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**NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS**

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

Nunc Pro Tunc March 11, 2015

In the matter of:

MICHAEL C. LAFON, M.D.

FINAL ORDER REVOKING
LICENSURE

Overview

On December 29, 2003, respondent Michael Lafon, M.D. surrendered his license to practice medicine and surgery in the State of New Jersey. That surrender, deemed to be the equivalent of a license revocation, was predicated upon respondent's admissions that he had engaged in multiple acts of sexual misconduct with three female patients. The Board action was taken after Dr. Lafon pled guilty to charges of criminal sexual conduct and lewdness, also based on sexual activities and contacts that Dr. Lafon had during the course of medical examinations of three patients. Following Dr. Lafon's arrest, claims of more extensive misconduct (to include claims that Dr. Lafon had sexual intercourse with other patients, and with spouses of patients) were made by many additional individuals, including one male patient, but no further criminal charges were filed.

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Over seven years later, following a reapplication process which extended for a period exceeding eighteen months, we entered an Order conditionally reinstating Dr. Lafon's license to practice on March 10, 2011 (hereinafter the "March 2011" Consent Order). Mindful of the egregiousness of respondent's sexual misconduct, we sought to protect the public interest by limiting Dr. Lafon's practice to male patients only, and by expressly requiring that Dr. Lafon be accompanied by a Board-approved chaperone during every patient encounter. Dr. Lafon acknowledged his understanding of, and his agreement to, those conditions when he signed the Consent Order of Reinstatement.

On April 17, 2014, a modified Consent Order was agreed upon and entered (hereinafter the "April 2014" Consent Order). Therein, we relaxed and/or discontinued certain of the restrictions that had previously been placed on Dr. Lafon's practice. We did not, however, in any way then modify or discontinue the condition that Dr. Lafon's practice be limited to male patients alone, nor did we alter or discontinue the concomitant condition that all of his medical practice was to be conducted in the presence of a Board approved chaperone. Once again, Dr. Lafon expressly represented, when signing the April 2014 Consent Order, that he understood the terms of the Order and that he agreed to be bound by those terms.

The decision to reinstate Dr. Lafon's license in March 2011 was made after exhaustive deliberations, which required us to

weigh and balance the depravity of Dr. Lafon's admitted misconduct against the substantial evidence Dr. Lafon then presented of rehabilitation. As explicitly recounted in the March 2011 Consent Order, we ultimately decided to give Dr. Lafon the benefit of the doubt and afford him "one final chance" to again practice in New Jersey:

Our decision to reinstate respondent should in no way be considered to discount the gravity of the misconduct in which respondent engaged. It is clear that respondent misused his license to facilitate his own sexual desires and aims, and in doing so fundamentally shattered the trust that had been placed in him by countless patients, their families and his employees. Yet, we are also mindful that respondent has not only completed all conditions of his criminal sentence, but even more significantly, has gone to great lengths to secure treatment and to make changes to his life. He has been able to demonstrate, through his own testimony and through the strong support that he has received from the PAP and his treatment providers, that he has made a sincere effort to change.

On balance, then, we conclude that respondent should be provided one final chance to resume the practice of medicine. At this juncture, however, we conclude that it is prudent and appropriate to limit any resumed practice to male patients alone, and to require that all practice be chaperoned.

Order Reinstating License with Conditions, In the Matter of Michael Lafon, M.D., filed March 10, 2011. (P-1 in evidence)

The evidence before the Board today demonstrates that Dr. Lafon - through his own unilateral decisions and actions - has engaged in conduct which shattered the trust we placed in him in March 2011 and in April 2014. Specifically, Dr. Lafon has failed

to comply with the express requirement that he have a Board-approved chaperone accompany him during all patient visits, and he has fundamentally compromised and corrupted the integrity of his medical records. Taken together, those actions form a compelling predicate to support - if not dictate - our entry today of a second Order revoking Dr. Lafon's license to practice medicine in the State of New Jersey. Simply put, respondent has squandered the "one final chance" we offered him in March 2011, and we conclude that no action short of license revocation would suffice to redress his renewed misconduct. We set forth below a summary of the procedural history of this matter (to include a synopsis of the evidence and testimony offered during the March 11, 2015 hearing), our findings of fact and conclusions of law, a discussion commenting on the mitigation evidence presented and our final determination upon penalty.

Procedural History

The present action against Dr. Lafon was initiated by the Acting Attorney General of New Jersey, by Deputy Attorney General Bindi Merchant, upon the filing of a two count Administrative Complaint on February 18, 2015. In Count 1, the Attorney General alleged that Dr. Lafon violated the requirement within the April 2014 Consent Order that he be accompanied by a Board-approved chaperone. Specifically, the Attorney General alleged that no chaperone was present when Dr. Lafon examined an undercover

detective (who visited Dr. Lafon's office in the course of an investigation into possible indiscriminate prescribing, claiming to have plantar fasciitis) on three separate dates in April and May 2014. The Attorney General alleged that Dr. Lafon's conduct violated the requirements of the Uniform Duty to Cooperate Regulation, N.J.A.C. 13:45C-1.4,¹ thereby providing grounds for disciplinary sanction pursuant to both N.J.S.A. 45:1-21(e) (engaging in professional or occupational misconduct) and N.J.S.A. 45:1-21(h) (the violation or failure to comply with the provisions of any act or regulation administered by the Board).

Within Count 2, the Attorney General alleged that, during the course of an office inspection conducted on October 31, 2014 by two Diversion Investigators ("DI"s) employed by the Drug Enforcement Administration ("DEA"), Dr. Lafon was found to have been falsifying patient records by pre-recording progress notes for twelve patients who were scheduled for office visits but had not yet arrived in the office.² Specifically, the complaint alleged

¹ N.J.A.C. 13:35-1.4 provides that "the failure of a licensee to comply with an order duly entered and served upon the licensee or of which the licensee has knowledge shall be deemed professional or occupational misconduct."

² Count 2 of the Complaint included allegations that Dr. Lafon admitted to treating 129 patients under his federally-issued maintenance and detoxification registration, thereby exceeding the maximum number of 100 patients that could be treated under that registration. See Complaint, ¶13 and ¶14. While respondent does not dispute having exceeded the maximum allotment of Suboxone patients, the revocation of respondent's license which we herein order is not based on, or related to, that conduct.

that Dr. Lafon pre-populated his medical records with information to include blood pressures, weights, comments, complaints, pain scales, diagnoses and prescriptions; that he admitted to the DIs that he was aware that pre-recording patient notes was impermissible; and that he was criminally charged by the Camden County Prosecutor's Office with purposeful falsification of patient medical records, in violation of N.J.S.A. 2C:21-4.1.³ The Attorney General alleged that respondent's conduct violated the requirements of the Board's Record Keeping Regulation, N.J.A.C. 13:35-6.5(b)(3)(ii)⁴, thereby providing grounds for disciplinary sanction pursuant to N.J.S.A. 45:1-21(h). Additional statutory bases for disciplinary sanctions cited in Count 2 were N.J.S.A. 45:1-21(b) (engaging in the use or employment of dishonesty, fraud, deception, misrepresentation, false promise or false pretense), N.J.S.A. 45:1-

³ N.J.S.A. 2C:21-4.1 defines the fourth degree crime of "destruction, alteration, falsification of records" as follows:

A person is guilty of a crime of the fourth degree if he purposefully destroys, alters or falsifies any record relating to the care of a medical or surgical or podiatric patient in order to deceive or mislead any person as to information, including, but not limited to, a diagnosis, test, medication, treatment or medical or psychological history, concerning the patient.

⁴ The specific subsection of the Record Keeping Regulation [namely, 13:35-6.5(b)(3)(ii)] cited applies to records that are prepared and maintained on computer, and thus is not directly relevant. It is apparent, however, that the conduct alleged in the Complaint is proscribed generally by N.J.A.C. 13:35-6.5(b), which requires licensees to prepare "contemporaneous" treatment records which "accurately reflect the treatment or services rendered."

21(e), N.J.S.A. 45:1-21(f) (engaging in acts constituting a crime or offense involving moral turpitude or relating adversely to the activity regulated by the Board) and N.J.S.A. 45:9-6 (failure to maintain good moral character).

