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