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

May 23, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Barry Leonard Singer, M.D.
39 Country Road
Mamaroneck, New York 10543

Bruce Brady, Esq.
Callan, Regenstreich, Koster & Brady
One Whitehall Street, 10th Floor
New York, New York 10004

Denise Quarles, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

RE: In the Matter of Barry Leonard Singer, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-156) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:cah
Enclosure

COPY

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

OF

ORDER # BPMC 00-156

BARRY LEONARD SINGER, M.D.

----------X

DETERMINATION AND ORDER OF THE HEARING COMMITTEE

The undersigned Hearing Committee consisting of **CAROLYN C. SNIPE**, chairperson, **JACK SCHNEE, M.D.**, and **ZORAIDA NAVARRO, M.D.**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by BARRY LEONARD SINGER M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

SUMMARY OF PROCEEDINGS

Pre-Hearing Conferences:	September 7, 1999
Hearing dates:	September 16, 1999 October 13, 1999 October 15, 1999 October 29, 1999 November 18, 1999 December 16, 1999 January 14, 2000
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Date of Deliberation:	February 17, 2000
Petitioner appeared by:	Denise Quarles, Esq. Associate Counsel NYS Department of Health
Respondent appeared:	Callan, Regenstreich, Koster & Brady One Whitehall Street, 10th Floor New York, New York 10004 By: Bruce Brady

WITNESSES

For the Petitioner:	Patient A Amy S. Hoffman, M.D. Patient A's son Helen Post
For the Respondent:	Respondent Joseph Singer Susan Kirsch Abraham Halpern, M.D.

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee when asked regarding to the definitions of medical misconduct as alleged in this proceeding.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on or about November 29, 1962, by the issuance of license number 089761 by the New York State Education Department.

2. On or about April 21, 1973, Patient A became a patient of the Respondent until 1995. (T. 39, 70, 1122, 1123, 1124.

3. Respondent submitted patient records regarding the treatment of Patient A from August 5, 1973 (T. 1253) till December 1976 (T. 1254) (Exh. 5, 5A, 5B).

4. The Respondent testified that he failed to take any notes regarding the treatment and the medications prescribed for Patient A after 1975. (T. 987-8, 852)

5. The Respondent testified that he changed psychiatric modality from psychoanalysis to psychotherapy on or about 1975 but failed to note that change in the patient's record. (T. 852, 1144, 1289-90) Respondent testified the reason why he failed to take notes was because he didn't see the purpose since he knew what was going on with the Patient; because of McCarthism; his horrible handwriting. (T. 853); and his need to concentrate on the patient. (T. 854)

6. Patient A testified that she had sex with the Respondent from 1977 to 1996. (T 287, 418,

517)

7. Patient A testified that on or about November 1994, after Respondent's wife died, Patient A and the Respondent went out in public together with other people, to the theatre, and they were a couple. (T. 210, 211, 286)

8. Patient A testified that she received jewelry from the Respondent in late 1994, 1995, 1996. (T. 400)

9. Respondent testified he had a personal relationship with Patient A in late 1994, early 1995. (T. 1170, 1171)

10. Respondent testified he gave Patient A several pieces of jewelry in the years 1995 and 1996. (T. 1025 -1036)

11. Respondent billed Patient A for psychiatric treatment from October 1, 1973 until on or about December 1995. (Exhibit 22, T 182 1/14/00)

12. Respondent testified that on or about March 25, 1996 he deleted the bills for Patient A for the year 1995. (T. 192, 199)

13. Respondent testified that his billing system process is the following: "...I keep an appointment book... and I write the dates down and then at that time I have a piece of paper that has the names of the patients and whether they paid me cash or not and they're listed from 2, 3, 4, and 5 and I give those to the office manager at the end of the day and then she compiles those bills." (T. 187)

14. Respondent further testified that he makes a list of the patients he sees during the day and then gives that list to the billing person at the end of the day. (T. 188)

15. Respondent testified that in late 1994, early 1995 he was seeing Patient A socially but he continued to place her name in the appointment book. (T. 188, 194)

16. Respondent testified he didn't know how the bills for 1995 for Patient A were generated and that his computer may have "... screwed up .... "(T. 195 1/14/00)

17. Respondent testified that in 1995, he kept the appointment book from his billing person to intentionally hide from her that he was having a social relationship with Patient A. (T. 197)

18. Respondent testified that his testimony before the Panel regarding his billing of Patient A during 1995 was contradictory. (T. 197, 198)

19. Respondent testified that Patient A wrote portions of prescriptions for him. (T. 1243)

20. Patient A testified that Respondent told her many facts regarding other patients. (T. 261, 262, 263) Respondent testified that he gave Patient A other patients names and phone numbers. (T. 1241)

21. The Respondent testified that Patient A was from time to time out of touch with reality. (T. 844, 485) Respondent also testified that Patient A was honest and he believed that she did not fabricate or make up stories. (T. 1163)

