IN THE MATTER OF	*	BEFORE THE MARYLAND
RUY DAN ARROYO, M.D.	*	STATE BOARD OF PHYSICIAN
Respondent	*	QUALITY ASSURANCE
License No: D27436	*	Case Nos: 91-0139 and 95-0040

* * * * * * * * * * * * *

FINAL OPINION AND ORDER

PROCEDURAL BACKGROUND

This case arose from complaints by two patients that Ruy Dan Arroyo, M.D., aka Ruy Dan Arroyo-Barada, M.D. (The "Respondent") engaged in sexually inappropriate conduct. After an investigation, the Board of Physician Quality Assurance (the "BPQA" or "Board"), on June 13, 1995, charged Respondent with violating Md. Code Ann., Health Occ. § 14-404(a)(3), which provides:

> (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]

Respondent failed to appear for a scheduled Case Resolution Conference on July 5, 1995 and the matter was referred to the Office of Administrative Hearings for a hearing on the merits of the

[1] The conduct for which Respondent was charged occurred between 1987 and 1991. Prior to July 1, 1989, this statute, codified as H.O. § 14-504(a)(3), provided, "[i]s guilty of immoral conduct in the practice of medicine."

case.[2]

A hearing in the matter was held on February 27 and 28, 1996. Jeffrey S. Gulin, Administrative Law Judge (the "ALJ"), presided over the hearing. Respondent failed to appear at the hearing but was represented by counsel. On March 7, 1996, the ALJ issued a Recommended Decision wherein he concluded that Respondent violated H.O. § 14-404(a)(3) and recommended revocation of Respondent's medical license and that the BPQA not consider reinstating that license for at least 15 years.

By letter dated March 7, 1996, the ALJ notified the parties of their right to file exceptions to the Recommended Decision. Respondent's exceptions were filed with the BPQA on March 29, 1996. On April 17, 1996, the Administrative Prosecutor filed a response to the exceptions. On June 26, 1996, Respondent's counsel and the Administrative Prosecutor appeared before the BPQA for an oral hearing on exceptions. Respondent did not appear for the hearing. On that date, the BPQA convened for a final decision in the case.

FINDINGS OF FACT

The BPQA adopts and incorporates by reference the Findings of Fact made by the ALJ in the Recommended Decision issued on March 7, 1996. The entire Recommended Decision is attached and incorporated into this Final Order as Appendix A.

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[2] Respondent was notified of the scheduled Case Resolution Conference by certified mail to two addresses maintained by the BPQA. Notice was also sent to Respondent's counsel. Neither Respondent nor his counsel appeared for the Case Resolution Conference. H.O. § 14-206(c) provides, "[i]f after due notice the individual against whom the action is contemplated fails or refuses to appear, nevertheless the Board may hear and determine the matter."

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and after consideration of the Respondent's exceptions and the Administrative Prosecutor's response to those exceptions, there is clear and convincing evidence for the BPQA to conclude as a matter of law that Respondent has committed the following act:

> Is guilty of immoral or unprofessional conduct in the practice of medicine. [H.O. § 14-404(a)(3)].

OPINION

Dr. Arroyo, a board-certified psychiatrist, was charged with sexual misconduct and boundary violations involving three of his patients. Patient 1 alleged that Dr. Arroyo made inappropriate sexual comments and touching which ultimately culminated in non-consensual sexual intercourse. Patient 2 alleged that Dr. Arroyo kissed and fondled her. Patient 3 alleged that Dr. Arroyo made sexually inappropriate comments and fondled her legs during her hospitalization. Patients 1, 2, and 3 did not know each other, and all made independent complaints of Dr. Arroyo's conduct to either the BPQA or some other individual. After a trial on the merits in which all three patients testified, the ALJ found the patients to be credible, and concluded that Dr. Arroyo had committed the conduct as alleged.

Though Dr. Arroyo did not present testimony in the hearing before the ALJ, he filed exceptions to the ALJ's findings and conclusions as set out in the Recommended Decision. In his exceptions, Dr. Arroyo fundamentally challenges the credibility of Patients 1, 2, and 3. In particular, Dr. Arroyo impugned the credibility of each patient by, inter alia, using their drug and

alcohol histories. For the reasons set out herein, the BPQA rejects Dr. Arroyo's exceptions and accepts and adopts the recommended findings of the ALJ.

1. Standard for Agency Review of Recommended Decision

The relationship between the credibility findings of an administrative law judge and the agency's final decision has been well set out by the Maryland Court of Appeals. In Anderson v. Dept. of Public Safety, 330 Md. 187, 623 A.2d 198 (1993), the Court stated that:

> the credibility findings of the person who sees and hears the witnesses - be he ALJ, juror or judge - is entitled to considerable deference. While the degree of deference due the ALJ's final decision is related to the importance of credibility in a particular case, the ALJ's decision to give or deny credit to a particular witness' testimony should not be reversed absent an adequate explanation of the grounds for the reviewing body's source of disagreement with the ALJ.

Id. at 217, 623 A.2d at 212-13, quoting Koch, Administrative Law and Practice (1985), Vol. 1, § 6.73. That standard was further defined in Dep't of Health and Mental Hygiene v. Shrieves, 100 Md. App. 283, 641 A.2d 899 (1994):

> where credibility is pivotal to the agency's final order, ALJ's findings based on the demeanor of witnesses are entitled to substantial deference and can be rejected by the agency only if it gives strong reasons for doing so.

Id. at 302, 641 A.2d at 914. The Shrieves court distinguished demeanor-based or testimonial inferences from derivative inferences. The former derive from the fact-finder's personal observations of the witness and are entitled to special deference. The latter derive from the evidence in the record and are entitled to no special deference. Id.

Here, because little exists on the record to corroborate the testimony of Dr. Arroyo's patients, the issue is fundamentally one of demeanor-based credibility determinations. The BPQA finds nothing in the record warranting a departure from the well-accepted rule that the ALJ's

findings on that score are entitled to considerable deference. The BPQA rejects the notion that the drug and alcohol histories of certain of Dr. Arroyo's patients requires a different conclusion.

2. Standard for Impeachment of Witness Credibility Using Patient Mental Health and Drug History

Because credibility of a witness is always at issue, any witness is subject to cross-examination on matters relevant to credibility. Smith v. State, 273 Md. 558, 573, 611 A.2d 581, 588 (1992). A witness's psychiatric history is admissible if relevant to assess credibility. Testerman v. State, 61 Md. App. 257, 268, 486 A.2d 233, 238 (1985). However, that inquiry must be limited to determining whether a particular condition affects factors related to credibility, such as "memory, observation, exaggeration, imagination, etc." Id., citing Reese v. State, 54 Md. App. 281, 289-90, 458 A.2d 492, 497 (1983). In addition, the judge is charged with preventing "annoying, harassing, humiliating and purely prejudicial attacks ... [not] relevant to a witness's credibility." Reese v. State, 54 Md. App. at 290, 458 A.2d at 497, citing Burgess v. State, 161 Md. 162, 173, 155 A.2d 153 (1931).

In Testerman, the trial judge refused to permit the defendant to cross-examine a witness on her hospitalization in a mental hospital where the defendant did nothing more than proffer that the witness had been diagnosed as schizophrenic. Because the defendant presented no nexus between the disorder and the witness's credibility, the reviewing court held that the trial judge properly limited cross-examination of the witness on that issue. In contrast, in Eiler v. State, 63 Md. App. 439, 492 A.2d 1320 (1985), expert testimony on the defendant's mental disorder was permitted where the expert explained in detail how the manifestations of the illness impacted the credibility of the defendant. See also Hartless v. State, 327 Md. 558, 611 A.2d 581 (1992)

(witness's psychological profile not admissible absent nexus to defense); Shpak v. Schertle, 97 Md. App. 207, 629 A.2d 763 (1993) (expert permitted to testify how witness's psychiatric history tended to show she had been the victim of child abuse).

As with psychiatric histories, Maryland courts allow liberal testimony regarding a witness's drug use so long as it is relevant to assess credibility. However, the evidence must demonstrate that the witness can neither accurately perceive nor recollect the incidents about which he is testifying. Clarke v. State, 97 Md. App. 425, 429, 630 A.2d 252, 255 (1993), citing Lyba v. State, 321 Md. 564, 583 A.2d 1033 (1991).

In Mitchell v. Montgomery County, 88 Md. App. 542, 596 A.2d 93 (1991), an expert toxicologist testified regarding the intoxication of a pedestrian struck by a county vehicle. Dr. Caplan testified that tests taken at Suburban Hospital shortly after the accident indicated that Mitchell had a blood alcohol level of 0.08. In addition, Mitchell tested positive for cocaine and PCP. Dr. Caplan opined that, at the time of the accident, Mitchell likely had a blood alcohol level of 0.09 to 0.10, rendering him significantly intoxicated. Dr. Caplan described the effects of this level of intoxication on an individual's coordination, vision, depth perception and other factors which might impact Mitchell's perception of the events. Id. at 557, 596 A.2d at 100. The reviewing court upheld that propriety of this testimony. In contrast, though Dr. Caplan testified in similar detail regarding the effects of PCP and cocaine, the reviewing court ruled that such evidence was inadmissible because the defendant was unable to demonstrate that Mitchell was under the influence of those substances at the time of the accident. Because there was no causal link between the drugs and a legally significant issue in the case, the court determined that the testimony, while prejudicial, had little probative value and so was inadmissible. Id. at 559, 596

A.2d at 100-101. See also Matthews v. State, 68 Md. App. 282, 511 A.2d 548 (1985) (refusal to permit testimony of defendant as to whether victim was under influence of drugs at time of criminal act where defendant did not testify regarding the victim's demeanor or other factors which would support such testimony). Thus, a proper foundation for evidence of drug impairment requires proof of drug use and an explanation of how the drug impaired either the witness's perception at the time of the events complained of or of the witness's ability to recall those events.

For the BPQA to consider the effects of their mental health and drug histories on the credibility of Patients 1, 2, and 3 required, at minimum, expert testimony to establish a nexus between the mental condition or drug use and their perception or recall of events. No such testimony was presented by Dr. Arroyo. In contrast, expert testimony offered by the State indicates that neither the mental conditions nor the drug use by any of the three patients had a bearing on their credibility. Dr. Arroyo's bare citation to mental health histories and drug use in the record fails to lay an adequate foundation for their consideration.

Dr. Arroyo is a psychiatrist. Almost by definition, his patient population consists of troubled individuals, often suffering mental disorders and under the influence of medication. By Dr. Arroyo's reckoning, almost no psychiatric patient could be believed when alleging sexual misconduct on the part of the therapist. The BPQA soundly rejects this notion.

3. Patient-Specific Analysis

Patient 1

Patient 1, diagnosed with "major depression," was treated by Dr. Arroyo for approximately two years, from May, 1987 through February, 1988. During this period, Dr.

Arroyo frequently attempted to kiss and fondle her, discussed sexual matters, and made inappropriate comments. On February 22, 1988, Dr. Arroyo scheduled an appointment for Patient 1 for 9:00 p.m., met her in the office alone, and forced her to have sexual intercourse. Patient 1 terminated her therapy with Dr. Arroyo and subsequently discussed the incident with her new therapist, who reported it to the police. Patient 1 was reluctant to pursue charges against Dr. Arroyo.

Dr. Arroyo excepted to these findings, arguing that Patient 1 was not credible and her testimony inconsistent. Dr. Arroyo referred to Patient 1's medical records, wherein Patient 1 had described "talking to God" and self-destructive thoughts. Dr. Arroyo has failed to establish, through either testimony or his exceptions, any link between these events and Patient 1's credibility. Indeed, this single episode occurred in 1983, approximately five years prior to the period when Patient 1 sought treatment from Dr. Arroyo. Dr. Brandt, the State's expert, testified that nothing in Patient 1's medical record indicated that she suffered psychosis, delusions, or hallucinations while being treated by Dr. Arroyo. T.180-81. Likewise, Dr. Brandt opined that there was no evidence in Patient 1's medical record of a psychiatric condition which would impact on Patient 1's ability to know or to tell the truth. T.181.

Dr. Arroyo also questions Patient 1's credibility based on her delay in making a complaint to the appropriate authorities. While Patient 1 testified that she reported his conduct to her subsequent therapist, Dr. Arroyo notes that this therapist reported no ethical violation, thus implying that Patient 1 could not have made such a disclosure. Similarly, Dr. Arroyo points out that, though Patient 1 testified that she confided in her subsequent therapist, her mother, and a friend, these individuals were not called upon to provide corroborating testimony. Finally, Dr.

Arroyo argues that, though Patient 1 reported the incident to the Washington County Police Department, she did not do so until three years later and no criminal charges resulted. The BPQA finds none of these factors either dispositive of the issue in the case or negatively impacting Patient 1's credibility.

First, the fact that Patient 1's subsequent therapist did not report Dr. Arroyo's conduct to the BPQA does not render Patient 1's testimony false. As Dr. Brandt recognized, there is no absolute ethical duty to report, T.198, and issues of confidentiality, consideration of the patient's wishes, and overall well-being of the patient may warrant otherwise. Likewise, Patient 1's delay in reporting the incident does not mean that she was lying. Dr. Brandt testified that:

> [t]hese kinds of violations are often reported months or years later. And the reason for that is that the feelings that patients have surrounding boundary violations are complex. Patients are often gratified that their physician could show attention to them ... they may feel powerful, they may feel like here the doctor has compromised his professional reputation and taken major risk [sic] because he must find me attractive or he must be drawn to me.

T.176. Similarly,

> [i]t doesn't surprise me that the patient did not make an immediate report of such behavior. It fits with my experience, having treated many patients who have been involved in similar circumstances.

T.184. Indeed, Patient 1 consistently testified that she did not want her therapist to confront Dr. Arroyo, T.52, that she did not want to pursue criminal charges, T.62, and that she did not want to testify in a hearing, T.62. Patient 1 stated that it was not until several years later, after addressing Dr. Arroyo's conduct in therapy, that the incident was reported. T.53.

As noted by the Administrative Prosecutor in her response to exceptions, Maryland law does not require that Patient 1's testimony be corroborated in order for the BPQA to find by clear

and convincing evidence that Dr. Arroyo committed the acts alleged. See Perkins v. State, 11 Md. App. 527, 275 A.2d 513 (1971) (testimony of victim of a sex-related crime without other corroboration is sufficient proof beyond a reasonable doubt). The ALJ observed Patient 1 to be credible. Nothing on the record convinces the BPQA to reject that demeanor-based determination.

Patient 2

Dr. Arroyo treated Patient 2 for depression from March, 1988 to January, 1989, when he closed his local office. After approximately two months into the therapeutic relationship, Dr. Arroyo began kissing and fondling Patient 2, encouraged her to dress in a sexually provocative manner, and commented on her breasts. Patient 2 tried to avoid night appointments scheduled by Dr. Arroyo. Several years after her treatment, Patient 2 filed a complaint with the BPQA regarding Dr. Arroyo's conduct, after seeing a television show about sexual misconduct by psychiatrists.

Dr. Arroyo impugns Patient 2's credibility, arguing that her complaint filed with the BPQA appears to be written in two different handwritings. Further, Dr. Arroyo notes Patient 2's "serious problem" with prescription drugs, her nearly six year delay in filing a complaint with the BPQA, and her supposed anger at Dr. Arroyo for closing his local practice. Again, nothing in the record persuades the BPQA that these factors implicate Patient 2's truthfulness.

Patient 2 testified that she alone filled out the complaint form sent to her by the BPQA. T.85-87. An examination of the complaint reveals that it is partially printed and partially in cursive writing. Respondent's Ex. 1. Patient 2 testified that her printing is different from her cursive writing. T.87. Dr. Arroyo presented no evidence which persuades the BPQA that his

unilateral determination that the complaint was completed by an individual other than Patient 2 is sufficient justification to reject the ALJ's demeanor-based findings that Patient 2 was a credible witness.

Dr. Arroyo argues that Patient 2 had a "serious problem" with prescription drugs, implying some stain on her ability to perceive or to tell the truth. That conclusion is not borne out by evidence in the record. Indeed, absent from the record is any foundation whatsoever which creates a nexus between Patient 1's drug use and her credibility in recounting Dr. Arroyo's conduct. The drug use cited by Dr. Arroyo occurred approximately four years after termination of her treatment with him and involved medications prescribed by physicians, which Patient 2 discontinued "cold-turkey" after her friends expressed concern about the amount of medication she was taking. T.103-106. Nothing in the record indicates how Patient 2's use of legitimately prescribed medications more than five years after termination of her treatment with Dr. Arroyo had any impact whatsoever on her ability to perceive or tell the truth. Even assuming these medications were relevant to Patient 2's credibility, nothing in the record suggests that she was using them during her treatment with Dr. Arroyo or that he treated her for drug abuse.

As with Patient 1, Patient 2's nearly six year delay in filing a complaint against Dr. Arroyo with the BPQA does not necessarily suggest that the incidents did not occur as described in the complaint. As noted by Dr. Brandt:

> often it's only later that the patient realizes what a violation this has been and ultimately what an exploitation it's been and what a rejection it's been, similar to children who are abused by patient [sic] parents in incestuous relationships. But often, I could add to that, patients wipe out a painful experience using psychological defenses such as disassociation, an attempt of the patient's unconscious, the patient's mind to put certain conflict laden material into the unconscious. And it may be several years later or maybe never that a patient

recalls what actually happened.

T.176. Patient 2 testified that it was not until after watching a television show on sexual misconduct that she reported the incident to the BPQA to try to protect other women. T.80. Patient B testified that she continued to see Dr. Arroyo, despite the pattern of sexual misconduct, because she was referred to him for treatment by her family physician who she trusted, and believed that he could help her with her problems. T.75.

Finally, the record fails to support Dr. Arroyo's hypothesis that Patient 2 filed her complaint with the BPQA in retaliation, either because she was supposedly angry that Dr. Arroyo relocated his practice or because she was sent a bill several years after termination of her treatment with him. Patient 2 testified that she was not upset when informed by Dr. Arroyo that he would be relocating and was, in fact, relieved. T.94, 96. Indeed, Patient 2 also testified that in approximately the last five months of her therapy with Dr. Arroyo, she canceled half of her appointments in order to avoid nighttime visits scheduled by him. T.92-93. Likewise, Patient B testified that she was not angry at receiving a bill from Dr. Arroyo nearly four years after termination, but merely called to find out why she had been billed when he had assured her prior to termination that she owed nothing. T.97. Patient B subsequently paid the bill. T.80.

Patient 3

In 1987, Patient 3 was hospitalized for severe migraine with neurological impairment with a secondary diagnosis of depression with anxiety. Dr. Arroyo, the attending psychiatrist, saw Patient 3 twice alone in her hospital room. Patient 3 alleged that, during those visits, Dr. Arroyo made inappropriate comments regarding her husband and her marriage, and made a sexually suggestive comment while massaging her legs. Patient 3 feigned a headache and subsequently

reported Dr. Arroyo's conduct to the hospital administration. Dr. Arroyo stated that Patient 3 had exaggerated the incident, but admitted that he had used "seduction therapy."

