Exhibit A

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

BOARD OF REGISTRATION
IN MEDICINE

Adjudicatory Case No. 86-1-BO

In the Matter of

LEONARD FRIEDMAN, M.D.

FINAL DECISION AND ORDER

Appearances: James J. Barrett, Esq., for the Board of Registration in Medicine
Nathaniel M. Sherman, Esq., for the Respondent

I. SUMMARY OF PROCEEDINGS

This case was commenced by Order to Show Cause, dated July 17, 1985, in which the Board of Registration in Medicine (the "Board") alleged that Leonard Friedman, M.D. (the "Respondent") had violated M.G.L. c. 112, secs. 5(c)(gross misconduct in the practice of medicine), 5(h)(violation of the Board's rules and regulations) and 61 (malpractice in the practice of medicine), and 243 CMR 1.03 (5)(a)(3). Specifically, the Board alleged that the Respondent had sexually assaulted a female patient (the "Patient") during two office visits. The Board further alleged that the Respondent had sexual intercourse with the Patient during a third office visit. The Respondent's Answer to the Order to Show Cause (the "Answer") admitted that the three office visits had taken place but denied that there had been any sexual activity between himself and the Patient during the visits.

Following the Hearing Officer's rulings on a number of motions to continue, a change of Hearing Officer, and rulings by the substituted Hearing Officer on further motions to continue, a full adjudicatory hearing on this matter commenced on April 17, 1986, continued on May 6, 1986 and June 3, 1986, and concluded on June 20, 1986. Both parties provided proposed findings of fact. Complaint Counsel also submitted written closing argument.

II. Description of the Evidence Presented

The following is a brief description of the relevant evidence presented:

Complaint Counsel offered the testimony of:

(a) "LD" (the "Patient"), concerning the care and treatment provided by the Respondent from July 29, 1980 through August 9, 1982; the events surrounding the alleged sexual activity occurring between herself and the Respondent during three visits to the Respondent's office on June 7, 1986, June 22, 1986 and July 6, 1986 (hereinafter collectively referred to as the "Visits"); and an August 9, 1982 telephone conversation with the Respondent;

(b) George C. Galitis, D.M.D., the Patient's dentist, concerning treatment provided to the Patient during a June 8, 1986 office visit and statements made by the Patient during that visit about the events that allegedly occurred during the Patient's June 7, 1986 visit with the Respondent; and

(c) "FD," son of the Patient, concerning statements made by the Patient about the events that allegedly occurred during the Visits; and telephone conversations on August 9, 1982 between (1) himself and the Respondent, and (2) the Patient and the Respondent.

Complaint Counsel also offered the following documentary evidence:

Exhibit 1: Handwritten Questionnaire, dated 7/29/80 and completed by the Patient during her initial office visit with the Respondent;

Exhibit 2: Appointment card;

Exhibit 3: Tape of August 9, 1982 conversation between the Patient and the Respondent, submitted for identification purposes only and later withdrawn by Complaint Counsel;

Exhibit 4: Diagram of the Respondent's office drawn by Judith A. Golden, the Respondent's secretary;

Exhibit 5: The Respondent's records of the Patient's office visits;

Exhibit 6: Bournewood Hospital records for the Patient;

Exhibit 7: Huntington General Hospital records for the Patient;

Exhibit 8: Letter dated August 12, 1983 from Joseph G. Abromovitz, P.C., the Patient's attorney, to Michael Driscoll, a Board investigator;

Exhibit 9: Letter dated September 25, 1983 from the Respondent to Mr. Driscoll;

Exhibit 10: Print-out of medications prescribed for Dennis Cook, a witness for the Respondent;

Exhibit 11: Page dated June 22, 1982 from the Respondent's appointment book;

Exhibit 12: Letter dated June 23, 1982 from the Respondent to Attorney Abromovitz;

Exhibit 13: Page dated April 29, 1982 from the Respondent's appointment book;

Exhibit 14: Letter dated June 12, 1986 from Attorney Abromovitz to James J. Barrett, Esq., with attached Motion to Impound Certain Documents;

Exhibit 15: Document and Handwriting Analysis Report re: certain daily record book ("Day Book") entries, dated November 24, 1986 from Joan McCann & Associates to Joseph G. Abromovitz, P.C., and provided to the Hearing Officer by letter dated December 9, 1986 from Marsha A. Morello, Esq.; and

Exhibit 16: Report of Tape Analysis, by letter dated September 9, 1986 from Charles W. Dietrich, The Dietrich Group, Inc., to the Hearing Officer.

The Respondent offered the testimony of:

(a) Patricia Sullivan, Respondent's former full-time and present part-time secretary, concerning the Visits, Respondent's billing practices, and certain Day Book entries;

(b) Judith A. Golden, Respondent's secretary, concerning the Visits, an August 4, 1982 Day Book entry, and the layout of

the Respondent's office;

(c) Rocco LaMattina, a former patient of the Respondent, concerning various conversations with the Patient and a taped conversation between the Respondent and FD;

(d) William Wall, a patient of the Respondent, concerning various conversations with LaMattina and the Respondent and a taped conversation between the Respondent and FD;

(e) Russell Butera, a patient of the Respondent, concerning various conversations with LaMattina and the Respondent;

(f) Dennis Cook, a patient of the Respondent, concerning the Visits and his relationship with the Respondent; and

(g) Nancy Mann, former claims representative for Combined Insurance Company (LaMattina's insurance company) and friend of LaMattina, concerning certain conversations with LaMattina.

The Respondent also offered the following documentary evidence:

Exhibit A: Last page of Questionnaire (Exhibit 1) completed by the Patient;

Exhibit B: Diagram of the Respondent's office by the Patient;

Exhibit C: Letter dated June 11, 1982 from Howard McIntyre, M.D., G. Richard Paul, M.D., David Segal, M.D. and Jonathan P. Strong, M.D., Boston City Hospital, Department of Orthopedic Surgery, to Thomas May, M.D., U.S. Department of Labor;

Exhibit D: Letter dated June 8, 1982 from Attorney Abromovitz

to the Respondent;

Exhibit E: Letter dated July 17, 1982 from the Patient to Daniel Sullivan, Deputy Commissioner, Department of Labor;

Exhibit F: Memo to File dated July 21, 1982 from Omar Canty, Rehabilitation Specialist, U.S. Department of Labor;

Exhibit G: Letter dated June 24, 1982 from the Respondent to Attorney Abromovitz;

Exhibit H: Page dated August 4, 1982 from the Respondent's Day Book (Exhibit J-2);

Exhibit I: Photograph of the Patient and LaMattina's brother at LaMattina's house;

Exhibits J-1, J-2 and J-3: Respondent's Day Books;

Exhibit K: Letter dated March 10, 1982 from Attorney Abromovitz to Hartford Insurance Company;

Exhibit L: Cash records of Dr. Galitis for the Patient;

Exhibit M: Article entitled "Forensic Psychiatry: The Challenge to Bring Psychiatry Back Into Mainstream Medicine," by the Respondent;

Exhibit N: Article entitled "The Post-Concussion Syndrome," by the Respondent;

Exhibit O: Article entitled "Unwrapping the Riddle of the Brain-Injured Patient by Utilizing the BEAM EEG," by the Respondent;

Exhibit P: Seminar booklet "Medical Psychiatric Unit Approach to the Treatment of Postconcussion Syndrome," dated June 23, 1984;

Exhibit Q: Seminar booklet "Post Concussion Syndrome

Seminar," dated July 13, 1983;

Exhibit R-1: Letter dated December 4, 1980 from the Respondent to Mubeyyin Altan, Vocational Disability Examiner, Massachusetts Rehabilitation Commission;

Exhibit R-2: Letter dated November 3, 1981 from the Respondent to the Massachusetts Rehabilitation Commission;

Exhibit R-3: Massachusetts Rehabilitation Commission form dated October 23, 1981 completed by the Respondent;

Exhibit S: Respondent's billing records for the Patient; and

Exhibit T: List of medications in the Patient's handwriting.

