STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 19, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy M. Fascia, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237-0032

Joseph K. Strang, Esq.
Birzon, Quinn & Strang
222 East Main Street
Smithtown, New York 11787

Deiter Heinz Eppel, D.O.
48 Willow Brook Drive
Auburn, New York 13021

RE: In the Matter of Dieter Heinz Eppel, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-82) 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.

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.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER

OF

DIETER HEINZ EPPEL, M.D.

COPY

DETERMINATION

AND

ORDER

BPMC #02-82

MARY MEAGHER, R.N., Chairperson, **HRUSIKESH PARIDA, M.D.** and **JOEL H. PAULL, DDS, M.D.**, 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 Section 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 **DONALD P. BERENS, Jr.**, General Counsel, **CINDY M. FASCIA, ESQ.**, Associate Counsel, of Counsel. The Respondent appeared by **BIRZON, QUINN & STRANG, ESQS., JOSEPH K. STRANG, 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 eight (8) specifications of professional misconduct, including allegations of moral unfitness, harassing, abusing or intimidating a patient, revealing of personally identifiable facts or information obtained in a professional capacity, gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion and failure to maintain accurate records. The charges are more specifically set forth in the Statement of Charges dated August 16, 2001, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	July 31, 2001
Pre-Hearing Conference	August 20, 2001
Hearing Dates:	August 22, 2001
	August 23, 2001
	October 2, 2001
	October 4, 2001
	November 13, 2001
	November 14, 2001
	December 3, 2001

WITNESSES

For the Petitioner:	Patient A Vincent Iannone, Rph John Gilfus Andrea J. Gilfus

David C. Brittain, M.D.
Joel P. Amidon II, D.O.

For the Respondent:

Christopher Rogers
Frank LoTurco, D.O.

Rosalyn McCormick, RN
Nikolaus Satelmajer, M.D.I.V.
Charles M. Desy
Dieter H. Eppel , D.O.
Rebecca Dickerson

FINDINGS OF FACT

1. Patient A first saw Respondent for medical care in 1980, for her premarital blood test. Patient A became pregnant during her honeymoon, and Respondent provided obstetrical care for her throughout the course of the pregnancy, and cared for her during her labor. Respondent did not perform the actual delivery, as Patient A's son was delivered by caesarian section. Subsequent to the birth of her first child, Patient A continued to see Respondent for medical care. Respondent also was the primary care physician for most of Patient A's family, including her husband, her mother and father, her sister and brother-in-law, and her grandmother. Respondent also provided pediatric care for Patient A's older son for the first two years of his life. (T. 26-27; Pet. Ex. 3)

2. Patient A, subsequent to the birth of her first child, had difficulty conceiving. She sought treatment from Respondent for infertility. Respondent eventually prescribed Clomid. Patient A had problems with the Clomid, and it had to be discontinued. Eventually, Patient A conceived again in February 1984, and Respondent provided prenatal care for her. In the second trimester of her pregnancy, Patient A experienced a traumatic fetal demise. Respondent attended Patient A during her labor and the delivery of her stillborn child.

Following the delivery of the child, Patient A had a retained placenta. Respondent had to perform a manual removal. (T. 28-37; Pet. Ex. 3). Patient A subsequently hemorrhaged, and had to be readmitted for a D&C and a transfusion.

3. On June 21, 1984 Respondent noted that he discussed her recent concerns over adopting to the reality of life. (Pet. Ex. 3)

4. Respondent did not provide further obstetric care to Patient A after the stillbirth. However, he continued as Patient A's primary care physician, providing medical care for everything except her obstetrical care at that point. (T. 40 ; Pet. Ex. 3)

5. On August 21, 1995, Patient A was seen by Respondent for palpitations, chest pain, tightness and shortness of breath. Respondent discussed lengthy problems, personal situations and felt this was the cause. (Ex. 3, p. 9)

6. In January 1996, Patient A called Respondent's office, and the prescription for Prozac was called in to Wegman's. (T. 43-45 ; Pet. Ex. 4) The pharmacy records from Wegman's Pharmacy in Auburn, New York indicate that on January 26, 1996, Becky from Respondent's office called in a prescription for Prozac for Patient A, with three refills. (Pet. Ex. 4, p. 6)

7. Subsequent to Patient A's visit to Respondent's office in August 1995, Respondent called Patient A on the telephone at her home. Respondent told Patient A that he was looking to expand his circle of friends. Respondent told Patient A that he valued her judgment and

thought she was a very intelligent person, and asked her if she would consider being his friend. Thereafter, Respondent would call Patient A and talk to her about his relationships with women he was dating or had dated. (T. 47)

8. Patient A, during the course of her long term doctor-patient relationship with Respondent, had occasion to have professional contact with Respondent in the course of her employment as a tax preparer for two accounting firms in Auburn. In 1990, when Patient A was employed as a tax preparer for [redacted] Respondent and his wife Janet came in for an appointment with the managing partner. Patient A was a part-time employee, as she was still attending school. During the course of her employment, Patient A was given Respondent's tax return to prepare. Patient A asked Respondent if this would be acceptable to him, as she was his patient. Respondent and his wife had no problem with Patient A preparing the return, and she did so. The managing partner checked the return and signed it- Patient A did not. Patient A had no further business contact with Respondent while she was at [redacted]

9. In January 1991, Patient A began working for Accounting Firm #1. Shortly after her employment, one of the managing partners had a meeting about bringing new business into the office, and assigned each person a goal. Thereafter, Patient A, during an appointment for medical care, asked Respondent if he would be interested in bringing his business to Accounting Firm #1. She offered to set up a meeting between Respondent and the managing partner, and Respondent agreed. Patient A set up the meeting, and Respondent subsequently became a client of Accounting Firm #1. She would pick up the ledgers and other materials from Respondent's office, but she did not work on the account itself. (T. 50-53)

10. In approximately 1992, when Respondent and his wife were involved in divorce proceedings, Respondent left Accounting Firm #1 as a client, and obtained an accountant who had not previously represented him and his wife together. Thereafter, in late 1995, the partners at Accounting Firm #1 were again seeking new business, and the managing partner asked Patient A to try to get Respondent to return to Accounting Firm #1 as a client. Patient A told Respondent that the firm would like his business again. Thereafter, the managing partner asked Patient A to call Respondent to invite him to the firm's annual Christmas party, because he thought it would be a good opportunity to get Respondent to come back to the firm. Patient A called Respondent and invited him to come to the party, and told Respondent that the managing partner had asked her to call and wanted Respondent to attend. Patient A did not invite Respondent as her guest, nor did she drive to or leave the party with Respondent. Respondent called Patient A at home just before she was leaving for the party to say he would attend. Respondent arrived late at the party, had dinner and talked with the partner, and left early on his own. (T. 54-57)

