STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

August 17, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ivan S. Fisher, P. C.
746 Fifth Avenue-9th Floor
New York, New York 10151

Sylvia Finkelstein, Esq.
NYS Department of Health
5 Penn Plaza-6th Floor
New York, New York 10001

Jerome Steiner, M.D.
451 East 83rd Street Apt. 2B
New York, New York 10028

RE: In the Matter of Jerome Steiner, M.D.

Dear Mr. Fisher, Ms. Finkelstein and Dr. Steiner:

Enclosed please find the Determination and Order (No. 95-180) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 all action 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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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:rlw
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

JEROME STEINER, M.D.

DETERMINATION AND ORDER OF THE HEARING COMMITTEE

BPMC-95-180

The undersigned Hearing Committee consisting of **DAVID T. LYON, M.D.**, Chairperson, **DANIEL W. MORRISSEY, O.P.** and **RICHARD D. MILONE, M.D.** was duly designated and appointed by the State Board for Professional Medical Conduct. **DAVID A. SOLOMON, ESQ.**, Administrative Law Judge, served as Administrative Officer.

The Hearing was conducted pursuant to the provisions of Section 230, subdivision 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 **JEROME STEINER, M.D.** (hereinafter referred to as the "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 Hearing Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	August 24, 1994
Affidavit of Service of Notice and Statement:	September 13, 1994
Department of Health appeared by:	Silvia P. Finkelstein, Esq. Associate Attorney Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York 10001
Respondent appeared in person represented by:	Ivan S. Fisher, Esq. 745 Fifth Avenue Suite 935 New York, New York 10151
Location of the Hearing: and Conferences:	NYS Department of Health 5 Penn Plaza New York, New York
Dates of Hearing:	[1]September 26, 1994 October 5, 1994 December 5, 1994 December 13, 1994 December 19, 1994 January 23, 1995 February 23, 1995 April 3, 1995 April 17, 1995 [1]June 14, 1995
Submission of Proposed Findings of Fact and Conclusions of Law by the Dept. of Health:	May 23, 1995

[1]NOTE: The Pre-Hearing Conference was held on September 26, 1994; the Hearing Committee's deliberations on June 14, 1995.

Submission of Proposed Findings of Fact, Conclusions of Law and Recommendations by the Respondent	May 29, 1995
Deliberations of the Hearing Committee:	June 14, 1995
Closing of the Record:	June 14, 1995

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges the psychiatrist Respondent treated Patient A from 1978 to 1988. During the Spring of 1982 through March of 1988, on numerous occasions, the Respondent persuaded Patient A to submit to sexual contact and performed fellatio on Patient A as a part of treatment and/or therapy. In about April, 1980, the Respondent induced Patient A to lend him $3,000.00, and in about March of 1985, to lend him $5,000.00 for Respondent's personal use. In about September of 1985, Respondent asked Patient A to lend him $5,000.00 for Respondent's personal use. During therapy sessions, Respondent discussed his own personal and financial problems with Patient A. From about 1978 through 1988, Respondent conducted psychotherapy sessions with Patient A in restaurants and coffee shops. Finally, Respondent failed to maintain a medical record of Patient A which accurately represents Patient A's treatment, condition and/or diagnosis.

The allegations are set forth more particularly in the Statement of Charges attached hereto as Appendix I.

In addition to the usual scheduling problems, unusual prior commitments of the Respondent's attorney, the Respondent and Patient A delayed the hearing date schedule:

a. A United States District Court trial date at the Middle District of Florida, Tampa Division, resulted in a further delay when a hung jury placed the action back on the calendar.

b. The Respondent's father died in Florida on 10/23/94. The period of mourning for an observant Jew included a scheduled hearing date that was adjourned.

c. An Amended Notice Setting Trial for 11/2/94 was served.

d. In mid-November, the Respondent informed the Administrative Officer he would be available to continue the hearing.

e. Patient A could not continue testimony until return from his honeymoon after Thanksgiving.

f. The Hearing Committee determined the scheduled dates of 12/5, 12/13 and 12/19 would be the continuation dates.

g. The second of the two US District Court commitments by the Respondent's attorney in the Eastern District of New York was during the 1/23 and 2/23 open dates. (T. 682-601)

h. The Respondent reported the suggested hearing date, to meet his expert witnesses scheduled after 2/23, should be 4/3/95. (T. 846)

Two (2) observers, J. Elkin and T. Stark, acting pursuant to the authority of Chapter 606, Laws of 1991, Section 27, were present at the February 23, 1995 hearing date. (T. 698-699)

On November 28, 1994, the Administrative Officer forwarded a determination on the confidentiality of communications between Patient A's psychotherapist Everett and the Patient. Several contentions of the Respondent's attorney were reviewed. The letter memorandum and attachments were entered into the record as A.O. Ex. I.[2] (T. 147)

On December 9, 1994, the Administrative Officer forwarded a letter memorandum to the attorneys incorporating their stipulation on the status of psychotherapist Everett and the determination that a confidentiality privilege does not exist under the CPLR Section 4507. It is entered in the record as A.O. Ex. II (T. 298)

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[2]NOTE: The last paragraph of A.O. Ex. I recites relevant data concerning scheduling delays noted supra.

The State called the following witnesses:

Patient A	Fact Witness
Rollin M. Gallagher, M.D.	Expert Witness

The Respondent called the following witnesses:

Sherrye Everett	Fact Witness
Loren Bailey, Esq.	Fact Witness
Thomas Hotz	Fact Witness
Arthur T. Meyerson, M.D.	Expert Witness

SIGNIFICANT LEGAL RULINGS

During the course of the Hearing, the Hearing Committee had access to and consulted a memorandum dated February 5, 1992, entitled "Definitions of Professional Misconduct under the New York Education Law" prepared by the General Counsel for the Department of Health. The document contains suggested definitions for gross negligence and negligence on more than one occasion. Negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, or deviation from acceptable medical standards of treatment of a patient. Negligence has been proved if it is established that there was a deviation from acceptable standards of care; there is no requirement that there be established that injury actually resulted from the deviation. Gross negligence has been defined by New York's highest court to be " a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct" Roh v. Ambach, Spero v. Board of Regents, 158 AD2d 763, 764 (3rd Dept. 1990).

The intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine, constitutes the fraudulent practice of medicine. Choudhry v. Sobol, (Choudhry), 170 AD2d 893, 566 NYS2d 723 (3d Dept. 1991), citing Brestin v. Commissioner of Education (Brestin), 116 AD2d 357, 501 NYS 2d 923 (3d Dept. 1986) (dentistry). To sustain a charge that a licensee was engaged in the fraudulent practice of medicine, the Hearing Committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew that representation was false, and (3) the licensee intended to mislead through the false representation. Sherman v Board of Regents, 24 AD2d 315, 266 NYS2d 870 (1967). The licensee's knowledge and intent may properly be inferred from facts found by the hearing committee, but the committee must specifically state the inferences it is drawing regarding knowledge and intent. Choudhry, supra at 894 citing Brestin.

FINDINGS OF FACT

All findings and conclusions herein were unanimous unless noted otherwise. The findings and conclusions of the Petitioner and Respondent submitted herein were each considered and rejected by the Hearing Committee unless specifically set forth herein as findings and/or conclusions of the Committee.

The following findings of fact were made after review of the entire records. Numbers following a finding refer to page numbers of the transcript (T.) Numbers and/or letters following a finding preceding by a reference to exhibits refer to exhibits in evidence (Ex.) The citations represent evidence the Committee found persuasive in arriving at a particular finding. All Findings of fact were established by at least a preponderance of the evidence. Evidence which conflicted with any finding of the Hearing Committee was considered and rejected. The extent that one expert or witness's opinion was given more weight than another's is demonstrated by the Committee's reference to one person's testimony rather than another's.

