STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

November 10, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Henry Herrera, M.D.
115 Countess Drive
West Henrietta, New York 14586

Thomas G. Smith, Esq.
Harter, Secrest and
Emery
700 Midtown Tower
Rochester, New York 14604

Cindy M. Fascia, Esq.
NYS Department of Health
Bureau of Professional Medical
Conduct
Corning Tower - Room 2429
Empire State Plaza
Albany, New York 12237

RE: In the Matter of HENRY HERRERA, M.D.

Dear Dr. Herrera, Ms. Fascia and Mr. Smith:

Enclosed please find the Determination and Order (No. BPMC-93-185) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

New York State Department of Health
Office of Professional Medical Conduct
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must than 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), "(t)he determination of a committee on professional medical conduct may be reviewed by the administrative review board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Corning Tower -Room 2503
Empire State Plaza
Albany, New York 12237-0030

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rg
Enclosure

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

IN THE MATTER	:	HEARING COMMITTEE'S FINDINGS OF FACT, CONCLUSIONS, DETERMINATION AND ORDER NO. BPMC- 93-185
OF	:	
HENRY HERRERA, M.D.	:	

PRISCILLA R. LESLIE, Chairperson, ARLENE B. REED-DELANEY, M.D., and MURRAY A. YOST, JR., M.D., duly designated members of the State Board for Professional Medical Conduct, appointed pursuant to Section 230(1) of the Public Health Law of the State of New York, served as the hearing committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. GERALD H. LIEPSHUTZ, ESQ., served as administrative officer for the hearing committee.

After consideration of the entire record, the hearing committee issues its Findings of Fact, Conclusions, Determination and Order.

SUMMARY OF CHARGES

Respondent was charged with the following acts of professional misconduct as more fully set forth in a copy of the AMENDED STATEMENT OF CHARGES attached hereto. A copy of

Respondent's original **ANSWER TO AMENDED STATEMENT OF CHARGES** is also attached.

1. Practicing the profession of medicine with gross negligence pursuant to New York Education Law Section 6530(4) **(FIRST SPECIFICATION)**

2. Practicing the profession of medicine with gross incompetence pursuant to New York Education Law Section 6530(6) **(SECOND SPECIFICATION)**

3. Conduct in the practice of medicine which evidences moral unfitness to practice medicine pursuant to New York Education Law Section 6530(20) **(THIRD SPECIFICATION)**

4. Failing to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient pursuant to New York Education Law Section 6530(32) **(FOURTH SPECIFICATION)**

RECORD OF PROCEEDINGS

Service of **NOTICE OF HEARING** and **STATEMENT OF CHARGES:**	November 17, 1992
AMENDED STATEMENT OF CHARGES entered into record:	February 24, 1993
ANSWER by Respondent entered into record:	February 24, 1993
Department of Health (Petitioner) appeared by:	Cindy M. Fascia, Esq. Associate Counsel Office of Professional Medical Conduct

Respondent appeared by:	Thomas G. Smith, Esq. Harter, Secrest and Emery 700 Midtown Tower Rochester, NY 14604
Pre-hearing conference: (before Administrative Officer Michael McDermott)	January 8, 1993
Hearing dates:	1993 February 24 February 25 April 27 April 28 June 10 June 22 July 28
Adjournment of hearing day:	May 26, 1993, due to the unavailability of the administrative officer
Hearing Committee absences:	Dr. Yost was not present during the hearing days of April 27, April 28 and June 10. He affirms that he has read and considered evidence introduced at, and transcripts of, the times of his absences.
Witnesses called by Petitioner:	Haroutun M. Babigian, M.D. Nancy Meierdierks Bowlan, clinical nurse specialist Denise A. Plane, social worker Betsy Mitchell, Assistant Dean, William Smith College Rebecca MacMillan, Dean, William Smith College Melvin J. Steinhart, M.D. Reuben J. Silver, M.D.

Witnesses called by Respondent:	Herzl R. Spiro, M.D. Henry Herrera, M.D., Respondent Deborah Ann White, Director of Residential Services for Winship Community Residences
Intra-hearing conferences on the record for legal determinations without the presence of the Hearing Committee:	1993 February 24 April 28 June 8 June 22
Post-hearing written submissions received from	
Petitioner:	September 9, 1993
Respondent:	September 9, 1993
Date of Hearing Committee's deliberations:	September 22, 1993

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record in this matter. Numbers in parentheses preceded by "T." refer to transcript pages, while numbers or letters preceded by "Ex." refer to exhibits in evidence. These citations represent evidence found persuasive by the hearing committee while arriving at a particular finding. Conflicting evidence was considered and rejected in favor of the cited evidence. All findings of fact were made by a unanimous vote (3-0) of the hearing committee.