11. In April of 1996, Patient A developed a severe migraine headache. Respondent had called Patient A at home, and she told him that she had a terrible migraine. Respondent told Patient A he would treat her for her migraine headache. Respondent called Wegman's Pharmacy and ordered Imitrex syringes. Respondent injected the Imitrex. The records of Wegman's Pharmacy indicate that Respondent called in a telephone prescription for Imitrex prefilled syringes on April 19, 1996. (T. 59-60; Pet. Ex. 4, p. 11) Respondent's office records also indicate that Wegman's Pharmacy called Respondent's office and said that Respondent had telephoned in a prescription for Imitrex prefilled syringes. (Pet. Ex. 3)

12. In September 1997, Patient A again sought treatment with Respondent for stress related issues. (T. 66-69; Pet. Ex. 3) The source of the severe stress Patient A was experiencing was work related. She was extremely anxious, and was experiencing physical manifestations of her stress, including chest pain and pressure. (T. 65-66; Pet. Ex. 3)

13. Respondent also wrote Patient A a prescription for Valium. (T. 71-72; Pet. Ex. 3, 5) Respondent explained to Patient A that he could not give her samples of Valium, that he would have to write her a prescription, but that he could give her samples of Paxil. (T. 71)

14. Respondent wrote Patient A a doctor's note for her to be out of work. (T. 72-73; Pet. Ex. 3, 27)

15. Patient A again saw Respondent in his office for medical care on October 6, 1997. She presented with multiple stress-related physical complaints: episodes of vomiting, sudden sweats, shakiness, chest pains, abdominal pain and diarrhea. (T. 66; Pet. Ex. 3) She described having panic attacks. (Pet. Ex. 3) Respondent continued to keep Patient A out of work, due to the severity of her work stress-related condition. (T. 912-926; Pet. Ex. 27)

16. Respondent's "plan" for Patient A's office visit of October 6, 1997 reads "continue OOW; recommended counseling. Stress management." Respondent does not document any specific referral for counseling. (Pet. Ex. 3)

17. In mid-October 1997, Patient A was again diagnosed with ovarian cysts, a problem for which she had required surgery in the past. Patient A's OB/GYN, Dr. Starkey, admitted Patient A to the hospital on October 16, 1997, for a total abdominal hysterectomy. However, Patient A did not have the hysterectomy during this admission. Respondent, as Patient A's primary care physician, was concerned about her breathing and diagnosed her with bronchitis. Patient A was discharged from the hospital with medications, and saw Respondent in his office for medical care on October 24, 1997. Patient A was readmitted and Dr. Starkey performed the hysterectomy on October 31, 1997. (T. 76-78; Pet, Exs. 3, 19)

18. Patient A was discharged from the hospital on November 3, 1997. She was subsequently readmitted to the hospital on November 4, 1997 for an incisional infection. She was discharged from the hospital on November 7, 1997. (T. 78-80; Pet. Ex. 19)

19. On December 18, 1997, the accounting firm where Patient A had been employed was having its annual Christmas party. Respondent offered to accompany Patient A to the party. Patient A agreed to go to the party with Respondent. (T. 87-88)

20. On the evening of the party, Respondent picked Patient A up at her home, and they drove to the party together in Respondent's car. (T. 88-89)

21. The weekend after the party, Respondent called Patient A and asked her if she would do him a favor, that he "needed a woman's opinion" on a coat that he was thinking of buying for Employee B, his office manager with whom Respondent was involved. Patient A thought Respondent had been so nice in going to the party with her that she should help him out, so

she accompanied him to the Carousel Mall. Respondent showed Patient A the coat he wanted to buy and she agreed it was a nice coat. Respondent purchased the coat. Patient A did some shopping of her own in Hills, and Respondent brought her home. (T. 94-95)

22. On Christmas Eve, at about 5 p.m., Respondent called Patient A and asked if he could stop by, because he had a Christmas gift for her. Patient A was surprised, because she and Respondent had never exchanged gifts before, and she had nothing for him. She put together a plate of Christmas cookies for him. Respondent arrived at Patient A's house and gave her an envelope which contained a gift certificate to the Finger lakes Mall in Auburn. (T. 95-96 ; Pet. Ex. 11; See also: T. 1015-1016) Patient A gave Respondent the plate of cookies. They hugged and Respondent left. (T. 95)

23. On or about December 27, 1997, Respondent and Patient A went for a ride to Fillmore Glen in Moravia, New York. Upon arrival, Respondent suggested they go for a walk. Patient A and Respondent kissed. (T. 96, 100, 840)

24. The weekend of January 9, 1998, Respondent asked Patient A out to dinner. Respondent then took Patient A back to his home. Respondent and Patient A began to kiss and then eventually had sexual intercourse. (T. 104-105)

25. Respondent and Patient A thereafter engaged in sexual intercourse on various occasions. (T. 107)

26. Respondent, during the time period in which he was engaging in a sexual relationship with Patient A, continued to provide medical care to Patient A. Respondent prescribed medication to Patient A for various medical conditions, including Ceftin in January 17, 1998; Cipro on March 16, 1998 and Septra on March 16, 1998. Respondent wrote Patient A a prescription for the Cipro. Respondent personally called in telephone prescription orders to the Owasco Pharmacy for the Ceftin and the Septra. (T. 111-112, 215-218, 221-222; Pet. Ex. 5 [Owasco Pharmacy records]; Pet. Ex. 9 (Respondent's cell phone records); T. 394-408 [V. Iannone]; T. 409-429, 433-443 [J. Gilfus]) Respondent also gave Patient A samples of medication during this time, including "Z-Pak." (T. 216)

27. Respondent's January 17, 1998 prescription for Ceftin for Patient A was to treat Patient A for bronchitis, a condition for he had frequently treated her. (T. 111-112, 215-218, 221-222[A]; See Pet. Exs. 3, 5) Respondent prescribed Septra for Patient A on March 16, 1998 for a urinary tract infection. (Pet. Ex. 5, p. 4)

28. Respondent did not document in Patient A's medical record any of the medical care or prescriptions that he provided to Patient A during the time period that he was engaging in a sexual relationship with Patient A. (Pet. Exs. 3, 5; T. 111-118)

29. Patient A had frequent toothaches. Respondent offered to call his own dentist/oral surgeon Dr. Karpinski and set up an appointment for Patient A. Patient A did see Dr. Karpinski, and ended up having two root canals. Respondent offered to pay for Patient A's dental care. She accepted $300.00 toward the first visit, but paid the remaining $150 herself, as well as the entire payment for the second visit. (T. 125-127; Pet. Ex. 3)