On February 27, 2015, respondent filed an Answer to the Complaint, wherein he admitted all of the specific factual allegations pled. Respondent asserted, however, that his conduct did not violate the chaperoning requirements of the Consent Order because his chaperone -- while concededly not in the examining room -- was in the office. Respondent further maintained that he did not intend to falsify records. Finally, respondent denied all paragraphs of the complaint which alleged that his conduct violated any provisions of the Uniform Enforcement Act (N.J.S.A. 45:1-21), any of the cited Board regulations and/or the provisions of N.J.S.A. 45:9-6.

The parties jointly requested that the Board retain jurisdiction of this matter and that the case be tried before the full Board as a contested case. We granted the request, and scheduled the case for hearing on March 11, 2015. The parties were specifically advised that the proceedings would be bifurcated, with an initial hearing limited to the issue of liability, to be followed (only if liability were found) by a penalty phase hearing, at which Dr. Lafon could present mitigation evidence.

Hearings before the Board on March 11, 2015

1) Liability Hearing

On March 11, 2015, Deputy Attorney General Bindi Merchant appeared for the Complainant Acting Attorney General of New Jersey. Respondent appeared, represented by David Evans, Esq.

Following opening arguments by counsel, Deputy Attorney General Merchant presented her case, which was supported by documentary evidence alone.⁵ Specifically, the Attorney General offered an Investigative Report prepared by Detective Bernard John Dougherty (P-2 in evidence) to establish the allegations that Dr. Lafon violated the chaperoning requirements in the April 2014 Consent Order. In that report, Detective Dougherty details three undercover visits to Dr. Lafon's office, on April 16, 2014, April

⁵ In support of her case-in-chief, Deputy Attorney General Merchant offered the following documents, all of which were moved into evidence without objection:

P-1 Consent Order I/M/O Michael Lafon, M.D., filed on April 17, 2014.

P-2 Supplemental Investigative Report of Detective Bernard Dougherty (with certification of authenticity by Detective Bernard Dougherty, dated December 10, 2014).

P-3 Office Inspection Report dated November 3, 2014 prepared by Diversion Investigator Janelle DiMatteo, with twelve (12) individual patient's progress notes (with certification of authenticity by Diversion Investigator Janelle DiMatteo, dated November 25, 2014, describing report as an "Office Inspection Report with pre-recorded progress notes").

P-4 Complaint/summons in State v. Michael C. Lafon dated November 19, 2014, Complaint Number 0401-S-2014-000156 (with certification of authenticity by Detective Grace Clodfelter, Camden County Prosecutor's Office, dated December 1, 2014).

25, 2014 and May 6, 2014, pursuant to an investigation regarding "the indiscriminant (sic) prescribing practices of Oxycodone by Dr. Michael LAFON, M.D.." Detective Dougherty described what occurred on the April 16, 2014 visit as follows:

On April 16, 2014, I went to Doctor Lafon's office, 426 S. White Horse Pike, Audobon, NJ 08106, while acting in an undercover capacity. While there, I made contact with Doctor Lafon at the receptionist desk. Doctor Lafon then escorted me to an exam room. While in the exam room there were no other subjects present with the exception Dr. Lafon and I for the duration of my exam.

Detective Dougherty's recitation of events that occurred on his April 25 and May 6 visits paralleled his description of what occurred on April 16.⁶

A copy of a U.S. Department of Justice, DEA Report of Investigation, prepared November 3, 2014 by DI Janelle, was offered to support the allegations that Dr. Lafon pre-populated his patient records. Therein, DI DiMatteo set forth details regarding an inspection of Dr. Lafon's office premises which occurred on October 31, 2014.⁷ During the inspection, the DIs were provided access to

⁶ Detective Dougherty's investigative report referenced a "master incident report" created on May 27, 2014, for additional details regarding the three office visits. That "master" report, however, was not offered as evidence.

⁷ A substantial portion of the Investigative Report is focused on issues that are not the basis for any charges in the Administrative Complaint, to include issues concerning the manner in which Dr. Lafon drug tested OBOT patients, his prescription writing practices for patients on buprenorphine, and the circumstances where he would terminate treatment contracts. Our focus, when reviewing and considering P-3, was limited to the portions of the report which described Dr. Lafon's record keeping practices and to the twelve appended "progress notes."

Dr. Lafon's patient records. On review, the DIs found that Dr. Lafon was falsifying those records:

Further review of patient records disclosed that Dr. LAFON was falsifying patient records by pre-recording progress notes prior to the patient coming into the office for an appointment. DIs reviewed the pile of patient files who were scheduled to be seen by Dr. LAFON that day but had not yet arrived to the office for their appointments. The records disclosed that Dr. LAFON was writing out the patient's blood pressure, weight, comments, complaints, diagnosis and prescriptions before even seeing the patient. Ms. Brodzinski stated that he pre-writes his patient notes to save time while he is with the patient. During the investigation, one of the patients whose record was pre-recorded and was scheduled for the day arrived. Ms. Brodzinski took his file out of the pile of pre-recorded files and handed it to Dr. LAFON who proceeded to conduct the appointment with the patient. DIs advised Dr. LAFON that pre-recording patient files is not permitted to which Dr. LAFON stated "yes, I know."

P-3; Report of Investigation, p. 8.

Twelve pre-recorded "Patient Encounter Forms" were copied at the time of the inspection and appended to the Investigative Report. Each of the twelve was for a patient who was scheduled to be seen by Dr. Lafon on October 31, 2014, but had not yet arrived at the office.⁸ In each case, the patient's name, date of birth, age, weight and height had been completed, along with sections of

⁸ We note that the Investigative Report does not include specific details regarding the copying of the twelve appended progress notes. Respondent acknowledged, during his testimony, that the twelve records were records that he had in fact pre-completed on October 31, 2014, and that all twelve were for patients that were scheduled to be seen that day, but had not yet come in to the office. See Hearing Transcript, 54:3-10 (hereinafter "T").

the form labeled "CC/HPI" (chief complaint/history of presenting illness), "PE: Abnormal & Comments" (physical examination) and "Assessment/Plan." Eleven of the twelve records included a blood pressure recording, and ten of the twelve reports were signed by Dr. Lafon. None of the twelve records were dated.

Finally, the Attorney General offered as Exhibit P-4 a copy of a Complaint/Summons in the matter State of New Jersey v. Michael C. Lafon, wherein Dr. Lafon is charged (in a case pending before the Audubon Boro Municipal Court) with violating N.J.S. 2C:21-4.1 by "purposely falsify(ing) patient medical records by pre-recording progress notes and patient's medical history prior to their arrival for appointments, a crime of the fourth degree." That complaint was filed on November 19, 2014, and remained pending at the time of the Board hearing.

After the Attorney General rested, Dr. Lafon and his treating psychiatrist, Laurie Deerfield, D.O., testified during the liability hearing. Dr. Lafon's counsel also offered numerous documents into evidence, to include three pictures depicting Dr. Lafon's office layout (R-5) and a letter from Dr. Deerfield discussing, among other items, her visit to Dr. Lafon's office on

February 25, 2015 to observe the manner in which his practice was being chaperoned (R-2).⁹

⁹ The following documents were offered by Dr. Lafon as evidence during the liability hearing, all of which were moved into evidence without objection:

R-1 Answer to Complaint.

R-2 Letter from Dr. Deerfield dated March 2, 2015.

R-3 19 patient letters (with printouts from the New Jersey Prescription Monitoring and Reporting System listing prescriptions written for one of the 19 individual patients).

R-4 35 patient letters.

R-5 3 pictures depicting Dr. Lafon's medical office layout [note: while no direct proffer was offered establishing when the pictures were taken, or what was displayed in any of the pictures, on cross examination Dr. Lafon testified regarding each of the pictures and then explained what was depicted in each photograph (see T45:22 - 49:8)]. Additionally, the photographs are alluded to in Dr. Lafon's January 12, 2015 certification addressing the chaperoning of his practice (see below).

R-6 Information concerning PBI Medical Record Keeping Course.

R-7 Information concerning courses offered by American Society of Addiction Medicine.

R-8 16 patient letters.

R-9 67 patient letters.

R-10 Copy of form Agreement for Use of Controlled Substances used by Dr. Lafon at his medical practice.

R-11 List of 26 "Suboxone Pain Patients."

Although all of the above exhibits were moved into evidence without objection during the liability hearing, the vast majority of the offered exhibits -- to include all of the supportive patient letters -- were offered for consideration only as mitigation evidence. The only evidence which was directly related to liability issues were portions of R-2 (namely, those portions which described Dr. Deerfield's observations of the chaperoning of Dr. Lafon's practice) and R-5 (the photographs taken at Dr. Lafon's office). When offering exhibits, Mr. Evans stated that R-11 was a "list of Suboxone patients that Dr. Lafon gave to the DEA when

On direct examination, Dr. Lafon initially testified about his medical practice following the reinstatement of his license. Dr. Lafon stated that he was "extremely grateful to the Board for a second chance" and that he first worked as an employee for Dr. John Wilson, a physician with an addiction medicine practice (T22:9-20). In October 2012, Dr. Lafon started his own practice after receiving permission to do so from the Board (T22:21-25, T23:22 - 24:4). Dr. Lafon testified generally about the substantial challenges he faced establishing his own practice, his "philosophy" to be an "affordable" doctor by charging \$20 for office visits, and his efforts to secure referrals by meeting with

they came to visit his office" (T20:15-17). The relevance of exhibit R-11 was not otherwise established.

Prior to the hearing, respondent provided seven additional documents for Board review (all seven were attached to a certification of David G. Evans, Esq. dated January 13, 2015). Respondent's counsel alluded to those exhibits when introducing evidence and asked that they be "moved" into evidence (T17:23 - 18:6). As numbered and described in Mr. Evans' certification, the specific exhibits attached to the certification were: (1) records from the Logan Township Police Department; (2) Records sent to counsel by DAG Merchant; (3, 5 and 7) Certifications of Dr. Lafon; (4) Dr. Lafon's prescriptions; and (6) the April 2014 Consent Order.

The cited documents, although not specifically marked during the March 11, 2015 hearing, were all in fact available for Board member review prior to the hearing, by joint agreement of the parties. Certain of those documents, to include portions of Exhibit 2 and Exhibit 6, were moved into evidence by the Attorney General (P-3 and P-1, respectively). The remainder of the documents, with the exceptions of Exhibits 5 and 7, were not relevant to the issues before the Board. Exhibit 5 (a certification of Michael Lafon, M.D., dated January 12, 2015, addressing the allegations in Count 1 regarding Detective Dougherty's undercover visits and detailing the manner in which Dr. Lafon's practice was chaperoned) and Exhibit 7 (another certification of Dr. Lafon, also dated January 12, 2015, addressing within §§9-12 his practice of pre-writing progress notes) were clearly relevant to the charges in the Administrative Complaint and thus were directly reviewed and considered.

many emergency room doctors and triage nurses (T24:7 - 25:9). Dr. Lafon pointed out that almost all of the referrals he received from emergency room physicians were of chronic pain patients on high doses of pain medicine, and he testified that he worked diligently with those patients to wean the doses of medications that they were taking or get them off of pain medication completely (T25:9-15).

Dr. Lafon took great pride in his office and with the successes he was able to achieve treating chronic pain and addiction patients, describing it as the "crowning achievement in my life." He described his office as having a "laid back," "friendly" atmosphere, akin to a "barbershop" (T25:16 - 26:22). Dr. Lafon testified that he was "one hundred percent of the time mindful of the restrictions" that had been placed on his practice (T26:22 - 27:2).

With regard to chaperoning, when Dr. Lafon first began practice, his chaperone was always present in the exam room (T29:5-12). He explained that while his patients initially accepted a chaperone presence, as time went on patients who were seen regularly would want to discuss personal matters (such as relationship issues or sexual performance issues), and would not be overly comfortable having anyone else (i.e., anyone other than Dr. Lafon) in the room (T29:13 - 30:10). Dr. Lafon testified that, in response to those requests, he thought it would be to a patient's advantage to have the chaperone outside the office, and he pointed

out that "if she wanted to hear what was going on, she certainly could have" because his office was very small (T30:10-20). Dr. Lafon repeatedly maintained that his chaperone policy developed in the best interests of his patients, as it addressed "modesty" concerns and individual requests to be able to talk privately, and he asserted that he "never for one minute felt that [he] was not chaperoned" because of the way the office was physically set up (T:34:2-10, T62:7-63:1).¹⁰

Dr. Lafon then testified about the October 31, 2014 office inspection by investigators from the DEA. He recounted the concerns that were raised by the investigators regarding his treating an excessive (greater than 100) number of patients on

¹⁰ See also, Certification of Dr. Lafon, Exhibit 5 to Evans Certification. Within paragraph 4 of that certification, Dr. Lafon explained his chaperoning practices as follows:

On each occasion when Mr. Dougherty came to my office for treatment, I had a chaperone present. My office is very small, containing only a waiting room, an office with a reception desk, and the exam room. My chaperone sits at the reception desk. She greets patients and takes care of any necessary paperwork. For example, she recalls when Mr. Dougherty first came in. She took his information and set up his chart. After that, I greeted Mr. Dougherty at the reception desk and we went to the exam room, which is less than 10 feet from the reception desk. I have an open door policy, which means that I conduct all exams with the door open. My chaperone is able to see into the exam room while sitting at the reception desk. See the attached photos. She is also able to hear anything and everything that takes place in the exam room. I set up the office in this way so that I am complying with the chaperone requirement in the consent order, but also am cognizant of my clients' modesty and privacy concerns. (emphasis added)

Suboxone, but pointed out that the DEA did not pursue any action against him based on those concerns (T36:2 - 38:8; 38:13-18).

With regard to his practice of pre-completing patient records, Dr. Lafon testified he wrote out progress notes for patients before they came into the office in an effort to address complaints he had received from neighbors and his landlord and to deal with patients arriving at the "last minute" (T41:15-25). Dr. Lafon explained that his chronic pain patients would not come in at the scheduled time for their appointments, but instead would typically arrive toward the very end of office hours. The patients would congregate in the office parking lot, smoking cigarettes on the sidewalk in front of the office (T39:9-25). Dr. Lafon initially attempted to address the noise complaints by putting signs in the waiting room and telling patients verbally to come when scheduled (T40:4-6).

On the day of the DEA inspection, Dr. Lafon was anticipating a rush of patients at the end of the day, and wrote out templates for those patients' examinations (T40:13-18). Specifically, he wrote out "the things that were consistent from patient visit to patient visit, while "reserving" the right to correct records if there were a "significant change in the findings" (T40:20-41:1). Dr. Lafon further testified that he would not have pre-recorded any finding that was of "critical significance" for an individual patient's visit, pointing out that

he did not pre-record a blood pressure for one patient who had a significant blood pressure problem (T42:2-12). Dr. Lafon maintained that the records were for his own use alone, and not for any billing purposes (T41:1-3). He additionally stated that, if a patient did not show up for a visit, he would throw the template out (T41:3-4). Dr. Lafon conceded that it was a "mistake" on his part to have pre-completed records, explained that he had not done so "since this issue came up" and that he "would never do it again" (T41:6-12).¹¹

¹¹ See also, Certification of Dr. Lafon, Exhibit 7 to Evans Certification. Within that certification, Dr. Lafon described his practice of completing notes as follows in ¶¶11-12:

11. . . . I realized that, as I waited for my patients, I had down time during which I could write up a template for that day's progress notes for patients who were due in that day but were late for their appointments. I did this by reviewing the progress notes from past visits and writing out the information that was the same for each visit. For my Suboxone patients, their addiction history did not change from month to month. Similarly, for my chronic pain patients, the injury which led to their chronic pain issues did not change from month to month. In addition, many of my patients are young adult males who are otherwise in relatively good health, so their vital signs are stable and do not change significantly from month to month. Therefore, I felt comfortable writing this information in the template I created on the morning of their appointment. However, I never included any finding that was clinically significant to their presentation. For example, of the notes copied by the DEA, one was for N.P. Mr. P. has a significant blood pressure issue for which I prescribe him medication. I did not write in his blood pressure in the template I created for his visit that day.

12. In addition, I never included the date, and, if the patient did not arrive for his appointment that day, I simply discarded the template. It never became a part of the patient's medical record. Finally, I always performed a full exam when the patients arrived, and changed any clinically significant information. In this way, I was able to shorten

On cross examination, Dr. Lafon initially acknowledged that one of the complaints made against him prior to the revocation of his license in 2003 was made by a male patient. (T43:1-15). Although Dr. Lafon claimed that on "most occasions" he would have both a chaperone and a receptionist in his office, he conceded that there were times when only one employee (his chaperone) was present. At those times, the employee would sit at the receptionist's desk and act as the receptionist (T45:1-21).

DAG Merchant questioned Dr. Lafon about the three pictures that had been offered into evidence (R-5), establishing that the chaperone, from a seat at the receptionist desk, would only have had a partial, limited view of the examination room, which would not have included any view of a patient on Dr. Lafon's examining table (T45:22 - 49:8).¹² Dr. Lafon further conceded that the chaperone would also have simultaneously been performing other duties to include answering phones, greeting patients and preparing

each patient visit a bit, not by spending less time on the examination, but by spending less time writing progress notes. These templates were in no way meant to mislead or defraud anyone. They were simply my office notes and have never been used to obtain reimbursement or any other financial gain. I realize now, however, that the notes may have created the impression that I was doing something inappropriate. However, at the time, I simply felt that I had come up with a means to address the concerns of my landlord and neighbors that also allowed me to continue providing quality medical care to my patients. (emphasis added)

¹² Dr. Lafon testified that his examining room was perhaps seven to ten feet in length (T48:13-15), that the examining table took up approximately one-half of the room and that the examining table would not be visible to the receptionist/chaperone from her seat at the reception desk (T48:25 - 49:8).

charts for initial visits (T49:9 - 50:7). On redirect examination, Dr. Lafon stated that his patients were ordinarily seated on the chair (where they could have been seen from the reception desk) (T59:13 - 60:7).

Dr. Lafon was specifically questioned about his entries for patient M.B., which included a presenting blood pressure and weight, a presenting complaint of chronic low back pain, findings on physical examination of a 25 percent range of motion in the lumbar spine with spasm noted more on the right than the left, radicular pain into the buttocks, straight leg raising test to 45 degrees and pain on flexion and rotation, an assessment of chronic low back pain and herniated lumbar disc, and prescriptions for Oxycodone 10 three times a day and Xanax, 1 milligram, one at bed time. Dr. Lafon asserted that the weight and blood pressure recorded were taken from the patient's last visit, and that other recorded information - such as the complaints, assessment and findings -- were entered based on review of the last visit and his knowledge of "the way the patient normally presented" (T51:21 - 53:19; quoted language at 53:7-8). He further asserted that the prescriptions listed were "the medicine that [the patient] normally gets" (T53:9-19).¹³

¹³ Dr. Lafon was not further questioned about entries made in the other eleven progress notes (other than specifically regarding blood pressure entries, see discussion *infra*). We note, however, that each of the twelve progress notes appear to include a level of detail similar to that in M.B.'s record (see also footnote 18, *infra*).

Dr. Lafon conceded that the blood pressures listed for five of the twelve patients were identical readings of 130/80 (T54:11 - 56:9). He maintained that his practice of pre-populating records was not meant to replace actually taking vital signs and conducting a physical examination, clarified that the information which was pre-filled was always taken from prior exams, and testified that he would have crossed out entries in the template if needed after conducting an actual exam (T56:20 - 58:14).

In response to Board member questioning, Dr. Lafon conceded that an individual patient's blood pressure would be subject to change from one visit to the next, and that when pre-populating records he "guessed" the blood pressure (T64:20 - 65:3). He also asserted that he had never thought about seeking clarification from the Board whether the chaperone was required to be in the office, or seeking permission from the Board to change the terms of the Consent Order, before being asked that question during the hearing (T63:2 - 14). Dr. Lafon conceded that there may have been times, such as when there was a "rush" of patients toward the end of the day, that his receptionist would not have been able to be performing any chaperoning function (T68:12 - 69:13). Dr. Lafon maintained that he "interpreted the intention of the Consent Order" to be that someone would need to "know what's going on," and asserted that he "never thought for one minute that I wasn't

chaperoned with any patient if we were in the hallway, in the room, or at the desk" (T77:5-13).

Laurie Deerfield, D.O., a psychiatrist with Board certifications in psychiatry and addiction, first began treating Dr. Lafon in 2008 on a referral from the Professional Assistance Program of New Jersey for severe boundary violation issues (T83:23 - 24:5). Dr. Deerfield testified generally about the scope of the treatment she has provided Dr. Lafon, to include individual and group treatments (T84:14:21). Dr. Deerfield was not aware that Dr. Lafon ever had sexual boundary issues with men, although she did recall that one male patient had made a complaint of sexual misconduct against Dr. Lafon (T88:7-13, 89:2-6, 90:24 - 91:7). Had Dr. Lafon requested to remove the chaperoning requirement, Dr. Deerfield would have supported the request (T89:7 -11).

Dr. Deerfield personally visited Dr. Lafon's office, to observe his office set up and see for herself the manner in which the practice was being chaperoned, after learning about the current complaint (T85:15 - 86:1). She described the office as "small," with a waiting room, a reception area (where the chaperone sits) and a "very small examining room," separated from the reception area by a hallway (T86:2-10). Dr. Deerfield stated that "it seemed like the chaperone could see almost directly down into the examining room" (T87:1-3). When Dr. Deerfield visited, there was

only one person (Donna) present, but there were no patients in the office (T90:12 - 23).¹⁴

In rebuttal, the State called Detective Bernard Dougherty. Detective Dougherty believes he visited Dr. Lafon's office four times (T101:24 - 102:4). When he first went to Dr. Lafon's office, he arrived in the office waiting area and Dr. Lafon came to meet him at the receptionist desk (T:102:5-21). The only person other than Dr. Lafon in the office was the receptionist (T102:22 - 103:2). On the second visit, Detective Dougherty engaged the receptionist in conversation while Dr. Lafon was seeing another patient. While doing so, he could overhear Dr. Lafon's conversation with his patient (T104:19 - 105:1).

Detective Dougherty conceded that the purpose of his investigation had not been to determine whether Dr. Lafon was complying with chaperoning requirements, but instead was for the purpose of seeing if he would be able to obtain pain medications (T105:8 - 106:23). The receptionist did not identify herself as a chaperone, and Dr. Lafon did not state that the receptionist also functioned as a chaperone (T115:3-12). The receptionist sat facing the waiting room, perpendicular to the hallway, and would have had to turn her head to the left to look into the examining room (T:115:13 - 116:2). When being examined by Dr. Lafon, Detective

¹⁴ Dr. Deerfield testified by phone from Arizona. At the request of Dr. Lafon's attorney, we allowed Dr. Deerfield to testify on issues related to both liability and mitigation simultaneously. See discussion infra of Dr. Deerfield's mitigation testimony.

Dougherty was seated on the exam table, and from that location he could not see the receptionist (T116:8 -116:21). The door to the examination room was open (T117:6-8).¹⁵

Following Detective Dougherty's testimony, the liability phase of the proceeding concluded, and the hearing proceeded to closing arguments. Mr. Evans maintained that Dr. Lafon did not intentionally ignore the Board Order, and that all of Dr. Lafon's actions were taken in an effort to look out for the best interests of patients and for the purpose of trying to build trust. Mr. Evans conceded that Dr. Lafon's medical record keeping was "sloppy," but maintained that the practice was not done to mislead or for any personal gain.

DAG Merchant urged the Board to find that Dr. Lafon violated the clear language of the Consent Order, which language left no room for deviation. She further argued that the evidence demonstrated that Dr. Lafon had completely made up data, such as

¹⁵ DAG Merchant questioned Detective Dougherty about the care provided by Dr. Lafon. On four office visits, his weight was taken only once and his blood pressure was never taken (T:104:1 - 14).

While no objection was made by defense counsel during Detective Dougherty's direct testimony, on a subsequent objection we ruled that the scope of Detective Dougherty's testimony should be limited to issues directly alleged in the Complaint - namely, whether or not Dr. Lafon had complied with chaperoning requirements. In doing so, we noted that no allegations had been made in the Complaint that care provided by Dr. Lafon during Detective Dougherty's undercover visits was negligent or otherwise inappropriate. Additionally, we point out that there was no testimony offered, or suggestion made, that Dr. Lafon pre-populated Detective Dougherty's patient record.

blood pressure readings, when he pre-completed patient records, and that Dr. Lafon's intent was irrelevant.

Following deliberations, we unanimously sustained all of the factual allegations of the complaint, and concluded that those facts supported the vast majority of cited statutory violations (see findings of fact and conclusions of law, *infra*). We then proceeded to the penalty/mitigation phase of the hearing.

Mitigation Evidence

As noted previously, Dr. Deerfield was called both as a liability and mitigation witness. In her mitigation testimony, Dr. Deerfield recounted that Dr. Lafon has progressed over time in treatment, while conceding that he continues to have ongoing anxiety issues (T91:18 - 92:2). Dr. Deerfield stated that she wrote a letter on Dr. Lafon's behalf because she wanted to support him for his good qualities, pointing out that he has come a long way in building his practice and noting that there is a "family man side" of Dr. Lafon (T93:19 - 94:6). Dr. Deerfield believes Dr. Lafon has a "valuable role" in the addiction field (T94:2-23). Dr. Lafon expressed remorse to her regarding the record keeping issues, and understands that his conduct was wrong (T95:13 - 24). She doesn't think he purposely evaded Board requirements on the chaperoning issue (T95:25 - 96:4), or that his actions were taken in anything other than what he perceived to be the best interests of his patients (T96:6 - 11). In her written letter, Dr. Deerfield

stated that she "commend[ed] Dr. Lafon for the good work he is doing with [his] patients," noting that "he treats many patients that other doctors would not be interested in having as patients, and he has helped them tremendously" (R-2 in evidence, page 2).

Three patients offered mitigation testimony. Tom Hewitt, who first came to know Dr. Lafon after being referred by another physician, testified that he initially attempted to obtain prescriptions from Dr. Lafon, but that Dr. Lafon "called" him on that and told him to take anti-inflammatories. Mr. Hewitt testified that Dr. Lafon treated him with dignity and respect, and that with Dr. Lafon's support and counsel, he was able to wean himself from "outrageous" doses of Suboxone to very small doses. Mr. Hewitt testified that Dr. Lafon treated him like a human being when no one else would give him that dignity, and that Dr. Lafon took a genuine interest in him and his well-being (T:135:14 - 139:20).

Brian Winks testified that he had been to many assembly line practices for opiate addiction, and never experienced anything like that with Dr. Lafon. Mr. Winks testified that Dr. Lafon saved his life, as he was initially addicted to opiates after being in a crippling accident. Mr. Winks explained that Dr. Lafon, unlike other doctors, "really cares," and would go to the extraordinary length of calling him on his cell phone after a visit if he felt

something wasn't "going right." Mr. Winks attributes his six years of being clean from opiates to Dr. Lafon's care (T140:6 - 142:19).

Stephen Forbes, who first started treating with Dr. Lafon in 1989 for depression and post-traumatic stress disorder, testified that Dr. Lafon was always concerned about his welfare and mental health. He stated that Dr. Lafon would always take time and talk with him, and that Dr. Lafon had a positive impact on his life (T143:15 - 146:15).

In addition to the live testimony, over 130 letters written by patients of Dr. Lafon were offered for Board review. Mr. Evans pointed out that the letters uniformly demonstrate that Dr. Lafon is a caring physician serving an underserved population with dignity and respect, and that patient after patient recounted how Dr. Lafon had a profound influence on their life.¹⁶

In closing arguments, Mr. Evans stated that Dr. Lafon would be willing to do whatever the Board might presently request, to include having the chaperone in the office, attending medical records keeping courses, having records reviewed at his own expense, attending ASAM courses and continuing in treatment. In her closing, DAG Merchant urged the Board to revoke Dr. Lafon's

¹⁶ The Attorney General did not call any witnesses during the penalty phase of the hearing, but did offer into evidence a Certification of Costs (P-5) which detailed that a total of \$14,250.26 in costs were incurred in the prosecution of this matter, to include \$5,750.50 in investigative costs and \$8,499.76 in attorneys' fees. DAG Merchant also moved into evidence the two prior public Board Orders involving Dr. Lafon (December 29, 2003 Consent Order of Revocation, P-6, and March 10, 2011 Consent Order Reinstating License, P-7).

license, arguing that Dr. Lafon was before the Board - even after he had been given a second chance -- as a result of his own misconduct, poor judgment and lack of integrity.

Findings of Fact

The underlying facts in this case are not in dispute, and are fully established both by the offered proofs and Dr. Lafon's admissions. We dissect our findings of fact into the two major components of the complaint - the chaperoning issues and the record-keeping issues.

Chaperoning Issues

Dr. Lafon in March 2011, and again in April 2014, entered into Consent Orders with the Board that limited his practice to male patients alone and required chaperoning of all medical practice. Specifically, both Orders included the following identical language:

Dr. Lafon shall not examine, treat, or provide any medical care to any female patient. Dr. Lafon is hereby authorized to treat male patients, but shall be required to be accompanied by a Board-approved chaperon during all patient visits. Prior to resuming practice, Dr. Lafon shall obtain written approval from the Board for any proposed chaperone. The chaperone shall initial all patient charts to signify his or her presence during the physician-patient visit. The approved chaperone(s) shall be required to provide written quarterly reports to the Board, and shall provide an immediate written report to the Board in the event that any information is received that Dr. Lafon has seen or examined any patient without the chaperone being present, or in the event that Dr. Lafon is witnessed engaging in inappropriate conduct of any manner with any patient. Dr. Lafon shall be solely

responsible for all costs incurred in the chaperoning of his medical practice.

P-1, ¶7 and P-7, ¶7 (emphasis added)

The proofs establish that Dr. Lafon, in April and May 2014, was visited on three occasions by Officer Brian Dougherty.¹⁷ On each visit, Detective Dougherty posed as a patient. On all three visits, Dr. Lafon examined Detective Dougherty without having a Board approved chaperone present in the examining room. Dr. Lafon never advised Detective Dougherty that he was required to be accompanied by a chaperone, and never identified his receptionist as a "chaperone."

At the time of Detective Daugherty's visits, Dr. Lafon's chaperone, "Donna," was present in the office, seated at a receptionist's desk located approximately 10-13 feet away from the door to Dr. Lafon's examining room (there was a hallway between the reception desk and the door to the examining room). Donna greeted Detective Dougherty on his arrival to the office, and was the only employee present in the office on each occasion. As the only employee, her responsibilities would have included greeting

¹⁷ There is a conflict between Detective Dougherty's testimony (specifically, his testimony that he was examined on four occasions by Dr. Lafon without a chaperone present) and his written certification (listing only three visits). While we view that conflict as *de minimus*, given that the evidence clearly establishes that no chaperone was present on any of Detective Dougherty's visits (whether three or four), we herein limit our findings to the three office visits detailed in Detective Dougherty's certification (P-2 in evidence).

patients in the waiting room, answering telephones and preparing patient intake forms.

From a seated position at the receptionist's desk, Donna did not have a direct view into Dr. Lafon's examination room, and would have had to turn her head to the left to see into the examination room. Even if she had done so, at best, she would have had an obscured and partial sightline into the examination room. She would have been able to see a portion of the examining room to include a scale, a blood pressure cuff and a chair, but she would not have been able to see the examination table (where Detective Dougherty was seated). Donna would have been able to overhear conversation between Dr. Lafon and Detective Dougherty, as the door to the examining room was open, but in all likelihood would have had her attention diverted if she were simultaneously performing other job responsibilities, such as greeting patients or answering phone calls.

While the Attorney General's allegations that Dr. Lafon violated the provisions of the Board's Consent Order are limited to the three office visits by Officer Dougherty in April and May, 2014, it is clear -- from both the testimony offered by Dr. Lafon and from the explanations he provided in his written certification -- that Dr. Lafon violated the chaperoning requirements of the Order on a pervasive scale. Dr. Lafon began the practice of seeing patients without having a chaperone physically present in the

examining room long before Officer Dougherty's visit, and that practice was routinized by the time of Officer Dougherty's undercover visits.

Record Keeping

On October 31, 2014, Dr. Lafon was the subject of an office inspection conducted by two DIs from the DEA at his Audobon, New Jersey office. During the course of the investigation, the two DIs observed a stack of twelve records for patients who were scheduled for office visits that day, but had not yet arrived at Dr. Lafon's office. The DIs reviewed those patient records and found that Dr. Lafon had pre-completed progress notes for each patient. Dr. Lafon's receptionist/chaperone explained to the DIs that Dr. Lafon pre-wrote his progress notes to save time while he was with the patient. The DIs advised Dr. Lafon that pre-recording patient files was impermissible, to which Dr. Lafon responded "yes, I know."

Each and every one of the twelve records was pre-populated with significant clinical data, to include recorded vital signs (weights were included in 12 of 12 records, and blood pressure measurements in 11 of 12 records), listings of a patient's presenting complaints (12 of 12 records), findings made on physical examination (12 of 12 records), diagnoses and assessments made at the conclusion of a physical examination (12 of 12 records) and prescriptions issued (10 of 12 records).

It is undisputed that Dr. Lafon filled out each chart, notwithstanding the fact that that none of the twelve patients had yet arrived in his office. 10 of the 12 records were pre-signed by Dr. Lafon, but none of the records were dated.

In each and every one of the 12 cases, Dr. Lafon falsified his medical record by pre-completing progress notes. Dr. Lafon did not know, and could not have known, any of the information that he recorded in the 12 patient charts. Dr. Lafon clearly did not know, and could not have known, what an individual patient's blood pressure was going to be, and the blood pressures entered were nothing more than "guesses." Dr. Lafon certainly did not know, and could not have known, what findings he would make on physical examination (such as the findings recorded in M.B.'s chart of a 25 percent range of motion in the lumbar spine with spasms, radicular pain into the buttocks, straight leg raising test to 45 degrees and pain on flexion and rotation). All findings recorded, in each of the 12 records, were thus completely fabricated. Further, while Dr. Lafon may have been familiar with an individual patient's prior medical history, he did not know and could not have known what specific complaints that patient would make on the day of the visit, nor could he possibly have known with certainty what assessments or diagnoses he would make following examination. Similarly, while Dr. Lafon might have anticipated the prescriptions he would issue at the conclusion of a patient visit based on review

of prior prescriptions, he did not and could not have known with certainty whether he would in fact issue those prescriptions.¹⁸

As was the case with the chaperoning issues, it is again clear from both Dr. Lafon's testimony and his written certification that his practice of pre-populating records was a practice that had been initiated and established prior to October 31, 2014. Dr. Lafon discontinued the practice after the DEA office inspection, and now concedes that the practice was a "mistake."

Conclusions of Law

We find and conclude that, by failing to have a Board approved chaperone present in the examination room during any of Detective Dougherty's three visits, Dr. Lafon purposefully and knowingly violated the plain, unambiguous requirements of both the March 2011 and April 2014 Consent Orders that he entered with the Board. When doing so, he clearly violated the provisions of the Duty to Cooperate Regulation, N.J.A.C. 13:35-1.4, and thereby both engaged in professional misconduct and violated provisions of regulations administered by the Board. We thus sustain all allegations made in Count 1, and find bases for disciplinary

¹⁸ Portions of the patient encounter forms, to include in particular much of the recorded information set forth in the sections "CC/HPI" and "PE (Abnormal and Comments)" were difficult to read or illegible, and no transcriptions were provided. What is clear, however, is that each and every one of the twelve patient records was completed prior to the patient having been seen or examined by Dr. Lafon, and thus the inclusion of any information therein was deceptive and false.

sanction against Dr. Lafon exist pursuant to both N.J.S.A. 45:1-21(e) and (h).

We specifically reject respondent's claims and arguments that he should be found to be compliant with the terms of the Board Order. Dr. Lafon testified that, when he first returned to practice in 2011, he was grateful for the opportunity presented to him by the Board and he further testified that a Board approved chaperone was present in the examining room for every patient visit. Dr. Lafon thus initially fully understood, and fully complied with, the requirements of the Board's Order. His decision to discontinue that practice and to have the chaperone exit the examining room was his alone. We find no ambiguity in the meaning of the word "accompany," particularly in the context that the word was used in the Board's Order, and categorically reject respondent's claims that the term is vague, ambiguous or otherwise ill-defined.

We additionally point out that the evidence establishes that it would have been impossible for anyone to have "chaperoned" Dr. Lafon's practice while seated at the receptionist desk. The testimony established that the receptionist's desk was some 10-13 feet from the entrance to the examination room, and that when seated at the desk, the chaperone had, at best, an obscured and partial line of vision into the room. Further, it was established that, at the same time she was to be "chaperoning" his practice,

the chaperone was simultaneously responsible to answer phones, greet patients and complete paperwork. Simply put, given those facts, Dr. Lafon's claim that his receptionist could also "chaperone" his practice is illusory.

In making the above findings, we do not discount Dr. Lafon's testimony that his chaperoning practices evolved in order to afford individual patient's privacy and/or respect their modesty concerns. Dr. Lafon may well have received an occasional request from an individual patient that the chaperone exit the room, to allow privacy for a conversation regarding sensitive issues and/or for reasons related to modesty. Rather than act unilaterally, however, Dr. Lafon should have first approached this Board and sought clarification as to what he could or could not do in those situations, and/or requested specific modification of the terms of the Order to address those limited situations. He clearly should not, however, have then unilaterally decided how to proceed in those circumstances. Even more significantly, he should not have made universal changes to the manner in which his practice was being chaperoned, applicable to all patients and all patient visits, regardless whether or not his patient had even requested that the chaperone exit the room.¹⁹

¹⁹ Clearly, no such request was made by Detective Dougherty. Rather, as a result of Dr. Lafon's unilateral decisions and actions, a new patient such as Detective Dougherty, coming to Dr. Lafon's office for an initial visit in April 2014, was not told that he had an option to have a chaperone present, was not told that the receptionist was also

Prior to the revocation of his license in 2003, Dr. Lafon repeatedly overstepped and obliterated recognized boundaries between a physician and his patients when having sexual relationships and/or contact with patients. His present conduct, while of a different nature, nonetheless again evinces a failure by Dr. Lafon to respect boundaries. This Board determined in 2011 that a chaperone presence was required for all patient visits, well knowing that the practice was limited to male patients only. We reaffirmed that conclusion in 2014 when we decided to continue the chaperoning requirements of the 2011 Order without modification. Even if we accept Dr. Lafon's claims that he believed he was acting in the "best interests" of his patients, and even if we further assume that nothing inappropriate occurred during any non-chaperoned patient visit, Dr. Lafon's unilateral decision to allow his chaperone to exit the examining room was an action which eviscerated the boundary lines that we established when we required

supposed to be "chaperoning" the visit, and was not told that Dr. Lafon was required, by Board order, to be accompanied by a chaperone.

Given the above findings, we are constrained to point out that Dr. Lafon clearly misled this Board when he signed the April 2014 Consent Order, and then expressly agreed to continue to practice with the condition that he be accompanied by a chaperone for all patient visits. Even accepting Dr. Lafon's testimony that he had not thought to request specific clarification from the Board (i.e., as to whether his modified practices were acceptable) prior to April 2014, he could and should have sought that clarification before signing the modified Consent Order in April 2014. Instead, by remaining silent, signing the Order and expressly representing that he understood all of the terms of the Order, Dr. Lafon deceived the Board by "agreeing" to the continuation of terms that he knew were being routinely disregarded and violated.

him to be accompanied by a chaperone. His actions evinced a fundamental disdain for the authority of this Board, and a cavalier willingness to substitute his judgment for ours.

Turning to the allegations in Count 2 focused on Dr. Lafon's pre-completion of patient records, we unanimously conclude that his conduct violated the specific requirements of N.J.A.C. 13:35-6.5 that records be "contemporaneous" and "accurately reflect the treatment or services rendered." Dr. Lafon's violation of the Board's record keeping regulation in turn establishes a basis for disciplinary sanction pursuant to N.J.S.A. 45:1-21(h).

We also conclude that respondent's falsification of patient records was fundamentally dishonest conduct, which independently supports the charges within Count 2 that allege violations of N.J.S.A. 45:1-21(b)²⁰, 45:1-21(e) and 45:9-6.²¹ We decline, however, to sustain the charge in Count 2 that an

²⁰ N.J.S.A. 45:1-21(b) provides that a Board may suspend or revoke the license of an individual who engages in the use or employment of dishonesty, fraud, deception, misrepresentation, false promise or false pretense. We find the record herein clearly supports findings that Dr. Lafon, by falsifying patient records, engaged in the use of dishonesty and misrepresentation, which is recognized to be a sufficient predicate, standing alone, to support and justify license revocation. See In re Zahl, 186 N.J. 341, 354 (2006) ("Under N.J.S.A. 45:1-21(b) dishonesty is a sufficient basis to justify license revocation."). We find it unnecessary to reach or explicitly determine whether Dr. Lafon's pre-population of patient records would support a finding that he engaged in the use of fraud, and we decline to reach that issue on the record before us.

²¹ It is established that the requirement in N.J.S.A. 45:9-6 that an applicant be of good moral character is a continuing requirement for licensure. See In re Zahl, 186 N.J. at 355, In re Polk License Revocation, 90 N.J. 550, 576 (1982).

independent basis for disciplinary action against respondent exists pursuant to N.J.S.A. 45:1-21(f). While it is established on this record that respondent has been formally charged with having engaged in criminal acts that involve moral turpitude and relate adversely to the activity regulated by this Board, there is no evidence that those charges have been adjudicated presently.

In making the above conclusions of law, we expressly reject respondent's purported justification for falsifying his medical records - namely, that he was only seeking to save time and thereby address loitering complaints from his landlord and neighbors. Dr. Lafon could have sought to address those complaints in a myriad of legitimate ways, but his receipt of those complaints in no way forms a sufficient predicate to justify his pre-population of medical records.

While Dr. Lafon has claimed that he used the pre-populated records as a template only, he offered no documentary evidence at all to support that testimony. Significantly, looking only at any one of the twelve records, there would be no way that anyone could tell or know that the record was completed prior to an actual patient visit. Indeed, but for the fortuity of the DIs having visited Dr. Lafon's office on October 31, 2014, those progress notes would presumably have made their way into the medical chart of each patient (assuming the patient in fact came to

the office on that date), and thereafter served as a fictitious, made-up memorialization of that day's office visit.

Respondent's falsification of information in his patient's medical record was far from innocuous conduct. Applying our collective medical expertise, we point out that his practice of pre-recording blood pressures, based on guesses alone, presented serious risks to his patient population which consisted primarily of patients being prescribed opioids for pain management and/or Suboxone. Those drugs are recognized to have serious, potentially life-threatening side effects, to include effects on blood pressure which in turn require a prescribing physician to carefully and accurately monitor his or her patient's blood pressure.

We cannot know, on the record before us, whether Dr. Lafon in fact weighed and took blood pressure readings for patients whose records he pre-completed, and/or whether he performed the level of examination that would be necessary to support detailed findings such as those he recorded in M.B.'s chart. His practice of pre-recording that information, however, clearly heightened the risk or likelihood that he neglect to take the readings, and/or that he would short-cut patient examinations. Even if we accept Dr. Lafon's otherwise naked testimony that he pre-populated patient records solely to save time, that he in fact took blood pressure readings and conducted full examinations on all visits, and that he changed pre-recorded information if "clinically significant"

variations were found,²² his practice was still at odds with basic principles of record keeping and was, at its core, a dishonest and misleading practice.

Finally, we reject Dr. Lafon's suggestion that the significance of any misconduct found is minimized because his medical records were prepared solely for his own use, and were not submitted to third party payors for reimbursement. Simply put, Dr. Lafon could not have known whether any individual patient's records would be needed by a subsequent treatment provider(s), whether for emergency care, on transfer of care or for any other reason. Any subsequent care provider, however, would have reviewed Dr. Lafon's patient records with the expectation and the assumption that those records were complete and accurate, and could well have based significant care decisions upon information gleaned from review of those records. Accordingly, Dr. Lafon's falsification of his medical records could well have compromised medical decisions made by subsequent care providers, and thereby placed patients at risk of harm.

²² No definition of the term "clinically significant" was established during this hearing, but Dr. Lafon's use of the term suggests that he would not have changed pre-recorded information where discrepancies were found between the actual findings made at the time of the exam and the pre-recorded information if those discrepancies did not rise to a level that Dr. Lafon considered to be "clinically significant."

Discussion on Penalty Determination

The mitigation evidence presented by Dr. Lafon -- particularly, the oral testimony offered by Messrs. Hewitt, Winks and Forbes and the supportive letters written by over one hundred patients - demonstrate that Dr. Lafon practiced in a compassionate and caring manner, and was able to garner the respect and admiration of many patients. It is undisputed that Dr. Lafon provided needed medical services to an underserved patient population, and it is likewise clear that Dr. Lafon was able to achieve successful results in his practice, to include weaning a significant number of patients from opiate dependency. Dr. Deerfield's testimony further establishes that Dr. Lafon progressed in therapy, and has taken many strides to address his prior sexual misconduct.

We in no way question or minimize the evident support Dr. Lafon enjoyed from his patients, or the sincerity of his efforts to obtain treatment, nor have we ignored that testimony in our deliberations upon penalty assessment. In this case, however, we unanimously conclude that the gravity of the findings we have made - particularly in the unique circumstances of this case - substantially outweighs the mitigation evidence presented, and militates in favor of ordering the revocation of Dr. Lafon's license. Succinctly stated, the mitigation showings made cannot serve to excuse respondent's brazen and stark violations of the

chaperoning requirements of our Orders, the flagrant lack of respect for the authority of this Board evident therein, or Dr. Lafon's willingness to compromise the integrity of his medical records and his overall practice of medicine by authoring progress notes which were in reality works of fiction.

Dr. Lafon was afforded an extraordinary second chance to return to medical practice by this Board in 2011. He knew, or certainly should have known, that our determination to allow him an opportunity to return to medical practice in New Jersey was conditioned on his absolute compliance with all of the terms and conditions imposed (and agreed to by Dr. Lafon) in the March 2011 Board Order. He clearly knew that we then deemed it necessary to limit his practice to male patients and to require, even for the male patients, a chaperone presence. He also knew that, three years later, this Board considered the chaperoning requirement to continue to be essential for the protection of Dr. Lafon's patients. Finally, Dr. Lafon knew, or should have known, that his practice, as a licensee with substantial restrictions, would be under a microscope of Board scrutiny, and he thus knew, or should have appreciated, that he had an absolute need to practice in a manner beyond reproach.

Dr. Lafon may not have believed that the chaperoning requirement was essential, and may have perceived that relaxing the requirements was in the best interests of his patients. But his

willingness to unilaterally make that decision, and thereby substitute his judgment for ours, evidences a brazen disregard for the authority of this Board that would be inappropriate for any licensee, let alone a licensee whose practice was as conditioned and limited as Dr. Lafon's practice was by operation of the two Consent Orders.

Taken alone, Dr. Lafon's audacious flaunting of the authority of this Board -- evidenced by his repeated violations of the chaperoning requirements for his practice -- forms an ample predicate to support an Order of license revocation. In this case, however, additional support for such action is provided by his having falsified patient records. We underscore the seriousness of that violation, as it ultimately trivialized not only his medical records but also compromised the very integrity of his medical practice.

We find it striking, if not ironic, that this is not the first time that we have had to consider and balance two polar opposite portraits of Dr. Lafon. Indeed, this Board was presented with a markedly similar dichotomy in 2011, when we needed to balance the egregiousness of Dr. Lafon's sexual misconduct prior to the revocation of his license against the substantial evidence of rehabilitation he presented in support of his petition for reinstatement. In 2011, we resolved that conflict in Dr. Lafon's favor, allowing him a limited and "final" opportunity to reenter

the practice of medicine. Today, we unanimously resolve that conflict against Dr. Lafon, in favor of a second order of revocation. We conclude, on balance, that the need to protect the public must be our paramount and most compelling concern, and that the need militates against any penalty short of the revocation of Dr. Lafon's license.

Upon consideration of the substantial mitigation showings made, we are persuaded that cause exists to waive imposition of monetary penalties otherwise authorized by law. We also find the mitigation showings to be sufficiently compelling to limit any assessment of costs to 50% of the aggregate total of the cost assessment sought.²³ Finally, based on the strength of the mitigation evidence, we decline to specifically conclude now that the revocation of respondent's license be permanent, and instead will leave the door open for Dr. Lafon to seek reinstatement after a minimum period of five years (see additional conditions set forth below).

²³ Respondent was provided with the State's cost certification in advance of the hearing dates, and did not raise any objection thereto. Independently, we point out that we found the aggregate amount of costs sought to be reasonable. Specifically, we found both the number of hours of attorney time billed by the Attorney General and the number of hours of investigator time billed by the Enforcement Bureau to be reasonable and entirely commensurate with the important interests advanced by this prosecution. Additionally, as we have repeatedly done in prior cases, we find the hourly rates charged for both attorney (\$155/hour) and investigator (\$147.45/hour) reasonable. Our decision to limit the costs assessed against Dr. Lafon to 50% of those sought is thus simply an exercise of administrative discretion, based solely on consideration and weighing of the mitigation evidence presented on Dr. Lafon's behalf.

WHEREFORE, it is on this ¹⁷ day of April, 2015

ORDERED nunc pro tunc March 11, 2015:

1. The license of respondent Michael Lafon, M.D. to practice medicine and surgery in the State of New Jersey is revoked, effective as of the close of business on April 10, 2015. Between March 11, 2015 (the date on which the Board's determination was verbally pronounced) and the effective date of revocation, respondent is to take all measures necessary to ensure an orderly transition of medical care of his patients to other providers. Upon revocation, respondent shall comply with all attached Directives Applicable to Suspended/Revoked Licensees.

2. Respondent is assessed costs, to include investigative costs and attorneys' fees, in the aggregate amount of \$7,125.13, to be paid in full to the Board, by certified check, money order or other form of payment acceptable to the Board, not later than thirty days from the date of entry of this Order.

3. Respondent may not petition for reinstatement of license for a minimum period of five years (i.e., no petition may be filed prior to April 10, 2020). Should respondent petition for reinstatement thereafter, he shall be required to then appear before a Committee of the Board and demonstrate, to the satisfaction of the Board, that he is fit to resume practice. Additionally, he shall then need to provide the Board with documentation of successful completion of record keeping,

professional ethics and professional boundaries courses acceptable to the Board. Respondent shall also then need to present a position statement from the Professional Assistance Program of New Jersey. Any determination whether to reinstate respondent's license at that time shall rest in the sole discretion of the Board. Should reinstatement be granted, the Board expressly reserves the right to impose any and all conditions and/or restrictions on any future practice that may be deemed appropriate, to include, without limitation, conditions limiting practice to male patients alone, requiring chaperoning of all office visits and/or requiring monitoring of patient records.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By:


Stewart A. Berkowitz, M.D.
Board President

**DIRECTIVES APPLICABLE TO ANY MEDICAL BOARD LICENSEE
WHO IS DISCIPLINED OR WHOSE SURRENDER OF LICENSURE
HAS BEEN ACCEPTED**

APPROVED BY THE BOARD ON MAY 10, 2000

All licensees who are the subject of a disciplinary order of the Board are required to provide the information required on the Addendum to these Directives. The information provided will be maintained separately and will not be part of the public document filed with the Board. Failure to provide the information required may result in further disciplinary action for failing to cooperate with the Board, as required by N.J.A.C. 13:45C-1 et seq. Paragraphs 1 through 4 below shall apply when a license is suspended or revoked or permanently surrendered, with or without prejudice. Paragraph 5 applies to licensees who are the subject of an order which, while permitting continued practice, contains a probation or monitoring requirement.

1. Document Return and Agency Notification

The licensee shall promptly forward to the Board office at Post Office Box 183, 140 East Front Street, 2nd floor, Trenton, New Jersey 08625-0183, the original license, current biennial registration and, if applicable, the original CDS registration. In addition, if the licensee holds a Drug Enforcement Agency (DEA) registration, he or she shall promptly advise the DEA of the licensure action. (With respect to suspensions of a finite term, at the conclusion of the term, the licensee may contact the Board office for the return of the documents previously surrendered to the Board. In addition, at the conclusion of the term, the licensee should contact the DEA to advise of the resumption of practice and to ascertain the impact of that change upon his/her DEA registration.)

2. Practice Cessation

The licensee shall cease and desist from engaging in the practice of medicine in this State. This prohibition not only bars a licensee from rendering professional services, but also from providing an opinion as to professional practice or its application, or representing him/herself as being eligible to practice. (Although the licensee need not affirmatively advise patients or others of the revocation, suspension or surrender, the licensee must truthfully disclose his/her licensure status in response to inquiry.) The disciplined licensee is also prohibited from occupying, sharing or using office space in which another licensee provides health care services. The disciplined licensee may contract for, accept payment from another licensee for or rent at fair market value office premises and/or equipment. In no case may the disciplined licensee authorize, allow or condone the use of his/her provider number by any health care practice or any other licensee or health care provider. (In situations where the licensee has been suspended for less than one year, the licensee may accept payment from another professional who is using his/her office during the period that the licensee is suspended, for the payment of salaries for office staff employed at the time of the Board action.)

A licensee whose license has been revoked, suspended for one (1) year or more or permanently surrendered must remove signs and take affirmative action to stop advertisements by which his/her eligibility to practice is represented. The licensee must also take steps to remove his/her name from professional listings, telephone directories, professional stationery, or billings. If the licensee's name is utilized in a group practice title, it shall be deleted. Prescription pads bearing the licensee's name shall be destroyed. A destruction report form obtained from the Office of Drug Control (973-504-6558) must be filed. If no other licensee is providing services at the location, all medications must be removed and returned to the manufacturer, if possible, destroyed or safeguarded. (In situations where a license has been suspended for less than one year, prescription pads and medications need not be destroyed but must be secured in a locked place for safekeeping.)

3. Practice Income Prohibitions/Divestiture of Equity Interest in Professional Service Corporations and Limited Liability Companies

A licensee shall not charge, receive or share in any fee for professional services rendered by him/herself or others while barred from engaging in the professional practice. The licensee may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of the Board action.

A licensee who is a shareholder in a professional service corporation organized to engage in the professional practice, whose license is revoked, surrendered or suspended for a term of one (1) year or more shall be deemed to be disqualified from the practice within the meaning of the Professional Service Corporation Act. (N.J.S.A. 14A:17-11). A disqualified licensee shall divest him/herself of all financial interest in the professional service corporation pursuant to N.J.S.A. 14A:17-13(c). A licensee who is a member of a limited liability company organized pursuant to N.J.S.A. 42:1-44, shall divest him/herself of all financial interest. Such divestiture shall occur within 90 days following the the entry of the Order rendering the licensee disqualified to participate in the applicable form of ownership. Upon divestiture, a licensee shall forward to the Board a copy of documentation forwarded to the Secretary of State, Commercial Reporting Division, demonstrating that the interest has been terminated. If the licensee is the sole shareholder in a professional service corporation, the corporation must be dissolved within 90 days of the licensee's disqualification.

4. Medical Records

If, as a result of the Board's action, a practice is closed or transferred to another location, the licensee shall ensure that during the three (3) month period following the effective date of the disciplinary order, a message will be delivered to patients calling the former office premises, advising where records may be obtained. The message should inform patients of the names and telephone numbers of the licensee (or his/her attorney) assuming custody of the records. The same information shall also be disseminated by means of a notice to be published at least once per month for three (3) months in a newspaper of

general circulation in the geographic vicinity in which the practice was conducted. At the end of the three month period, the licensee shall file with the Board the name and telephone number of the contact person who will have access to medical records of former patients. Any change in that individual or his/her telephone number shall be promptly reported to the Board. When a patient or his/her representative requests a copy of his/her medical record or asks that record be forwarded to another health care provider, the licensee shall promptly provide the record without charge to the patient.

5. Probation/Monitoring Conditions

With respect to any licensee who is the subject of any Order imposing a probation or monitoring requirement or a stay of an active suspension, in whole or in part, which is conditioned upon compliance with a probation or monitoring requirement, the licensee shall fully cooperate with the Board and its designated representatives, including the Enforcement Bureau of the Division of Consumer Affairs, in ongoing monitoring of the licensee's status and practice. Such monitoring shall be at the expense of the disciplined practitioner.

(a) Monitoring of practice conditions may include, but is not limited to, inspection of the professional premises and equipment, and inspection and copying of patient records (confidentiality of patient identity shall be protected by the Board) to verify compliance with the Board Order and accepted standards of practice.

(b) Monitoring of status conditions for an impaired practitioner may include, but is not limited to, practitioner cooperation in providing releases permitting unrestricted access to records and other information to the extent permitted by law from any treatment facility, other treating practitioner, support group or other individual/facility involved in the education, treatment, monitoring or oversight of the practitioner, or maintained by a rehabilitation program for impaired practitioners. If bodily substance monitoring has been ordered, the practitioner shall fully cooperate by responding to a demand for breath, blood, urine or other sample in a timely manner and providing the designated sample.

**NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which revokes or suspends (or otherwise restricts) a license,
- (2) Which censures, reprimands or places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.