In his exceptions, while Dr. Arroyo describes Patient 3 as the "most credible" of the three complainants, he characterizes his own conduct as more "innocuous." Furthermore, he implies that Patient 3's description of the events was not accurate as she was under the influence of pain medication and "became delusional as a result...." Dr Arroyo also notes that Patient 3 stated that she believed that he meant her "no harm," that she was reluctant to pursue charges, and that the BPQA initiated contact with Patient 3 in order to bolster their case against him. Again, the BPQA rejects the notion that these factors impact Patient 3's reliability as a witness and that the conduct described was "innocuous."

As with Patient 2, Dr. Arroyo again fails to establish some concrete nexus between the effect of the medications used by Patient 3 at the time of her hospitalization and her reliability in perceiving or describing Dr. Arroyo's conduct. In any event, Patient 3 testified that she was not under the influence of any medications during Dr. Arroyo's visits and was "completely lucid and clear." T.118, 127-28. This is supported by Patient 3's medical records, which document only the use of a nasal spray, a sinus medication, and a topical hydrocortisone medication. State's Ex. F, p. 240; T.190. Dr. Arroyo's clinical notes state that Patient 3 "does not appear delusional." State's Ex. F, p. 184. Furthermore, Dr. Brandt testified that nothing in the record indicates that Patient 3 was delusional or psychotic when Dr. Arroyo saw her in her hospital room, T.193, and that it is not abnormal for a hospitalized patient to be lucid and coherent though disoriented to time and date, T.210.

The BPQA is not persuaded that Patient 3's reluctance to pursue charges in any way

undermines the credibility of either this patient or its investigation of Dr. Arroyo. Patient 3 immediately notified the hospital administration of Dr. Arroyo's conduct, which ultimately resulted in a report to the BPQA. The BPQA has the authority and the duty to investigate physicians who pose a risk to the public health, safety, and welfare. See Dr. K v. Board of Physician Quality Assurance, 98 Md. App. 103, 632 A.2d 453 (1993), cert. denied, 334 Md. 18, 637 A.2d 1191, cert. denied, 115 S. Ct. 75 (1994). Nothing in the record supports Dr. Arroyo's contention that the BPQA acted inappropriately in investigating Patient 3's allegations.

Finally, the BPQA soundly rejects Dr. Arroyo's characterization of his conduct with Patient 3 as in any way "innocuous." Dr. Brandt testified that the incident described by Patient 3 constituted "grossly immoral and unprofessional conduct," T.191, and a "serious and egregious boundary violation," T.192. Dr. Brandt characterized Dr. Arroyo's conduct with Patient 3 as "crossing the sacred boundary of appropriate behavior and behaving in a way that is destructive to the patient and to himself." T.192.

The American Medical Association Council on Ethical and Judicial Affairs has recognized the deleterious effect of sexual contact between physicians and their patients:

> most researchers agree that the effects of physician-patient contact are almost universally negative or damaging to the patient. Studies show that 85% to 90% of patients experience such sexual contact as damaging. Similar to the reactions of women who have been sexually assaulted, female patients tended to feel angry, abandoned, humiliated, mistreated, or exploited by their physicians. Victims have been reported to experience guilt, severe distrust of their own judgment, and mistrust of both men and physicians. Patients who have been involved in therapist-sexual relationships can suffer from depression, anxiety, sexual disorders, sleeping disorders, and cognitive dysfunctions and are at risk for substance abuse.

Council Report, Council on Ethical and Judicial Affairs of the American Medical Association, Sexual Misconduct in the Practice of Medicine, Journal of the American Medical Association,

Vol. 266, No. 19, November 20, 1991 (hereinafter "AMA Council Report").

While Patient 3 stated that she believed at the time that Dr. Arroyo had not intended to harm her, T.122, on re-direct, she testified that:

> I was entrusting Dr. Arroyo -- I really had no one when I was in the hospital at that point. My husband had basically abandoned me in a way, and Dr. Arroyo I felt took advantage of me at probably the most vulnerable time of my life. This is probably the worst time of my life, this hospitalization, and Dr. Arroyo I felt violated me at a time when -- no one ever needs it, but when I seriously -- when I really needed someone to assist me and help me. I did not feel that Dr. Arroyo did that. He actually caused a time which I couldn't think -- I can't imagine being worse to be worse, because the -- he violated a trust. I mean, he closed the door and then proceeded to touch me in inappropriate ways that I have never had a physician then, before or after touch me that way, talk to me that way.

T.132. The BPQA cannot accept the notion that Dr. Arroyo's conduct with Patient 3, while perhaps less egregious than the forcible sexual intercourse described by Patient 1, is in any way innocuous.

4. Appropriate Sanction

The BPQA adopts the sanction recommended by the ALJ, namely, revocation of Dr. Arroyo's Maryland medical license. While sexual contact occurring contemporaneously with the physician-patient relationship always constitutes unprofessional conduct in the practice of medicine, the sanction is determined on a case-by-case basis. Factors relevant to this determination include: 1) consent- lack of consent or degree of consent offered by the patient; 2) degree of transference or dependence in the particular physician-patient relationship, which may involve assessment of the physician's medical specialty; 3) location of the initiation of the relationship and the occurrence of the sexual contact; 4) degree of sexual contact or conduct; and 5) number of patients with whom the physician engaged in sexual relations and duration of time.