1. Henry Herrera, M.D., Respondent, was authorized to practice medicine in New York State on September 26, 1983 by the issuance of license number 155856 by the New York State Education Department. He was registered with the Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from 300 Crittenden Boulevard, Rochester, New York 14642. (uncontested)

FIRST, SECOND AND THIRD SPECIFICATIONS

Paragraph A of the Amended Statement of Charges

2. Respondent provided inpatient psychiatric care to Patient A from approximately March 31, 1989 through approximately August 25, 1989, at Strong Memorial Hospital, Rochester, New York. Thereafter, from approximately August 25, 1989 through approximately May 9, 1990, Respondent provided outpatient psychiatric care to Patient A at 601 Elmwood Avenue, Rochester, New York, and at 300 Crittenden Boulevard, Rochester, New York. (Admitted: Ex. A)

Paragraph A(1)(a) of the Amended Statement of Charges

3. Respondent, during Patient A's inpatient psychiatric treatment at Strong Memorial Hospital, hugged Patient A and told her that she was very special to him, or words to that effect. (T. 189, 219, 241-242)

Paragraph A(1)(b) of the Amended Statement of Charges

4. Respondent did not invite Patient A to come to a "club" to see him perform as a musician. He may have invited her, as he had other patients and colleagues, to see him perform musically at Strong Memorial Hospital, Rochester Psychiatric Center or Monroe Community Hospital. (T. 779-781)

Paragraph A(2) of the Amended Statement of Charges

5. Transference is a phenomenon whereby the patient develops certain feelings about the therapy and about the therapist. These feelings, thoughts, and conflicts are based on significant prior feelings that a patient has had toward significant people in his or her life. The patient carries these feelings, thoughts, and conflicts and then projects them onto other people with whom the patient has relationships. Transference occurs in any therapeutic relationship. It must be recognized and dealt with as part of the therapy. Patients develop all kinds of feelings towards the therapist throughout the course of therapy. These feelings may be explored and used therapeutically to help the patient develop insight, to understand why he or she is having certain feelings and to resolve them. Even if a therapist chooses not to use the patient's transference therapeutically, its existence must be recognized and should

always be in the forefront of the therapist's mind as to what is going on with the patient emotionally and psychologically. (T. 88-89, 94-96, 273-275)

6. Countertransference is the transference of the therapist toward the patient. As human beings, all therapists have conflicts, feelings, and wishes of their own in relationship to their past. It is important for a therapist to be aware of his or feelings toward a patient. Countertransference must be recognized and dealt with so that it does not interfere in the therapeutic process. (T. 88-89, 275-277)

7. Psychiatrists, during the course of their training, are taught the importance of recognizing and dealing with their countertransference issues. If a therapist realizes that he or she is becoming overly involved with a patient, or that a patient is special, the therapist must step back and examine his or her feelings. If a psychiatrist cannot adequately deal with these feelings himself, he should discuss these feelings with a colleague in a serious, professional manner. If necessary, the psychiatrist should receive therapy himself to deal with these issues. If a psychiatrist cannot deal with countertransference feelings toward a patient, he should explore with a colleague whether it would be in the patient's best interest to transfer that patient to another therapist and, if necessary, the patient is transferred. (T. 88-89, 276-283)

8. It is common for patients to have a romantic or sexual transference to their therapist. Often such transference is really pre-sexual in that the patient has sexualized dependency and other issues as a way of relating to another person. (T. 95, 275)

9. A psychiatrist who is experiencing conflict in his or her personal life is more vulnerable to experiencing countertransference issues. A therapist who is experiencing marital problems may be experiencing unconscious feelings which make him much more vulnerable to such issues. A therapist who is experiencing personal stress or unhappiness, such as from an unhappy marriage, should be particularly wary of vulnerability to countertransference issues. (T. 279-281)

10. If a patient is exhibiting romantic or pre-sexual transference to a psychiatrist who is himself in an unhappy marriage, there is a danger that the psychiatrist will act out his countertransference issues by becoming romantically involved with the patient. A mutual interdependency may develop that will lead to a sexual relationship. Accordingly, if a therapist realizes that he is experiencing romantic countertransference to a patient, it is important for him to deal with these issues. (T. 281-282)

11. It is not accepted medical practice for a therapist to discuss his own countertransference feelings with the patient. If a therapist does so, it may "poison the well" of therapy by playing into transference feelings that the patient is experiencing. A therapist who does so risks worsening of the problem, because at an unconscious level the patient may incorporate the therapist's countertransference feelings into her own transference, so that a mutuality may develop which is detrimental. (T. 277)

12. Respondent had strong countertransference feelings toward Patient A. His repeated comments to his colleagues about Patient A's physical beauty and his repeated discussion about romantic fantasies in which he envisioned himself and Patient A together clearly show that Patient A invoked very strong feelings in Respondent. (T. 158-159, 277-278)

13. It is the therapist's responsibility to manage any transference or countertransference issues that arise during the course of therapy. It is the therapist's responsibility to manage these issues in the best interests of the patient. It is never appropriate for a therapist to manage these issues for his own benefit. (T. 285-286)

14. Patients such as Patient A, who have issues about a

parent (Ex. 3, p. 84) are vulnerable to transference issues regarding their feelings about that parent. (T. 294)

15. Respondent mismanaged Patient A's transference and his own countertransference issues. (T. 273-311, 331-336, 1129-1130) An intimate relationship between Respondent and Patient A places Patient A at risk, because that relationship developed out of unresolved transference issues. (T. 1129-1130). An improvement in Patient A would not be based on any real understanding or working through of her transference issues. In fact, there has been no real resolution of those issues. (T. 306-311, 320-321, 1129-1130)

16. Respondent mismanaged his own countertransference, as well as Patient A's transference, by taking this Patient, with her needs and wishes to be taken care of, and making her a special patient. Furthermore, by disclosing personal information about his own unhappy marriage to Patient A, Respondent played into Patient A's own transference and fantasies about their relationship. Such disclosure by Respondent was counter-therapeutic, and it served as an invitation to development of an intimate personal relationship between Patient A and Respondent. (T. 333-335)

17. Transference does not end with the termination of therapy. Transference issues remain long after therapy has ended.

(T. 91, 284-285, 1158-1160) Even if there is clinical improvement in a patient's condition, the transference issues are still there and may be operative for many years after the end of therapy. (T. 284) Even if a patient improves, regains competency and personal autonomy, there will always be a power differential between the patient and the therapist. The therapeutic situation is such that the power differential is always present, even after therapy has ended. (T. 81-82, 282-285) The therapist directs the therapy, and he must be aware of all the patient's vulnerabilities. (T. 283-284)

Paragraphs A(3), A(3)(a), and A(3)(b) of the Amended Statement of Charges

18. Respondent, shortly after the termination of Patient A's therapy on or about May 9, 1990, engaged in an intimate personal relationship with Patient A in that from about June, 1990 through September, 1990, their relationship included dating and sexual intercourse. [redacted] (uncontested; admitted: Ex. A; Ex. 8)

Paragraph A(4) of the Amended Statement of Charges

19. Respondent engaged in the aforesaid intimate personal relationship with Patient A despite factors in Patient A's history which increased the risk of harm to Patient A from such a relationship. (T. 81-82, 91, 282-285, 1158-1160)

20. The risk of harm to Patient A from Respondent's commencement of a personal, intimate relationship with her was increased by the presence of certain issues in Patient A's therapy and by particular factors in her history. These include Patient A's history of sexual abuse, her dependency needs, and her fears of rejection and abandonment. The risk is great that if the personal relationship is disrupted, Patient A would regress dramatically. There is a great risk of harm to Patient A from the personal, intimate relationship that Respondent entered into with her. (T. 54, 319-320, 1129)

21. Respondent was aware, before he commenced his intimate relationship with Patient A, that the literature recommended in such situations that Patient A be referred to someone else for psychiatric evaluation. Respondent disregarded that recommendation and, instead, placed total reliance on his personal belief that Patient A was well and would not be harmed by such a relationship with him. (T. 878-879) Respondent was also aware that the literature described cases where former patients had suffered harm from such relationships. (T. 855-856) Respondent relied solely on his own personal belief that the well-

documented and known risk for such harm would not be a risk for Patient A.

FOURTH SPECIFICATION

Paragraph A(5) of the Amended Statement of Charges

22. Regarding Respondent's medical recordkeeping, it is still common and accepted professional practice among psychiatrists in private, out-patient psychotherapy to use summary notes, as opposed to daily or contemporaneous notes of each patient contact. (T. 592, 752)

23. It is critical for psychiatrists conducting out-patient therapy to record the main themes and issues involved in that patient's therapy, and Respondent's notes from August, 1989 through May, 1990 accurately reflect his evaluation and treatment of Patient A during this period of time. (T. 591, 751-752)

CONCLUSIONS

The administrative officer reviewed the parties' written arguments regarding the definitions of professional misconduct to be applied in this matter. Also reviewed was the memorandum dated February 5, 1992 by Peter J. Millock, General Counsel, New York State Department of Health. This memorandum was prepared to aid the members of the Board for Professional Medical Conduct and

others during hearings concerning the Department's position on the definitions of misconduct. All Board members, Health Department prosecutors and administrative officers were provided a copy of the memorandum in 1992. At the commencement of each hearing, the existence of the memorandum is noted by the hearing committee chairperson, and the Respondent is offered a copy. Respondent is also notified at this time of Respondent's right to contest the definitions in writing prior to the closing of the hearing.

Pursuant to the review of the above-mentioned documents, the administrative officer directed the Hearing Committee herein to apply the following definitions of professional misconduct as a matter of law:

1. Gross negligence is a 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. The act or omission must be of an aggravated nature manifesting a disregard of the consequences which may ensue from the act and indifference to the rights of others. There must, therefore, be evidence of a consciousness on the part of the physician of impending dangerous consequences if

he persists in his conduct.[1] Proof of actual injury is not an element of gross negligence.

2. Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the physician in the practice of medicine. There must be a total and flagrant lack of necessary knowledge or ability.

The following conclusions were reached pursuant to a review of the findings of fact herein. All conclusions resulted from a unanimous vote of the hearing committee.

The factual allegations in the Statement of Charges relating to the charges of gross negligence, gross incompetence and moral unfitness to practice medicine were substantially sustained by the hearing committee. (Findings of Fact 2-21) Exceptions were that Respondent did not invite Patient A to see him perform musically in a "club" (Finding of Fact 4), and the therapy relationship between Respondent and Patient A ended on or about May 9, 1990 rather than on or about May 21, 1990 as alleged.

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[1]The administrative officer noted that counsel for Petitioner argued in her memorandum that to make a finding of gross negligence it is unnecessary to find that a physician acted in disregard of the consequences which might ensue from his acts. This view would remove the element of a consciousness of impending dangerous consequences in order to find gross negligence. The administrative officer instructed the committee that it would be legally improper to disregard the element of consciousness, inasmuch as the Health Department's position that this element is indeed part of the definition of gross negligence has been made clear by its distribution of the February 5, 1992 memorandum prior to and during this hearing. Respondent had a right to rely on what was stated to be the Department's position in the memorandum.

(Finding of Fact 18) Neither of these exceptions affected the ultimate conclusions of the hearing committee.

The factual allegations relating to the failure of Respondent to keep accurate medical records were not sustained. (Findings of Fact 22-23)

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE (FIRST SPECIFICATION)

The hearing committee concluded that Respondent's actions (Findings of Fact 2-21) did not constitute gross negligence. He was negligent in that he failed to exercise the care that would have been exercised by a reasonably prudent physician under the circumstances, but a preponderance of the evidence did not show a consciousness on Respondent's part of impending dangerous consequences if he persisted in his conduct. Although Respondent was aware that the psychiatric literature did not condone all of his actions, he believed that Patient A would not be harmed by their relationship. This belief negates the required element of a consciousness of impending dangerous consequences necessary to sustain a charge of gross negligence.

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE (SECOND SPECIFICATION)

The hearing committee concluded that Respondent's actions (Findings of Fact 2-21) did not constitute gross incompetence in that those actions did not show an unmitigated lack of skill or knowledge. A total and flagrant lack of necessary knowledge or ability was not proven.

CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE MEDICINE (THIRD SPECIFICATION)

The hearing committee concluded that Respondent's actions in the practice of medicine regarding Patient A (Findings of Fact 2-17) did not evidence moral unfitness. Respondent's intimate relationship with Patient A did not begin until after she was his patient. (Finding of Fact 18) Although, as previously stated, Respondent's actions while treating Patient A were negligent, he believed that she was not at risk and therefore, he should not be held morally culpable. It is noted that even the Department's expert witness testified that he did not consider Respondent's conduct evidence of moral unfitness. (T. 350)

FAILING TO MAINTAIN A RECORD WHICH ACCURATELY REFLECTS THE EVALUATION AND TREATMENT OF THE PATIENT (FOURTH SPECIFICATION)

The hearing committee concluded that this charge should not be sustained. Respondent's records for Patient A accurately reflected her evaluation and treatment. (Findings of Fact 22-23)

DETERMINATION AND ORDER

Pursuant to the hearing committee's findings of fact and conclusions herein,

IT IS DETERMINED THAT

THE FIRST, SECOND, THIRD AND FOURTH SPECIFICATIONS ARE NOT SUSTAINED,

and

IT IS HEREBY ORDERED THAT

ALL CHARGES ARE DISMISSED.

DATED: Syracuse, New York
November 10, 1993

Priscilla R. Leslie

PRISCILLA R. LESLIE
Chairperson

ARLENE B. REED-DELANEY, M.D.
MURRAY A. YOST, JR., M.D.

APPENDIX I

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

	:	AMENDED
IN THE MATTER	:	STATEMENT
OF	:	OF
HENRY HERRERA, M.D.	:	CHARGES

HENRY HERRERA, M.D., the Respondent, was authorized to practice medicine in New York State on September 26, 1983 by the issuance of license number 155856 by the New York State Education Department. The Respondent was registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from 300 Crittenden Boulevard, Rochester, New York 14642.

FACTUAL ALLEGATIONS

A. Respondent provided inpatient psychiatric care to Patient A [identified in the Appendix] from approximately March 31, 1989 through approximately August 25, 1989, at Strong Memorial Hospital, Rochester, New York. Thereafter, from approximately August 25, 1989 through approximately May 9, 1990, Respondent provided outpatient psychiatric care to Patient A at 601 Elmwood Avenue, Rochester, New York, and at 300 Crittenden Boulevard, Rochester, New York.

1. Respondent, during Patient A's inpatient psychiatric treatment at Strong Memorial Hospital, engaged in the following conduct:

   a. Respondent hugged Patient A and told her that she was very special to him, or words to such effect.

   b. Respondent told Patient A that he was a musician and invited Patient A to come to a club to see him perform.

2. Respondent inappropriately managed issues of transference and/or countertransference with regard to Patient A.

3. Respondent, shortly after the termination of Patient A's therapy on or about May 21, 1990, engaged in an intimate personal relationship with Patient A, in that:

   a. Respondent, from on or about June 1990 through September 1990, engaged in an intimate personal relationship with Patient A, which included dating and sexual intercourse.

   b. Respondent, on or about September 1990, began living with Patient A in an intimate personal relationship which included sexual intercourse.

4. Respondent engaged in the aforesaid intimate personal relationship with Patient A, despite factors in Patient A's history which increased the risk of harm to Patient A from such a relationship.

5. Respondent failed to maintain adequate records for Patient A, in that Respondent failed to record adequate progress notes of his outpatient sessions with Patient A.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) (McKinney Supp. 1992) by reason of his practicing the profession of medicine with gross negligence, in that Petitioner charges:

1. The facts in Paragraphs A and A.1(a), A and A.1(b), A and A.2, A and A.3(a), A and A.3(b), and/or A and A.4.

SECOND SPECIFICATION

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) (McKinney Supp. 1992) by reason of his practicing the profession of medicine with gross incompetence, in that Petitioner charges:

2. The facts in Paragraphs A and A.1(a), A and A.1(b), A and A.2, A and A.3(a), A and A.3(b), and/or A and A.4.

THIRD SPECIFICATION

CONDUCT EVIDENCING MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(20) (McKinney Supp. 1992) by reason of his conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

3. The facts in Paragraphs A and A.1(a), A and A.1(b), A and A.3(a), A and A.3(b), and/or A and A.4.

FOURTH SPECIFICATION

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1992) 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:

4. The facts in Paragraphs A and A.5.

DATED: Albany, New York
February 4, 1993

Peter D. Van Buren

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

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

Matter of HENRY HERRERA, M.D.

Respondent.

ANSWER TO AMENDED STATEMENT OF CHARGES

Respondent Henry Herrera, M.D., by his attorneys, Harter, Secrest & Emery, for his answer to the Amended Statement of Charges, states as follows:

1. Dr. Herrera admits the facts set forth in Paragraph "A" relating to the dates he provided inpatient and outpatient psychiatric care to Patient A.

2. With respect to the allegations set forth in Paragraph "A(1)," Dr. Herrera admits that he, along with other members of the treatment team at Strong Memorial Hospital, gave Patient A a goodbye hug upon the completion of her five month stay as an inpatient at the hospital, and words of encouragement and support during her hospitalization and that he may have invited her, as he has other patients and colleagues, to a musical performance at the Rochester Psychiatric Center. Dr. Herrera denies the remainder of these allegations and further denies any suggestion of impropriety.

3. With respect to the allegations set forth in Paragraph "A(2)," Dr. Herrera denies that he inappropriately managed issues of transference and/or countertransference with regard to Patient A.

4. With respect to the allegations set forth in Paragraph "A(3)," Dr. Herrera denies that the termination of Patient A's therapy occurred on or about May 21, 1990, and states that the final psychotherapy session between him and Patient A took place on May 9, 1990, and that the physician/patient relationship terminated on this date. Dr. Herrera further admits that he and Patient A entered into a personal relationship beginning in mid June, 1990, which became intimate and which continues to this day, more than two and one half years later. Dr. Herrera further admits that, beginning in September, 1990, he and Patient A decided to live together.

5. With respect to the allegations set forth in Paragraph "A(4)," Dr. Herrera denies that he disregarded risk factors respecting Patient A, or that any factors then existed which actually created or increased any risk of harm that Patient A faced by entering into an intimate personal relationship with him, and further states that, prior to engaging in any personal or intimate relationship with Patient A, he and Patient A carefully considered any possible risks that might exist from such a relationship. Dr. Herrera further states that, to his knowledge, no physician, psychologist or other professional representing the Department of Health has ever examined or even spoken to Patient A or to Dr. Herrera to determine whether any generalized or speculative risk of harm actually existed.

6. With respect to the allegations contained in Paragraph "A(5)," Dr. Herrera denies these allegations of inadequate recordkeeping, and further states that he maintained records that adequately documented the evaluation and treatment of this patient in accordance with New York law. Dr. Herrera further states that, contrary to the Department's original allegation (now withdrawn), he recorded an adequate note regarding the termination of his outpatient therapy with Patient A on May 21, 1990, and that the Department of Health has now acknowledged the hospital's recent production of this termination note.

7. Dr. Herrera denies each and every specification of charges listed in Specifications 1 through 4.

**FOR A FIRST AFFIRMATIVE DEFENSE,
RESPONDENT HENRY R. HERRERA, M.D.
RESPECTFULLY ALLEGES:**

8. The conduct for which Dr. Herrera has been charged, development of an intimate personal relationship in June, 1990 with a former patient after the physician/patient relationship concededly had ended, does not violate any promulgated, absolute standards, rules or principles of the American Psychiatric Association or of New York State law. Moreover, the propriety of such conduct is the subject of ongoing debate and disagreement in the medical profession and in the field of psychiatry.

**FOR A SECOND AFFIRMATIVE DEFENSE,
RESPONDENT HENRY R. HERRERA, M.D.
RESPECTFULLY ALLEGES:**

9. The Department of Health's allegations of misconduct, insofar as they seek to discipline Dr. Herrera for developing an intimate personal relationship with a former patient, in the absence of a promulgated prohibition against such conduct under State law, regulation, or professional code, and in the absence of any evidence of actual harm to the former patient, violate the rights of Dr. Herrera and his former patient under the Constitutions of the United States and of the State of New York, including their rights to privacy and their freedom to associate without intrusion by the government, and further violate their civil rights under 42 U.S.C. §1983 et seq.

FOR A THIRD AFFIRMATIVE DEFENSE, RESPONDENT HENRY R. HERRERA, M.D. RESPECTFULLY ALLEGES:

10. Dr. Herrera's development of an intimate, personal relationship with a former patient does not involve his conduct in the practice of medicine, but involves private, consensual conduct between Dr. Herrera and another adult.

DATED: Rochester, New York
February 22, 1993

Thomas G. Smith, Esq.
HARTER, SECREST & EMERY
Attorneys for Respondent
Henry Herrera, M.D.
Office and Post Office Address
700 Midtown Tower
Rochester, New York 14604
(716)232-6500