STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

Bernard Raxlen, M.D.
License No. 016443

Petition No. 980108-001-001

MEMORANDUM OF DECISION

Procedural Background

On September 30, 1999, the Department of Public Health ("the Department") presented the Connecticut Medical Examining Board ("the Board") with a Statement of Charges ("the Charges") brought against license number 016443 of Bernard Raxlen, M.D. ("respondent"). Panel Exh. 1. The Charges allege that respondent violated Conn. Gen. Stat. §20-13c *et seq*. Panel Exh. 1.

On December 20, 2000, the Department sent the Notice of Hearing and the Charges to respondent via certified mail, return receipt requested. Panel Exh. 1.

On January 5, 2000, respondent filed an Answer along with four Special Defenses to the Second to Fifth Counts, and a Motion to Sever the Third Count from the rest of the Charges. Panel Exhs. 2, 4.

On January 19, 2000, the Department filed an Objection to Respondent's Motion to Sever and a Reply to Respondent's Special Defenses. Panel Exhs. 3, 5.

On March 9, 2000, the Department filed a Pre-Hearing Brief. On March 14, 2000, respondent filed a Pre-Hearing Brief. Rt. Exh. A.

On May 22, 2000, the Department filed a Motion to Present Testimony of Dr. Jihad Slim by Telephone. On June 1, 2000, respondent filed an Objection to the Department's Motion to Present Expert Testimony by Telephone. On June 5, 2000, the Department filed a Reply to Respondent's Objection to Telephonic Testimony by Dr. Jihad Slim. On June 6, 2000, the Board denied the Department's Motion to Present Testimony of Dr. Jihad Slim by Telephone.

At the hearing on June 13, 2000, respondent moved to dismiss the complaint. The panel denied the motion. Tr., 6/13/00, p. 218, Tr., 10/17/00, p. 27.

On July 6, 2001, the Department withdrew the Fourth Count. *See* Post-hearing Brief, p. 2.

On July 16, 2001, the Department filed a Motion for the Exclusion of New Evidence Offered by Respondent. Respondent filed an Objection to Motion Exclude. On July 30, 2001, the Board granted the Department's Motion to Exclude New Evidence.

A hearing was held regarding the allegations contained in the Charges on the following dates: March 14, 2000, June 13, 2000, October 17, 2000, May 8, 2001, and June 21, 2001, before a duly authorized panel of the Board comprised of Mary L. Warner, PA-C, Mary P. Olson, M.D., and Grant H. Miller, Esq. ("the panel").

The panel conducted the hearing in accordance with Conn. Gen. Stat. Chapter 54 and the Regulations of Connecticut State Agencies ("the Regulations") §19a-9a-1 *et seq.* Respondent appeared with his attorney Elliot Pollack, Esq., of Hartford, CT. David Tilles, Esq., represented the Department. Both the Department and respondent presented evidence, conducted cross-examination, and provided arguments on all issues.

All panel members involved in this decision attest that they have either heard the case or read the record in its entirety. The Board reviewed the panel's proposed final decision in accordance with the provisions of Conn. Gen. Stat. §4-179. The Board considered whether respondent poses a threat, in the practice of medicine, to the health and safety of any person. This decision is based entirely on the record and the specialized professional knowledge of the Board in evaluating the evidence.

Allegations

1. In paragraphs 1, 4, 10, 18, and 22 of the Charges, the Department alleges that respondent is and has been at all times referenced in the Charges, the holder of Connecticut physician and surgeon license number 016443. Panel Exh. 1.

First Count

2. In paragraphs 2 and 3 of the Charges, the Department alleges that respondent's license is subject to disciplinary action pursuant to Conn. Gen. Stat. §20-13c, including, but not limited to §20-13c(4) in that at various times in 1993 and 1994, respondent treated A.J. and failed to make or maintain records of her treatment. Panel Exh. 1.

Second Count

3. In the Second Count, the Department alleges that respondent's license is subject to disciplinary action pursuant to Conn. Gen. Stat. §20-13c, including, but not limited to §20-13c(4) (*see*, paragraph 9 of the Charges) based on the following allegations:

4. In paragraphs 5 of the Charges, the Department alleges that on several occasions between April 28, 1994 and August 28, 1995, the Department of Public Health requested or demanded by subpoena that respondent produce a copy of his records in regard to A.J. Respondent refused on each occasion. Panel Exh. 1.

5. In paragraph 6 of the Charges, the Department alleges that on or about June 27, 1995, respondent commenced an action in Superior Court for the Judicial District of Bridgeport in which he sought a permanent injunction against the Department to prevent the Department from obtaining his records concerning A.J. or any other of his patients. On or about September 9, 1996, the Superior Court denied the respondent's motion for summary judgment in said action and set the matter for a November 14, 1996 hearing on the complaint for permanent injunction. Panel Exh. 1.

6. In paragraph 7 of the Charges, the Department alleges that on or about November 7, 1996, respondent informed A.J. of the impending hearing. A.J. retained Attorney Jeffrey Grant of Mamaroneck, New York, who demanded that respondent send him all of respondent's records regarding A.J. Before the November 14, 1996 hearing, without consulting his own attorney, respondent transferred his entire original file to Attorney Grant. Respondent did not keep a copy of the file. Panel Exh. 1.

7. In paragraph 8 of the Charges, the Department alleges that respondent transferred the file deliberately to thwart the Department's subpoenas and the court's *in camera* review of the records, or with reckless disregard for his obligations to the Department under the subpoenas and under sections 19a-14-41 through 19a-14-43, inclusive, of the Regulations to preserve all medical records that are relevant to a matter in litigation or to a complaint of unprofessional conduct with respect to particular patient.

Third Count

8. In the Third Count, the Department alleges that respondent's license is subject to disciplinary action pursuant to Conn. Gen. Stat. §20-13c, including, but not limited to §20-13c(4) (*see*, paragraph 17 of the Charges) based on the following allegations:

9. In paragraphs 11 and 18 of the Charges, the Department alleges that respondent treated G.F. from approximately April 25, 1995 through approximately February 23, 1996. Panel Exh. 1.

10. In paragraph 12 of the Charges, the Department alleges that when respondent performed his initial examination, respondent ordered diagnostic tests for Lyme Disease. The tests were performed on April 27, 1995, and were all negative for Lyme Disease. Panel Exh. 1.

11. In paragraph 13 of the Charges, the Department alleges that throughout his course of treating G.F., respondent prescribed Plaquenil and Biaxin for the treatment of Lyme Disease. Panel Exh. 1.

12. In paragraph 14 of the Charges, the Department alleges that respondent also treated G.F. for obsessive-compulsive disorder, for which respondent prescribed various medications, including Anafranil. Panel Exh. 1.

13. In paragraph 15 of the Charges, the Department alleges that at no time during his treatment of G.F. did respondent performed liver enzyme tests or blood counts on G.F., although such tests are recommended in conjunction with prescriptions of Anafranil and Plaquenil. Panel Exh. 1.

14. In paragraph 16 of the Charges, the Department alleges that respondent's care failed to meet the applicable standard of care in that:
    (a) Respondent treated for Lyme Disease when the patient's symptoms did not indicate Lyme Disease; and/or
    (b) Respondent prescribed medications for Lyme Disease which are not acceptable for that purpose; and/or
    (c) Respondent failed to monitor the effect of the medications he prescribed. Panel Exh. 1.

Fourth Count

15. In the Fourth Count, the Department alleges that respondent's license is subject to disciplinary action pursuant to Conn. Gen. Stat. §20-13c, including, but not limited to §20-13c(4) (*see*, paragraph 21 of the Charges) based on the following allegations:

16. In paragraph 19 of the Charges, the Department alleges that in late February 1997, respondent sent his entire original file regarding G.F. to G.F.'s father in New Jersey, without keeping a copy. At the time he sent his entire file to the patient's father, he knew that G.F. had filed a medical malpractice claim against him. Respondent also had testified in court regarding the transfer of A.J.'s records, at which time the statutes and regulations applicable to retention of records were discussed at length in open court in respondent's presence. Panel Exh. 1.

17. In paragraph 20 of the Charges, the Department alleges that respondent transferred the aforementioned G.F. file in knowing or reckless disregard of sections 19a-14-41 through 19a-14-43, inclusive, of the Regulations requiring physicians to preserve all medical records that are relevant to a matter in litigation or to a complaint of unprofessional conduct with respect to a particular patient. Panel Exh. 1.

