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

August 25, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Carolyn Shearer, Esq.
Hinman, Straub, Pigors
& Manning, P.C.
121 State Street
Albany, New York 12207-1693

Cindy Fascia, Esq.
NYS Department of Health
Corning Tower Room 2509
Empire State Plaza
Albany, New York 12237

Camilo Marquez, M.D.
REDACTED

RE: In the Matter of Camilo Marquez, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-237) 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.

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.

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,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

---X

IN THE MATTER

OF

CAMILO MARQUEZ, M.D.

COPY

ORDER #

BPMC-00-237

---X

Andrew J. Merritt, M.D., Chairperson, Walter M. Farkas, M.D, and Deanna Woodhams, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(1)(e) and 230(12) of the Public Health Law. Susan F. Weber, Esq., served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with negligence and incompetence, each on more than one occasion, with gross negligence and gross incompetence, with fraudulent practice, with making or filing a false report, with failure to maintain accurate records, and with moral unfitness.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto as Appendix 1 and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	March 30, 2000
Served:	April 6, 2000
Prehearing Conference:	April 24, 2000
Hearing Dates:	
Hedley Building, Troy, NY	May 3, 2000
Quality Inn, Watervliet Ave., Albany, NY	June 7, 2000
Deliberation Date:	July 26, 2000

Petitioner Appeared By:

Henry M. Greenberg, Esq.
General Counsel
NYS Department of Health
By: Cindy M. Fascia,Esq.
Associate Counsel
Bureau of Professional Conduct
Corning Tower
Empire State Plaza
Albany, NY 12237

Respondent Appeared By:

Hinman, Straub, Pigors & Manning, PC
By: Carolyn Shearer, Esq.
121 State St.
Albany, NY 12207-1693

WITNESSES

For the Petitioner:

Carol Crews
Kevin Smith, MD
Melvin Steinhart, MD
Elfriede Eidam

For the Respondent:

Stephen J. Deutsch, MD
Camilo Marquez, MD

POST-HEARING ISSUES

Petitioner in this matter requested, by letter brief dated June 29, 2000, that the Administrative Law Judge instructed the Hearing Committee with regard to conduct evidencing moral unfitness and that a "missing witness" charge be given. Respondent did not submit argument on the request.

The Administrative Law Judge gave the requested charge regarding conduct evidencing moral unfitness. However, Judge Weber declined to give the requested missing witness charge for the reasons that follow.

Under a missing witness charge, the ALJ would instruct the Hearing Committee that it must assume that as a witness, Patient A would testify unfavorably to Respondent's case. Patient A had been listed as a witness for Respondent throughout the hearing but was not called to testify. Petitioner did not raise the issue of Respondent's failure to call Patient A prior to adjournment, nor did Petitioner ask that her case be reopened in order to call Patient A as a witness for the Petitioner.

A party is entitled to a missing witness charge if the witness in question is solely within the control of the other party, evidence expected to be provided by the witness is relevant and probative, and the party seeking the charge does not have access to the witness or evidence in another way.

Patient A's testimony was not relevant to or probative of the charges before the Hearing Committee. Respondent admitted the sexual relationship with her. Circumstances surrounding the relationship, such as whether Patient A pursued Respondent and whether they remain friendly, are peripheral at most to the issues before the Committee. The Committee may wonder and conjecture why Respondent chose not to call Patient A. But Petitioner could have raised the issue during the hearing, and also had the opportunity to subpoena Patient A as a witness. Consequently, the ALJ declined to direct the Hearing Committee's conclusions regarding the fact that Patient A was not called as a witness for Respondent.

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

FINDINGS OF FACT

GENERAL FINDINGS

1. Respondent is a physician duly licensed to practice medicine in the State of New York (Pet. Ex 3).

2. Respondent is Board-certified in adult and child psychiatry (Tr.373) and in developmental psychiatry (Tr.372).

3. Respondent's initial contact with Patient A was in the spring of 1997, when he collaborated with her in a professional consultation on a student whom Patient A, a special education teacher, was tutoring (Tr. 380).

4. Patient A next contacted Respondent in November of 1997 concerning difficulties she was having with one of her sons (Tr. 381).

5. Following a consultation concerning the son, Patient A, herself commenced a course of treatment with Respondent (Tr. 382) which included twenty sessions from December 31, 1997 through July 7, 1998 (Pet. Ex 4).

6. At the commencement of this course of therapy, Respondent failed to perform or document the taking of a mental status examination or a medical history of Patient A (Tr. 144-148, Pet. Ex 4).

7. A mental status examination and history are necessary to establish the patient's current medical and psychological condition. Information gained is used to establish a differential diagnosis from which to proceed. Although a patient's history and mental status comes out over time as he or she feels more comfortable talking, certain basic information should be obtained and documented initially, such as prior psychiatric treatment, history of the birth family, patient's previous illnesses, academic and job history and the like, to give the clinician a baseline, assist in making a differential diagnosis, and

provide documentation for any future treating physician, or for the therapist's comparison later. (Tr. 144-151).

8. There is no set format for the documentation of a mental status examination and history. Degree of formality in documenting the history will depend upon the purpose of the consultation – whether, for example, it is an in-patient setting, whether others will be reviewing the chart, whether there will be a written report required. In an outpatient private therapy setting, an experienced therapist will be less formal. (Tr. 271-274)

9. Information gained from the mental status exam and history enables the clinician to work with the patient to form treatment goals. A treatment plan may then be developed. Although the therapy goals and the plan to achieve them may change over time, without an adequate initial evaluation, treatment is just free-association. (CITE)

10. During the course of Patient A's therapy, Respondent evaluated her mental status, finding her to be cooperative and oriented, appropriately dressed and groomed, without evidence of motor abnormalities, able to engage in appropriate interaction, appropriate in affect, without evidence of thought disorder or delusions, functioning responsibly in terms of insight and judgment, depressed in mood but without indication of suicide risk or suicide risk factors. (Tr. 382-383)

11. During the course of therapy, Respondent explored and noted in the treatment notes certain pertinent details of Patient A's medical and social history, including:

her prior therapy, her irritable bowel syndrome, and the pattern and significance of her somatic symptoms in relation to life events. (Pet. Ex 4, Tr. 384, 389-392)

12. Respondent's failure to document a mental status exam and adequate history upon initial examination was a deviation from accepted standards of care. (Pet. Ex 4, Tr. 148-152)

13. Although no diagnosis is specified in the treatment notes for Patient A, Respondent testified that he diagnosed Patient A as having "Adjustment Disorder." (Tr. 385)

14. Failure to document a diagnosis was a deviation from accepted standards of care. (Tr. 148-152)

15. Transference is a phenomenon in psychotherapy in which the patient unconsciously "transfers" or projects onto the therapist wishes, needs conflicts and feelings, including feelings of attraction, which really apply to significant people from the patient's life. It is important for the therapist to be aware of, recognize and use the patient's expressions of transference to assist in the therapy. Transference makes the patient vulnerable to the physician. (Tr. 159-163)

16. Unrecognized and resolved transference issues can lead the patient to act inappropriately toward the therapist, to make inappropriate overtures and demands upon the therapist, to seek self-disclosures from the therapist. (Tr. 163-164)

17. Counter-transference is the phenomenon where the therapist's feelings, wishes, conflicts, and the like which relate to important people in the therapist's life, and which are unconsciously projected onto the patient. It is the responsibility of the therapist, as the trained professional in the therapeutic relationship, to be in control of the transference-counter-transference issues in the therapeutic relationship. (Tr. 170-171**)

18. Patient A raised topics in therapy which would indicate the presence of transference issues. She described attractions to older men in positions of authority, such as her high school guidance counselor. She told Respondent that he "checked [her] out." She attempted to engage Respondent in personal revelations and voiced the desire to maintain a relationship with him when therapy ended, even inviting him to a concert. (Pet. Ex 4, p**)

19. Respondent attempted to develop treatment objectives with Patient A, to work toward treatment goals, such as Patient A's disillusionment with her expectations of herself and society. Patient A repeatedly brought the focus back to circumstantial events. (Tr. 386-396, Pet. Ex 4)

20. Eventually, Respondent determined that he was unable to establish a therapeutic alliance with Patient A and initiated the termination of therapy in late June or early July, 1998. Pet. Ex 4, p. 11)

21. After the termination of therapy, Respondent accepted an invitation from Patient A to attend a concert and commenced a social relationship with her. Patient A was persistent in her pursuit of Respondent, and the relationship progressed to a sexual one

in September, 1998. (Tr. 400-401)

22. Respondent did not attempt to hide the social relationship with Patient A; they appeared in public together, took dancing lessons, hiked. (Tr. 401)

23. Respondent and Patient A are no longer intimately involved, but maintain a friendly relationship. (Tr. 410)

24. After therapy had terminated, Respondent prescribed Allopurinol three times and Probenecid once for Patient A=s gout without maintaining a medical record for Patient A in connection with them. (Resp. Ex 2, Pet. Ex 5, Tr. ***)

Findings of Fact Regarding the Oregon Application

25. Respondent had a professional business association with Hudson Valley Psychiatric Association (HVPA), beginning January 1, 1996. HVPA's employment agreement states that a breach of currently accepted ethical standards of the American Psychiatric Association (APA) would constitute cause for termination. (Pet. Ex 6, p5)

26. Section 2, subparagraph 1 of the APA's *Principals of Medical Ethics (1995 and 1998 Editions)*, state, in pertinent part, "Sexual activity with a current or former patient is unethical." (Pet. Ex 18 and 19)

27. In December, 1998, Respondent brought up his plans to leave the area and HVPA with the practice group. In January or February, at HVPA's request, he tendered

a letter of resignation. The plan was that Respondent would leave in June, 1999, contingent upon HVPA finding an acceptable child adolescent psychiatrist. (Tr.71-72, 402-405)

28. On or about May 27, 1999, HVPA learned that Respondent was seeing a former patient, Patient A, whose therapy had terminated nearly a year previously. When questioned, Respondent did not deny the involvement.

29. Dr. Kevin Smith, president of the physician group practice, HVPA, by letter dated June 4, 1999, reported to the Office of Professional Medical Conduct that Respondent had admitted violating NYS Education Law Section 6530 (44)[1]. (Pet. Ex 15)

30. HVPA terminated Respondent's employment relationship as of June 4, 1999. (Tr. 74-80)

31. Following this termination, business disputes arose between Respondent and HVPA over 401(k) funds, administrative fees, accounts receivable, and return of capital contributions. (Tr. 101-103, Resp. Ex C)

32. On or about December 7, 1999, while visiting his sister in Oregon, Respondent applied for a license to practice medicine in that state (Pet. Ex 7, Tr. 407)

[1] Subsection 44 defines misconduct as any physical contact of a sexual nature between a psychiatrist and patient. Contact between a psychiatrist and former patient is not specifically addressed.

33. In such application, Respondent acknowledged that he was currently under investigation in New York (Pet. Ex 7 p.4), and further stated truthfully, "I am not under any investigation relating to a patient complaint, an allegation by a patient, or dissatisfaction by a patient." (Pet. Ex 7, explanation page.)

34. Respondent further explained:

> "Certain business disputes arose in my relationship with a former employer, Hudson Valley Psychiatric Association (HVPA), after I tendered my notice of resignation from that group in 1999. In the context of those disputes, HVPA reported the termination of my employment to the NYS Office of Professional Medical Conduct, although no reportable termination had occurred and no report to OPMC was required by law. ..."

35. Dr. Smith's report to OPMC and HVPA's termination of Respondent's employment was the result of Respondent's admitted involvement with a former patient, in violation of currently applicable ethical standards, and arguably in violation of Education Law Section 6530 (44). (Tr. 94-96)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact set forth above. All conclusions were unanimous unless otherwise stated.

First Specification: Moral Unfitness	Sustained
Second Specification: Gross Negligence	Not Sustained

Third Specification: Negligence on More than One Occasion	Sustained
Fourth Specification: Gross Incompetence	Not Sustained
Fifth Specification: Incompetence on More than One Occasion	Not Sustained
Sixth Specification: Fraudulent Practice	Not Sustained
Seventh Specification: Making or Filing a False Report	Sustained
Eighth Specification: Failure to Maintain Accurate Records	Sustained

DETERMINATION OF THE HEARING COMMITTEE

Respondent was charged with eight specifications alleging professional medical misconduct under Education Law Section 6530 in the care and treatment of one patient. Education Law Section 6530 sets forth numerous forms of conduct, which constitute professional misconduct but does not provide definitions. During its deliberations, the Hearing Committee employed the suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine set forth in the memorandum of NYS Department of Health General Counsel Henry M. Greenberg entitled "Definitions of Professional Misconduct Under the New York Education Law." They are:

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, which failure is manifested by conduct that is egregious or conspicuously bad.

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

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of the profession.

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

Fraudulent Practice of Medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that s/he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

Respondent was also charged with **Making or Filing a False Report, Failure to maintain accurate records**

Moral unfitness is inferred from the totality of the circumstances of Respondent's practice of medicine. An otherwise moral individual may commit one or more acts evidencing moral unfitness due to a lapse in judgment or temporary aberration.

Pursuant to the Findings of Fact and Conclusions of Law set forth above, the Hearing Committee unanimously determined that Respondent's license to practice medicine in the State of New York should be suspended for a period not to exceed five years, that such suspension may be stayed after two years if the Respondent obtains retraining and counseling to addresses the issues underlying the charges sustained in this case, as more fully described below. Finally, when Respondent does resume the practice

of psychiatry, such practice should be limited to children and adolescents. A practice monitor should provide oversight of Respondent's charting for a period of one year upon resumption of practice, to assure that he performs and documents the initial taking of a mental status exam and social and medical history.

CONCLUSIONS REGARDING FACTUAL ALLEGATIONS

The basis for the Committee's conclusions is the testimony of the witnesses and the documentary evidence in the record. Both the Petitioner's expert, Dr. Melvin Steinhart and Respondent's expert, Dr. Stephen Deutsch, were well-qualified as expert witnesses on the issues presented, and convincingly articulated their versions of the case. Each has been responsible for training medical students in psychiatry, and has a background in medical ethics. The hearing Committee found Dr. Steinhart to be straightforward, very definite and direct. Dr. Deutsch at times appeared evasive or non-responsive in his answers. The Hearing Committee gave his testimony less weight as a consequence. Dr. Deutsch was also more inclined to go beyond the "black and white" of the facts presented, and to stress the need for an appropriate remedy to allow both the Respondent and Patient A to learn and grow. He stated that his concern was what would be the best remedy, the most appropriate recommendation to make, given that these events had occurred. The Hearing Committee did not agree that this was the most important issue before the panel.

As might be expected, Dr. Steinhart found Respondent's record keeping deficient, and such deficiency slightly more serious, than did Dr. Deutsch. Dr. Deutsch testified that in private practice there is a wide range of adequate record keeping styles and that the Respondent's notes were private notes a practitioner makes as reminders to himself, rather than a formal record for another's review. (Tr. 281-282) Dr. Steinhart, when asked to assume the facts found herein concerning Respondent's post-termination social and then intimate relationship with Patient A, expressed the opinion that it was a gross deviation from accepted standards of care in psychiatry. This is so, Steinhart stated, because the transference never ends, and once a patient, always a patient. Such a relationship has the potential to do harm to the patient; it leads the patient to believe that ...they are on an equal plane with the therapist, and they are not. (Tr. 186-188) The Committee found this witness direct, straightforward and easy to follow, and agreed with his assessment.

Dr. Deutsch acknowledged that the Respondent's relationship with Patient A constituted a deviation from the standard of care, but went on to discuss the circumstances surrounding this case which he seemed to believe set it apart. Examples included the fact that out of hundreds of patient contacts over the course of a twenty or thirty year practice, there has been only this one deviation, that transference and counter-transference are by definition issues below the level of conscious awareness and are perhaps only understood from the perspective of hindsight. (Tr. 287-288) Dr. Deutsch pointed out that this case does not involve a physical assault, embezzlement, or premeditated sexual abuse (Tr. 292) but

rather what Dr. Deutsch described as an understandable, explainable and regrettable departure, an adverse event, which he believed was the result of the professional risks and liabilities involved in intensive types of psychotherapeutic relationships. (Tr. 287)

DISCUSSION REGARDING NEGLIGENCE

The Hearing Committee found that Respondent initially failed to obtain and to chart an adequate medical and social history for Patient A, or to chart a mental status. There are few appropriate facts set forth about Patient A's physical health, family of origin, current family status, evidence of mental status, or prior counseling history. An adequate history is necessary to enable the practitioner to establish the patient's status, make a diagnosis and create a treatment plan. (Tr. 146-152) Therapeutic goals can change as therapy progresses, but without a treatment plan based upon the patient's current mental and emotional status at the time of the initial consultation, the therapy is merely floating around. (Tr. 153).

Respondent's failure to obtain an adequate initial history , and to document a diagnosis and treatment plan, were not seen as major shortcomings in and of themselves, given the particular therapeutic setting. But in this case the results were unfortunate. Although much pertinent medical and social information was elicited by Respondent during the course of therapy, it was clear to the Hearing Committee that, had information about Patient A's prior therapeutic and counseling history been obtained by Respondent at the

beginning of Patient A's treatment, he would have been more likely to identify Patient A's tendency toward attractions to male authority figures, such as her high school guidance counselor and prior therapist, which are indicative to the practitioner of transference issues. Although these topics did surface during therapy, had they been revealed early on, Respondent would have been more likely to anticipate, recognize, and deal therapeutically with the transference issue when it arose.

Reading back through Respondent's case notes, it is clear that Patient A=s issues, as she presented them during therapy, mainly involved unsatisfactory relationships with men, dissatisfaction with her financial situation, and career goal conflicts. Although she found her work with at-risk children fulfilling, it was not well paid and she worried that she would never have a male relationship. She tried to obtain personal information about Respondent, and challenged him, "You checked me out." (Pet. Ex 4, p.11) It was difficult for the Hearing Committee to understand how Respondent had failed to see where this might be taking him. Indeed, Respondent admitted as much in testimony. (Tr. 511)

Had he properly attended to his work with Patient A, Respondent would have realized that the therapy was not going anywhere productive. As Respondent related to the State's investigator, Ms. Eidam, probably with the benefit of hindsight, the transference issues kept getting in the way. Respondent's appropriate course of action would have been to refer Patient A elsewhere, or to obtain supervision himself in dealing with the situation. Instead, he took steps to terminate the therapy apparently without attempting to

address the transference/counter-transference issues that had arisen.

Although transference and counter transference are unconscious processes, the professional must make them conscious. The Committee felt strongly that, as the professional in the relationship, Respondent had a duty to identify the transference issues and maintain appropriate boundaries in order to protect his patient. Respondent clearly lacked sufficient awareness of the need to maintain boundaries with Patient A, or lacked the will to maintain them. Only nine days after therapy was terminated, Respondent did in fact attend the concert with Patient A. By his testimony, the sexual relationship followed some two months later. Proper boundary setting would have prevented this.

There was testimony from Respondent that Patient A persistently pursued him, even "forced herself" upon him, despite his explanation to her that such a relationship would violate APA ethical standards. Both Ms. Eidam and Dr. Smith testified that Respondent described the relationship this way. Chart notes (Pet. Ex 4) and Ms. Eidam's testimony concerning Respondent's interview (Tr. 237) indicate that Respondent and Patient A never formed a therapeutic alliance during the twenty counseling sessions, but rather dealt with circumstantial rather than substantive issues. The Committee does not believe that this explanation, even though uncontroverted and probably true, excuses the Respondent from his professional responsibility to his patient.

No matter how strong and independent the former patient may be, the Hearing Committee strongly believes that the practitioner must never traverse the ethical boundary

and venture into a sexual relationship. In this case, a consensual affair, which commenced after formal treatment, had ended, where the psychiatrist and the former patient had associated prior to treatment, and where the former patient has not made a complaint, the psychiatrist has an ethical duty to maintain the appropriate boundaries. The risk of harm to the former patient, who is vulnerable because of the therapeutic relationship, is too great. Respondent did not evidence an understanding of the harm he might have caused his former patient by failing to maintain the appropriate boundaries, the Committee felt. Nor did he appear to apprehend the seriousness of this ethical violation.

DISCUSSION REGARDING FAILURE TO MAINTAIN ADEQUATE RECORDS

Following termination of therapy and during the friendship with Patient A, Respondent prescribed medication for Patient A's gout without maintaining an adequate medical record. Given that these medications are specific for the condition named, were for the woman's own use, and the fact that Respondent derived no personal gain, the Committee viewed this as a relatively minor violation.

DISCUSSION REGARDING MAKING OR FILING A FALSE REPORT AND MORAL UNFITNESS

In about December, 1998, a few months after Respondent became involved with his former patient, he decided to relocate, and resigned from his position with Hudson Valley Psychiatric Associates, effective upon his replacement. In late May, 1999, it came to the attention of the practice that Respondent was involved with a former patient. HVPA terminated his employment and reported the relationship to OPMC. An investigation followed, centered upon the relationship with Patient A.

When Respondent applied for licensure in Oregon in December, 1999, he was fully aware of the precise issues under investigation in New York, having received correspondence (Pet. Ex 11) and been interviewed (Tr. 232) concerning them. Although it was true, as Respondent stated in the Oregon application, that the investigation was not the result of a patient complaint or allegation, the investigation directly concerned his relationship with a former patient. And although certain financial issues or business disputes did arise between Respondent and HVPA after he had tendered his resignation, his statement that the group reported his termination to OPMC "in the context of those disputes" is misleading.

Respondent further stated that "no report to OPMC was required by law." There may be legitimate disagreement over whether a mandatory reportable event had occurred.

Although Education Law Section 6530 (44) prohibits sexual contact with a patient and is silent about a former patient, the APA's code of ethics treats a relationship with a former patient the same as a relationship with a patient. The Hearing Committee is strongly of the opinion that a such a relationship with a former patient should be viewed with the same degree of disapprobation as a relationship with a current patient. Consequently, the Hearing Committee saw Respondent's explanation on the Oregon application as an intentional twisting of the facts. The relationship arguably constituted a violation of Education Law Section 6530(44), a mandatory reportable event under 230(11).

The Hearing Committee believes that the totality of Respondent's explanation on the application was misleading, that Respondent knew it was misleading and therefore is deemed to have intended to mislead. Consequently, the Committee found that Respondent's Oregon application was false in violation of Education Law Section 6530(21). The Committee found this a serious ethical violation since it could have resulted in Respondent's licensure in Oregon. It is because of this additional act that the Committee determines that the specification of Moral Unfitness should be sustained.

ORDER

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

1. Respondent's license to practice medicine in the State of New York be **SUSPENDED** for a period of **FIVE (5) years** from the date of this Determination and Order; but that such suspension may be **STAYED after TWO (2) YEARS** upon the following conditions:

a) that Respondent has successfully completed a continuing education course for psychiatric practitioners which included training in out-patient record keeping and proper patient charting, medical ethics, and dealing with transference issues; and

b) that Respondent has completed a course of therapy or counseling under the direction of the New York State Department of Health Impaired Physician Program with regard to transference and counter-transference issues and the ethical considerations of relationships with former patients.

2. Upon the expiration of this SUSPENSION, whether after five years or after the foregoing conditions are met, Respondent's psychiatric practice in the State of New York shall be limited to child and adolescent psychiatry, and

3. For the period of one year a practice monitor shall be assigned to oversee Respondent's charting and record keeping.

IT IS FURTHER ORDERED that

4. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail.

DATED: [illegible], **New York**
5/24 ,**2000**

REDACTED

ANDREW J. MERRITT, M.D.
(Chairperson)

WALTER M. FARKAS, M.D.
DEANNA WOODHAMS

APPENDIX I

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

IN THE MATTER : STATEMENT
OF : OF
CAMILO MARQUEZ, M.D. : CHARGES

CAMILO MARQUEZ, M.D., Respondent, was authorized to practice medicine in New York State on July 1, 1977 by the issuance of license number 131274 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine, with a registration address of 275 Fair Street, Kingston, New York 12401.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric care to Patient A (identified in Appendix), including therapy sessions from approximately December 31, 1997 through approximately July 17, 1998. Respondent thereafter engaged in the following conduct, despite the presence of transference issues in Patient A's therapy and/or Patient A's problems regarding the termination of her therapy:

1. Respondent, as of approximately July 25, 1998, began having a social relationship with Patient A, which relationship has included socializing with Patient A

on more than one occasion.

2. Respondent, as of approximately October 1998, was having a sexual relationship with Patient A, which relationship has included sexual intercourse on more than one occasion.

B. Respondent, during the course of therapy with Patient A:

2. Failed to perform and/or document a mental status examination.

3. Failed to perform and/or document an adequate history.

4. Failed to develop and/or document an adequate treatment plan and/or treatment goals.

C. Respondent, subsequent to termination of formal therapy with Patient A, and during a time period in which he was having a social and/or sexual relationship with Patient A, continued to provide medical care to Patient A, including prescribing medications for Patient A.

D. Respondent, despite the fact that he continued to provide medical treatment to Patient A after termination of formal therapy, failed to maintain an adequate medical record for Patient A subsequent to termination.

E. Respondent, on or about December 7, 1999, submitted an Application for Licensure to the Oregon Board of Medical Examiners. The Oregon Application required written explanation concerning any affirmative responses to personal history questions. Respondent answered "yes" to the question "Have you ever been asked to make a written or verbal response to an investigation or inquiry about you or your medical practice by this or any other licensing board?" Respondent then submitted the following as his required written explanation:

RE: Personal History Question #5

I am not under any investigation relating to a patient complaint, a patient allegation, or patient dissatisfaction.

1999

Certain business disputes arose in my relationship with a former employer, Hudson Valley Psychiatric Association (HVPA), after I tendered my notice of resignation from that group in 1999. In the context of those disputes, HVPA reported the termination of my employment to the NYS Office of Professional Medical Conduct, although no reportable termination had occurred and no report to OPMC was required by law. Inasmuch as OPMC is statutorily required to investigate all reports it receives, even when a report lacks merit, an investigation is being processed by them.

I emphasize that no professional disciplinary charges have ever been served on me, and I anticipate a favorable disposition. However, I have not yet received notice that the current OPMC investigation has been closed.

1. Respondent's statement "I am not under any investigation relating to a patient complaint, a patient allegation, or patient dissatisfaction" was false and/or intentionally misleading and/or deceptive in that Respondent knew that OPMC's investigation involved his care and treatment of Patient A, and his relationship with Patient A.

2. Respondent's statement regarding the circumstances of the termination of his employment with Hudson Valley Psychiatric Associates was false and/or intentionally misleading and/or deceptive in that Respondent was terminated from Hudson Valley Psychiatric Associates on or about June 4, 1999 because of Respondent's relationship with Patient A, and Respondent knew such fact.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
MORAL UNFITNESS

Respondent is charged with professional misconduct by reason of his committing conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20), in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A.2 and/or E and E.1 and/or E.2.

SECOND SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of his practicing medicine with gross negligence on a particular occasion in violation of New York Education Law §6530(4), in that Petitioner charges:

2. The facts Paragraphs A and A.1 and/or A.2 and/or C.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of his practicing medicine with negligence on more than one occasion in violation of New York Education Law §6530(3), in that Petitioner charges:

3. The facts in Paragraphs A and A.1 and/or A.2 and/or B and B.1 and/or B.2 and/or B.3 and/or C and/or D.

FOURTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with professional misconduct by

reason of his practicing medicine with gross incompetence in violation of New York Education Law §6530(6), in that Petitioner charges:

4. The facts in Paragraphs A and A.1 and/or A.2 and/or C.

FIFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of his practicing medicine with incompetence on more than one occasion in violation of New York Education Law §6530(5), in that Petitioner charges:

5. The facts in Paragraphs A and A.1 and/or A.2 and/or B and B.1 and/or B.2 and/or B.3 and/or C and/or D.

SIXTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with professional misconduct by reason of his practicing medicine fraudulently in violation of New York Education Law §6530(2), in that Petitioner charges:

6. The facts in Paragraphs E and E.1 and/or E.2.

SEVENTH SPECIFICATION

MAKING OR FILING A FALSE REPORT

Respondent is charged with professional misconduct by reason of his willfully making or filing a false report in violation of New York Education Law §6530(21), in that Petitioner charges:

7. The facts in Paragraphs E and E.1 and/or E.2.

EIGHTH SPECIFICATION

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with professional misconduct under New York Education Law §6530(22)by reason of his failure to maintain a record for each patient which accurately reflects the evaluation of treatment of the patient, in that Petitioner charges:

8. The facts in Paragraphs B and B(1) and/or B.2 and/or B.3 and/or D.

DATED: March 30, 2000
Albany, New York

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

ATTACHMENT "II"

Requirements for Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension of a Medical License

1. Respondent shall immediately cease and desist from engaging in the practice of medicine in New York State, or under Respondent's New York license, in accordance with the terms of the Order. In addition, Respondent shall refrain from providing an opinion as to professional practice or its application and from representing that Respondent is eligible to practice medicine.

2. Within 5 days of the Order's effective date, Respondent shall deliver Respondent's current biennial registration to the Office of Professional Medical Conduct (OPMC) at Hedley Park Place, 433 River Street 4th Floor, Troy, NY 12180-2299.

3. Within 15 days of the Order's effective date, Respondent shall notify all patients of the cessation or limitation of Respondent's medical practice, and shall refer all patients to another licensed practicing physician for continued care, as appropriate. Respondent shall notify, in writing, each health care plan with which the Respondent contracts or is employed, and each hospital where Respondent has privileges, that Respondent has ceased medical practice. Within 45 days of the Order's effective date, Respondent shall provide OPMC with written documentation that all patients and hospitals have been notified of the cessation of Respondent's medical practice.

4. Respondent shall make arrangements for the transfer and maintenance of all patient medical records. Within 30 days of the Order's effective date, Respondent shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate and acceptable contact persons who shall have access to these records. Original records shall be retained for at least 6 years after the last date of service rendered to a patient or, in the case of a minor, for at least 6 years after the last date of service or 3 years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information in the record is kept confidential and is available only to authorized persons. When a patient or a patient's representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient (not to exceed 75 cents per page.) Radiographic, sonographic and similar materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of an inability to pay.

5. In the event that Respondent holds a Drug Enforcement Administration (DEA) certificate for New York State, Respondent shall, within fifteen (15) days of the Order's effective date, advise the DEA, in writing, of the licensure action and shall surrender his/her DEA controlled substance privileges for New York State to the DEA. Respondent shall promptly surrender any unused DEA #222 U.S. Official Order Forms Schedules 1 and 2 for New

York State to the DEA. All submissions to the DEA shall be addressed to Diversion Program Manager, New York Field Division, U.S. Drug Enforcement Administration, 99 Tenth Avenue, New York, NY 10011.

6. Within 15 days of the Order's effective date, Respondent shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement of the New York State Department of Health. Respondent shall destroy all prescription pads bearing Respondent's name. If no other Respondent is providing services at Respondent's practice location, Respondent shall properly dispose of all medications.

7. Within 15 days of the Order's effective date, Respondent shall remove from the public domain any representation that Respondent is eligible to practice medicine, including all related signs, advertisements, professional listings (whether in telephone directories, internet or otherwise), professional stationery or billings. Respondent shall not share, occupy, or use office space in which another Respondent provides health care services.

8. Respondent shall not charge, receive or share any fee or distribution of dividends for professional services rendered by Respondent or others while Respondent is barred from engaging in the practice of medicine. Respondent may be compensated for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Order's effective date.

9. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine, Respondent shall divest all financial interest in the professional services corporation, in accordance with New York Business Corporation Law. Such divestiture shall occur within 90 days. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of the Order's effective date.

10. Failure to comply with the above directives may result in a civil penalty or criminal penalties as may be authorized by governing law. Under N.Y. Educ. Law § 6512, it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when a professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, which include fines of up to $10,000 for each specification of charges of which the Respondent is found guilty, and may include revocation of a suspended license.