30. In February 1998, Patient A had carried a heavy bag of salt from her driveway, and experienced pain in her abdominal area. Patient A told Respondent about the pain, and that there was a bulge at the base of her incision. She was not sure if she had injured herself or had another infection. Respondent had Patient A lay down on the bed and examined her incision. He told her that she had a hernia. (T. 128-129) Patient A eventually had the hernia repaired in August 2000. (T. 129; Pet. Ex. 19)

31. Respondent took Patient A on a weekend trip to Alexandria Bay. (T. 140-141)

32. During the time that Respondent was engaging in a sexual relationship with Patient A, Respondent continued to allow Employee B to work in his office and to have access to Patient A's medical records. Respondent permitted this situation to continue, even after several incidents occurred. (T. 164)

33. Respondent continued to allow Patient A's chart to remain in a place where Employee B had access to it, and took no steps to safeguard Patient A's medical record. (T. 1047-1048)

34. Employee B made an unauthorized telephone call to the Owasco Pharmacy in which she spoke to the pharmacist, Andrea Gilfus, and asked questions about Patient A's prescriptions and medications. The pharmacist at some point thought that the call was strange, and began to doubt that the call was from Respondent's office, because the questions being asked were not those that she was used to being asked by a professional office. (T. 449-450, 458-459)

35. The pharmacist, in checking into the phone call she had received, called Respondent's office. She also spoke to Patient A. (T. 450-452) Patient A called Respondent's office, and Employee B answered the phone. Patient A asked about the telephone call made from Respondent's office to Owasco Pharmacy. (T. 157-158)

36. Respondent, on April 20, 1998, made a tape recording of a confrontation/conversation he had with Employee B regarding Patient A, brought the tape recording to Patient A. (T. 162-163) The issues raised on the tape were discussed at the hearing, but the tape recording was not played.

37. Respondent, during the time he was involved in a sexual relationship with Patient A, had Patient A doing his personal finances for him. Respondent did not pay Patient A for this service.(T. 151)

38. Respondent, during the time period that he engaged in a sexual relationship with Patient A, revealed personally identifiable facts and/or information about other patients to Patient A. (T. 116-117)

39. Respondent also revealed information about Patient E's medical condition to Patient A.

[redacted] Respondent wanted Patient A to intervene [redacted] Patient A told Respondent it wasn't her place to do this, and felt very uncomfortable. Respondent told Patient A that she had to because if someone didn't, Patient E would die. Patient A asked Respondent to please not put her in that position. (T. 168-169)

40. Respondent also revealed personal medical information about Patient F to Patient A. [redacted] (T. 170-171)

41. Patient A, on approximately April 13, 1998, the day after Easter, claimed to have a threatening letter at her residence. The letter was in a blank envelope, was typed and was unsigned. (T. 174-176)

42. Patient A was afraid to tell Respondent about the letter. Patient A finally showed Respondent the letter. Respondent told Patient A that he would discuss the letter with his counselor. Patient A also showed the letter to a friend who was an attorney. Patient A's friend told her that the letter was unsigned and it would be difficult to prove it was from Employee B. He advised Patient A to let it go. (T. 178-179)

43. Respondent, the evening of May 10, 1998, called Patient A on his cell phone and told her that he needed to stop by and talk to her, and that he had something to return to her. (T. 187; Pet. Ex. 9, p. 57, Item #49) Respondent arrived five minutes later. He brought in a pair of Patient A's shoes that she had left in his car. Patient A pointed to her kitchen counter, where she had put personal finances; his checkbook, folders containing bills, his savings account passbook; and the key to his house, which he had given Patient A. Patient A told Respondent to take his things and leave her house. (T. 187-188)

44. Respondent had told Patient A, prior to the time that Patient A ended their relationship, that he was going to dismiss Employee B because of her inappropriate and unprofessional behavior regarding Patient A's medical record. After Patient A ended their relationship, Respondent changed his mind. He told Patient A that he was not going to dismiss Employee B. He told Patient A that no one was going to tell him who he could or couldn't have working in his office. (T. 189-190)

45. Respondent began to make statements to Patient A to the effect that there was nothing wrong with what Employee B had done regarding Patient A's medical record. Respondent told

Patient A that any one of his office staff could review any patient's chart at any time for any reason, and that there was nothing wrong with that. Respondent told Patient A that she needed to drop the issue. Patient A was upset and confused by Respondent's statements, particularly because Respondent had made the tape of the conversation between himself and Employee B, where he told Employee B what she had done regarding Patient A's medical record and that calling Owasco Pharmacy was wrong and inappropriate. In the tape, Respondent asked Employee B if she "understood the gravity of her actions." (T. 191) Patient A told Respondent that she felt violated by what Employee B had done, and told him that now he was saying the complete opposite of what he had said previously about Employee B's actions. (T. 191-192)

46. Patient A, on or about May 26, 1998, made a written request to Respondent that her medical records be transferred to another physician. Patient A wrote the letter and brought it to Respondent's office. Patient A gave the letter to Respondent's receptionist and requested that her records be transferred that day. (T. 193; Pet. Ex. 7)

47. Respondent continued to call Patient A on the telephone. (T. 192)

48. Respondent, on or about May 28, 1998 came to Patient A's house and told Patient A that he had been under a lot of stress, and that he wanted Patient A to cease having contact with his children. Patient A had developed a close relationship with two of Respondent's children, his daughter and his son, Dieter, Jr. Respondent said that Patient A's relationship with his children was putting stress on him and causing a strain and problems in his relationship with Employee B. Respondent wanted Patient A to end her relationships with his children.

Respondent drew a "relationship diagram" for Patient A, to facilitate her understanding of the situation. (T. 200-203 [Patient A]; T. 975-980 [Respondent]; Pet. Ex. 12) Respondent showed Patient A, in the "relationship diagram" that he drew, that he had brought Patient A inside the circle of his life, but that now she was on the outside. Respondent told Patient A that she could not stay on the inside and have a relationship with his children. (T. 200-203 [Patient A]; T. 975-980 [Respondent]; Pet. Ex. 12)

49. Respondent, on or about June 5, 1998, called Patient A three times in succession. (Pet. Ex. 9, p. 77, Items 7, 9, 88; T. 204-205)

50. In early June, Patient A called an attorney and asked him to send Respondent a letter telling him to stop contacting Patient A. The attorney sent the letter. (T. 204)

51. Patient A called OPMC in June 1998. Respondent's daughter, who works at Community General Hospital in Syracuse, told Patient A where to find the number in the Syracuse phone book. Patient A called and talked to Judy Stafford, an investigator from the Syracuse office. Patient A was too frightened to give her Respondent's name. Ms. Stafford mailed complaint forms to Patient A, but Patient A never filed a complaint against Respondent with OPMC until March 1999, after she had begun counseling. (T. 210-211)