Fifth Count

18. In paragraphs 23 and 24 of the Charges, the Department alleges that respondent's license is subject to disciplinary action pursuant to Conn. Gen. Stat. §20-13c, including, but not limited to §20-13c(9) in that respondent failed to maintain professional liability insurance or other indemnity against liability for professional malpractice from October 1, 1994 (effective date of Public Act 94-71, now codified as Conn. Gen. Stat. §20-11(b)) until on or about October 16, 1998. Panel Exh. 1.

Findings Of Fact

1. Respondent is, and has been at all times referenced in the Charges, the holder of Connecticut physician and surgeon license number 016443. Panel Exh. 2.

2. At various times in 1993 and 1994, respondent treated A.J. for chronic fatigue syndrome, premenstrual syndrome, and Lyme Disease. Dept. Exh. 21; Tr., 6/13/00, pp. 110, 117-118, 124.

3. Sometime between 1994 and 1995, Aetna placed a complaint with the Department alleging that respondent maintained no records of his treatment of A.J. The Department then requested that respondent produce a copy of the records. When respondent refused, the Department issued two subpoenas duces tecum, one dated April 12 and the other on August 23, 1995. Dept. Exhs. 19-21, 23, 24, p. 29; Tr., 6/13/00, pp. 115-117, 123-124.

4. Respondent refused to provide A.J.'s file claiming the records contained confidential psychiatric and personal information. However, the billing records did not reflect treatment of any psychiatric condition. Respondent also failed to provide redacted copies. Dept. Exhs. 22, 23; Tr., 6/13/00, pp. 131-132.

5. Respondent's chart and testimony indicate that A.J. was in remission and she had no medical need for an immediate transfer of her file to another doctor, let alone a doctor in another state. Tr., 6/13/00, pp. 148-150.

6. On or about June 27, 1995, respondent brought an action in Superior Court to enjoin the Department from obtaining the records of A.J. On September 9, 1996, the Superior Court denied respondent's motion for summary judgment and scheduled a hearing for November 14, 1996. One week before the hearing, respondent sent A.J.'s medical records to Attorney Jeffrey Grant in New York without consulting with his attorney in Connecticut and without maintaining a copy of the file. Dept. Exhs. 24, 25; Tr., 6/13/00, pp. 115, 133-134, 140, 141, 145-154.

7. Respondent transferred the file deliberately to thwart the Department's subpoenas and the court's *in camera* review of the records, or with reckless disregard for his obligations to the Department under subpoenas and under sections 19a-14-41 through 19a-14-43, inclusive, of the Regulations to preserve all medical records that are relevant to a matter in litigation or to a complaint of unprofessional conduct with respect to a particular patient. Dept. Exhs. 23, 24, 25, 26.

8. On April 25, 1995, G.F., a twenty-year old male, presented to respondent's office with a complaint of fatigue, severe anxiety, depression, and irritability. Respondent's examination of G.F. established that he had obsessive compulsory disorder ("OCD"). G.F. frequently visited relatives in Connecticut, an endemic area for Lyme disease. Respondent ordered blood tests including uric acid, vitamin B12, folic acid, glucose, cholesterol, triglicerides, thyroid profile, dihydroepiandsterone ("DHEA") sulfate (one of the markers for adrenal insufficiency), and serotonin. G.F. did not tell respondent that he suffered from any rash. Respondent prescribed Anafranil, Biaxin, and Plaquenil. Dept. Exh. 11, pp. 25, 36; Rt. Exh. M; Tr., 3/14/00, pp. 203, 134-137, 140, 193; Tr., 5/8/01, pp. 99, 101, 102, 103, 106.

9. On April 25, 1995, respondent ordered diagnostic tests for Lyme disease which were performed on April 27, 1995. The Lyme Disease by Western Blot technique resulted in IgG and IgM bandings. The IgG was negative, IgM was equivocal, and the 37 KDA was positive. 37 KDA is a test that detects a specific protein on the coat of the Borrelia burgdorferi spirochete, the etiologic agent that causes Lyme Disease. Dept. Exh. 11, pp. 49-53; Tr., 6/13/00, pp. 155, 157; Tr., 5/8/01, pp. 104-106.

10. Respondent treated G.F. regularly for a period of approximately nine months. During that time, G.F. complained of digestive problems, sleepiness, and decreased sexual interest. Tr., 3/14/00, p. 150.

11. In June of 1995, respondent prescribed Nystatin, an anti-fungal agent for G.F. Tr., 6/13/00, p. 204.

12. After the initial blood tests performed on April 25, 1995, respondent did not perform additional blood tests. Tr., 6/13/00, pp. 202, 203.

13. Respondent prescribed Biaxin to G.F. for nine months and Plaquenil for six months. Dept. Exh. 11; Tr., 10/17/00, p. 36; Tr., 5/8/01, p. 54.

14. Respondent failed to maintain professional liability insurance or other type of indemnity against liability for professional malpractice from October 1, 1994 (the effective date of Public Act 94-71, now codified as Conn. Gen Stat. §29-11(b) until on or about October 16, 1998. . Panel Exh. 2; Tr., 6/13/00, pp. 109-110.

Discussion And Conclusions Of Law

Conn. Gen. Stat. § 20-13c provides, in pertinent part, that:

> The Board is authorized to restrict, suspend or revoke the license or limit the right to practice of a physician or take any other action in accordance with section 19a-17, for any of the following reasons: . . . (4) illegal, incompetent or negligent conduct in the practice of medicine; . . . .

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Steadman v. Securities and Exchange Commission*, 450 U.S. 91, 101 S. Ct. 999, *reh'g denied*, 451 U.S. 933 (1981); *Swiller v. Comm'r of Public Health*, No. CV970573367, Superior Court, J.D. Hartford/New Britain at Hartford, February 19, 1998.

The Department sustained its burden of proof with regard to the First and Second Counts of the Charges. Respondent failed to provide the Department with A.J.'s medical records. First, respondent falsely claimed he could not provide A.J.'s records because they contained personal and psychiatric records. Secondly, respondent filed an action in Superior Court in which he tried to prevent the Department from obtaining the records. Finally, one week before the scheduled hearing to adjudicate the merits of respondent's case, respondent shipped A.J.'s entire file to an attorney in New York to prevent an *in camera* review of the records. Accordingly, respondent's conduct constitutes grounds for disciplinary action pursuant to Conn. Gen. Stat. §20-13c.

With regard to the third count of the Charges, the Department alleged that respondent's conduct fell below the standard of care in that he failed to promptly and properly order diagnostic tests, diagnose, manage, and treat G.F. A preponderance of the

evidence establishes that the Department failed to sustain its burden of proof. . The Department failed to demonstrate that, at the time in question, the Respondent's conduct fell below the then developing diagnostic and treatment standards applicable to Lyme disease patients. Therefore, the Department did not meet its burden of proof with regard to these allegations.

With regard to the Fifth Count of the Charges, the Department sustained its burden of proof in its allegations that respondent failed to maintain professional liability insurance or other type of indemnity against liability for professional malpractice from October 1, 1994 (the effective date of Public Act 94-71, now codified as Conn. Gen Stat. §29-11(b)) until on or about October 16, 1998. FF 21. Accordingly, respondent's conduct constitutes grounds for disciplinary action pursuant to *Conn. Gen. Stat.* §20-13c.

Order

Based upon the record in this case, the above findings of fact and the conclusions of law, and pursuant to the authority vested in it by Conn. Gen. Stat. §19a-17 and §20-13c, the Board orders the following in the case of Bernard Raxlen, M.D., who holds Connecticut physician and surgeon license number 016443, Petition Number 980108-001-001:

1. For counts one, two, and five, the Board orders the issuance of a reprimand; for count two, a civil penalty of $10,000; and, for count five, a civil penalty of $10,000.
2. The $20,000.00 civil penalty is payable in twenty-five installments of $750.00 per month and one installment of $500.00. The first monthly installment of $750.00 is due on or before June 1, 2002.
3. Payment of the civil penalty shall be made by certified check payable to "Treasurer, State of Connecticut" and shall be sent to:

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION
410 Capitol Avenue, MS #12HSR
P. O. Box 340308
Hartford CT 06134-0308

4. This order is effective as of the date of signature.

Connecticut Medical Examining Board

April 23, 2002
Date

By: Dennis O'Neill, M.D., Chairperson