STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Ausust 25, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Rodney Drake, Esq.
600 Johnson Avenue
Suite A-8
Bohemia, NY 11716

Giovanni Biondi, M.D.
1607 White Road
Scarsdale, NY 10583

Terrence Sheehan, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

RE: In the Matter of Giovanni Biondi, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-216) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested

items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

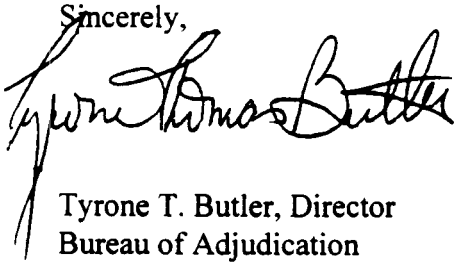
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER

OF

GIOVANNI BIONDI, M.D.

DETERMINATION

AND

ORDER

BPMC 99-216

NAOMI GOLDSTEIN, M.D., (Chair), **JOHN H. MORTON, M.D.** and **MS. CAROLYN C. SNIPE**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) and §230(12) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health appeared by **HENRY M. GREENBERG, ESQ.**, General Counsel, by **TERRENCE SHEEHAN, ESQ.**, Associate Counsel.

Respondent, **GIOVANNI BIONDI, M.D.**, appeared personally and was represented by **RODNEY DRAKE, ESQ.**

Thirteen (13) Hearing days were held between February 11, 1999 and June 9, 1999. Evidence was received and examined, including witnesses who were sworn or affirmed. A Transcript of the proceeding was made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq. of the Public Health Law of the State of New York [hereinafter "**P.H.L.**"]).

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Department**") pursuant to §230(12) of the P.H.L. Under §230(12) of the P.H.L., a Commissioner's Summary Order and Notice of Hearing ("**Order**") dated February 4, 1999, and a Statement of Charges, dated February 4, 1999, were issued by **DENNIS P. WHALEN,** as Executive Deputy Commissioner of Health of the State of New York. Said Order and Statement of Charges were served on Dr. Giovanni Biondi on February 5, 1999.

The Commissioner's Order summarily suspended Respondent's license to practice medicine in the State of New York. The Order was accompanied by a Statement of Charges setting forth eight specifications of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**"). On February 25, 1999, the Department issued an Amended Statement of Charges which added one patient and one specification (the new patient was also added to the other specifications) of professional misconduct. On March 17, 1999, DENNIS P. WHALEN issued a Commissioner's Supplementary Order incorporating the Amended Statement of Charges.

GIOVANNI BIONDI, M.D., ("**Respondent**") is charged with Gross Negligence (§6530[4]), Gross Incompetence (§6530[6]), Negligence on more than one occasion (§6530[3]), Incompetence on more than one occasion (§6530[5]), Willful patient abuse (§6530[31]), Failure to maintain records (§6530[32]), and Moral unfitness (§6530[20]) (Department's Exhibit # 1-A).

The Charges concern the medical care, treatment and services provided by Respondent to two patients. Respondent admits to being licensed to practice medicine in New York and acknowledges that he undertook the psychiatric care and treatment of the two patients. Respondent denies each and every factual allegation and denies each and every specification of professional misconduct.

Copies of the Commissioner's Order and Notice of Hearing, the Commissioner's Supplementary Order, and the Amended Statement of Charges are attached to this Determination and Order as Appendix I.

The Hearing consisted of 13 separate days. The Department called 7 witnesses. The Respondent called 6 witnesses, including himself. Respondent agreed to continue to abide by the Suspension Order (and not practice medicine) until the Hearing Committee issued its Order (not more than 53 days after the date of deliberations) [T-1485-1486, 2768-2769][1]. The Hearing Committee deliberated on July 12, 1999.

PROCEDURAL HISTORY

Date of Commissioner's Order and Notice of Hearing:	February 04, 1999
Date of Service of Order and Notice of Hearing:	February 05, 1999
Date of Statement of Charges:	February 04, 1999
Date of Service of Statement of Charges:	February 05, 1999
Answer to Statement of Charges:	February 08, 1999

1 Numbers in brackets refer to Hearing transcript page numbers [T-]; to Pre-Hearing transcript page numbers [P.H.T-] or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee did not review or read the Pre-Hearing or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

Pre-Hearing Conferences Held:	February 10, 1999 and February 11, 1999
Hearings Held: - (First Hearing day):	February 11, 1999 February 16, 1999; February 26, 1999; March 08, 1999; March 15, 1999; March 23, 1999; March 30, 1999; April 07, 1999; April 09, 1999; April 19, 1999; May 18, 1999; May 25, 1999; and June 09, 1999.
Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendation	Received June 30, 1999
Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendation:	Received July 02, 1999
Deliberations Held: - (Last Hearing day):	July 12, 1999

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. All Findings and Conclusions herein were unanimous. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was authorized to practice medicine in New York State on April 3, 1981 by the issuance of license number 145370 by the New York State Education Department (Department's Exhibit # 2)[2].

2. Respondent is not currently authorized to practice medicine in New York because his license was summarily suspended on February 5, 1999 by service of the Commissioner's Summary Order (Department's Exhibit # 1).

[2] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit) or submitted on behalf of Dr. Giovanni Biondi (Respondent's Exhibit).

3. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (Respondent was personally served - P.H.L. §230[10][d]); (Department's Exhibit # 1); (determination made by the ALJ [P.H.T-18-19]).

4. Howard Telson, M.D., board certified psychiatrist, has been in private practice since 1985. He was called by the Department as its expert witness [T-361-569, 576-815, 1494-1739]; (Department's Exhibit # 11).

5. Jonathan House, M.D., has been in private practice since 1982. He was called by Respondent as his expert witness (Respondent's Exhibit # H); [T-2535-2766].

6. Giovanni Biondi, M.D., testified on his own behalf [T-1008-1242, 1248-1488, 1748-1770, 1967-2038, 2047-2259, 2267-2403, 2513-2527].

Patient A

7. On October 2, 1995 Respondent undertook the psychiatric care and treatment of Patient A for borderline personality disorder and other conditions (Respondent's Exhibit # 9 [3]); [T-375, 391, 1773].

8. The psychiatric care and treatment of Patient A is documented by Respondent through January of 1998 (Respondent's Exhibit # 9); [T-398, 1813, 2012].

9. Respondent continued to prescribe medications (18 prescriptions written after January 13, 1998) to Patient A until at least August of 1998 and continued to meet with Patient A, ostensibly for treatment purposes, until at least September 1998 (Respondent's Exhibits # 9, p. 55 & # 10); [T-2012].

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3 Department's Exhibit # 9 is Patient A's Medical Records (also referred to as chart or Respondent's notes) which was certified by Respondent to be the complete, true and exact copies of the original medical records maintained by Respondent (on his computer).

10. On the first visit of October 1995, Respondent's notes show no thorough discussion of the onset of Patient A's psychiatric illness, any specific past providers, no systematic discussion of the course of previous treatment, the response to treatment, or the outcome to treatment. Respondent did not obtain or note an appropriate history of Patient A (Respondent's Exhibit # 9); [T-373-376, 2560-2562, 2651-2652].