22. Patient A testified that on or about May 1997 she had a stroke. (T. 165)

DISCUSSION

This panel has considered all the evidence and testimony before them. This panel also recognizes that Patient A had serious psychiatric disorders which caused her to threaten suicide in 1987 (T.299), isolate herself from her family (T.365) and caused her to act in inappropriate ways such as taking photos of the Respondent with a telephoto lens (T.388, 575), calling Respondent's house just to hear his voice during the present hearing (T.340), calling Respondent's son with tapes of homosexual suggestions (T. 336, 337) and her refusal to remove jewelry that the Respondent gave her. (T. 432, 433). Patient A was unable to identify some scars on the Respondent's body such

as a lypomia on the Respondent's body. (T. 413, 419, 421, 447, 449) (T. 421, 447) However, there was neither evidence nor testimony submitted that Patient A was so out of touch with reality as to fabricate or lie about the sexual relationship between herself and Respondent. In fact, the Respondent testified that although Patient A had breaks with reality,(T. 844) she was an honest person that did not lie. (T.1163, 1227) To compound Patient's A mental state, in May 1997 she had a stroke.(T. 165) Often during her testimony, it took time for her to recall information and articulate answers promptly. However, after a thorough review of the testimony, this panel finds that Patient A was honest and forthright in answering the questions, even when the answers may have been detrimental to her, i.e. calling the Respondent and hanging up during the hearing (T.340; lying to her family regarding when her sexual relationship began with Respondent. (T. 462)

On the other hand the Respondent's testimony is replete with inaccuracies; for example, Respondent testified he had no pension plan,(T.1153) while his son testified the opposite. (T. 1206) The Respondent testified that his billing system is one where he has a personal involvement on a daily basis and then forwards his statement to the billing clerk, and yet blames a computer for his continuing to bill Patient A for the entire year 1995 when there was "only" a personal relationship. (T. 1170,1171) Respondent testified that he and Patient A spent New Year's Eve of 1995 together. (T. 1042, 1172) Respondent testified that on or about December 1995 Patient A was making him uncomfortable with her demands but they were friendly. (T. 1173) Respondent's daughter testified that Respondent was with her on New Year Eve 1995 or 1996. (T. 79, 80) that he left at about 10:00 PM and she assumed he was going home. (T. 116) Respondent's son testified that Respondent was missing New Year's Eve 1994 and he called his sister and that the police were called to the Respondent's house. (T. 16, 1/14/00) The panel does not accept the Respondent's testimony as credible, nor Respondent's son or daughter.

Both Patient A and the Respondent testified of their "personal" relationship during late 1994, early 1995. Patient A testified that the relationship was a sexual one from approximately

1976. There was no testimony that the patient told anyone about sexual relations with the Respondent until she told her son on or about 1997. (T. 99-101) However the Respondent acknowledges that she is a very shy, private person. (T.1085)

This panel concludes that there was a sexual relationship between the Patient and Respondent at least during late 1994 until 1996. The Respondent's billing records of Patient A during 1994 and 1995 establishes that their was a physician-patient relationship during that time. This panel does not accept the Respondent's explanation of billing during 1995 as a computer error. Therefore, the Respondent had a sexual relationship with Patient A during the physician-patient relationship.

Additionally, the Panel recognizes that Respondent's medical practices with Patient A such as "car therapy",(T. 1209, 1210, 1232, 1233) "dinner therapy",(T. 497-503, 527, 529, 542, 561, 591, 592) "vacation therapy"(T. 384, 385, 490, 491, 1194, 1218, 1219, 1250) established early on in the therapy with this Patient was both non-professional and medically questionable.

After giving consideration to all the penalties available, the Panel has unanimously voted to revoke Respondent's license based on the aggregate of all the charges particularly the aggregious nature of the sexual contact between the Respondent a physician, who is a psychiatrist and a patient. In addition, the Panel unanimously votes to impose a substantial financial penalty due to charges of fraud stemming from the Respondent continuing to bill the Patient for professional visits while the Respondent admits to a social relationship with the Patient from 1996, and billing records indicating same, thus using his position to take advantage of a psychiatric patient.

PANEL'S DETERMINATION ON CHARGES

Paragraphs A(1), A(2), A(3), A(4) A(5) is sustained

Paragraphs B(1) is not sustained
B(2) is sustained
B(3) is sustained
B(4) is not sustained

Paragraphs C, C(1) - C(2) is sustained

PANEL'S DETERMINATION ON SPECIFICATION

1. First Specification of Sexual Contact between Psychiatrist and Patient for Paragraphs A, A(1), A(2) and A(3) is partially sustained as to the years 1994 through 1996

2. Second Specification of Gross Negligence for Paragraphs A, A(1) through A(3), B(2), B(3), C, C(1), C(2) is partially sustained as to the years 1994 through 1996

Third Specification of Negligence for Paragraphs A, A(1) through A(3), B(2), B(3), C, C(1), C(2) is partially sustained as to the years 1994 through 1996

Fourth Specification of Incompetence is not sustained

5. Fifth Specification of Moral Unfitness for Paragraphs A, A(1), A(2) and A(3) is partially sustained as to the years 1994 through 1996

6. Sixth Specification Fraudulent Practice for Paragraphs A, A(1), A(2) and A(3) is partially sustained as to the years 1994 through 1996

7. Seventh Specification Failure to Maintain Records Paragraphs A, A(5), B, B2 and B3 is sustained

8. Eighth Specification Revealing Personally Identifiable Facts of A Patient for Paragraphs C, C1 and C2 is sustained

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee, in a unanimous vote, after giving due consideration to all the penalties available have determined that the Respondent's license to practice medicine in the state of New York should be **REVOKED** in additional to a fine of $10,000.00 for each specification that has been sustained.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is **REVOKED.**

2. A fine in the amount of Eighty Thousand Dollars ($80,000.00) is imposed upon the Respondent. The Respondent shall pay that sum to the Bureau of Accounts Management, New York State Department of Health, Erastus Corning Tower Building, Room 1258, Empire State Plaza, Albany, New York 12237 within thirty (30) days of the effective date of this **ORDER.**

3. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes, but is not limited to, the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses (tax law 171(27); state finance law 18; CPLR 5001; executive law 32).

4. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: May 17, **2000**
New Hyde Park, New York

CAROLYN C. SNIPE, Chairperson

JACK SCHNEE, M.D.
ZORAIDA NAVARRO, M.D.

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

IN THE MATTER

OF

BARRY LEONARD SINGER, M.D.

AMENDED STATEMENT OF CHARGES

BARRY LEONARD SINGER, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 29, 1962, by the issuance of license number 089761 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about August 5, 1973, until in or about October of 1997, the Respondent treated Patient A with psychotherapy at his office. During the time period that the Respondent treated Patient A, she would present at the Respondent's office sometimes five to six times per week for psychotherapy sessions. The Respondent treated Patient A for depression and prescribed various medication, including sedatives, to Patient A until in or about October of 1997. (Patient A is identified in the Appendix).

1. From in or around 1976, until in or around May of 1997, the Respondent engaged in a personal, social and sexual relationship with Patient A.

2. The Respondent engaged in sexual encounters with Patient A in his office during what were purported to be psychotherapy sessions.

3. The Respondent billed Patient A for psychotherapy sessions when only sexual encounters occurred.

4. The Respondent failed to maintain a medical record for Patient A which accurately reflects Patient A's treatment, condition and/or diagnoses.

5. The Respondent engaged in the conduct alleged in sub-paragraphs 1 through 3, in the course of ostensibly rendering medical care, but not for a legitimate medical purpose.

B. In or around November of 1987, the Respondent intervened in a suicide planned by Patient A. Patient A told the Respondent that she planned to take sedatives and other medication that the Respondent prescribed for her and that she stockpiled.

1. The Respondent inappropriately continued to prescribe sedatives and other medication that the Respondent knew Patient A was likely to stockpile.

2. The Respondent failed to note in Patient A's medical records any justification for prescribing sedatives or other medication for her.

3. The Respondent failed to note in Patient A's medical records any indication that he monitored Patient A's reaction to or progress on the sedatives and other medication that he prescribed for her.

4. The Respondent failed to monitor Patient A for her reaction to or progress on the medication that he prescribed for her.

C. In or around 1992, and again in or around 1994, the Respondent underwent hip surgery. During the time period prior to the Respondent entering the hospital for surgery, the Respondent requested Patient A to assist him with tasks involving the Respondent's psychiatric patients.

1. The Respondent revealed the names and telephones numbers for several of his patients to Patient A. The Respondent requested that Patient A call these patients and cancel their scheduled appointments with the Respondent.

2. The Respondent requested that Patient A write prescriptions for medications for the Respondents patients.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
SEXUAL CONTACT BETWEEN PSYCHIATRIST AND PATIENT

The Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(44)(McKinney Supp. 1999) by having physical contact of a sexual nature with a patient in his practice of psychiatry as alleged in the facts of the following:

1. Paragraph A, A1, A2 and/or A3.

SECOND SPECIFICATION

GROSS NEGLIGENCE

The 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:

2. Paragraph A, A1, A2, A3, A4, B, B1, B2, B3 and/or B4.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

The 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. Paragraph A, A1, A2, A3, A4, B, B1, B2, B3 and/or B4.

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. Paragraph A, A1, A2, A3, A4, B, B1, B2, B3 and/or B4.

FIFTH SPECIFICATION

MORAL UNFITNESS

The 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:

5. Paragraph A, A1, A2, A3, A4 and/or A5.

SIXTH SPECIFICATION

FRAUDULENT PRACTICE

The Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

6. Paragraph A, A1, A2, A3, A4 and/or A5.

SEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

The 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 that accurately reflects the care and treatment of the patient,

as alleged in the facts of:

7. Paragraph A, A5, B, B2 and/or B3.

EIGHTH SPECIFICATION

REVEALING PERSONALLY IDENTIFIABLE FACTS OF A PATIENT

The Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(23)(McKinney Supp. 1999) by revealing of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law as alleged in the facts of:

8. Paragraph C, C1 and/or C2.

DATED: October 5, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct