IN THE MATTER OF	*	**BEFORE THE MARYLAND**
GERALD H. FINK, M.D.,	*	**STATE BOARD OF PHYSICIAN**
Respondent.	*	**QUALITY ASSURANCE**
License Number: D 02125	*	**Case Number: 98-0019**

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FINAL ORDER

PROCEDURAL HISTORY

On August 18,1999, the Maryland State Board of Physician Quality Assurance (the "Board") issued charges against the Respondent, Gerald H. Fink, M.D. ("Dr. Fink"), a physician specializing in the practice of psychiatry, for violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("HO"), §§ 14-401 et seq. (Supp. 1999). Specifically, the Board's charges were issued against Dr. Fink for: (1) rendering substandard medical care to one of his patients;[1] and (2) for engaging in immoral or unprofessional conduct in the practice of medicine, in violation of HO §§ 14-404(a)(3) and (22). These statutes provide as follows:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of immoral or unprofessional conduct in the practice of medicine;

[1]For purposes of confidentiality, the name of this patient will not be identified by name, but will be referred to as Patient A throughout this Final Order.

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State.

The basis for the Board's issuance of these charges was a complaint filed with the Board by Patient A against Dr. Fink. This complaint alleged excessive appointments, excessive charges, and violation of trust during the course of psychiatric treatment that Dr. Fink provided to Patient A from about January 1996 to September 1996. The Board referred Patient A's complaint to the Peer Review Management Committee (the "PRMC") of the Medical and Chirurgical Faculty of Maryland, the state medical society. The PRMC referred this investigation to the Suburban Psychiatric Society Peer Review Committee (the "Committee"). This Committee found that Dr. Fink breached the standard of care and engaged in unprofessional conduct in the course of providing psychiatric treatment to Patient A.

These charges ultimately led to an evidentiary hearing held on November 3, 4, 1999, and February 16, and May 17, 18, 2000 at the Office of Administrative Hearings before Linda Golden, Administrative Law Judge ("ALJ"), pursuant to Md. Code Ann., HO § 14-405(a).[2] On November 3, 2000, Administrative Law Judge Laurie Bennett issued a Proposed Decision upholding the charges issued by the Board, specifically finding that Dr. Fink violated the standard of care and engaged in unprofessional conduct in the practice of medicine under HO §§ 14-404 (a)(3) and (22). The ALJ's Proposed Decision

[2] The hearing record closed on May 18, 2000, and a Proposed Decision was to have been issued by August 16, 2000. ALJ Linda Golden, however, resigned from the Office of Administrative Hearings effective July 31, 2000. By agreement of the parties, this case was assigned to ALJ Laurie Bennett to issue a Proposed Decision based on her review of the existing record.

recommended a sanction of a ninety-day suspension, to be stayed pending the satisfactory completion of a one-year probationary period; peer reviews conducted at the Board's discretion, and supervision of his medical practice during the probationary period; and a $10,000.00 fine.

Dr. Fink filed with the Board written Exceptions to the Administrative Law Judge's Proposed Decision. The State filed with the Board a written Response to Dr. Fink's Exceptions. An Exceptions Hearing was held before the Board on January 24, 2001.

After considering the entire record in this case, including the record made before the Administrative Law Judge at the November 1999, February and May 2000 evidentiary hearing, the written Exceptions and Response filed by both parties, and the hearing held before the Board on these Exceptions, the Board issues this Final Order.

FINDINGS OF FACT

The Board adopts the Administrative Law Judge's Findings of Fact numbers 2-38 as set forth in the Administrative Law Judges's November 3, 2000 Proposed Decision. (The Administrative Law Judge's Proposed Decision is incorporated by reference into this Final Order and is appended to this Final Order as Attachment A.) The Board does not adopt the ALJ's Finding of Fact #1 because, as Dr. Fink correctly points out in his written Exceptions submitted to the Board, the date that Dr. Fink was initially licensed by the Board is November 10, 1961, not September 17, 1969. The Board thus modifies the ALJ's Finding of Fact #1 accordingly. The Board finds all of these facts by clear and convincing evidence.

The Board has considered Dr. Fink's other exceptions to the ALJ's Proposed Decision. Dr. Fink's other exceptions are in essence arguments that the ALJ made erroneous conclusions, and should have emphasized certain facts in the Proposed Decision. The Board, however, using its expertise, has reviewed the entire record and evaluated the evidence in this case and agrees with the ALJ's findings of fact and conclusions of law (with the exception of Finding of Fact #1 as noted above).

In sum, Dr. Fink violated the standard of care and engaged in unprofessional conduct in the treatment he rendered to Patient A. He violated the standard of care by failing to maintain a pre-set schedule of appointments, by routinely extending treatment sessions without adequate cause or notice, and by negotiating the amount of his fees during sessions – all with a patient whom Dr. Fink was treating for a borderline personality disorder and for whom such actions were particularly psychiatrically detrimental. Dr. Fink's failure to maintain a pre-set schedule of appointments for Patient A, the routine extension of treatment sessions without adequate cause or notice, and the negotiation of the amount of his fees during sessions with this borderline patient also constituted unprofessional conduct in the practice of medicine.[3]

CONCLUSIONS OF LAW

Based on the foregoing facts, the Board concludes as a matter of law that Dr. Fink committed prohibited acts under the Maryland Medical Practice Act. Specifically, the Board

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3 The ALJ was unclear as to which of Dr. Fink's actions constituted unprofessional conduct. The Board concludes that Dr. Fink engaged in unprofessional conduct in the practice of medicine by negotiating extended treatment sessions and the fees for those sessions on an impromptu basis during the treatment sessions themselves. (*See* Transcript of hearing before the ALJ at pp. 68-69.) This abuse of the psychiatrist's power inherent in the psychiatrist-patient relationship, especially with a patient with borderline personality disorder, was unethical and unprofessional.

concludes that Dr. Fink violated Md. Code Ann., Health Occupations (HO) § 14-404 (a) (22) of the Act because he breached the standard of care clinically by pursuing a treatment program that was highly idiosyncratic and dangerous to the patient. The Board also concludes that Dr. Fink violated HO § 14-404(a)(3) because he committed ethical violations by negotiating extended treatment sessions and the fees for those sessions in the midst of psychiatric treatment sessions.

SANCTION

The ALJ proposed that Dr. Fink's be suspended for ninety (90) days and that the suspension be stayed pending the satisfactory completion of a one-year probationary period. In addition, the ALJ proposed that Dr. Fink be subject to peer reviews and supervision during the probationary period and that a $10,000 fine be imposed. The Board will not impose a stayed suspension on Dr. Fink's license. Rather, the Board will impose a Reprimand and a longer probationary period subject to the conditions proposed by the ALJ. The Board will impose an additional requirement that Dr. Fink complete a medical ethics course. The Board will not impose a fine.