1. Respondent, JEROME STEINER, M.D., was issued an approval to practice medicine in New York State on July 15, 1963 by the New York State Department of Education issuing License Number 90510. He is currently registered to practice medicine from 451 East 83rd Street with the New York State Education Department. At all times herein mentioned, Respondent maintained a private practice as a psychiatrist from the following address: 451 East 83rd Street, Apartment 2B, New York, New York 10028-0000. (Pet's Ex. 2)

2. Respondent treated Patient A from about February, 1978 until about October, 1988. At the time Patient A commenced treatment with Respondent, his primary complaint was depression. (T. 36-37, 66-67)

3. Initially, Patient A saw the Respondent twice a week for individual therapy sessions, one evening per week for group therapy sessions, and one weekend per month for additional six hour group therapy sessions (T. 623-634)

4. By about 1982, Patient A felt he had overcome his depression as a result of the treatment received by Respondent. At about this time, Respondent suggested that they work on Patient A's relationships and Patient A agreed. (T. 38, 602, 606)

5. From about the Spring of 1982 through March of 1988, Respondent engaged in sexual contact with Patient A on numerous occasions. Respondent told Patient A that the sexual contact would be helpful to him in the therapeutic context of Patient A's learning to give and experience pleasure. (T. 41) During this period of time, on numerous occasions, Respondent fondled Patient A's genitals and performed fellatio on Patient A in the course of therapy sessions (T. 40-45; 47-48; 63-65; 615-617; 621-623; 625-626; 630-631; 634-635; 639-641; 1045-1047)

6. In about April of 1980, Respondent asked Patient A to loan money to him in the amount of $3,000.00 for Respondent's personal use. (T. 56-59; Pet. Ex. 5)

7. In about March of 1985, Respondent asked Patient A to lend him $5,000.00 for Respondent's personal use. (T. 60)

8. In about September of 1985, Respondent asked Patient A to lend him $5,000.00 for Respondent's personal use. (T. 60-62; Pet. Ex. 4)

9. On numerous occasions, in the course of therapy sessions held at his office, at restaurants, or at resort locations, Respondent discussed his own personal and financial problems with Patient A. (T. 45-56; 637-638; 644-645) Respondent regularly socialized with Patient A at restaurants or in the course of "workshop/vacations" held in the summer in France, Canada and several locations in the United States. (T. 84-86) Respondent gave a large portrait photograph of himself to Patient A. (T. 1077-1079; HC. Ex. 1)

10. In or about August of 1980, Respondent persuaded Patient A to attend a "workshop" in France and indicated that this experience was required for Patient A's psychiatric treatment. (T. 66, 68, 378; Pet. Ex. 7)

11. From about 1978 through about 1988, on numerous occasions, Respondent conducted psychotherapy sessions with Patient A in restaurants and coffee shops. (T. 48-55, 63-64; Pet. Ex. 6, 3)

12. The relationship between therapist and patient is rooted in trust; the therapist has and must maintain control over the boundaries of the therapeutic relationship. (T. 320-321)

13. It is a deviation from acceptable standards of medical practice for a therapist to have physical contact of a sexual nature with a patient. (T. 320-322)

14. It is a deviation from acceptable standards of medical practice for a therapist to discuss his own personal problems or relationships with a patient. (T. 318-319)

15. It is a deviation from acceptable standards of medical practice for a therapist to socialize with a patient. It is also such a deviation to conduct therapeutic sessions in restaurants unless such is done within strict outlines of a desensitization protocol. There is no such protocol outlined in Respondent's notes. (T. 311, 313-317, 365-366)

16. It is a deviation from acceptable standards of medical practice for a therapist to borrow money from a patient for the therapist's own personal use. (T. 317-318, 364-365)

17. The medical record maintained by the Respondent for Patient A had an initial entry dated January 2, 1980. The Respondent's treatment of Patient A commenced about February of 1978. There are no entries in the medical record between February of 1978 and December of 1979, reflecting the treatment by the Respondent of Patient A. (T. 304-306, 357-358; Pet. Ex. 3)

18. At the minimum, generally acceptable standards of psychiatric medical care require that a proper medical record should contain an initial evaluation and workup, including past psychiatric history; medical developmental history; a mental status evaluation; diagnosis, formulation of a treatment plan; notations as to medications prescribed and dosage; and a note for each visit. (T. 305, 368-370, 373-374, 403, 405)

19. The medical record maintained by Respondent for Patient A did not contain a mental state evaluation, an initial evaluation, a treatment plan, nor adequate progress notes that accurately reflect the treatment or condition of the Patient. (T. 370-374, 378-379, 387-388, 395-396, 412, 1048-1050, 1051-1055, 1056-1058; Pet. Ex. 3)

20. The Respondent has not denied any of the facts in evidence.[3] (Resp. Ex. F; T. 179) Patient A's motivation was a desire to hold the Respondent accountable for his own actions. (T. 531, Lines 11-12)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS

1. Respondent, a psychiatrist, treated Patient A from about April of 1978 until October of 1988. (Findings 1, 2)

2. From about the Spring of 1982 through March of 1988, on numerous occasions Respondent engaged Patient A in sexual contact ostensibly as part of treatment and/or therapy. (Finding 5)

3. From about the Spring of 1982 through March of 1988, on numerous occasions, Respondent performed fellatio of Patient A during therapy sessions, ostensibly as part of treatment and/or therapy. (Finding 5)

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[3]NOTE: The Administrative Officer advised the Committee they had an option of drawing an adverse inference from the respondent's failure to testify in his defense.

4. In about April of 1980, Respondent induced Patient A to lend him $3,000.00 for Respondent's personal use. (Finding 6)

5. In about March of 1985, Respondent persuaded Patient A to lend him $5,000.00 for Respondent's personal use. (Finding 7)

6. In about September of 1985, Respondent asked Patient A to lend him $5,000.00 for Respondent's personal use. (Finding 8)

7. On numerous occasions, in the course of therapy sessions, Respondent discussed his own personal and financial problems with Patient A. (Finding 9)

8. From about 1978 through about 1988, on numerous occasions, Respondent conducted psychotherapy sessions with Patient A in restaurants and coffee shops. (Finding 11)

9. Respondent failed to maintain a medical record for Patient A which accurately represents Patient A's treatment, condition and/or diagnoses. (Findings 17, 18 and 19)

CONCLUSIONS WITH REGARD TO SPECIFICATIONS OF CHARGES

FIRST SPECIFICATION: GROSS NEGLIGENCE

Having sustained the facts in paragraphs A, A.1, A.2, A.3, A.4, A.5 and A.6, the Hearing Committee unanimously concludes that the Respondent practiced with gross negligence by engaging Patient A in multiple instances of both sexual contact and fellatio, ostensibly as a part of treatment and/or therapy, by inducing Patient A to lend him money in two separate instances and by requesting a loan on a third occasion, all for Respondent's personal use, and by the Respondent discussing his own personal and financial problems with Patient A in the course of therapy sessions.

SECOND SPECIFICATION: NEGLIGENCE ON MORE THAN ONE OCCASION

Having sustained the allegations of fact in paragraphs A through A.6, as set forth in the First Specification above, and the facts in paragraphs A.7 and A.8, the Hearing Committee unanimously concludes that the Respondent practiced on more than one occasion with negligence by, from 1978 through 1988, frequently conducting psychotherapy sessions with Patient A in restaurants and coffee shops and by failing to maintain an accurate medical record of Patient A's treatment, condition and/or diagnoses, as well as, from 1978 to 1988, practicing with the gross negligence set forth in the first specification.

THIRD SPECIFICATION: FRAUDULENT PRACTICE

Having sustained the facts set forth in paragraphs A through A.6 as set forth in the First Specification and the facts in paragraphs A.7 and A.8 set forth in the Second Specification, the Hearing Committee unanimously concludes the Respondent practiced the profession fraudulently as set forth in the first and Second Specifications.

FOURTH SPECIFICATION: WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT EITHER PHYSICALLY OR VERBALLY

Having sustained the facts set forth in paragraphs A, A.1 and A.2 as set forth in the First Specification, the Hearing Committee unanimously concludes the Respondent willfully harassed, abused or intimated Patient A during his professional practice by engaging Patient A in multiple instances of both sexual contact and fellatio, ostensibly as a part of treatment and/or therapy.

FIFTH SPECIFICATION: SEXUAL CONTACT BETWEEN PSYCHIATRIST AND PATIENT

Having sustained the facts set forth in paragraphs A, A.1 and A.2 as set forth in the First Specification, the Hearing Committee unanimously concludes the Respondent had sexual contact between himself and Patient A during professional practice as set forth in the Fourth Specification.

SIXTH SPECIFICATION: EXERCISING UNDUE INFLUENCE ON A PATIENT FOR THE FINANCIAL GAIN OF THE LICENSEE

Having sustained the facts set forth in paragraphs A, A.3, A.4 and A.5, as set forth in the First Specification, the Hearing committee unanimously concludes the Respondent exercised undue influence on Patient A for the financial gain of the licensee/Respondent by inducing Patient A to lend him money on two separate instances and by requesting a loan on a third occasion.

SEVENTH SPECIFICATION: ENGAGING IN CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE THE PROFESSION

Having sustained the facts set forth in paragraphs A, A.1, A.2, A.3, A.4, A.5 and A.6 as set forth in the First Specification, the Hearing Committee unanimously concludes the Respondent engaged in conduct in the practice of medicine which evidences moral unfitness to practice the profession.

EIGHTH SPECIFICATION: FAILURE TO MAINTAIN ACCURATE RECORDS

Having sustained the facts set forth in paragraphs A and A.8, as set forth in the Second Specification, the Hearing Committee unanimously concludes the Respondent failed to maintain accurate records of Patient A's medical treatment, condition and/or diagnoses.

In summary, the Hearing Committee sustains the eight charges of professional misconduct by the Respondent within the meaning of NY Education Law Section 6530(4) (McKinney Supp. 1994), gross negligence; Section 6530(3), Negligence on more than one occasion; Section 6530(2), Fraudulent practice; Section 6530(31), Willfully harassing, abusing or intimidating a patient either physically or verbally; Section 6530(44),Sexual contact between psychiatrist and patient; Section 6530(17), Exercising undue influence on a patient for the financial gain of the licensee; Section 6530(20), Engaging in conduct in the practice of medicine which evidences moral unfitness to practice the profession; and Section 6530(32), Failure to maintain accurate records.

SUMMARY OF CONCLUSIONS

The record herein supports the unanimous findings and conclusions of the Hearing Committee that the Department's key fact witness had no intent to mislead the State. After ten years of therapy by the Respondent, Patient A was fully facing the result of a decade of questionable care.

Patient A was the single fact witness for the State. His credibility was put to the test in a lengthy and probing cross-examination lasting several days by the Respondent's attorney. The Hearing Committee unanimously determined that no persuasive evidence was presented that would seriously question Patient A's testimony. The Respondent was the only other possible fact witness to the sexual allegations that permeated the charges. His failure to take the stand and testify did result in an adverse inference conclusion by the Committee.

Beyond the sexual allegations were three key charges that supported the veracity of the Patient. Three requests by the Respondent to borrow money from Patient A resulted in two loans. A third request was withdrawn by the Respondent. Documentary evidence in support of Patient A's testimony was admitted into the record. Such loans went beyond the ethical boundaries of psychiatric practice. (Finding 16)

A proposal and an active program by the Respondent to conduct some of Patient A's therapy sessions in restaurants and coffee shops without any treatment protocol or rationale, other than the Respondent's assurance that it would support Patient A's socialization, was questionable. Similarly, week end and week long workshops in America, Canada and overseas, without any defined therapeutic protocol do not meet psychiatric standards of acceptable treatment. (Findings 9, 10, 11, 12, 13, 14 ad 15)

The medical records of the Respondent for Patient A do not meet even minimal standards. The initial entry is dated January 2, 1980; Patient A's treatment started about February 1978. Almost two years with no record reflecting Respondent's treatment of Patient A. No record does not meet generally accepted standards for psychiatric care. Nor does a record without a mental state evaluation, a treatment plan, progress notes that accurately reflect the treatment, and condition of the patient. The Respondent's own records speak to the failure of the Respondent to meet standards of care that are required. (Findings 17, 18 and 19)

As charged in the Third Specification citing all eight of the factual allegations, similar elements were basic to each of the three charges noted above. A false representation made by the Respondent that he should have disclosed when he knew the representation was false, but chose to mislead Patient A, the fraudulent practice of medicine.

The Respondent engaged in sexual contact and fellatio with Patient A while purportedly rendering medical care during therapy sessions. By identifying a goal of assisting Patient A to give and receive pleasure, the Respondent led the Patient into physical contact by a misrepresentation of his motives. The sexual acts were, byfar, the self-serving benefit of the Respondent. During the entire period of ten years of treatment by the Respondent, the psychiatrist-patient relationship existed. Sexual contact was an egregious abuse of trust--as well as the violation of several other provisions of NY Education Law Section 6530.

ORDER

In accordance with the provision of Sections 230, subdivision 10, Paragraph (g) and 230-a, Subdivision 4 of the Public Health Law, the Hearing Committee unanimously orders that the license to practice medicine in the State of New York of **JEROME STEINER, M.D.** be and hereby is **REVOKED.**

DATED: Schenectady
Albany, New York
August 14 1995

DAVID T. LYON, Chairperson

DANIEL W. MORRISSEY, O.P.
RICHARD D. MILONE, M.D.

APPENDIX I

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

IN THE MATTER

OF

JEROME STEINER, M.D.

STATEMENT

OF

CHARGES

JEROME STEINER, M.D., the Respondent was authorized to practice medicine in New York State on July 15, 1963, by the issuance of license number 090510 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 451 East 83rd Street, Apt. 2B, New York, New York 10028.

FACTUAL ALLEGATIONS

A. Respondent, a psychiatrist, treated Patient A from in or about April 1978 until in or about October 1988. (The identity of Patient A is disclosed in the annexed Appendix).

1. From in or about the Spring of 1982 through March, 1988, on numerous occasions, Respondent persuaded Patient A to submit to sexual contact ostensibly as part of treatment and/or therapy.

2. From in or about the Spring of 1982 through March 1988, on numerous occasions, Respondent performed fellatio of Patient A during therapy sessions, ostensibly as part of treatment and/or therapy.

3. In or about April 1980, Respondent induced Patient A to lend him Three Thousand ($3,000) Dollars for Respondent's personal use.

4. In or about March, 1985, Respondent persuaded Patient A to lend him Five Thousand ($5,000) Dollars for Respondent's personal use.

5. In or about September, 1985, Respondent asked Patient A to lend him Five Thousand ($5,000) Dollars for Respondent's personal use.

6. On numerous occasions, in the course of therapy sessions, Respondent discussed his own personal and financial problems with Patient A.

7. From in or about 1978 through in or about 1988, on numerous occasions, Respondent conducted psychotherapy sessions with Patient A in restaurants and coffee shops.

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

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law section 6530(4) (McKinney Supp. 1994), by practicing the profession with gross negligence, in that Petitioner charges:

1. The facts in paragraph A, A.1, A.2, A.3, A.4, A.5 and/or A.6.

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct within the meaning of N. Y. Educ. Law, Sec. 6530(3) (McKinney Supp. 1994) by practicing the profession with negligence on more than one occasion, in that Petitioner chargesat least two of the following:

2. The facts in paragraph A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, and/or A.8.

THIRD SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Sec. 6530(2) (McKinney Supp. 1994), by practicing the profession fraudulently, in that Petitioner charges:

3. The facts in paragraph A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, and/or A.8.

FOURTH SPECIFICATION

WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT EITHER PHYSICALLY OR VERBALLY

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(31) (McKinney, Supp. 1994), by willfully harassing, abusing or intimidating a patient either physically or verbally, in that Petitioner charges:

4. The facts in paragraph A, A.1 and/or A.2.

FIFTH SPECIFICATION

SEXUAL CONTACT BETWEEN PSYCHIATRIST AND PATIENT

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(44) (McKinney Supp. 1994), by engaging in physical contact of a sexual nature with a patient, in that Petitioner charges:

5. The facts in paragraph A, A.1 and/or A.2.

SIXTH SPECIFICATION

EXERCISING UNDUE INFLUENCE ON A PATIENT FOR THE FINANCIAL GAIN OF THE LICENSEE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law section 6530(17) (McKinney Supp. 1994), by exercising undue influence on a patient in such manner as to exploit the patient for the financial gain of the licensee, in that Petitioner charges:

6. The facts in paragraph A, A.3, A.4, and/or A.5.

SEVENTH SPECIFICATION

ENGAGING IN CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE THE PROFESSION

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law section 6530(20) (McKinney, Supp. 1994), by engaging in conduct in the practice of medicine which evidences moral unfitness to practice the profession, in that Petitioner charges:

7. The facts in paragraph A, A.1, A.2, A.3, A.4, A.5, and/or A.6.

EIGHTH SPECIFICATION

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law section 6530(32) (McKinney Supp. 1994), by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

8. The facts in Paragraph A and/or A.8.

DATED: NEW YORK, NEW YORK
August 24, 1994

CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct