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

February 9, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kathleen S. Wasson, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy & Schoppmann, P.C.
420 Lakeville Road
Lake Success, New York 11042

Eugene Lloyd Bellin, M.D.
4621 Livingston Avenue
Bronx, New York 10471

RE: In the Matter of Eugene Lloyd Bellin, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-39) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

IN THE MATTER OF

OF

EUGENE LLOYD BELLIN, M.D.

DETERMINATION

AND

ORDER

ORDER #00-39

COPY

BENJAMIN WAINFELD, M.D., Chairperson, **SHELDON GAYLIN, M.D.**, and **MS. EUGENIA HERBST**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, 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 on more than one occasion (one specification) and incompetence on more than one occasion (one specification), having committed conduct in the practice of medicine which evidences moral unfitness to practice medicine (one specification), having willfully harassed, abused or intimidated a patient either physically or verbally (one specification), having ordered excessive

tests or treatment not warranted by the condition of the patient (one specification), and by failing to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient (one specification).

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

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	July 7, 1999
Date of Service of Notice of Hearing and Statement of Charges:	August 13, 1999
Answer to Charges Dated:	August 24, 1999
Prehearing Conference Date:	August 31, 1999
Hearing Dates:	September 9, 1999 October 14, 1999 October 26, 1999
Deliberation Date:	December 16, 1999
Place of Hearing:	NYS Department of Health 5 Penn Plaza, 6th Floor New York, New York
Petitioner Appeared By:	Kathleen S. Wasson, Esq. Senior Attorney NYS Department of Health, Bureau of Professional Medical Conduct
Respondent Appeared By:	Kern Augustine Conroy & Schoppmann, P.C. 420 Lakeville Road Lake Success, N.Y. 11042 By: T. Lawrence Tabak, Esq.

WITNESSES

For the Petitioner:	Patient A Steven Lawrence Cohn, M.D.
For the Respondent:	Eugene Lloyd Bellin, M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations 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.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Eugene Lloyd Bellin, M.D. ["the Respondent"] was authorized to practice medicine in New York State on April 24, 1962 by the issuance of license number 087504 by the New York State Education Department (Ex. 2).
2. The Respondent has been engaged in the practice of medicine as a solo practitioner of internal medicine since 1965. The Respondent's medical office is located at 3205 Grand Concourse, Bronx, New York. (Tr. 432-434; Ex. B).

FINDINGS AS TO PATIENT A

3. Patient A was hired by the Respondent on February 16, 1976 as a medical assistant. Shortly thereafter, she was promoted to the position of office manager and held that position in the Respondent's medical office until September of 1992. (Tr. 31-33, 134, 147-148, 150-152 and 187).

4. At the time Patient A was hired by the Respondent, she was 23 years old. The Respondent was 45 years old - 22 years older than Patient A. (Tr. 39 and 450; Ex. 2, p. 22 and Ex. 5, p. 1).

Physician-Patient Issue

5. In February of 1976, Patient A was not seeing any other physician on a regular basis (Tr. 212). In addition, at the time Patient A started working for the Respondent she was not taking any medication (Tr. 180).

6. The Respondent provided medical care and treatment to Patient A at his medical office from March or April of 1976 through September of 1992. During this time, the Respondent with respect to Patient A undertook responsibility for care and treatment, had office visits, ordered many laboratory tests, prescribed and provided numerous medications, and consulted with and made referrals to other physicians. Therefore, Patient A was the Respondent's patient. (Tr. 34-35, 214, 297-298, 350-352 and 355-356; Exs. 3, 4, 5, 6A and 6B).

Moral Unfitness Issue

7. Within the first few months of Patient A's employment in the Respondent's medical office, Patient A contemplated leaving her job because of the Respondent's behavior

towards her and others. Patient A found the Respondent to be gruff, crude and rude. (Tr. 216-218).