For Dr. Fink's violation of HO § 14-404 (a)(22) by failing to meet the standard of care, the Board will impose the following sanctions/remedial requirements: (1) supervision by a Board-certified psychiatrist for three full years of the probationary period; (2) peer reviews at the Board's discretion and as further ordered below for the same three-year probationary period; and (3) successful completion of a course in medical ethics. For Dr. Fink's violation of HO § 14-404 (a)(3) by committing unprofessional conduct in the practice of medicine, the Board imposes a requirement of successful completion of a course in

medical ethics. The Board is requiring a medical ethics course as a sanction for violating HO § 14-404 (a)(22) and is imposing the same requirement for violating HO § 14-404 (a)(3); however, Dr. Fink need successfully complete only one medical ethics course to comply with this Final Order.

ORDER

Based on the foregoing, it is this 4th day of April 2001, by a majority of the full authorized membership of the Board,

ORDERED that the charges filed against Gerald H. Fink, M.D. License Number D02125. be **UPHELD** as to both HO § 14-404(a)(3) and HO § 14-404(a)(22): and be it further

ORDERED that Gerald H. Fink, M.D., be **REPRIMANDED**; and be it further

ORDERED that Gerald H. Fink , M.D. shall be placed on **PROBATION** immediately and that the period of probation continue for no less than a period of **THREE (3) YEARS** from the date that the Board-approved supervisory arrangement begins according to the terms and conditions set forth in paragraph (1) below; and be it further

ORDERED that the **PROBATIONARY PERIOD** shall be subject to the following terms and conditions:

(1) Dr. Fink's entire medical practice shall be subject to supervision for a continuous period of three (3) years by a Board-approved physician who is Board-certified in psychiatry. Within forty-five(45) days of the date of this Final Order, Dr. Fink must submit the name of a proposed monitor/supervisor ("supervisor") to the Board. Dr. Fink must obtain prior Board approval of the physician who will serve as his supervisor before the monitoring/supervision begins. If the Board rejects a proposed supervisor, Dr. Fink must submit the name of another proposed supervisor within thirty(30) days. The supervision/monitoring of Dr. Fink's medical

practice shall continue uninterrupted for a three-year period. Dr. Fink shall meet with the Board-approved supervisor at least once per month during the three-year probationary period. Dr. Fink shall be responsible for ensuring that the supervisor submits quarterly written reports to the Board detailing his review and assessment of Dr. Fink's psychiatric care and medical practices in general. Dr. Fink shall cooperate at all times with the supervisor and the Board's monitoring role of the supervisory arrangement;

-and-

(2) Dr. Fink shall successfully complete a course in medical ethics. Prior to enrolling in this required ethics course, Dr. Fink shall submit to the Board, within 60 days of the date of this Final Order, written documentation regarding the particular course he proposes as fulfillment of this condition. The Board reserves the right to require Dr. Fink to provide further information regarding the course he proposes, and further reserves the right to reject Dr. Fink's proposed course and require submission of an alternative proposal. If the Board rejects a proposed course, Dr. Fink must submit another proposed course within 60 days of the date of the Board's rejection. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to fulfill the need. Dr. Fink shall also be responsible for all costs incurred in fulfilling this course requirement and for submitting written documentation to the Board of his successful completion of this course.

and be it further:

ORDERED that Dr. Fink shall undergo a peer review of his medical practice, or a chart review by a Board designee, one year after the date that the three-year supervisory period begins, after which the Board may require performance of additional peer or chart reviews conducted at the Board's discretion. Dr. Fink shall cooperate at all times with the Board's peer review monitoring role; and be it further

ORDERED that if the peer reviews and the supervisory reports are satisfactory to the Board, and if there are no pending complaints against Dr. Fink, probation may be lifted at the end of the three-year period set out in condition (1) above; and be it further

ORDERED that there shall be no early termination of the probationary period; and be it further

ORDERED that Dr. Fink shall practice medicine within the standard of care; and be it further

ORDERED that if Dr. Fink fails to comply with any of the terms of this Final Order, the Board, after notice and hearing and a determination of violation, may impose any other disciplinary sanctions it deems appropriate, said violation of this Final Order being proved by a preponderance of evidence; and be it further

ORDERED that Dr. Fink shall be responsible for all costs necessary to comply with this Final Order; and be it further

ORDERED that this is a Final Order of the Maryland State Board of Physician Quality Assurance, and, as such, is a **PUBLIC DOCUMENT** pursuant to the Maryland State Gov't Code Ann., §§ 10-611 et seq.

4/4/01
Date

C. Irving Pinder, Jr.
Executive Director
Maryland State Board of Physician Quality Assurance

NOTICE OF RIGHT TO APPEAL

Pursuant to Maryland Health Occupations Code Ann., § 14-408, Respondent has the right to take a direct judicial appeal. Any appeal shall be made as provided for judicial review of a final decision in the Administrative Procedure Act, State Government Article and Title 7, Chapter 200 of the Maryland Rules of Procedure.

STATE BOARD OF PHYSICIAN	*	BEFORE AN LAURIE BENNETT,
QUALITY ASSURANCE	*	ADMINISTRATIVE LAW JUDGE
V.	*	OF THE MARYLAND OFFICE
GERALD H. FINK, M.D.	*	OF ADMINISTRATIVE HEARINGS
License No.: D02125	*	CASE NO.: DHMH-BPQA-71-200000232

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUE
SUMMARY OF THE EVIDENCE
FINDINGS OF FACT
DISCUSSION
CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On August 18, 1999, the Maryland State Board of Physician Quality Assurance ("Board") issued charges against Gerald H. Fink, M.D. ("Respondent") for clinically and ethically breaching the standard of care in his psychiatric treatment of his patient in violation of the Medical Practice Act. Md. Code Ann., Health Occ. §14-404(a)(3), (22) (1994 and Supp. 1999).[1]

An evidentiary hearing was held on November 3, 4,1999, February 16, and May 17, 18, 2000 at the Office of the Administrative Hearings ("OAH"), 11101 Gilroy Road, Hunt Valley, Maryland, before Linda Golden, Administrative Law Judge ("ALJ"). Md. Code Ann., Health Occ. §14-405(a) (Supp. 1999). The Respondent was present and was represented by Natasha S. Wesker, Esquire. Jean Baron, Assistant Attorney General for DHMH, represented the Board.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules of Procedure of the Board of Physicians Quality Assurance, and the

APPENDIX A

Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (1999); Code of Maryland Regulations ("COMAR") 10.32.02; COMAR 28.02.01.

