with her family and aiding her with the initiation of legal action against them. Specifically:

i. Your treatment of Patient C rendered her unable to take care of her children whom she frequently neglected to spend time with you. Said neglect resulted in Child Protective Services removing the children from Patient C's custody.

ii. You encouraged Patient C's divorce from her husband and actively participated by referring her to an attorney, with whom you were friends, to represent her in the matter. You often consulted with said attorney in regards to Patient C's legal matters without her knowledge or consent.

iii. Subsequent to Patient C's divorce, you attempted to disrupt her relationship with her boyfriend through the use of threats.

h. You became inappropriately involved with Patient C's personal finances. Specifically:

i. Despite Patient C's indication to you that she needed help learning to control her compulsive spending you encouraged her spending behavior by advising her that extravagant spending of her inheritance from her father would be therapeutic. Simultaneously, you advised her not to "blow [her] money away...to conserve [her] resources" and remarked that money was useful "for some decent therapy."

ii. You encouraged Patient C to sell her home and buy a condominium so that she could spend her money "elsewhere" and had your bookkeeper help Patient C with her finances and payment of her bills. You also had Patient C bring her financial statements in for your review and personally appraised her valuables for sale.

i. You failed to keep complete and accurate records of what transpired during your therapy sessions with Patient C, frequently documenting only the date and time span of the therapy sessions and omitted from her medical records approximately 40-50 pages of e-mailed letters sent between you and Patient C within the context of your treatment of her. Further, on or about April 2, 1998, you had an appointment with Patient C's husband, but failed to document this meeting in the patient's record.

j. You failed to provide proper medication management to Patient C, in that you prescribed various medications, to include: Ritalin; Zyprexa; cyclobenzaprine; Risperdal; Neurontin; Klonopin; Ecotrin; Ambien; Lamictal; Buspar; Paxil; Elavil; Flexeril; Tylenol with Codeine; Lithonate; Lithium; Lithobid; Carbitrol; Cytomel; Prozac; Tegretol; Ativan; Xanax; Bentyl; Celexa; Eskalith; Toradol; Cogentin; Dexedrine and Klonopin. Specifically:

i. You failed to properly monitor the dosage of and interactions among Patient C's medications despite receiving reports from several individuals, including Patient C, that she was experiencing side effects from the medications including: memory impairment; syncope; exhaustion; an inability to focus and uncontrollable shaking.

ii. You gave Patient C prescriptions for her heart, stomach, hormones, arthritis and irritable bowel syndrome, rather than referring her to appropriate specialists for treatment.

4. From on or about January 2, 1999 until on or about May 24, 1999, you treated Patients D and E, the minor children of Patient C, against the express written objections of their father, despite having no special training in child psychiatry. Your treatment of Patients D and E during this time was contrary to sound judgment, in that:

a. You failed to refer Patients D and E to an appropriately trained specialist in child psychiatry. Further, your simultaneous treatment of Patient D, E and their mother created a clear conflict of interest.

b. You erroneously used adult psychiatric criteria to diagnose Patient D, a four (4) year old child, contributing to your misdiagnosis of him as suffering from major depression, tourette's syndrome, obsessive compulsive disorder, attention deficit hyperactivity disorder, dissociative identity disorder, bipolar disorder and anxiety. Subsequent, treating professionals diagnosed him as suffering primarily from depression.

c. On or about February 27, 1999, after receiving a phone call from Patient C that Patient D was "out of control" and had attempted to "jump out of the car", you advised Patient C to bring Patient D into your office for a consultation at which you bound his ankles and feet with electrical tape in front of Patients C and E.

d. Following the conclusion of your therapeutic relationship with Patient D you interfered with his treatment by a subsequent therapist through your failure to communicate truthfully and completely with said therapist regarding your knowledge of possible causes of his depression, to include your relationship with Patient C. Consequently, said therapist was not able to immediately provide adequate treatment to Patient D. Further, you repeatedly consulted and communicated with Patient D's other treating physicians. You convinced Patient C to discharge Patient D's and E's treating physicians in favor of one you recommended despite the issuance of a court decree, entered September 29, 1999.

forbidding your involvement in the children's treatment and receiving written notice from their father that you were not to be involved.

e. You failed to provide proper medication management to Patients D and E to include the prescribing of medications that could have been harmful to children their age. Specifically:

i. With inadequate clinical rationale, you prescribed multiple medications for Patient D, including: Lithium, Prozac, Paxil, Zoloft, Buspar, Cogentin, Risperdal, Clonidine, Ritalin and Dexedrine. Buspar, Risperdal and Lithium are not approved for children under the ages of eighteen (18), twelve (12) and six (6) respectively. You also prescribed medications not recommended for use by children to Patient E, including Prozac.

ii. You failed to properly monitor the interactions of Patient D's medications and continued to dispense medication to Patient D after he was the patient of another psychiatrist.

iii. On occasion, you provided medication, including loose pills in unlabeled bags. to Patients D and E through Patient C, after they were no longer your patients.

5. From on or about July 18, 1997 to on or about July 27, 2001, you treated Patient F for attention deficit disorder, anxiety, migraines, restless legs syndrome, narcolepsy, obsessive-compulsive disorder, cataplexy, and complex partial seizures/generalized convulsive epilepsy. Your treatment of Patient F during this time was contrary to sound medical judgment, in that:

a. You ignored scientific evidence and medical opinion that directly conflicted with your diagnoses of Patient F. This failure to recognize possible alternative diagnoses and treatments resulted in Patient F receiving long term care that was both ineffective and harmful. Specifically:

i. You treated Patient F for epilepsy and narcolepsy despite results of an EEG. brain MRI, cerebral perfusion SPECT exam and sleep study that were all within normal limits. You failed to order a follow-up EEG and stated in your written response to the investigator from the Department of Health Professions ("Department") that "whether it was normal or not...would not have changed my treatment approach." Further, you insisted that his symptoms were biologically based despite neuropsychological testing which revealed that Patient F's chief symptoms (difficulty concentrating, anxiety, depression, and fatigue) were of psychological etiology. Subsequently, you indicated in your written response to the Departments investigator that, "his neuropsychological test...supported my opinion that there were...organic factors causing a significant part of his chief complaint."

ii. You disregarded the opinion of previous physicians that Patient F probably did not suffer from narcolepsy and did not need anti-epileptic therapy, and that his solitary seizure was related to Wellbutrin. In reinitiating Patient F's anti-epileptic therapy you falsely wrote that his seizures were of "unknown origin." A neurologist who examined Patient F subsequent to your treatment of him found that he did not have narcolepsy or epilepsy and diagnosed him with chronic depression, an alerting disorder, and a sleep disorder.

iii. You failed to properly pursue a diagnosis of depression for Patient F, despite his statement that he had "a long-standing depression." Further, you discontinued his

previously prescribed antidepressant without determining whether it needed to be replaced. His subsequent physician treated his depression successfully with Effexor.

b. You improperly prescribed inappropriate and conflicting medications for Patient F, including: Ritalin, Risperdal, Dexedrine, Desoxyn, Neurontin, Methamphetamine, Lamictal, Luvox, Klonopin, Xanax, Concerta, Aricept, and Gingko Biloba. The manner in which said medications were prescribed resulted in a delay in Patient F receiving appropriate treatment and unnecessarily exposed him to the risk of serious side effects. Patient F reported being confused by taking so many medications at once and suffered tremors as a result of "interactions of medications." Additionally, you prescribed Patient F Lamictal, an anti-epileptic medication, for "mood control," despite having listed it among the medications to which he was allergic.

6. From on or about November 14, 1991 to on or about April 2, 1997, you treated Patient G, a fifteen (15) year-old female referred to you by her school for depression and drug and alcohol use. At various times during the course of your treatment of Patient G, you diagnosed her with major/atypical depression, seasonal affective disorder, epilepsy, organic affective disorder, obsessive-compulsive disorder, attention deficit disorder and post concussion syndrome. Your treatment of Patient G during that time was contrary to sound medical judgment, in that:

a. You disregarded scientific evidence and other medical opinion that directly conflicted with your diagnoses of Patient G, your diagnosis of epilepsy in particular. This failure to recognize possible alternative diagnoses and treatments resulted in Patient G receiving long term care that was both ineffective and harmful. Specifically:

i. A telemetry report stated that, "patient was stimulated but a seizure could not be provoked" and the patient has no history of seizures; however, in your written response to the Department's investigator you stated that "a minimal amount of electrical stimulation led to an electrical seizure". Further, Patient G has always had normal MRI's, EEG's and SPECT scans.

ii. You stated in your written response to the Department's investigator that "the telemetry [confirmed] the diagnosis of temporal lobe epilepsy"; however, Patient G's PET scan revealed only "slight" deviation from normal. Additionally, a Georgetown University nuclear medicine specialist wrote, "normal cerebral perfusion study [with] no abnormalities in temporal lobes." Further, a George Washington University neurophysiologist wrote, "there were no EEG changes...to support [a diagnosis of] seizures." A consulting neuropsychiatrist noted that "she has no evidence of characteristic seizure events" and that "there is no family history of paroxysmal disorders such as epilepsy." He believed that "her mood instability may be...related to her excessive dependence on a variety of drugs and the frequent changing of drugs prescribed."

iii. Your records indicate that you presented Patient G to the George Washington University epilepsy conference as a candidate to undergo invasive "intracerebral electrode monitoring [to include] depth electrodes in both amygdala/hippocampi and electrode strips around both temporal lobes." You encouraged Patient G to undergo said procedure despite your own written admissions that, "[she does] not have a positive EEG, MRI, or SPECT, and [her] PET is not fully diagnostic...and does not have the weight to justify the surgery." and

that the proposed surgery was justified only by "the clinical experience that we have developed working together..."

iv. On or about December 19, 1994, you diagnosed Patient G with Attention Deficit Disorder, however, you failed to document medical indication or subjective and objective findings to substantiate said diagnosis.

v. Although you had history from the patient that she abused cocaine and marijuana, you did not include substance abuse in your list of working diagnoses. Additionally, you failed to address any Axis II issues with this patient.

b. You failed to properly manage multiple medications you prescribed for Patient G, to include: Ritalin, Neurontin, Valium, Luvox, Dexedrine, Lamictal, Ludiomil, Elavil, Desoxyn, Xanax, Vigabatrin, Risperdal, Cylert, Felbatol, Dilantin, Topamax, Ativan, Loestrin, Prozac, Ultram, Anafranil, Tranxene, Tegretol, Tylenol with Codeine, Imipramine, Procardia, Parnate, Buspar, Mesantoin, Paxil, Klonopin, Wellbutrin and Zoloft. Specifically:

i. You prescribed Vigabatrin, an experimental drug for patients unresponsive to other anti-epileptic medications, without having properly diagnosed Patient G with epilepsy.

You prescribed Dilantin and Prozac for Patient G despite being advised by a consulting neuropsychiatrist that Patient G is allergic to Dilantin and that Prozac had a paradoxical effect on her. Further, you prescribed Xanax and Klonopin for Patient G despite having earlier acknowledged that neither had worked for her previously.

iii. On or about November 8, 1994, you prescribed Dexedrine for Patient G without medical indication and failed to document an office visit on that date. At the time said prescription was written, you had not examined or personally consulted with Patient G since January 18, 1993.

iv. Despite having knowledge of Patient G's history of drug abuse (including the use of cocaine), you prescribed for her controlled substances, including large doses of benzodiazepines and amphetamines without properly monitoring her misuse of medication.

c. You failed to send Patient G for proper consultations regarding medical complaints outside your scope of practice. Specifically:

i. You failed to order a proper consultation for evaluation of her chronic stomach problems, despite her having suffered from esophagitis as a child. You inappropriately assumed that her stomach problems were of neuropsychiatric etiology, without pursuing adequate differential diagnosis.

ii. After documenting your belief that Patient G was "in need of a hospital setting for detox," you instructed her to enter the hospital, but failed to make certain that she was actually admitted before you left for a vacation. She did not enter the hospital.

7. In approximately January 2000, you entered into psychiatric treatment.

8. You failed to properly update your physician's practitioner profile, to include your failure to disclose the settlement of a malpractice claim filed against you by Patient C.

In order to protect the privacy of your patients, they have been referred to by letter only. Please see Attachment I for the identity of these individuals.

The following actions may be taken by this Committee:

1. If a majority of the Committee is of the opinion that a suspension or revocation of your license may be justified, the Committee shall present to the Board in writing its findings, and the Board may proceed with a formal hearing.

2. The Committee may notify you in writing that you are fully exonerated of any charge that might affect your right to practice psychiatry in Virginia.

3. The Committee may reprimand or censure you.

4. The Committee may impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

5. The Committee may place you on probation for such time as it may designate and direct that during such period you furnish the Committee or its chairman, at such intervals as the Committee may direct, evidence that you are not practicing in violation of the provisions of Chapter 29, Title 54.1 of the Code, which governs the practice of psychiatry in Virginia.

You have the right to information which will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents which will be distributed to the members of the Committee, and will be considered by the Committee when discussing the allegations with you and when deliberating upon your case. Since you have been noticed of an alleged violation of Section 54.1-2914.A(7) of the Code, enclosed in these documents are Sections 1, 2, 4 and 5 of the American Psychiatric Association's Principles of Medical Ethics. The Committee may consider these principles when determining whether you have conducted your practice in a manner contrary to the standards of ethics of the practice of psychiatry. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. I also enclose relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of psychiatry and other healing arts in Virginia.

Absent good cause shown to support a request for a continuance, the informal conference will be held on November 14, 2002. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made in writing to me at the address listed on this letter and must be received by 5:00 p.m. on **October 31, 2002**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **October 31, 2002**, will not be considered.

You may be represented by an attorney at the informal conference. If you obtain counsel, you should do so as soon as possible, as a motion for a continuance due to the unavailability of counsel will not be considered unless received by **October 31, 2002**. Further, it is your responsibility to provide the enclosed materials to your attorney.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Renee Dixson, Case Manager, Board of Medicine, Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717, by **October 31, 2002**. Your documents may not be submitted by facsimile. Should you or Assistant Attorney General Emily O. Wingfield wish to submit any documents for the Committee's consideration after **October 31, 2002**, such documents shall be considered only upon a ruling by the Chair of the informal conference committee that good cause has been shown for late submission.

Please advise the Board, in writing, of your intention to be present. You may waive your right to an informal conference, in writing, and proceed to a formal administrative hearing pursuant to Section 2.2-4020 of the Code. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions. Please contact Sheon J. Rose, Senior Adjudication Analyst, at (804) 662-7445 with any questions regarding this notice.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

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cc: Harry C. Beaver, M.D., President, Virginia Board of Medicine
Robert A. Nebiker, Director, Department of Health Professions
Emily O. Wingfield, Assistant Attorney General
Sheon J. Rose, Senior Adjudication Analyst
Renee Dixson, Discipline Case Manager, Board of Medicine
Charles F. Johnson, Senior Investigator (74368)
Susan Jo Tokarski, Senior Investigator (75475/82307)

Enclosures:
Virginia Code Sections:
54.1-2914
54.1-2915
54.1-2910.1
54.1-2919
2.2-4019
2.2-4021
18 VAC 85-20-100 [effective December 1999]
18 VAC 110-20-340 [Board of Pharmacy Regulations]
Informal Conference Package
Map
Attachment I