8. On June 8, 1977, the Respondent held a party for his office staff at the Rye Town Hilton. The party began in the early afternoon and continued until late evening. They drank alcohol throughout the day and into the night. (Tr. 35-36, 186-188 and 191-192).

9. After the office party ended, the Respondent drove his staff back to his office and called taxis for everyone except Patient A. The Respondent asked to speak with Patient A and provided her with more alcohol. When Patient A and the Respondent were alone in the waiting room of his office, the Respondent removed his jacket, got on top of Patient A, removed her slacks, and had sexual intercourse with her, in spite of her objections and without her consent. (Tr. 36-38, 186 and 188-189).

10. The day after the office party, Patient A felt shame and guilt. She called the Respondent's office and told the Respondent that she could not come to work because of what had happened the night before. The Respondent encouraged her to return to work. He assured Patient A that it need not happen again and said that he could give her some Valium to calm her down. (Tr. 38-40).

11. Patient A returned to work two days after the office party because she could not explain to her husband what had happened. She convinced herself that she could handle the situation with the Respondent. (Tr. 40).

12. Upon Patient A's return to work, the Respondent gave her some Valium and also offered her alcohol, but she refused. Thereafter, the Respondent provided Patient A with approximately four to five Valium pills a couple of times a week. He would also offer alcohol to Patient A later in the day, but she continued to refuse. Patient A took the

Valium provided by the Respondent on a regular basis over the next several months. (Tr. 40-44 and 46).

13. After several months, Patient A felt that she could trust the Respondent. One evening, she agreed to have a drink with him. That night, after the Respondent provided Patient A with Valium and vodka, he had sex with her. (Tr. 46-49).

14. The effect of the combination of Valium and vodka on Patient A was to make her relaxed and uninhibited. The Respondent always provided Patient A with alcohol and controlled substances prior to having sex with her. (Tr. 48-49, 53, 55, and 263).

15. The Respondent provided Patient A with alcohol and Ativan while she was pregnant with her daughter, who was born on June 7, 1982. The Respondent assured her that using alcohol and drugs during pregnancy was okay. (Tr. 69-70 and 73).

16. Patient A had concerns about drinking alcohol and taking drugs together. The Respondent assured her that he was taking care of her and it was okay to do so. (Tr. 48 and 55-56).

17. The Respondent had sex with Patient A on a regular basis until 1990 - at first once or twice a week, then three times a week. From 1990 through September 1992, the Respondent still had sexual relations with Patient A on various occasions, but less frequently. The Respondent exerted emotional pressure on Patient A to make her comply with his demands. (Tr. 49-52, 234-237, 262-263 and 274).

18. At various times when Patient A would try to leave the office against the Respondent's wishes, the Respondent physically blocked her way, shoved her, and yelled at her, until she relented. (Tr. 275-278).

19. The sexual encounters between the Respondent and Patient A took place mostly on the

waiting room floor in the Respondent's medical office and occasionally at various motels and occurred only when Patient A was under the influence of alcohol and drugs (Tr. 50 and 263). Patient A continued to have sex with the Respondent because she was afraid that she would lose her source of drugs (Tr. 266).

20. Patient A tried to leave the Respondent's employ several times between 1976 and 1992, but was unable to leave because the Respondent exploited her growing drug addiction. On two occasions, when Patient A had found other medical office jobs, the Respondent pressured her to stay by reminding her that he was her drug source. (Tr. 65-72, 106-107 and 269).

21. It is unethical for a physician to have any sexual contact or sexual relationship with a patient. Such relationship may cloud the physician's judgment concerning the care and treatment of the patient. The patient's level of comfort and trust in discussing personal information may be compromised, having an effect on patient care. If a physician becomes involved in a sexual relationship with his patient, he should discharge the care and treatment of the patient to another physician. (Tr. 333-335; Ex. 10).

22. Since the creation of the Hippocratic Oath, physicians have been prohibited from having sexual relations with patients. In December 1986, the Council on Ethical and Judicial Affairs of the American Medical Association ["the AMA Council"] codified this prohibition in Ethical Opinion 8.14. Ethical Opinion 8.14 was updated in March 1992, based upon a report of the AMA Council entitled "Sexual Misconduct in the Practice of Medicine". This report confirmed a long-standing consensus within the medical profession that sexual contact or sexual relations between physicians and patients are unethical. (Exs. 10, 13 and 18).

23. The Respondent violated his ethical responsibility as a physician by having sex with Patient A. (Tr. 333-335; Exs. 10, 13 and 18).

Medical Issues

24. Alcohol is a central nervous system depressant. Its use with controlled substances such as Ativan, Restoril and Valium can cause additive effects on the central nervous system, impacting on psychomotor skills and behavior. The combined sedative effects can cause respiratory depression to the point where breathing is stopped. A physician should advise the patient not to drink alcohol while taking such medications and note such conversation in the patient chart. (Tr. 330-331 and 395-396).

25. If a patient requires ongoing drug treatment for depression, with no improvement, a physician should refer such patient to a psychiatrist or psychologist (Tr. 317 and 323).

26. Similar drugs taken in combination may "potentiate", or increase the effects of the drugs, causing adverse reactions for the patient. When prescribing similar types of drugs in combination for a patient, a physician should prescribe in lower doses and monitor the side effects, such as respiratory depression and depressed mental status. If drugs from different categories, such as narcotics and benzodiazepines, are prescribed in combination, a patient may be more likely to experience such adverse reactions. (Tr. 306-308, 312, 317-318, 320 and 322).

27. A physician should monitor a patient taking habit-forming drugs for evidence of addiction or dependency, such as a patient's need for a higher dose or more pills on a more frequent basis, or a patient asking for other, additional types of drugs. In addition, a physician should pursue information about the effects of such drugs on the patient's work, home life and behavior. Such information should be noted in the medical record. (Tr.

314-315).

28. The medical indication for intramuscular, intravenous-type injections of narcotics, such as Demerol, is extreme acute pain. There should be documentation of the patient's complaints and medical findings after examination. (Tr. 326-327).

29. A physician who is regularly prescribing Ativan and Restoril for a patient who reports that he or she is using heroin, should refer that patient to a drug detoxification program. Further use of such drugs in combination may cause overdoses and/or additive effects on the patient's central nervous system. (Tr. 329-330).

30. It is not appropriate for a physician to prescribe controlled substances, such as Ativan and Restoril, for an employee or someone other than his patient (Tr. 390-391).

31. The prescribing of controlled substances by a physician must be based on proper medical indication and documented in the patient chart. (Tr. 390-391).

32. A patient chart should contain documentation of a history, physical examination, assessment and treatment plan for each patient visit. The documentation of this information is important not only for the physician's future reference and comparison concerning the patient's complaint, tests ordered, medical diagnosis and medications prescribed, but also for other physicians to have information about the patient. (Tr. 298-300).

33. An initial comprehensive patient history should record information about the present illness, past medical history, surgery performed, a social history, including tobacco, alcohol, drug abuse and medications taken, known allergies, family history, and a review of organ systems. (Tr. 301-302).

34. An initial comprehensive physical examination should record the patient's height and

weight, vital signs, blood pressure and pulse, and should include a complete examination of the patient (Tr. 302).

35. At a follow-up visit, an interval history should record information about changes since the last visit and any new problems and symptoms. The physical examination should include recording the patient's vital signs and focusing in on the patient's medical complaints and problems. The medical assessment should contain a diagnosis or a differential diagnosis. Finally, the treatment plan should contain information about medications prescribed, tests ordered and patient follow-up. (Tr. 302-303).

36. Tests on a patient must be ordered by the physician for a medical reason. The patient's chart should indicate the basis for the ordering of any tests. (Tr. 304-305).

37. A physician should make a note in the patient chart of the name, dose, frequency and amount of any medication prescribed. Such information should be recorded so that the physician has a record of what was prescribed, can evaluate the effects of the medication at a follow-up visit, can plan for future treatment, and can monitor for drug interaction with other medications. (Tr. 306-307).

38. The Respondent inappropriately prescribed Phenobarbital for Patient A, at near the maximum dose, without a diagnosis of epilepsy or of any condition that would require such medication at such dose (Tr. 393-395; Exs. 3, 4 and 5). Phenobarbital is a barbiturate that is used most commonly to treat epilepsy; sometimes for sedation. Phenobarbital is potentially habit-forming. (Tr. 309-310 and 393-394).

39. The Respondent inappropriately prescribed Tylenol with Codeine and Empirin with Codeine for Patient A without making and/or noting a diagnosis (Exs. 3, 4 and 5). Tylenol with Codeine and Empirin with Codeine are both analgesic drugs indicated for

mild to moderate pain. More importantly, Codeine is a narcotic which is potentially habit-forming. The side effects are sedation, nausea, vomiting and respiratory depression. (Tr. 310-311).

40. The Respondent inappropriately prescribed Fioricet for Patient A without making and/or noting a diagnosis (Exs. 3, 4 and 5). Fioricet is a combination barbiturate and analgesic drug which is potentially habit-forming. The side effects are drowsiness and respiratory depression. (Tr. 311).

41. The Respondent inappropriately prescribed Roxicet, Percocet, Demerol and Talwin without making and/or noting a diagnosis (Exs. 3, 4 and 5). Roxicet, Percocet, Demerol and Talwin are narcotics, oxycodone-type, and are potentially addictive. Their side effects are decreased mental acuity or physical ability and central nervous system effects, such as impaired judgment, thinking and motor skills. (Tr. 311-313).

42. The Respondent inappropriately prescribed Valium, Ativan and Xanax for Patient A without making and/or noting a diagnosis (Exs. 3, 4, 5 and 16). Valium, Ativan and Xanax are benzodiazepines which are potentially habit-forming and may cause drowsiness and fatigue (Tr. 312-313).

43. The Respondent inappropriately prescribed Restoril and Halcion for Patient A without making and/or noting a diagnosis. In addition, the Respondent inappropriately prescribed Restoril and Halcion for more than one month without making and/or noting any evaluation of whether Patient A should be continued on such medications. (Exs. 3, 4, 5 and 16). Restoril and Halcion are primarily indicated for insomnia and potentially addictive. Furthermore, they are for short-term use, one week to one month, and require reevaluation to determine whether the patient should be continued on the drug. (Tr. 312-

313 and 390).

44. The Respondent inappropriately prescribed Prozac and Norpramin for Patient A without making and/or noting any diagnosis (Exs. 3, 4 and 5). Prozac and Norpramin are antidepressants. The central nervous system side effects are impaired judgment, thinking and motor skills. Norpramin may cause arrhythmias, as well. Prozac and Norpramin are potentially habit-forming. (Tr. 312-314).

45. The Respondent inappropriately treated Patient A with Prozac from November 1990 through September 1991 without referring Patient A to any mental health professional or noting any such referral in her chart (Exs. 3, 4, 5 and 16).

46. The Respondent inappropriately prescribed and provided a number of controlled substances and habit-forming drugs for Patient A in various combinations of both similar and different categories and at high doses. For example, the Respondent prescribed Phenobarbital, Halcion and Ativan in July 1987. There is a warning against prescribing these three drugs in combination, due to their similar effects on the patient. Also, from September 1986 through July 1987, there was an overlap of multiple drugs given by the Respondent to Patient A, which were of similar and different types and in various combinations. These included Phenobarbital, Halcion, Ativan, Fiorinal, Tylenol with Codeine and Valium. (Tr. 383-388; Exs. 4, 5 and 16).

47. The Respondent failed to appropriately monitor Patient A for addiction to or dependency on any of the habit-forming drugs he prescribed for her (Tr. 314-317).

48. The Respondent prescribed Ativan and Restoril for Patient A for a period of more than twelve years and failed to appropriately monitor Patient A concerning the continued usefulness of such drugs (Tr. 68-69 and 315-316; Exs. 3, 4, 5 and 16).

49. Notwithstanding the Respondent's failure to appropriately monitor Patient A for addiction, he was aware of her addiction to Ativan and Restoril. On at least two occasions when Patient A told the Respondent that she was leaving his employment, he reminded her that he was her source of prescription drugs. (Tr. 106-107 and 269).

50. In addition to the numerous prescriptions and medications the Respondent provided to Patient A, he inappropriately gave her Demerol injections in his office and cocaine sphenopalatine ganglion blocks without making and/or noting any diagnosis or performing an examination prior to administering the blocks (Tr. 92-93, 101-102 and 264-265; Exs. 3 and 7).

51. Although the Respondent referred Patient A to Dr. Sumner Freeman, an ear, nose and throat specialist, for treatment of recurrent sinus infections, the Respondent contradicted the medical advice that Dr. Freeman gave to Patient A. Dr. Freeman advised Patient A to stop drinking, smoking and using the cocaine sphenopalatine ganglion blocks, which he said were injuring the inside of her nose. The Respondent, however, told Patient A that the blocks would not hurt her, and, he continued to give them to her. The Respondent also made light of Dr. Freeman's advice to stop drinking and smoking. (Tr. 56-59).

52. In the late summer or early fall of 1990, Patient A began using heroin (Tr. 105 and 107-108). Shortly after first trying heroin, Patient A told the Respondent of her heroin use (Tr. 108-109 and 494).

53. The Respondent inappropriately continued to prescribe and provide Patient A with controlled substances and habit-forming drugs even after the Respondent knew that she was using heroin. The Respondent provided no medical indication, specific to Patient A, for continuing her on such drugs. (Tr. 109-110 and 496; Exs. 3 and 16).

54. On August 30, 1992, at her family's request, Patient A was admitted to the Dr. Robert L. Yeager Health Center ["the Yeager Health Center"] for evaluation and treatment. (Tr. 110, 114-117, 122 and 129; Ex. 8).

55. After receiving initial detoxification treatment for addiction to Ativan, Restoril and heroin at the Yeager Health Center, Patient A was transferred on September 11, 1992 to the Good Samaritan Hospital Chemical Dependency Unit ["GSHCDU"] for further detoxification. Patient A was discharged from GSHCDU on October 9, 1992, after successfully completing her treatment. (Tr. 129-130 and 331-332; Exs. 8 and 9).

56. The Respondent failed to obtain and/or note an adequate history for Patient A. In addition, the Respondent failed to perform and/or note an adequate physical examination of Patient A. (Tr. 477-478; Ex. 3 and Ex. A, Paragraphs 6 and 7).

57. The Respondent, throughout the treatment period, ordered numerous blood tests for Patient A without noting a medical reason for such tests (Ex. 3 and Ex. A, Paragraph 8). Furthermore, the Respondent ordered some of these blood tests without seeing Patient A for an office visit. (Tr. 475-478; Ex. 3).

58. The Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, prescriptions and/or drugs provided, insurance bills and analysis of lab test results. (Tr. 268 and 477-478; Ex. 3 and Ex. A, Paragraph 9).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless otherwise specified.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patient A to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did practice medicine with incompetence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patient A.

The Respondent did engage in conduct in the practice of medicine which evidences moral unfitness to practice medicine. The Petitioner has proved by a preponderance of the evidence the following: 1) that the Respondent's conduct towards Patient A was in the practice of medicine and did evidence moral unfitness to practice medicine; and 2) that the Respondent's conduct towards Patient A violated the moral standards of the medical community which were in effect throughout the time of this conduct.

The Respondent did not willfully harass, abuse, or intimidate a patient either physically or verbally. The Petitioner has failed to prove by a preponderance of the evidence that the Respondent willfully struck Patient A on more than one occasion, once causing her to sustain a black eye.

The Respondent did order excessive tests or treatment not warranted by the condition of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent 1) inappropriately prescribed and/or provided a variety of controlled substances for Patient A; and 2) inappropriately ordered numerous blood tests for Patient A.

The Respondent did fail to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent in connection with the Respondent's treatment of Patient A, failed to maintain adequate records that accurately reflect the Respondent's evaluation and treatment of Patient A.

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

At the outset, the Hearing Committee wishes to point out that the moral unfitness issue required a thorough assessment of the credibility of the two "fact" witnesses – Patient A

and the Respondent - who testified about the events in question. On the other hand, the negligence, incompetence and other medical issues required a thorough evaluation of the medical testimony regarding the Respondent's care and treatment of Patient A.

The Petitioner relies primarily upon the factual testimony of Patient A and the medical testimony of Steven Lawrence Cohn, M.D., to establish its case against the Respondent.

The Hearing Committee found Patient A to be honest, sincere, straightforward, and non-evasive. She was frank and direct and did not attempt to avoid difficult questions. The Hearing Committee believes her and finds her testimony highly credible. Her stated emotional responses to the various situations and actions were particularly believable. She was consistent throughout her testimony, including while under a thorough cross-examination. The Hearing Committee was impressed by the fact that after removing herself from this noxious situation, she was able to pick herself up and turn her life around, obtaining an advanced professional degree and maintaining a responsible position of employment.

Following the testimony of Patient A, the Petitioner presented Steven Lawrence Cohn, M.D., as an expert witness. Dr. Cohn is Board Certified in Internal Medicine and has an impressive medical background. He is currently an Attending Physician in Medicine at Downstate Medical Center – State University Hospital in Brooklyn, Kings County Hospital, and The New York Methodist Hospital in Brooklyn. He is also the Director of the Medical Consultation Service at Kings County Hospital, the Director of the Preoperative Medical Consultation Clinic at Kings County Hospital, the Acting Chief of the Division of General Internal Medicine at State University of New York Health Science Center at Brooklyn, and the Associate Medical Director for Performance Improvement at University Hospital in Brooklyn. In addition he is a Consultant for the Department of Medicine at Brooklyn Veterans

Administration Medical Center, a Consultant for Quality Assurance at Center for Nursing and Rehabilitation in Brooklyn, and a Clinical Associate Professor of Medicine at State University of New York Health Science Center at Brooklyn. (Tr. 284-286; Ex. 15).

The Hearing Committee found Dr. Cohn to be a convincing and highly credible witness. He was knowledgeable, organized and concise and his testimony was balanced. Furthermore, his testimony was straightforward and non-evasive.

The only witness to testify in support of the Respondent's case, was the Respondent himself. The Respondent graduated medical school in 1958 receiving an M.D. degree, has been licensed to practice medicine in New York State since 1962, and has been continuously engaged in a private medical practice as a single practitioner since 1965. He has been primarily practicing internal medicine. (Tr. 428-436; Ex. 2 and Ex. B).

The Hearing Committee was not impressed with the Respondent's testimony and had various concerns about his credibility. He did not maintain a consistent level of believability throughout his testimony. For example, at different times during his testimony, he willingly conceded obvious mistakes that he had made. However, at other times during his testimony, he made unconvincing attempts to justify or minimize other mistakes and transgressions. Consequently, while certain portions of his testimony appeared truthful, other portions of his testimony appeared self-serving and questionable.

In fact, the Respondent attempted to excuse his conduct by claiming that he did not consider Patient A a patient (Tr. 471-472). However, in view of the testimonial and documentary evidence presented by the Petitioner, the Hearing Committee found this claim to be without merit.

The Hearing Committee found that the testimony of the Respondent was often evasive, unclear and frequently unresponsive to specific questions. In addition, the Hearing Committee observed that while the Respondent admitted many of the facts alleged by the Petitioner, he did not appear to fully comprehend the seriousness of the charges and he did not genuinely accept responsibility for his acts.

Discussion of the Charges

At the outset of this discussion of the charges, the Hearing Committee wishes to make it perfectly clear that it unanimously found that Patient A was in fact a patient of the Respondent. Furthermore, after having found that Patient A was the Respondent's patient, the Hearing Committee unanimously found that the Respondent's conduct towards Patient A was deficient in two major areas. First, the Respondent had a sexual relationship with a patient. Secondly, there were major deficiencies in the medical care and management of the patient provided by the Respondent.

The resolution of the moral unfitness issue initially required a painstaking evaluation of the credibility of Patient A and the Respondent in order to determine what, if anything, actually happened between them during the time period in question. Once a determination was made as to what actually occurred during this period, the Hearing Committee had to then determine what were the applicable moral standards of the medical community during this period. Finally, the Hearing Committee had to apply the Respondent's conduct to the applicable moral standards of the medical community and determine whether the Respondent's conduct violated those standards.

As mentioned earlier, the Hearing Committee unanimously believed the testimony of Patient A. She was a credible witness and her testimony was found to be reliable.

Furthermore, her testimony was essentially supported by the Respondent's testimony and various documents admitted into evidence. Although there is a difference between her testimony and the Respondent's testimony as to whether or not the sexual relationship was truly consensual, the difference is inconsequential. Ultimately, the issue at this hearing is not whether the sexual relationship between the Respondent and Patient A was consensual or not consensual. Rather, it is the inappropriate conduct of a physician having a sexual relationship with a patient.

The Hearing Committee unanimously believes that a sexual relationship between a physician and a patient is inappropriate, unprofessional and unacceptable behavior. Such behavior violates the moral standards of the medical community and the public trust which is bestowed upon a physician by virtue of his professional status.

Although Patient A was a highly credible witness, the Hearing Committee isn't quite sure what actually happened during the incident in which Patient A was struck in the eye by the Respondent. The Hearing Committee still has questions as to whether Patient A was struck intentionally or inadvertently. Giving the Respondent the benefit of the doubt, the Hearing Committee finds that the Petitioner did not meet its burden of proof with respect to either the factual allegation relating to this incident or the specification that is based solely upon this factual allegation – that the Respondent willfully harassed, abused or intimidated Patient A.

The resolution of the negligence, incompetence and other medical issues, required the evaluation of the medical testimony of Dr. Cohn and the Respondent as well as a thorough review of the documentary evidence relating to Patient A. The Hearing Committee noted that Dr. Cohn was critical of the Respondent's care and management of Patient A. In weighing the testimony of both doctors, the Hearing Committee found Dr. Cohn to be the more convincing witness and accordingly gave greater weight to his opinions.

After conducting a thorough evaluation of the medical testimony and an extensive review of the documents admitted into evidence relating to Patient A, the Hearing Committee found that the Petitioner had met its burden of proof with respect to each of the factual allegations relating to the Respondent's medical treatment of Patient A and each of the specifications supported by the proven factual allegations. Accordingly, the Hearing Committee finds that the Respondent was negligent, incompetent, and ordered excessive and unnecessary tests or treatment in connection with the medical care that he provided to Patient A, and he failed to maintain a record for Patient A which accurately reflects the evaluation and treatment of Patient A.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

Factual Allegations

Factual Allegations relating to Patient A

A	Sustained
A1(a)	Sustained
A1(b)	Sustained
A1(c)	Not Sustained
A2	Sustained
A3	Sustained
A4	Sustained
A5	Sustained

Specifications

First Specification	Negligence on More than One Occasion	Sustained

Sustained Factual Allegations in Support of the First Specification:

A, A1(a), A1(b), A2, A3, A4 and A5

Second Specification	Incompetence on More than One Occasion	Sustained

Sustained Factual Allegations in Support of the Second Specification:

A, A1(a), A1(b), A2, A3, A4 and A5

Third Specification	Moral Unfitness	Sustained

Sustained Factual Allegations in Support of the Third Specification:

A, A1(a) and A1(b)

Fourth Specification	Willfully Harassing, Abusing or Intimidating a Patient	Not Sustained
Fifth Specification	Excessive Tests or Treatment	Sustained[1]

Sustained Factual Allegations in Support of the Fifth Specification:

A, A1(b) and A4

Sixth Specification	Failure to Maintain a Patient Record	Sustained

Sustained Factual Allegations in Support of the Sixth Specification:

A, A2, A3 and A5

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law

[1] The medical records of the Respondent failed to provide an adequate medical basis for any of the tests ordered by the Respondent and performed at his request.

set forth above, unanimously determines that the Respondent's license to practice medicine in the State of New York should be revoked.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough evaluation of the Respondent's testimony and demeanor during the hearing.

The Respondent's conduct was unacceptable and cannot be ignored. In view of the Respondent's long-term egregious behavior and deficient medical care and management of Patient A, and his failure to fully appreciate the seriousness of and genuinely accept the responsibility for his actions, the Hearing Committee finds that the only acceptable penalty is revocation.

ORDER

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

1. The First, Second, Third, Fifth and Sixth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I), are **SUSTAINED**; and

2. The Fourth Specification of professional misconduct contained within the Statement of Charges (Appendix I) is **DISMISSED**; and

3. The Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

4. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: New York, New York
February 4, 2000

BENJAMIN WAINFELD, M.D.
Chairperson

SHELDON GAYLIN, M.D.
MS. EUGENIA HERBST

TO: **KATHLEEN S. WASSON, ESQ.**
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EUGENE LLOYD BELLIN, M.D.
3205 Grand Concourse
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APPENDIX I

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

IN THE MATTER
OF
EUGENE LLOYD BELLIN, M.D.

STATEMENT
OF
CHARGES

EUGENE LLOYD BELLIN, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 24, 1962, by the issuance of license number 087504 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A at his office located at 3205 Grand Concourse, Bronx, NY from approximately May 5, 1977 through approximately September, 1992. Patient A also worked for Respondent, at his medical office, from in or about 1976 through in or about September, 1992. (The identity of Patient A is disclosed in the annexed Appendix.)

1. Throughout the treatment period, Respondent deviated from accepted medical standards in that he:

a. Had sexual intercourse with Patient A at his office, in or about June, 1977, after an office party. Thereafter, Respondent continued to have sexual relations with Patient A on a regular basis until in or about September, 1992.

b. Inappropriately prescribed and/or provided a variety of controlled substances for Patient A including, but not limited to, Ativan, Restoril and cocaine sphenopalatine ganglion blocks.

Respondent continued to prescribe and/or provide Patient A with such controlled substances, even after she informed Respondent that she was addicted to one or more of such controlled substances and was using heroin.

c. Struck Patient A on more than one occasion, once causing her to sustain a black eye.

2. Throughout the treatment period, Respondent failed to obtain and/or note an adequate history for Patient A.

3. Throughout the treatment period, Respondent failed to perform and/or note an adequate physical examination of Patient A.

4. Throughout the treatment period, Respondent inappropriately ordered numerous blood tests for Patient A without noting a medical reason for such tests and, in some cases, without seeing Patient A for an office visit.

5. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, prescriptions and/or drugs provided, insurance bills and analysis of lab test results.

SPECIFICATION OF CHARGES

FIRST 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:

1. Paragraphs A and A1 through A5, including the subparagraphs thereof.

SECOND 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:

2. Paragraphs A and A1 through A5, including the subparagraphs thereof.

THIRD 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:

3. Paragraphs A and A1(a) through A1(c).

FOURTH SPECIFICATION

WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT

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

4. Paragraphs A and A1(c).

FIFTH SPECIFICATION

UNNECESSARY TESTS OR TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1999) by ordering excessive tests or treatment, as alleged in the facts of:

5. Paragraphs A and A1(b) and/or A4.

SIXTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

6. Paragraphs A and A2, A3 and A5.

DATED: July 7, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct