STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

December 24, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

E. Marta Sachey, Esq.
NYS Department of Health
Corning Tower Room 2503
Empire State Plaza
Albany, New York 12237

Paul M. Hanrahan, Esq.
Hancock & Estabrook, LLP
1500 MONY Tower 1
P.O. Box 4976
Syracuse, New York 13221-4976

Andrew C. Godwin, M.D.
317 Crossett Street
Syracuse, New York 13207

RE: In the Matter of Andrew Godwin, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 97-328) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:nm
Enclosure

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

COPY

IN THE MATTER

OF

ANDREW GODWIN, M.D.

DETERMINATION

AND

ORDER

BPMC-97-328

MICHAEL R. GOLDING M.D., Chairperson, **ARTHUR ZITRIN, M.D.**, and **REV. JAMES H. MILLER**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **E . MARTA SACHEY, ESQ.**, Associate Counsel. The Respondent appeared by **HANCOCK & ESTABROOK, LLP**, **PAUL M. HANRAHAN, ESQ.** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged forty-one specifications of professional misconduct, including allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more that one occasion, physical harassment, intimidation or abuse, inadequate records, violation of Article 33 of the Public Health Law, conduct evidencing moral unfitness, fraud and filing a false report.

The charges are more specifically set forth in the Statement of Charges dated May 19, 1997, a copy of which is attached hereto and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	May 19, 1997
Pre-Hearing Conference:	July 17, 1997
Hearing Dates:	July 17, 1997 July 18, 1997 September 3, 1997 September 4, 1997 September 5, 1997
Received Petitioner's Proposed Findings of Fact, Conclusions of Law:	October 30, 1997
Received Respondent's Proposed Findings of Fact, Conclusions of Law:	October 31, 1997
Deliberation Date:	November 10, 1997 and November 15, 1997
Place of Hearing:	NYS Department of Health Hedley Park Place 433 River Street Troy, New York

WITNESSES

For the Petitioner:	Melvin J. Steinhart, M.D. Andrea M. Lefton, M.D.
For the Respondent:	Andrew C. Godwin, M.D.

FINDINGS OF FACT

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

GENERAL FINDINGS

1. Respondent was authorized to practice medicine in New York State on April 30, 1964 by the issuance of license number 092095 by the New York State Education Department. Respondent is currently registered with the New York State Education Department through June 30, 1998 with a registration address of 317 Crossett Street, Syracuse, New York 13207. (Ex.3)

A. PATIENT A

2. Respondent provided psychiatric care to Patient A at various times from March 20, 1992 through April 19, 1992 at the Benjamin Rush Center, a psychiatric hospital [hereafter "BRC"]. (Ex.5 [BRC record])

3. Patient A was an eighteen-year old girl who was referred for long-term treatment at the psychiatric facility from Binghamton General Hospital where she had been hospitalized for approximately a month prior to her BRC admission. She had resided at a boarding house before the Binghamton General hospitalization. On admission to Binghamton General she reported auditory and visual hallucinations and a desire to hurt herself. She had a history of several years of deteriorating functioning and numerous previous psychiatric admissions. The patient was discharged from Binghamton General with a primary diagnosis of oppositional disorder with schizotypical personality. However, schizophrenic disorder was

also considered due to her bizarre behavior. On discharge from Binghamton General the patient was on Haldol. (Ex.6, pp.238-241 discharge summary; pp.236 emergency psychiatric evaluation [Binghamton General Hospital record])

4. Respondent's admitting diagnoses were undifferentiated conduct disorder, personality disorder not otherwise specified and rule out early schizophrenia. Discharge diagnoses were not otherwise specified psychotic and personality disorders. (Ex.5, p.7 admission assessment; p.4 final summary [BRC record])

5. On admission the patient reported having auditory and visual hallucinations. Respondent's admitting plan was to observe Patient A to determine if she had a personality disorder or a psychotic disorder. (Ex.5, pp.5-8 admission assessment [BRC record])

6. Respondent placed Patient A on medications immediately. He placed her on Trilafon, an antipsychotic neuroleptic, on March 20, 1992, the first day of admission, he added Prozac, a SSRI used to treat depression, the second day. (Ex.5, p.27 physician's order sheet [BRC record]); T.15, 18 [Dr. Steinhart])

7. Patient A was confined to ICU during her entire BRC hospitalization due to her very intrusive and inappropriate behavior towards others. (Ex.5, p.3 final summary [BRC record]) Attempts to transfer her from ICU were not successful due to this behavior. (T.676 [Resp.]) There was difficulty getting the patient to maintain personal hygiene. At times she would get angry, scream and physically assault others. This necessitated emergency treatment with Thorazine and confinement to a seclusion room. (Ex.5, p.4 final summary [BRC record])

8. Respondent's assessment of the patient during her hospitalization and at the time of discharge was that she could not function on her own. (Ex.5, p.15 3/31/92 note [BRC record]).

9. Respondent's note of 4/17/92 concludes as follows: "The patient's mother plans to come and take the patient from the hospital on the 19th two days hence. She has procured an apartment for [Patient A] more or less as a test. That is to say [Patient A] will either be able to survive in this apartment and take care of her basic needs or they will apparently take her back to the residence she was at in Pennsylvania prior to this admission. Frankly it appeared to me that residence might have been the best place for [Patient A]. That is to say at this place they insist that [Patient A] clean up after herself and pull her own weight or else they give her negative consequences. Needless to say, [Patient A] did not like living there but I don't think there is any chance that she will ever learn to take care of herself unless she's forced to. Her mother has continued to call the nursing staff and myself regularly and frequently. Her mother certainly is overprotective and intrusive herself and obviously continues to[sic] with her daughter. My concern is when [Patient A] does return to Binghamton that her mother will probably move in and enable [Patient A] more as she has done in the past. Nevertheless we have procured an appointment for [Patient A] at the local mental health clinic there as well as getting intense case management for her. Our social worker, Cathy, had to work very hard at getting [Patient A] to sign the necessary papers even for this kind of help. Therefore the patient will be discharged on the 19th with Haldol 5 mg qd. Condition unchanged." (Ex. 5 pp. 24-25, {BRC record}

10. Trilafon is a neuroleptic antipsychotic drug used to treat symptoms of psychosis. (T.15-18 [Dr. Steinhart])

11. Respondent placed Patient A Trilafon for only about seven days. On March 21, 1992, 8 mg was ordered to be continued three times the following day. On March 25th the dose was reduced to 4 mg three times a day and on March 27th the drug was discontinued. (Ex.5, pp. 27-29 orders [BRC record]; T.15-16 [Dr. Steinhart])

B. PATIENT B

12. Respondent provided psychiatric care to Patient B at various times from March 26, 1992 through October 22, 1993 at his office and from January 24, 1994 through February 8, 1994 at BRC. (Ex. 8 [office record]; Ex.7 [BRC record]) Respondent also treated Patient B during two hospitalizations at BRC in 1992 which preceded Respondent's outpatient treatment of Patient B. (Exs. B & C final summaries for 1/29/92 to 2/12/92 and 3/4/92 to 3/19/92 admissions)

13. Patient B was a thirty-year old man seen by Respondent in outpatient treatment eight times over the course of nineteen months for paranoia, alcoholism and depression. His treatment consisted of lithium, which he had been placed on during the March 1992 BRC admission. Lithium or its equivalents continued from October 1992 throughout the outpatient treatment period although the patient decreased the dose for three weeks in late 1992. At that time he reported increased drinking and paranoia and that he had been stopped by the police for driving while impaired. The patient was also on Trilafon but discontinued it in less than a week. Respondent last saw Patient B as an outpatient on October 22, 1993. At that time the patient was taking Eskalith irregularly. (Ex.8 [office record]; Ex. B [final summary March 1992 BRC admission])

14. Patient B was hospitalized from January 24, 1994 through February 8, 1994 for alcohol abuse, paranoia and chronic depression. He had been involved in two DWI incidents since the end of December 1993. The patient was treated with lithium and Trilafon followed by Mellaril. Respondent diagnosed bipolar disorder and alcohol abuse. (Ex.7, pp. 4-6 final summary; p. 51 nurse's note [BRC record])

15. Respondent continued Patient B on lithium on March 26, 1992 which the patient had been on during a March 1992 BRC hospital admission. Two months later Respondent discontinued the drug. Then from October 1992 through approximately October 1993 the patient continued on lithium, although at times the patient decreased his dose or took the drug irregularly. (Ex.8 [office record]; Ex. C [final summary 3/4/92 to 3/19/92 BRC admission])

16. Patient B had a drinking problem. This could affect the patient's lithium levels. The diuretic effect of alcohol can raise lithium levels. (T.104-107, 122-123 [Dr. Steinhart])

17. Respondent's failure to monitor Patient B's lithium levels constituted a serious deviation from accepted standards of care. Respondent did not ascertain whether the patient achieved a therapeutic level. He did not know whether the levels were in the toxic range. (T.106-107 [Dr. Steinhart])

18. Respondent failed to adequately document the drug regimen he placed Patient B on during the patient's 1994 BRC hospitalization. On January 31, 1994 Respondent made an initial order for Eskalith 900 mg b.i.d. However, in Respondent's physician's note of that date he noted that he would start the patient on 600 mg b.i.d. (Ex.7, p.16 1/31/94 order, p.38 1/31/94 note [BRC record]) On February 2, 1994 Respondent ordered discontinuance of Trilafon. Yet, in his progress note of the same date he noted that he was going to reduce the dose.

There is no order reducing the dose on February 2nd or thereafter. Additionally, on February 1, 1994 Respondent ordered Mellaril but did not mention this drug in his note of the same date. (Ex.7, pp. 16-17 order sheets, p. 40 2/1/94 note [BRC record]) On February 2, 1994 Respondent noted that the patient was compliant in taking Trilafon when Respondent had, in fact, discontinued the medication. Further, there is no mention of Mellaril which Respondent had ordered the day before. (Ex.7, p. 44 2/2/94 note [BRC record])

19. Respondent's documentation of Patient B's drug regimen did not comport with accepted standards of care. There were numerous discrepancies between what Respondent ordered and what he thought he ordered. This posed risk to the patient in the resulting confusion regarding what drugs and doses the patient was really on and what Respondent thought the patient was on. (T.108-109 [Dr. Steinhart]) Respondent's inconsistent documentation and confusion about the patient's drug regimen resulted in the patient being discharged with inappropriate medications. (Ex.7, p.51 nurses notes [BRC record]. BRC's peer review faulted Respondent for his inaccurate documentation of the patient's drug regimen. (Ex.28, pp.197-201 [BRC credential and peer review file)

C. PATIENT C

20. Respondent provided psychiatric care to Patient C at various times from July 22, 1991 through August 15, 1991 at BRC. (Ex.9 [BRC record])

21. Patient C was a twenty-eight year old woman with diagnoses of major depressive disorder and general anxiety disorder. (Ex.9, pp.2-5 final summary [BRC record])

22. Prozac is a serotonin re-uptake inhibitor. It is used as an antidepressant, among other uses. It has a long half-life. (T.128-130 [Dr. Steinhart])

23. Parnate is a monoamine oxidase inhibitor which results in increased neurotransmitters at brain receptor sites. It is used to treat depression and also has amphetamine-like effects. (T.128-130 [Dr. Steinhart])

24. Respondent placed Patient C on Prozac for eight days from July 23, 1991 until July 31, 1991 when the patient refused her morning dose. He then discontinued Prozac and placed the patient on Parnate on August 2, 1991, three days after the Prozac had been discontinued. (Ex.9, pp. 9, 14, 16, 20 [BRC record])

25. On August 9, 1991 the BRC medical director contacted Respondent and read Respondent an article which described the serotonin syndrome and the danger of using a MAO inhibitor shortly after use of Prozac. Respondent discussed with the medical director the options of discontinuing Parnate temporarily or continuing the Parnate and closely monitoring the patient's vital signs. Respondent chose the latter option. (T.138, 143, 144 [Dr. Steinhart]) Respondent conceded that this was an option. (T.724 [Resp.]) He did not consider it at the time he treated Patient C. At the hearing Respondent's judgment about this option was faulty. He discounted the possibility of a short-term use of a benzodiazepine until enough time had elapsed when Parnate could be reinstituted. Rather, Respondent's concern was the abuse potential in long-term use of a benzodiazepine. (T.724-725 [Resp.])