III. Findings of Fact

Based on the evidence introduced at the hearing, we find the following facts:

1. The Patient, a widowed woman, became a registered nurse in 1951. She has held various nursing and administrative positions with several hospitals, a nursing home and, most recently, the federal government. (Tr. 78, 79)(4/17/86)

2. The Respondent graduated from Syracuse Medical College in 1960 and Harvard Law School in 1966. He was registered and licensed to practice medicine in Massachusetts in 1966. The Respondent became a Board certified psychiatrist in 1972 and a Board certified forensic psychiatrist in 1979. (Tr. 86, 87)(6/3/86)

3. On or about September 13, 1979, while she was employed by the U.S. Department of Health and Human Services, Health Care Financing Administration, a separation wall fell on the Patient, rupturing an intervertebral disc at the L3-4 level. (Tr. 15, 16)(4/17/86)(Ex. C)

4. The Patient filed a Workmen's Compensation claim regarding the September 13, 1979 accident with the U.S. Department of Labor Industrial Accident Board. At the time of the hearing, the Patient was receiving weekly benefit payments from the Department of Labor. (Tr. 52, 77, 90) (4/17/86)

5. After the September 13, 1979 accident, the Patient consulted with and received treatment from various physicians. (Tr. 16, 25)(4/17/86)(Ex. C) The Patient testified that she was treated by a Dr. Sterns and Dr. Rubin and was referred by them to Dr. John J. Walsh, Jr., an orthopedic surgeon. She was referred by Dr. Walsh to Dr. Welch, a neurologist. After Dr. Welch moved out of town, the Patient telephoned the Respondent and scheduled her first office visit for July 29, 1980. (Tr. 16-18, 25 (4/17/86); Tr. 109 (6/3/86))(Ex. C) The Patient testified that she thought the Respondent was a neurologist when she arranged for the initial visit. (Tr. 19, 20, 93, 104)(4/17/86)

6. According to the Patient, the purpose of the July 29, 1980 visit was to obtain treatment for her physical injuries and depression. (Tr. 19, 23-25)(4/17/86) The Respondent's

record of this initial visit describes the Patient's general education and accident/injury history, notes the death of the Patient's husband, and under "Psychiatric Examination," includes the statement "feels deserted and alone." (Tr. 113, 114)(6/3/86)

7. The Patient visited the Respondent at his office on a monthly or bi-monthly basis during the period from July 29, 1980 through June 7, 1982. (Tr. 27, 37, 43, 44 (4/17/86); Tr. 132, 134, 149 (6/3/86))(Ex. 5)

8. The Respondent admitted the Patient to Bournewood Hospital, a psychiatric facility, on September 2, 1980 and to Huntington General Hospital (now known as the Massachusetts Osteopathic Hospital) on at least seven occasions during the period from July 29, 1980 through June 7, 1982. (Tr. 125, 128, 136 (6/3/86); Tr. 38, 43 (4/17/86))(Exs. 6 and 7)

9. Psychological tests performed on the Patient by Dr. Arthur J. Bindman during her initial admission to Huntington General Hospital on August 4, 1980 indicated moderate depressive neurosis, unresolved grief reaction, agitation and elements of hysteria. (Tr. 125, 126, 206, 207)(6/3/86)

10. At some time prior to December 4, 1980, the Patient filed a disability claim with the Commonwealth of Massachusetts, Massachusetts Rehabilitation Commission. At the Commission's request, the Respondent provided two letters and other information regarding the Patient's medical

history. (Tr. 114-123)(6/3/86)(Exs. R-1, R-2 and R-3)

11. The Patient testified that both the Respondent and Dr. Walsh provided "progress reports" to the Department of Labor regarding her case and that the Respondent was aware that Dr. Walsh was sending such reports. (Tr. 51, 53, 56, 159 (4/17/86); Tr. 42 (5/6/86)) The Respondent denied that the Patient was dependent on any reports from him for any of her benefits but admitted that many of his patients, including the Patient, had been successful in obtaining social security disability benefits as a result of his diagnoses and the reports that he was required to file. (Tr. 106, 107, 231) (6/3/86) The Respondent testified that he knew the Patient was seeing "somebody" but didn't know who it was and that he had no clear memory as to when the Patient informed him that she was being treated by Dr. Walsh. (Tr. 115, 225, 226) (6/3/86) The Patient claims that she told the Respondent that she was being treated by Dr. Walsh "at the very beginning." (Tr. 41)(5/6/86) The Board notes that Dr. Walsh was apparently aware the Patient was being treated by the Respondent since he referred to the Respondent in a December 9, 1980 letter to the Department of Labor regarding the Patient. (Tr. 224)(6/3/86)

12. In connection with her Worker's Compensation claim, the Patient was examined and evaluated by a panel of physicians at the Boston City Hospital ("BCH") on April 20, 1982. (Tr. 10)(5/6/86)(Ex. C) The BCH report stated the panel had

found the Patient to be totally disabled for a year and recommended to Thomas May, M.D., U.S. Department of Labor, that the Patient's psychiatric care be provided by a university based, board certified and experienced psychiatrist. (Ex. C) The Patient discussed the BCH recommendations with Omar Canty, Rehabilitation Specialist, U.S. Department of Labor, on July 15, 1982. (Tr. 63)(5/6/86)

13. We are required to make credibility determinations relating to the Respondent and the Patient to resolve material factual issues in this case. Arthurs v. Board of Registration in Medicine, 383 Mass. 299, 308 n. 21 (1981). In making these determinations, we are mindful of the difficulty of the task of dissecting the facts from the emotionally-charged issues present in this case. Doubts about the accuracy of particular points of a witness's testimony, however, do not mean that we discredit the entire testimony. For example, as more fully discussed below, while we do not entirely accept the Patient's testimony describing the alleged sexual activity between the parties during the June 7, 1986 office visit (as set forth below in Paragraph 16), we do find that the Patient's "sexual exploitation" claim made during an August 9, 1982 telephone conversation with the Respondent (as set forth below in Paragraph 24), was valid. Similarly, although we do not deem credible the Respondent's claim that the Patient never visited his office on June 22, 1982 (as set forth below in Paragraph 19), we do accept his testimony that the Patient had complained to him

about the treatment of the BCH physicians who evaluated her Worker's Compensation claim and that she may have been afraid that the BCH report might result in the discontinuation of her disablity benefits. (Tr. 155)(6/3/86) (Ex. 5)

14. On May 10, 1982, FD, the Patient's son, drove the Patient to the Respondent's office and waited outside while the Patient visited the Respondent. The Patient testified that the Respondent spoke "very strange" and was "giddy" during this visit and that he took her hand and said, "What are we sitting here for? We should be at the Ritz." (Tr. 45, 46)(4/17/86) The Respondent testified that the Patient had visited his office on this date and noted that his records indicated that the Patient had made comments about the BCH evaluation during this visit; specifically, that the BCH physicians were like the "Gestapo." (Tr. 155)(6/3/86) The Patient did not recall making any complaints to the Respondent about the way she was treated by the BCH physicians. She denied that she had made any comment about "gestapo tactics" or that she had any fear that the BCH report would cause the termination of her Worker's Compensation benefits. (Tr. 10, 11)(5/6/86) The preponderance of the evidence shows that, as the Respondent's opinions had assisted the Patient in maintaining benefits for a substantial period of time, the extremely detailed BCH evaluation of both the Patient's case and also the treatment provided by the Respondent was a cause for her concern.

15. In May of 1982, the Respondent had a "flashing thought" that some of his sessions were being taped. (Tr. 202, 208, 212)(6/3/86) He also stated that he had a suspicion in late May of 1982 that the Patient was taping office visits. (Tr. 212)(6/3/86) His suspicions were based on "comments" made by two of his patients, Russell Butera and Diane Butera, during office visits on May 15, 1982 and May 18, 1982. (Tr. 193, 209, 210)(6/3/86) According to the Respondent, the Buteras had spoken with Rocco LaMattina, another patient and witness for the Respondent, about tapes and had told the Respondent that "Rocco was very angry and Rocco was going to use somebody to get me." (Tr. 210)(6/3/86) Diane Butera had also allegedly spoken with Nancy Mann, a friend of LaMattina and witness for the Respondent, who confirmed that "something is happening." (Tr. 193, 209)(6/3/86) Nancy Mann, however, provided no testimony as to any conversation with Diane Butera. (Tr. 94-104)(6/3/86) The Respondent testified that the Buteras did not tell him who LaMattina was "intending to use." (Tr. 193, 211)(6/3/86) The Respondent also stated that during an office visit in June of 1982, another patient, William Wall, a witness for the Respondent, had told him that LaMattina had a small tape recorder. (Tr. 211)(6/3/86) Although the Respondent testified that the Patient had held up a "little green pocketbook" during a visit in May or June of 1982 which "could have held a tape recorder," there was no evidence presented that the Respondent made any notations in his records or reported his suspicions to anyone. (Tr. 202)

(6/3/86)

The Board finds numerous contradictions in the testimony of the Respondent and several of the witnesses as to the date, content and location of their various conversations. LaMattina first testified that the Patient had told him in May of 1982 that she was going to "get even" with the Respondent because "she has having some trouble with checks." (Tr. 179, 180)(5/6/86) He later testified that this conversation took place in April and that "we both lost our checks." (Tr. 191)(5/6/86) After they had this conversation, LaMattina said he went to Wall's house and told Wall "what had happened" to the Patient and that they then called the Buteras and told them: "The way [the Patient] sounds, she's going out to get him." (Tr. 180)(5/6/86) LaMattina also testified that several months later, in August of 1982, after going to the Patient's house at her request and listening to a tape of a conversation between the Respondent and FD, he "called up Mr. Wall and I made him hear the tape." (Tr. 180) (5/6/86) Later, he testified that, after hearing the tape, he "went over to Bill Wall's house. After he heard the tape, we called up Rusty and Diane [Butera]." (Tr. 182)(5/6/86) Wall, however, was not questioned about, nor did he provide any information regarding, any conversation or meeting with LaMattina in May of 1982, any office visit with the Respondent in June of 1982, any conversation with the Respondent at any time relating to the tape or the content thereof, or any conversations with the Buteras. (Tr. 194-

211)(5/6/86) Wall did relate the details of a telephone call from LaMattina in August of 1982 and described a taped conversation between the Respondent and FD which LaMattina had played for him during the telephone conversation with LaMattina. (Tr. 195-197)(5/6/86) Russell Butera testified that LaMattina had visited his home in May of 1982 and that during this visit, they had a conversation relative to the Patient and that LaMattina had told him and his wife that "they had tapes of Dr. Friedman." (Tr. 213-215, 220, 225)(5/6/86) Butera later stated that he had no idea who had the tapes, that he had called the Respondent to "put him on alarm," and that he had visited the Respondent's office more than a week after his visit from LaMattina and that he had told the Respondent that they had "incriminating tapes against him." (Tr. 214, 215, 225, 226)(5/6/86) Butera provided no testimony as to any conversations with or visits from LaMattina in August of 1982.

The Board takes note of the numerous inconsistencies in the testimony of LaMattina, Wall, Butera and the Respondent as to what information each party received from, and conveyed to, the other parties. If the Board were to believe certain portions of the testimony of the Respondent and Butera, it would follow that the Respondent would have known that the Patient had made tapes as early as May of 1982. Based on the above-described testimony, the Board finds that if, in fact, the Respondent did suspect that someone was taping his sessions, the Respondent knew or

should have known that LD was the Patient who LaMattina had allegedly indicated to several witnesses was "out to get" the Respondent. As more fully discussed below, the Board is far from persuaded that the Respondent actually had any such suspicions in view of the fact that there is no evidence of any notations in his records or conversations with anyone about such suspicions, and, except for allegedly asking a patient, Dennis Cook, to sit outside his office during LD's visits, he failed to take any precautions to assure the avoidance of any difficulties during the Patient's subsequent visits. The Board finds it implausible that the Respondent could represent that he had suspicions of a nature which caused him to recruit Cook to observe the Patient's visits while simultaneously claiming that he had "no particular memory" of the events occurring during this and the other visits. (Tr. 158)(6/3/86)

16. On June 7, 1982, FD drove the Patient to another scheduled visit with the Respondent and waited downstairs while the Patient visited with the Respondent. (Tr. 48 (4/17/86); Tr. 111 (5/6/86)) The Patient did not recall any other patients or either secretary being present in the office when she entered. (Tr. 18)(5/6/86) According to the Patient, the Respondent greeted her and then got up from his desk to close both doors to his office. The Patient further alleged that the Respondent then rubbed her neck, sat on his desk in front of her with his zipper down and penis exposed, forced her head down to his penis and ejaculated on her

hands. (Tr. 48-53 (4/17/86); Tr. 18-26 (5/6/86)) She asserted further that following this incident, the Respondent said, "You being a nurse . . . you never had - didn't you have oral sex?" and that he reminded her, "You have to come see me every two weeks or it's going to be bad for your case with the Department of Labor. I have to make out the progress reports." (Tr. 50, 51)(4/17/86) The Respondent admitted that the June 7, 1986 visit took place but described it as "no different than any other visit" and said he had "no particular memory" of what occurred on that day. (Tr. 157-162)(6/3/86) He stated that Golden, Sullivan and Cook were in the office that day and that his door was approximately eight inches ajar during the visit. (Tr. 158)(6/3/86) The Respondent denied that he locked the door that day. (Tr. 160)(6/3/86)

Although it is undisputed by the parties that the June 7, 1986 visit occurred, it is obviously disputed as to what actually transpired between the parties during this visit. Golden and Sullivan testified to being present in the office on June 7, 1986, but neither had any specific memory of the events of that day. (Tr. 108, 136, 169)(5/6/86). Both secretaries recalled nothing "unusual" about the visit. (Tr. 83, 84, 140)(5/6/86)

In response to Complaint Counsel's inquiry as to whether the Respondent locked his office doors, Golden stated that the Respondent had asked her if she had ever known him to lock the door and if she had ever heard the sound of him

locking the door. She related the details of a demonstration where the Respondent turned the bolt which locked the door as she stood next to him and stated that she had never heard the sound before. She said, "I would assume I could hear it sitting at my desk if I ever heard him lock it." (Tr. 165-167)(5/6/87) On further questioning of the Hearing Officer, Golden indicated that she had, in fact, gone back to her desk and listened and heard the sound of the Respondent locking the door. (Tr. 168)(5/6/86) The Board notes the likelihood that the sound of a bolt turning would indeed be audible to one who is intently focused on hearing the specific sound. Since Golden and Sullivan admitted that there were occasions when they would leave the office to go to the supply room or to the bathroom and that they spent a "great deal" of time on the telephone, the Board finds their testimony of little probative value as to whether the Respondent ever locked the door. (Tr. 95, 96, 163-165)(5/6/86)

Cook testified that he sat opposite the door leading into the Respondent's office during the June 7, 1986 visit and that he had observed nothing unusual about the Patient or the visit in general. (Tr. 32)(6/3/86) He also stated that the Respondent's door was open more than half-way during the Patient's visits. (Tr. 84)(6/3/86) It detracted from the credibility of both the Respondent and Cook, that the Respondent expended some effort to show that the door may have been closed but never locked, only to have Cook testify that the door was never closed.

17. In considering Cook's credibility, the Board finds it very odd that, although Cook was allegedly in the office for the specific purpose of being a witness for the Respondent in the event of a subsequent legal dispute, there was no evidence that he took any notes of his observations during or near the time of this or any of the other visits. Furthermore, the Respondent made no contemporaneous documentation of Cook's presence or observations and neither secretary provided any testimony which convincingly corroborated Cook's claimed presence during the Visits. (Tr. 80, 84, 108, 142, 169)(5/6/86)

The Hearing Officer observed Cook's demeanor and found him to be substantially lacking in credibility. We accord this observation significant weight. The Board gives little weight to Cook's testimony as to the events occurring in the Respondent's office during this and the other visits of the Patient described below. Cook had first been a patient of the Respondent in 1981 in connection with an automobile accident injury. (Tr. 69)(6/3/86) He later sought assistance from the Respondent in 1982 regarding his Veterans Administration ("V.A.") disability claim. (Tr. 58, 71)(6/3/86) According to Cook, "Senator Kennedy's office said they had like a hundred patients that went down [to Washington, D.C.] and Dr. Friedman was the doctor and they won all the cases." (Tr. 71)(6/3/86) Cook testified that he and the Respondent had an "understanding" whereby Cook would come to the Respondent's office when the Patient

was scheduled for a visit in exchange for the Respondent's appearance at a V.A. hearing in Washington, D.C. on behalf of Cook. (Tr. 61)(6/3/82) As to this V.A. appearance, the Respondent ultimately provided Cook with a letter, which Cook apparently submitted to the V.A., evaluating Cook as having a one hundred percent disability. (Tr. 79, 203, 204)(6/3/86) Cook did not present this letter at the hearing but stated that the Respondent was "very very helpful" in Cook's continuing to receive his V.A. disability benefits. (Tr. 79, 80)(6/3/86)

Although we are unable to determine by a preponderance of the evidence whether Cook was actually present in the Respondent's office during the Visits, our consideration of the Hearing Officer's assessment of Cook's demeanor while testifying, coupled with Cook's lack of records as to his observations and the various inconsistencies in the testimony of Cook, the Respondent, and his secretaries as to such a simple and basic matter as whether the office doors were "open more than half-way," "eight inches ajar," or open at all, lead the Board to conclude that Cook is not a credible source of information as to the events occurring during the Visits.

18. On June 8, 1982, the Patient visited Dr. Galitis for the purpose of having a tooth repaired which the Patient claimed was damaged in the course of her resistance to the Respondent's alleged sexual assault on the previous day. (Tr. 54, 114-116)(4/17/86) Dr. Galitis' testimony and

medical records for the Patient indicate that he placed a temporary filling in the Patient's upper left molar on June 8, 1982 to relieve the pain due to a fractured tooth and filling. (Tr. 24)(6/3/86)(Ex. C) The Patient testified that during this visit she told Dr. Galitis about the events occurring during her June 7, 1986 visit with the Respondent. (Tr. 55, 56)(4/17/86) Dr. Galitis' testimony as to the Patient's description of her visit with the Respondent essentially corroborated the Patient's version of the visit as set forth above in Paragraph 17. (Tr. 114-116)(4/17/86)

The Respondent sought to discredit the Patient's claim that she had a tooth repaired on June 8, 1982 by directing the Board's attention to an April 29, 1982 Day Book entry which noted that the Patient would not be in for her scheduled visit because she had broken a tooth and had to go to the dentist. (Tr. 154)(6/3/86)(Ex. R-1) The handwriting analysis arranged by Attorney Abromovitz and provided to the Board, reported that the entry at issue ("broke a tooth has to go to Dentist") was entered at a later time ("time frame unknown") after the first entry: "[LD]-cannot come in today [telephone number]." (Ex. 15) Thus, the Day Book entries are substantially unreliable and the Board accords no evidentiary weight to them. The Board also notes here that the Respondent's description of certain entries in his appointment book as "out of order" similarly places the validity of the "log book" as a business record in dispute. (Tr. 218, 221, 229)(6/3/86)(Exs. 11 and 13)

The Board notes that the fact that the Patient may or may not have had a tooth repaired on April 29, 1982 is not dispositive of the question of whether Dr. Galitis treated the Patient on June 8, 1982. As to whether the Patient visited Dr. Galitis on April 29, 1982, the Board gives greater weight to Dr. Galitis' testimony that he did not treat the Patient between December 29, 1981 and May 12, 1982. (Tr. 11)(6/20/86) Although the issue is not before the Board, we note here that the Respondent's appointment book and billing records indicate that the Patient was charged $80 for April 29, 1982. (Exs. 13 and 5)

19. The occurrence of a June 22, 1982 office visit is disputed by the parties. The Patient testified that she was again driven to the Respondent's office by FD, who waited downstairs for her, and that she was met in the lobby by the Respondent. (Tr. 57 (4/17/86); Tr. 112 (5/6/86)) Except for a receptionist "way up in the front," the Patient did not believe that there was anyone present when she and the Respondent entered the waiting room. (Tr. 58)(4/17/86) The Patient testified that the Respondent closed the doors, turned around with his pants unzipped, and that while they were standing, he sexually assaulted her with his fingers, placed her hands on his penis and ejaculated on her hands and clothing. After this incident, the Patient stated that the Respondent said to her, "You being a nurse, you know how the nurses used to fool around in the hospitals years ago" and that he again reminded her that she had to come to him every

two weeks or "it's going to be bad for your case with the Department of Labor." (Tr. 58, 59)(4/17/86) On the following day, according to the Patient and FD, the Patient told her son about the events occurring during the June 7, 1982 visit and some of the events occurring during the June 22, 1982 visit. (Tr. 61, 62 (4/17/86); Tr. 113 (5/6/86))

The Respondent testified that his admission to the occurrence of this visit in Paragraph 5 of the Answer was an error caused by his failure to review the Day Books prior to preparing the Answer and that he had later discovered a Day Book entry for June 22, 1982 suggesting that the Patient did not keep the appointment. (Tr. 167)(6/3/86)(Ex. R-2) He also attributed certain statements in his September 25, 1983 letter to the Board, indicating that the Patient had several office visits after her attorney's June 8, 1982 request for information from the Respondent, to his failure to "go over the notes." (See Ex. 9 - "Soon afterwards in the office appointments . . . . " and "She continued in her remaining future visits . . . .") (Tr. 199)(6/3/86) The Respondent stated that he did not believe there was an office visit made by the Patient on this date and that he was "90 percent certain at this point that she did not come." (Tr. 197, 198)(6/3/86) Respondent also testified that he could not tell from his medical records whether an office visit or a telephone conversation had occurred and that, under certain circumstances, he would bill a patient for a visit when a

cancellation, issed appointment or telep..ne conversation had, in fact, occurred. (Tr. 142, 175-178, 220, 230)(6/3/86) The Respondent's appointment book and billing records again note an $85.00 charge to the Patient for that date. (Exs. 11 and 5)

After earlier stating that the Patient had kept her June 22, 1982 appointment, Sullivan was recalled to testify after the Respondent's appearance and stated that she was not certain whether the Patient was present on June 22, 1982. (Tr. 83 (5/6/86); Tr. 14, 22 (6/20/86)) Golden testified that she did not remember the exact date that the Patient had come in. (Tr. 140, 141)(5/6/86) Cook claimed that he was present in the office on that date and that he did not see the Patient come to the office between 11:30 a.m. and 1:20 p.m. (Tr. 33)(6/3/86) Again, Cook was supposedly present to provide later exculpatory testimony, yet his testimony as to this visit was consistent with neither the Answer nor the Respondent's initial testimony.

The Board finds that a preponderance of the evidence supports the Patient's claim that she visited the Respondent's office on June 22, 1982. We also believe that, if the Patient was running a "scam" as the Respondent claims, it is highly unlikely that the Patient would claim she was sexually assaulted on a day that she never appeared at the Respondent's office.

20. On July 6, 1982, FD again drove the Patient to the Respondent's office for a scheduled appointment. (Tr. 62)

(4/17/86) The Patient went up to the office alone, noticed no other patients and could not remember if there were any secretaries in the office when she entered. (Tr. 62 (4/17/86); Tr. 44 (5/6/86)) The Patient testified that the Respondent again locked both doors and then took off his pants, forced her down on the couch and had intercourse with her against her will. (Tr. 116 (5/6/86); Tr. 63 (4/17/86); Tr. 47-50 (5/6/86)) FD testified that on the day following this visit, the Patient told him that "Dr. Friedman had inserted his penis into her vagina. He raped her." (Tr. 116)(5/6/86) The Respondent admitted that the Patient kept her July 6, 1982 appointment but denied that anything "unusual" happened during this visit. (Tr. 169, 171) (6/3/86)

Both secretaries and Cook testified that they were present in the office that day and that they heard or observed nothing "unusual" on that day. (Tr. 80, 140 (5/6/86); Tr. 35 (6/3/86)) Sullivan testified that she brought in some charts, or a legal form, to the Respondent for his signature during the July 6, 1982 visit but later stated that she had no recollection of what the paper was because she "never really looked at them that thoroughly." (Tr. 82, 86, 103, 110)(5/6/86) She also stated that she could not say "one way or the other" whether she recalled any other specific dates when she had entered the Respondent's office while the Patient was in the office because she "would have no reason to be taking any particular

note of any patient that was in there." (Tr. 102)(5/6/86) Golden remembered Sullivan "getting up for something" but did not recall if it was for supplies, the bathroom or the Respondent's office. (Tr. 170, 171)(5/6/86) Cook stated that he remembered Sullivan going into the Respondent's office during that visit. (Tr. 84)(6/3/86) Sullivan recalled that the Patient had called the Respondent a "cheap miser" as she left the office that day. (Tr. 80)(5/6/86) Golden and Cook stated that the Patient had commented about "something to do with money" on her way out, although Cook said that he "didn't really get too much of the gist." (Tr. 143 (6/3/86); Tr. 35 (5/6/86))

The Respondent stated that he believed that he had Sullivan bring in the letter which he had prepared at the request of Attorney Abromovitz during this visit and that he was later asked by his secretaries why the Patient had called him a "cheap miser" as she left the office. (Tr. 234) (6/3/86) The Respondent testified that he remembered "one point" that they had discussed during this visit, namely, her headaches and the progesterone compound to be prescribed for her. (Tr. 169)(6/3/86) In response to the Hearing Officer's inquiry, however, the Respondent later stated that during this visit he had explained his "policy with the letters" to the Patient, that is, that he would not send out the report requested by her attorney prior to receipt of his fee. (Tr. 234)(5/6/86) The Respondent had also earlier testified that he had explained this "policy" to the Respondent during

a telephone conversation on June 22 or June 23, 1982. (Tr. 144)(5/6/86) The Patient denied that she had ever had a conversation with the Respondent regarding the report requested by her attorney. (Tr. 17)(5/6/86)

The testimony of Sullivan and Golden as to the events occurring during this and the other visits at issue is of limited probative value to the Board since they were primarily testifying from general recollection and not from specific memory. (Tr. 108, 136, 141)(5/6/86) The Board finds that it strains credibility that the various witnesses, Sullivan included, would recall Sullivan entering the Respondent's office on a particular date. Again, there is no evidence of any contemporaneous notes of these events, although the Respondent claims that he was concerned enough "about a patient doing something or pulling a scam" to have Cook sit in the waiting area. (Tr. 212, 213)(6/3/86) The Board notes here the insufficiency of the Respondent's explanation for his failure to include or involve Golden and Sullivan in his efforts to provide future exculpatory testimony: "I think if I would have told them that I'm concerned about a patient doing something or pulling a scam, then they would have started looking at all the patients I have and become very concerned about each and every one who might have had the remotest contact with Rocco or with Rocco's friends." (Tr. 213)(6/3/86) In any case, establishing whether Sullivan entered the Respondent's office during the Patient's July 6, 1982 visit is not dispositive of

the primary issue of what transpired between the parties during the entire visit.

21. The Patient testified that she spoke with a secretary when she called the Respondent's office to cancel her July 20, 1982 appointment. (Tr. 64)(4/17/86) Contrary to his previous testimony that he could not tell from his records whether an office visit or a telephone conversation had taken place, the Respondent testified that his record reflected a telephone conversation with the Patient on July 19, 1982. (Tr. 178, 190)(6/3/86) The Respondent stated that he and the Patient had discussed narcissism during this telephone conversation. He provided no explanation as to why he had made no notation of any "narcissistic" comments made by the Patient during this discussion in his notes of the conversation in his office records. (Tr. 191)(6/3/86)(Exs. S and 5) The Board notes that the Respondent's billing records for the Patient indicate an $85 charge for July 19, 1982.

22. The Board takes special note and believes it necessary to discuss further the Respondent's failure to record relevant medical information concerning certain "sexualized" or "narcissistic" comments allegedly made by the Patient during various hospitalizations and office visits beginning as early as March of 1982 and continuing through August of 1982. (Tr. 188, 200)(4/3/86)

In his September 25, 1983 letter to the Board, the Respondent stated that he explained to the Patient his

"policy" of requiring the payment of his fee prior to providing a report to her attorney and that "[s]oon afterwards in the office appointments, the patient made a number of very sexualized comments to me which I thought were quite unusual and made me suspect that something was being taped." (Tr. 188)(6/3/86)(Ex. 9) In response to the Board's questions as to the "sexualized comments" reference, the Respondent initially explained that the comments were actually "narcissistic" and "would probably go back to her last hospitalization" or "one of the last two hospitalizations." He later stated that the sexualized comments were made during office visits in June of 1982 and "a number of times from let's say March of 1982." (Tr. 188-191, 200)(6/3/86) Although he described the comments as "unusual for her" and "out of character for her over the almost two years I had been seeing her," the Respondent neglected to document that the Patient had made "sexualized comments" during any of her office visits and had made only one notation in his records of a discussion of "narcissism" during the July 19, 1982 telephone conversation. (Tr. 190)(6/3/86)(Ex. 5)

The Board finds the Respondent's testimony that the "sexualized comments" were "out of character" to be directly contradictory to his representations that nothing "unusual" had occurred during the Patient's office visits in June and July of 1982. (Tr. 192)(6/3/86) The Respondent stated that in his office records, he "tried to make notice of the

patient complaints, any improvement that the patient had and what was going on in the life of the patient if - what the patient was telling me basically." (Tr. 135)(6/3/86) We view the omission of any reference to alleged "sexualized" or "narcissistic" comments in the office records to be significant since the Respondent had been providing psychiatric services to the Patient for approximately two years and if, in fact, the Patient had made such comments, the documentation of same would clearly be highly relevant medical information which should have have been entered in her records and, quite possibly, factored into her diagnosis and treatment plan. The Board does not view his statement "[t]hat the patient made comments about her attractiveness and if I had answered in any way it might have been inappropriate and I thought these were being taped," as any justification for failing to note the occurrence of "unusual" and "out of character" comments or behavior in a patient's records. (Tr. 195)(6/3/86)

23. The Respondent testified that his secretary had called the Patient's home on August 4, 1982 to remind her about her appointment and that he had a brief conversation with FD at that time. (Tr. 184, 186)(6/3/86) The Respondent alternately stated that he did not speak with the Patient during this telephone call, that he did not know if he had spoken to her, and that he had discussed headache patterns with her. (Tr. 184, 186, 187)(6/3/86) He had no memory of his conversation with FD. (Tr. 187, 188, 235)(6/3/86) The

Patient testified that the Respondent's secretary had called her on August 4, 1982 regarding a missed appointment. (Tr. 65)(4/17/86) The Patient later testified that FD spoke to the Respondent on August 4, 1982. (Tr. 54)(5/6/86) FD recalled that during this conversation the Respondent had "essentially" said, "If she doesn't come into the office, this is going to have an effect on her Social Security as well as Workmen's Comp. claim." (Tr. 117, 118)(5/6/86) The Board again notes that the Respondent's billing records for the Patient indicate an $85 charge for August 4, 1982.

Cook provided several inconsistent statements regarding the August 4, 1982 appointment. He initially stated, "I got a call from the doctor saying [the Patient] was not going to be able to come in on that day and I wasn't to show, I didn't have to come in." (Tr. 36)(6/3/86) When later questioned as to whether the Respondent had told him before August 4, 1982 that the Patient was not going to keep that appointment, he stated, "I think -- I really don't remember. I think so, I don't know. I know that he told me that she was coming in on the 4th of August and that I was to sit in like I was sitting in on the other appointments." (Tr. 81)(6/3/86) Cook also stated that the Respondent had told him, "Stay, she'll be in" and that the Respondent "didn't know whether or not that she would show up." (Tr. 81, 82)(6/3/86)

24. The Respondent or one of his secretaries next telephoned the Patient on August 9, 1982. (Tr. 66, 67 (5/6/86); Tr. 214 (6/3/86)) FD stated that he answered the telephone

and spoke with the Respondent and that he listened on a downstairs telephone while the Patient spoke to the Respondent upstairs in her bedroom. (Tr. 118, 119)(5/6/86) The Patient said that when she picked up the telephone, the Respondent's secretary asked her to hold for the Respondent and that she then spoke to the Respondent. (Tr. 66, 67) (4/17/86)

According to the Patient's recollection of this conversation, the Respondent said he was writing a report and that the Patient then told him that she was not coming in to see him anymore because she was being sexually exploited. The Respondent, according to the Patient, agreed with her, said he was sorry and "we got off track," and that he wanted to see her that day. The Respondent then told her he had a patient in the office, that he agreed with her and that he would call her back. (Tr. 76)(4/17/86) FD essentially corroborated the Patient's version of the conversation, also stating that the Patient had said to the Respondent, "you tried -- your forced yourself on me. You exposed yourself continuously. You're always -- all you're looking to do is have sexual relations." (Tr. 119, 120)(5/6/86)

The Respondent testified that he did not specifically remember the August 9, 1982 conversation. He recalled the Patient telling him that she felt sexually exploited by him and that she had made certain comments that "something happened sexually in the office." The Respondent stated that he responded "okay" and that he had patients there and he

would call back. The Respondent did not claim that he denied any of the allegations during this conversation but, rather, that he was "flabbergasted" and that he was "trying to placate her." (Tr. 214-217)(6/3/86) There is no evidence that the Respondent made any contemporaneous office record or notation of this conversation.

The parties' versions of the August 9, 1982 telephone conversation are fundamentally consistent. Their recollections were "refreshed" by a tape of the conversation made on the Patient's answering machine; which tape was not introduced into evidence but was played during the hearing for the purpose of buttressing their memories. The Respondent's explanation of his responses to the Patient's accusations of sexual exploitation was not borne out by a professional analysis of the tape. The Respondent had theorized that the tape of the August 9, 1982 conversation was actually "a number of conversations and answers" on "three different occasions" which were "taped and spliced together, to add up to this tape." (Tr. 216, 240, 245) (6/3/86) The Respondent first postulated that his "therapy off track" comment may have been made to FD, according to Wall's version of the taped conversation which Wall had heard and described to the Respondent, and later, he stated that such a statement "could have been in response to the Boston City Hospital report." (Tr. 239, 244)(6/3/86) The tape analysis arranged for by Attorney Abromovitz and provided to the Board, however, reported "that the tape recording could

be the original recording and that it has not been mechanically or electrically altered." (Ex. 16) (Wall and LaMattina testified that the tape which they had listened to in August of 1982 was a recording of a conversation between the Respondent and a male who, in view of the context of the conversation, they believed was FD. (Tr. 85, 195)(5/6/86) LaMattina said that he didn't remember the whole tape and stated, "I guess the tape really didn't show me too much." (Tr. 188-190 (5/6/86)) LaMattina said that Wall's reaction after hearing the tape was: "that's bad what she has." Wall, however, testified that he "didn't see any real problem in it" and that it "was not an incriminating type of tape." (Tr. 184, 197, 209)(5/6/86) Wall said that the Respondent did not respond to the "sexual exploitation" allegations directly. (Tr. 206)(5/6/86) It is possible that Wall and LaMattina may have heard a tape of either of the conversations between FD and the Respondent on August 4, 1982 or August 9, 1982. (In any event, we further note the irrelevance of the testimony of Wall and LaMattina as to the possibility that the tape of the conversation between the Patient and the Respondent was created by splicing, dubbing or some other mechanical alteration technique, in view of the results of the professional analysis.)

The Board finds it incredible that a physician who had been providing psychiatric care to a patient for at least two years would neglect, at the very least, to note the occurrence of, or, more appropriately, extensively document a

conversation which caused the physician to ask the questions the Respondent claims that he asked himself after the August 9, 1982 conversation; such questions as: "[W]hat's going on in the patient's mind? Is it an overdose? Has there been some psychiatric problem that I don't know about? Is this hysteria?" (Tr. 217)(6/3/86) Although the Respondent testified that he thought that the Patient was now "acutely psychotic" and possibly "very sick," he made no meaningful effort to get her help, he made no notes of these concerns in the Patient's records, and he made no record of the existence and substance of this telephone conversation for future use and reference in the event of the alleged suspected subsequent dispute between the parties. (Tr. 237-239) (6/3/86) He also contradictorily explained to the Hearing Officer that he had continued to see the Patient because "[t]he reports still seemed to be good." (Tr. 247) (6/3/86) We certainly cannot believe his alleged speculation that she had overdosed or was acutely psychotic, in light of his explanation of why he had made no record of this conversation: "Wall had heard the conversation and Wall said that, in talking to the son, that there was nothing incriminating that he had heard. So I just had gone - I had not made a record, and I fell back on Wall's reassurance that he had heard these tapes." (Tr. 235)(6/3/86)

25. The Respondent testified that he called the Patient back later in the day on August 9, 1982 "out of concern, on the is she psychotic basis" and spoke with FD. (Tr. 240)(6/3/86)

The Respondent stated that FD said that the Patient had told FD about the "sexual problems in the office" and that there was a discussion to the effect that "something's gone off track, something has to be done with your mother, she needs to see either myself in the office or with somebody or to go see somebody else." The Respondent said he thought the Patient was psychotic at that point and that he "believed" he "denied to the son that anything had happened." He said FD told him, "Don't bother us and we won't bother you." (Tr. 236, 237)(6/3/86) When asked by the Hearing Officer if he was "content to leave it at that," the Respondent said, "I think that's all I could do." (Tr. 238)(6/3/86) FD stated that after he told the Respondent that "[t]here's no way she's coming back into the office," the Respondent said, "If she doesn't come back to this office her claim is going to suffer. She's going to have a problem with the Labor Board and with Social Security. I'm going to strongly advise that she return." (Tr. 120, 121)(5/6/86)

26. As briefly noted above, the resolution of the material factual issues present in this case necessitates that the Board make several important credibility determinations as to the Patient, the Respondent, their witnesses and the respective testimony given and various theories offered by each party.

As part of our credibility evaluation of the Patient's testimony, we discount the Respondent's theory that she had perpetrated a "scam" to "get even" with him. The primary

sources of testimony as to the existence of a "scam" were LaMattina and the Respondent. The Board places little probative value on the testimony of LaMattina, who was described by another witness for the Respondent (Nancy Mann) as being "kind of flakey," having "grandiose ideas" and who allegedly had spoken about how he "was going to conquer the world" on several occasions. (Tr. 102)(6/3/86) There was little consistency in the testimony of those witnesses whom LaMattina claimed to have met with or spoken to regarding the Patient's alleged scheme. LaMattina also failed to proffer any valid explanation or substantiate any motive for the Patient's statement that she was going to "get even" with the Respondent. (Tr. 180)(5/6/86) According to LaMattina, the Patient "was having some troubles with checks, and I was having troubles too. They stopped my disability and we were both bitching about Dr. Friedman, and we were both cussing him up and down." (Tr. 179)(5/6/86) His explanation for the "cussing" was the following: "I guess I was blaming him, and I guess she was doing the same thing, too. We were both bad-mouthing him, cutting him up and down." (Tr. 179, 180) (5/6/86) The record, however, does not indicate that the Patient's benefits had ever been terminated or that she blamed the Respondent for any of the possibly negative recommendations of the BCH evaluation. The Board finds LaMattina's allegations that the Patient plotted a "scam" to be unreliably vague and unsubstantiated.

The Respondent similarly failed to adequately support

any of his claims of his various alleged suspicions as to the Patient's performance of or involvement in a blackmail scheme or her motive or motives therefor. As detailed above, the Respondent made several contradictory, or at the least, alternate, statements as to the dates of and reasons for his alleged suspicions. The Respondent at different times stated that he had a suspicion in May of 1982 (Tr. 200)(6/3/86); that the Patient held up her pocketbook "which could have held a tape recorder" in May or June of 1982 (Tr. 212) (6/3/86); that her "sexualized" comments began in June of 1982 after he explained to her his "policy" of not providing reports prior to receiving his fee (Ex. 9); and that he "knew" he was involved in a scam when he spoke with Cook after the August 9, 1982 telephone conversation. (Tr. 242) (6/3/86)

Our skepticism as to the Respondent's claims that he suspected a conspiracy at any time is reinforced by his failure to make any notation or speak with anyone, except for Cook, if, in fact, he did speak to Cook, regarding his suspicions. As to the Patient's motive or motives for concocting and executing a "get even" scheme, the Respondent essentially dismissed his own theory as set forth in his June 25, 1983 response to the Board (Ex. 9) and his testimony; that his explanation of his "policy" of refusing to provide the report requested by her attorney in June of 1982 prior to receiving his $150 fee for such information was the catalyst prompting the "sexualized" comments which the

Patient began to make "[s]oon afterwards in her office visits," by his admissions that, "in retrospect," the comments he was referring to as "sexualized" were actually "narcissistic" and were first made in March of 1982. (Tr. 191, 200)(6/3/86) The Respondent did not claim that the Patient viewed him as responsible for any of the allegedly negative aspects of the BCH evaluation. The Patient was aware that the BCH report recommended the transferral of her psychiatric care to a university based, board certified and experienced psychiatrist. (Tr. 63)(5/6/86)(Fx. C) The Respondent also stated that the Patient was not dependent on reports from him for any of her benefits. (Tr. 23)(6/3/86) He later did admit, however, that he may have referred to the "usual reports" during the August 9, 1982 telephone conversation. (Tr. 242)(6/3/86) No other plausible motive or reason for the Patient to "get even" with the Respondent was developed by the Respondent or any of his witnesses.

Further detracting from the credibility of his claims that he suspected a scam, the Respondent's reactions to his alleged belief that he was being "set up" by the Patient were extremely illogical behavior which did not comport with his representations that he suspected such a plan. If he, in fact, was convinced that he was the target of a scheme, it is highly unlikely that he would have responded in the manner that he claims he did. First, we note our surprise that the Respondent did not contact LaMattina to verify the various reports that had reputedly originated with him and been

communicated to the Respondent by several of the witnesses. Secondly, as mentioned above, continuing to provide treatment and schedule office visits with the Patient after allegedly suspecting a blackmail plot was inconsistent with accepted standards in the context of a physician/patient relationship and never sufficiently justified or explained by the Respondent during the hearing. A substantial suspicion that a patient is orchestrating a scam indicates that the professional relationship between the physician and the patient has deteriorated to the point of dissolution. We view his behavior of continuing to see and provide treatment to the Patient after he suspected her perpetration of a scam, prompting his claim of arranging for Cook to sit outside his office, as most peculiar. Such a suspicion is a clear signal that the core and most integral element of the physician/patient relationship, the trust between the parties, is no longer present. The destruction of the foundation of the relationship prevents a physican from providing the quality care that is necessary for a patient's rehabilitation and well-being and would generally require the termination of the physician/patient relationship by the physician. The Respondent could not have reasonably believed that his behavior in continuing to invite the Patient to his office for treatment would be above reproach.

After considering all of the Respondent's various actions in response to his claimed suspicions of a "careful plot in conspiracy to blackmail" him (Ex. 9); specifically,

his failure to inform his secretaries of such suspicions or involve them in his alleged scheme with Cook, his arrangement for a "one hundred percent disabled" patient to monitor the Patient's visits, Cook's neglect to record any information or observations regarding the Visits, and, most importantly, the inexplicable absence of any notes, records or other documentation by the Respondent as to his suspicions and actions in response thereto, his conversations with Cook, and the events surrounding and occurring during the Visits in general, the Board is far from convinced that Cook was present in the office during any or all of the Visits and/or that the Respondent ever had any suspicions of a scam. As to the Patient's capacity or inclination to plan and execute an extortion scheme, we note that neither the Respondent nor any of the other various physicians who also treated the Patient during the period in question at any time ever diagnosed the Patient as being psychotic, hallucinatory, delusional or schizophrenic. (Tr. 205, 206)(6/3/86) We find it appropriate here to acknowledge the similarity between the pattern of behavior that would likely be exhibited in a situation where sexual exploitation is involved and a situation where a "set up" is being conducted. A preponderance of the evidence presented herein, however, especially the consistent recollections of the Patient and the Respondent that the August 9, 1982 telephone conversation discussed "sexual exploitation," supports the inference that sexual exploitation was more likely the activity taking place in the

a finding that the Respondent had sexual intercourse with the Patient against her will during the July 6, 1982 office visit. There was insufficient evidence that the Respondent acted with the degree of violence claimed by the Patient, and we ascribe her testimony on this point to her apparent humiliation and her need for a face-saving version of the events. We make these observations only as background, however, to our finding that a preponderance of the evidence, specifically, the parties' consistent recollections of the August 9, 1982 telephone conversation, does indicate that some form of sexual activity did take place during one or more of the Visits. We emphasize the fact that the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, as cited and discussed below, does not incorporate any reference to or requirement that either violence or resistance be factored into a determination of the propriety of sexual activity in a physician/patient relationship. Without exception for any qualifying conditions or special circumstances, the Principles state: "Sexual activity with a patient is unethical." (See below Section IV, Paragragh E)

IV. Conclusions of Law

A. The Board is charged with the duty to determine when a

physician's actions* in the course of his medical practice depart from good and accepted medical practice constituting "gross misconduct in the practice of medicine" within the meaning of M.G.L. ch. 112, sections 5(c) and 61 and 243 CMR 1.03 (5)(a)(3). Ryan v. Board of Registration in Medicine, No. 82-1 (Supreme Judicial Court, August 13, 1982) (Memorandum of Decision)(citing Levy v. Board of Registration and Discipline in Medicine, 378 Mass. 519, 524-525 (1979)), aff'd, 388 Mass. 1013 (1983) (Rescript); In the Matter of Ivor S. Smith, M.D., Case No. 679 (Board of Registration in Medicine, December 13, 1985) (Final Order).

B. It has been established that "gross misconduct in the practice of medicine is not too indefinite as a ground for discipline of a registered physician." Lawrence v. Board of Registration in Medicine, 239 Mass. 424, 428-30 (1921); See Forziati v. Board of Registration in Medicine, 333 Mass. 125 (1955).

C. The relationship between a physician and his or her patient is necessarily based on trust and confidence. **

---

* The Supreme Judical Court of Massachusetts has held that the relevant actions include "all conduct of the practitioner in carrying on his professional activities" and are not limited to the diagnosis and treatment of the patient. Forziati v. Board of Registration in Medicine, 333 Mass. 125 (1955).

** "The Psychiatrist's loyalty to the needs of the patient will permit no selfish interest of his own to divert him from the patient's psychiatric needs. . . . The trust upon which successful treatment rests comes from this loyalty." Donald J. Davidson, The Malpractice of Psychiatrists, pp. 43, 44 (1972)

D. A physician in his dealings with patients occupies a position of trust and confidence, requiring that the physician confine himself/herself to a professional role and maintain a professional objectivity and distance from his/her patients. The physician should take all reasonable steps to avoid crossing the boundaries separating acceptable professional conduct and unacceptable personal relations. In the Matter of Harold J. Kosasky, M.D., Case No. 10071 (Board of Registration in Medicine, March 4, 1987) (Final Decision and Order); In the Matter of Rodolph Turcotte, M.D., Case No. 85-21-DE (Board of Registration in Medicine, November 19, 1986) (Final Decision and Order).

E. "It is a recognized principle of administrative law that an agency may adopt policies through adjudication as well as through rule making." Arthurs v. Board of Registration in Medicine, 383 Mass. 299, 418 N.E.2d 1236, 1246 (1981). The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (published by the American Psychiatric Association), cited in the Turcotte decision, states minimal standards for ethical behavior for psychiatrists. As we declared in Turcotte, departure from these Principles is evidence that the Respondent departed from good and accepted standards in the practice of medicine and can therefore be considered as grounds for a finding of "gross misconduct in the practice of medicine."