Here, an assessment of these factors points squarely to revocation as the appropriate sanction. First, in no case was the sexual contact even remotely consensual. Second, Dr. Arroyo provided psychiatric services, one of the most intimate and fiduciary of all medical specialties. Almost by definition, patients seeking psychiatric treatment are vulnerable to exploitation. Third, in every case, Dr. Arroyo's misconduct occurred in the therapeutic setting, including the hospital. Fourth, the evidence shows a range of physical contact, from kissing, fondling, and touching, to nonconsensual sexual intercourse. Finally, multiple patients were victimized by Dr. Arroyo's misconduct. The BPQA is persuaded that nothing less than revocation is appropriate, given the serious and egregious nature of the conduct. Furthermore, the BPQA has adopted the ALJ's recommendation to preclude Dr. Arroyo from applying for a Maryland medical license for a significant period of time, namely, fifteen years. The conduct exhibited by Dr. Arroyo is such a serious departure from accepted norms of ethical conduct for a physician, that it is difficult to conceive that appropriate rehabilitative measures, such as intensive psychiatric counseling and training in medical ethics, could be achieved in a shorter period of time.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 29th day of July, 1996, by a majority of the full authorized membership of the Board of Physician Quality Assurance considering this case

ORDERED that the Maryland medical license of Respondent, RUY DAN ARROYO, M.D., aka RUY DAN ARROYO-BARADA, M.D., is hereby REVOKED, and it is further

ORDERED that Respondent shall not be eligible to apply for reinstatement of that license

for at least FIFTEEN YEARS from the effective date of the revocation; and it is further

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

NOTICE OF RIGHT TO APPEAL

Pursuant to the Md. Code Ann., Health Occ. § 14-408, you have a right to take a direct judicial appeal. A petition for appeal shall be filed within thirty days from your receipt of this Final Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't §§ 10-201 et seq., and Title 7, Chapter 200 of the Maryland Rules.

7/29/96
Date

J. Michael Compton
BPQA Executive Director

APPENDIX A

IN THE MATTER OF:	*	BEFORE JEFFREY S. GULIN
RUY DAN ARROYO-BARADA, M.D.	*	AN ADMINISTRATIVE LAW JUDGE
RESPONDENT	*	OF THE MARYLAND OFFICE
(LICENSE NO. D27436)	*	OF ADMINISTRATIVE HEARINGS
	*	CASE NO. 95-DHMH-BPQA-71-285

* * * * * * * * * * *

PROPOSED DECISION

STATEMENT OF THE CASE

Pursuant to Health Occ. Code Ann. § 14-404 (1994)[1], on or about June 13, 1995, the Maryland Board of Physician Quality Assurance (the "Board") issued charges against Respondent and referred the case to the Office of Administrative Hearings for an adjudicatory hearing before an administrative law judge.

A pre-hearing conference was set for September 12, 1995, before me. Kate O'Donnell, Assistant Attorney General appeared on behalf of the Board but Respondent, or a representative, failed to appear. Prior to the scheduled hearing on the merits set for September 19-21, 1995, I conducted a telephone conference on September 15, 1995, with Ms. O'Donnell and Charles Zuravin, Esq., purporting to represent Respondent. Mr. Zuravin represented that Respondent assented to the Board's proposed

[1] Formerly § 14-504.

disposition and requested to withdraw the hearing. However, on September 29, 1995, I received a copy of a letter from Mr. Zuravin stating that Respondent subsequently changed his mind and rejected the settlement. Ultimately, a hearing on the merits was held on February 27-28, 1996. Ms. O'Donnell continued to represent the Board. Respondent did not appear but was represented by Scott M. Rotter, Esq.

Procedure in this case is governed by Health Occ. Code Ann. § 14-405 (1994); the Contested Case provisions of the Administrative Procedure Act, Md. State Gov't Code Ann. §§ 10-201 through 227 (1995); and the Rules of Procedure of the Office of Administrative Hearings, Code of Maryland Regulations (COMAR) 28.02.01.

ISSUE

The issue is whether Respondent is guilty of immoral and/or unprofessional conduct in the practice of medicine and, if so, what sanction is appropriate.

SUMMARY OF THE EVIDENCE

The following witnesses testified on behalf of the Board: Patient #1[2]; Patient #2; Patient #3; Diana Donegan, a former patient advocate at Washington County Hospital; and Dr. Harry

[2] The patients' names are identified in Board's Exhibit "C".

Brandt, M.D., who was accepted as an expert in the field of psychiatry with special knowledge regarding "sexual boundary violations." No witnesses testified on behalf of Respondent.

The following exhibits were introduced by the Board and admitted into evidence:

Board's Exhibit "A":	Application for Maryland License
Board's Exhibit "B":	Charging Document
Board's Exhibit "C":	Confidential Patient List
Board's Exhibit "D":	Medical Records of Patient 1
Board's Exhibit "E":	Medical Records of Patient 2
Board's Exhibit "F":	Medical Records of Patient 3
Board's Exhibit "G":	July 16, 1991 letter from Respondent to the Board of Physician Quality Assurance (regarding Patient 1)
Board's Exhibit "H":	January 9, 1989 letter from Respondent to Chief of Psychiatry, Washington County Hospital
Board's Exhibit "I":	Report of Diana Donegan, R.N., Patient Advocate (regarding Respondent/Patient 3)
Board's Exhibit "J":	Curriculum Vitae of Harry A. Brandt, M.D.

One exhibit, consisting of the Complaint filed by Patient #2, was introduced by Respondent and admitted as Respondent's Exhibit #1.

FINDINGS OF FACT

By clear and convincing evidence[3], I find the following facts:

1. At all times relevant to these charges, Respondent was and is licensed to practice medicine in the State of Maryland, holding license number D27436.

2. At all times relevant to these charges, Respondent represented himself to the public as a psychiatrist providing psychotherapy.

3. Respondent provided care to Patient #1 for "major depression" from approximately May, 1987 through February 22, 1988.

4. Throughout the course of treatment, Respondent frequently attempted to touch, hug, kiss, and fondle the breasts of Patient #1.

5. Throughout the course of treatment, Respondent frequently urged Patient to "trust" him.

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[3] Pursuant to Health Occ. Code Ann. § 14-405 (b)(1994), all findings of fact must be supported by clear and convincing evidence.

6. Throughout the course of treatment, Respondent frequently directed the conversation abruptly to sexual matters.

7. During the course of treatment, Respondent told Patient #1 the following:

a. He would like her for a "girlfriend."

b. She was his "favorite patient."

c. She was "sexually dead" and needed to trust him.

d. He would like her to take a class with him at a local community college.

8. During a hospital stay, Respondent met with Patient #1 in a private examining room. Respondent told Patient #1 that she reminded him of someone he had once loved but who had rejected him. Respondent then placed his hand over her mouth, forcibly pushed her legs apart and stated, "You are sexually dead."

9. Respondent arranged an appointment for Patient #1 at 9:00 p.m. on or about February 22, 1988. When she arrived for the scheduled appointment, they were alone in the office. Respondent proceeded to remove her clothes. Despite repeated pleas to stop, Respondent forced Patient #1 into sexual intercourse. She cried throughout the act. After cleaning his semen from the floor and showering, Respondent stated, "I did not have intercourse with you."

10. Patient #1 immediately terminated contact with Respondent but, for a substantial period of time thereafter, she was too embarrassed and humiliated to report the rape. In February 1991, her new therapist prodded her to discuss the circumstances surrounding the termination of care by Respondent. Patient #1 revealed the rape and the therapist called the police.

11. Patient #1 is a rather shy, vulnerable, and introverted woman who did not wish to testify nor pursue any action against Respondent. Despite constant inappropriate conduct by Respondent; until Respondent raped her on or about February 22, 1988, Patient #1 continued seeing Respondent because she loathed the process of finding and establishing a relationship with a new psychiatrist.

12. After a referral from her family doctor, Respondent provided psychiatric care to Patient #2 for depression from approximately March 1988 through January 1989.

13. Throughout the first two months of treatment, Respondent's wife worked as a receptionist at his office. During this period, Respondent's conduct was unremarkable. However, after approximately two months, Respondent hired a new receptionist and his conduct changed.

14. Respondent began directing conversation to sex and began touching, hugging and kissing Patient #2 in a sexual manner. He encouraged Patient #2 to wear tight clothes and

frequently discussed her physical beauty - particularly her breasts.

15. Whenever Respondent arranged night appointments, she contrived excuses to avoid being with him alone at night.

16. Though distraught about Respondent's conduct, she continued treatment because she trusted and respected her family doctor who referred her to Respondent.

17. Treatment continued until Respondent moved from the area in early 1989.

18. Several years later, after watching a television show concerning abusive and exploitive psychiatrists, Patient #2 filed a complaint with the Board.

19. On or about November 28, 1987, Patient #3 was admitted to Washington County Hospital due to "severe migraine syndrome with neurological impairment."

20. Due to a secondary diagnosis of "depression with anxiety," Patient #3 was transferred to a psychiatric ward. Respondent was the attending psychiatrist and, accordingly, saw Patient #3 alone on two occasions in her hospital room.

21. On the first occasion, Patient #3 disclosed recent marital problems to Respondent. Respondent told Patient #3 that

her problems were all due to her husband. Respondent advised her to "bleed" her husband "for all he is worth." Respondent also called her husband an obscene name.

22. The following evening, Respondent again entered the private hospital room and closed the door behind him. Respondent sat on the bed close to Patient #3 and began massaging her legs, progressing above her knees. Respondent stated that he understood what a lonely woman needed and desired to "jump under the covers" with her.

23. To terminate the contact, Patient #3 feigned a severe headache. Respondent then escorted her to a nurse and instructed the nurse to "give her whatever she wants." Patient #3 construed this peculiar instruction to be a reward.

24. Feeling violated, the following morning Patient #3 reported the incident to the hospital patient advocate, Diane Donegan.

25. Ms. Donegan reported the complaint to the hospital administration and a meeting was arranged with Respondent.

26. Among others, Respondent, Ms. Donegan and the hospital president were present at the meeting. When confronted with the complaint by Patient #3, Respondent stated that Patient #3 exaggerated the incident but Respondent acknowledged utilizing "seduction therapy." The president expressed astonishment and

instructed Respondent to never again utilize this "therapy" at the hospital.

DISCUSSION

Health Occ. Code Ann. § 14-404 (1994)[4] provides in pertinent part:

> (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 licensee, if the licensee:
>
> (3) is guilty of immoral or unprofessional conduct in the practice of medicine.

[4] The charges against Respondent are based on conduct that occurred between 1987 and 1991. The applicable statute in effect during part of that time was Health Occ. Code Ann. § 14-503 (3) which provided:

> Subject to the hearing provisions of § 14-504 of this subtitle, the Board, on the affirmative vote of the 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 conduct in the practice of medicine.

Section 1, Chapter 109, Acts 1988, effective July 1, 1988, recodified former § 14-504 (3) as § 14-504 (a)(3), and inserted the following underlined words in the existing statute:

> (3) Is guilty of immoral <u>or unprofessional</u> conduct in the practice of medicine.

Section 11, Chapter 6, Acts 1990, effective January 1, 1991, renumbered § 14-504 (a)(3) as § 14-404 (a)(3).

Accordingly, with respect to medical treatment rendered to Patients 1, 2, and 3 *after* July 1, 1988, Respondent is charged with immoral *and* unprofessional conduct.

In the instant case, Respondent declined to appear or present any witnesses. Accordingly, Respondent's defense was essentially limited to attacking the veracity and credibility of the Board's witnesses. Patient #2 was a poor historian, but despite aggressive cross examination by competent counsel, all three patients presented as wholly credible. Their testimony was consistent on all material points and often corroborated by other witnesses and documentary evidence. I perceived no serious bias or motivation to fabricate or embellish their testimony. Moreover, the record is devoid of any evidence suggesting they were incapable of accurately recalling the events they described.

In his testimony, Dr. Brandt merely stated the painfully obvious. The conduct of Respondent constitutes egregiously immoral and unprofessional conduct. Respondent grossly violated the doctor-patient boundary for the purpose of self gratification apparently without the slightest regard for the potentially destructive consequences to his patients.

Counsel for Respondent placed significance upon the delay in reporting the rape by Patient #1 and argued that Patients #2 and #3 were "recruited" to merely bolster the otherwise incredible testimony of Patient #1. These arguments are unsupported by fact. The delay in reporting by both Patients #1 and #2 were credibly explained by both and their demeanor was consistent with their testimony. Moreover, Dr. Brandt opined that a delay in reporting sexual abuse, particularly by either a child or vulnerable psychiatric patient, is not at all atypical. Finally,

the suggestion that the Board "recruited" patients to manufacture a case against Respondent is unfounded. Indeed, the testimony elicited from Patient #1 alone is compelling.

As to the appropriate sanction, nothing less than revocation can be considered. Respondent engaged in a course of outrageous self-stimulating and self-gratifying conduct up to and including rape. He perpetrated this conduct upon vulnerable women at times when they most required help. Instead, Respondent chose to systematically exploit and violate these patients. One cannot possibly imagine the sense of betrayal they must have experienced.

I do not hesitate to recommend revocation of Respondent's license. Indeed, I cannot envision any occupation or position of trust appropriate for this man. In light of the heinous nature of Respondent's misconduct, including rape of a patient, it is clear that his moral character is not amenable to rehabilitation in the near future. Accordingly, I urge the Board to reject any application for license reinstatement for a *minimum* of 15 years.

CONCLUSIONS OF LAW

Based upon my Findings of Fact and Discussion, I conclude, as a matter of law, that pursuant to Health Occ. Code Ann. § 14-404 (1994) and predecessor statutes, Respondent is guilty of immoral and unprofessional conduct in the practice of medicine from May 1987 through January 1989.

PROPOSED DISPOSITION

I propose that Respondent's license (No. D27436) be **REVOKED** and that the Board decline to consider license reinstatement for a **MINIMUM** of 15 years.

March 7, 1996
Date

Jeffrey S. Gulin
Administrative Law Judge

JSG/kc

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this Recommended Decision has the right to file exceptions with the Board of Physician Quality Assurance within 21 days of receipt of the Recommended Decision, in accordance with Md. State Gov't Code Ann. § 10-220 (Supp. 1995) and Md. Health Occ. Code Ann. § 14-405 (1994).