D. <u>PATIENT D</u>

26. Respondent provided psychiatric care to Patient D at various times from February 16, 1994 through April 5, 1994 at BRC. (Ex.10 [BRC records])

27. Patient D was a seventy-six year old woman with diagnoses of major depressive disorder and generalized anxiety disorder. The patient was treated with Xanax and Parnate. Parnate was discontinued and approximately a week later the patient was put on Wellbutrin. On March 28, 1994 she was found to have a left shoulder fracture and was treated at a general hospital and returned to BRC. Eight days later the patient was found to have another fracture. She was admitted to a general hospital for treatment. Respondent noted that it was the medical consultant's opinion that the patient may have had seizures which resulted in the fractures. (Ex.10, pp.5-7 final summary; p.105 4/5/94 Crouse-Irving Hosp. admission sheet [BRC record])

E. PATIENT E

28. Respondent provided psychiatric care to Patient E at various times at his office from March 1993 through July 1993 following the patient's January 1993 BRC admission, at his office from July 15, 1994 through October 1996 and at BRC during a January 1993 admission and an admission from March 27, 1994 through May 20, 1994. (Ex.11, 3/27/94 to 5/20/94 admission [BRC record]; Ex.12, 1/22/93 to 3/23/93 admission [BRC record/admission summary sheet and final summary only]; Ex.12A 2/93 laboratory test results [BRC record]; Ex.13 [office record])

29. Patient E was a fifty-six year old woman who was involuntarily admitted to BRC from January 22, 1993 through March 23, 1993. On admission, it was noted that the patient had paranoid delusions, flight of ideas and pressured speech. The patient refused to cooperate throughout the admission and was discharged to be followed by Respondent on a regular outpatient basis. She reported a history of tardive dyskinesia and Respondent noted that she did seem to have involuntary tongue movement. She was discharged on lithium with a diagnosis of bipolar disorder, manic with paranoid features. (Ex.12, 1993

admission [BRC record]) Respondent saw Patient E as an outpatient after the March 1993 hospital discharge and through July 1993 according to his final summary of the patient's 1994 hospital admission. (Ex.11, p. 4 [BRC record])

30. Respondent provided no office notes for Patient E for his outpatient treatment of her from March 1993 through July 1993. (Ex.11, p. 4 final summary 1994 admission noting prior outpatient care [BRC record]; Ex.13 [office record]) The records Respondent did provide for outpatient treatment from July 1994 through October 1996 did contain sufficient information regarding the patient's mental status and history during the treatment period.

F. PATIENT F

31. Respondent provided psychiatric care to Patient F at various times from October 8, 1993 through November 16, 1993 and from February 17, 1995 through February 28, 1995 at BRC. (Ex.14 1993 admission [BRC record]

32. Patient F was a forty-six year old man who was hospitalized in 1993 with symptoms of depression and a recent relapse of drinking alcohol and using cocaine. He had been recently discharged from a methadone maintenance program because of these relapses. Testing during the hospitalization revealed a borderline EKG and abnormal liver function. The patient was hospitalized again in 1995 because of depression. At that time he was noted to have a history of hepatitis C for which he received Interferon treatment for six months prior to admission. His liver function studies were still abnormal. (Ex.14, pp.4-6 final summary, p. 170 laboratory tests, pp. 175-176 EKG [BRC record 1993 admission]; Ex.15, pp. 4-5 final summary, p. 63 laboratory tests [BRC record 1995 admission])

33. During the 1993 hospitalization, Patient F's laboratory tests showed abnormal liver function, as well as a mild degree of anemia and low platelet count. An EKG was labeled "borderline" and read as probably normal but a posterior infarct should be considered. (Ex.14, p.170 laboratory tests, pp. 175-176 EKG [BRC record 1993 admission]; T.232-235, 246 [Dr. Steinhart]

G. PATIENT G

34. Respondent provided psychiatric care to Patient G at various times from August 31, 1990 through March 2, 1993 at Respondent's office and from March 3, 1993 through March 12, 1993 at BRC. (Ex.16 [BRC record]; Ex.17 [office record])

35. Patient G was a forty-five year old woman seen by Respondent as an outpatient for approximately two and one half years prior to the 1993 hospital admission. She was treated with Imipramine 250 mg daily during this entire period. Her last office visit was on March 2, 1993, the day before she was admitted to the hospital. Respondent noted on that day that the patient had stopped taking Imipramine sometime before and was depressed and paranoid but that he would try to treat her as an outpatient. She was admitted to BRC and discharged improved after ten days. (Ex.17 [office record]; Ex.16, pp. 2-3 final summary [BRC record])

H. PATIENT H

36. Respondent provided psychiatric care to Patient H at various times from June 4, 1992 through August 20, 1992 at BRC. (Ex.18 [BRC record])

37. Patient H was a fourteen year old girl who was admitted to BRC with a diagnosis of major depression, single episode. She had complained of increasing depression over the preceding several months, including suicidal ideation and attempt. She frequently spoke of suicide during her hospital stay. During the hospitalization the patient revealed a history of being sexually abused by her older brother. She attended a hospital survivors' group regularly and found this helpful but emotionally very stressful. Respondent had suggested and discussed with the patient a meeting with the abusing older brother in a family conference. The patient refused this. (Ex.18, pp. 5-7 final summary; p.199-200 7/1/92 physician's note; p.202 7/1/92 note; p. 197-199 7/1/92 dangerous behavior alert summary [BRC record])

I. PATIENT I

38. Respondent provided psychiatric care to Patient I at various times from June 1985 through November 3, 1985 at his office. He also provided such care after November 3, 1985 until about February 1987 during his contacts with the patient at Respondent's home and at the patient's apartment. In January 1987 Respondent prescribed Valium for Patient I. (Ex.19 [psychiatric report; Ex.20 [billing record]; Ex.21 [letter]; Ex.22, pp. 94, 96, 99, 252-253 [trial testimony]; Ex.23A, pp. 44-59 [EBT]; Ex.23B, p. 27 [EBT])

39. Patient I was a thirty-seven year old married woman estranged from her physician husband. She had a ten year old daughter and an older son not of that marriage. She had been a victim of extreme poverty and sexual abuse by her father. Her mother was inadequate and refused to help Patient I with regard to dealing with the father. Patient I began seeing Respondent in June 1985 in his home-based office because of her anxiety, depression, confusion concerning her relationship with her husband and custody of her daughter and, later, concern about her finances, her husband abusing her and a pending

divorce. Respondent also saw the patient's two children in conjunction with the patient's therapy. Respondent diagnosed the patient as having an adjustment disorder with mixed emotional features. (Ex.19. [psychiatric report]; Ex.22, pp. 34-39, 118-120)

40. Respondent had approximately sixty-four psychotherapy sessions with Patient I from June 14, 1985 through November 3, 1986, a seventeen month period. Included in these was a September 24, 1986 psychotherapy session with the patient and her children in the hallway outside the court while Respondent waited to testify at the custody proceeding. Patient I's sessions with Respondent increased starting in September 1986 partly because the patient had moved to Syracuse from Olean and no longer had to drive three and one-half hours one way to see Respondent. In September 1986 Respondent, with the patient's permission, spoke to his friend Dick B. about giving Patient I a job. Patient I was given a job and began working in September 1986. In September 1986 and October 1986 Respondent saw Patient I, on some occasions with her children, in twenty-four psychotherapy sessions, twelve times each month. Respondent has no records of his psychotherapy sessions with Patient I. According to Respondent such records up until the September 1986 custody trial were not returned to Respondent. However, Respondent kept no notes of his sessions with the patient subsequent to that trial. (Ex.19 [billing record]; Ex.21 [7/5/88 letter]; Ex.22, pp. 63-64, 91-93 [trial testimony]; Ex.23A, pp. 39, 41 [EBT]; T.434, 440-442, 588-589, 597-599, 662, 667 [Resp.])

41. On November 7, 1986, according to Respondent, treatment was "terminated" with Patient I at the patient's request. (Ex.22, pp. 94, 193-194 [trial testimony]; Ex.23A, pp. 63, 80 [EBT]; Ex.23C, pp. 19-20 [EBT]; T.444 [Resp.])

42. After November 3, 1986 and through approximately February 1987, Respondent saw Patient I at his home and at her apartment and other places. He spoke frequently with the patient on the telephone. In January 1987 Respondent prescribed Valium for the patient, according to Respondent, for the patient's resurgent temporal mandibular joint syndrome. In January 1987 Respondent referred Patient I to a pastoral counseling center. (Ex.22, pp. 248, 252 [trial testimony]; Ex.23A, p. 52 [EBT]; T.568-569 [Resp.]) Respondent conceded that he did not discourage Patient I from discussing issues he had discussed with her prior to November 3, 1986. (T.625-629 [Resp.])

43. After November 1986, Respondent's relationship with Patient I included socialization and gift giving. In February 1987, Respondent recognized the need for clarification of his relationship with Patient I. During a conversation regarding this subject, Respondent physically attempted to have Patient I look at him. Patient I inadvertently fell backward and hit her head. Thereafter, Respondent sent Patient I an audiotape which Respondent explained was his attempt to distance himself from the patient and to explain his feelings for her. Patient I eventually sued Respondent. The suit was settled and payment made to Patient I by both Respondent and his insurance company. (T.585-586, 652-653 [Resp.])

44. Respondent socialized with Patient I including, without limitation, as follows:

a. Respondent in approximately October 1986 invited Patient I to a Halloween party at Respondent's home;

b. Respondent, approximately one week before Thanksgiving 1986, invited Patient I and her children to Thanksgiving dinner at Respondent's home;

c. Respondent, in approximately December 1986, took Patient I to dinner at the General Hutchinson Restaurant with Respondent's grandchildren;

d. Respondent, in approximately December 1986, had Patient I and Patient I's daughter to his home so Patient I's daughter could play with Respondent's grandchildren.

45. Respondent gave Patient I numerous gifts including, without limitation, the following:

a. Respondent, brought groceries to Patient I at her apartment;

b. Respondent gave and/or loaned Patient I approximately $1,200.00 in approximately December 1986 and $6,500.00 in approximately January 1987;

c. Respondent, in approximately December 1986, gave Patient I and Patient I's children Christmas gifts;

d. Respondent gave Patient I an oriental carpet for which Respondent had paid approximately $300.00;

e. Respondent, approximately just before Valentine's Day 1987, gave Patient I a used mink coat for which Respondent had paid $1,300.00;

f. Respondent, at various times, gave Patient I makeup, candy, jewelry and/or flowers.

46. Respondent, in approximately November or December 1986, employed Patient I's son to paint Respondent's office.

47. Respondent, in approximately autumn 1986, gave Patient I a plastic rat.

48. Respondent, on approximately February 14, 1987, gave and/or sent Patient I approximately six Valentine's Day cards which read and/or on which Respondent variously wrote and/or signed the following or words to such effect:

a. "I wanted a card as big as my love for you. Andy;"

b. "Your candyman" in reference to the message on the card;

c. "I just bought this one and it's in my bedroom" on a card which reads "Especially for you, a pornographical Valentine. Now all you need is a phonograph to play it on; Happy Valentine's Day;"

d. "Your favorite shrink" on a card which reads "I'm not interested in a nice, normal relationship. I like ours better. Happy Valentine's Day;"

e. "Please heed my plead-o before I lose my libido" on a card which reads "When presented to sender on Valentine's Day, this card is redeemable for five hugs, seven kisses, two hickeys and one miscellaneous."

49. The American Medical Association Principles of Medical Ethics with Annotations Applicable to Psychiatry sets forth the ethical standards which should be operative in the psychiatrist-patient relationship. Sections one and two of those annotations describe the nature of the psychiatric relationship and the psychiatrist's ethical responsibility to

maintain an appropriate relationship and act only in the patient's interests. Annotations to section one essentially state that a patient may place trust in the psychiatrist knowing that the psychiatrist's ethics and professional responsibilities preclude the psychiatrist from gratifying his or her own needs by exploiting the patient. This is particularly important because of the essential private, highly personal and sometimes intensely emotional nature of the relationship established with the psychiatrist. Under section two's annotations is the requirement that the physician conduct himself with professional propriety. This is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her therapist by identification. Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist while weakening the objectivity necessary for control. (T.325-326, 328-329, 379-380 [Dr. Steinhart]

50. Appropriate boundaries must be maintained even with former patients. (T.363, 380-384, 404-406 [Dr. Steinhart])

51. Accepted standards of psychiatric practice require certain steps when a patient's treatment is terminated. Absent unusual circumstances, the decision to terminate is usually a mutual one. It is done over a period of time, often at a reduced schedule of appointments, depending on the length of the preceding treatment. There should be assessment by both the psychiatrist and patient regarding what goals have been achieved, what problems resolved and what improvement there has been. Plans should always be made for future treatment should the need arise. The psychiatrist should express to the patient his or her future availability. (T.337-338 [Dr. Steinhart])

52. The manner in which Respondent terminated treatment with Patient I and his failure to plan with Patient I for future therapy, if that should become necessary, constituted serious deviations from accepted standards. The patient wished to stop treatment and Respondent considered that appropriate because she apparently felt better and her concerns were of a lesser degree. However, Respondent made no discharge plans for the patient. There was no gradual reduction in the number of sessions. Patient I felt that her treatment with Respondent had ended in February 1987: "I would say in my own head that last day when he said I can't be your shrink or your friend anymore, was the day I realized my life was gone." (T.338-342, 407-408 [Dr. Steinhart]; Ex.22, pp. 94, 193-194, 248, 252 [trial testimony]; Ex.23A, pp. 52, 60-61, 63-65, 80 [EBT]; Ex.23C, pp. 19-20 [EBT]; Findings of Fact 110, 111, 113, 131)

53. Countertransference, in the context of a therapist-patient relationship, refers to feelings, wishes, needs, conflicts of the therapist, projected onto or transferred to the patient which often originally concerned others significant in the therapist's life. Like transference, which is the same as countertransference but on the part of the patient, the phenomenon takes a long time to work through or dissipate. It lasts after formal therapy stops. Psychiatrists are trained to recognize their inappropriate feelings and wishes regarding patients and to understand their origin and meaning. They are also trained to take corrective action if these feelings cannot be resolved and threaten the therapeutic relationship. Corrective measures include speaking to a colleague. If that is not successful, getting supervision or even therapy is necessary. In cases where the psychiatrist cannot satisfactorily resolve countertransference issues and they are affecting the therapeutic relationship, the psychiatrist should refer the patient to another for treatment. (T.342-344 [Dr. Steinhart])

54. Countertransference issues may surface with a patient after termination of therapy as well as during it. In such an event, a psychiatrist still has an obligation to maintain professional boundaries and distance and not act upon his feelings. A psychiatrist is also responsible for discouraging a patient or former patient who tries to engage in other than a professional relationship. (T.346 [Dr. Steinhart])

55. Respondent had countertransference issues with Patient I which he failed to recognize or appropriately deal with. (T.624-625 [Resp.])

J. ARTICLE THIRTY-THREE VIOLATION

56. Respondent, by Order dated July 13, 1994 pursuant to a stipulation entered into by Respondent and the New York State Department of Health, was found by the Commissioner of Health to be in violation of Article Thirty-Three of the Public Health Law. Specifically:

> Respondent, on twenty-four occasions between September 10, 1990 and April 24, 1992, wrote twenty-four prescriptions for controlled substances, including Oxazepam 30 mg, Diazepam 5 mg and Aspirin with Codeine #3 30 mg, for his own use without maintaining adequate patient records.

(Ex.27 [7/13/94 Stipulation and Order]; Ex. A [answer]; T.841-842 [Resp.])

K. DECEMBER 10, 1988 BENJAMIN RUSH CENTER REAPPOINTMENT APPLICATION

57. Respondent, on approximately December 10, 1988, filed a Reappointment Application with BRC. (Ex.28, pp.125-126 [BRC credential and peer review file])

58. The Application was filled out by Respondent's secretary and Respondent's signature was stamped on it. Respondent's secretary of ten years filled out the Application pursuant to Respondent's authority. It was Respondent's practice to have his secretary fill out such forms. (T.851, 852, 855, 866 [Resp.])

59. The Application question "Are any malpractice claims pending?" was answered "No." (Ex.2, p. 125 [BRC credential and peer review file])

60. The negative answer to the Application question was false. On December 10, 1988, the date of the Application, there was a pending malpractice action by Patient I against Respondent. Respondent had been personally served with the Summons and Complaint in that action on June 27, 1988. Respondent had a law firm representing him in that action. Respondent knew such facts. He knew he had been served with the Summons and Complaint. He knew that an attorney had been retained by his insurance company and he knew the name of the attorney. (Ex.29 [affidavit of personal service in malpractice action]; Ex. 30 [10/17/88 answer in malpractice action]; T.851-852, 855, 857, 861-863 [Resp.]; Ex. A [answer])

L. FEBRUARY 16, 1991 BENJAMIN RUSH CENTER MALPRACTICE ACTION APPLICATION

61. Respondent, in a written communication of approximately February 16, 1991 to BRC, explained the malpractice action of Patient I. Respondent described the malpractice action as concerning the patient blaming Respondent for the loss of custody of her child because Respondent was unable to attend a second court appearance in the custody suit between the patient and her husband and the patient claiming that Respondent gave her Valium which resulted in causing the patient amnesia. In fact, the malpractice action also concerned, among other matters, allegations that Respondent struck the patient and otherwise abused her in the course of treatment, made sexual and romantic advances toward the patient in the course of therapy and failed to maintain a professional therapeutic relationship with the patient. (Ex.28, p. 82 [BRC credential and peer review file]; Ex.29 [Summons and Complaint])

62. The above explanation, dictated by Respondent, was the first explanation Respondent gave to BRC regarding the malpractice suit, either when it was pending or after it was settled. (T.875, 880 [Resp.]) Respondent testified that he probably did not have the Summons and Complaint in front of him when he prepared the explanation; the explanation represented his recollection of the details of the lawsuit. (T.826-878 [Resp.])

M. OCTOBER 24, 1995 COMMUNITY GENERAL HOSPITAL APPLICATION FOR PRIVILEGES

63. Respondent, on approximately October 24, 1995, filed an Application for Privileges at Community General Hospital of Greater Syracuse. (Ex.31, pp.18-28)

64. Respondent signed the Application. Respondent had indicated in his answer and on direct examination that the signature on the Application was not his. (Ex.A [answer]; T.885 [Resp.]) However, at the hearing he testified that when he disregarded the date next to that signature he was much less certain as to whether it was his signature. (T.902-903 [Resp.] Respondent also affirmed other signatures as his own which he could ascertain as such when he disregarded the dates next to the signatures. He testified that the signatures on Pages 29 and 30 of the Application were his. (Ex.31) He testified that disregarding the date, the signature on the February 19, 1996 New York State Registration Application was his. (Ex.3; T.906) There are numerous other signatures of Respondent throughout the exhibits in this proceeding. Those signatures, as well as those acknowledged by Respondent to be his and referenced here, all support the conclusion that the signature which Respondent is uncertain about on Page 26 of the Application is, in fact, his. (Ex.31, p. 26; see also, p. 28 [signature on application's authorization for release of information]) Further, even assuming the signature was not Respondent's, Respondent is fully responsible for the contents of documents he authorized his secretary to prepare for him. Respondent agrees that this is so. (T.907 [Resp.]) Additionally, Respondent conceded that it would be especially important to be as accurate as possible on the Application, which was his first one to Community General Hospital. He would assume his secretary would inquire if there was something she was uncertain about or if she needed information. He agreed that his secretary was aware of his status at BRC and that something was happening there in October 1995. (T.900-902 [Resp.])

65. Respondent answered "No" to the Application question "Have you at any time been subject to limitation, suspension, revocation, denial or non-renewal of employment, appointment or privileges at any hospital or health related institution." Respondent was, in fact, subject to such limitation or suspension at BRC and knew this. On August 4, 1995 BRC notified Respondent that it intended to reduce his privileges. Among other

matters, Respondent would no longer be a qualified psychiatrist able to treat patients fourteen years or older but a general psychiatrist able to treat patients sixteen years or older. He would not be allowed to undertake treatment of known victims of sexual abuse. (Ex.28, pp. 275-276 8/4/95 letter; p. 45 5/23/93 reappointment as qualified psychiatrist [BRC] credential and peer review file]) Respondent appealed the proposed reduction. (Ex.28, p. 277 8/14/95 letter acknowledging appeal request) On September 20, 1995, Respondent participated in the Ad Hoc Committee proceeding regarding his appeal. (Ex.28, pp. 281-284) By letter of October 6, 1995, Respondent was apprised that the Ad Hoc Committee recommended, among other matters, that Respondent be allowed to treat patients fourteen years or older but that for a period of one year Respondent have regular consultations with another psychiatrist regarding Respondent's treatment of patients with sexual abuse problems. Respondent was also advised that he could appeal this recommendation within ten days. (Ex.28, pp. 284-286) On October 20, 1995, four days before Respondent's October 24, 1995 Application to Community General Hospital, Respondent called BRC and asked for a few more days to make a decision. (Ex.28, p. 278) BRC suspended Respondent's privileges until further notice on October 24, 1995. Under BRC by-laws supervision of a physician's practice is deemed a change in privileges which would result in suspension if the physician does not comply. (Ex.28, pp. 287, 28) By letter dated October 25, 1995, Respondent submitted his "written resignation" from the BRC staff. At the top of the letter he stated "I wouldn't have seen it if I hadn't believed it." (Ex.28, p. 289) BRC viewed Respondent's resignation as following a limitation of his privileges. (Ex.28, pp. 293-294, 302)

66. The timing of Respondent's October 20, 1995 request to BRC for more time to make a decision regarding limitation of privileghis October 24, 1995 Application to Community General Hospital supports a fair inference that Respondent was trying to "buy" time to submit an application in which he would not have to reveal BRC's actions. Further,

Respondent's statement on his written resignation of October 25, 1995 "I wouldn't have seen it if I didn't believe it" fairly reflects his knowledge that BRC had suspended him the previous day. Respondent was "subject" to limitation of privileges and suspension at BRC at the time he filed the Community General Hospital Application and knew that.

67. Respondent answered "No" to the Application question "Have you at any time been subject to professional malpractice claims..." Respondent was, in fact, subject to Patient I's malpractice claim. Respondent knew this. He had undergone examinations before trial on three occasions in 1989 and had testified in June 1990 at the trial of that malpractice action. (Ex.31; Exs.22, 23A, 23B, 23C)

68. Respondent answered "No" to the Application question "Have you at any time been subject to judgment, settlement, or findings of any medical malpractice action..." Respondent, in fact, was subject to such a matter. The malpractice action against Respondent by Patient I was settled on approximately June 14, 1990.

69. The totality of the circumstances surrounding Respondent's application to Community General Hospital demonstrates that Respondent provided information which he knew was false concerning several matters in that Application.

N. FEBRUARY 1, 1996 HMO-CNY APPOINTMENT APPLICATION

70. Respondent, on approximately February 1, 1996, filed an Appointment Application with HMO-CNY. (Ex.33, pp. 3-8) Respondent signed the Application. (T.917 [Resp.])

71. Respondent answered "No" to the Application question "Has your employment, association, privileges, practice or membership at any hospital, health care facility or health maintenance organization ever been deemed, suspended, diminished, revoked, not renewed or placed on probation." Respondent, in fact, at BRC was subject to the matters set forth in Finding of Fact 65.

72. Respondent answered "No" to the Application question "Are there now, or have there ever been, any proceedings or investigation of you by the New York State Office of Professional Medical Conduct or other governmental agency." In fact, Respondent was the subject of an investigation by the New York State Department of Health's Bureau of Controlled Substances which resulted in the Order set forth in Finding of Fact 56. Respondent also was the subject of investigation by the New York State Office of Professional Medical Conduct in approximately 1992 with regard to Patient I, in approximately 1993 and 1994 with regard to the Order set forth in Finding of Fact 56 and with regard to Respondent's self-prescribing. Respondent knew such facts and conceded that he did. He testified that the answer to the question was "made in error." (T.916; Ex.A [answer])

73. Respondent's answers on the HMO-CNY Application were false. They misrepresented circumstances of which Respondent was well aware.

O. FEBRUARY 19, 1996 NEW YORK STATE REGISTRATION APPLICATION

74. Respondent, on approximately February 19, 1996, filed a Registration Application for the period July 1, 1996 through June 30, 1998 with the New York State Education Department. (Ex.3)

75. Respondent answered "No" to the Application question "Since you last registered has any hospital and/or licensed facility restricted or terminated your professional training, employment or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence." In fact, Respondent was subject to the matters set forth in Finding of Fact 65 at BRC. Further, it is a fair inference that on October 25, 1995 Respondent resigned from BRC to avoid such matters. Respondent conceded that he had called BRC on October 20, 1995 to ask for more time to decide whether to accept the limitation of his privileges or appeal. At a minimum, his written resignation of October 25, 1995 should be construed as a resignation to avoid restrictions. (T.922-923, 926-927 [Resp.]; Ex.28, pp. 223, 286, [BRC credential and peer review file])

76. Respondent's February 19, 1996 Registration Application was false.

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(2 through 11)
Paragraph A.1:	Not Sustained
Paragraph A.2:	Not Sustained
Paragraph A.3:	Not Sustained
Paragraph A.4:	Not Sustained

Paragraph B:	(12)
Paragraph B.1 :	Not Sustained
Paragraph B.2 :	(14 through 17)
Paragraph B.3 :	(18)
Paragraph B.4 :	(19)
Paragraph C:	(20)
Paragraph C.1:	(21 through 25)
Paragraph D:	(26)
Paragraph D.1:	Not Sustained
Paragraph D.2:	Withdrawn
Paragraph E:	(28)
Paragraph E.1:	Not Sustained
Paragraph E.2:	Not Sustained
Paragraph E.3:	Not Sustained
Paragraph E.4:	(28,29)
Paragraph E.5:	Not Sustained
Paragraph E.6:	Not Sustained
Paragraph F:	(31)
Paragraph F.1:	Not Sustained
Paragraph F.2:	Withdrawn
Paragraph F.3:	Withdrawn
Paragraph G:	(34)
Paragraph G.1:	(35)
Paragraph G.2:	(35)
Paragraph G.3:	(35) (only with respect to failure to adjust drug regimen in a timely manner)
Paragraph G.4:	Not Sustained

Paragraph H:	(36,37)
Paragraph H.1:	Not Sustained
Paragraph H.2:	Not Sustained
Paragraph H.3:	Not Sustained
Paragraph I:	(38)
Paragraph I.1(a):	(43,44)
Paragraph I.1(b):	Withdrawn
Paragraph I.1(c-e):	(43,44)
Paragraph I.2(a-f):	(43,44)
Paragraph I.3:	Not Sustained
Paragraph I.4:	(47)
Paragraph I.5(a-e)	(48)
Paragraph I.6:	(43)
Paragraph I.7:	(43)
Paragraph I.8:	(51,52)
Paragraph I.9:	(49-50,53-55)
Paragraph I.10:	(42-45, 47-55) (except with respect to romantic)
Paragraph J:	(56)
Paragraph K:	(57)
Paragraph K.1:	(58-60)
Paragraph L:	(61-62)
Paragraph L.1:	Not Sustained
Paragraph M:	(63)
Paragraph M.1:	(63-66,69)
Paragraph M.2:	Withdrawn
Paragraph M.3:	(63-64, 67,69)
Paragraph M.4:	(63-64, 68-69)

Paragraph N:	(70)
Paragraph N.1:	(65,70-71,73)
Paragraph N.2:	Withdrawn
Paragraph N.3:	(56,70,72-73)
Paragraph O:	(74)
Paragraph O.1:	(74-76)

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parenthesis refer to the Factual Allegations which support each specification:

PRACTICING WITH GROSS NEGLIGENCE

Not Sustained

PRACTICING WITH GROSS INCOMPETENCE

Not Sustained

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Seventeenth Specification:	(Paragraphs B and B.2)
	(Paragraphs E and E.4)
	(Paragraphs G and G.1 through G.3)
	(Paragraphs I and I.1(a) and (c-e), I.2 (a-f), I 4, I.5(a-e), I. 6, I.7, I.8, I.9 and I.10)

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Eighteenth Specification: (Paragraphs C and C.1)

(Paragraphs E and E.4)

PHYSICAL HARASSMENT, INTIMIDATION OR ABUSE

Not Sustained

INADEQUATE RECORDS

Twentieth Specification: (Paragraphs B and B.3 through B.3)

VIOLATION OF ARTICLE 33 OF THE PUBLIC HEALTH LAW

Twenty-Fifth Specification: (Paragraphs J and J.1)

CONDUCT EVIDENCING MORAL UNFITNESS

Not Sustained

FRAUD

Thirty-Fourth Specification: (Paragraphs M and M.1 and M.3 through M.4)

Thirty-Fifth Specification: (Paragraphs N and N.1 and N.3)

Thirty -Sixth Specification: (Paragraphs O and O.1)

FILING A FALSE REPORT

Thirty-Seventh Specification: (Paragraphs K and K.1)

Thirty-Ninth Specification: (Paragraphs M and M.1 and M.3 through M.4)

Fortieth Specification: (Paragraphs N and N.1 and N.3)

Forty-First Specification: (Paragraphs O and O.1)

The Hearing Committee further concluded that the following specifications should not be sustained:

First through Sixteenth Specifications

Nineteenth Specification

Twenty-First through Twenty-Fourth Specifications

Twenty-Sixth through Thirty-Third Specifications

Thirty-Eighth Specification

DISCUSSION

Respondent is charged with forty-one (41) specifications alleging professional misconduct within the meaning of Education Law Section 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York

Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

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

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

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

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

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

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that eleven (11) of the forty-one (41) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset, the Hearing Committee made a determination as to the credibility of the witnesses presented by the parties. The Department's witnesses were Melvin J. Steinhart, M.D. and Andrea M. Lefton, M.D. Dr. Steinhart is a board certified psychiatrist, who is a Professor of Clinical Psychiatry and Professor of Clinical Medicine at Albany Medical College of Union University. (Ex. 4) Although Dr. Steinhart is experienced and well educated, the Hearing Committee found his testimony to be more of that of an advocate and not an expert , particularly with respect to Patients A through H. The Hearing Committee found that his evaluations of the seriousness of Respondent's errors for Patients A through H were exaggerated and too severe. The Hearing Committee found that Dr. Steinhart refused to acknowledge room for disagreement on clinical judgments. The Hearing Committee concurs with Respondent's analogy of Dr. Steinhart as a "good soldier" for testifying that Respondent's failure to seek a consultation for Patient A was gross error, without regard to her difficult history and consistency of Respondent's diagnosis with his psychiatric predecessors. (see Respondent's brief at p.3) With respect to Patient I, Dr. Steinhart exhibited current knowledge of boundary crossings by psychiatrists and its resulting harm or potential harm to patients. Overall, the Hearing Committee gave Dr. Steinhart's testimony only moderate weight.

The Department also offered the testimony of Andrea M. Lefton, M.D, who is board certified in both general and child and adolescent psychiatry. At present, she is a staff psychiatrist at the Veteran's Administration Hospital in Albany, New York, where she practices general psychiatry, including family therapy. She also engages in private practice in child, adolescent and adult psychiatry. (Ex.34) Dr. Lefton testified as an expert, adolescent psychiatrist only for Patient's A and H. The Hearing Committee found Dr. Lefton to be well trained, but relatively inexperienced in a sense that she was not disposed to consider reasonable alternatives with difficult patients. The Hearing Committee believes that Dr. Lefton knows the rules, but not the exceptions. As a result, the Hearing Committee afforded her testimony minimal weight.

Respondent testified on his own behalf. The Hearing Committee found Respondent 's testimony to be credible and forthcoming with respect to Patient's A through H. The Hearing Committ found Respondent's testimony with respect to Patient I to be less than straightforward. The Hearing Committee further found that Respondent's testimony with respect to various application for re-appointment, employment and license registration was not credible. Respondent exhibited a careless attitude when testifying before the Hearing Committee on these particular matters. Therefore, Respondent's testimony on these charges was given little credence.

PATIENT A

Charge A.1 alleges that Respondent placed Patient A on Trilafon and/or Prozac for inadequate periods of time and/or in inadequate doses for the drugs to take effect. Respondent testified that he first saw Patient A upon her admission to Benjamin Rush Hospital on March 20th, 1992. (T. 673) Respondent conducted a psychiatric exam and prescribed Prozac for depression and Trilafon in case she was psychotic. (T. 675-677) Respondent further testified that he did not have access to Patient A's previous hospital records at the time of admission. Approximately a week later, he reviewed these records and noted that the patient had been "on many antipsychotic medications in fairly substantial quantities." (T. 679) At that point he discontinued the medications as means of viewing her baseline behavior before making his diagnosis. (T. 679) Dr. Steinhart testified that this practice was substandard because the medications were not given for a sufficient time period to have a therapeutic effect. (T. 17-20) The Hearing Committee rejects this opinion because they believe that Respondent did not intend these medications to be definitive and that Respondent discontinued them only after reviewing Patient A's prior medical records.

Charge A. 2 alleges that Respondent placed Patient A on Prozac which was not indicated and/or without documenting the indications as per Dr. Steinhart's opinion. (T. 24-25). Respondent testified that he initially placed Patient A on Prozac due to her somatic complaints and that "her slothfulness perhaps might be of depressive equivalent." (T. 677) When Respondent decided to view the patient's baseline behavior as explained above, he discontinued the drug, particularly because "it was too early to expect any benefit from the Prozac." (T. 680) The Hearing Committee finds that Respondent provided a reasonable explanation for his judgment in this instance.

Charge A.3 alleges that Respondent failed to obtain a consultation from another psychiatrist. Dr. Steinhart opined that this was warranted due to the patient's lack of progress and need for new insight with regard to diagnoses. (T. 26) Respondent testified that Patient A had been seen in the past by several doctors and psychiatrists as evidenced by her previous admissions records. All "had worked with her without success." (T. 682) He further stated, "I didn't think any of my colleagues would have any better luck than I did." (T. 682-683). The Hearing Committee does not find this to be substandard practice.

Charge A.4 alleges that Respondent inappropriately discharged Patient A to an independent living situation. Both of Petitioner's experts testified that this was a serious deviation from accepted standards of medical care because Patient A's status was unchanged and she was discharged to an arrangement less structured than the one she had come from prior to admission. (T. 35-36, 53[Dr. Steinhart]; T.544, 555[Dr. Lefton]) The Hearing Committee finds that Respondent's final summary notes provide a reasonable disposition of this matter particularly since upon discharge, Patient A was provided with Social Service follow-up in her local community and was to return to her former psychiatrist. (Ex. 5, p.4, Finding of Fact #9)

In conclusion, the Hearing Committee sustains no charges or specifications to Patient A.

PATIENT B

Charge B.1 alleges that Respondent failed to obtain and/or document adequate supplemental histories and/or mental status evaluations and/or progress notes of his sessions at his office with Patient B during the course of treatment as per Dr. Steinhart. (T. 92-96) ??? At the hearing, Respondent offered Exhibits B and C which represent his record of office visits with Patient B. The Hearing Committee finds these to meet the minimum standard of care and the charge is not sustained.

Charge B.2 alleges that Respondent failed to periodically monitor and/or document Patient B's lithium levels with respect to care provided in his office. Dr. Steinhart testified that this violated accepted standards of medical care because Respondent did not ascertain whether the patient achieved a therapeutic level or whether the levels were in the toxic range. (T. 106-107) The Hearing Committee concurs that the records do not reflect adequate monitoring or documentation of Patient B's lithium levels and sustains this as an act of negligence.

Charge B.3 alleges that Respondent failed to adequately document Patient B's drug regimen during his hospitalization. Dr. Steinhart testified that Respondent's documentation here did not comport with the accepted standards of medical care because there were numerous discrepancies between what Respondent ordered and what he thought he ordered. This posed a risk to the patient and he was in fact discharged with inappropriate medications. (T. 108-109, Ex. 7, p.51) The Hearing Committee concurs that the records in this instance are inadequate.

Charge B.4 alleges that Respondent failed to maintain adequate records for Patient B. Considering that the Hearing Committee found some of Respondent's office records to be adequate, this charge is deemed overbroad and is not sustained by the Hearing Committee. Therefore, the Seventeenth and Twentieth Specifications are sustained.

PATIENT C

Charge C.1 alleges that Respondent placed Patient C on Parnate without allowing sufficient time to elapse after Respondent discontinued the patient's Prozac. Dr. Steinhart testified that this was a serious deviation from the accepted standards of care. Prozac can interact with an MAO inhibitor and cause the "serotonin syndrome." (T. 129-132,137) The Hearing Committee finds that Respondent acted incompetently in this instance because if Respondent's Medical Director did not point out the error, Respondent would not have known. (Ex. 9, p.22).

Therefore the Eighteenth Specification is sustained.

PATIENT D

Charge D.1 alleges that Respondent placed Patient D on Wellbutrin without allowing sufficient time to elapse after Respondent discontinued the patient's Parnate. Dr. Steinhart testified that this was inconsistent with accepted standards of care because two weeks is the minimum "washout" period one should wait after discontinuing Parnate. (T. 158-159, 172-173) Respondent acknowledged that 14 days is the recommended waiting period for Parnate . (T.735) He however, stated that he compromised because Patient D "was quite discouraged and threatening to leave the hospital, "and he had to work and encourage her to stay so that he could keep trying to find medications that would help her. He further added that he would not do this if she was an outpatient, but an inpatient can be closely monitored. (T. 736) The Hearing Comittee finds that Respondent's actions were within reasonable parameters of accepted standards of care and thus does not sustain the charge.

PATIENT E

Charge E. 1 alleges that Respondent failed to obtain and/or document adequate supplemental histories and/or mental status evaluations and/or progress notes during outpatient treatment. Although Dr. Steinhart testified that these records were insufficient, (T. 186-187, 218-219) the Hearing Committee found them not perfect, but adequate, particularly those from July 15, 1994 through November 1996.(Ex. 11, p. 4)

Charge E.2 alleges that Respondent failed to accurately and/or consistently document in orders and progress notes the drug regimens he placed Patient E on during the 1994 hospital admission. Dr. Steinhart again found the records to be inconsistent with accepted standards of care. (T. 190) The Hearing Committee finds the records to be adequate. (Ex. 11, pp.8-9)

Charge E. 3 alleges that Respondent placed Patient E on Cogentin at various times during the 1994 hospital admission despite Pateint E's signs of tardive dyskinesia, which was contraindicated. Dr. Steinhart testified that given Patient E's history and current evidence of tardive dyskinesia, Respondent's use of Cogentin was contraindicated and represented a serious deviation from accepted practice. (T. 193, 197, 200-202) Respondent testified that he was cognizant that Patient E had demonstrative signs of tardive dyskinesia for years. In order to treat the acute psychosis upon the patient's admission, Respondent indicated he prescribed Haldol and Cogentin and, once stabilized, he intended to discontinue their use. When Patient E did stabilize and improve, these drugs were discontinued and the patient was placed on Risperdal and Lithium. (T. 753- 754,757-758) The Hearing Committee accepts Respondent's explanation as a reasonable clinical option under these circumstances and does not sustain the charge.

Charge E.4 alleges that Respondent failed to diagnose Patient E's hypothyroidism and/or adequately address the patient's abnormal thyroid function test values during the 1994 admission. Respondent acknowledged he missed this information in the chart. (T. 758, 765) The Hearing Committee finds that this constitutes incompetence and negligence.

Charge E.5 alleges that Respondent failed to adequately/timely address hypothyroidism during outpatient treatment. Dr. Steinhart testified that this was a serious deviation from accepted statndards of care. (T. 205) Respondent testified that as an outpatient, he became suspicious because Patient E was lethargic. At that point, he advised her to see a physician. He stated that she initially resisted, but eventually went and was diagnosed. (T. 758, 765-766) The Hearing Committee finds no deviation from accepted standards of care since he acted upon it once he noted the patient's lethargy.

Charge E.6 alleges that Respondent failed to maintain adequate records for Patient E. The Hearing Committee finds Respondent's record keeping to be adequate in this instance.

Therefore, the Seventeenth and Eighteenth Specifications are sustained.

PATIENT F

Charge F.1 alleges that Respondent failed to follow up on abnormal laboratory values and/or borderline EKG. Dr. Steinhart testified that Respondent was responsible for the patient. He was not absolved by obtaining a medical consult and thus deviated from the standard of care. (T. 237, 239-240) The Hearing Committee disagrees. They find that the record indicates that very early on, Dr. Dougherty was writing notes and following the patient on a regular basis. He was actively managing the patient and was not a single consult. (Ex. 14, pp. 91,95, 97, 103, 111, 113, 115,121,125,133,137,141,143,145,149-152,177) Therefore, the Hearing Committee does not sustain this charge.

PATIENT G

Charge G.1 alleges that Respondent failed to obtain/document adequate supplemental histories/mental status evaluation/progress notes during outpatient treatment. Dr. Steinhart testified that Respondent's office records would be inadequate to a subsequent treating psychiatrist to provide the patient a continuum of care. (T. 254-256) The Hearing Committee concurs that the records contain insufficient information regarding the patient's mental status and history during the approximately two and one- half years of treatment provided.

Charge G.2 alleges that Respondent made an initial order for Imipramine for Patient G in an erroneous dose which was too high during the patient's hospitalization. On 3/3/93, Respondent ordered a total of 500 mg., 300mg. in the morning and 200 mg. in the evening. (Ex. 16, p.24) Respondent testified that he intended to order 250 mg. a day . He acknowledged that he had miswritten the order. (T. 802,814) The Hearing Committee find, this to constitute negligence.

Charge G.3 alleges that Respondent failed to appropriately evaluate somnolence and/or adjust Imipramine dose in a timely manner. Respondent testified that he did evaluate Patient G for somnolence in that he observed her sleeping and woke her up to evaluate her. He found her to be coherent, but she complained of feeling tired. Respondent had expected some somnolence regardless of the dose. (T. 814-815) The Hearing Committee finds that Respondent appropriately evaluated the patient for somnolence and does not sustain this part of the charge. The Hearing Committee, however, does sustain the remainder of the charge that Respondent failed to adjust the Imipramine dose in a timely manner.

Charge G.4 alleges that Respondent failed to maintain adequate records for Patient G. The Hearing Committee finds that the hospital records were adequate and thus does not sustain this overbroad charge. Therefore, the charges sustained support the Seventeenth Specification.

PATIENT H

Charge H. 1 alleges that Respondent failed to appropriately manage the issue of Patient H's claimed sexual abuse by her older brother. Both Dr. Steinhart and Dr. Lefton testified that the record indicated that Respondent did not respect Patient H's decision not to confront her brother and that he doubted her veracity. (T. 278-279,285 [Dr. Steinhart]; 457-475, 479-481), 530 [Dr. Lefton] The Hearing Committee disagrees. In review of the record, the Hearing Committee finds that Respondent recognized Patient H's reluctance to confront her brother and showed empathy for her. While Respondent may have urged the meeting, he did not coerce it. (Ex. 18, pp.174 (6/24/92 note); 178 (6/25/92)) note In a subsequent meeting, the Hearing Committee finds that Respondent gave Patient H encouragement on how to act when confronted with sexual abuse by her grandfather. (Ex. 18,p. 271 (7/18/92 note)) Thus, the Hearing Committee conclude that Respondent's clinical judgment as to the propriety of the family meeting is not below the accepted standard of medical care.

Charge H.2 alleges that Respondent failed to adequately document the attempted family meeting and the patient's reaction in the final and/or interim hospital summaries. Charge H.3 alleges that the overall patient record is inadequate. The Hearing Committee finds, after considerable review, that the records in both instances are adequate. Therefore, no charges are sustained with respect to Patient H.

PATIENT I

Charge I. 1 (a, c, d, and e) alleges that Respondent inappropriately socialized with Patient I. Dr. Steinhart testified that the socialization represented numerous instances of boundary violations in a patient with whom Respondent was still involved in a therapeutic process despite the purported November 3, 1986 termination of treatment. He noted that there

was an intensive treatment period just prior to November 3rd, in fact twelve sessions in October alone. There would have been no time for the power disparity between Respondent and Patient I to become neutralized. (T. 323-326) The Hearing Committee concurs that the socialization with Patient I constitutes a boundary violation.

Charge I.2 (a-f) alleges that Respondent gave Patient I numerous gifts. Dr. Steinhart testified that this was a violation of accepted practice standards as well as ethical standards. Some of the gifts were quite personal and emotionally charged. They are the kind of gifts that would be given between family members or intimates. (T. 326-329) Respondent even testified that he got "overinvolved" and that "it was a mistake." (T. 647) The Hearing Committee concurs and sustains this charge.

Charge I.3 alleges that Respondent acted inappropriately when he employed Patient I' s son to paint his office. Dr. Steinhart testified that this was inappropriate.(T. 329-330) Respondent testified that the son only worked a few days because he was "totally inept." The Hearing Committee finds that this was of short duration and not significant enough to rise to the level of inappropriate practice or a boundary violation. This charge is not sustained.

Charge I.4 alleges that Respondent gave Patient I a plastic rat. Dr. Steinhart testified that this was another violation of accepted practice and ethical standards. (T. 330-331) The Hearing Committee finds that even if it was meant to be a joke it was totally inappropriate particularly since it was given at the patient's workplace.

Charge I.5 alleges that Respondent inappropriately gave Respondent numerous Valentine's Day cards. Dr. Steinhart testified that whatever Respondent's intent in giving Patient I the cards and whatever humor one might discern in them, their sexual or romantic message is clear. (T. 332) The Hearing Committee finds the sending of the cards to be inappropriate.

Charge I.6 alleges that while attempting to discuss their relationship, Respondent grabbed Patient I underneath both arms and tried to raise Patient I so that she would look at him, causing Patient I to fall backward and hit her head. Dr. Steinhart testified that here Respondent was clearly acting out of his own needs and not Patient I's. It was an escalation of the previous acts

of socialization and gift giving. (T. 333-334) The Hearing Committee finds that these actions were not of a willful nature to harass or intimidate the patient but certainly acts of negligence in violation of the American Medical Association Principles of Medical Ethics.

Charge I. 7 alleges that Respondent made and sent to Patient I an audiotape, which revealed his personal feelings for her. The tape was played at the hearing. (Ex.25) Dr. Steinhart stated that this was inappropriate particularly since Respondent had now burdened the patient with his own psychiatric problems. In content and tone he assumed the role of a patient.(T. 335-337) The Hearing Committee concurs.

Charge I.8 alleges that Respondent failed to appropriately terminate his treatment of Patient I and/or plan for future therapy if necessary. Dr. Steinhart testified that accepted standards of psychiatric practice require certain steps when a patient's treatment is terminated. Absent unusual circumstances, the decision to terminate is usually a mutual one. It is done over a period of time, often at a reduced schedule of appointments, depending on the length of the preceding treatment. There should be assessment by both the psychiatrist and patient regarding goals achieved, problems solved and improvements made. The psychiatrist should express to the patient his or her future availability should the need arise, (T. 337-338)

In this instance, Respondent acted inappropriately because there was no gradual reduction in the number of sessions once the patient decided to stop treatment. No discharge plans were made for Patient I. The custody decision was imminent and that alone would have been reason enough to continue therapy to deal with any resulting psychological problems. Respondent engaged in a therapeutic relationship with Patient I after the "termination" although other aspects of the relationship developed. There was no clean break in therapy and no professional distance was maintained. (T. 338-342, 407-408) The Hearing Committee concurs with Dr. Steinhart's opinion and finds that Respondent did not terminate his relationship with Patient I appropriately.

Charge I.9 alleges that Respondent failed to recognize and/or appropriately deal with Respondent's countertransference issues with Patient I. Dr. Steinhart testified that Respondent's failure to appropriately deal with his countertransference issues with Patient I are clearly evidenced by his conduct. He stated that Respondent was initially motivated by a rescue fantasy in that he helped Patient I get a job and tried to assist her financially. He then tried to produce a family by molding her family into his through numerous dinner invitations. He appeared to develop romantic feeling for her as reflected by the personal gifts and cards he gave her. He ultimately confronted her about the mixed messages he was receiving from her. (T. 344-345) The Hearing Committee finds that although Respondent demonstrated his knowledge of boundary violation issues, (T. 642-647) he failed to appropriately deal with them.

Charge I.10 alleges that Respondent engaged in an inappropriate personal, social and/or romantic relationship with Patient I during the period he provided psychiatric care to Patient I and/or in the period following such care. For reasons discussed above, the Hearing Committee sustains this charge with respect to Respondent's inappropriate personal and social relationship with Patient I. They, however, note that there was no proof of an actual romantic relationship between both parties, thus that part of the charge is not sustained.

In conclusion, these charges sustain the Seventeenth Specification.

CHARGE J

Charge J alleges that Respondent was found by the Commissioner of Health to be in violation of Article Thirty-Three of the Public Health Law. The Hearing Committee finds that Respondent signed a Stipulation and Order with the Department of Health on July 13,1994 in which he admitted to violations of Article Thirty-Three of the Public Health Law. (Ex. 27) At the hearing, Respondent testified that he wrote these prescriptions for himself. He acknowledged that he wrote a prescription for Valium for muscle spasm and aspirin and codeine for severe pain. He also wrote several prescriptions for oxazepam for sleep. (T. 841-842)

The Hearing Committee therefore sustains the Twenty-Fifth Specification.

CHARGE K

Charge K alleges that Respondent answered "No" to the question, "Are any malpractice claims pending" on a re-appointment application to Benjamin Rush Center on December 10, 1988, when he knew otherwise. The Hearing Committee finds that Respondent was aware of a pending malpractice action filed by Patient I on June 27, 1988 when he was personally served with the summons and complaint. (Ex. 29) They further find that by October 17, 1988 Respondent had filed an answer and was represented by counsel. (Ex. 30) At the hearing, Respondent testified that his secretary, who had been in his employ for several years, routinely filled out the re-application forms and stamped his name on it. (T. 854, 859-860) He acknowledged that in 1988, his secretary probably knew that he was involved in a legal matter. He further stated that she probably consulted him and that it's possible he said, "Let's say no. Maybe it won't happen." (T. 861-863) The Hearing Committee sustains the charge as filing a false report but feels that these actions do not rise to the level of moral unfitness or fraud.

Therefore, the Thirty-Seventh Specification is sustained.

CHARGE L

Charge L alleges that Respondent failed to disclose all allegations made by Patient I in the malpractice action in a written communication to Benjamin Rush Center on February 16, 1991. The Hearing Committee finds that Respondent's letter of February 16, 1991 and the letter from his attorney, Harold P. Goldberg, Esq., dated September 13, 1991 acknowledge the malpractice suit and provide adequate information about it. (Ex. 28, pp. 68, 82) The Hearing Committee further notes that Respondent was re-appointed to Benjamin Rush at that time and ultimately settled the lawsuit.

Therefore, the Hearing Committee does not sustain Charge L.

CHARGE M

Charge M.1 alleges that on an October 24, 1995, application for privileges at Community-General Hospital, Respondent indicated that he had not incurred any change in his privilege status at any previous institution, when in fact his privileges at BRC had been subject to suspension and/ or limitation and he knew this. Respondent testified that he did not believe the signature on p. 26 of Exhibit 31, the aforesaid application, was his signature. The Hearing Committee, after reviewing Respondent's signature on pages 28,29, 30, 81,82,83 and 85 finds that it is. The Hearing Committee notes that Respondent agreed that this was not a routine application because it was his first one to Community General.(T. 900) The Hearing Committee rejects Respondent's argument that the transactions between BRC and the Respondent result ed from his "uneven" relationship with the Medical Director and not considered as corrective action, discipline, investigation, reduction or suspension of his privileges.(Resp. brief p. 27) The Hearing Committee concludes that Respondent was trying to deliberately "buy" time to submit this application without revealing his modified privilege status at BRC.

Charge M.3 alleges that on the aforesaid application, Respondent answered "No" to a question regarding whether Respondent had ever been subject to any malpractice claims. The Hearing Committee finds that in 1995, Respondent was well aware of the claims made by Patient I in her malpractice action which had initiated in 1988.

Charge M.4 alleges that on the aforesaid application, Respondent answered "No" to a question regarding whether Respondent had ever been subject to "judgment, settlement or findings of any medical malpractice action..." Again, the Hearing Committee finds that Respondent was well aware in 1995 that he had settled his malpractice suit with Patient I in 1990 and he was deliberately concealing this information from a prospective employer.(Ex. 32)

The Hearing Committee sustains the above three charges not only as filing a false report, but also fraudulent practice.

Therefore the Thirty-Fourth and Thirty-Ninth Specifications are sustained.

CHARGE N

Charge N.1 alleges that on a February 1, 1996 appointment application with HMO-CNY, Respondent answered in the negative to a question addressing changes in privilege status. For the reasons discussed in Charge M.1, the Hearing Committee finds that Respondent continied to deliberately conceal the change in status of his privileges at BRC.

Charge N.3 alleges that in the aforesaid appointment application, Respondent answered "No" to an inquiry whether he had ever been subject to investigations by the Office of Professional Medical Conduct or any other governmental agency. At the hearing, Respondent acknowledged that the answer to that question was made in error. (T. 916)

The Hearing Committee finds these acts constitute both filing a false report and fraudulent practice.

Therefore, the Thirty-Fifth and Fortieth Specifications are sustained.

CHARGE O

Charge O .1 alleges that on a February 19, 1996, Respondent filed a license registration application with the New York State Education Department and answered "No" to a question regarding any changes in privilege status at any hospital or licensed facility. As per the discussion in Charge M.1, the Hearing Committee finds that Respondent continued his pattern of concealing all facts concerning his privilege changes at BRC.

Therefore, the Thirty-Sixth and Forty-First Specifications are sustained.

MORAL UNFITNESS

The Hearing Committee believes that none of the specifications of moral unfitness should be sustained as Respondent's misconduct did not rise to that level. The Hearing Committee believes that Respondent suffers from an inadequate, self-defeating personality and is not a "bad or immoral" person.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee believes that Respondent demonstrated poor judgment particularly with the countertransference with Patient I and all consequences resulting therefrom. The Hearing Committee further believes that the evidence in the record indicates that Respondent is often careless and exhibits an attitude that the rules do not apply to him. Although not deemed morally unfit, the Hearing Committee believes his history of slipshod practice and pattern of lying to conceal his problems at BRC and the Patient I lawsuit creates a danger to the public. They also believe that Respondent is not a good candidate for re-training. Therefore, the Hearing Committee concludes that the collection of offenses taken together warrant revocation.

ORDER

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

1. The Seventeenth, Eighteenth, Twentieth , Twenty-Fifth, Thirty-Fourth, Thirty-Fifth, Thirty-Sixth, Thirty-Seventh, Thirty-Ninth, Fortieth and Forty-First Specifications of Professional Misconduct, as set forth in the Statement of Charges dated May 19, 1997 (Petitioner's Exhibit # 1) are **SUSTAINED**; and

2. The First through Sixteenth, Nineteenth, Twenty-First through Twenty-Fourth, Twenty-Sixth through Thirty- Third and the Thirty-Eighth Specifications are **NOT SUSTAINED**; and

3. Respondent's license to practice medicine in New York State be and is hereby **REVOKED.**

DATED: **New York, New York**
December 23, 1997

MICHAEL R. GOLDING, M.D.(Chair)
ARTHUR ZITRIN, M.D.
REV. JAMES H. MILLER

TO: E. Marta Sachey, Esq.
Associate Counsel
NYS Department of health
Corning Tower-Room 2503
Empire State Plaza
Albany, New York 12237

Paul M. Hanrahan Esq.
Hancock & Estabrook, LLP
1500 MONY Tower 1
P.O. Box 4976
Syracuse, New York 13221-4976

Andrew C. Godwin, M.D.
317 Crossett Street
Syracuse, New York 13207

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ANDREW C. GODWIN, M.D.	:	CHARGES

----------X

ANDREW C. GODWIN, M.D., the Respondent, was authorized to practice medicine in New York State on April 30, 1964 by the issuance of license number 092095 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period July 1, 1996 through June 30, 1998 with a registration address of 317 Crossett Street, Syracuse, New York 13207.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric care to Patient A [patients are identified in the Appendix] at various times from approximately March 20, 1992 through approximately April 19, 1992 at the Benjamin Rush Center, Syracuse, New York [hereafter "Benjamin Rush Center"].

1. Respondent placed Patient A on Trilafon and/or Prozac for inadequate periods of time and/or in inadequate doses for the drugs to take effect.
2. Respondent placed Patient A on Prozac which was not indicated and/or without documenting the indications.
3. Respondent failed to obtain a consultation from another psychiatrist for Patient A.

4. Respondent inappropriately discharged Patient A to an independent living situation.

B. Respondent provided psychiatric care to Patient B at various times from approximately March 26, 1992 through approximately October 22, 1993 at Respondent's office at 317 Crossett Street, Syracuse, New York 13207 [hereafter "Respondent's office"] and from approximately January 24, 1994 through approximately February 8, 1994 at the Benjamin Rush Center.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient B for care provided at Respondent's office, failed to obtain and/or document adequate initial and/or supplemental histories and/or mental status evaluations and/or progress notes of his sessions with Patient B during the course of treatment.

2. Respondent, with regard to care provided at Respondent's office, failed to obtain and/or document a lithium work-up before placing Patient B on lithium and/or failed to periodically monitor and/or document Patient B's serum lithium levels while the patient was on the drug.

3. Respondent failed to adequately document the drug regimen he placed Patient B on during the patient's hospitalization.

4. Respondent failed to maintain adequate records for Patient B.

C. Respondent provided psychiatric care to Patient C at various times from approximately July 22, 1991 through approximately August 15, 1991 at the Benjamin Rush Center.

1. Respondent placed Patient C on Parnate without allowing sufficient time to elapse after Respondent discontinued the patient's Prozac.

D. Respondent provided psychiatric care to Patient D at various times from approximately February 16, 1994 through approximately April 5, 1994 at the Benjamin Rush Center.

1. Respondent placed Patient D on Wellbutrin without allowing sufficient time to elapse after Respondent discontinued the patient's Parnate.

2. Respondent placed Patient D on Wellbutrin and Dexedrine at the same time, which combination was contraindicated.

E. Respondent provided psychiatric care to Patient E at various times at Respondent's office from approximately March 1993 through approximately July 1993 following the patient's January 1993 admission at the Benjamin Rush Center, at Respondent's office from approximately July 15, 1994 through approximately August 1996 and at the Benjamin Rush Center during the January 1993 admission and an admission from March 27, 1994 through approximately May 20, 1994 [hereafter "1994 hospital admission"].

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient E for care provided at Respondent's office, failed to obtain and/or document adequate supplemental histories and/or mental status evaluations and/or progress notes of his sessions with Patient E during the course of treatment.

2. Respondent failed to accurately and/or consistently document in orders and progress notes the drug regimens he placed Patient E on during the 1994 hospital admission.

3. Respondent placed Patient E on Cogentin at various times during the 1994 hospital admission despite Patient E's signs of tardive dyskinesia, which was contraindicated.

4. Respondent failed to diagnose Patient E's hypothyroidism and/or adequately address Patient E's abnormal thyroid function test values during the 1994 hospital admission and/or to document such matters.

5. Respondent, after Patient E's 1994 hospital admission, failed to adequately and/or in a timely manner follow-up on and/or address Patient E's hypothyroidism and/or abnormal thyroid function test values during the course of outpatient treatment and/or document such matters.

6. Respondent failed to maintain adequate records for Patient E.

F. Respondent provided psychiatric care to Patient F at various times from approximately October 8, 1993 through approximately November 16, 1993 [hereafter "1993 hospital admission"] and from approximately February 17, 1995 through approximately February 28, 1995 [hereafter "1995 hospital admission"] at the Benjamin Rush Center.

1. Respondent failed to adequately follow up on Patient F's abnormal laboratory values and/or borderline EKG during the 1993 hospital admission and/or document such matters.

withdrawn

2. ~~Respondent failed to adequately follow up on Patient F's abnormal liver function test values during the 1995 hospital admission and/or document such matters.~~

3. Respondent failed to maintain adequate records for Patient F.

G. Respondent provided psychiatric care to Patient G at various times from approximately August 31, 1990 through March 2, 1993 at Respondent's office and from approximately March 3, 1993 through approximately March 12, 1993 at the Benjamin Rush Center.

1. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient G for care provided at Respondent's office, failed to obtain and/or record adequate supplemental histories and/or mental status evaluations and/or progress notes of his sessions with Patient G during the course of treatment.

2. Respondent made an initial order for Imipramine for Patient G in an erroneous dose which was too high during the patient's hospitalization.

3. Respondent, on or about March 4, 1993, failed to appropriately and/or adequately evaluate Patient G's somnolence and/or adjust Patient G's drug regimen in a timely manner during the patient's hospitalization.

4. Respondent failed to maintain adequate records for Patient G.

H. Respondent provided psychiatric care to Patient H at various times from approximately June 4, 1992 through approximately August 20, 1992 at the Benjamin Rush Center.

1. Respondent failed to appropriately manage the issue of Patient H's claimed sexual abuse by her older brother, Richard.

2. Respondent failed to adequately document in the final and/or interim summary of Patient H's hospitalization the incident involving an attempted family meeting, including Patient H's brother Richard, and/or Patient H's reactions to this incident.

3. Respondent failed to maintain adequate records for Patient H.

I. Respondent provided psychiatric care to Patient I at various times from approximately June 1985 through approximately February 1987 including, without limitation, during appointments at Respondent's office from approximately June 14, 1985 through approximately November 3, 1986 and/or during contacts with Patient I in Respondent's home at 317

Crossett Street, Syracuse, New York and/or Patient I's apartment from approximately November 1986 through approximately February 1987 and/or by prescribing Valium for Patient I in approximately January 1987. Respondent's conduct in relation to Patient I during treatment and/or during the post-treatment period failed to conform to accepted standards of psychiatric practice in that:

1. Respondent socialized with Patient I including, without limitation, as follows:

   a. Respondent in approximately October 1986 invited Patient I to a Halloween party at Respondent's home;

   b. Respondent, at the above Halloween party, asked Patient I to accompany him to his bedroom and to assist him in applying makeup for his lion costume;

   c. Respondent, approximately one week before Thanksgiving 1986, invited Patient I and her children to Thanksgiving dinner at Respondent's home;

   d. Respondent, in approximately December 1986, took Patient I to dinner at the General Hutchinson Restaurant with Respondent's grandchildren;

   e. Respondent, in approximately December 1986, had Patient I and Patient I's daughter to his home so Patient I's daughter could play with Respondent's grandchildren.

2. Respondent gave Patient I numerous gifts including, without limitation, the following:

   a. Respondent brought groceries to Patient I at her apartment;

   b. Respondent gave and/or loaned Patient I approximately $1,200.00 in approximately December 1986 and $6,500.00 in approximately January 1987;

   c. Respondent, in approximately December 1986, gave Patient I and Patient I's children Christmas gifts;

   d. Respondent gave Patient I an oriental carpet for which Respondent had paid approximately $300.00;

e. Respondent, approximately just before Valentine's Day 1987, gave Patient I a used mink coat for which Respondent had paid $1,300.00;

f. Respondent, at various times, gave Patient I makeup, candy, jewelry and/or flowers.

3. Respondent, in approximately November or December 1986, employed Patient I's son to paint Respondent's office.

4. Respondent, in approximately autumn 1986, gave Patient I a plastic rat at Patient I's place of employment and/or told Patient I that the rat was to remind her of all men except Respondent or words to such effect.

5. Respondent, on approximately February 14, 1987, gave and/or sent Patient I approximately six Valentine's Day cards which read and/or on which Respondent variously wrote and/or signed the following or words to such effect:

a. "I wanted a card as big as my love for you. Andy;"

b. "Your candyman" in reference to the message on the card;

c. "I just bought this one and it's in my bedroom" on a card which reads "Especially for you, a pornographical Valentine. Now all you need is a pornograph to play it on; Happy Valentine's Day;

d. "Your favorite shrink" on a card which reads "I'm not interested in a nice, normal relationship. I like ours better. Happy Valentine's Day;"

e. "Please heed my plead-o before I lose my libido" on a card which reads "When presented to sender on Valentine's Day, this card is redeemable for five hugs, seven kisses, two hickeys and one miscellaneous."

6. Respondent, in approximately February 1987 when Respondent was talking to Patient I in Respondent's bedroom about Respondent's and Patient I's relationship, grabbed Patient I underneath both her arms in anger and tried to raise Patient I so she would look at Respondent when he talked to her, causing Patient I to fall backward on Respondent's bed and hit her head on the bed railing and causing Respondent to fall on top of Patient I.

7. Respondent, on approximately February 20, 1987, made an audiotape and sent it to Patient I in which Respondent, among other matters, spoke of his feelings concerning Patient I and his relationship with her.

8. Respondent failed to appropriately terminate his therapeutic relationship with Patient I and/or take appropriate measures to plan for future therapy for Patient I should it become necessary.

9. Respondent failed to recognize and/or appropriately deal with Respondent's countertransference issues with Patient I.

10. Respondent engaged in an inappropriate personal, social and/or romantic relationship with Patient I during the period he provided psychiatric care to Patient I and/or in the period following such care.

J. Respondent, by Order dated July 13, 1994 pursuant to a stipulation entered into by Respondent and the New York State Department of Health, was found by the Commissioner of Health to be in violation of Article Thirty-Three of the Public Health Law. Specifically:

1. Respondent, on twenty-four occasions between September 10, 1990 and April 24, 1992, wrote twenty-four prescriptions for controlled substances, including Oxazepam 30 mg., Diazepam 5 mg. and Aspirin with Codeine #3 30 mg., for his own use without maintaining adequate patient records.

K. Respondent, on approximately December 10, 1988, filed a Reappointment Application with the Benjamin Rush Center.

1. Respondent answered "No" to the application question "Are any malpractice claims pending" when, in fact, a malpractice action of Patient I against Respondent was pending and Respondent had been personally served with the Summons and Complaint in that action on June 27, 1988 and/or Respondent had the law firm of Martin, Ganotis and Brown, Syracuse, New York representing him in that action, and Respondent knew such facts.

L. Respondent, in a written communication of approximately February 16, 1991 to the Benjamin Rush Center, explained the malpractice action referred to in Paragraph K(1), above.

1. Respondent described the malpractice action as concerning the patient blaming Respondent for the loss of custody of her child because Respondent was unable to attend a second court appearance in the custody suit between the patient and her husband and the patient claiming that Respondent gave her Valium which resulted in causing the patient amnesia or words to such effect when, in fact, the malpractice action concerned and/or also concerned, among other matters, allegations that Respondent struck the patient and otherwise abused her in the course of treatment, made sexual and romantic advances toward the patient in the course of therapy and failed to maintain a professional therapeutic relationship with the patient, and Respondent knew such facts.

M. Respondent, on approximately October 24, 1995, filed an Application for Privileges at Community-General Hospital of Greater Syracuse, Broad Road, Syracuse, New York.

1. Respondent answered "No" to the application question "Have you at any time been subject to limitation, suspension, revocation, denial or non-renewal of employment, appointment or privileges at any hospital or health care related institution" when, in fact, on approximately August 4, 1995, a Medical Executive Committee of the Benjamin Rush Center recommended, among other matters, that Respondent's privileges be reduced in that Respondent have the privileges of a General Psychiatrist, instead of those of a Qualified Psychiatrist that Respondent had had, and that Respondent not undertake treatment of known victims of sexual abuse and/or that on approximately August 29, 1995 the aforesaid reduction in privileges were put in effect and/or on approximately October 5, 1995 an Ad Hoc Committee of the Benjamin Rush Center, in lieu of the aforesaid, recommended, among other matters, that Respondent have a one year course of professional supervision involving regular consultation with another psychiatrist regarding Respondent's treatment of patients with sexual abuse problems and Respondent's practice of psychopharmacology and/or on approximately

October 24, 1995 the Benjamin Rush Center suspended Respondent's admitting privileges, and Respondent knew such facts.

2. Respondent answered "No" to the application question "Have you at any time been subject to investigation, corrective action, or discipline by any hospital or health care related institution" when, in fact, the Benjamin Rush Center had investigated Respondent's medical care in at least nine patient cases and/or investigated the malpractice action against Respondent set forth in Paragraphs K(1) and L(1), above, and/or Respondent was subject to the matters set forth in Paragraph M(1), above, and Respondent knew such facts.

3. Respondent answered "No" to the application question "Have you at any time been subject to professional malpractice claims, actions or medical conduct proceedings in this or any other state" when, in fact, Respondent was subject to the malpractice action set forth in Paragraph K(1), above, and Respondent had undergone examinations before trial on three occasions in 1989 in that malpractice action and Respondent had testified in June 1990 at the trial in that malpractice action, and Respondent knew such facts.

4. Respondent answered "No" to the application question "Have you at any time been subject to judgement, settlement or findings of any medical malpractice action or any finding of professional misconduct in this or any other state" when, in fact, the malpractice action against Respondent set forth in Paragraph K(1), above, was settled on approximately June 14, 1990, and Respondent knew such fact.

N. Respondent, on approximately February 1, 1996, filed an Appointment Application with HMO-CNY, 344 South Warren Street, Syracuse, New York.

1. Respondent answered "No" to the application question "Has your employment, association, privileges, practice or membership at any hospital, health care facility or health maintenance organization ever been denied, suspended, diminished, revoked, not renewed or placed on probation" when, in fact, Respondent was subject to the matters set forth in Paragraph M(1), above, at the Benjamin Rush Center, and Respondent knew such facts.

2. Respondent answered "No" to the application question "Have you ever been subject to any investigation,

corrective action, or discipline by any hospital, health care facility or health maintenance organization" when, in fact, Respondent was subject to the investigation set forth in Paragraph M(2), above, at the Benjamin Rush Center and/or Respondent was subject to the matters set forth in Paragraph M(1), above, at the Benjamin Rush Center, and Respondent knew such facts.

3. Respondent answered "No" to the application question "Are there now, or have there ever been, any proceedings or investigation of you by the New York State Office of Professional Medical Conduct or other governmental agency" when, in fact, Respondent was the subject of an investigation by the New York State Department of Health's Bureau of Controlled Substances which resulted in the Order set forth in Paragraph J, above, and/or Respondent was the subject of investigation by the New York State Office of Professional Medical Conduct in approximately 1992 with regard to Patient I and/or in approximately 1993 and/or 1994 with regard to the Order set forth in Paragraph J, above, and/or with regard to Respondent's self-prescribing, and Respondent knew such facts.

O. Respondent, on approximately February 19, 1996, filed a Registration Application for the period July 1, 1996 through June 30, 1998 with the New York State Education Department.

1. Respondent answered "No" to the application question "Since you last registered has any hospital and/or licensed facility restricted or terminated your professional training, employment or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence" when, in fact, Respondent was subject to the matters set forth in Paragraph M(1), above, at the Benjamin Rush Center and/or on October 25, 1995 Respondent resigned from the Benjamin Rush Center to avoid such matters, and Respondent knew such facts.

SPECIFICATIONS

FIRST THROUGH EIGHTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) (McKinney Supp. 1997) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges:

1. The facts in Paragraphs A and A.4.
2. The facts in Paragraphs B and B.1 and/or B and B.2.
3. The facts in Paragraphs C and C.1.
4. The facts in Paragraphs D and D.2.
5. The facts in Paragraphs E and E.1, E and E.3, E and E.4 and/or E and E.5.
6. The facts in Paragraphs G and G.1.
7. The facts in Paragraphs H and H.1.
8. The facts in Paragraphs I and I.1(a), I and I.1(b), I and I.1(c), I and I.1(d), I and I.1(e), I and I.2(a), I and I.2(b), I and I.2(c), I and I.2(d), I and I.2(e), I and I.2(f), I and I.3, I and I.4, I and I.5(a), I and I.5(b), I and I.5(c), I and I.5(d), I and I.5(e), I and I.6, I and I.7, I and I.8, I and I.9 and/or I and I.9(10).

NINTH THROUGH SIXTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) (McKinney Supp. 1997) by reason of his

practicing the profession of medicine with gross incompetence, in that Petitioner charges:

9. The facts in Paragraphs A and A.4.

10. The facts in Paragraphs B and B.1 and/or B and B.2.

11. The facts in Paragraphs C and C.1.

12. The facts in Paragraphs D and D.2.

13. The facts in Paragraphs E and E.1, E and E.3, E and E.4 and/or E and E.5.

14. The facts in Paragraphs G and G.1.

15. The facts in Paragraphs H and H.1.

16. The facts in Paragraphs I and I.1(a), I and I.1(b), I and I.1(c), I and I.1(d), I and I.1(e), I and I.2(a), I and I.2(b), I and I.2(c), I and I.2(d), I and I.2(e), I and I.2(f), I and I.3, I and I.4, I and I.5(a), I and I.5(b), I and I.5(c), I and I.5(d), I and I.5(e), I and I.6, I and I.7, I and I.8, I and I.9 and/or I and I.9(10).

SEVENTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) (McKinney Supp. 1997) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

17. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, C and C.1, D and D.1, D and D.2, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, F and F.1, F and F.2, G and G.1, G and G.2, G and G.3, H

and H.1, H and H.2, I and I.1(a), I and I.1(b), I and I.1(c), I and I.1(d), I and I.1(e), I and I.2(a), I and I.2(b), I and I.2(c), I and I.2(d), I and I.2(e), I and I.2(f), I and I.3, I and I.4, I and I.5(a), I and I.5(b), I and I.5(c), I and I.5(d), I and I.5(e), I and I.6, I and I.7, I and 1.8, I and I.9 and/or I and I.9(10).

EIGHTEENTH SPECIFICATION

INCOMPETENCE ON MORE
THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5) (McKinney Supp. 1997) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

18. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, C and C.1, D and D.1, D and D.2, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, F and F.1, F and F.2, G and G.1, G and G.2, G and G.3, H and H.1, H and H.2, I and I.1(a), I and I.1(b), I and I.1(c), I and I.1(d), I and I.1(e), I and I.2(a), I and I.2(b), I and I.2(c), I and I.2(d), I and I.2(e), I and I.2(f), I and I.3, I and I.4, I and I.5(a), I and I.5(b), I and I.5(c), I and I.5(d), I and I.5(e), I and I.6, I and I.7, I and 1.8, I and I.9 and/or I and I.9(10).

NINETEENTH SPECIFICATION

PHYSICAL HARASSMENT,
INTIMIDATION OR ABUSE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(31) (McKinney Supp. 1997) by reason of his

willfully harassing, abusing or intimidating a patient physically, in that Petitioner charges:

19. The facts in Paragraphs I and I.6.

TWENTIETH THROUGH TWENTY-FOURTH SPECIFICATIONS

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1997) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

20. The facts in Paragraphs B and B.1, B and B.2, B and B.3 and/or B and B.4.

21. The facts in Paragraphs E and E.2, E and E.4, E and E.5 and/or E and E.6.

22. The facts in Paragraphs F and F.1, F and F.2 and/or F and F.3.

23. The facts in Paragraphs G and G.1 and/or G and G.4.

24. The facts in Paragraphs H and H.2 and/or H and H.3.

TWENTY-FIFTH SPECIFICATION

ARTICLE THIRTY-THREE VIOLATION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(9)(e) (McKinney Supp. 1997) by reason of his

having been found by the Commissioner of Health to be in violation of Article Thirty-Three of the Public Health Law, in that Petitioner charges:

25. The facts in Paragraph J and J.1.

TWENTY-SIXTH THROUGH THIRTY-FIRST SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(20) (McKinney Supp. 1997) by reason of his conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

26. The facts in Paragraphs I and I.2(b), I and I.2(c), I and I.2(d), I and I.2(e), I and I.2(f), I and I.4, I and I.5(a), I and I.5(b), I and I.5(c), I and I.5(d), I and I.5(e), I and I.6, I and I.7, I and 1.8, I and I.9 and/or I and I.10.

27. The facts in Paragraphs K and K.1.

28. The facts in Paragraphs L and L.1.

29. The facts in Paragraphs M and M.1, M and M.2, M and M.3 and/or M and M.4.

30. The facts in Paragraphs N and N.1, N and N.2 and/or N and N.3.

31. The facts in Paragraphs O and O.1.

THIRTY-SECOND THROUGH THIRTY-SIXTH SPECIFICATIONS

FRAUD

Respondent is charged with professional misconduct under

N.Y. Educ. Law §6530(2) (McKinney Supp. 1997) by reason of his practicing the profession of medicine fraudulently, in that Petitioner charges:

32. The facts in Paragraphs K and K.1.

33. The facts in Paragraphs L and L.1.

34. The facts in Paragraphs M and M.1, M and M.2, M and M.3 and/or M and M.4.

35. The facts in Paragraphs N and N.1, N and N.2 and/or N and N.3.

36. The facts in Paragraphs O and O.1.

THIRTY-SEVENTH THROUGH FORTY-FIRST SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(21) (McKinney Supp. 1997) by reason of his willfully making or filing a false report, in that Petitioner charges:

37. The facts in Paragraphs K and K.1.

38. The facts in Paragraphs L and L.1.

39. The facts in Paragraphs M and M.1, M and M.2, M and M.3 and/or M and M.4.

40. The facts in Paragraphs N and N.1, N and N.2 and/or N and N.3.

41. The facts in Paragraphs O and O.1.

DATED: May 19, 1997
Albany, New York

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