52. Patient A began counseling in February 1999.

53. Respondent has sometimes had occasion to discharge a patient from his practice. Respondent himself admitted that his practice in such situations is to give the patient a

written statement that he will no longer continue to provide care, and that the patient should find another physician. In this written notice to the patient, Respondent states that he will provide emergency care for the next 30 days, but that after that time, he will no longer provide care. When Respondent sends such a letter to a patient, the fact that the letter was sent is documented in the patient's chart. Respondent sends the letter and documents that is was sent for two reasons: to avoid compromising the patient's care, and to protect himself legally. (T. 1001-1003)

54. Respondent never sent such a letter to Patient A. Patient A on May 26, 1998, hand delivered her written request to Respondent's office requesting that her records be sent to another physician. (T. 1001-1004; T. 111-112, 214-215 ; Pet. Ex. 7)

55. Respondent prescribed medications to Patient A until May 1998, but failed to maintain accurate records. (T. 111-112, 214-215; Pet. Ex. 3, 5) Respondent's medical record for Patient A contains no medical care entries after October 29, 1997. (Pet. Ex. 3)

56. Family practitioners such as Respondent have become the initial point of psychiatric care for the majority of the population. Family practitioners commonly provide first and even second line therapy, including counseling and medication therapy with antidepressants and/or anti-anxiety drugs. If further psychiatric care or referrals are needed, that is commonly done by family practitioners as well. Providing first and second line psychiatric care has become an increasing part of family practice care in the past ten years, and is a daily part of family practice for many physicians. (T. 540-542)

57. Psychiatrists are absolutely prohibited from engaging in sexual relationships with their patients. (T. 550-551)

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:	(1,2) w/r to geographic locations only
Paragraph A.1 (a):	Not Sustained
Paragraph A.1 (b):	Not Sustained
Paragraph A.1 (c):	Not Sustained
Paragraph A.1 (d):	Not Sustained
Paragraph A.1 (e)	(19) only w/r to attendance at party
Paragraph A.1 (f):	Not Sustained
Paragraph A.1 (g):	Not Sustained
Paragraph A.1 (h):	(22) except w/r to Respondent hugged her
Paragraph A.1 (i)(1):	(23)
Paragraph A.1 (i)(2)	(23) except w/r to Respondent initiated the kiss
Paragraph A.1 (i)	Not Sustained
Paragraph A.2:	(24 - 25)
Paragraph A.2 (a):	Not Sustained
Paragraph A.2 (b):	Not Sustained
Paragraph A.2 (c):	(24)
Paragraph A.2 (d):	(24)
Paragraph A.2 (e):	Not Sustained
Paragraph A.2 (f):	Not Sustained
Paragraph A.2 (g):	Not Sustained
Paragraph A.3 :	(30)
Paragraph A.3 (a):	Not Sustained

Paragraph A.3 (b):	Not Sustained
Paragraph A.3 (c):	Not Sustained
Paragraph A.3 (d):	(29) except w/r to he told her to fix her teeth
Paragraph A.3 (e):	Not Sustained
Paragraph A.3 (f):	Not Sustained
Paragraph A.3 (g):	(30)
Paragraph A.4:	Not Sustained
Paragraph A.4 (a):	Not Sustained
Paragraph A.4 (b):	Not Sustained
Paragraph A.4 (c):	Not Sustained
Paragraph A.4 (d):	Not Sustained
Paragraph A.4 (e):	Not Sustained
Paragraph A.5:	(32-33)
Paragraph A.5 (a):	Not Sustained
Paragraph A.5 (b):	Not Sustained
Paragraph A.5 (c):	(32)
Paragraph A.5 (c) (1):	Not Sustained
Paragraph A.5 (c) (2):	(34)
Paragraph A.5 (c) (3):	(33-35)
Paragraph A.5 (d):	(36)
Paragraph A.6:	(38-40)
Paragraph A.7:	Not Sustained
Paragraph A.8:	(46,48)
Paragraph A.8 (a):	Not Sustained
Paragraph A.8 (b):	Not Sustained
Paragraph A.8 (c):	Not Sustained
Paragraph A.8 (d):	Not Sustained
Paragraph A.8 (e):	Not Sustained
Paragraph A.8 (f):	Not Sustained
Paragraph A.8 (g):	(48)
Paragraph A.8 (h):	Not Sustained
Paragraph A.8 (i):	Not Sustained
Paragraph A.9:	(25)
Paragraph A.9 (a):	Not Sustained
Paragraph A. (b):	(13)

Paragraph A.10:	(28)
Paragraph A.10 (a):	(13, 28) except w/r to Paxil
Paragraph A. (b):	(28)
Paragraph A. (c):	Not sustained

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

MORAL UNFITNESS

Paragraphs: A and A.1(i)(2)

Paragraphs: A and A.2(c) and A.2 (d)

Paragraphs: A and A.3 (d) and A.3 (g)

Paragraphs: A and A.9 (b)

HARASSING, ABUSING OR INTIMIDATING A PATIENT

Paragraphs: A and A.8 (g)

REVEALING OF PERSONALLY IDENTIFIABLE FACTS OR INFORMATION OBTAINED IN A PROFESSIONAL CAPACITY

Paragraphs: A and A.6

GROSS NEGLIGENCE

NOT SUSTAINED

GROSS INCOMPETENCE

NOT SUSTAINED

NEGLIGENCE ON MORE THAN ONE OCCASION

NOT SUSTAINED

INCOMPETENCE

NOT SUSTAINED

FAILURE TO MAINTAIN RECORDS

Paragraphs: A and A.10 (a) and A.10(b)

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

Fourth Specification

Fifth Specification

Sixth Specification

Seventh Specification

DISCUSSION

Respondent is charged with eight (8) specifications alleging professional misconduct within the meaning of Education Law § 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 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.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that four (4) of the eight (8) 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 of deliberations, the Hearing Committee made a determination as to the credibility of the witnesses presented by the parties. The Department called Patient A as its main witness. The Hearing Committee found Patient A to be very smart and articulate, although at times her testimony appeared to be coached. On a scale of 1 to 10 they gave her a credibility rating of 5. The Department also called Joel P. Amidon, II, D.O. who has been in a group,

primary care practice in Rome, New York for the past 14 years. (T. 532) The Hearing Committee finds Dr. Amidon to be a qualified, credible witness. They, however, note that even Patient A had no complaints about the medical care rendered by Respondent. (T. 333) They further find that the main issues here were factual not medical and thus Dr. Amidon's testimony was not very helpful. The remaining witnesses called by the Department were generally found to be credible by the Hearing Committee.