The hearing record closed on May 18, 2000, and a Proposed Decision was to have been issued by August 16, 2000. ALJ Golden, however, resigned from the OAH effective July 31, 2000. By agreement of the parties the case was assigned to ALJ Laurie Bennett to issue a decision based on review of the existing record.

ISSUE

The issue in this case is whether the Respondent clinically and ethically breached the standard of care in his psychiatric treatment of his patient in violation of § 14-404(a) (3), (22).

SUMMARY OF THE EVIDENCE

Exhibits

The Board submitted the following exhibits that were admitted into evidence:

Bd. Ex. 1 - Curriculum Vitae for William J. Polk, M.D.

Bd. Ex. 3 - Peer Review Report, dated December 15, 1998.

Bd. Ex. 4 - Statement of Charges, dated August 18, 1999

Bd. Ex. 5 - Complaint Form completed by the Patient, dated June 10, 1997.

Bd. Ex. 6A - Handwritten letter to Carol from the Patient, dated February 1, 1998.

Bd. Ex. 6B - Photocopy of check # 1141 paid to the Respondent, dated July 3, 1996.

Bd. Ex. 7 - Handwritten billing record for the Patient for period February 8, 1996 through October 1, 1996.

Bd. Ex. 8 - Respondent's response to complaint of the Patient, dated August 12, 1997.

Bd. Ex. 9 - Principles of Ethics

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[1] Unless otherwise provided, all statutory citations are to the Health Occupations article.

Bd. Ex. 10 - Photocopies of front page of January 1989 Psychiatric Annals, and table of contents for January 1989 and March 1989.

Bd. Ex. 11 - Holy Cross Hospital Discharge Summary for the Patient, dated April 21, 1994.

Bd. Ex. 12 - Bill for professional services rendered to Respondent by Dr. Goodrich, dated December 1, 1999.

Bd. Ex. 13 - Letter to Respondent from Dr. Goodrich, dated February 3, 2000.

Bd. Ex. 14 - Time Log – Forensic Work for Respondent by Dr. Goodrich, for period July 19, 1999 through November 4, 1999.

Bd. Ex. 15 - Memorandum from Respondent to Dr. Polk, re: the Patient dated November 20, 1998.

Bd. Ex. 16 - Clinical History for the Patient, dated August 12, 1997, sent to Harold Rose, BPQA from Respondent.

Bd. Ex. 18 - Blowup of Handwritten Billing Record for the Patient for period February 8, 1996 through October 1, 1996. (Same as Bd. Ex. 7) This exhibit was missing from the records forwarded to the OAH by ALJ Golden in August 2000.

The Respondent submitted the following exhibits that were admitted into evidence:

Resp. Ex. 1 - Typed Billing Record for the Patient for period February 8, 1996 through October 1, 1996. (Same as Bd. Ex. 7)

Resp. Ex. 2 - Chart – Instances of Separation I Can Remember, dated May 9, 1996.

Resp. Ex. 4 - Curriculum Vitae for Michael H. Stone, M.D.

Resp. Ex. 5 - DSM-4 Criteria for Borderline Personality Disorder

Resp. Ex. 6 - Respondent's typed notes of the Patient's sessions, beginning February 8, 1996.

Resp. Ex. 7 - Respondent's hand-written notes of the Patient's sessions, beginning February 8, 1996.

Resp. Ex. 8 - Two-page compilation prepared by Dr. Stone from Respondent's notes, listing the Patient's mentions of suicide and self-destructive behavior.

Resp. Ex. 9 - Curriculum Vitae of Donald Wells Goodrich, M.D.

Resp. Ex. 10 - Memorandum from Dr. Goodrich to To Whom It May Concern, dated October 8, 1999.

Resp. Ex. 11 - Curriculum Vitae for Gerald H. Fink, M.D.

Resp. Ex. 12 - Blow up of excerpt from DSM-4 Criteria for Borderline Personality Disorder. (same as Resp. Ex. 5) This exhibit was missing from the records forwarded to the OAH by ALJ Golden in August 2000.

Testimony

The following witnesses testified on behalf of the Board: William J. Polk, M.D., who testified as an expert in medicine with a specialty in psychiatry; and the Patient.

The Respondent testified on his own behalf and presented the following witnesses: Michael H. Stone, M.D., who testified as an expert in psychiatry and borderline personality disorder; and Donald Wells Goodrich, M.D., who testified as an expert in psychiatry.

FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by clear and convincing evidence:

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland specializing in psychiatry. He maintained a private practice at 220 Farmgate Lane, Silver Spring, Maryland. The Respondent has been licensed to practice medicine in Maryland since on or about August 6, 1969.
2. The Patient sought treatment from the Respondent in February 1996. She was experiencing anxiety, she was not able to sleep or eat, and she was not able stay focused on her work because of her personal problems.
3. Prior to treatment with the Respondent, the Patient was in therapy with [redacted], a social worker.

4. The Respondent initially diagnosed the Patient as having major depression. He later treated her for a borderline personality disorder.

5. A borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:

   a. frantic efforts to avoid real or imagined abandonment

   b. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

   c. identity disturbance: markedly and persistently unstable self-image or sense of self

   d. impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)

   e. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

   f. affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

   g. chronic feelings of emptiness

   h. inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)

   i. transient, stress-related paranoid ideation or severe dissociative symptoms

Respondent Ex. 5.

6. People with borderline personality disorder are very intense and flamboyant emotionally. They are sometimes overwhelmed, even swamped by their feelings, which makes them unable to exhibit consistent behavior. These patients are aggravating to treat and treatment sessions are frequently very intense and highly emotional.

7. There are 3 different types of treatment for individuals with borderline personality disorder: insight and supportive psychotherapy, pharmacotherapy, psychoanalysis. The Respondent used psychotherapy and pharmacotherapy to treat the Patient.

8. Psychotherapy involves the patient and therapist meeting to discuss the patient's problems. The therapist helps the patient sort out and make sense of what is happening in the patient's life and how the patient is reacting to other people. Supportive psychotherapy, as the name implies, means the therapist is supportive, encouraging, sympathetic, and educative of the patient. Insight psychotherapy, as the name also implies, is when the therapist tries to make the patient aware of the patient's motivations.

9. Pharmacotherapy means treatment with medications.

10. During their first visit, the Respondent told the Patient that his fee was $150 per session. A standard session was 45 minutes.[2] The Respondent was not a provider under the Patient's health insurance, and the Patient, therefore, agreed to pay him privately.