11. On the first visit of October 1995, the Medical Records maintained by Respondent do not reflect that he performed a mental status evaluation of Patient A (Respondent's Exhibit # 9); [T-376-377, 2652].

12. On the first visit of October 1995, Respondent's notes indicate that he diagnosed that Patient A had major depression, but there is no information to show how or why he arrived at that diagnosis or that he assessed the current dangerousness of Patient A to herself or others (Respondent's Exhibit # 9); [T-377].

13. On the first visit of October 1995, Respondent's chart indicates "Paxil" and "Anafranil". It is impossible to determine from the note whether this refers to past, current or future medications (Respondent's Exhibit # 9); [T-380-381].

14. On multiple occasions throughout his treatment of Patient A, Respondent prescribed a variety of medications, to wit: Ambien, Trazodone, Prozac, Vistaril, Wellbutrin, Clonidine, Nifedipine, Parnate, Depakote, Nardil, Ativan, Valium, Xanax, Restoril, Klonopin, Halcion, Dexedrine and Lithium (Respondent's Exhibits # 9 & # 10).

15. Patient A's medical records do not provide the indications for most of the above prescriptions. Patient A's medical records are unclear as to how much medication had been given to the patient and what the instructions are for the patient to take the medication. It is unclear whether the other medications that the patient was taking had been evaluated in the context of a new prescription. It is impossible to determine from reviewing the chart what the patient was told to do regarding medications. Patient A was a very unreliable and non-compliant patient and Respondent knew that. Patient A's unreliability made it even more important for Respondent to carefully assess and limit the medications he prescribed to her (Respondent's Exhibit # 9); [T-384-385].

16. Many of the above medications are psychotropic drugs, that have significant effects on both a person's body and a person's psychological functioning, and should not to be prescribed without clear justification (Respondent's Exhibit # 9); [T-385-386].

17. Throughout his treatment of Patient A, Respondent prescribed the above medications (some simultaneously) without appropriate medical rationale or justification and/or failed to note a medical rationale or justification (Respondent's Exhibits # 9 & # 10); [T-381-382, 384-388].

18. Patient A was given multiple medications (often simultaneously) which potentially interacted with one another. The combinations of medications had the potential to cause significant side effects, as well as psychiatric effects (Respondent's Exhibits # 9 & # 10); [T-388].

19. Throughout his treatment of Patient A, Respondent did not make a systematic review and did not monitor which medications caused which side effects. Generally, Respondent failed to assess and/or note side effects or interactions caused by the medications he prescribed (Respondent's Exhibit # 9); [T-388-389].

20. When Patient A did present with side effects, Respondent failed to evaluate and clinically intervene (Respondent's Exhibit # 9); [T-388-389].

21. Respondent prescribed medications to Patient A without appropriately monitoring Patient A (Respondent's Exhibits # 9 & # 10); [T-380-390].

22. Respondent prescribed some of the above medications to Patient A because she wanted them, even though sometimes Respondent felt they were not necessary or indicated, and even though Respondent had inadequate justifiable medical indications for many of the prescribed medications (Respondent's Exhibits # 9 & # 10); [T-390].

23. Respondent knew and documented that Patient A had a pattern of overdosing, and that she was a non-compliant patient with regard to medications, as well as other matters (Respondent's Exhibit # 9); [T-390-394].

24 There was a necessity for medical evaluations of Patient A during the course of her treatment by the Respondent (Respondent's Exhibit # 9); [T-417-418].

25 Respondent did not consult with any other physician (other than Patient A's father). There is no indication of a systematic evaluation of Patient A's medical status, or of the effect of specific medications on symptoms (Respondent's Exhibit # 9); [T-417-418].

26. During Respondent's treatment of Patient A, there are indications of various symptoms and medical problems that confronted Patient A. Respondent did not consult or follow-up with respect to Patient A's medical issues (Respondent's Exhibit # 9); [T-417-418].

27. Respondent did request of Patient A that she be medically evaluated for certain complaints. Patient A generally used her father (a physician) as her clinician and was non-compliant otherwise (Respondent's Exhibit # 9); [T-2575-2576].

28. On at least one occasion, Respondent refused Patient A access to her medical records (Respondent's Exhibit # 9 back of page 7); [T-786, 2576, 2647-2648].

29. On at least one occasion, Respondent changed Patient A's medical records when Patient A asked him to do so. Respondent indicated in the chart that he altered the chart (Respondent's Exhibit # 9 back of page 5); [T-415-416, 1161, 1163, 2609-2610].

30. A psychiatric treatment plan is an outline of the treatment approach. It contains, at least, a listing of the way that the treatment is going to be conducted. Treatment plans can be very extensive and elaborate, or they can be an outline, but they usually identify the problem, the goal, and the method of achieving the goal. Respondent did not establish a clear treatment plan for Patient A (Respondent's Exhibit # 9); [T-403-405, 2578, 2653).

31. Respondent made himself available to Patient A for extended sessions on her request. Patient A set the schedule. Respondent also allowed the patient to determine the length of the sessions, as well as the frequency of the sessions. Respondent conducted numerous multi-hour sessions, sometimes three hours long, and sometimes a number of multi-hour sessions during the same week. The length and frequency of the sessions make them questionable. The additional fact that Respondent did not identify or note any clinical justification for these frequent and multiple "therapy" sessions makes them inappropriate and not reasonable (Respondent's Exhibit # 9); [T-396-398, 2580-2581].

32. Respondent's medical records do not address Patient A's dangerousness to herself and others (Respondent's Exhibit # 9); [T-379-380, 2176, 2564].

33. When going on vacation, the standard practice for a psychiatrist consists of working with a colleague who would cover his practice. Standard practice would include providing some basic information about the patient, and making sure that the covering psychiatrist is available in the location that the patient is at so that the patient could contact that covering psychiatrist in case of emergency or if the patient required some kind of care. When Respondent went on vacation, he did not arrange for coverage by a local or by any psychiatrist (Respondent's Exhibit # 9); [T-396].

34. Respondent had numerous telephone sessions with Patient A while he was on a vacation trip in Italy (Respondent's Exhibit # 9); [T-1189, 1191, 1195]. Considering a difficult patient such as Patient A, these numerous telephone sessions were not a totally unreasonable choice by Respondent, although it is not clear whether any specific therapeutic benefit occurred (Respondent's Exhibit # 9); [T-721-722, 2590-2591].

35. Respondent did identify his emotional interest in Patient A. Respondent did not monitor or appropriately and fully understand or deal with his emotional interest in Patient A. (Respondent's Exhibit # 9, page 41, back of page 41, pages 42, 54-55); [T-1087, 2177, 2662].

36. Respondent's emotional interest is further indicated by Respondent as follows:

Q. Could you explain to me what you mean by: "I felt my own need for her love and that I could never leave her"?

A. I felt that her love, our love and our connection was something that had definitely taken up a big portion of my life, or my time, and my -- and so I had to acknowledge to myself as well as to her that, that this was not --that indeed, you know, she -- she had a very big place in my life, and that I would, I -- I loved her, and that I did not want to leave her.

(Respondent's Exhibit # 9 back of page 54); [T-2177].

37. Respondent developed a personal relationship with Patient A. Respondent's personal relationship with Patient A included: holding "therapy" sessions with Patient A in Respondent's van, meeting Patient A at a motel (on at least 2 occasions), paying for a motel room for Patient A, spending time with Patient A in a motel room, and holding Patient A for hours (Respondent's Exhibits # 8 & # 9); [T-405, 1348-1380, 1472-1473, 2055, 2061-2062, 2179, 2181, 2184].

38. Respondent did not provide information in Patient A's medical records indicating that her treatment was ending or where follow-up treatment would be provided (Respondent's Exhibit # 9 page 55, note of 1/13/1998); [T-417-419]. Patient told Respondent that she would no longer see him in his office. In some sense that was the termination of treatment. Yet Respondent continued to meet with Patient A, now outside of his office and continued to prescribe medications. There is no clear delineation of when "treatment" ended (Respondent's Exhibit # 9); [T-2598-2599].

39. Respondent did not treat Patient A in accordance with accepted standards of psychiatric practice [T-361-569, 576-815].

40. Patient A needed to have clearly defined and strict boundaries in the therapy relationship. Patient A had a pattern of inappropriate relationships with previous therapists, as well as intense attachments to other individuals, and seemed particularly prone to make characteristic frantic attempts to avoid being alone. Patient A also seemed to have the characteristic borderline personality of over idealizing, and then devaluing therapists. It would be very important in order to maintain a professional, appropriate relationship, to help this patient understand these patterns [T392-394, 447, 453, 722, 732-737].

41. Boundaries, in psychiatric-patient relationships, are defined as what is appropriate and what is not appropriate in the relationship, as well as the nature of the infractions.. For example, there are certain times for meetings, certain times when meetings do not take place and certain physical things that you do not do with patients. Boundaries are defined by the psychiatrist to set the format for the therapy, ie: when, where and how long. Boundaries include: the nature of the interactions between the therapist and the patient; reasons for prescribing medication; scheduling of appointments; what the fees will be and how payments are to be made. Boundaries are set to provide a clear separation between the psychiatrist having a professional relationship with the patient rather than a personal relationship. Minimum accepted standards of psychiatric practice prohibit most physical contact or any sexual contact between a psychiatrist and his/her patient [T392-394, 447, 453, 722, 732-737].

42. Respondent did not set, or ever attempt to define, any boundaries with Patient A. No boundaries were set between Respondent and Patient A regarding: medications; scheduling of office visit length; session duration or time; scheduling of telephone sessions; structuring vacations appropriately; level of permissible emotional involvement; touching of or by the patient; holding of or by the patient; or conducting sessions outside of Respondent's office [T-392-394, 401, 734-735, 781-782, 1347, 1352].

43. Respondent met Patient A at the Capri Motel at least once in July 1998 and at least once in August 1998. Respondent sometimes paid for the motel room and spent many hours in the motel room with Patient A, holding her for hours (Department's Exhibit # 8); [T-211-213, 302-305, 1351-1356, 1822-1824, 1870-1872, 1910-1912, 1928-1932, 1986].

44. While at the Capri Motel on the morning of August 15, 1998 or in Respondent's van, between 9 A.M. and 10:15 A.M., Respondent and Patient A struggled physically and Patient A was injured. Respondent, with Patient A in his van, drove toward his home in Scarsdale. Respondent left or abandoned Patient A near his home with no means of transportation, contact or aid. Patient A contacted the Scarsdale Police and was seen at the Emergency Room at White Plains Hospital, White Plains, NY. The White Plains Hospital record notes that Patient A was found to have multiple bruises on her right knee and lower leg. Patient A reported to the police and the hospital that she and her boyfriend, Giovanni Biondi, had an altercation and he beat her up (Department's Exhibits # 3 & # 4); [T-49, 51-55, 72, 99-100, 1376-1379, 1464-1468, 1831-1833, 1912, 1988-1991].

45. Sometime between September 10, 1998 and September 12, 1998 Respondent and Patient A had another physical altercation. On September 12, 1998, Patient A contacted the Harrison Police and was transported to St. Agnes Hospital in White Plains, NY (Department's Exhibits # 5 & # 6); [T127-128, 175, 1963-1965, 1988-1990]. Patient A was then taken, and admitted, to Saint Vincents Hospital., a psychiatric hospital. She was discharged on September 18, 1998 (Department's Exhibit # 7).

46. Respondent maintained medical records for Patient A "most of the time as one might use a sketch pad one carried in one's pocket, and kept notations of one's dreams, associations, laundry list, people to be called, anxieties, mixed in with a little bit of what appears to be typical charting." (Department's Exhibit # 9); [T-2546] In Patient A's chart, Respondent does not distinguish between the patient's statements, his own observations, his speculations, or his clinical assessments (Department's Exhibit # 14).

47. Respondent failed to document in the Medical Records of Patient A, numerous office visits, telephone sessions and other contacts that he had with Patient A. Respondent's own billing records and clinical notes acknowledges this failure (Department's Exhibit # 9); [T-413, 2609].

48. Accepted standards of psychiatric practice include, in part, the documenting of each session, noting the date of the session and documenting telephone contacts [T-413].

49. Respondent used obscure terms in the Medical Records of Patient A and, in terms of communicating information, much of Patient A's Medical Record is obscure and bizarre. A "treatment plan" prepared for Patient A's parents, one year after the initial evaluation of Patient A, was contained in her Medical Records and was also written in obscure and bizarre language (Department's Exhibit # 9); [T-2609, 2648].

Patient B

50. On August 20, 1991 Respondent undertook the psychiatric care and treatment of Patient B (Department's Exhibits # 15 & # 16 & # 17).

51. Respondent's psychiatric care and treatment of Patient B continues through at least January of 1999 (Department's Exhibit s # 15 & # 16 & # 17).

52. On multiple occasions throughout Respondent's care and treatment of Patient B, Respondent prescribed a variety of medications to Patient B, to wit: Zoloft, Ritalin, Percocet, Fioricet, Dexedrine, Ambien, Xanax, Halcion, Doxepin, Zantac, Nicorette, Motrin, Prilosec, Catapres, Compazine, Finasteride (Propecia) and Viagra (Department's Exhibits # 15 & # 16 & # 17); [T-2723].

53. Patient B's medical records do not support the indications for most of the above prescriptions. Patient B's medical records are unclear as to how much medication had been given to the patient and what the instructions are to the patient to take the medication. It is impossible to determine from a review of Patient B's medical records what instructions were given to the patient regarding the prescribed medications. Numerous prescriptions were issued without corresponding office visits or notations in the medical records (Department's Exhibits # 15 & # 16 & # 17); [T-1505-1513, 1521].

54. From a review of the medical records of Patient B provided by Respondent, as well as copies of the prescriptions signed by Respondent, it is apparent that Respondent did not see Patient B for lengthy periods of time but continued to prescribe various controlled substances to Patient B (Department's Exhibits # 15 & # 16 & # 17).

55. Minimum acceptable psychiatric standards of practice require that documentation be maintained in the patient's medical records regarding prescriptions given, the reason therefor and the dosage prescribed [T-1508-1509]. Patient B's medical records indicate that he has or had a substance abuse disorder. A psychiatrist needs to be particularly cautious when prescribing medications, especially controlled substances, to a patient with a history of substance abuse (Department's Exhibits # 15 & # 16 & # 17); [T-1511-1513, 1695]. Patient B's medical record does not indicate an appropriate, or any, level of caution regarding the prescription of controlled substances in light of Patient B's substance abuse history (Department's Exhibit # 15); [T-1511-1513].

56. Respondent's failure to exercise a proper level of caution when prescribing controlled substances to Patient B was likely to cause harm to Patient B [T-1513].

57. Respondent did not obtain or note a proper history of Patient B. Respondent's progress notes show no thorough discussion of Respondent's subjective findings, objective findings, or assessments nor do Respondent's progress notes explain a plan (Department's Exhibit # 15); [T-1514].

58. Although a treatment plan is present in Patient B's medical records, overall the medical records maintained by Respondent for Patient B do not meet minimum accepted psychiatric standards of care (Department's Exhibit # 15); [T-1516, 2729].

59. Respondent uses a number of terms in Patient B's medical records that are highly unusual or bizarre in the context of psychiatric treatment (Department's Exhibit # 15); [T-1515].

60. Respondent developed a personal relationship with Patient B. Respondent's personal relationship with Patient B included: meeting Patient B outside of Respondent's office on numerous occasions; involving himself in Patient B's life in other than a therapeutic manner; co-signing a loan and/or apartment lease for Patient B; staying at Patient B's apartment on a number of occasions; and allowing Respondent's daughter to use Patient B's apartment [T-1519-1520, 2723]. Patient B considered Respondent his friend; Respondent considered Patient B his friend (Department's Exhibit # 5); [T-2277-2278].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions as to the allegations contained in the Statement of Charges were by unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the February 25, 1999 Amended Statement of Charges are SUSTAINED[4]:

Paragraph A.		(1, 7 - 9, 31, 35 - 37, 40 – 45)
Paragraph B.1.		(7, 10)
Paragraph B.2.		(7, 11)
Paragraph B.3.		(7, 12)
Paragraph C.		(7 – 9, 14 – 25)
Paragraph C.1.		(7 – 9, 14 – 17)
Paragraph C.2.		(7 – 9, 14, 15, 18, 19, 20)
Paragraph C.3.		(7 – 9, 14, 15, 19 – 21)
Paragraph C.4.		(7 – 9, 14, 15, 21)
Paragraph C.5.		(7 – 9, 14, 15, 22)
Paragraph D.		(7 – 49)
Paragraph D.1.	(in part)[5]	(7 – 9, 24 – 26)
Paragraph D.2.		(7 – 9, 28 – 29)
Paragraph D.3.		(7 – 9, 30)
Paragraph D.4.		(7 – 9, 31, 42, 47)
Paragraph D.5.		(7 – 9, 12, 32)
Paragraph D.6.		(7 – 9, 33)
Paragraph D.9.		(7 – 9, 35 – 37, 40 – 45)
Paragraph D.10.		(7 – 9, 37, 40 –45)
Paragraph D.11.		(7 – 9, 38 – 39)

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4 The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee.

5 Respondent failed to insure that Patient A had appropriate, and on-going, medical evaluation(s) is SUSTAINED.

Paragraph E.1.		(7 – 9, 14 – 24, 40 – 42)	
Paragraph E.2.		(7 – 9, 31, 33 – 34, 40 –42)	
Paragraph E.3.		(7 – 9, 33, 40 –42)	
Paragraph E.4.		(7 – 9, 35 – 45)	
Paragraph E.5.		(7 – 9, 37, 40 – 45)	
Paragraph F.1.		(7 – 9, 43 – 44)	
Paragraph F.2.		(7 – 9, 45)	
Paragraph G.		(7 – 49)	
Paragraph G.1.		(7 – 9, 31, 34, 38 – 39, 40 – 42, 46 – 48)	
Paragraph G.2.	(in part)[6]	(7 – 9, 49)	
Paragraph G.3.		(7 – 9, 29)	
Paragraph I.		(50 – 51)	(as amended to 8/21/1991 [on 4/7/1999])
Paragraph I.1.		(50 – 56)	
Paragraph I.2.		(50 – 51, 59 – 60)	
Paragraph I.3.	(in part)[7]	(50 – 51, 57 –59)	

The Hearing Committee concludes that the following Factual Allegations, from the February 25, 1999 Amended Statement of Charges are NOT SUSTAINED

Paragraph D.1.	(in part)	(7 – 9, 27)	(see footnote # 5)
Paragraph D.7.		(7 – 9, 34)	
Paragraph D.8.		(7 – 9)	
Paragraph H.		(Withdrawn by the Department on 2/26/1999)	

Based on the above, the complete Findings of Fact and the entire record, the Hearing Committee unanimously concludes and determines that the following SPECIFICATIONS contained in the February 25, 1999 Amended Statement of Charges are SUSTAINED:

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6 Respondent used obscure terms is SUSTAINED.

7 Failure to maintain a treatment plan IS NOT SUSTAINED. The remainder of Paragraph I.3. is SUSTAINED

FIRST SPECIFICATION (GROSS NEGLIGENCE)

(Factual Allegation Paragraphs A., B.1. – B.3., C. – C.5, D. – D.6, D.9 – D.11, E.1 – E.5, F.1., F.2., G. – G.3., I. – I.3.)

SECOND SPECIFICATION (GROSS INCOMPETENCE)

(Factual Allegation Paragraphs A., B.1. – B.3., C. – C.5, D. – D.6, D.9 – D.11, E.1 – E.5, F.1., F.2., G. – G.3., I. – I.3.)

THIRD SPECIFICATION (NEGLIGENCE ON MORE THAN ONE OCCASION)

(Factual Allegation Paragraphs A., B.1. – B.3., C. – C.5, D. – D.6, D.9 – D.11, E.1 – E.5, F.1., F.2., G. – G.3., I. – I.3.)

FOURTH SPECIFICATION (INCOMPETENCE ON MORE THAN ONE OCCASION)

(Factual Allegation Paragraphs A., B.1. – B.3., C. – C.5, D. – D.6, D.9 – D.11, E.1 – E.5, F.1., F.2., G. – G.3., I. – I.3.)

FIFTH and SIXTH SPECIFICATION (WILLFUL PATIENT ABUSE)

(Factual Allegation Paragraphs A., F.1., F.2.)

SEVENTH SPECIFICATION (FAILURE TO MAINTAIN RECORDS {Patient A})

(Factual Allegation Paragraphs A., B.1. – B.3., C. – C.5, D. – D.6, G. – G.3.)

EIGHTH SPECIFICATION (FAILURE TO MAINTAIN RECORDS {Patient B})

(Factual Allegation Paragraphs I. – I.3.)

NINTH SPECIFICATION (MORAL UNFITNESS)

(Factual Allegation Paragraphs A., D., D.2, D.10 – D.11, E.1 – E.5, F.1., F.2., G., G.3., I. – I.2.)

The Hearing Committee concludes that the Department of Health has shown, by a preponderance of the evidence, that Respondent's conduct constitutes professional misconduct under the laws of New York State. The Department of Health has met its burden of proof.

DISCUSSION

Respondent is charged with nine specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of many of the types of misconduct charged in this matter. A psychiatrist is a physician and the terms are used interchangeably.

The ALJ provided to the Hearing Committee the definitions of medical misconduct as alleged in this proceeding. These definitions were obtained from a memorandum, prepared by the New York State Department of Health[8]. This document, entitled: Definitions of Professional Misconduct under the New York Education Law, ("**Misconduct Memo**"), sets forth suggested definitions of practicing the profession: (1) fraudulently; (2) with negligence on more than one occasion; (3) with gross negligence; (4) with incompetence on more than one occasion; and (5) with gross incompetence. During the course of its deliberations on these charges, the Hearing Committee consulted the relevant definitions contained in the Misconduct Memo, which are as follows:

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee (physician) under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his conduct.

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8 A copy of this memorandum, was made available to Respondent [P.H.T-80-81]; [T-3-4].

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

The Misconduct Memo does not contain a discussion of moral unfitness. The Hearing Committee determined that to sustain an allegation of moral unfitness, the Department must show that Respondent committed acts which "evidence moral unfitness". There is a distinction between a finding that an act "evidences moral unfitness" and a finding that a particular person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Hearing Committee is asked to decide if certain conduct is suggestive of, or would tend to prove, moral unfitness. The Hearing Committee is not called on to make an overall judgment regarding a Respondent's moral character. The Department is not required to prove that a physician is morally unfit to practice psychiatry. The Department must prove that a physician committed an act which shows a lack of moral fitness to practice medicine. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgment or other temporary aberration.

The standard for moral unfitness in the practice of medicine or psychiatry has two separate and independent possibilities. Physicians have privileges that are available solely due to the fact that one is a physician.

First, there may be a finding that the accused has violated the public trust which is bestowed by virtue of his or her licensure as a physician. The public places great trust in physicians solely based on the fact that they are physicians. For instance, physicians have access to controlled substances and billing privileges that are available to them solely because they are physicians. Patients may be asked to place themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment. Hence, it is expected that a physician will not violate the trust the public has bestowed on him or her by virtue of his or her professional status.

Second, moral unfitness can be seen as a violation of the moral standards of the medical community which the Hearing Committee, as delegated members of that community, represent.

The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. All findings by the Hearing Committee were established on their own merits and based on the evidence presented. If evidence or testimony was presented which was contradictory, the Hearing Committee made a determination as to which evidence was more believable based on their observations as to credibility, demeanor, likelihood of occurrence and reliability.

The ALJ told the Hearing Committee, that under present law, injury, damages and proximate cause are not essential legal elements to be proved in a medical disciplinary proceeding. The State does not need to present evidence of injury to demonstrate that negligence has occurred or that substandard care was given; Matter of Morfesis v. Sobol, 172 A.D. 2d 897, leave to appeal denied 78 N.Y. 2d 856 (1991); Matter of Loffredo v. Sobol, 195 A.D. 2d 757, leave to appeal denied 82 N.Y. 2d 658 (1993).

Acceptable medical standards are based on what a reasonably prudent physician, possessed of the required skill, training, education, knowledge or experience to act as a physician, would do under similar circumstances (and having the same information, ie: without the benefit of hindsight). Proof that a physician failed to exercise the care that a reasonably prudent physician would exercise under the circumstances is sufficient to sustain a finding of negligence in a medical misconduct proceeding; Matter of Bogdan v. NYS-BPMC, 195 A.D.2d 86 appeal dismissed and leave to appeal denied, 83 N.Y.2d 901 (1994); Matter of Enu v. Sobol, 171 A.D.2d 302 (3rd. Dep't., 1991) and 208 A.D.2d 1123 (3rd. Dep't., 1994) (expert witness qualifications).

A physician can make a mistake or an error in medical judgment without being negligent. However, a physician's decision or act which is without proper medical (psychiatric) foundation, or not the product of careful examination, or deviates from acceptable medical (psychiatric) standards or knowledge, is more than a mere error in medical judgment; Krapvika v. Maimonides Medical Center, 119 A.D.2d 801, 805 (2d Dep't., 1986) (dissent- citing Bell v. New York City Health & Hosps. Corp. and Huntley v. State of New York [citations omitted]).

The Hearing Committee used ordinary English usage and understanding for all other terms, allegations and charges.

With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility.

Dr. Howard Telson, as the State's expert, had no professional association with Respondent. Dr. Telson was considered to be knowledgeable in the area of psychiatry with sufficient experience in the treatment of personality disorders. No reason was advanced to show that Dr. Telson had any prejudice against Respondent.

Overall, the Hearing Committee found Dr. Telson to be credible, honest, straightforward, and forthright and accepted many of his opinions, as supported by the patients' medical records. Dr. Telson gave detailed, impartial testimony regarding areas in which he believed Respondent's care fell below minimum standards of accepted medical practice and why a reasonably prudent physician would have responded differently given the circumstances at hand.

Dr. Jonathan House, as the Respondent's expert, was also considered to be knowledgeable in the area of psychiatry with sufficient experience in the treatment of personality disorders. Dr. House was credible, logical and made appropriate observations. Dr. House was consistent in his testimony.

Ultimately, in many areas, Dr. Telson and Dr. House were consistent in their views of the totality of the circumstances presented by the Medical Records reviewed. The Hearing Committee did note that Dr. Telson was more conservative in his treatment views than Respondent's expert. The Hearing Committee found both experts to be internally consistent with their own viewpoint. Both experts expressed serious questions regarding Respondent's judgment. Dr House made many assumptions, which were not supported by the Medical Records, but were obtained from information provided to him by Respondent. In addition, Respondent did not provide to Dr. House a number of the exhibits and information given to the Hearing Committee and to Dr. Telson. Overall, the Hearing Committee gave more weight to the testimony presented by Dr. Telson.

Obviously Respondent had the greatest amount of interest in the results of these proceedings. Respondent is articulate and is able to explain and justify to himself everything he has done and why. Many of Respondent's explanations are rationalizations and justifications for his questionable actions. The Hearing Committee observed an intelligent physician who had a tendency to engage in self deception, dubious justifications and unwillingness to admit his mistakes. Respondent was very evasive in many of his answers, including his answers to the Hearing Committee's questions.

The Hearing Committee found that neither Respondent nor Patient A were credible. A number of inconsistencies were testified to by both individuals. For example, Respondent's accounts of his whereabouts on the night of the 14th and through the 15th of August, 1998. It appeared to the Hearing Committee that Patient A and Respondent were in collusion. They discussed the proceedings and they continue to be "involved" with each other. Much of Patient A's testimony was in direct conflict with other statements she had previously made to police officers, hospital employees and other health care individuals, including Respondent (Department's Exhibits # 3, 4, 5, 6, 7 & 9).

Using the above definitions and understanding, including the relevant portions of the remainder of the Misconduct Memo and the legal understanding set forth above, the Hearing Committee concludes by a unanimous vote that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State.

Additional rationale for The Hearing Committee's conclusions is set forth below.

Although there is substantial circumstantial evidence regarding a sexual relationship between Respondent and Patient A, the Hearing Committee does not make that ultimate conclusion. The Hearing Committee was concerned that Respondent was cavalier about his physical interactions with Patient A, including the long hours of holding and comforting, both in his office and in the Capri Motel.

The Hearing Committee has no doubt regarding the existence of an abusive relationship between Respondent and Patient A. The physical assaults or altercations between them are the sole responsibility of Respondent as the treating professional. In 1998, on two occasions, Respondent struck Patient A and threw her to the ground. Respondent's conduct was willful, unacceptable and unjustifiable. The charge of willfully abusing a patient while practicing the profession of medicine (psychiatry), within the meaning of §6530(31) is sustained.

Under the circumstances of this case, the willful physical abuse of Patient A also constitutes moral unfitness by Respondent. In addition, Respondent formed a personal and extremely emotional relationship with Patient A and Patient B. The combination of these relationships and Respondent's ability to foster dependence on him by both patients (using drugs and other means) is deemed to be a violation of the public trust and of the moral standards of the medical (psychiatric) community. The charge of conduct in the practice of medicine (psychiatry) which evidences moral unfitness to practice medicine (psychiatry), within the meaning of §6530(20) is sustained.

Respondent does not know his limitations. Respondent is dangerous to patients, sometimes under medicating, sometimes over medicating. Respondent had no reservations about prescribing medications with potentials for dangerous interactions knowing that both patients were highly unreliable. Although Respondent ceased his "treatment" of Patient A in January 1998, Respondent continued to prescribe medications to Patient A after she was no longer his patient. Respondent prescribed controlled substances to Patient B without medical justification and many times without even seeing Patient B. Patient B's Medical Records shows no continuity, no consistency. It appears that Respondent "throws" medications at Patient B. There is no ongoing pattern of treatment. Patient B shows up, gets his medication and the patient is gone for lengthy periods of time. The prescribing of controlled substances to a drug addict, without medical monitoring or justification and without seeing the patient, is not acceptable and well below minimum standards of care. It constitutes Gross Negligence by Respondent.

Respondent's statements that "... I began to get angry at her, as she destabilized and eroded my standing and my, my – what I had come to love as this treatment. This was a beautiful thing, and she ruined it (the treatment), ..." (in part because she sexualized and trivialized the matter) is astonishing but consistent with Respondent's lack of understanding and skill necessary to practice psychiatry [T-2258-2259]. There is no question that Patient A was an extremely difficult patient to manage. However, Respondent undertook her care and was therefore responsible for his actions and failures. Respondent was not able to separate himself from either Patient A or Patient B.

Respondent failed to recognized the numerous boundaries which needed to be maintained between himself and Patient A and B as well as some other of his patients (for example, Respondent had a discussion, in his van, with Patient J.G. about Respondent's personal life). Respondent showed an egregious lack of understanding of the practice of psychiatry and his conduct constitutes Gross Incompetence.

Respondent breaks any rule he wishes by justifying his "treatment" as innovative or experimental therapy. However, Respondent provided no evidence of a coherent basis that his treatment of Patients A and B were really innovative or experimental therapy. Respondent destroyed the capacity to provide these patients with competent treatment.

Respondent allowed Patient A to take control of the treatment and thereby failed to respect any ethical boundaries which would reflect minimum accepted standards of psychiatric practice. Respondent indicated that he allowed her to have control as part of his philosophy of treatment. This "treatment" choice by Respondent showed extremely poor judgment, especially since there is no history provided in Patient A's Medical Records to show that other treatments have failed.

In addition to failing to abide by boundaries, Respondent refuses to fill out insurance forms for some of his patients because they are not compatible with his computer usage. Respondent also failed to keep records of sessions when his computer was unavailable (the hard drive being repaired).

Respondent's conduct in the psychiatric care and treatment of Patients A and B was egregious and showed a lack of observance of minimally accepted standards of care. On numerous occasions with both patients, Respondent acted in his own self-interest and attended to his own emotional needs. Respondent showed a pattern of providing inadequate and potentially harmful psychiatric treatment. Respondent's record keeping practices, manner of handling treatment planning, dangerousness, medical issues, scheduling of sessions, medication side effects and boundaries all fall grossly below the generally accepted standard of care. The charge of practicing the profession with Gross Negligence on a particular occasion, within the meaning of §6530(4) is sustained separately for each patient.

A finding of Gross Negligence also includes a finding of Negligence on a particular occasion. Respondent, having committed Gross Negligence as to Patient A and as to Patient B has committed Negligence as to each of those patients as well. Therefore, Respondent is guilty of practicing the profession with Negligence on more than one occasion in that he failed to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. The charge of practicing the profession with Negligence, within the meaning of §6530(3) is sustained.

Respondent showed lack of the skill or knowledge necessary to appropriately treat Patients A and B. Respondent's lack of appreciation for boundaries as to each patient and lack of understanding in the unconcerned prescribing of controlled substances was flagrant and outrageous.

The charge of practicing the profession with Gross Incompetence on a particular occasion, within the meaning of §6530(6) is sustained separately for each patient.

A finding of Gross Incompetence also includes a finding of Incompetence on a particular occasion. Respondent, having committed Gross Incompetence as to Patient A and as to Patient B has committed Incompetence as to each of those patients as well.

Therefore, Respondent is guilty of practicing the profession with Incompetence on more than one occasion in that he failed to show the minimum skill or knowledge necessary to practice psychiatry that would be exercised by a reasonably prudent psychiatrist under the circumstances. The charge of practicing the profession with Incompetence, within the meaning of §6530(5) is sustained.

Generally accepted standard of care requires that each time medication is prescribed there be a progress note indicating the name and dosage of the medication, the number prescribed, the directions for taking the medication and some justification or rationale for the medication. Respondent's progress notes make only occasional mention of the multitude of medications he prescribed. Respondent's progress notes are devoid of the remainder of information necessary for appropriate care and treatment.

The medical records consists of sentence fragments, which are unclear and confusing. At times, the medical records read like a confessional novel, at other times like the testimony of someone being tried for malpractice, and at other times like a caricature of psychoanalytic theory.

The charge of failure to maintain records for each patient which accurately reflects the evaluation and treatment of the patient does not need much discussion. Both experts, as well as Respondent, indicated that the patients' medical records were wholly inadequate. The charge against Respondent under §6530(32) is sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that Respondent's license to practice medicine (psychiatry) in New York State should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

Respondent's deviation from minimally acceptable practices are substantial, multi-faceted, long term and countless. The record establishes that Respondent developed uncontrolled and unmonitored emotional relationships with his patients. Respondent failed to recognize that neither Patient A nor Patient B benefited or improved under his care. Respondent attributes blame to his patients for ruining his "beautiful therapy" and crossing boundaries and fails to take responsibility for his actions. Respondent was emotionally involved in the outcome of his treatment.

A psychiatrist who goes to a motel with a patient compromises the professional care. The record establishes that Respondent was abusive to Patient A on more than one occasion and is guilty of gross negligence. The extensive periods of time when Respondent was prescribing controlled substances to Patient B without seeing the patient is in itself sufficient to justify revocation of Respondent's license. The Hearing Committee believes that Respondent is an imminent danger to the patient population that he had to serve.

The Hearing Committee finds no reason to believe that Respondent can be corrected. Respondent shows no remorse or regret for his actions. Respondent believes nothing he did was wrong. Respondent told the Hearing Committee that the patients were "better" because of his care, when in fact he had abandoned both patients and used them.

Respondent's medical records fall grossly below the general accepted standards of care to such an extent that the records fail to convey any objectively meaningful information concerning the treatment of the patients.

Respondent's failure to monitor and record the numerous prescriptions he issued to both patients constituted a direct relationship between his inadequate record keeping and patient care and treatment. Respondent failed to use caution or good judgment after learning of the patients' use/abuse of medications. Further, Respondent continued to prescribe medications to the patients knowing that the patients were abusing the medications.

The medical records maintained by Respondent are so grossly inadequate that they alone are sufficient to establish Respondent's gross negligence.

The Hearing Committee believes that revocation is the appropriate penalty where Respondent has violated the fundamental trust placed in him by abusing, physically and mentally, his patients.

Given the above, the Hearing Committee does not believe that censure and reprimand is sufficient to address the severe weaknesses & deficiencies shown by Respondent. Respondent lacks personal insight, true remorse and said he did not really do anything wrong. Similarly, Respondent's complete incompetence in the practice of psychiatry can not be addressed with limiting Respondent's practice or by retraining. The Hearing Committee does not believe that monitoring would be beneficial or appropriate under the circumstances. As previously discussed, Respondent believes he did nothing wrong and would not change the course of his treatments. The Hearing Committee believes that monitoring would serve no purpose with respect to Respondent.

The Hearing Committee does not find that public service is indicated or will provide any learning benefits to Respondent. Although Respondent benefited financially from the numerous sessions he charged to Patient A, the Hearing Committee does not chose to impose a monetary penalty on Respondent.

The Hearing Committee, in the course of a long and intense hearing process, had an opportunity to learn and observe Respondent, both through extensive contact and dialogue with the physician himself. The Hearing Committee believes that Respondent has an inherent emotional limitation that he cannot be educated or salvaged. Respondent shows a total lack of remorse, attempts to blame his patients, and lacks an understanding of the gravity of his emotional involvement. The Hearing Committee believes that Respondent continues his relationship with Patient A and rehearsed the testimony with the patient. As previously mentioned, the Hearing Committee finds that Respondent was not credible. The Hearing Committee was not given any reason to believe that Respondent's actions could not occur again. Respondent's acts were deliberate, not accidental and not unconscious.

The Hearing Committee is concerned by both the severity of Respondent's misconduct, which we have sustained as charged, and Respondent's patent betrayal of trust, which is of special concern in the psychiatrist/patient relationships at issue here. Respondent's conduct represents no mere isolated lapse in judgment but constitutes continuous and egregious behavior.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines that revocation is the appropriate sanction under the circumstances. The Hearing Committee unanimously concludes that the sanction of revocation is necessary to protect the public and to deter future misconduct. The Hearing Committee believes that the sanction of revocation will send a sufficiently sobering message to Respondent and the medical community that there can be no tolerance for such abysmal performance.

In so finding the Hearing Committee considered the thoughts expressed previously in the conclusions of this decision. In the violation of patient trust perpetrated by Respondent herein, he has damaged the reputation of all those who practice the medical arts. From physicians to aides in health care facilities, this sort of behavior disrupts the necessary trust which must flow from patient to practitioner and back again if medical care is to be provided. With regard to the particular patients herein, the physician/patient trust they developed or should have developed has been permanently damaged.

As a final note, the Hearing Committee makes the following observations which we feel needs to be mentioned regarding Respondent's practices. Although these practices are disconcerting, they were not addressed in the findings of fact or discussion. Nor were these practices considered in the forming of an appropriate penalty determination made by the Hearing Committee.

Disconcerting practices by Respondent: Having sessions at midnight; Meeting patients in his van; Bringing current patients of Respondent (J.K., C.C. V.P.) to testify at this proceeding; Having business relationships with a patient (J.G.); Failure to have boundaries even in Respondent's role as a supervisor of a certified social worker (intermixing [confusing] treatment, supervision and business) (J.G.); The likelihood that the "therapy" for Patient A was really about more & more sessions resulting in more & more billing; Sleeping over Patient B's house; Accompanying Patient B to a casino; Failure to take progress notes because Respondent's computer was not working; long term denial that Patient A was a woman (a sexual being interested in him); additional medical records of these patients lumped together, with other patient medical records, in a pile or in bins in Respondent's basement because they did not "fit" in his computer.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The Specifications of professional misconduct contained within the Amended Statement of Charges (Department's Exhibit # 1-A) are **SUSTAINED**; and

2. Respondent's license to practice medicine (psychiatry) in the State of New York is hereby **REVOKED**.

DATED: **Troy, New York**
August 24 **, 1999**

NAOMI GOLDSTEIN, M.D., (Chair)
JOHN H. MORTON, M.D.
MS. CAROLYN C. SNIPE

TO:

Giovanni Biondi, M.D.
1607 White Road
Scarsdale, NY 10583

Rodney Drake, Esq.
600 Johnson Avenue,
Suite A-8
Bohemia, NY 11716

Terrence Sheehan, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GIOVANNI BIONDI, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

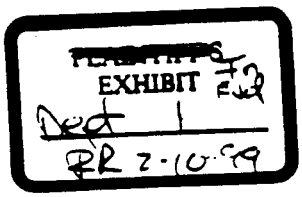
TO: GIOVANNI BIONDI, M.D.
167 White Road
Scarsdale, N.Y. 10583

The undersigned, Dennis P. Whalen, Executive Deputy Commissioner, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by GIOVANNI BIONDI, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 1999), that effective immediately GIOVANNI BIONDI, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 1999).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1999), and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1999). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on February 11, 1999, at 10:00 a.m., at the offices of the New York State Health Department, 5 Penn Plaza, Sixth Floor, New



York, NY 10001, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed

or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a (McKinney Supp. 1999). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
February 4 ,1999

Dennis P. Whalen
Executive Deputy Commissioner
New York State Health Department

Inquiries should be directed to:

Claudia Morales Bloch
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
145 Huguenot Street
Suite 601
New Rochelle, New York 10801
(914) - 632-3547

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GIOVANNI BIONDI, M.D.

COMMISSIONER'S SUPPLEMENTARY ORDER

TO: GIOVANNI BIONDI, M.D.
167 White Road
Scarsdale, N.Y. 10583

The undersigned, Dennis P. Whalen, Executive Deputy Commissioner, after further investigation and in compliance with the terms of N.Y. Public Health Law §230(12), hereby amends the Order dated February 4, 1999 previously issued in this matter by the incorporation of the attached Amended Statement of Charges dated February 25, 1999.

The Hearing Committee is directed to adjudicate said charges in the course of the currently ongoing hearing. All provisions of the Order dated February 4, 1999, remain in effect.

DATED: Albany, New York
March 17, 1999

Dennis P. Whalen
Executive Deputy Commissioner
New York State Health Department

EXHIBIT 1-B
for identification
in evidence
4/7/99 REPORTER
REPORTING SERVICE, INC.

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GIOVANNI BIONDI, M.D.

AMENDED STATEMENT OF CHARGES

GIOVANNI BIONDI, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 3, 1981, by the issuance of license number 145370 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent (at his office located at 211 West 56 Street, New York, N.Y and at various other locations) undertook the psychiatric care and treatment of Patient A (identity of Patients A and B is set forth in the annexed Appendix), and engaged in an inappropriate relationship with her, from on or about October 2, 1995 through in or about September, 1998.

B. On Patient A's initial visit to him, Respondent failed to:

1. obtain and/or note an appropriate history.

2. conduct and/or note a mental status evaluation.

3. assess and/or note the current dangerousness of Patient A to self and others.

EXHIBIT 1-A

3i 7/99

C. On multiple occasions throughout his treatment of Patient A, Respondent inappropriately prescribed a variety of medications, to wit: Ambien, Trazodone, Prozac, Vistaril, Welbutrin, Clonidine, Nifedipine, Paranate, Depokote, Nardil, Ativan, Valium, Xanax, Restoril, Klonopin, Halcion, and Dexadrine. Respondent:

1. prescribed the medications without appropriate medical rationale or justification, and/or without noting a medical rationale or justification.

2. failed to assess and/or note side effects caused by the medication(s) and failed to evaluate and clinically intervene when Patient A presented with side effects.

3. inappropriately prescribed multiple medications to Patient A simultaneously. Additionally, Respondent failed to appropriately monitor and address the effects and side effects of the multiple medications and the interactions of these medications with each other.

4. prescribed medications to Patient A without appropriately monitoring the patient.

5. inappropriately prescribed medications at the request of Patient A without appropriate and justifiable medical indication.

D. Respondent failed to treat Patient A in accordance with accepted standards of

psychiatric practice. Respondent:

1. failed to insure that Patient A had appropriate, and on-going, medical evaluation(s) and to appropriately refer Patient A for consultation with a neurologist and/or internist;

2. inappropriately dealt with Patient A with regard to her access to her medical record;

3. failed to appropriately formulate and/or note a treatment plan for Patient A;

4. failed to conduct treatment sessions according to a reasonable and appropriate schedule and, inappropriately failed to identify and/or note a clinical justification for the frequent and multiple therapy sessions he had with Patient A.

5. failed to appropriately assess and address, and/or note, Patient A's dangerousness to herself and others;

6. failed to arrange for coverage by another psychiatrist for Patient A when Respondent went on vacation;

7. inappropriately had lengthy and numerous telephone sessions with Patient A while Respondent was on trips abroad;

8. failed to consult with another psychiatrist when he and Patient A

speculated that his treatment was causing harm to her;

9. failed to appropriately identify and monitor his emotional interest in Patient A;

10. inappropriately developed a personal relationship with Patient A;

11. failed to appropriately address the issue of termination of treatment with Patient A.

E. Respondent failed to appropriately define boundaries for Patient A with regard to his treatment, and, inter alia, as to:

1. medications;

2. scheduling of office and telephone sessions;

3. vacation coverage;

4. emotional involvement between himself and Patient A;

5. meeting Patient A at the Capri Motel, 555 Hutchinson River Parkway, Bronx, N.Y., on more than one occasion.

F. Respondent physically abused Patient A, in that:

1. on or about August 15, 1998, Respondent was checked into a

room at the Capri Motel with Patient A. At this location, Respondent physically abused Patient A. Respondent then drove with Patient A to a location at or near his home and abandoned Patient A there.

2. on or about September 10, 1998, and/or through on or about September 12, 1998, Respondent physically abused Patient A at the Capri Motel or another Bronx Hotel, and/or at a location in Harrison, N.Y.

G. Respondent failed to maintain medical records for Patient A in accordance with accepted medical/psychiatric standards and in a manner which accurately reflects his care and treatment of the patient. Additionally, Respondent:

1. failed to document numerous office sessions, telephone sessions and contacts with Patient A;

2. used obscure and medically unacceptable terms;

3. inappropriately altered and falsified his record.

H. During his interview with an Office of Professional Medical Conduct investigator and medical coordinator on December 8, 1998, Respondent stated that, in his practice of child psychiatry, it is not unusual for him to "pal around" with his patients, taking them for walks in the park; to a movie, show or other event; or to places for a meal. Respondent's practice in this regard is not in accordance with accepted standards of psychiatric practice.

WITHDRAWN

I. Respondent undertook the psychiatric care and treatment of Patient B from on or about August ~~31~~ 20, 1991 ~~1993~~ through the present. Respondent:

1. inappropriately prescribed Zoloft, Ritalin, Percocet, Fiuricet, Dexadrine, Ambien, Xanax, Halcion, Doxepin, Zantac, Nicorette, Motrin, Prilosec, Catepres, Compozine, Propecia, and Viagra to Patient B.

2. inappropriately engaged in a personal relationship with Patient B;

3. failed to maintain a record which accurately reflects his care and treatment of Patient B, including proper history, treatment plan, progress notes, prescription regimens, and diagnosis.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. The facts in paragraphs A, B, B(1), B(2), B(3), C, C(1) through C(5), D, D(1) through D(11), E, E(1) through E(5), F, F(1), F(2), G, G(1), G(2), G(3), H, I, I(1), I(2), and I(3).

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

2. The facts in paragraphs A, B, B(1), B(2), B(3), C, C(1) through C(5), D, D(1) through D(11), E, E(1) through E(5), F, F(1), F(2), G, G(1), G(2), G(3), H, I, I(1), I(2), and I(3).

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

3. The facts in paragraphs A, B, B(1), B(2), B(3), C, C(1) through C(5), D, D(1) through D(11), E, E(1) through E(5), F, F(1), F(2), G, G(1), G(2), G(3), H, I, I(1), I(2), and I(3).

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1999) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of

two or more of the following:

4. The facts in paragraphs A, B, B(1), B(2), B(3), C, C(1) through C(5), D, D(1) through D(11), E, E(1) through E(5), F, F(1), F(2), G, G(1), G(2), G(3), H, I, I(1), I(2), and I(3).

FIFTH AND SIXTH SPECIFICATIONS

WILLFUL PATIENT ABUSE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(31)(McKinney Supp. 1999) by willfully abusing a patient physically, as alleged in the facts of:

5. The facts in paragraphs A, F, and F(1).

6. The facts in paragraphs A, F, and F(2).

SEVENTH AND EIGHTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 1999) by failing to maintain a record for the patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

7. The facts in paragraphs A, B(1), B(2), B(3), C(1), C(2), D(3), D(4), D(5), G, G(1), G(2), and G(3).

8. The facts in paragraphs I and I(3).

NINETH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1999) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

9. The facts in paragraphs A, D(2), D(4), D(8) through D(11), E, E(1) through E(5), F, F(1), F(2), G(2), G(3), H, I, and I(2).

DATED: February 25, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct