STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

	)	
In re Mario J. Hasaj, MD	)	Docket No. MPC 026-0317
	)	

Board Members Participating:
Richard Bernstein, MD, Chair
William K. Hoser, PA
David Liebow, DPM
Margaret Tandoh, MD
Leo LeCours, Public Member
Sarah McClain, Public Member
Robert E. Tortalani, MD

Presiding Officer:
George K. Belcher, Esq.

For the State of Vermont:
Kassandra P. Diederich, Esq.

For the Respondent:
(did not appear and was not represented)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DECISION

1. On December 2, 2020 the Vermont Board of Medical Practice considered the above-captioned matter. The State of Vermont was represented by Kassandra P. Diederich, Esq. The Respondent did not appear and was not represented.

2. A report from a Hearing Panel, dated October 26 and October 29, 2020, was filed with the Board on October 29, 2020. The Report of the Hearing Panel is attached to this order as Exhibit A.
3. Notice of the Hearing Panel Report, and Notice of the December 2, 2020 Board Meeting and Hearing was sent to the Respondent by United Parcel Service to the same address to which notice was previously delivered to the Respondent. Notice of the Hearing Panel Report and the December 2, 2020 Board Meeting and Hearing was also sent to the Respondent at the email address to which prior notices were sent to him.
4. There were no exceptions, briefs or arguments filed regarding the Report of the Hearing Panel. 3 VSA Sec. 811
5. The Hearing Panel Report is entitled "Hearing Panel Findings of Fact, Conclusions of Law and Recommended Decision". The Hearing Panel conducted its hearing on October 2, 2020.
6. After considering the Hearing Panel Report, its Findings of Fact and Conclusions of Law, the Board accepts and adopts the Findings of Fact and Conclusions of Law therein. The Board concludes that the Respondent committed unprofessional conduct as set forth in Counts 1-10 of the Specification of Charges by violating 26 VSA Sec. 1354(a)(22) and Sec. 1354(b)(1-2).
7. The Board does accept the proposed sanction which was recommended by the Hearing Panel and does ORDER:
    a. That the Respondent is assessed and shall pay an administrative penalty in the amount of Five Thousand Dollars ($5,000.00) in accordance with 26 VSA Sec. 1374(b); and
    b. That the Respondent's Vermont Medical License and his ability to practice medicine in the State of Vermont is REVOKED.
8. This Order shall be in full force and effect upon entry until further order of the Board or until further order of a court of competent jurisdiction. 26 VSA Sec. 1374(d).

SO ORDERED.

RH Bernstein
____
Richard Bernstein, MD, Chair

12/2/20
____
Date of Entry

12/2/20
____
Date of Order

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

	)	
In re Mario J. Hasaj, MD	)	Docket No. MPC 026-0317
	)	

HEARING PANEL FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED DECISION

Hearing Panel:
Rick A. Hildebrant, MD, Chair
Marga Sproul, MD
Patricia Hunter, Public Member

Presiding Officer:
George K. Belcher, Esq.

For the State of Vermont:
Kassandra Diederich, Esq.

For the Respondent:
(did not appear and was not represented)

Exhibits:
State Exhibit 1: Specification of Charges and Revised Notice of Hearing
State Exhibit 2: Affidavit of Medical Licensing and Operations Administrator
State Exhibit 3: Complaint Form
State Exhibit 4: Complaint Narrative
State Exhibit 5: Authorization to release medical records
State Exhibit 6: Affidavit or Investigator, Paula Nenninger
State Exhibit 7: Curriculum Vitae, James Jacobson, M.D.
State Exhibit 8: Report of James Jacobson, M.D. dated 7/25/18

FINDINGS OF FACT

Introduction and Background

1. This matter was considered on October 2, 2020 by a Hearing Panel of the Vermont Board of Medical Practice pursuant to 26 VSA Sec. 1372.
2. The Vermont Board of Medical Practice received a complaint regarding the care rendered to a patient by the Respondent. The complaint was received in March of 2017. (Exhibit 6, Page 1)
3. The Respondent met with the Investigative Committee of the Board on October 12, 2018. By email from the Respondent to AAG Diederich on March 31, 2019 the Respondent advised that he had retired in December of 2018 and was now living in Argentina. The Respondent's Vermont medical license has lapsed. On November 22, 2019 the Investigative Committee authorized the filing of charges against the Respondent. (Exhibit 6, Page 3)
4. Specification of Charges were issued on May 7, 2020 and a Revised Notice of Hearing was issued on August 25, 2020 (See Exhibit 1).
5. After many attempts to contact and serve the Respondent by ordinary mail, the Respondent was served the Specification of Charges, the Revised Notice of Hearing, and the Emergency Rules for Remote Hearings for the Board of Medical Practice on September 2, 2020 in Lomas De Zamora, Argentina. (See State's Exhibit 2, Page 102).
6. In addition to service of the material on September 2, 2020, various notices of earlier events concerning the case (the filing of the Specification of Charges, pre-hearing conferences, and the like) were sent to the Respondent at the email address which was on file with the Vermont Board of Medical Practice and which the Respondent had used when he last communicated with Attorney Diederich. Following November 22, 2019 (the date the Specification of Charges were authorized) no responses were received from the Respondent in response to the many email communications which were sent to him regarding this matter. (See Exhibit 2, Pages 15 and 16).

7. The Respondent did not participate in the hearing on October 2, 2020 and did not file an answer to the Specification of Charges. Although the Respondent was represented by counsel for a "brief" period of time early in the process, as of April 30, 2020 that attorney no longer was representing the Respondent and did not have communication with him at that time. (See State Exhibit 6, Page 115) The Respondent was not represented by counsel at this hearing.

Facts Regarding Patient Care, Treatment and Records

8. During the times relevant to the Specification of Charges, the Respondent was a practicing psychiatrist at Grace Cottage Hospital in Townshend, Vermont. He treated a patient (hereinafter "the patient") from 10/20/2011 through 7/10/2013. The Respondent assumed the psychiatric care of the patient who was already being prescribed Adderall, 40 mg, by mouth four times daily with a diagnosis of Attention Deficit Hyperactivity Disorder and Hypertension. (State's Exhibit 6, Pages 151-152, chart entry 10/20/2011).
9. During the period in which the patient was treated by the Respondent, he would see the respondent approximately every four weeks. The chart notes show that the patient was essentially stable with no dramatic changes in his condition during this period. (State's Exhibit 6)
10. The patient was observed to be "mildly obese" and smoked 1-2 pkg of cigarettes per day. (State Exhibit 6, Page 151and 130)
11. The usual upper limit of Adderall at present, and at the time during which the Respondent treated the patient, is 60 mg/day. Generally the "upper limit" for a drug speaks to the increased risk of the drug, or the decreased effectiveness of the drug, or both. (Testimony of Dr. Jacobson) The patient was prescribed 160 mg/day of Adderall during the entire time he was treated by the Respondent. This amount was excessive.
12. From the time that the patient entered the treating relationship with the Respondent until the relationship ended, the chart notes do not demonstrate that the Respondent:

a. Conducted a comprehensive medical history, specific symptom review, or rationale which supported, confirmed or led to the patient's original ADHD diagnosis (Exhibit 8);
b. Conducted his own analysis of the appropriateness or legitimate rationale for continuing the extremely high dose of Adderall (Exhibit 8);
c. Discussed with the patient the possibility that the high dose of Adderall may have posed risks to the patient;
d. Communicated with or advised the patient to communicate with other medical providers of the patient about the dosage and the cardiac risks associated with the high dosage (Exhibit 8);
e. Considered alternatives to the excessive dosage of Adderall including other medications, other non-pharmacological treatments, or non-medical ways to address the ADHD (testimony of Dr. Jacobson);
f. Considered or thoughtfully analyzed the risk versus benefits of the continued excessive dosage of Adderall in light of the overall medical condition of the patient or discuss that analysis with the patient (Exhibit 8);
g. Conducted clinical monitoring of the patient including simple blood pressure checks, either in his treatment or by recommendation to other providers;
h. Conducted attempts to reduce the excessive dose of Adderall by a monitored weaning of the patient (testimony of Dr. Jacobson).

13. The patient died on May 28, 2016 from myocardial infarction.
14. Dr. James L. Jacobson is a Professor of Psychiatry at the University of Vermont College of Medicine. He is a medical doctor and has practiced psychiatry for over thirty (30) years. From 2001 to the present Dr. Jacobson has been the Chair of the Quality Assurance and Improvement Committee for Psychiatry in his Department at the UVM College of medicine and served on the Interdepartmental Morbidity and Mortality/ Quality Assurance Committee at the UVM Medical Center. He is familiar with chart review and treatment reviews in both his teaching and in his practice. (See State Exhibit 7)

15. Dr. Jacobson conducted a review of the Respondent's treatment of the patient by reviewing: the patient's entire medical record from Grace Cottage Hospital; the Respondent's prescribing history for the patient; the Respondent's response to the initial complaint; the patient's toxicology report; a summary of the patient's office visits with the Respondent as prepared by the Complainant; the Complainant's review of the medical record of the patient; information on the background of the patient as provided by the Complainant; and the Complainant's complaint.[1]
16. It was the opinion of Dr. Jacobson, to a degree of medical certainty, that the Respondent's treatment of the patient as shown by the medical records

> "… demonstrated a gross failure to use and exercise on repeated occasions, the degree of care, skill, and proficiency commonly exercised by the ordinary, skillful, careful and prudent physician engaged in similar practice under the same or similar circumstances. This constitutes a failure to practice competently over an extended course of treatment for this patient and includes unsafe practices, which do not conform to the essential standards of acceptable and prevailing practice." (State Exhibit 8, Page 3)

17. Dr. Jacobson found the medical charting of the Respondent's treatment was "sparse". The Respondent's records did not include expected information including assessments or the Respondent's overall thinking about his treatment plan. Moreover, Dr. Jacobson testified that the absences in the medical records were not isolated or minor deficiencies. Dr. Jacobson testified that the cumulative evidence of continuing the excessive dosage without thoughtful and documented planning, monitoring, or collaboration approached "willful neglect". In Dr. Jacobson's long experience in psychiatry, he had never seen anyone prescribe Adderall at the level of 160 mg/day.
18. The Hearing Panel accepts the testimony of Dr. Jacobson and, to the extent that his testimony asserted factual information, the Hearing Panel finds those facts to have been proven.

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[1] The Complainant is a medical doctor and father of the patient.

Conclusions of Law and Discussion

19. The burden of proof in a disciplinary action is upon the State to prove unprofessional conduct by a preponderance of the evidence. 26 VSA Sec. 1354(c).
20. An agency having jurisdiction to adjudicate unprofessional conduct by a licensee does not lose jurisdiction if the license is not renewed, is surrendered or is otherwise terminated prior to the initiation of the discipline proceeding. 3 VSA Sec. 814(d).
21. Vermont Law defines unprofessional conduct by a physician to include: "… in the course of practice, gross failure to use and exercise, or the failure to use and exercise on repeated occasions, that degree of care, skill, and proficiency that is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred;" 26 VSA Sec. 1354(a) 22.
22. The term "gross" is considered to address the magnitude of the breach. For example, "gross negligence" is more than a simple mistake.[2]
23. Unprofessional conduct may also include "failure to practice competently" which includes, "(1) performance of unsafe or unacceptable

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[2] "The concept of gross negligence has been defined by this Court in the context of our repealed guest-passenger statute. *Deyo v. Kinley*, 152 Vt. 196, 207-08, 565 A.2d 1286, 1293 (1989). In that [164 Vt. 481] context, we stated that gross negligence is " 'more than an error of judgment, momentary inattention, or loss of presence of mind' "; rather, " 'it amounts to a failure to exercise even a slight degree of care' " and an " 'indifference to the duty owed [to another].' " *Rivard v. Roy*, 124 Vt. 32, 35, 196 A.2d 497, 500 (1963) (quoting Emery v. Small, 117 Vt. 138, 140, 86 A.2d 542, 543 (1952)); see *Shaw, Adm'r v. Moore,* 104 Vt. 529, 531, 162 A. 373, 374 (1932) ("Gross negligence is substantially and appreciably higher in magnitude and more culpable than ordinary negligence.... It is a heedless and palpable violation of legal duty respecting the rights of others.")." *Hardingham v. United Counseling Service of Bennington County, Inc.*, 164 Vt. 478, 672 A.2d 480, (1995)

See also, *Colorado State Bd. of Dental Examiners v. Savelle*, 8 P.2d 693 (1932) where it was stated, "As to the meaning of the words, 'gross violation of professional duty,' a definition of the word 'gross' contained in Webster's New International Dictionary is as follows: '9. Out of all measure; beyond allowance; not to be excused; flagrant; shameful; as a gross dereliction of duty; a gross injustice; gross carelessness.'"

patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice." 26 VSA Sec. 1354 (b)

24. It was the opinion of Dr. Jacobson that the Respondent had violated each of these professional standards in his treatment of the patient. The Hearing Panel accepts his opinion and agrees with it. The Hearing Panel concludes that the Respondent committed unprofessional conduct under both 26 VSA Sec. 1354(a)(22) and 26 VSA Sec. 1354 (b)(1-2)
25. The State recommended that the Board: (1) impose an administrative penalty in the minimum amount of $5,000.00; (2) condition the license of the Respondent in the event that he reapplies for a Vermont medical license and that the conditions include a practice monitor for three years, continuing medical education regarding medical record-keeping and the treatment of ADHD, and such other conditions as the Licensing Committee might require; and (3) order any additional disciplinary action as the Board deems proper. (See Specification of Charges, page 9)
26. The hearing panel accepted the recommendation concerning the administrative penalty and it is contained in the recommendation below.
27. Under 26 VSA Sec. 1374(b)(2)(A) the Board may reprimand the individual, or "…condition, limit, suspend or revoke the license" of the individual, or "… take such other action relating to discipline or practice as the Board determines appropriate including imposing an administrative penalty…".
28. The Hearing Panel debated the proper sanction concerning the license of the Respondent. As was stated above, his license has lapsed. The Respondent has stated that he is retired and living in Argentina.
29. An essential function of professional licensing is the protection of the public.[3] The Hearing Panel is of the view that the recommended sanction (pre-stated conditions in the event that the Respondent applies for a license) implies or contemplates that he should be relicensed with conditions if he were to reapply for a Vermont License. The Hearing

[3] "…the protection of the public comprises an essential goal of professional discipline…" In re Taylor, 2016 VT 82, 150 A.3d 625, (2016)

Panel is not persuaded that this is the optimal sanction which will protect the public.

30. The proven unprofessional conduct here is found to have been "gross" and continuing during the time period alleged.
31. The Respondent has not participated in the hearing process after the Specification of Charges were filed, despite a clear opportunity to do so, including virtual participation. Had he participated, the Hearing Panel would be more likely to believe that conditions, or a pathway to re-licensure would be effective or warranted.
32. The Hearing Panel considers that the listed sanctions under 26 VSA Sec. 1374(b) are progressive with revocation of a license being the strongest action which the Board may take to protect the public. The Hearing Panel considers that revocation of a license should be taken reluctantly, and only where other reasonable alternatives for protection of the public are not available which may still allow a licensee to continue to practice, or to rehabilitate his or her practice safely.
33. Here, given the nature of the unprofessional conduct, the lack of explanation or engagement by the Respondent in the hearing process, and the overall risks to the public if the Respondent were to be relicensed, the Hearing Panel is convinced that revocation is warranted. A person whose medical license has been revoked may still apply for a medical license but the revocation would alert any subsequent licensing authority that a significant licensing problem existed for that licensee as it did in this case.

Decision and Proposed Order

The Hearing Panel finds that the facts contained in the Specification of Charges have been proven by a preponderance of evidence. The Respondent committed unprofessional conduct as set forth in Counts 1-10 of the Specification of Charges by violating 26 VSA Sec. 1354(a)(22) and Sec. 1354(b)(1-2).

The Hearing Panel recommends that the Board of Medical Practice adopt the above Findings of Fact, Conclusions of Law, and order that:

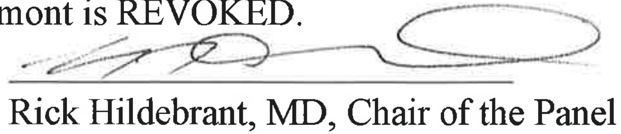
(1) The Respondent shall pay an administrative penalty in the amount of $5,000.00 in accordance with 26 VSA Sec. 1361(b): and

(2) The Respondent's Vermont Medical License and his ability to practice medicine in the State of Vermont is REVOKED.

______________________	______________________________
Date	Rick Hildebrant, MD, Chair of the Panel
______________________	______________________________
Date	Marga Sproul, MD
______________________	______________________________
Date	Patricia Hunter

(1) The Respondent shall pay an administrative penalty in the amount of $5,000.00 in accordance with 26 VSA Sec. 1361(b): and

(2) The Respondent's Vermont Medical License and his ability to practice medicine in the State of Vermont is REVOKED.



10/26/20	
Date	Rick Hildebrant, MD, Chair of the Panel
Date	Marga Sproul, MD
Date	Patricia Hunter

(1) The Respondent shall pay an administrative penalty in the amount of $5,000.00 in accordance with 26 VSA Sec. 1361(b): and

(2) The Respondent's Vermont Medical License and his ability to practice medicine in the State of Vermont is REVOKED.

______________________	______________________
Date	Rick Hildebrant, MD, Chair of the Panel
10·26·20	
Date	Marga Sproul, MD
______________________	______________________
Date	Patricia Hunter

(2) The Respondent's Vermont Medical License and his ability to practice medicine in the State of Vermont is REVOKED.

______________________ Date	______________________ Rick Hildebrant, MD, Chair of the Panel
______________________ Date	______________________ Marga Sproul, MD
10/29/2020 Date	Pat Hunter Patricia Hunter