11. One of the hallmarks of treating a patient with borderline personality disorder is to impose structure, including a pre-set schedule of treatment sessions lasting a pre-determined length of time.

12. A standard 45-minute session may be extended in advance of the session if the patient is in crisis. A session may be extended during the session, in rare instances where the patient is acutely suicidal or the therapist cannot assess the patient's risk of suicide. In either event, the

[2]The Respondent testified that he prorated his fee for fractions of a 45 minute session. His testimony conflicts with his written statement to the Board, which states, "My standard charges for my professional time are $150.00 per 45 minutes or fraction thereof." Board Exhibit 8. Because the Respondent's charges to The Patient were erratic and not based on his standard fee, whether or not he prorated, it is not necessary to decide which billing practice he actually employed. That said, his inconsistent statements call into question his credibility. Additionally, the Respondent also noted in his letter to the Board that although it was he who wanted to negotiate realistic fees with her, it was The Patient "who insisted on paying [his] full fee at the end of each session. Board Exhibit 8. The Respondent's written statement is inconsistent with his own records. In fact, the Patient did not frequently pay his full fee.

session must be extended for a predetermined period of time. Extending a session for an undetermined period of time prevents a private pay patient from calculating the total fee and making an informed decision about whether she wishes to participate in an extended session and can afford the extended session.

13. The standard of care requires that a patient be informed of the physician's cost in advance of the session. It violates the standard of care to negotiate a fee during the session, especially when the patient is in crisis, even if the fee is ultimately reduced from the standard fee.

14. The Patient did not have a set schedule of appointments with the Respondent. For instance, she did not have a standing appointment on Tuesdays and Thursdays at 1:00. The Respondent and the Patient scheduled the next appointment at the conclusion of one appointment

15. The Respondent had 54 sessions with the Patient. Although each of these sessions was scheduled to last only the standard 45 minutes, only 6 of them, or 11%, did.

16. At or near the end of a standard session, if the Respondent believed the Patient was in crisis, he would recommend an extended session. He did not recommend that the session be extended for a specific period of time. Rather, the session would continue until either the Patient or the Respondent decided it should end. The Respondent sometimes scheduled the Patient's appointments before a break in his schedule, so that a session could be extended, if necessary.

17. At the end of an extended session, the Patient frequently expressed concern about the fee. The Respondent and the Patient would negotiate the fee, and the Respondent would sometimes reduce it. For instance:

a. On July 17, 1996, the Respondent saw the Patient for 3 hours, or 180 minutes, which is the equivalent of four 45-minute sessions. At a standard rate of $150.00 per session, the Respondent's fee should have been $600.00. The Respondent charged the Patient $300.00.

b. On May 7, 1996, the Respondent saw the Patient for 1 hour and 50 minutes, or 110 minutes, which is the equivalent of over two 45-minute sessions. Whether the excess of two 45-minute sessions was prorated or charged as a full session, the Respondent's fee should have been greater than $300.00. The Respondent charged the Patient $150.00.

c. On May 9, 1996, the Respondent saw the Patient for 1 hour and 15 minutes, or 75 minutes. Whether the excess of 45 minutes was prorated or charged as a full session, the Respondent's fee should have been greater than $150.00. The Respondent charged the Patient $150.00.

d. On April 15, 1996, the Respondent saw the Patient for 3 hours and 45 minutes, or 225 minutes, which is the equivalent 5 sessions. The Respondent's fee should have been $750.00, but he charged the Patient $700.00.

18. Because the Respondent did not always reduce his fee, he sometimes charged the Patient varying amounts for the same period of time. For instance, the Patient had 3-hour sessions each on February 16, July 17 and August 30, 1996. The Respondent charged her $600.00, $300.00 and 400.00 respectively.

19. The Respondent sometimes charged the Patient the same amount for varying lengths of a session. For instance, the Respondent charged the Patient $150.00 for each the following sessions:

a. May 7, 1996 — 1 hour 50 minutes

b. May 9, 1996 — 1 hour 15 minutes

c. May 13, 1996 — 1 hour 25 minutes

d. May 18, 1996 — 1 hour 30 minutes

e. May 28, 1996 — 1 hour

f. September 4, 1996 — 1 hour 30 minutes

g. September 10, 1996 — 1 hour

20. The Respondent frequently extended sessions during the session when the Patient was not suicidal and the Respondent could assess her risk or suicidality. For example,

a. On February 9, 1996, the Respondent had a 3-hour session with the Patient. They discussed the Patient's relationships with men, including how to deal with [redacted], her married boyfriend. The Patient was not suicidal and any risk of suicidality could have been assessed by the Respondent without difficulty.

b. On February 12, 1996, the Respondent had a 2-½ hour session with the Patient. They discussed how the Patient has never felt desirable, her family history, having confronted [redacted] the day before, a prior bad relationship, and her inability to trust her own instincts. In his session notes, which were written contemporaneously with the session, the Respondent described the Patient as "looking better groomed and appear[ing] in a better mood." The Patient was not suicidal and any risk of suicidality could have been assessed by the Respondent without difficulty.

c. On February 14, 1996, the Respondent had a 3 ¼ hour session with the Patient. They discussed [redacted], her need for affirmation, her feelings of lack of desirability, and her

anxiety about seeing [redacted] wife. The Patient was not suicidal and any risk of suicidality could have been assessed by the Respondent without difficulty.

d. On February 16, 1996, the Respondent had a 3-hour session with the Patient. They discussed [redacted], her childhood and her half-brother. The Patient was not suicidal and any risk of suicidality could have been assessed by the Respondent without difficulty.

21. The Patient reported to the Board that her sessions with the Respondent were as long as 5 and 7 hours. The longest session was actually 3¾ hours.

22. While she was in treatment with the Respondent, the Patient was involved in a relationship with [redacted], a married man. The Patient desperately wanted [redacted] to leave his wife and marry her, which he refused to do. The Patient was happy when she became pregnant by [redacted] because she thought it would prompt him to leave his wife. [redacted] was not pleased, though, and insisted that she either have an abortion or give the baby up for adoption. When a sonogram revealed that there was no fetal heartbeat, the Patient's doctor concluded the fetus was not viable and the Patient had a D & C to remove the placenta. Nonetheless, The Patient told [redacted] she had an abortion. She told him that so he would think she carried out his wishes, which she hoped would increase his feelings for her.

23. After the Charges were issued in this case, the Patient reported to the Board that sometime after she started treatment with the Respondent, he hugged her in a way that their genitals touched at the end of every session.

24. The Respondent never initiated hugging the Patient. The Patient, however, initiated hugging him twice. The first occasion occurred at the end of a session where they discussed the Patient's mother's cancer diagnosis. The Patient put her arms around him, and he put his arm around her and patted her on the back. The hug lasted only a few seconds. The second time

was just after the Patient learned that her fetus was no longer viable. The Patient was devastated by the news and at the end of the session, she put her arms around the Respondent, and he put his arm around her and patted her on the back.

25. The Respondent did not hug the patient for the purpose of sexual gratification.

26. It would have been inappropriate to push the patient away when she hugged him. Instead, the standard of care required the Respondent to tell the Patient they would need to discuss the hugs. The Respondent did not discuss the hugs with the Patient.

27. Prior to beginning treatment with the Respondent, the Patient had been prescribed Dilantin for temporal lobe epilepsy and Prozac for depression. An overdose of Dilantin and Prozac, in combination with alcohol, could present a medical emergency.

28. When she started treatment with the Respondent, the Patient consumed alcohol in combination with the Dilantin and Prozac. The Respondent discontinued the Prozac when the Patient threatened to take an overdose and kill herself. Instead of Prozac, he prescribed Serzone, because an overdose of the medication would not be fatal.

29. It is difficult to adjust the dosage of Serzone if it is used in combination with alcohol. The Respondent counseled the Patient about using alcohol in combination with the Serzone.

30. The Respondent temporarily reduced the dosage of Serzone when the Patient complained that it made her sleepy. The Patient did not report other side effects to the Respondent.

31. Because it was a new drug at the time the Respondent was prescribing Serzone to the Patient, and he had insufficient current knowledge about it, the Respondent telephoned the manufacturer, Bristol-Meyers, on July 17, 1996. After speaking with a pharmacist, the Respondent concluded that the dosage he had prescribed the Patient was appropriate.

32. On at least one occasion, the Patient decreased the dosage of Serzone without first talking to the Respondent. On another occasion, again without consulting the Respondent, she stopped the medication altogether.

33. Sometime during the doctor/patient relationship, either the Respondent asked for or the Patient volunteered the Patient's home and office telephone numbers and pager numbers. The numbers would allow the Respondent to contact the Patient if he needed to cancel an appointment or to return the Patient's calls if she was in acute distress. The Patient purchased a pager so people could easily reach her while she was managing a camp.

34. The Respondent met monthly with Donald Wells Goodrich, M.D. over a period of approximately 10 years. They discussed the Patient only approximately 3 times. They talked about the Patient's use of alcohol, the Patient's reluctance to enter the hospital for treatment, the diagnosis of borderline personality disorder and the extended sessions. Dr. Goodrich initially approved of the extended sessions, but later urged the Respondent to curtail them, which the Respondent did not do. They did not discuss the manner in which the Respondent and the Patient negotiated a fee during treatment, extending sessions during the session and scheduling the next session at the end of the last session.

35. The Patient cancelled one appointment with the Respondent, on May 20, 1996.

36. The Patient terminated treatment with the Respondent in September 1996.

37. After the Patient terminated treatment with the Respondent, she went to a pharmacy to renew a prescription for Serzone, the medication the Respondent had prescribed for her. The pharmacist called the Respondent to ask permission to renew the prescription. The Respondent called the Patient to inquire whether she had in fact terminated treatment, and, if so, which physician would be responsible for monitoring the medication.

38. The Respondent renewed the prescription with instructions to the Patient on how to safely discontinue the medication. It would have been unsafe to abruptly discontinue the medication.

DISCUSSION

Section 14-404(a) of the Act authorizes the Board to reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee commits certain conduct. In this case, the Board alleged that the Respondent:

- Is guilty of immoral or unprofessional conduct in the practice of medicine (Section 14-404(a)(3); and
- Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State (Section 14-404(a)(22).

The allegations result from a June 10, 1997 complaint filed with the Board by the Patient. The Patient made numerous claims, including that her therapy sessions lasted as long as 7 hours; his fees were excessive; the Respondent telephoned and paged her repeatedly to ask why she had cancelled appointments or, in the end, had terminated therapy with him; and he maintained her on medication that was not indicated and was actually harmful to her. In addition, the State alleges that the Respondent acted improperly when he repeatedly hugged the Patient at the end of their sessions.[3]

The Patient's testimony is crucial to some of the State's allegations. Although I have a transcript of the hearing, I did not have an opportunity to observe her witness. I did not observe her general demeanor, body language, facial expression, or vocal tone. Nor did I have the

[3] The Charging Document does not reference improper physical contact because the Patient did not make the claim until after the charges were filed. Although the State never moved for leave to amend the charges, ALJ Golden overruled the Respondent's objection to any testimony relating to hugging. While not conceding that ALJ Golden's ruling was correct, I am bound by her rulings. Accordingly, I have made findings on this issue.

opportunity to compare her demeanor on direct examination to cross-examination. All of these factors are important in assessing her credibility.

The Patient's credibility is at issue because the evidence shows that as a result of her mental disorder, she has difficulty perceiving reality.[4]

The most noteworthy testimony that calls into question the Patient's ability to perceive reality involves a miscarriage she had while involved with [redacted].

The Patient thought a baby would prompt [redacted] to leave his wife, which she very much wanted. [redacted], however, was angry about the pregnancy and insisted that the Patient have an abortion or give the baby up for adoption. To make [redacted] think she granted his wish, which she thought would make him desire her more, The Patient told [redacted] she had an abortion. She did not tell [redacted] that in reality a D & C was performed because the sonogram revealed there was no fetal heartbeat and The Patient's physician determined the fetus was not viable. Although she told the Respondent the truth, she testified at the hearing that she had had an abortion. The Patient was not just using D & C interchangeably with abortion. On the contrary, her testimony is quite clear that to please [redacted] she believes she aborted a viable fetus.

In addition to having difficulty perceiving reality, the Patient made claims about the Respondent that are uncorroborated and which further strain her credibility. For instance, she alleged that the Respondent conducted sessions lasting as long as 5 and 7 hours. The only evidence presented by the Board to support this claim was the Patient's testimony. The Patient did not did give the dates of those sessions. Furthermore, the complaint she filed with the Board is internally inconsistent on this point, at first stating that the extended appointments lasted 2-5

[4] This is not to say that that the Patient is inherently unreliable. Quite to the contrary, the Patient is presumed truthful unless the evidence casts doubt on her credibility.

hours and later changing her statement, without explanation, to 2-7 hours. Board Exhibit 5. By the Respondent's own account, he conducted a number of 3-hour sessions and one 3¾ hour sessions. It is unlikely that he would report these sessions and intentionally fail to mention longer sessions. Thus, the Patient's claim is not credible.

The Patient also claimed that the Respondent told her he obtained a VISA account just so she could charge her sessions and continue to afford his services. The only evidence presented by the Board to support its claim was the Patient's testimony, which, as to this particular charge, I did not find credible. It is unbelievable that the Respondent began accepting VISA to accommodate one patient, who only used it twice and, despite the mounting cost of treatment, paid cash for the other sessions. Thus, this claim also lacks credibility.

At the hearing, the Patient also claimed that the Respondent hugged her inappropriately after every session. She explained that their genitals would touch, and she was very uncomfortable. The Patient did not explain why she did not include this claim in her complaint to the Board. In fact, she did not make the allegation until two years later, after the Board filed charges against the Respondent. Thus, notwithstanding the fact that the Respondent acknowledged that he returned her hugs twice under appropriate circumstances, the claim that he hugged her repeatedly, with sexual overtones, is suspicious and further calls into question her credibility.

Because the Patient has difficulty perceiving reality and some of her claims are wholly unsubstantiated, I hesitate to assess any weight to her testimony. Therefore, where the State has relied on her testimony to prove a particular claim, I cannot find in the State's favor unless the Patient's testimony is undisputed, or there is corroborating evidence.

DID THE RESPONDENT TELEPHONE AND PAGE THE PATIENT REPEATEDLY TO ASK WHY SHE HAD CANCELLED APPOINTMENTS OR TERMINATED THERAPY?

One basis for the Board's charge that the Respondent was unprofessional in the practice of medicine is that he repeatedly telephoned and paged the Patient to ask why she had cancelled appointments and terminated therapy. This is one of the charges that relies on the Patient's credibility.

The Patient testified that the Respondent telephoned and paged her repeatedly to inquire about why she had cancelled appointments and had terminated therapy with him. She said that she did not think the Respondent needed to know why she cancelled appointments, and the more she cancelled the more frequently he called her, as late as 11:30 p.m. She felt very badgered by all the calls.

For the reasons already stated, I assess no weight to her testimony and turn to other relevant evidence. The only other evidence on this issue came from the Respondent.

The Respondent denied calling the Patient repeatedly. He recalled telephoning her after she terminated therapy to discuss a call he received from a pharmacist asking to renew the Patient's prescription. In addition, the Respondent called her about routine scheduling matters, and he returned her calls when she was in acute distress and needed to talk. He did not call her an excessive number of times or at inappropriate times of the time, and he did not badger her. In the absence of credible evidence to refute the Respondent's account, I accept it as accurate.

Having accepted as truthful the Respondent's account, I cannot conclude that his conduct was improper. The record does not reflect that the Respondent's call to the Patient about the prescription renewal or other calls related to scheduling violated any established standard of care. In fact, there was no expert testimony clearly establishing the standard of care for a physician contacting a patient by telephone or pager for the reasons the Respondent contacted the Patient.

The Board suggested that the Respondent should not have even requested the Patient's pager number. There is a dispute about whether he requested it, or the Patient volunteered it. How he obtained the number is irrelevant. What is important is that the Patient's reason for getting a pager is the same reason the Respondent found it valuable to have the number. On this point, the Patient testified, "I got [the pager] because of my – running my camp. And I was leaving the camp, especially to come to sessions, and I needed to be able to be reached." Tr. 159.

Therefore, I conclude that the Board has not shown the Respondent repeatedly telephoned and paged the Patient to ask why she had cancelled appointments and terminated therapy. Accordingly, he was not unprofessional in the practice of medicine.

DID THE RESPONDENT HUG THE PATIENT AT THE END OF TREATMENT SESSIONS?

Another basis for the Board's charge that the Respondent was unprofessional in the practice of medicine is that he hugged the Patient at the end of treatment sessions. This is another charge that relies on the Patient's credibility because there is no corroboration.

The Patient testified sometime after her treatment with the Respondent began, she began seeing him as a father figure and felt safe with him. After one session, she hugged him, apparently in gratitude of his help, and after that day the hugs became routine. When they hugged, her breasts touched his body and their genitals touched. Near the end of treatment, she became uncomfortable with him and told him that she felt he was getting too attached to her.

For the reasons already, stated, I assess no weight to her testimony and turn to other relevant evidence. The only other evidence on this issue came from the Respondent.

The Respondent disputed the Patient's allegations, although he acknowledged that on two occasions he reciprocated hugs that she initiated. He explained that the hugs were prompted by

particularly difficult sessions where they discussed traumatic events in the Patient's life—her mother's cancer diagnosis and the sonogram results. The Patient hugged him at the end of those sessions, and he put his arm around her and patted her on the back.

The State questioned why the Respondent did not mention the hugs in the Patient's chart. The Respondent explained that because they were isolated incidents occasioned by traumatic events, he did not attach much significance to the hugs and therefore there was no need to write about them.

In the absence of credible evidence to refute the Respondent's account, I accept it as accurate.

The State did not present evidence that the hugs described by the Respondent were inappropriate. Although the Respondent's expert, Dr. Michael Stone, testified that the Respondent did not act unprofessionally by allowing the Patient to hug him, he commented on how the Respondent should have dealt with the behavior:

> *Question by Ms. Wesker*: And is it a breach in the standard of care for a – was it a breach in the standard of care for [the Respondent] to, for example, not push her away?
>
> *Answer*: No.
>
> *Question*: Would pushing her away if she initiated a hug be an appropriate response between a therapist and a patient?
>
> *Answer*: It wouldn't be appropriate to push her away. It would be appropriate to separate himself more gently as quickly as he could and mention to her that this was something that needed to be talked about rather than done – again, an acting-out of something rather than speaking about what it all meant.
>
> *Question*: And if [the Respondent] had pushed her away, what, if any, risk was there to the patient?
>
> *Answer*: She might feel rejected and that might lead her to escalate her suicidal threats or even actions.

Question: Was there any evidence in the record that she had a fear of rejection or a history of rejection in the past?

Answer: There was.

Question: Was she particularly sensitive to that issue?

Answer: She seemed remarkable sensitive to that.

Question: And based on your review of the records, was [the Respondent] aware of that?

Answer: Yes.

Tr. 333.

The Respondent did not discuss the hugs with the Patient, even though he knew the Patient had issues of transference with him. Thus, while the hugs themselves may not have been inappropriate, according to the standard of care set forth by his own expert, he did not appropriately follow through by having a discussion with the Patient.

In conclusion, the State has not shown that the Respondent violated the standard of care by hugging the Patient. Accordingly, he was not unprofessional in the practice of medicine.

WERE THE RESPONDENT'S FEE SETTING PRACTICES WITHIN THE STANDARD OF CARE?

One basis for the State's claim that the Respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care involves his fee setting practices. With respect to this charge, certain facts are not in dispute.

The Respondent's fee is $150.00 for a standard 45-minute session. He charged the Patient varying amounts for appointments of the same length; he charged her the same amount for appointments of varying length; he discounted his fee for some sessions; and he negotiated the reduced fee during a session. Also, the length of a session was not pre-determined, and the decision to extend it was frequently made during the session. Therefore, the Patient did not

know in advance of a session how long it would last. Irrespective of whether extended sessions were necessary, the Respondent's fee practices violated the standard of care.

The evidence is undisputed that the standard of care requires a physician to set his fee in advance. In this way, a patient can decide whether she can afford the physician's services, especially if the session is extended. In this case, because the Respondent's fee varied, the Patient could not make an informed decision.

The Respondent testified that his fee varied because he sometimes discounted it. He explained that he discounted it so the Patient could afford his services, especially the longer sessions. At first blush, the Respondent's actions seem noble. Upon further consideration, however, it is clear that he was taking advantage of the Patient's vulnerable state.

According to the Respondent, the sessions were extended because the Patient was in crisis and in immediate need of his care. Assuming that it was the case, and I do not concede that it was, the Respondent negotiated a fee with someone who was in crisis, or as Dr. Polk said, during "the emotional heat of the session." Tr. 68. As a result, the balance of power was tipped, and she could not have been an equal negotiating partner.

In addition, the Patient possessed certain qualities that made negotiating a fee while she was in crisis inappropriate. The Patient idealized the Respondent, she had a distorted degree of trust in him, and, as might be expected with from a patient with borderline personality disorder, she craved more and more time with him. Dr. Polk best explained why the Respondent's practice was improper under these conditions:

> *So, he had this person with a hunger for him, with an idealization of him. And in the heat of the session, he was setting the amount of time they were going to work together and how much he was going to charge. This is – this puts him ethically in a serious conflict of interest.*

* * *

Well, [the Respondent] described to [the peer reviewers] the mechanics of how these sessions were set up, which I explained. He described this impromptu sort of spur-of-the-moment in-the-heat-of-the-battle decision, which he referred to, I believe, as negotiating a fee with her, although it really is hard to use the word negotiating when the person you're negotiating with has stars in their eyes and idealizes you and has a hunger and craving for more and more attention from [you]....

Tr. 69-70.

Although the Respondent's experts condoned the extended sessions, they did not affirmatively approve his fee setting practices. Thus, I accept Dr. Polk's opinion.

Therefore, the Respondent's practice of negotiating a fee with the Respondent during a treatment session violated the standard of care.

WAS THE LENGTH OF THE SESSIONS WITH THE PATIENT WITHIN THE STANDARD OF CARE?

Another basis for the State's assertion that the Respondent violated standard of care is that his treatment sessions with the Patient were unnecessarily long. The Respondent asserted that extended sessions were necessary because the Patient was in crisis. In support of his position, the Respondent presented the testimony of Dr. Stone.

Dr. Stone opined that:

> *...with some patients, particularly some very fragile, borderline patients in times of crisis, I may have scheduled longer than ordinary sessions. And on rare occasions, if I feel that they're between life and death, or that they're thinking about suicide, or that I can't initially determine the degree of risk, I may extend the session in order to make very sure that the patient is all right, or it gives me time to take any necessary steps that I may have to take, including sometimes taking them to the hospital.*

Tr. 467-68.

Assuming Dr. Stone set forth the standard of care, the evidence clearly shows that the Respondent violated it.

Unlike Dr. Stone, who generally pre-scheduled extended sessions for patients in crisis, the Respondent did not schedule extended sessions in advance. Rather, his sessions with the Patient were typically scheduled for 45 minutes, and they were extended during the session. And although Dr. Stone said that sessions may be extended during the session in rare instances, where the patient is suicidal or he cannot assess the patient's risk, the Respondent routinely extended sessions during the session, even though the Patient was not in suicidal and he could assess her risk. In fact, with rare exception, the Respondent's session notes do not document that the Patient was suicidal.

One such exception was on July 16, 1996, when the Respondent described how the Patient "[h]as suicidal thoughts. Thoughts of taking her dilantin and Prozac which she has refilled and using it to kill herself." Respondent Ex. 6 at 20. The Respondent testified that he did not document similar instances of acute suicidality, although he has a clear recollection that she was suicidal and extended sessions helped him meet his goal of keeping her out of the hospital.

The Respondent's notes, however, were made contemporaneously with his sessions with the Patient. It is hard to imagine that if the Patient were frequently acutely suicidal, the Respondent would have consistently failed to record that fact in his notes. Likewise, a clinical history of the Patient that the Respondent prepared nearly one year after he stopped treatment with her,[5] and which purports to more fully describe the Patient's condition during treatment is not as reliable as the session notes. Thus, the absence of such information in the contemporaneous notes leads me to believe that the notes, and not the Respondent's recollection,

[5] Respondent Exhibit 6, "Confidential clinical psychiatric report on [the Patient.]

accurately represent the Patient's condition. I therefore conclude that the Patient rarely exhibited the level of acute need that the Dr. Stone testified would justify extending a session.

Therefore, using the standard set forth by the Respondent's expert, I conclude that the Respondent violated that standard by routinely extending treatment sessions without adequate cause.

DID THE RESPONDENT VIOLATE THE STANDARD OF CARE BY FAILING TO DEVELOP A PRE-SET SCHEDULE OF APPOINTMENTS?

Another basis for the State's assertion that the Respondent violated the standard of care is that he failed to develop a pre-set schedule of appointments for the Patient (e.g. every Tuesday); instead, he scheduled the next appointment at the conclusion of the last one.

The Respondent did not dispute the State's contention. In his defense, however, he testified that he scheduled many more appointments than the Patient actually attended. He explained that she frequently cancelled appointments. The Respondent's billing records do not support his assertion. On the contrary, the records, which he prepared, show only one cancellation, on May 20, 1996. Respondent Exhibit 1; State Exhibit 7. Regardless of the number of cancellations, the question remains whether his scheduling protocol violates the standard of care.

Dr. Polk testified that treatment includes "an agreement made in advance as to how often [the therapist and patient are] going to meet. ...A major feature in psychiatry for all kinds of technical reasons...is the standardization and the advance agreement on what these parameters are going to be." Tr. 65. Dr. Polk further explained the danger in allowing someone like the Patient, who idealized the Respondent, determine when the next appointment will be:

> *In psychiatry, it's a dangerous situation when you gratify someone's unrealistic wishes. When you have someone who has distorted needs for closeness with you, for time spent together with you, to kind of*

be one with you, spend as much time with you as possible, to simply gratify those wishes is only looking for trouble.

The person may feel a short term satisfaction from this, but it encourages a dependent relationship on the doctor. It infantalizes the patient, it runs the risk of setting up mistaken ideas in the patient that she's the special favorite of the doctor and that the doctor is going to do all kinds of special things to her, for her.

And when these don't materialize, typically – because they can't materialize they're so unrealistic, typically patients feel betrayed, they feel angry. They are inclined to break off treatment. Many patients, even before they feel betrayed by this, are highly suspicious of someone who seems to be gratifying their wishes all the time letting them just set the pace for everything.

It's a broad principle in psychiatric treatment, and it's even more relevant in borderline patients who have these needs, that the psychiatrist has to protect the patient from her bad judgement [sic]. If the patient with stars in her eyes who wants to spend all day every day with the doctor. And if that's not really healthy, the doctor has to protect her from that distorted judgement [sic].

* * *

In addition, borderline patients tend to have stormy chaotic lives. And the major writers, authors in psychiatry, the major textbooks, all emphasize that stability, organization, consistency, is, in itself, very therapeutic for borderline patients.

Tr. 72-73, 77.

The Respondent's experts did not dispute Dr. Polk's opinion about the standard of care.

Drs. Stone and Goodrich testified frequent visits might be necessary for someone such as the Patient. Neither, however, specifically approved of the Respondent's scheduling protocol. Furthermore, because there is no dispute that the Respondent did not maintain a pre-set schedule of appointments with the Patient, he violated the standard of care.

DID THE RESPONDENT CONSULT WITH DR. GOODRICH ABOUT HIS CARE OF THE PATIENT?

Finally, Dr. Polk noted that the Respondent should have sought external validation about his treatment protocol (e.g. negotiating a fee during treatment, extending sessions during the session and scheduling the next session at the end of the last session). The Respondent testified that he received external validation from Dr. Goodrich. The State disputed whether the Respondent and Dr. Goodrich consulted about the Patient. In this regard, the State presented testimony that during its investigation, Dr. Polk specifically asked the Respondent whether he had consulted anyone, and the Respondent said no. Assuming they did consult, the record does not establish the external validation about which Dr. Polk spoke.

Dr. Goodrich testified that he and the Respondent met monthly for a period of 10 years or more, although they discussed the Patient only approximately 3 times. Dr. Goodrich stated that they talked about the Patient's drinking, the Patient's reluctance to enter the hospital for treatment, the diagnosis of borderline personality disorder and the extended sessions. Dr. Goodrich testified that he initially approved of the extended sessions, but later urged the Respondent to curtail them. Dr. Goodrich did not testify that they consulted about negotiating a fee during treatment, extending sessions during the session and scheduling the next session at the end of the last session. I therefore conclude that the Respondent did not obtain appropriate external validation from Dr. Goodrich.

WHAT SANCTION SHALL BE IMPOSED FOR VIOLATING THE STANDARD OF CARE?

The State requested that the Respondent shall be suspended for 90 days; fined $15,000.00; placed on probation for three years, subject to additional peer review; upon reinstatement, he shall practice with a supervisor, as directed by the Board; and attain tutorials in the ethical practice of fee-for-service medicine and boundary violations

Because I did not find in the State's favor on the so-called boundary violations (e.g. the hugging, the telephone calls), the tutorial in ethics and boundary violations is inappropriate.

The question then is whether the proposed penalty is appropriate for the violations I did find (e.g. extending sessions during the session, failing to set up a schedule of appointments, negotiating the fee during the session and conducting unnecessarily long treatment sessions).

The Board may suspend or revoke the Respondent's license, or reprimand him. Section Health-Occ. § 14-404.

A suspension of the Respondent's license is appropriate, given the seriousness of the violations. Therefore, I accept the Board's recommendation of a 90-day suspension. I further recommend, however, that the suspension be stayed pending the satisfactory completion of a 1-year probationary period, during which the Respondent shall practice under supervision and be subject to peer review to determine whether there are additional violations of the type found here

Additionally, I recommend a fine. The Board may impose a fine, subject to the Board's regulations:

> *(1) Instead of suspending the license; or*
> *(2) In addition to suspending or revoking the license or reprimanding the licensee.*

Section 14-405.1 (1994).

The Board's regulations offer a non-exclusive list of factors to consider when deciding whether to impose a fine, including:

- The extent to which the Respondent derived any financial benefit from the sanctioned conduct;
- The willfulness of the sanctioned conduct; and
- The extent of actual or potential harm caused by the sanctioned conduct.

Whether the Respondent derived any financial benefit from his conduct is dependent on whether the Patient actually needed the extended sessions. As I already discussed, there is persuasive evidence that the treatment sessions with the Patient were not typically extended for good cause. That said, there is nothing in the record that leads me to believe the Respondent's conduct was willful. As for the final factor, there is no evidence that the Patient suffered emotional harm from the conduct, although it is clear she incurred a financial loss from sessions from sessions that were extended unnecessarily. Although it is impossible to determine the amount of the financial benefit to the Respondent or loss to the Patient, a penalty is an appropriate sanction.

The Board's regulations link the amount of the civil penalty to the imposition of a suspension, revocation or reprimand. For a penalty in addition to suspension, the penalty shall be not less than $10,000 and not more than $40,000. COMAR 10.32.02.06.

Because the extent of the benefit and loss cannot be calculated, I propose the minimum penalty of $10,000.00, in addition to the suspension.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact and Discussion, I conclude, as a matter of law, that the Respondent violated Sections 14-404(a)(3)(22). I further conclude that, as a result, the Board may discipline and fine] the Respondent. Md. Code Ann., Health Occ. §§14-404(a), 14-405.1 (1994 & Supp. 1999).

PROPOSED DISPOSITION

I **PROPOSE** that the charges filed by the Board on August 18, 1999 against the Respondent be **UPHELD**.

I **PROPOSE** that:

(a) The Respondent be suspended for 90 (ninety) days;

(b) That the suspension be stayed pending the satisfactory completion of a 1-year probationary period;

(c) That during the probationary period, the Respondent shall be subject to peer reviews, as deemed appropriate by the Board, and that he practice under supervision, as approved by the Board; and

(d) That, in addition to the suspension, the Respondent remit to the Board a $10,000.00 (ten thousand) dollar fine.

November 3, 2000
Date

Laurie Bennett
Administrative Law Judge