The Hearing Committee found that Respondent had a selective memory particularly when it came to the two interviews that he had with the Department. The remainder of Respondent's witnesses were generally found to be credible. In particular they found Pastor Satelmajer credible in testifying that it was Patient A who freely initiated the discussion about her sexual harassment settlement (T. 607-608) when she had testified at the hearing that she had told no one but Respondent and her attorney. (T. 171-172)

Since neither Respondent nor Patient A were found to be wholly credible, it was very difficult for the Hearing Committee to resolve a lot of the factual allegations in the Statement of Charges. The Hearing Committee focused its attention instead on events that occurred once the relationship became consensual.

MORAL UNFITNESS

(First Specification)

The Hearing Committee, as already discussed, found fault with the credibility of both Patient A and Respondent. As a result, they found it difficult to resolve a great number of the interactions between Patient A and Respondent as outlined in the Statement of Charges. The Hearing Committee finds however, that after the parties kissed at Fillmore Glen in late December 1997, Respondent, by his own admission became involved with Patient A while

continuing to act as her physician. He entered into an albeit consensual relationship knowing that he had been her long time physician. During the course of their approximately five month sexual relationship, he prescribed medications including Ceftin, Cipro and Septra, (Pet. Ex.5) paid for some of her dental care and examined her hysterectomy incision after an injury. (T.125-127, 128-129) The Hearing Committee concludes that the sexual relationship, even if consensual, breached the patient's trust. As a result, the Hearing Committee sustains the First Specification.

HARASSING, ABUSING OR INTIMIDATING A PATIENT

(Second Specification)

The Hearing Committee finds that Respondent acted in an intimidating matter when he drew the "relationship diagram" (Ex.12) to show Patient A that she was no longer on the inside of his life but on the outside. Respondent did this to discourage Patient A from contacting his children. The Hearing Committee sustains this as an act of intimidation. The Hearing Committee finds insufficient evidence to sustain the other allegations charged under this specification.

REVEALING OF PERSONALLY IDENTIFIABLE FACTS OR INFORMATION OBTAINED IN A PROFESSIONAL CAPACITY

(Third Specification)

The Hearing Committee sustains Charge A. 6 for revealing personally identifiable facts or information about other patients, particularly Patient A's legally separated husband as well as Patient A's brother-in law. The Hearing Committee, however, does not sustain Charge A.7 . In this instance, Patient A testified that Respondent revealed details of her sexual harassment

lawsuit to third parties without authorization. The Hearing Committee finds that this is not true in light of Pastor Satelmajer's testimony that it was Patient A who "talked about it quite openly" when they met her in February of 1998. (T. 607-608) Thus, the Hearing Committee sustains the Third Specification with respect to Charge A.6.

GROSS NEGLIGENCE

(Fourth Specification)

The Hearing Committee finds no evidence in the record to sustain the Fourth Specification.

GROSS INCOMPETENCE

(Fifth Specification)

The Hearing Committee finds no evidence in the record to sustain the Fifth Specification.

NEGLIGENCE ON MORE THAN ONE OCCASION

(Sixth Specification)

The Hearing Committee finds no evidence in the record of negligence on more than one occasion. Therefore the Sixth Specification is not sustained.

INCOMPETENCE ON MORE THAN ONE OCCASION

(Seventh Specification)

The Hearing Committee finds no evidence in the record to sustain the Seventh Specification.

FAILURE TO MAINTAIN ACCURATE RECORDS

(Eighth Specification)

The Hearing Committee sustains Charges A.10(a) and A.10(b) for failure to maintain accurate records for prescribing Prozac and other treatments and medications for Patient A. They find no proof in the record to sustain Charge A.10(c) As a result, the Eighth Specification is sustained.

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 suspended for a period of Five (5) years following the effective date of this Determination and Order. The first two (2) years will be an actual suspension but the remaining three (3) years of the suspension shall be stayed and Respondent will be placed on general probation. During the two (2) years of actual suspension, Respondent will submit to a psychiatric evaluation and also complete 150 hours of CME with courses that include medical ethics and patient boundary violations. The complete terms of probation are attached to this Determination and Order as Appendix II. 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 notes that the Department went to great lengths to cast Respondent as the seducer in this relationship. Respondent categorically denied that he was the initiator of the relationship, but agreed at some point that it became consensual. It was very difficult for the Hearing Committee to resolve these issues based on the often frequent contradictory evidence in the record. Regardless, the Hearing Committee finds that after the ride

to Fillmore Glen, Respondent consented to the sexual relationship which then continued on for several months. The Hearing Committee finds that once he either initiated or consented to the relationship with Patient A, Respondent breached the trust that Patient A had placed in him as her longtime physician. The Hearing Committee believes that the imposition of a two (2) year actual suspension is reasonable in the belief that the Respondent will be able to return to active practice at the end of that period of time. The Hearing Committee suggests the psychiatric evaluation and the CME courses in hopes that the two (2) years of actual suspension will be best utilized to assist Respondent in his rehabilitation. Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

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

1. The First, Second, Third and Eighth Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The Fourth, Fifth, Sixth and Seventh Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;**

3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **FIVE (5) YEARS,** said suspension to be **STAYED for a period of THREE (3) YEARS with (2) YEARS of ACTUAL suspension;**

4. During the first two (2) years of the five (5) year suspension, Respondent shall submit to a **PSYCHIATRIC EVALUATION** and successfully complete **150 hours of CME;**

5. Respondent's license shall be placed on **PROBATION** during **the last THREE (3) YEARS** of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and

5. This Order shall be effective upon service on the Respondent or the Respondent's

attorney by personal service or by certified or registered mail.

DATED: Rochester , New York
March 14, **2002**

Mary Meagher

MARY MEAGHER, R.N.
(Chairperson)

HRUSIKESH PARIDA, M.D.
JOEL H. PAULL, DDS. M.D.

TO: Cindy M. Fascia, Esq.
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Deiter Heinz Eppel, D.O.
48 Willow Brook Drive
Auburn, NY 13021

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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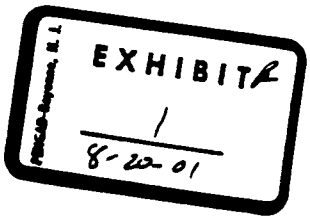
IN THE MATTER	:	NOTICE
OF	:	OF
DIETER HEINZ EPPEL, D.O.	:	HEARING

----------X

TO: DIETER HEINZ EPPEL, D.O.
48 Willow Brook Drive
Auburn, New York 13021



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 22nd and 23rd of August, 2001, at 10:00 AM, in the forenoon of those days at the State Office Building, (on August 22 - Room A and on August 23 - Room B), 333 E. Washington Street, Syracuse New York, and at other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the

production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180 (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and

the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
July 31, 2001

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

CINDY M. FASCIA
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Room 2509 Corning Tower
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
DIETER HEINZ EPPEL, D.O.	:	CHARGES

----------X

DIETER HEINZ EPPEL, D.O., Respondent, was authorized to practice medicine in New York State on September 14, 1979, by the issuance of license number 139666 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine in New York State.

FACTUAL ALLEGATIONS

A. Respondent provided medical care, including obstetric and gynecologic care, and psychiatric care, including treatment for stress and panic attacks, to Patient A on various occasions from approximately March 21, 1980 until approximately May 26, 1998, when Patient A requested that her records be transferred to another physician. Respondent's care and treatment of Patient A occurred at Respondent's medical offices in Auburn, New York and Port Byron, New York, and at Auburn Memorial Hospital.

1. Respondent, during the time that he was providing medical care to Patient A, engaged in an ongoing and inappropriate personal relationship with Patient A, including the following:

a. Respondent, after Patient A underwent a total abdominal hysterectomy on or about October 31, 1997 at Auburn Memorial Hospital and was recovering at home, stopped by Patient A's home unannounced several times a week.

b. Respondent, on at least one such occasion at Patient A's home in November 1997, hugged Patient A.

c. Respondent, on at least one such occasion at Patient A's home, told Patient A that he was going to see his own counselor about relationship issues and asked Patient A to come with him for the ride.

d. Respondent, on more than one such occasion, invited Patient A to take a ride in his car with him. When Patient A refused Respondent's invitations, Respondent asked Patient A, "Don't you ever use the word 'yes'?" or words to such effect.

e. Respondent, when Patient A discussed with him her anxiety and stress over attending the upcoming holiday party of her soon to be former employer, (1) told Patient A that it was a good idea for her to attend the party to bring closure or resolution to the situation; (2) offered to escort Patient A to the party himself; and (3) picked Patient A up at her home in his car and drove Patient A to the party, which he attended with Patient A.

f. Respondent, after leaving the party with Patient A, told her that she was "too upset to go home, that she would upset her children" or words to such effect.

g. Respondent, after leaving the party with Patient A, drove Patient A in his car to a back road overlooking Owasco Lake and parked the car. Respondent then (1) pulled Patient A toward him and hugged her; and (2) told Patient A that she "felt so good and was a very attractive woman" or words to such effect.

h. Respondent, on or about December 24, 1997, called Patient A on the telephone and told her that he had something for her and wanted to bring it to her house, or words to such effect. Respondent came to Patient A's home and gave her a gift certificate and hugged her.

i. Respondent, on or about December 27, 1997, engaged in the following conduct:

(1) Respondent asked Patient A if she would go for a ride with him.

(2) Respondent drove Patient A to Fillmore Glen, a park in Moravia, New York. Respondent and Patient A went for a walk, and Respondent hugged Patient A and kissed her on the lips.

(3) Respondent, when Patient A expressed concerns about what would happen if they had a personal relationship, and whether Respondent would still be able to be her doctor, told Patient A "I have always taken care of you and I always will," or words to such effect.

2. Respondent, during the time that he was providing medical care to Patient A, and beginning in approximately January 1998 through approximately May 7, 1998, engaged in an ongoing and inappropriate sexual and personal relationship with Patient A, including the following:

a. Respondent called Patient A several times a day.

b. Respondent, on numerous occasions, took Patient A for a ride in his car and asked Patient A to fondle him while he was driving.

c. Respondent, on or about January 9 or 10, 1998, took Patient A to dinner and to a movie.

d. Respondent, on or about January 9 or 10, 1998, took Patient A to his house and had sexual intercourse with her.

e. Respondent engaged in unprotected sexual intercourse with Patient A on numerous occasions at Respondent's home, at Patient A's home, and at other locations.

f. Respondent, on one occasion, engaged in sexual intercourse with Patient A at Respondent's medical office in Port Byron, New York.

g. Respondent took intimate photographs of Patient A.

3. Respondent, during the time period that he was engaging in a sexual relationship with Patient A, provided undocumented medical care to Patient A and/or performed or suggested cosmetic medical procedures to Patient A, and engaged in the following conduct:

a. Respondent, on or about February 1998, removed several skin tags and moles from Patient A's body at Respondent's medical office in Port Byron, New York.

b. Respondent, on or about February 1998, removed a cyst from Patient A's back at Respondent's medical office in Port Byron, New York.

c. Respondent failed to send any specimens to pathology from said procedures.

d. Respondent told Patient A she should have her teeth fixed, and gave Patient A money for dental work.

e. Respondent told Patient A that he would save money to pay for a "tummy tuck" for her.

f. Respondent talked to Patient A about how the scars on her breasts from her breast biopsies could be "taken care of" with plastic surgery.

g. Respondent, on or about February 1998, examined Patient A's hysterectomy incision and diagnosed an incisional hernia.

4. Respondent, during the time period that he was engaging in a sexual relationship with Patient A, provided inappropriate counseling and/or psychiatric advice and/or treatment to Patient A, including but not limited to the

following conduct:

a. Respondent told Patient A that she had a "passive-aggressive personality," that she needed to be more direct, and that she "needed to and could work on this with him" or words to such effect. Respondent would thereafter point out examples of what he labeled as such behavior in his personal interactions with Patient A, and tell her how she should change her behavior.

b. Respondent told Patient A that she would feel better about herself and have better self-esteem if she dressed a certain way. Respondent thereafter would insist that Patient A dress a certain way when he was with her, and offered Patient A money for a clothing allowance.

c. Respondent told Patient A that her former boyfriend was obsessive-compulsive, and that Patient A should stay away from him.

d. Respondent, when he and Patient A were at Alexandria Bay and saw Patient A's former employer there, told Patient A that she had to go up to her former employer and speak to him "to have closure and get past the situation." Respondent, despite Patient A's reluctance, persisted until Patient A acquiesced.

e. Respondent repeatedly advised Patient A that she should keep a journal, and that keeping a journal would benefit her psychologically. Respondent told Patient A that he would read her journal entries, and that he would review and discuss them with her.

5. Respondent, during and after the time period that he was engaging in a sexual relationship with Patient A, inappropriately allowed a personal/sexual relationship that he was also engaged in with an employee in his office, "Employee B", to become related with and negatively affect his relationship with Patient A, as follows:

a. Respondent, on more than one occasion from January 1998 through May 1998, told Patient A that Employee B had a violent temper and had physically assaulted him several times, and that at least one such assault resulted from Respondent's involvement with another woman.

b. Respondent, on or about April 3, 1998, invited Patient A to come to his house to look at pictures of Respondent's recent trip to Belize. While Patient A was at Respondent's house, Employee B came to Respondent's house three times in less than three hours. On one of these occasions, Employee B handed Respondent photographs that had been taken during Respondent's and Patient A's trip to Alexandria Bay, which photographs Respondent had Employee B pick up from the developer for him.

c. Respondent, during the time that he was engaging in a relationship with Patient A, continued to allow Employee B to work in Respondent's office and have access to Patient A's medical records, despite the following:

1. After Respondent became involved with Patient A, Employee B confronted Respondent and told him "I read Patient A's chart. She has a lot of medical problems. You're going to have your hands full if you stay with her" or words to such effect.

2. Employee B made an unauthorized telephone call to at least one pharmacist and asked questions about Patient A's prescriptions and medications from Respondent.

3. Employee B looked at Patient A's medical records for personal motives and/or without a valid professional purpose, and Respondent knew such facts.

d. Respondent made a tape recording of a confrontation/conversation he had with Employee B about Patient A, brought the tape recording to Patient A and played it for her.

6. Respondent, during the time period in which he engaged in a sexual relationship with Patient A, revealed personally identifiable facts and/or information about other

patients to Patient A, including information about the following patients: Patient C and/or Patient D and/or Patient E and/or Patient F.

7. Respondent, during the time period in which he engaged in a sexual relationship with Patient A, personally or through his office staff revealed personally identifiable facts and/or information about Patient A, including the circumstances under which Patient A had left a particular employment situation, to third parties without authorization.

8. Respondent, subsequent to Patient A's written request on or about May 26, 1998 that her medical records be transferred to another physician, engaged in the following conduct:

a. Respondent called Patient A on the telephone on or about May 26, 1998 and yelled at Patient A for requesting that her records be transferred.

b. Respondent came to Patient A's home on or about May 26, 1998 and (1) told Patient A that he could still be her physician and still take care of her, or words to such effect; and (2) told Patient A she should "stop seeing this [Respondent's relationship with her and Employee B's behavior] so negatively" and that Patient A "should see this as a compliment" or words to such effect.

c. Respondent told Patient A that what had occurred between them was "a personal matter, not a professional matter" and that Patient A could not discuss it with anyone, "only with God," or words to such effect.

d. Respondent told Patient A that he could still continue to be her physician and that he and Patient A "could still be friends" if Patient A did not pursue the confidentiality issues, or words to such effect.

e. Respondent came to Patient A's house, and repeatedly accused Patient A of writing herself a threatening letter that she had received, or words to such effect.

f. Respondent, while accusing Patient A of writing the letter herself, backed Patient A up against the wall.

g. Respondent drew a "relationship diagram" of his personal relationships, and showed Patient A on the diagram how she "had been on the inside but was now on the outside" or words to such effect.

h. Respondent, on or about June 4, 1998 called Patient A. When Patient A again expressed her concern about how her confidentiality had been violated by Employee B's actions, Respondent said "What do you want her to do, sweep the streets? Clean the toilets at the jail? Why don't you just go shoot her?" or words to such effect.

i. Respondent, on or about June 5, 1998, called Patient A three times. Respondent, in one of said calls, told Patient A "if you know what's good for you, you'll defuse the situation", or words to such effect.

9. Respondent engaged in a personal and sexual relationship with Patient A, despite the following:

a) Respondent had accepted responsibility for providing psychological counseling for Patient A and/or failed to refer Patient A to a qualified counselor or psychiatrist.

b) Respondent had accepted responsibility for prescribing and/or dispensing psychotropic medications to Patient A.

10. Respondent failed to maintain a medical record for Patient A which accurately reflected his care and treatment of Patient A, including but not limited to the following:

a. Respondent, despite prescribing or providing medication for Patient A, including Prozac and Paxil, failed to maintain accurate records of such treatment.

b. Respondent failed to maintain accurate records of the treatment and medications he provided to Patient A from on or about November 1997 through May 1998.

c. Respondent failed to document in Patient A's medical record, or in Patient A's hospital record, medical visits for which Respondent billed Patient A's insurance provider.

SPECIFICATIONS

FIRST SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20), in that Petitioner charges:

1. The facts in Paragraphs A, A.1 and A.1(a) and/or A.1(b) and/or A.1(c) and/or A.1(d) and/or A.1(e) and/or A.1(f) and/or A.1(g) and/or A.1(h) and/or A.1(i)(1) and/or A.1(i)(2) and/or A.1(i)(3); A.2 and A.2(a) and/or A.2(b) and/or A.2(c) and/or A.2(d) and/or A.2(f) and/or A.2(g); A.3 and A.3(a) and/or

A.3(b) and/or A.3(c) and/or A.3(d) and/or A.3(e) and/or A.3(f) and/or A.3(g); A.4 and A.4(a) and/or A.4(b) and/or A.4(c) and/or A.4(d) and/or A.4(e); A.5 and A.5(a) and/or A.5(b) and/or A.5(c)(1) and/or A.5(c)(2) and/or A.5(c)(3) and/or A.5(d); A.6 and/or A.7; A.8 and A.8(a) and/or A.8(b) and/or A.8(c) and/or A.8(d) and/or A.8(e) and/or A.8(f) and/or A.8(g) and/or A.8(h) and/or A.8(i); A.9 and A.9(a) and/or A.9(b).

SECOND SPECIFICATION

HARASSING, ABUSING OR INTIMIDATING A PATIENT

Respondent is charged with willfully harassing, abusing or intimidating a patient physically and/or verbally in violation of New York Education Law §6530(31), in that Petitioner charges:

2. The facts in Paragraphs A, A.1 and A.1(a) and/or A.1(b) and/or A.1(c) and/or A.1(d) and/or A.1(e) and/or A.1(f) and/or A.1(g) and/or A.1(h) and/or A.1(i)(1) and/or A.1(i)(2) and/or A.1(i)(3); A.2 and A.2(a) and/or A.2(b) and/or A.2(c) and/or A.2(d) and/or A.2(f) and/or A.2(g); A.3 and A.3(a) and/or A.3(b) and/or A.3(c) and/or A.3(d) and/or A.3(e) and/or A.3(f) and/or A.3(g); A.4 and A.4(a) and/or A.4(b) and/or A.4(c) and/or A.4(d) and/or A.4(e); A.5 and A.5(a) and/or A.5(b) and/or A.5(c)(1) and/or

A.5(c)(2) and/or A.5(c)(3) and/or A.5(d); A.6 and/or A.7; A.8 and A.8(a) and/or A.8(b) and/or A.8(c) and/or A.8(d) and/or A.8(e) and/or A.8(f) and/or A.8(g) and/or A.8(h) and/or A.8(i); A.9 and A.9(a) and/or A.9(b).

THIRD SPECIFICATION

REVEALING OF PERSONALLY IDENTIFIABLE FACTS OR INFORMATION OBTAINED IN A PROFESSIONAL CAPACITY

Respondent is charged with revealing personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient in violation of New York Education Law §6530(23), in that Petitioner charges:

3. The facts in Paragraphs A.6 and/or A.7.

FOURTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of his practicing medicine with gross negligence on a particular occasion in violation of New York Education Law §6530(4), in that Petitioner charges:

4. The facts in Paragraphs A, A.1 and A.1(a) and/or A.1(b) and/or A.1(c) and/or A.1(d) and/or A.1(e) and/or A.1(f) and/or A.1(g) and/or A.1(h) and/or A.1(i)(1) and/or A.1(i)(2) and/or A.1(i)(3); A.2 and A.2(a) and/or A.2(b) and/or A.2(c) and/or A.2(d) and/or A.2(f) and/or A.2(g); A.3 and A.3(a) and/or A.3(b) and/or A.3(c) and/or A.3(d) and/or A.3(e) and/or A.3(f) and/or A.3(g); A.4 and A.4(a) and/or A.4(b) and/or A.4(c) and/or A.4(d) and/or A.4(e); A.5 and A.5(a) and/or A.5(b) and/or A.5(c)(1) and/or A.5(c)(2) and/or A.5(c)(3) and/or A.5(d); A.6 and/or A.7; A.8 and A.8(a) and/or A.8(b) and/or A.8(c) and/or A.8(d) and/or A.8(e) and/or A.8(f) and/or A.8(g) and/or A.8(h) and/or A.8(i); A.9; and A.9(a) and/or A.9(b).

FIFTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of his practicing medicine with gross incompetence in violation of New York Education Law § 6530(6), in that Petitioner charges:

5. The facts in Paragraphs A, A.1 and A.1(a) and/or A.1(b) and/or A.1(c) and/or A.1(d) and/or A.1(e) and/or A.1(f) and/or A.1(g) and/or A.1(h) and/or A.1(i)(1) and/or A.1(i)(2) and/or A.1(i)(3); A.2 and

A.2(a) and/or A.2(b) and/or A.2(c) and/or A.2(d) and/or A.2(f) and/or A.2(g); A.3 and A.3(a) and/or A.3(b) and/or A.3(c) and/or A.3(d) and/or A.3(e) and/or A.3(f) and/or A.3(g); A.4 and A.4(a) and/or A.4(b) and/or A.4(c) and/or A.4(d) and/or A.4(e); A.5 and A.5(a) and/or A.5(b) and/or A.5(c)(1) and/or A.5(c)(2) and/or A.5(c)(3) and/or A.5(d); A.6 and/or A.7; A.8 and A.8(a) and/or A.8(b) and/or A.8(c) and/or A.8(d) and/or A.8(e) and/or A.8(f) and/or A.8(g) and/or A.8(h) and/or A.8(i); A.9; and A.9(a) and/or A.9(b).

SIXTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of his practicing medicine with negligence on more than one occasion in violation of New York Education Law §6530(3), in that Petitioner charges:

6. The facts in Paragraphs A, A.1 and A.1(a) and/or A.1(b) and/or A.1(c) and/or A.1(d) and/or A.1(e) and/or A.1(f) and/or A.1(g) and/or A.1(h) and/or A.1(i)(1) and/or A.1(i)(2) and/or A.1(i)(3); A.2 and A.2(a) and/or A.2(b) and/or A.2(c) and/or A.2(d) and/or A.2(f) and/or A.2(g); A.3 and A.3(a) and/or A.3(b) and/or A.3(c) and/or A.3(d) and/or A.3(e) and/or A.3(f) and/or A.3(g); A.4 and A.4(a) and/or

A.4(b) and/or A.4(c) and/or A.4(d) and/or A.4(e); A.5 and A.5(a) and/or A.5(b) and/or A.5(c)(1) and/or A.5(c)(2) and/or A.5(c)(3) and/or A.5(d); A.6 and/or A.7; A.8 and A.8(a) and/or A.8(b) and/or A.8(c) and/or A.8(d) and/or A.8(e) and/or A.8(f) and/or A.8(g) and/or A.8(h) and/or A.8(i); A.9; and A.9(a) and/or A.9(b); A.10 and A.10(a) and/or A.10(b) and/or A.10(c).

SEVENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of his practicing medicine with incompetence on more than on occasion in violation of New York Education Law § 6530(5), in that Petitioner charges:

7. The facts in Paragraphs A, A.1 and A.1(a) and/or A.1(b) and/or A.1(c) and/or A.1(d) and/or A.1(e) and/or A.1(f) and/or A.1(g) and/or A.1(h) and/or A.1(i)(1) and/or A.1(i)(2) and/or A.1(i)(3); A.2 and A.2(a) and/or A.2(b) and/or A.2(c) and/or A.2(d) and/or A.2(f) and/or A.2(g); A.3 and A.3(a) and/or A.3(b) and/or A.3(c) and/or A.3(d) and/or A.3(e) and/or A.3(f) and/or A.3(g); A.4 and A.4(a) and/or A.4(b) and/or A.4(c) and/or A.4(d) and/or A.4(e); A.5 and A.5(a) and/or A.5(b) and/or A.5(c)(1) and/or A.5(c)(2) and/or A.5(c)(3) and/or A.5(d); A.6 and/or

A.7; A.8 and A.8(a) and/or A.8(b) and/or A.8(c) and/or A.8(d) and/or A.8(e) and/or A.8(f) and/or A.8(g) and/or A.8(h) and/or A.8(i); A.9; and A.9(a) and/or A.9(b); A.10 and A.10(a) and/or A.10(b) and/or A.10(c).

EIGHTH SPECIFICATION

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in violation of New York Education Law §6530(32), in that Petitioner charges:

8. The facts in Paragraphs A.10 and/or A.10(a) and/or A.10(b) and or A.10(c).

DATED: July 31, 2001
Albany, New York

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

APPENDIX II

APPENDIX II

TERMS OF PROBATION

1. Respondent shall conduct him/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19),

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Suite 303, Troy, New York12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation

shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall submit to a psychiatric evaluation by a physician proposed by Respondent and subject to the written approval of the Director of OPMC. A psychiatric evaluation shall be completed during the first 2 years of the 5 year suspension. The results of the psychiatric evaluation shall be provided to the Respondent and to OPMC. Respondent shall be solely responsible for all expenses associated with the psychological evaluation.

9. Respondent shall enroll in and complete a continuing medical education program to be equivalent to at least 150 credit hours of Continuing Medical Education. Programs on medical ethics and patient boundaries are to be included. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed during the first 2 years of the 5 year suspension.

10. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and all assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding any/or any such other proceeding against Respondent as may be authorized pursuant to the law.