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

PUBLIC

March 28, 2005

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy Fascia, Esq.
Bureau of Professional Medical
Conduct – 25th Floor
Division of Legal Affairs
NYS Department of Health
Corning Tower, ESP
Albany, New York 12237

Catherine Gale, Esq.
Gale & Dancks, LLC
7136 East Genesee Street
Fayetteville, New York 13066-0097

RE: In the Matter of George Michael Innes, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 05-53) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

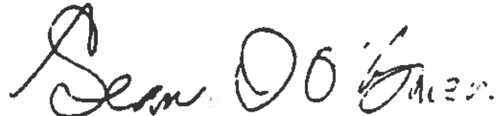
The notice of review served on the Administrative Review Board should be forwarded to:

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

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

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

Sincerely,



Sean D. O'Brien, Director
Bureau of Adjudication

SDO:djh
Enclosure

IN THE MATTER

OF

GEORGE MICHAEL INNES, M.D.

COPY

BPMC NO. 05-53

DETERMINATION

AND

ORDER

A Notice of hearing, dated January 23, 2004, and a Statement of Charges, dated January 23, 2004, were served upon the Respondent, **GEORGE MICHAEL INNES, .MD.**

JOEL H. PAULL, M.D., D.D.S., Chairperson, **RICHARD LEE, M.D.** and **STEPHEN WEAR, Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (the "Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. **FREDERICK ZIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer.

The Department of Health ("the Department") appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, by **CINDY MARIE FASCIA, ESQ.**, of Counsel. The Respondent appeared by **GALE & DANCKS, LLC, CATHERINE GALE, 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 Committee issues this Determination and Order.

PROCEDURAL HISTORY

Answer Filed	February 10. 2004
Amended Answer Filed	October 25, 2004
Pre-Hearing Conference	February 10, 2004
Witnesses for Petitioner	Patient A, Patient A's mother, A5, Richard Braen, M.D., David C. Brittain, M.D., Patient B, Patient B's mother, Susan Crump, Carol Currier, Cynthia Ciabotte, Patient C, Patient C's mother, Patient D, Tracey Eckstein, Patient F, Patient F's mother, Patricia Grant, Valerie Grossman Aarne, Patient G, Patient G's husband, Steven Hanks, M.D., [redacted] Employee H, Employee I, Employee J, Employee K, Marlinda LaValley, Martha Loveland, Anita Miller, Nurse M, Nurse N, Nurse O, [redacted] Christine Porter, Employee P, Employee P's sister, Employee Q, Employee R, [redacted] Employee S, Neil Stroman, Robert Swidler, Esq., Mabel Walker
Witnesses for Respondent	George Innes, M.D., A.4, Cheryl DiShaw, Christine Hopkins, Lewis Jones, Linda Land, Pamela McLenon, Kathryn Nichol, Jenna Ponnwitz, Jo Ann Reid, Tamara Robinson, Nicole Simmons, Melissa Waldeck
Hearing Dates	February 18 and 19, May 3, 4, 24 and 25, June 7 and 8, August 5, 9, 10, 23 and 24, September 20, 22, 23, 27, 28 and 29 and October 25, 2004
Deliberation Dates	January 6, 7, 20 and 21, 2005

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter P.H.L.]).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. Via a Statement of Charges, dated January 23, 2004, **GEORGE MICHAEL INNES, M.D.** ("Respondent") was charged with fifty specifications of professional misconduct, as defined in §6530 of the Education Law of the State of New York ("Education Law"). Various amendments to the Statement of Charges were accepted by the Administrative Law Judge, on June 8, 2004 (T.1493-1495) and on August 23, 2004 (T. 2246-2250). An Amended Statement of Charges was offered and accepted into evidence on September 20, 2004, which added Factual Allegations "U" through "W" and five additional specifications. Respondent was ultimately charged with twenty three specifications of committing conduct in the practice of medicine which evidence moral unfitness to practice medicine, ten specifications of willfully harassing, abusing or intimidating a patient either physically or verbally, two specifications of revealing patient related information without patient consent, seven specifications of practicing medicine fraudulently, five specifications of practicing medicine with negligence on more than one occasion, four specifications of willfully making or filing a false report, two specifications of failing to maintain a record which accurately reflects the evaluation and treatment of the patient and two specifications of violating Section 2803-d or 2805-k of the Public Health Law.

Both parties stipulated on the first hearing date, February 18, 2004, that they would waive the statutory requirement that the hearing be completed in 120 days (T. 87-88).

On the August 5, 2004 hearing date, Respondent's attorney informed the Administrative Law Judge that Respondent would be absent from the hearing due to an illness which required his hospitalization. There was no notice given to the Administrative Law Judge that Respondent would be absent prior to the hearing. Respondent's attorney attended the hearing and requested an adjournment which was denied (Transcript of 8/5 intra-hearing conference at 10:00 a.m. T. 2-6). The Department had brought in a witness, Nurse O, from Alaska to testify at the August 5 hearing. Respondent's attorney was available to cross examine Nurse O, Employee J and the other witnesses presented by the Department on that day. The Administrative Law Judge specifically acknowledged the possibility on the record that if there was a need, witnesses could be recalled for further cross examination (T. 1644 and Transcript of 8/5 intra-hearing conference at 10:00 a.m. T.5). Although, Respondent subsequently testified that he was unable to remember Nurse O (T. 3945) or to remember giving a backrub to Employee J (T. 4035), no request was made during the course of the hearing to bring back these individuals, or any of the other witnesses who testified on August 5, 2004, for further cross examination.

Department's Exhibit 23, a Verified Complaint filed with the New York State Division of Human Rights, was entered into evidence on August 5, 2004 and provided to the Committee with the identity of the complainant redacted. The Committee was instructed that the complainant had filed the Verified Complaint which alleged sexual harassment by Respondent subsequent to 1991 and sometime during a period between 1991 and 1996, a period prior to the issuance of Dr. Krueger's report on September 1, 1999 (Dept's Ex. 8). The Committee was further instructed that the complainant was not the person whose

complaint gave rise to the Memorandum of Agreement which Respondent entered into while at Albany Memorial Hospital (Dept's Ex. 11A). The Committee was, also, instructed that the complaint went solely to the issue of Respondent's notice and awareness of allegations, instances or accusations of sexual misconduct against him prior to the alleged incidents in the Watertown area (T. 1761-1765).

At the conclusion of the Department's case in chief, on September 22, 2004, the Administrative Law Judge instructed the Committee to disregard Factual Allegations "L" and "L.1" through "L.6.c" and the corresponding specifications (T. 3287). This instruction was given as a result of the Department's failure to present competent proof concerning those allegations and related specifications during the presentation of its case. The Committee was instructed that they could only consider Factual Allegation L in the context of the allegations contained in Factual Allegation M, i.e.- that it was alleged that Nurse M had reported to her supervisor allegations made by Nurse L with the result that Respondent engaged in certain conduct toward Nurse M in Albany Memorial Hospital's utility room and/or medication room.

The Administrative Law Judge also instructed the Committee with regard to a number of lawsuits against Respondent concerning which the Committee heard testimony or received documentary evidence. The Committee was instructed that although it could consider the outcome of these lawsuits, it was in no way bound by the results of these lawsuits and needed to consider all of the evidence and testimony with respect to the allegations in the Statement of Charges.

The charges to be considered by the Committee, included among other matters, numerous allegations of sexual misconduct by Respondent towards both patients and others beginning in the late 1980s and continuing through the course of the hearing, up

until the summer of 2004. A copy of the Amended Statement of Charges is attached to this Determination and Order as Appendix I.

Voluminous testimony was presented by both parties during the course of the hearing. At the conclusion of the hearing on October 25, 2004, the Administrative Law Judge inquired of Respondent if there was anything further that needed to be presented, and, also, stated that Respondent could even inform the Administrative Law Judge the next day if there were anything compelling that needed to addressed. Respondent's attorney replied, "We have no further proof." (Intra-Hearing Transcript of 10/25/04, pgs. 12-13).

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Committee in arriving at a particular finding.

Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Committee hereby makes the following findings of fact::

1. **GEORGE MICHAEL INNES, M.D.**, the Respondent, was authorized to practice medicine in New York State on February 16, 1988, by the issuance of license number 173637 by the New York State Education Department (uncontested).

2. A physician-patient relationship exists when a physician is using or is purporting to use his professional knowledge in dealing with a person. If the other person is relying on the physician to act in the role of a physician, and places trust in the physician based on the assumption that the physician will act according to that role, a physician-patient relationship exists. If a physician is asked or offers to help a person with a medical or psychological problem, a physician-patient relationship exists (Braen, T. 2270-2271).
3. No financial renumeration is required for a physician-patient relationship to exist. Furthermore, even if the physician does not document the encounter, a physician-patient relationship still exists. The fact that the physician did not make a medical record of an encounter where he offered or was asked to use his professional knowledge or skill, or purported to be acting in such a role, does not change the fact that a physician-patient relationship exists (Braen,T. 2270-2271).
4. If an Emergency Department physician is asked to or offers to provide treatment to a co-worker, that staff person is a patient for the purposes of the treatment encounter. During that encounter, a physician-patient relationship exists (Braen, T. 2271-2272).
5. During the encounter, a staff person places trust in the physician to treat them in a medical capacity. The same standards apply to that interaction which apply to any physician-patient relationship. The patient's comfort, care and trust have the same priority. The basis of the relationship and the standards to be observed are the same (Braen, T. 2272).
6. The Director and Assistant Director of an Emergency Department play important roles in setting the tone for the conduct of staff. They are role models for how people,

patients and staff, are to be treated in the Department, and their behavior may have a definite effect on how the Emergency Department functions (Braen, T. 2273-2278).

7. The more authority or perceived authority the person engaging in the inappropriate behavior has, the more intimidated and reluctant to complain the staff may be. If the person engaging in the inappropriate behavior is known to have not only a professional but a close personal friendship with people in powerful or authoritative positions, that may also intimidate staff from making complaints (Braen, T. 2500-2501).

8. Unwelcome sexual comments are inappropriate in the workplace. When the person making the comments is in a position of authority, has or may be perceived to have the ability to influence jobs and livelihoods, the comments and conduct can be more egregious. Such comments and conduct by a person in position of authority may make a subordinate feel threatened and fearful. When a physician engages in such behavior, he/she violates the ethical standards of the profession (Braen, (T. 2919-2920).

9. Patient comfort and trust require that patients' privacy and modesty be respected. Failing to do so is a deviation from the standard of care (Braen, T. 2472-2473; 2914-2915).

10. An Emergency Department physician's encounter with a patient is often the first and perhaps only time the physician sees that patient. An Emergency Department physician must be able to generate trust and comfort from the beginning or as soon as possible in the encounter with the patient. The way a physician speaks to a patient and the way a physician deals with a patient's family are important parts of the Emergency Department physician's function (Braen, T. 2268-2269).

11. Emergency Department physicians evaluate patients in a focused fashion, based on a chief complaint. The focused Emergency Department examination is different from the

annual physical examination a patient receives in his primary care physician's office. For most patients seen in the Emergency Department, the focus is on the particular problem that brought the patient to the Emergency Department (Braen, T. 2266-2268).

PATIENT A

12. On June 29, 2001, Patient A, a fifteen year old female, was admitted to the emergency room at Via Health/Newark Hospital in Newark, New York and was assessed as having overdosed on Celebrex 100 mg. after ingesting approximately half a bottle of her grandfather's pills (Dept's Ex. 3).

13. Respondent told Melissa Waldeck, one of the nurses caring for Patient A, that he wanted to speak to Patient A alone (Valerie Grossman, T. 1040-1041).

14. There was no policy in effect at VIA Health requiring a chaperone to be present when a physician examined a patient (Waldeck, T. 3394).

15. Patient A was brought into a room, gowned and a nurse administered charcoal to Patient A, and then Patient A was left alone in a room with Respondent (Patient A, T.1855-1857).

16. When Respondent was alone with Patient A, Respondent said to her, "It's time to go under the cover." Respondent then lifted Patient A's examination gown, in a manner which exposed her breasts, and then touched Patient A's breasts (Patient A, T.1797-1801).

17. The examination of a female patient's breasts by a male physician in the absence of a chaperone fails to meet accepted standards of medical care (Braen, T. 2970-2973).

18. Respondent asked Patient A if she was sexually active or had received anal sex or if she had given or received oral sex (Patient A, T.1797-1798).

19. When presented with a minor female patient with suicidal ideation in an emergency room situation, it is within accepted standards of medical care for the emergency room physician to question the patient concerning her sexual history (Braen, T. 2973-2978).

20. Respondent did not document in Patient A's medical record that he had examined her breasts or that he had asked Patient A questions pertaining to sex (Dept's Ex. 3).

PATIENT B

21. On December 17, 2002, Patient B, a fifteen year old female, presented to the Emergency Department of Canton-Potsdam Hospital for an evaluation, after her school notified Child Protective Services that Patient B had bruises on her arm (Dept's Ex. 4).

22. Respondent examined Patient B in her street clothing and did not request that Patient B be gowned (Patient B, T.2376; Innes; T.4696-4698).

23. Patient B [redacted] (Innes, T. 4733).

24. In the course of examining Patient B, Respondent attempted to unhook Patient B's bra, and had difficulty in doing so. Respondent stated, "I used to be good at this." (Patient B, T. 2376-2378; Innes, T. 4733).

25. Respondent, after Patient B's bra was removed, examined each of Patient B's breasts from underneath to look for bruises (Patient B, T. 2379).

26. Respondent then asked Patient B to drop her skirt and she proceeded to do so (Patient B, T. 2380-2381).

27. Respondent then pushed Patient B'S thighs apart to look for bruises (Patient B's Mother, T. 2418).

28. Respondent then stated that it was obvious that Patient B was sexually active, promiscuous and that she dressed promiscuously (Patient B, T. 2382-2383).

29. Respondent left the room. When he returned, he stated that Patient B should not dress so provocatively (Patient B's mother, T. 2420).

PATIENT C

30. On January 12, 2003, Patient C, a twelve year old female, was admitted to the Emergency Department at Canton-Potsdam Hospital with a diagnosis of suicidal ideation. Patient C had recently broke up with her boyfriend (Dept's Ex. 5; Patient C's mother, T. 1310-1311).

31. At the time of Patient C's admission, her mother was employed [redacted] (Patient C's mother, T. 1299).

32. Respondent and a nurse, Sue Crump, attended to Patient C while Patient C's mother waited in the break room. Nurse Crump came to the break room and informed Patient C's mother that Respondent wished to talk to Patient C alone. Patient C's mother did not object and Respondent was subsequently left alone with Patient C (Patient C's mother, T. 1313; Respondent, T. 4777-4778).

33. Respondent, while alone with Patient C, among other things, questioned her as to whether she was sexually active, whether anyone had ever touched her vagina or whether she had touched her boyfriend's genitalia or put his penis in her mouth. Patient C answered no to all of these questions except that she acknowledged that she did allow her boyfriend to put his hand down her pants (Respondent, T. 4780; Patient C, 1385).

34. Respondent did not document in Patient C's medical record either his questions or her responses (Dept's Ex. 5).

PATIENT D

35. On November 11, 2002, Patient D, a twenty year old male, was admitted to the Emergency Department at Canton-Potsdam Hospital with a complaint of severe pain when urinating, and frequency (Dept's Ex. 6, pg. 16; Patient D, T. 885-886).

36. Patient D was accompanied to the Emergency Department by his friend, [redacted] [redacted] Patient D, T. 880-881).

37. Patient D was not having discharge from his penis and when questioned by Respondent and others, Patient D gave no history of having discharge from his penis or of having had venereal disease (Patient D, T. 883, 896, 920; [redacted]; Currier, T. 941; Grant, T. 959-960; Dept's Ex. 6, pg. 16).

38. On questioning by Respondent, Patient D told Respondent that he had yellow stains on his underwear. Such questioning is appropriate when a physician suspects venereal disease (Innes, T. 3831, 3870; Braen, T. 2889-2890).

39. The yellow staining plus Patient D's dysuria provided a reasonable basis for Respondent to suspect gonorrhea (Innes, T. 3831, 3870).

40. Respondent's examination of Patient D was conducted with [redacted] in the examining room. After Patient D stated that he had burning pain on urination including pain in his rectum and testicles, Respondent directed Patient D to drop his pants and examined Patient D's testicles. Respondent told Patient D in [redacted] presence that he had gonorrhea (Patient D, T. 883, 885-889; [redacted]).

41. Respondent did not request that [redacted] leave the room before making his diagnosis, or inquire whether Patient D minded if [redacted] remained in the room ([redacted]; Patient D, T. 883, 889).

42. When Patient D stated to Respondent that he had not slept with anyone besides his girlfriend, and that his girlfriend had not slept with anyone since they had been together, Respondent is said to have replied that maybe Patient D's girlfriend was not such "a good girl' ([redacted] Patient D, T. 885-886).

43. Gonorrhea would be the most likely diagnosis for a twenty year old patient with dysuria. The presence of penile discharge, or microbial proof through an adequate microscopic examination, culture or other antibody testing, can form a basis for a definitive diagnosis of gonorrhea (Braen, T. 2852-2853, 2896).

44. A culture had been obtained from Patient D after he urinated. Respondent believed that the urination presumably diminished the efficacy of the culture (Innes, T. 3826-3828, 3894-3895; see also, Grant 961-962; Braen, T. 2853-2855;).

45. Respondent recorded in Patient D's medical record that Patient D had "...history of "clap" in past. Patient with yellow penile discharge." (Dept's Ex. 29, pg. 3 and Ex. 10, pg. 5).

46. Respondent treated Patient D with eight Zithromax tablets, 2 grams po (by mouth) and with one Doxycycline tablet in the emergency room, and prescribed 100 mg. of Doxycycline to be taken twice daily (Patient D, T. 887; Dept's Ex. 20).

47. After leaving the emergency room, Patient D became ill and vomited during the trip back to his [redacted] house. He vomited and had diarrhea when he arrived at the [redacted] house (Patient D, T. 890-891).

48. While Zithromax by mouth can result in side effects such as vomiting and diarrhea, Respondent's treatment of Patient D with the antibiotics he prescribed was within the standard of care for treatment of a presumptive diagnosis of gonorrhea (Braen, T. 2876-2879).

49. Patient D called his girlfriend and asked her to come over. When she arrived, Patient D was still ill and she telephoned Respondent to tell him Patient D was vomiting and had diarrhea (A.5 [Patient D's girlfriend], T. 860-863; Patient D, T. 891-893).

50. Respondent did not advise that Patient D should be reevaluated in the Emergency Department or that his medication regimen should be altered. Instead, Respondent advised that Patient D have some crackers or bread and Maalox (Patient D, T. 893; A.5 [Patient D's girlfriend], T. 863).

51. Respondent did not record this conversation in Patient D's medical record (Dept's Ex. 6 and 29).

PATIENT E

52. On September 10, 2002, Patient E, a seventeen year old female, presented to the Emergency Department at Canton-Potsdam Hospital, with a complaint of back pain after another player collided with her during a soccer match and fell on top of her (Dept's Ex. 7, pg. 3; T. 1135-1136).

53. Respondent ordered x-rays of Patient E's lumbosacral spine and her pelvis (Innes, T. 3769).

54. Respondent told Patient E's parents that the x-rays were negative and that she had contusions and muscle spasms (Patient E's mother, T. 1139; Dept's Ex. 7, pg. 2).

55. Patient E's discharge instructions state that she had a diagnosis of back/pelvic contusion and conjunctivitis of her right eye. She was instructed to take Motrin 600 mg. one tablet by mouth every six hours as needed, and to apply Erythromycin Opthalmic Ointment to both eyes every six hours. Her school discharge information sheet states "no gym for 3 days". (Dept's Ex. 7, pgs. 8, 11).

56. Respondent reviewed the lumbrosacral x-ray but misread it as negative. Respondent learned of the misread when he was contacted by the hospital's radiologist (Innes, T. 3769-3774).

57. Upon returning home, Patient E's mother found that Respondent had left a telephone message to call him. Patient E was still in great pain. When Patient E's mother returned his call, Respondent told her that the radiologist had read the x-ray as showing a compression fracture of lumbar vertebra number one and that Patient E's treatment would remain the same, i.e.- no gym for three days and a warm bathtub or warm compresses (Patient E's mother, T. 1143-1144).

58. There was no pressing need for Respondent to have had Patient E seen by an orthopedic surgeon (Braen, T. 2310). There was nothing more Respondent could have done for Patient E beyond arranging for an orthopedist or Patient E's primary care physician to see Patient E (Braen, T.2321-2324).

59. Patient E had an appointment to see her primary care physician the following day for conjunctivitis (Patient E's mother, T. 1146).

60. Respondent documented the misread of the x-ray and his post discharge conversation with Patient E's mother on a continuation sheet to the medical record which was subsequently lost (Innes, T. 3774-3779).

PATIENT F

61. In the summer of 1998, Patient F, [redacted] was a part time employee [redacted] was employed by [redacted] [redacted] (Patient F, T. 331).

62. On July 24, 1998, the last day of the [redacted] picnic was held for students, parents and other family members and the staff of the [redacted]s at Respondent's house (Innes, T. 4317-4318; Patient F, T. 336-337).

63. Patient F's family had a prior connection with Respondent in his capacity as a physician. [redacted] Patient F's aunt had been brought to the Emergency Department of Samaritan Medical Center. Respondent was the physician there who interacted with Patient F's family. Patient F's family had expressed a very high opinion of Respondent based on their experience with him (Patient F, T. 334-335).

64. Patient F rode with Respondent and his children from the [redacted] to Respondent's house (Patient C, T. 338-340).

65. Respondent asked Patient F about her personal life including whether she had a boyfriend. Respondent asked Patient F how long she had been dating her boyfriend, and Patient F responded that they had been dating for five years, since she was sixteen (T. 343-344).

66. Respondent replied that if she had been dating her boyfriend for so long, she was going to need a "Sugar Daddy" in her life to get the affairs out of her system (T. 344).

67. Respondent raised the issue of a skin rash that Patient F had previously had and suggested that he could check it out with his "bacterial light". Patient F's rash had been on her arm and was no longer causing Patient F problems beyond her putting a little calamine lotion on it (Patient F, T. 341-343).

68. When they arrived at Respondent's home, Patient F was shown around the house. Shortly afterwards, while the children were swimming, Respondent threw Patient F who was wearing a T- shirt and shorts over her bathing suit into his pool. Respondent knew where Patient F's bag was and he brought it to her. Patient F took out her contact

lenses, removed her wet clothing and remained in the pool in her bathing suit. When she emerged from the pool, she put a dry pair of shorts over her bathing suit bottom and participated in the [redacted] (Patient F, T. 349-353).

69. Following the awards ceremony, in front of some of the participants at the picnic, Respondent began speaking about the "bacterial light" and asked Patient F, "Are you ready to see the light now?". Because Patient F trusted Respondent, she agreed in front of these people to see the "bacterial light" (Patient F, T. 354-356; Innes, T. 4324).

70. Respondent testified that he told Patient F "This is a good time for me to take a look at the rash." (T. 4324).

71. Respondent took Patient F to a staircase on the outside of the house that led to the second floor. Patient F went up the staircase, onto the second floor of the house and was then led her around to a back staircase that led to the downstairs of the house and to a tiny room that was off a big recreation room. The room was small, had tools in it and a door. Respondent closed the door of the room behind them and turned on the "bacterial light" which had a handle on it. The light itself looked like a fluorescent tube and glowed a purplish hue. Respondent had turned the room light off, and the "bacterial light" was the only light on in the room (T. 356-358)

72. Respondent asked Patient F to stand with her hands out to her sides and to turn her back to him and when she had, he directed the light down her back and pulled Patient F's shorts and bathing suit bottom away from her body, exposing her buttocks and, then, directed the light on that area (Patient F, T. 358-359).

73. When Patient F turned backed around, Respondent grabbed the top of Patient F's bathing suit and exposed one breast (Patient F, T. 360-361).

74. Respondent, then, grabbed the front of Patient F's shorts and bathing suit and pulled them away from her body, exposing her pubic area, and moved the "bacterial light" so that it shone on Patient F's groin area, and Respondent said "Not even any bacteria down there" (Patient F, T. 361-362).

75. Respondent's conduct during his examination deviated from acceptable medical standards and had no legitimate medical purpose because the rash had been on Patient F's arm and had healed (Braen, T. 2983-2984, 2988).

76. Patient F left the room and was confused and distressed. She remained at the picnic after the parents and children left because her supervisor encouraged her to do so as staff would be discussing the program (Patient F, T. 364-365).

77. After the parents and children left, alcoholic beverages were served and consumed by Patient F and others (Innes, T. 4340-4343).

78. During the course of the latter part of the day, Patient F needed to use the bathroom and Respondent followed her into his house to assist her due to concerns that she was inebriated (Innes, T. 4347-4349).

79. Respondent stated to Patient F, "...You know you're too drunk to go to work. You need to call in to work." (Patient F, T. 376).

80. Subsequently, Patient F, Respondent and a number of other people were sitting around a campfire, and Patient F was eating the salt off a pretzel rod. Respondent remarked that "he would like to see what she could do with a banana" (Innes, T. 4350).

81. Patient F, eventually, told her colleagues, [redacted], about Respondent's conduct toward her that day. She left the picnic shortly thereafter and spent the night at [redacted] (Paitent F, T. 382-386; [redacted]; [redacted]s, [redacted]).

82. Patient F ultimately reported the matter to the state police. Testimony was taken before a grand jury and a trial date was scheduled (Patient F, T. 388-393).

83. Respondent entered into a plea agreement and received an adjournment in contemplation of dismissal including conditions that he obtain counselling, that there be an order of protection for Patient F and that he not make any public statements in contradiction to the following statement which Respondent read in open court;

> On July 24, 1998, my wife and I entertained at our home students who participated in the [redacted] at [redacted] as well as the parents of those students and the moderators of that Program.
>
> In the course of that day, I engaged in conduct, resulting in the charges, that was inappropriate and that was offensive to Patient F[1]. My conduct was uninvited, was my sole responsibility, and was in no way the result of anything that Patient F did.
>
> I apologize to Patient F and to her family.

(Patient F, T. 395-396; Stipulation of parties, T. 396-399; Dept's Ex. 15).

PATIENT G

84. On July 5, 1999 shortly before 11:00 pm., Patient G, a 31 year old female [redacted] presented to the Emergency Department at Samaritan Medical Center in Watertown with a severe right sided headache and nausea. Patient G who had a

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[1] Patient F's name is coded. Her real name was used when Respondent read the statement.

history of migraine headaches was treated by Respondent. The Emergency Department staff typically treated Patient G's headaches with injections of Demerol and Phenergan (Dept's Ex. 25, pg. 4; Patient G, T. 1971-1972).

85. Patient G vomited in the waiting room and was bypassed directly into a room in the back because of the severity of her symptoms (Patient G, T. 1973-1974).

86. Patient G was well known by hospital staff because of her frequent visits for headaches and because of the substantial medication necessary for her migraines (T. 4549-4550).

87. Respondent ordered Demerol 100 mg. and Phenergan 25 mg. to make Patient G comfortable before embarking on a more complete history and physical (Innes, T. 4551: Dept's Ex. 25).

88. Respondent returned about a half-hour later and performed a head to toe evaluation including a basic neurological examination and an examination of the four quadrants of Patient G's abdomen. He used a hand over hand motion to palpate her abdomen and listened to her abdomen with a stethoscope due to concerns about Patient G's vomiting (Innes, T. 4554-4557, 4572-4573).

89. Using a stethoscope, Respondent listened to Patient G's heart. It was unnecessary for Respondent to remove Patient G's bra to do so because she had no pulmonary or chest complaints and he did not have a concern about her lungs. Rather, he was just listening to her lungs and heart as part of a screening evaluation (T. 4555, 4574, 4591).

90. Patient G's husband claimed that when he walked into the examination room, he found Respondent with his hand down Patient G's pants, and that he complained to a nurse who did not respond to his complaint (Patient G's husband, T. 2156-2158).

91. Patient G's husband did not call an administrator, did not go to the nurse's station and complain and permitted a nurse to give his wife a second Demerol injection. Approximately 75 minutes transpired between the time of the 2nd Demerol 100 mg. administration and the time of Patient G's discharge (Patient G's Husband, T. 2153-2161; Dept's Ex. 25).

92. Patient G filed a complaint with Samaritan Medical Center at approximately 9:00 AM the next morning (Patient G, T. 1993-1994).

93. Patient G commenced a civil lawsuit for money damages against Respondent and Samaritan Medical Center and settled the lawsuit against Samaritan Medical Center for a sum of money (Patient G, T. 2057-2060).

94. Patient G's husband testified that he drove up to Respondent's house less than a week after the hospital visit "to beat the shit out of him" but admitted that he gave contrary testimony during his deposition testimony in the civil action because he "didn't think it really mattered." (Patient G' Husband, T. 2151-2152, 2168-2169).

95. The lawsuit against Respondent was tried before a jury which returned a unanimous verdict in favor of Respondent in less than an hour of deliberations. Patient G's subsequent appeal was dismissed because Patient G failed to timely perfect the appeal (T. 2065-2066; Resp Ex. C and C-1).

96. Prior to Patient G's presentation on July 5, 1999 to the hospital, she read in the newspaper about the Patient F allegations. Furthermore, the sexual harassment lawsuit commenced by employee H had received prominent billing in the local newspaper (T. 2097, 4560-4563).

97. On two occasions, Tamara Robinson, an emergency room clerk, observed Patient G and [redacted], Employee H, to be deep in conversation. One occasion occurred in the spring of 1999 (T. 2785-2786, 2816, 2817).

98. Mabel Walker is involved with numerous civic organizations in the Watertown area including numerous committees which operate in conjunction with Samaritan Medical Center. She is not an employee of the hospital and has no official capacity or business in which she deals with patient complaints (Walker, T. 2177-2185).

99. Respondent disclosed to Ms. Walker that Patient G had complained about his care, and asked Ms. Walker to arrange a meeting between Patient G and himself to discuss her concerns and resolve the complaint. Ms. Walker knew that Respondent would have cared for Patient G in the Emergency Department (Innes, T. 4563-4565, 4578-4581).

100. Patient G ultimately received a telephone message from [redacted] who had been contacted by Ms. Walker, and who had worked with Patient G in [redacted] Patient G decided to tape record the conversation when she returned the telephone call to Ms. Jones (T. 2004-2010).

101. Patient G and her husband bought a "tap" at Radio Shack and attached it to their phone and returned Ms. Jones' telephone call (Patient G, T.2008-2009).

102. [redacted] told Patient G that she knew Patient G had "a problem with a doctor in the Emergency Room", and that a friend of hers, whom she later identified as Mrs. Walker, knew the doctor and had asked if she [[redacted]] could call Patient G and talk to her. [redacted] said Mrs. Walker "had related this story about your [Patient G's] problem", and intimated that she knew what had happened to Patient G by hearing it from others. [redacted] told Patient G that Mrs. Walker said that Respondent was very

worried that Patient G would pursue her complaint and that he would lose his medical license (Patient G, T. 2079-2080; Dept's Ex. 16).

EMPLOYEE H

103. Employee H was originally hired by Samaritan Medical Center [redacted] and was employed in that capacity from [redacted] until [redacted] (Employee H, T. 539).

104. Employee H worked for [redacted]. On one occasion, [redacted] returned to her office to find a three page note from Employee H saying that [redacted] was using her and was not paying her fairly. As a result, Employee H walked off her job temporarily. There was a problem with absenteeism due to Employee H's migraine headaches (Reid, T. 2727, 2730-2733).

105. When Respondent became [redacted], Employee H applied [redacted]. She was ultimately hired [redacted] (Employee H, T. 539-541).

106. Employee H was an employee of Samaritan Medical Center which paid her salary out of the nurse manager's budget (Employee H, T. 544; Nichol, T. 2525-2526).

107. Respondent and Employee H engaged in jovial teasing. Respondent could be a little salty at times and made remarks such as "Blow me." (T. 3345- 3346). .

108. In the fall of 1998, Employee H asked Respondent if there was anything that she could do for him, and he responded, "if you want to help my day, give me a blow job." Employee H left the office and walked to the nearby minor treatment or Fast Track area where Martha Loveland worked (Employee H, T. 563-564; Loveland, T. 769, 772).

109. Employee H told Ms. Loveland that Respondent had asked her for a blow job (Loveland, T. 771, 779-780; Employee H, T. 564).

110. Kathryn Nichol was a staff nurse at Samaritan Medical Center beginning in 1981 and assumed the position of nurse manager in March 1998. She had daily contact with Employee H (Nichol, T. 2520-2521, 2525-2526).

111. Employee H frequently complained to Ms. Nichol about Dr. Naradzay who was [redacted] and about her personal problems including financial difficulties, child support issues and her ill mother (Nichol, T. 2527-2537).

112. Employee H suffered from serious migraine headaches and cared for her ill mother. As a result, she missed substantial work time and at one point was hospitalized for four days. Employee H requested that physician notes be placed in her personnel file to substantiate that her absences were due to ill health (Employee H, T. 579-580, 667-672; [redacted]).

113. Employee H testified that she needed more income to pay her bills (Employee H, T. 581).

114. Employee H was unhappy with Respondent because [redacted] (Employee H, T. 646-650).

115. Employee H felt intimidated and threatened by Dr. Naradzay and complained to Respondent about Dr. Naradzay being demeaning at times (T. 657-659).

116. Employee H frequently confided in [redacted] and sought her help and advice even after she began working for Respondent. While Employee H complained about Respondent occasionally, the complaints concerned [redacted] and were never of a sexual nature. Employee H had positive things to say about Respondent whom she viewed as a very generous person with staff ([redacted]).

117. Employee H found an e-mail from Respondent to Tim Ryan, Director of the Human Resources Department, dated March 18, 1999, which had been left on her desk by a third party. The e-mail requested information on helping Employee H obtain disability due to her severe migraines. Respondent stated that "[redacted]" (Resp's Ex. G; Employe H, T. 583-585, 685).

118. Via a May 6, 1999 letter, Employee H resigned from her position at Samaritan Medical Center. Employee H stated that she found it necessary to resign due to her "moral, ethical and personal convictions", and noted she had "[redacted]" (Resp's Ex. E).

119. Employee H's last day of work was on May 21, 1999. Although Employee H had not discussed a lawsuit with management before her exit interview, she filed a civil lawsuit seeking millions of dollars in damages for 10 different causes of action, including sexual harassment, against the hospital and Respondent, within 3 days of her departure (Employee H, T. 590-591, 612-615, 720-725).

120. Ms. Nichol was surprised by Employee H's resignation and assumed it was related to her poor working relationship with Dr. Naradzay. Furthermore, Employee H was having significant problems with absenteeism as the result of health problems. Ms. Nichol was surprised when she learned of Employee H's lawsuit as she had no knowledge of the alleged sexual misconduct by Respondent (Nichol, T. 2526-2531).

121. [redacted] was not surprised that Employee H quit her job but was surprised that she claimed the resignation was related to sexual harassment, and that she had filed a sexual harassment lawsuit [redacted].

122. [redacted] last contact with Employee H was a phone message in 2003 in which Employee H asked for her help in her lawsuit against Respondent (Reid, T. 2745-2749).

123. Employee H never put anything in writing about the ongoing sexual harassment by Respondent (Employee H, T. 610).

124. Employee H gave Respondent numerous presents during the period in which the alleged harassment occurred, i[redacted] (Employee H, T. 697).

125. Employee H was not afraid of speaking her mind to Respondent, and on one occasion, slapped him because she was outraged at his comments (Employee H, T. 28-629).

126. Employee H was observed, on at least two occasions, in conversation with Patient G prior to the commencement of lawsuits by Patients G and H against Respondent (Robinson, T. 2786-2790).

127. Employee H requested that a co-worker, Christine Hopkins, pretend she was a newspaper reporter, and asked her to interview and photograph a woman whom she suspected was having an affair with her husband, so that Employee H could pass out brochures warning others that the woman could be stalking him. She also complained that people were going through her drawers and things were missing from her office, and that she was concerned that a co-worker was trying to take her job (Hopkins, T. 3298, 3301).

128. Shortly after Employee H resigned, she approached Ms. Hopkins and asked that she join her in a lawsuit against the hospital and Respondent. Employee H suggested that because previous lawsuits had settled out of court, it was as if Respondent had pled

guilty and people would be more apt to believe them than Respondent (Hopkins, T. 3303-3309; [redacted] 2745-2749).

129. Employee H settled her lawsuit with the hospital. Her lawsuit against Respondent was ultimately dismissed (Employee H, T. 591-596, 716-717).

130. Respondent shared e-mail jokes and cartoons with Employee H which had sexual overtones but none were graphic or pornographic (Innes, T. 4451-4452, 4478).

131. Ms. Hopkins was a recipient of an e-mail Christmas card which Employee H claimed to have found upsetting. The e-mail was not sexually explicit, was not pornographic, was "cute", and Ms. Hopkins even forwarded it on to her mother (Hopkins, T. 3296-2397).

EMPLOYEE I

132. Employee I, [redacted] at Albany Memorial Hospital in 1991, was evaluated by Respondent as part of an employee exam which took place in an examination room at the hospital (Employee I, T. 1699, 1706; Innes, T. 4094).

133. Employee I's examination would normally have been conducted by Mike Briggs, a physicians' assistant who was out of work that day (Employee I, T. 1704).

134. As Associate Director of the Albany Memorial Employee Health Department, Respondent performed physical examinations from time to time (Innes, T. 4094).

135. Respondent insisted that Employee I put on a gown for her examination but Patient I refused (Employee I, T. 1721; Innes, T. 4095-4096).

136. Respondent unhooked Employee I's bra (Innes, T. 4096).

137. Respondent pushed up Employee I's bra in a manner which exposed her breasts (Employee I, T. 1709).

138. Employee I then terminated the examination and left the examination room (Employee I, T. 1709-1710).

139. Respondent commented that "Today's my lucky day.,, Michael would be upset he wasn't here today" (Employee I, T. 1713).

140. After Employee I left the room, Respondent shouted down the hallway "You're fucking crazy" (Employee I, T. 1710-1711).

141. Employee I eventually entered a formal written complaint against Respondent (Employee I, T. 1713-1714).

142. Respondent was employed at Albany Memorial Hospital through Capital Region Emergency Medicine, P.C. ("CREM") (Innes, T. 4136-4138).

143. Following Employee I's complaint, Respondent signed a Memorandum of Agreement on July 25, 1991 between CREM and himself. Among other things, Respondent agreed to "...immediately and continually examine his practice of medicine to ensure that his behavior and procedures could not be misperceived by any patient as having a sexual implication beyond what is professionally and clinically appropriate. In particular, all female patients will be prepared for physical examination by undressing in privacy or with assistance of the nursing staff...". A breach of this agreement could result in his termination from CREM (Dept's Ex. 11A).

EMPLOYEE J

144. Employee J began working as a registered nurse in the [redacted] at Albany Memorial Hospital [redacted] and continued working there [redacted] (Employee J, T. 1734-1735, 1745).

145. Respondent was Assistant Director of the Emergency Department (Employee J, T. 1735-1736).

146. Employee J had suffered whiplash as a result of an automobile accident and frequently rubbed her neck to relieve headaches and muscle spasms. Respondent offered to give Employee J a neck message after he observed her rubbing her neck and she complained of headaches (Employee J, T. 1736-1737).

147. Respondent brought Employee J to a room in the Urgent Care Department which was linked to the Emergency Department, and asked Patient J to put on a gown which she did (Employee J, T. 1737).

148. Employee J was wearing only her underpants beneath the gown (Employee J, T. 1738).

149. Respondent closed the door and began to massage Employee J's neck with heated lotion while she was lying on her stomach (Employee J, T. 1739-1740),

150. Respondent asked Employee J to turn over on her back and proceeded to pull her gown down just above her breasts and started massaging all over her body and brushed against her breasts and crotch area (Employee J, T. 1740-1741).

151. During the summer of 1993, Respondent held a pool party at his house for the [redacted] staff which Employee J attended (Employee J, T. 1745-1746).

152. While Employee J and Respondent were in his pool, Respondent put his hand inside Employee J's bathing suit on her crotch. Employee J pulled away (Employee J, T. 1747-1748).

153. Employee J had to use the bathroom. Respondent offered to bring her upstairs to the bathroom at which time he attempted to kiss Employee J and put his hand on her buttocks (Employee J, T.1748).

154. Employee J pulled away and said, "Your wife is here. What are you doing?" (Employee J, T. 1749).

155. Sexual advances by a physician in a position of authority toward a subordinate may constitute conduct in the practice of medicine evidencing moral unfitness to practice medicine even outside the hospital setting (Braen, T. 3004-3009).

EMPLOYEE K

156. Employee K was employed at Albany Memorial Hospital [redacted] of the Emergency Department, from approximately [redacted] (Employee K, T. 102).

157. Employee K reported directly to Respondent, who was the Assistant Director of the Emergency Department, and to Dr. Sosnow, who was the Director of the Emergency Department (Employee K, T. 104).

158. On one occasion, Respondent, in Employee K's presence, and in the presence of other staff, made a comment about "running a bordello" and that "Employee K can be the main whore." (Employee K, T. 108, 133).

159. Employee K perceived the remark as an attempt at humor rather than as a proposition, but she did not find the remark funny. The remark was made in a group context where everyone was laughing and joking (Employee K, T. 108, 135).

160. Respondent, on another occasion, was walking by Employee K and said to her "Oh, Employee K, let's just get it over and have our affair." (Employee K, T. 107).

161. On another occasion, Respondent and Employee K were working a shift in the Emergency Department and Respondent commented that "Employee K wouldn't know what a big penis is because she's married to an Oriental." Employee K was infuriated but understood that Respondent was "joking around" (Employee K, T. 109-110).

162. On another occasion, Respondent and Employee K were sitting on chairs in the Emergency Department when Respondent leaned back and put his feet on Employee K's lap (Employee K,T. 111-112).

163. The instances cited above were not part of an ongoing pattern of conduct by Respondent toward Employee K (Employee K, T. 113,156).

NURSE M

164. Nurse M has worked in the Emergency Department at Albany Memorial Hospital [redacted]. In the mid-[redacted] Nurse M was a [redacted] in the Emergency Department (Employee M,T. 194-196).

165. Respondent testified that he had a consensual sexual relationship with Nurse L during his tenure at Albany Memorial (Innes, T. 4297).

166. The end of Respondent's relationship with Nurse L resulted in a lawsuit against Respondent and Memorial Hospital. The Emergency Department was divided into two camps, those for Nurse L and those for Respondent (Nurse M,T. 235-236; Innes, T. 4297-4298).

167. Nurses M and L worked together and maintained a close personal, social relationship both inside and outside of the hospital (Eckstein, T. 191; Nurse M, T. 196-198, 219).

168. In 1995, Nurse L complained to Nurse M that Respondent had sexually harassed and sexually abused her. Nurse M put this nurse into triage so that she could avoid Respondent (Nurse M, T. 196-198).

169. Nurse M disclosed Nurse L's complaint to the Clinical Coordinator, Ms. Eckstein, who then reported the allegations against Respondent to the Nurse Director (Nurse M, T. 198-199; Eckstein, T. 181-185).

170. A few weeks after Nurse M reported the allegations to hospital administration, Respondent approached Nurse M while she was alone in the dirty utility room and stood between Nurse M and the room's door which was closed. However, Respondent did not block her from leaving the room (Nurse M, T. 201-203; Innes, T. 4302-4303).

171. Respondent and Nurse M discussed that both he and Nurse L were married. Respondent said that he was aware Nurse M knew his family, and that Nurse M was hurting Respondent's wife and children by speaking of the allegations against him. Nurse M replied that she was not hurting Respondent's family but that his actions could harm his family, and that the complaining nurse had a family, too (Nurse M, T. 203-204).

172. When Respondent stated that he could not count on Nurse M, Nurse M said that Respondent could count on her for one thing, and that was to tell the truth (Nurse M, T. 204).

173. Respondent, then, told Nurse M that he knew many things about her including her whereabouts and routines, when she came to work and when she left, and the days that Nurse M was working. Respondent, also, told Nurse M that he knew that her daughter was home alone when Nurse M was not at home (Nurse M, T. 205, 222-223).

174. Nurse M reported her encounter with Respondent in the dirty utility room to the Nurse Director and to the Clinical Coordinator. She specifically reported to the Clinical Coordinator that Respondent had threatened the safety of her daughter if Nurse M were to continue to talk about the allegations (Nurse M, T. 207-208; Eckstein, T. 187).

175. Prior to this incident, Respondent had done a number of kindnesses for Nurse M's daughter. [redacted] (Nurse M, T. 206).

176. Nurse M believed Respondent was a "pretty good" doctor (Nurse M, T. 215).

177. Although Nurse M claims that she felt threatened for her daughter based on the incident in the dirty utility room, she never reported the incident to the police or to the hospital. Respondent never came by her house, and she never initiated any type of legal proceedings to obtain a restraining order against him (Nurse M, T. 232).

NURSE N

178. Nurse N has been employed as a registered nurse at St. Peter's Hospital in Albany, New York [redacted], when she began working in the Emergency Department at St. Peter's, Nurse N was approximately 25 years old (Nurse N, T. 290-291).

179. On one occasion, Respondent told Nurse N that he needed to discuss a patient with her and brought her into an office. Nurse N was fearful that she had made a patient care error. Respondent closed the door, grabbed her, kissed her full on the mouth without her consent and stuck his tongue in her mouth. Nurse N was taken completely by surprise and left the room (T. 292-295).

180. Nurse N was greatly upset by this incident and felt that Respondent brought her alone into an office under false pretenses. She reported this incident to Dr. Wales, the Director of the Emergency Department who laughed and said "Oh, that's just George." After receiving this reaction from Dr. Wales, Nurse N did not pursue reporting the incident (T. 294).

PATIENT (NURSE) O

181. Nurse O, an R.N., worked in [redacted] at St. Peter's Hospital, and then was employed full time in the Emergency Department [redacted]. Respondent was a staff physician and Nurse O took orders from him (Nurse O, T. 1647-1650).

182. After hearing Nurse O complain of back pain, Respondent told Nurse O that he had a special treatment for back pain and that Nurse O should go into a treatment room. He said that he would heat Keri lotion in the microwave and then come into the treatment room. Nurse O went into the treatment room, removed her bra, put on a gown and lay down on her stomach (Nurse O, T. 1650-1653).

183. Nurse O was unconcerned about going into the examination room with Respondent because it was a sub acute area with glass doors, and there were patients and a nurse outside (Nurse O, T. 1656).

184. Respondent entered the room, closed the door and curtain, and was alone with Nurse O. He applied some warm Keri Lotion to Nurse O's upper back and worked on the muscles there. He, then, told Nurse O to turn over on her back, so that he could work on the muscles on the top part of her back, in the front (Nurse O, T. 1653-1655).

185. After Nurse O turned over, Respondent began massaging Nurse O's breasts very hard, in a wild groping manner. Nurse O was shocked and told Respondent to "Stop that right now. I am not going to do this." (Nurse O, T. 1654, 1657-1658, 1690).

186. Shortly after these events, Nurse O informed a physician named Sherry Praska about the incident with Respondent (Nurse O, T. 1659, 1679).

187. When Respondent left St. Peter's Hospital to take a position at Albany Memorial Hospital in 1990, Nurse O received a telephone call from one of the administrative nurses at St. Peter's Hospital who asked Nurse O if Respondent had molested her. Nurse O told the administrative nurse that Respondent had molested her and described what Respondent had done to her (Nurse O,T. 1661-1662, 1681-1682).

188. Nurse O occasionally worked at [redacted]. When Respondent began his employment there, the [redacted] nurses asked Nurse O what Respondent was

like, and she replied "Just don't let him examine you." Nurse O was subsequently informed by her agency that she could no longer work at [redacted] (Nurse O, T. 1666).

189. Prior to the incident with Respondent, Nurse O noticed Employee P limping and recommended to her that she obtain a Keri lotion treatment from Respondent for her sciatica pain as Respondent had "helped a lot of people with sciatica" (Nurse O, T. 1671; Employee P, T. 33-35).

PATIENT (EMPLOYEE) P

190. Employee P received her registered nurse's degree in [redacted] She began working at St. Peter's Hospital [redacted] at the age of twenty-two (Employee P, T. 31-32).

191. Respondent was working at St. Peter's Hospital as an ER physician in 1988 when Employee P was an [redacted] (Employee P,T. 32).

192. Employee P had a problem with sciatica which caused her to have pain down the right side of her body, including pain in her posterior hip, down the back of her leg and into the knee (Employee P, T. 33).

193. After her conversation with Nurse O, Employee P spoke to Respondent about her sciatica. He told her that he would help her and directed her to an examination room. The room had three solid walls and a curtain, and was off to the side of the Emergency Department. Employee P went into the room, put on a patient gown and left on her bra, her underpants and her socks, and lay down on her stomach (Employee P, T. 34-36).

194. Respondent entered the room with lotion that he had warmed in the microwave and began rubbing the lotion on the back of Employee P's leg and on her hip, in areas where she had pain (Employee P, T. 37).

195. Respondent then told Employee P to turn over onto her back and when she did so, he removed her underpants (Employee P, T. 37).

196. Respondent put Employee P's foot on his shoulder, moved his hands from the outside of Employee P's leg where her pain was located and began to move his hands up the inner side of her thigh all the way up to her groin and very close to her pubic area (Employee P, T. 38).

197. When Employee P said "The pain is on the outside of my leg", Respondent just said "Sh-h-h". Employee P said again "The pain is on the outside" and jerked her leg away from Respondent and concluded the examination (T. 38-39).

198. Respondent then went to the sink and began washing his hands and stated, "You know what your problem is...you need to get fucked more", and walked out (Employee P, T. 39).

199. After this incident, Employee P continued to work as [redacted] from 4 P.M. to midnight. During the last hour of her shift, from 11 P.M. to midnight, she was the only [redacted] on duty until the midnight shift arrived. During the hour that Employee P was alone, Respondent would bring his own patients over from the Emergency Department to be [redacted] which was not the usual practice of the Emergency Department physicians (Employee P,T. 41).

200. On a number of occasions when Employee P [redacted] Respondent would come into the [redacted] and stand between Employee P and the door. He would not let her past him and would ask her for a kiss.

Employee P would say "No", Respondent would block her path and would get up very close to her face, and tell her that he would let her pass if she would kiss him. Employee P would continue to refuse, and eventually would get past Respondent and out of the [redacted] (Employee P, T. 41-42).

201. Employee P eventually changed her hours to 3 pm to 11 pm to avoid these situations with Respondent (Employee P, T. 43-44).

202. Employee P eventually told her sister, [redacted] about what Respondent had done to her in the treatment room (P.P., T. 90-93).

203. In approximately [redacted], after Employee P had become a registered nurse and was working at St. Peter's, she saw Nurse O for the first time in many years and said sarcastically, "Oh by the way, thanks a lot for your referral" in reference to seeking Respondent's help for her sciatica. Employee P told Nurse O what Respondent had done to her and Nurse O became very upset and apologized for sending Employee P to Respondent (Employee P, T. 48-50).

FACTUAL ALLEGATION Q

204. In August 1999, Respondent's attorney employed Richard B. Krueger, M.D., to evaluate Respondent for the purpose of doing a psychiatric evaluation and preparing a report which would be furnished to Respondent's attorney. Dr. Krueger advised Respondent that the report could be forwarded to OPMC and Respondent agreed to this (Innes, T. 4473-4474, 4510-4511; Pet. Ex. 8).

205. Dr. Krueger sent his report, dated September 1, 1999, to Respondent's attorney, who sent it to OPMC on October 11, 1999 (Pet. Ex. 8; Stipulation by Respondent).

206. Respondent represented to Dr. Krueger that he had had no sexual complaints against him prior to the complaint by Patient F. Dr. Krueger wrote in his report, "Of

great note is that the patient has had no prior sexual complaints other than before (sic) the complaint of a young woman in the summer of 1998", and that "Dr. Innes consistently denied any sexual motivation or abuse of staff or patients." (Dept's Ex. 8, pg. 12-13).

207. Dr. Krueger recommendations placed importance on and were based in part upon Respondent's representation that other than the incidents in Watertown, he had no complaints against him of sexual harassment (Dept's Ex. 8, pg. 13-14).

208. The "Memorandum of Agreement" concerning Employee I which Respondent entered into in 1991 included the following language: "In the event further allegations of sexual harassment or sexual impropriety arise, these allegations will be reviewed by the President of Capital Region Emergency Medicine, the President of Albany Memorial Hospital, and the Vice President of Human Resources of Albany Memorial Hospital. If in the opinion of these persons the allegations are found to be of merit, Dr. Innes will agree to submit his resignation to Capital Region Emergency Medicine." (Dept's Ex. 11A).

209. At a July 23, 1991 meeting with administration at Albany Memorial Hospital concerning the Employee I allegations, Respondent proposed that if administration believed his intent toward Patient I was not sexual, he would remain at the hospital. Otherwise, he would leave (Dept's Ex. 24).

210. A July 25, 1991 Albany Memorial Hospital Memorandum of Record described the Patient I incident as involving the removal of clothing by Respondent which caused "embarrassment and great concern". The memorandum stated that the incident did not involve improper contact or touching of her breasts (Dept's Ex. 11).

211. Respondent, during the years of 1991 through 1996 while he was Associate Director of the Emergency Department at Albany Memorial and Vice President of CREM, was sued for sexual harassment by a nurse employed by Albany Memorial who filed a complaint alleging sexual harassment with the State Division of Human Rights (Dept's Ex. 23; T. 1761-1765).

212. Respondent believed that due to a confidentiality agreement, he was prohibited from discussing the sexual harassment complaint with Dr. Krueger (Innes, T. 4514).

FACTUAL ALLEGATIONS R,S AND T

213. Respondent submitted an Application for Appointment to the Hospital at Sidney, New York on April 1, 2003. On that application, Respondent did not check either "Yes" or "No" in response to the question "Have you ever voluntarily or involuntarily terminated your medical staff membership at any other organization?". Instead, Respondent wrote in long hand "At the end of each contract" in answer to the question (Dept's Ex. 13, hand numbered pgs. 22, 27).

214. On January 31, 2002, Respondent entered into an "Employment Contract for Emergency Department" with Geneva General Hospital and Soldiers and Sailors Memorial Hospital which are part of Finger Lakes Health (Dept's Ex. 12, hand numbered pgs. 9, 23).

215. The contracts were to remain in full force and effect until June 30, 2003 (Dept's Ex. 12, hand numbered pgs. 15, 29).

216. Respondent resigned on May 8, 2002 as an Emergency Room physician for Finger Lakes Health (Dept's Ex. 12, hand numbered pg. 2).

217. Respondent's employment contract with Finger Lakes could be terminated without cause by either party (Dept's Ex. 12, hand numbered pgs. 15, 29).

218. Respondent's resignation was at his own option pursuant to his employment contract, was not for cause and was unrelated to patient care issues (Hanks, T. 1458-1462).

219. There was no formal complaint filed with the Chief Medical Officer or the Credentials Committee of Finger Lakes Health regarding inappropriate behavior by Respondent in the clinical setting (Hanks, T. 1439).

220. In the year 2000, Respondent was employed by the Division of Rural Emergency Medicine ("DCREM"), and through that group, worked at the Via Health hospitals at Newark Wayne and Myers (Stroman, T. 1489-1491).

221. Via Health lacked the capacity to terminate Respondent's employment because he was employed by DCREM and not Via Health (Stroman, T. 1490-1491).

222. In August of 2001, following the Patient A incident, Via Health, pursuant to its contract with DCREM, requested that DCREM cease scheduling Respondent for work at Via Health's hospitals which request was carried out (Stroman, T. 1498-1499).

223. Respondent filed a statement as part of his Sidney application detailing that he was investigated by OPMC in connection with various allegations (Dept's Ex. 13, pgs 16, 30).

224. Respondent submitted an Application for Appointment to the Medical Staff, dated April 22, 2002, to Canton-Potsdam Hospital ("Canton") in which he was asked a question with regard to his prior hospital medical staff membership which read "...has your membership, association, employment or practice ever been limited, suspended, revoked, not renewed, granted with stated limitations or voluntarily suspended?"

Respondent checked "No" in response to the question (Dept's Ex. 14, hand numbered pgs. 7, 8).

225. As part of the Canton application, Respondent submitted a statement concerning the OPMC investigations which stated, "...my record is currently spotless. There are no restrictions or censures recorded." (Dept's Ex. 14, hand numbered pg. 9, first paragraph).

226. On the Canton application, Respondent, also, checked "No" in response to the question, "Have you ever been refused membership on a hospital, medical or dental staff, association, employment, or practice at another facility, or has your membership, association, employment or practice ever been limited, suspended, revoked, not renewed, granted with stated limitations or voluntarily surrendered?" (Dept's Ex. 14, hand numbered pg. 7, third question from top).

227. Respondent checked "No" in response to another question on the Canton application, "Have your privileges at any hospital ever been suspended, denied, diminished, revoked, not renewed, or voluntarily surrendered?". (Dept's Ex. 14, hand numbered pg. 7, fourth paragraph).

228. No actions were taken against Respondent's hospital privileges at Via Health (Stroman, T. 1511; Innes, T. 4211-4214).

FACTUAL ALLEGATION U

229. Respondent began working at the Hospital at Sidney in June 2003, initially as the Chief Medical Officer and eventually as the CEO (Innes,T. 4745-4746).

230. Respondent was a guest speaker at a banquet for the Unadilla EMS squad, on May 1, 2004 (Employee Q, T. 3198-3199).

231. Following the banquet, Employees Q and R and Jenna Ponnwitz and Pamela McClenon, EMTs with the Sidney Fire Department, went to the Community Lounge, a local bar. Respondent arrived about an hour later (Employee Q, T. 3200; McLenon, T. 3665-3666; Ponwitz, T.3688).

232. Upon arriving at the bar, Respondent joined Ms. McClenon, her husband and Ms Ponnwitz (McLenon, T. 3665-3666).

233. Everyone was buying drinks that evening including Respondent (McLenon, T. 3677; Employee Q, T. 3201).

234. Employee Q, Ms. McClenon and Ms. Ponnwitz heard Employee R complain to Respondent about her job (Employee Q, T. 3241; Ponwitz, T. 3688-3689; McLenon, T. 3667; Innes, T. 4752).

235. At one point, Ms. McLenon observed Employee R make a remark to Respondent which caused considerable consternation at the bar (McLenon, T. 3668-3670).

236. Recognizing that Employee R had been drinking, Respondent promised that he would let her know if he heard about any jobs. He stepped outside with Ms. McLenon and Ms. Ponnwitz to get away from Employee R (Innes, T. 4750-4753).

237. Several days later, Respondent called Employee R into his office and stated that it might be possible for her to work with her friends, Employee Q and Shannon, in the next few months. During this conversation, the door to Respondent's office was open (Employee R, T. 3036-3038).

238. Respondent discussed employment opportunities with both Employees Q and R. The Department was being reorganized, the hospital was using an expensive consultant temporarily and was looking for a permanent person, and Respondent felt that Employee Q had the right abilities and qualities to take over. She was familiar with

troubleshooting, software and hardware and understood how the network functioned (Employee Q, T. 3236; Innes, T. 4754-4755).

239. Regarding Employee R, Respondent felt she had good computer skills and was hopeful the position could be filled before the current employee left for purposes of training. He sent Employee R an E-mail on June 24 with the subject "stop by my office" and which stated "I want to talk to you about a job." The E-mail discussed only the employment opportunity and did not suggest any quid pro quo (Innes, T. 4755-4756; Dept's Ex. 31).

240. On July 29, 2004, Employees R and Q filed Sexual Harrassment and Anti-Discrimination Complaint Forms with the hospital, after speaking to each other. They listed each other as witnesses to the offensive conduct (Dept's Ex. 33 and 34; Employee R, T. 3054; Employee Q, T. 3223).

241. The complaints occurred after Employee Q learned that people were saying that she and Respondent had been out together (Ex. 34; T. 3271-3273).

242. Employee Q did not leave her position at the hospital until after Respondent was terminated (Employee Q, T. 3195-3196, 3228).

FACTUAL ALLEGATION V

243. Employee S began her employment at The Hospital at Sidney [redacted] and eventually accepted a management position in the [redacted]. In her management position, she had daily interaction with administration, including Respondent who was the CEO (Employee S, T. 3090-93092).

244. On one occasion, Employee S was in a hospital meeting talking about a CT machine, and Respondent said to those present "We'll get you vibrating heated chairs and then you'll never want to leave." Employee S was the only female present in the

meeting. Senior team members, members of the staff, and outside salespeople were present (Employee S, T. 3098-3100; Innes, T. 4822).

245. On another occasion, in either December 2003 or January 2004, when Employee S was sitting at the conference table in Respondent's office, Respondent said to Employee S, "If you were the type of woman that dated married men, you would be the first on my list." Employee S replied "Well, we both know I'm not that type of person." (Employee S, T. 3101-3102).

246. On the same occasion, when Employee S mentioned that she was planning a trip to Florida, Respondent said, "Make sure you bring me back pictures of you in your bikini." (Employee S, T. 3102-3102).

247. In the winter of 2004, after Employee S became sick with a respiratory infection, Respondent gave her samples of an antibiotic, Levaquin, because she had a significant infection. Respondent, at that time, examined Employee S in the Emergency Department, in the usual patient treatment area and listened to her chest. He did not unhook or remove her bra, and he did not expose her breasts in any way (Employee S, T. 3105-3107).

248. On a later occasion when Employee S was still coughing and feeling ill, Respondent said to Employee S, "Maybe I should listen to your chest; maybe you're getting sicker." (Employee S, T. 3107-3108).

249. Respondent examined Employee S in his office. After Respondent had listened to Employee S' chest from the back, he suddenly and without warning unhooked Employee S' bra and pulled up her bra and shirt, exposing her breasts, and listened to her chest. Employee S' breasts were completely exposed (Employee S, T. 3108-3111).

250. Employee S ultimately told Christine Porter, her Senior Administrative Representative and the Director of Patient Care Services, about Respondent's exposure of her breasts. Employee S, then, filed a formal complaint with the hospital administration (Employee S, T. 3121-3123).

251. In May 2004, Respondent apologized to Employee S in Respondent's office in the presence of Ms. Porter (Employee S,T. 3124).

252. During the apology, Respondent acknowledged that he unhooked Employee S's bra, and he apologized for making Employee S feel uncomfortable (Employee S, T. 3125-3126).

RESPONDENT AND CPH

253. Respondent, pursuant to a contract he entered into with the Committee for Physicians' Health (CPH), has been in treatment with Linda Land, a CSW, since October 2001 (Land, T. 3518-3519; Resp. Ex. Z).

254. If CPH is made aware that a physician is out of compliance with his CPH contract, CPH is required to report the noncompliance to OPMC (Land, T. 3519-3521).

255. Respondent, on or about April 23, 2002, signed an Addendum to Conditions for Participation in the Committee for Physicians' Health which set forth the behavioral expectations that Respondent must meet to remain in compliance with his CPH contract (Land, T. 3547-3549; Resp. Ex. Z).

256. Among other things, Respondent agreed that he would treat all patients and staff with dignity regardless of the circumstances, refrain from sexual innuendos and sexual harassment, and avoid actions of intimidation or seduction including sexual advances, for any reason (Resp. Ex. Z; Land, T. 3548-3550).

257. Respondent did not report the allegations at the Hospital at Sidney to Ms. Land (Land, T. 3636).

FACTUAL ALLEGATION W

258. On August 7, 2004, Respondent sent an e-mail to Terry Watkins, Chairman of the Board of the Hospital at Sidney, with a copy to Kevin Haughney, CFO and Acting CEO, in which he requested that none of the recent events be reported to the Committee on Physician's Health or OPMC "or my license is gone." (Dept's Ex. 32; Innes, T. 4839-4842).

259. Respondent had already been terminated from the hospital at the time he sent the August 7, 2004 e-mail (Innes, T. 4762).

DISCUSSION

Respondent is charged with fifty five specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct that constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the former General Counsel for the Department of Health. The memorandum, which is entitled "Definitions of Professional Misconduct Under the New York State Education Law ", sets forth suggested definitions for negligence and fraudulent practice.

The following definitions, taken from this memorandum, were utilized by the Committee:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S. 2d 381 (3d Dept. 1993). It

involves a deviation from acceptable medical standards in the treatment of patients. Injury, damages and proximate cause are not essential elements in a medical disciplinary proceeding. (Id.).

Practicing the Profession Fraudulently involves the intentional misrepresentation or concealment of a known fact, in some connection with the practice of medicine and made with the intent to deceive. An individual's knowledge that he or she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. Fraud is also a statement or representation made with reckless disregard as to the truth of the statement or representation.

The attorneys and the Committee were instructed by the the Administrative Law Judge that in order for the Committee to sustain an allegation of moral unfitness, the Department must show that Respondent committed acts which "evidence moral unfitness". There is a distinction between a finding that an act "evidences moral unfitness" and a finding that a particular person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Committee is asked to decide if certain conduct is suggestive of, or would tend to prove, moral unfitness. The Committee is not called on to make an overall judgment regarding Respondent's character. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgment or a temporary aberration.

The standard for moral unfitness in the practice of medicine is twofold. First, there may be a finding that the accused has violated the public trust which is bestowed by virtue of the Respondent's licensure as a physician. Physicians have privileges which are are available solely due to the fact that they are physicians. The public places great trust in physicians solely based on the fact they are physicians. For instance, physicians have

access to controlled substances and have billing privileges that are available to them solely because they are physicians. Patients are asked to put themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment. Hence, it is expected that a physician will not violate the trust the public has bestowed upon the physician by virtue of the physician's professional status. Second, moral unfitness can be seen as a violation of the moral standards of the medical community which the hearing committee as delegated members of that community, represent (see paragraphs #18 and 19 at pages 11-12 of the Hearing Committee's Decision and Order in Matter of Steven St. Lucia, M.D. affirmed by the Appellate Division at 284 A.D. 2d 591, 726 N.Y.S. 2d 488 (3d Dept, 2001).

WITNESSES

The Administrative Law Judge provided an instruction to the Committee with regard to its considerations of whether or not a witness was credible. Specifically, the Committee was instructed that if it found that a witness had lied about one area of testimony, then an inference might be drawn that the witness' overall testimony was not credible.

With regard to Respondent's testimony, one Committee member did not find him to be a credible witness. However, the Committee as a whole declined to draw any overall inference regarding Respondent's testimony, finding that in certain instances, his testimony was credible and in others not.

Respondent's testimony was viewed by the Committee as clever in the sense that Respondent put the "best spin" on events and was not forthcoming. Respondent's failure to provide complete information to CPH and to Dr. Land were viewed as examples of Respondent's lack of credibility. It was noted, for example, that Respondent failed to disclose the events at the Hospital at Sidney to CPH. When Respondent was evaluated by

Dr. Krueger, he failed to disclose the sexual harassment suit against him (Dept's Ex. 23) and his Memorandum of Agreement concerning Patient I (Dept's Ex. 11A).

The Committee viewed Respondent as a generally reliable purveyor of medical information but as someone who did not understand the limits and boundaries of acceptable behavior. Overall, the Committee, believed that Respondent viewed his own testimony as truthful but that his view of reality was skewed by his inability to appropriately assess boundaries.

Respondent served as his own expert witness. The Department presented G. Richard Braen, M.D., as its expert. Dr. Braen was viewed as credible and knowledgable. However, the Committee did not always agree with his his opinions as to the appropriate standard of practice in certain situations.

Both the Department and Respondent presented numerous fact witnesses whose credibility will be discussed when necessary below.

GENERAL CONCLUSIONS

PATIENT A

Factual Allegation A.1 charged that Respondent told the nurse that he wanted to speak to Patient A alone, and asked the nurse to leave. The Committee heard voluminous testimony with regard to this allegation. Ultimately, the testimony of Valerie Grossman that Nurse Waldeck told her that Respondent intended to interview Patient A alone was viewed as being more credible than that of Nurse Waldeck whom the Committee believed changed her statement. Ms. Grossman's testimony was also consistent with that of Patient A and Patient A's mother who testified that Respondent asked to speak to Patient A alone. The Committee did not believe Nurse Waldeck's testimony that she was present when

Respondent examined Patient A (T. 3396-3397). The Committee, also, viewed Patient A's testimony as more credible than that of Respondent.

Although the Committee sustains "A.1" as being factually true, the allegation is not sustained as evidencing moral unfitness in the practice of medicine. There was no hospital policy requiring a chaperone to be present when Respondent attended to a patient. Standing alone, this allegation does not constitute an act evidencing moral unfitness and is not sustained as the willful harassment, abuse or intimidation of a patient or as negligence.

Factual Allegation A.2 alleged that Respondent said to Patient A, "It's time to go under the covers", or words to that effect, and that he lifted her gown over her head in such a manner that the gown was covering her face and exposing her breasts. Because Patient A was more credible than Respondent, the Committee concludes Respondent did make the comment "It's time to go under the covers" and that he, then, lifted Patient A's gown, and exposed her breasts. It was viewed as unlikely that Patient A would fabricate that Respondent stated "it's time to go under the covers" when he lifted Patient A's gown.

The Committee, however, does not accept that the gown was lifted in such a manner that it was covering Patient A's face. Factual Allegation A.2 is, therefore, sustained only to the extent that Respondent said "It's time to go under the covers" and lifted Patient A's examination gown, exposing her breasts. In the context of lifting Patient A's gown and exposing her breasts, the comment "It's time to go under the covers" was viewed as being inappropriate for a physician to make. The Committee concludes that the comment attributed to Respondent combined with the lifting of Patient A's gown and the exposure of her breasts constitutes an act evidencing moral unfitness in the practice of medicine.

With regard to Factual Allegation A.3, the Committee as a whole accepts that Respondent then touched Patient A's breasts as charged in the allegation. However, with

respect to that part of the allegation which charged that Respondent cupped each of Patient A's breasts, the Committee noted discrepancies in the testimony of Patient A and her mother. Patient A's mother testified that Patient A told her that Respondent cupped each breast with two hands, one at a time (T. 1857), while Patient A testified that Respondent cupped one hand on each breast at the same time (T. 1799-1800). Consequently, the Committee declines to find that Respondent cupped Patient A's breasts.

The Committee, therefore, sustains A.3 to the extent that Respondent's touched Patient A's breasts. The Committee, also, sustains that part of "A.3" which alleges that the touching was not part of the medical workup, was not medically indicated and had no legitimate medical purpose. When the Committee considered the touching in conjunction with the exposure of Patient A's breasts, the fact that she was being seen alone and that the her medical record documented that she was being seen for an overdose of Celebrex, the Committee concluded that the touching was unwarranted and inappropriate. Furthermore, the Committee does not accept that the touching was done pursuant to an examination with a stethoscope.

The Committee concludes that the touching was inappropriate and violated the trust which the public bestows upon a physician. Factual Allegation A.3, therefore, is sustained as constituting an act evidencing moral unfitness in the practice of medicine but did not find a preponderance of evidence that Respondent had engaged in the willful harassment, abuse or intimidation of a patient.

The Committee does not sustain Factual Allegations A.2 and A.3 as negligence. While the Committee concluded that "A.2" and "A.3" constituted moral unfitness in the practice of medicine, and that the touching of Patient A's breasts had no medical purpose and was inappropriate, the Committee believes that contrary to any testimony from Dr.

Braen, negligence is not an appropriate specification to categorize Respondent's conduct in this instance.

Factual Allegations A.4 and A.5 allege that Respondent inappropriately questioned Patient A regarding her sexual history. The Committee sustains "A.4" and "A.5" as being factually true based upon Patient A's testimony that Respondent questioned her concerning oral and anal sex. The Committee, also, concludes, on the basis of Dr. Braen's testimony, that such questions are not outside the standard of care. Factual Allegations A.4 and A.5 are, therefore, not sustained as conduct evidencing moral unfitness, as the willful harassment, abuse or intimidation of a patient or as negligence. Dr. Braen testified that Emergency Department physicians would probably ask questions concerning oral and anal sex when confronted by a minor patient with suicidal ideation. Factual Allegation A.7 alleged that Respondent's questioning was outside the standard of care, that the questions were medically inappropriate or that they had no legitimate medical purpose. Based on Dr. Braen's testimony, "A.7" is, also, not sustained.

Factual Allegations A.6, A.6.a and A.6.b charged that Respondent did not document the breast examination or his questioning of Patient A. "A.6", "A.6.a" and "A.6.b" are sustained as true based on the lack of documentation in Patient A's medical record concerning these matters. The Committee was instructed that in order for an omission in record keeping to constitute negligence, there must be at least some potential impact on the care of the patient which could result from the lack of documentation. The Committee, by a 2 to 1 vote, sustains Factual Allegation A.6.a and A.6.b as negligence based on the potential importance of conveying the information gleaned from the breast examination and questioning, to others who might need to rely upon the medical record (see Braen,T.2940-2941 re importance of documenting questioning).

PATIENT B

The Committee sustains as factually true Factual Allegation B.1 which charges that Respondent examined Patient B while she was wearing her street clothes. Nonetheless, the Committee does not find Respondent to be negligent in this regard. The Committee does not accept Dr. Braen's testimony that Patient B needed to be gowned for the examination (T. 2903-2909) and instead, accepts Respondent's explanation that Patient B did not need to be gowned (T. 4722-4723).

Factual Allegation B.2 alleges that Respondent tried to unfasten Patient b's bra and said that "I used to be good at this". The Committee sustains Factual Allegation B.2 as factually true based on the testimony of Patient B and her mother. Respondent acknowledged unhooking Patient B's bra and asserted that this was done to assist Patient B in disrobing due to the fact that Patient B [redacted]. The Committee accepts that Respondent was attempting to assist Patient B by unhooking her bra.

Respondent denied saying "I used to be good at this." (T. 4703). The Committee found Patient B's testimony and her mother's testimony more credible on this point than Respondent's denial. Nevertheless, the Committee did not view the statement as rising to the level of conduct evidencing moral unfitness in the practice of medicine or as rising to harassment, abuse or intimidation. The Committee finds no basis in the record for viewing this conduct as negligent.

Factual Allegation B.3 charges that Respondent cupped or lifted Patient B's breasts and then dropped or released them. The Committee accepts that Respondent lifted Patient B's breasts in the course of looking for bruises. Notwithstanding any testimony to the contrary by the Department's expert, the Committee does not find Respondent's

actions inappropriate, that they evidenced moral unfitness to practice medicine, that he willfully harassed, abused or intimidated Patient B or that he was negligent.

With regard to Factual Allegation B.4, the Committee concludes that Respondent did ask Patient B to drop her skirt and that after she did so, he pushed her thighs slightly apart. However, given the circumstances of this Factual Allegation, the Committee does not find Respondent's conduct unreasonable in that he was looking for bruises. The Committee does not find that Factual Allegation B.4 constitutes moral unfitness in the practice of medicine, the willful harassment, abuse or intimidation of a patient or negligence.

The Committee sustains allegations B.5, B.6 and B.7 which alleged that Respondent made remarks about Patient B's mode of dress and sexual activity, as being factually true. Respondent, himself, acknowledged that he discussed Patient B's mode of dress (Innes, T. 4705-4707). Whatever exact words were used, the Committee does not find that Respondent's actions in this regard rose to the level of conduct evidencing moral unfitness or the willful harassment, abuse or intimidation of a patient or negligence. The Department's expert, Dr. Braen, testified that it was inappropriate for Respondent to comment negatively on Patient B's sexual activity or mode of dress. Nevertheless, the Committee concludes that, however salient Dr. Braen's comments might be in different circumstances, his testimony is inapplicable to a situation as here, where a sexually active 15 year old female who was sent for assessment by Child Protective Services, presented to the emergency room in the company of her mother to be assessed for bruising. Given Patient B's clothing, the Committee believed Respondent's comments were not inappropriate under the circumstances.

Factual Allegation B.8 which alleged that Respondent's questions/statements were inappropriate or failed to meet the standard of care, is not sustained on a similar basis.

PATIENT C

Factual Allegation C.1 charges that Respondent told the nurse that he wished to speak to Patient C, a twelve year old female, alone. The Committee sustains Factual Allegation C.1 as factually true in that Respondent did tell Susan Crump that he was going to speak to Patient C alone. The Committee, however, finds no basis in the record for sustaining the specifications charged with regard to Factual Allegation C.1, i.e.- moral unfitness to practice medicine, the willful harassment, abuse or intimidation of a patient or negligence.

Factual Allegation C.2 alleges that Respondent asked Patient C questions concerning her sexual activity. Factual Allegation C.3 charges that the questions were not within accepted standards of care, were medically inappropriate or without legitimate medical purpose. The Committee sustains Factual Allegation C.2 as being factually true in that Respondent did question Patient C with regard to sexual relations, oral sex and the touching of private parts. The Committee notes its discussion above with respect to Patient A, and Dr. Braen's testimony that emergency physicians would probably ask questions concerning sexual activity, including questions concerning oral and anal sex when confronted by a minor patient with suicidal ideation. Based on the same reasoning under which the Committee declined to sustain the specifications relating to Factual Allegations A.4 and A.5, the Committee declines to sustain Factual Allegation C.2 as evidencing moral unfitness to practice medicine, or as the willful harassment, abuse or intimidation of a patient. Similarly, with regard to the negligence specification, the Committee did not find it inappropriate or outside the standard of care for Respondent to question Patient C who

was potentially suicidal and who had recently split up with her boyfriend, concerning her possible sexual practices.

In this regard, the Committee concludes that even if Respondent used a "street term" such as "blow job" in questioning Patient C, his questioning would not necessarily have been inappropriate. While such language may not comport with social niceties, the Committee believes it was up to Respondent to use whatever language he felt would be most understandable and which would best elicit the disclosure of medically necessary information from Patient C. Because the Committee does not conclude that Respondent's questions were outside the standard of care, it does not sustain Factual Allegation C.3.

The Committee sustains Factual Allegation C.4 as factually true in that Respondent did not record his questioning of Patient C or her answers in Patient C's medical record. By a 2 to 1 vote, the Committee views this omission in record keeping as negligence because the answers would have been potentially important to subsequent readers of the medical record (see Braen, T. 2940-2941).

PATIENT D

The Committee sustains that part of Factual Allegation D.1 which alleged that Respondent diagnosed that Patient D had gonorrhea, based on the testimony of Patient D and [redacted] both of whom testified that Respondent told Patient D that he had gonorrhea.

Additionally, the Committee concludes that the diagnosis was not medically justified. The Committee found the testimony of Patient D and the nurses, Grant and Currier, credible when they testified that Patient D had no discharge from his penis. The Committee also accepted Respondent's testimony that although Patient D denied having discharge, he nevertheless told Respondent that he had yellow stains on his underwear. The Committee

accepts that Respondent could have concluded that Patient D had discharge based upon this information. When combined with Patient D's other symptoms, Respondent could legitimately have made a presumptive diagnosis of gonorrhea.

However, the Committee believed that Respondent diagnosed gonorrhea when at most he should have made a presumptive diagnosis. Without microbial proof or the presence of discharge, Respondent should not have definitively diagnosed gonorrhea. The Committee, nevertheless, does not find Respondent negligent with regard to this allegation. Because the treatment prescribed by Respondent would have been appropriate as a prophylactic treatment even in the context of a presumptive diagnosis of gonorrhea, the Committee cannot fault Respondent for his diagnosis or treatment of Patient D. Ultimately, Respondent was hasty in making a definitive diagnosis of gonorrhea The diagnosis, with the benefit of hindsight, was incorrect but not unreasonable at the time and does not rise to the level of negligence (see Dr. Braen's testimony at T. 2876-2879).

The Committee finds the testimony of Patient D and [redacted] credible with respect to Factual Allegations D.2, D.3 and D.4. The Committee concludes that Respondent told Patient D that he had gonorrhea in the presence of his friend, [redacted], as alleged in "D.2", that Respondent did not inquire of Patient D whether he wanted [redacted] to be present when he diagnosed gonorrhea, as alleged in "D.3" and that when Patient D questioned the diagnosis, Respondent told Patient D that perhaps his girlfriend "isn't such a good girl", as alleged in "D.4".

With regard to "D.2" and "D.3", the Committee concludes that Respondent revealed personally identifiable facts or information concerning Patient D, that Respondent obtained this information in his professional capacity as a physician and that he released the information without Patient D's consent. The Committee concludes that Factual Allegations

D.2 and D.4 do not rise to the level of an act evidencing moral unfitness to practice medicine. While Respondent's comment about Patient D's girlfriend not being a good girl may have lacked tact and have been hurtful, the Committee does not accept that this comment rose to the level of moral unfitness.

The Committee does not sustain Factual Allegation D.5 which alleged that the antibiotic therapy prescribed by Respondent was inappropriate or not within the standard of care. The Committee notes that the Department's own expert, Dr. Braen, testified that Respondent's choice of antibiotics might not have been first line drug selection but was within the "spectrum of treatment". (T. 2876-2877).

With the exception of Factual Allegation D.7.b which is discussed below, the Factual Allegations contained in "D.6" through "D.9" all charge Respondent with failing to document information in Patient D's medical record, or with recording inaccurate information in the record. "D.6" alleges that the history taken by Respondent from Patient D was inadequate or not accurate. "D.7.a" alleges that Respondent failed to record his telephone conversation with Patient D's girlfriend in Patient D's medical record. "D.8" and "D.9" respectively charge that Respondent failed to record an accurate history when he noted that Patient D had a history of the "clap", and when he noted that Patient D had discharge from his penis. The Committee sustains Factual Allegations, D.6, D.7.a, D.8 and D.9, as true.

In the case of "D.7.a", the Committee finds credible the testimony of Patient D and his girlfriend regarding her telephone call to Respondent when Patient D became ill. Respondent never recorded this telephone conversation with Patient D's girlfriend in Patient D's medical record, and the Committee sustains D.7.a on that basis.

The Committee does not sustain Factual Allegations D.6 and D.7.a as negligence. In and of itself, deficient documentation does not constitute negligence. There must be a showing that the inaccurate documentation creates a risk that the patient's care will be impacted in the future. In the instant case, the Committee did not conclude that Respondent's failure to document his telephone conversation with Patient D's girlfriend, concerning Patient D's vomiting and diarrhea, would or did impact Patient D's care. Patient D had already taken the tablets which had apparently upset his stomach, and documenting the incident would have been unlikely to impact future treatment. Similarly, the inaccurate recording of whether Patient D had a history of venereal disease or whether he had discharge was unlikely to affect his future treatment.

Factual Allegation D.7.a is sustained as a failure by Respondent to maintain a record which accurately reflected Respondent's evaluation and treatment of Patient D. As previously noted, the Committee accepts that Patient D's girlfriend called Respondent concerning his vomiting and nausea. As is evident from Patient D's medical record, this conversation was not recorded.

The Committee sustains "D.8" as true in that it found credible Patient D's testimony that he never told Respondent or anyone else that he had a history of sexually transmitted disease and finds that Respondent recorded in Patient D's medical record that he had a history of the "clap".

With regard to "D.9", the Committee accepts Respondent's testimony that although Patient D did not recount that he had discharge, Respondent, nevertheless, believed there was discharge because Patient D stated he had yellow stains on his underwear. Instead of recording that Patient D had yellow stains on his underwear, Respondent recorded that

Patient D had "yellow penile discharge". This was not an accurate record of the history given by Patient D. The Committee, therefore, sustains Factual Allegation D.9 as true.

The Committee does not sustain Factual Allegation D.8 and D.9 as evidencing moral unfitness to practice medicine, as the fraudulent practice of medicine or as the willful filing of a false report. In the case of Factual Allegation D.8, Respondent's notation that Patient D had a history of "clap" did not reflect the actual history which Patient D gave to Respondent. Nevertheless, the committee believes that Respondent had no motive to fabricate false information on Patient D's medical record and had nothing to gain by doing so. Respondent was already treating Patient D for gonorrhea and the Committee accepts that he had a presumptive basis for doing so. While the Committee cannot determine on what basis Respondent recorded that Patient D had a history of "clap", it does not find that this notation evidences an intent to deceive or moral unfitness to practice medicine.

With regard to "D.9", the Committee accepts that Respondent assumed Patient D had penile discharge when Patient D told him that he had yellow stains on his underwear. Respondent's note that Patient D had yellow penile discharge evidences inaccurate reporting. The Committee believes this history was recorded in good faith.

Factual Allegations D.8 and D.9 are not sustained as a failure by Respondent to accurately reflect his evaluation and treatment of Patient D because Respondent did, in good faith, evaluate Patient D as having gonorrhea and, then, treated him accordingly. While his underlying assumptions, i.e.- that Patient D had penile discharge and a history of clap- were ultimately wrong- Patient D's evaluation and treatment by Respondent were accurately recorded.

Factual Allegation D.7.b alleges that after the telephone call from patient D's girlfriend, Respondent failed to advise that Patient D should either alter his medication

regimen or be reevaluated in the Emergency Department. This allegation is sustained as true. However, the Committee does not sustain any specifications with regard to this allegation. The Committee viewed that Respondent could legitimately have chosen to continue Patient D's treatment regimen based upon the presumptive diagnosis of gonorrhea.

PATIENT E

Factual Allegation E.1 alleges that Respondent failed to adequately review Patient E's x-rays and/or failed to diagnose her lumbar fracture. The Committee sustains only that part of "E.1" which states that Respondent failed to diagnose the fracture. Respondent acknowledged in his testimony that he missed the fracture. However, the Committee draws a distinction between adequately reviewing the x-rays and missing the fracture. The Committee believed that Respondent did adequately review the x-rays but, nevertheless, missed the fracture. The Committee finds no negligence with regard to "E.1".

The first part of Factual Allegation E.2 alleges that Respondent failed to adequately and appropriately treat the fracture. The remainder of E.2 essentially alleges that Respondent did not put into place an appropriate follow up mechanism with Patient E's orthopedist or primary care physician.

The Committee does not sustain Factual Allegation E.2. Respondent did not learn of the lumbar fracture until he was contacted by the hospital radiologist following Patient E's discharge. The Department's expert, Dr. Braen, testified that there was no need for Patient E to be admitted to the hospital, there was no immediate need for her to be seen by an orthopedic surgeon, and that, in any case, no further treatment could have been rendered in the emergency room. The Committee noted that Patient E was to be seen by her

primary care physician the following day and that Dr. Braen opined that the primary care physician could then follow up with Patient E's treatment (T. 2321-2322).

The Committee sustains as true Factual Allegation E.3 which essentially charges that Respondent did not change his treatment of Patient E after telling Patient E's mother about the misdiagnosis. The Committee found Patient E's mother credible with regard to her testimony concerning this conversation. However, the Committee again does not find that Dr. Braen's testimony supports a finding of negligence, for the same reasons discussed with regard to "E.2" above.

The Committee does not sustain Factual Allegations E.4 and E.5. Factual Allegation E.4 essentially alleges that Respondent failed to document in Patient E's medical record his misreading of the x-ray and his conversation with Patient E's mother. Factual Allegation E.5 charges that Respondent's documentation was not accurate or was intentionally misleading when he omitted this information. The Committee accepts Respondent's testimony that he, in fact, documented both the misread and his conversation with Patient E's family on a continuation sheet which was subsequently lost (Innes, T. 3774-3779). The Committee felt this testimony was believable. It was undisputed that Respondent telephoned Patient E's house and ultimately spoke with Patient E's mother to inform her of the misread. Therefore, Patient E's mother and the radiologist were all aware of the misread. It was against Respondent's own interest to omit the misread and his conversation with Patient E's mother from the medical record. He could not have hoped to hide these events. The Committee found it more credible to believe that Respondent documented these events, as he testified.

PATIENT F

The Patient F allegations concern the events leading up to and occurring at a party which Patient F attended at Respondent's house. F.1 alleges that while driving Patient F to the party, Respondent stated that Patient F would need a "Sugar Daddy" in her life. F.2 and its subparts essentially charge that Respondent exposed Patient F's breast and private parts under the guise of examining her or showing her his "bacterial light".

In reaching its conclusions regarding the Patient F allegations, the Committee notes there is no dispute that at some point during the party, Respondent and Patient F went into Respondent's house in connection with a "bacterial light". The Committee weighed the credibility of Respondent and Patient F and determined that with regard to the "F.2" allegations which focused on events prior to Patient F's consumption of alcohol, Patient F was more credible than Respondent. Patient F's testimony was particularly impressive due to the degree of specificity contained in her recounting of the events. Because Patient F's testimony was more credible with regard to these earlier events of the day, i.e.- Respondent's "sugar daddy" remark and the incident with the "bacterial light", the Committee sustains as true Factual Allegations F.1, F.2, F.2.a, F.2.b, F.2.c and F.2.b. In sustaining this series of allegations, reliance was, also, placed on Respondent's apology to Patient F in open court (Dept's Ex. 15). The Committee did not find credible Respondent's testimony (T. 4409-4411) that his apology, and his acknowledgement in court that he engaged in "uninvited, inappropriate and offensive conduct" toward Patient F, only related to his mistake in conducting an examination at his home and to his joke about Patient F sucking on a pretzel.

In determining whether or not to sustain the Specifications concerning the "Patient F" allegations, the Committee considered whether or not Patient F and Respondent had a

physician-patient relationship. Patient F remarked during her testimony that she did not believe Respondent was examining her as a physician or treating her as a patient, and that she thought she was only going to look at the light (T. 455). Nevertheless, the Committee did not find this testimony dispositive as to the existence of a physician-patient relationship. Respondent, himself, testified that he "told Patient F this is a good time for me to take a look at the rash." (T. 4324). The Committee concluded that by virtue of Respondent's own testimony, a physician-patient relationship had been established. Additionally, were it not for Respondent's status as a doctor, Patient F would not have gone along with Respondent's suggestion to view the "bacterial light". As Patient F testified, the fact that Respondent was a physician for whom her family had high regard, had a huge impact on her actions and contributed to her both going to view the light and remaining at the party after the incident (T.406-407). Furthermore, when Respondent exposed Patient F, he used the "bacterial light" in a manner which provided a medical veneer to his actions. Consequently, Factual Allegations F.2 and its subparts are viewed as having occurred within the context of a physician-patient relationship.

The Committee sustains Factual Allegations F.2 and its subparts as evidencing moral unfitness in the practice of medicine. As previously noted, the Committee accepts Patient F's account of this incident and finds that he exposed Patient F in the manner described in the allegations. The Committee accepts Patient F's testimony that Respondent was the one who brought up the rash, that the rash had basically healed and that she made no medical complaint to Respondent. It also notes Dr. Braen's testimony, that under such circumstances, there was no legitimate medical purpose for Respondent's examination (Braen, T. 2983-2984, 2988). Even assuming that Respondent engaged in the behavior described in the allegations for the purpose of examining Patient F's rash, his

behavior was highly inappropriate. The Committee notes Dr. Braen's testimony with regard to the propriety of exposing a patient and the need to protect a patient's modesty (Braen, T. 2914-2915, 2472-2473). The Committee, also, sustains these allegations under the specification which charges that the allegations constitute the willful harassment, abuse or intimidation of a patient.

The Committee believed Patient F's testimony concerning the "Sugar Daddy" remark notwithstanding Respondent's denial that he said this. Nonetheless, the Committee did not believe a physician-patient relationship had been established at the time of the "Sugar Daddy" remark and, therefore, does not sustain Factual Allegation F.1 as either an act evidencing moral unfitness in the practice of medicine or as the willful harassment, abuse or intimidation of a patient.

The Committee accepts Patient F's testimony that she was confused and distressed after the incident and remained at the party because her supervisor asked her to remain.

Factual Allegations F.3.a, F.3.b and F.3.c essentially allege that subsequent to the "bacterial light" incident, Respondent twice followed Patient F into his house when she went to the bathroom and made advances toward her.

The Committee declines to sustain these allegations. While the Committee was of the opinion that once established, the physician-patient relationship continued, it was also undisputed that Patient F consumed alcohol after the parents and campers left the picnic. While the Department objected that Respondent did not present his wife to testify as to Patient F's demeanor following her consumption of alcohol, the Committee noted that the Department presented testimony from a number of Patient F's colleagues who observed Patient F following her consumption of alcohol. The testimony of the Department's witnesses was viewed as being inconclusive on the question of whether Patient F was

intoxicated. The Committee, therefore, had concerns regarding Patient F's state of mind in light of her acknowledged ingestion of alcohol, and gave Respondent's denials as to allegations F.3.a, F.3.b and F.3.c every benefit of the doubt. While Respondent testified that he did follow Patient F into the house, the Committee accepts that he did this because of the possibility that Patient F was intoxicated. Patient F, herself, testified that when Respondent followed her to the bathroom, he stated that "she was too drunk to go to work". Therefore, the Committee does not believe that the Department established these allegations by a preponderance of the evidence.

The Committee sustains as true Factual Allegation F.3.d which charged that Respondent made suggestive remarks which speculated on Patient F's skill in performing oral sex. Respondent, in his testimony, acknowledged making an off color remark of this nature to Patient F while she was eating a pretzel (T. 4350). The Committee declined to sustain F.3.d as an evidencing moral unfitness in the practice of medicine or as the willful harassment, abuse or intimidation of a patient. The Administrative Law Judge instructed the Committee that in order to meet the element of willfulness, the Committee needed to find intent by Respondent. The Committee found that Respondent made a crude joke but did not intend to harass, abuse or intimidate Patient F.

PATIENT G

Factual Allegations G.1, G.2 and G.3 allege that Respondent pulled up Patient G's bra and exposed her breast and touched Patient G's vagina and clitoris without legitimate medical purpose. The Committee declines to sustain these allegations. After assessing Patient G's testimony against Respondent's testimony, the Committee could not find a clear cut preponderance of credibility in Patient G's favor. Consequently, the Committee accepted Respondent's testimony as to Factual Allegations G.1, G.2 and G.3.

The Committee noted discrepancies in Patient G's testimony. For example, Patient G testified that Respondent tore her bra, brushed his fingertips across the nipple of a breast, and placed the fingers of his left hand on her clitoris (Patient G ,T. 1981-1984). However, a typed statement prepared by Patient G on the day following the alleged event contains no mention of Respondent touching Patient G's breasts or nipples and does not contain the word clitoris (Patient G, T. 2067-2069; Resp's Ex. S). Three days later, on July 9, 1999, Patient G signed a second statement, and her signature was notarized by her attorney. This statement also fails to reference any touching of the nipple or the clitoris (Patient G, T. 2070; Resp's Ex. T).

Patient G met with New York State Department of Health Investigator, Beverly Ianuzi, R.N., on July 27, 1999, just three weeks following the alleged incident (Patient G, T. 2074; Resp's Ex. U). Patient G was allowed to "tell my story" and then was asked questions (Patient G, T. 2075). She testified that the events were disturbing to her and that touching or fondling were the kind of things she would have reported to the Health Department (Patient G, T. 2077-2078). However, her statement to Investigator Ianuzi does not contain any reference to the touching or fondling of her breasts or nipples by Respondent. Rather, the statement reports that Respondent "ripped back her bra". The statement also reports that Patient G discussed with Investigator Ianuzi the type of bra she was wearing including the fact that the bra had a clasp in the front (Patient G, T.2083-2084). The Committee concluded based on "G's" testimony that she mischaracterized her bra as clasping in front rather than the back (Patient G, T. 2139-2143).

Patient G also testified that her claim that Respondent touched her clitoris with his hand or fingers would have been the kind of information she would have reported to Investigator Ianuzi, but again, this information does not appear in Patient G's statement

(Patient G, T. 2084-2085; Resp's Ex. U). Rather, Ianuzi's report only documents that Patient G told her that Respondent "began feeling of her stomach and lifted up the waist of her slacks and put his hand low near her pubic area".

Neither did the Committee find the testimony of Patient G's husband credible. Patient G's husband testified that he drove up to Respondent's house less than a week after the hospital visit "to beat the shit out of him". However, he admitted that he gave contrary testimony during his deposition testimony in the civil action. Although the husband claimed he was aware of inappropriate conduct by Respondent, he did not call an administrator, did not go to the nurse's station and complain, and permitted a nurse to give his wife a second injection. Approximately 75 minutes transpired between the time of the 2nd Demerol administration and the time of discharge.

The Committee, therefore, could not support by a preponderance of the evidence, that the events alleged by Patient G had occurred. The Committee accepts Respondent's version of the events concerning Patient G, and that his actions were part of his medical examination of Patient G. Factual Allegations G.1, G.2 and G.3 are not sustained.

Factual Allegation G.4 alleges that Respondent disclosed to a mutual acquaintance that Patient G had filed a complaint and requested that the mutual acquaintance talk to Patient G and ask her to withdraw her complaint. The Committee sustains Factual Allegation G.4 as true based on Respondent's testimony that he asked Mabel Walker to intercede on his behalf and set up a meeting with Patient G to determine why she was upset. Respondent's own testimony convinced the Committee that regardless of the words actually used, it was understood by Respondent and Ms. Walker, that he wished to have the complaint resolved in his favor through withdrawal of the complaint.

However, the Committee was not convinced that Respondent's actions constituted acts evidencing moral unfitness in the practice of medicine or the willful harassment, abuse or intimidation of a patient. The Committee also did not view that Respondent had revealed personally identifiable patient information without the prior consent of Patient G. The Committee believed that to the extent Respondent had disclosed any information concerning Patient G to Ms. Walker (i.e., that he had treated Patient G in the emergency room, that she had headaches and that she had made a complaint), this information was already in the public realm. The Committee was not convinced that Respondent had disclosed to Ms. Walker that Patient G had been treated with Demerol. As Ms. Walker testified, "I happen to be a nurse myself, so if I talk about any medications, it's because of my own knowledge..... I didn't have any knowledge of what medications she received. If I said anything about medications, it would be on general principles." (T. 2211).

EMPLOYEE H

With the exception of Factual Allegations H.1 and H.8, the Committee sustains none of the allegations concerning Employee H. Employee H claims she was sexually harassed during the period beginning with her employment as Respondent's

Factual Allegation H.1 alleges that when Employee H asked Respondent if he needed anything, Respondent said "What I really need is a blow job." The Committee sustains this allegation based on the testimony of Martha Loveland, a nurse working

n. Ms. Loveland testified that Employee H complained to her on one occasion that Respondent spoke to her in the manner described in the allegation. The Committee found Ms. Loveland to be an extremely believable witness, and notes Ms. Loveland's testimony that she believed Employee H. The

Committee, however, did not find that Respondent's remark evidenced moral unfitness to practice medicine when the remark was considered in the overall context of his relationship with Employee H.

The Committee sustains Factual Allegation H.8 which alleges that Respondent sent e-mails or computer messages to Employee H that contained sexual images or sexual content. Respondent acknowledged that he sent e-mails to Employee H which had sexual connotations. While the Committee understands that sexual harassment is in "the eye of the beholder", it, nevertheless, notes Ms. Hopkins testimony that the e-mail which seemed to offend Employee H was not sexually explicit, was not pornographic, was "cute", and that she even forwarded it on to her mother. The Committee does not conclude that the e-mail evidenced moral unfitness to practice medicine.

The remaining allegations concerning Employee H involved allegedly inappropriate comments by Respondent including one occasion where he asked Employee H to perform oral sex on him (Factual Allegation H.7). The Committee did not accept Employee H's testimony regarding these allegations.

When it considered the record, the Committee did not find Employee H's account to be credible. Despite Employee H's claim that Respondent was inappropriate and used language she considered harassing throughout the entire period of her employment (T. 549-551), she never documented her discomfort. She never complained to Kathryn Nichol or to Jo Ann Reid about sexual misconduct by Respondent.

The Committee found Nurse Manager, Kathryn Nichol to be a credible witness. Ms. Nichol testified that Employee H made frequent complaints to her about issues and people other than Respondent. In particular, Employee H complained about Dr. Naradzay and the difficulties that she was having working with him particularly after he took over as

Department Chair. Employee H also confided about her personal problems including financial difficulties, problems with child support issues and issues regarding her ill mother.

The Committee noted that Ms. Nichol was surprised by Employee H's resignation and that she assumed it was related to the other matters which Employee H had complained of. Furthermore, Employee H was having significant problems with absenteeism as the result of health problems. Ms. Nichol was surprised when she learned of Employee H's lawsuit and commented that she had no knowledge of the alleged sexual misconduct by Dr. Innes.

The Committee found Jo Ann Reid to be a credible witness and noted her testimony that Employee H had a problem with absenteeism during her work with Ms. Reid due to migraine headaches, and that periods of illness were a problem. Additionally, Ms. Reid was a confidant of Employee H who frequently confided in Ms. Reid about problems in her personal life even after she began working for Respondent. The Committee believed Ms. Reid's testimony that Employee H never made complaints of a sexual nature about Respondent. Rather, the complaints dealt with management style issues. Ms. Reid was not surprised that Employee H quit her job, but like Ms. Nichol, was surprised that she claimed the resignation was related to sexual harassment and was surprised by the sexual harassment lawsuit. When queried why she would be surprised, the witness answered that "...it just didn't seem to fit with what I had observed for years." (T. 2740-2741). The Committee also noted that Employee H's last contact with Ms. Reid was a phone message in 2003 in which Employee H asked for her help in her lawsuit against Respondent.

Employee H corroborated much of Ms. Nichol's and Ms. Reid's testimony. She admitted that she suffered from serious migraine headaches during her employment and that the headaches caused her to miss substantial work time. Employee H's

testimony, even during the State's case in chief, reflects that the employee was concerned about losing her job, was upset with Respondent because he was not supporting her in her work situation, and that she had substantial financial problems.

Employee H explained that she never put anything in writing about the ongoing sexual harassment by Respondent. She explained that she did not want to put anything in writing because she was concerned about "burning bridges" (T. 612). Nevertheless, legal papers seeking millions of dollars in damages for 10 different causes of action were prepared and served on the hospital and on Respondent within 3 days of her departure. She claimed that a lawsuit was not even discussed until she met with management for her exit interview, and her letter of resignation mentions nothing about sexual harassment.

Employee H was familiar with Respondent's sense of humor before she started working for him (T. 624-627). There were people superior to Respondent to whom she could have complained if she had chosen to do so. Employee H admitted she was not afraid to tell Respondent how she felt and, even testified that she slapped him on one occasion because she was so outraged with his comments. Employee H testified that she gave Respondent numerous presents during the period in which the alleged harassment occurred, including a cactus garden which she gave him five months before she resigned.

The Committee found both Ms. Hopkins and Ms. Reid credible when they testified that after Employee H resigned, she invited Ms. Hopkins to join in her lawsuit against Respondent. The Committee found this event and the details of Employee H's invitation damaging to the credibility of Employee H's allegations. The Committee also found the other events described by Ms. Hopkins, i.e.- the request to follow a woman who she suspected of having an affair with her husband, and her suspicion that someone was searching through her office, as detracting from her credibility. The Committee also found

credible Ms. Hopkins' testimony that there was frequent sexual bantering in the [redacted] [redacted], including bantering between Respondent and Employee H (T. 3344).

Ms. Tamara Robinson testified that she observed Employee H, on at least two occasions, in conversation with Patient G prior to the commencement of the lawsuits by "G" and "H" against Respondent (T. 2785-2786). The Committee concludes that the apparent relationship between Patient G and Employee H further diminishes their credibility.

When the Committee considered all of the above testimony, including that of Ms. Hopkins, Nichol and Reid, and Employee H's financial and health problems and the lawsuit she initiated, the Committee concluded that there was not a preponderance of evidence to support the remaining allegations concerning Employee H.

EMPLOYEES I –P

The Committee sustains as true all of the Factual Allegations involving Employees I through P and S with the exception of Factual Allegation N.1 which is further discussed below, and with the exeption of the "L" allegations[2] which the Committee was instructed to disregard. With the exception of Nurse M, the bulk of these allegations charged Respondent with physical or verbal conduct of a sexual nature. The Committee sustained as true each of these allegations and found the witnesses presented by the Department to be credible.

With regard to the Specifications alleging conduct in the practice of medicine which evidenced moral unfitness to practice medicine, the Committee took into account the definition of moral unfitness provided by the Administrative Law Judge, and Dr. Braen's testimony concerning the formation of a physician-patient relationship and the treatment of

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[2] The allegations involving Employee L have been excluded from consideration by the Committee, as discussed in the section of this Determination and Order entitled Statement of Case.

staff and co-workers by a physician. The Committee concludes that because the events alleged occurred largely within a hospital setting where Respondent held a position of authority by virtue of his licensure as a physician and his position on staff, and because he provided either physical examinations or treatments for back and neck pain within the hospital context, the facts alleged in the sustained Factual Allegations concerning Respondent's treatment of Employees I, J, O, P and S were within the practice of medicine and constituted moral unfitness within the practice of medicine. They violated the public trust bestowed upon Respondent by virtue of his licensure, and the moral standards of the medical community which the Committee as delegated members of that community represent. The Committee viewed it as self-evident that the incidents charged involved no legitimate medical purpose, demonstrated inappropriate touching or conduct, and that expert testimony in each instance, was unnecessary for the Committee to draw its conclusions.

With regard to those specifications which alleged that Respondent willfully harassed, abused or intimidated a patient either physically or verbally, the Committee extensively discussed the definition of harassment. The Committee was ultimately instructed by the Administrative Law Judge that in a context where patients were hospital employees and co-workers of Respondent, inappropriate touching would by definition constitute harassment given Respondent's position as a doctor in the hospital and the authority his position implied. This would be particularly so if the acts occurred within the hospital premises and were already found by the Committee to be conduct evidencing moral unfitness to practice medicine. The Committee consequently concluded on the basis of the aforesaid instruction that the facts alleged concerning Respondent's actions during his treatment of Employees I, J, O, P and S constituted the willful harassment, abuse or intimidation of a patient.

EMPLOYEE I

As discussed, all of the "I" allegations are sustained as moral unfitness and as the willful harassment, abuse or intimidation of a patient.

The "I" allegations charge that during the course of an employee assessment/exam, Respondent unhooked Employee I's bra and lifted her bra exposing her breasts, and later said words to the effect that the person who usually performed the employee assessment had "missed a good one". In fact, Employee I testified that Respondent had actually stated "Today's my lucky day... Michael would be upset he wasn't here today". The Committee finds that the words uttered by Respondent, as testified by Employee I, are words to similar effect as are charged in the allegation. The Committee sustains the allegations as true.

The Committee considered that in isolation, Respondent's unhooking of Patient I's bra and his exposure of her breasts as part of a physical examination might not have risen to the level of conduct evidencing moral unfitness in the practice of medicine. However, in the context of a lengthy stream of all too similar events occurring over a lengthy period of time, as is demonstrated by the numerous sustained Factual Allegations concerning the employee/patients, the Committee concluded that the allegations concerning Patient I constitute moral unfitness. In reaching this conclusion, the Committee also took into account Respondent's acceptance of the Memorandum of Agreement (Dept's Ex. 11A).

EMPLOYEE J

The "J" allegations charge that during the course of providing back rubs to Patient J for her back and/or neck pain, Respondent touched or attempted to touch patient J's breasts and vagina, without medical purpose and that, at an [redacted] staff party at Respondent's house, he made advances toward Patient J including an attempt to put his hand on her crotch.

As previously discussed, Factual Allegations, J.1 through J.1.b are sustained as conduct within the practice medicine. Given that Respondent offered a neck massage to Employee J for headaches or neck discomfort, there was no medical purpose to his making contact with Employee J's vagina or breasts. The Committee concludes that the touching was inappropriate and constituted moral unfitness in the practice of medicine as well as the willful harassment, abuse or intimidation of a patient.

The Committee finds that the events which occurred at Respondent's party with respect to Employee J also constituted conduct within the practice of medicine given Respondent's position as Assistant Director [redacted] that the party had been given for [redacted] staff including Employee J. Also noted is Dr. Braen's testimony regarding the detrimental effects on staff which may result from inappropriate behavior by persons in positions of authority. The Committee concludes that Respondent's actions at the party constituted moral unfitness in the practice of medicine.

EMPLOYEE K

The Committee found Employee K to be an extremely credible witness and believed that the "K" allegations were true. The "K" allegations charged that Respondent made certain offensive verbal remarks to Employee K and that, on one occasion, he put his feet on her lap. Although these allegations are unpleasant, the Committee did not conclude that they rose to the level of moral unfitness. Employee K understood that Respondent's comments, however offensive, were generally made in a joking manner.

According to Employee K, the incidents cited happened "out of the blue" during the [redacted] period they worked together and were not part of an on-going pattern (T. 112-113). Employee K agreed that Respondent did not make life difficult for her (T. 157), never

threatened her employment or promotional possibilities (T. 157) and that he treated her fairly and respected her work (T. 160).

While the Committee did not find that the "K" allegations rose to the level of moral unfitness, it did believe that the allegations evidenced Respondent's capacity for inappropriate behavior.

NURSE M

The Committee sustains Factual Allegation M.1 to the extent that Respondent came into the dirty utility room and closed the door behind him. The Committee does not find that Respondent necessarily was blocking Nurse M's exit in the sense that he was preventing her from leaving the room.

The Committee was impressed with Nurse M's credibility and sustains Factual Allegations M.2 and M.3. These allegations essentially allege that Respondent told Nurse M that she should think about what her actions were doing to Respondent's family, and that he knew her working hours, where her daughter went to school, and when her daughter was home alone. The Committee believed it was not unreasonable under the circumstances for Respondent to point out to Nurse M how her actions were affecting his family. While the Committee did not find that the "M" allegations rose to the level of moral unfitness, it did believe that the allegations again evidence Respondent's capacity for inappropriate behavior.

NURSE N

Factual Allegation N.1 charges that Respondent offered to pay money if Nurse N and another nurse went to a hotel with him. The Committee finds that this allegation was based entirely on Nurse N's hearsay testimony which recounted what the other nurse had said to her. The Committee does not find the hearsay testimony reliable and declines to sustain this allegation.

The Committee found Nurse N's testimony credible with regard to Factual Allegations N.2 and N.3 which alleged that Respondent kissed her and stuck his tongue in her mouth without her consent. The Committee concludes that this conduct occurred on the hospital premises, under the guise of discussing a patient, and, therefore, constituted an act evidencing moral unfitness in the practice of medicine.

PATIENT (NURSE) O

Factual Allegation O alleges that Respondent during the course of Nurse O's treatment for a back/neck injury with Keri lotion, touched Nurse O's breasts which touching had no legitimate medical purpose. The Committee believed that Nurse O was extraordinarily credible and sustains Factual Allegation O as true. Because Nurse O was so extraordinarily credible, the Committee discounts any testimony, evidence or suggestion that Dr. Praska denied that Nurse O had complained to her of Respondent's conduct. The Committee found very believable Nurse O's testimony that she viewed herself as an unattractive [redacted] nurse and that she never would have expected Respondent to make a pass at her (Nurse O, T. 1655-1656). The Committee sustains Factual Allegation O as both moral unfitness and as the willful harassment, abuse or intimidation of a patient.

PATIENT (EMPLOYEE) P

The "P" allegations charge that during the course of treatment for Employee P's sciatica, Respondent removed her underpants, touched her upper inner thigh, groin and/or pubic area without medical purpose, and told her that she needed "to get fucked more" or words to that effect. On one occasion, he followed her into the darkroom x-ray area, blocked her exit and insisted that she kiss him.

The Committee found Employee P to be an [illegible] credible witness and believed her testimony. The Committee accepted Employee P's testimony that Respondent touched her upper inner thigh close to her pubic area without legitimate medical purpose as well as her testimony concerning the other "P" allegations. The "P" allegations are all sustained as acts evidencing moral unfitness to practice medicine and, with the exception of P.4, as the willful harassment, abuse or intimidation of a patient.

FACTUAL ALLEGATION Q

Factual Allegation Q.1 alleges that Respondent told his psychiatrist that there were no other allegations or instances of misconduct against him other than the Watertown incidents in 1998-1999 when Respondent knew there had had been other such instances or allegations. "Q.2" alleges that Respondent caused the psychiatrist to prepare an evaluation and recommendations which relied in part on his misrepresentation that other than the Watertown incidents, he had no complaints against him of sexual harassment. The evaluation and recommendations by the psychiatrist were ultimately submitted to OPMC.

The Committee sustains the "Q" allegations as true. Nevertheless, the allegations are not sustained under any of the Specifications. The Committee did not find that Respondent had the requisite intent to mislead Dr. Krueger. The Committee concluded

that Respondent genuinely believed that he was prohibited by a confidentiality agreement from disclosing the sexual harassment suit against him. With regard to Employee I, the Committee believed that notwithstanding any contrary language contained in the Memorandum of Agreement, there was ambiguity as to whether the agreement resulted from the hospital's perception that Respondent had engaged in inappropriate behavior that was not intended to be sexual (Dept's Ex. 11 and 24), or perhaps was triggered by his angry outburst following the examination of Employee I. It was simply not clear to the Committee that Respondent had knowingly lied to Dr. Krueger. In any event, absent Dr. Krueger's live testimony, the Committee was unable to determine what discussions Dr. Krueger had with Respondent or to gain adequate insight into Dr. Krueger's thought process in writing his report and recommendations,. Based on the above reasons, the Committee declines to sustain the Specifications of moral unfitness and fraud.

FACTUAL ALLEGATIONS R,S AND T

Factual Allegation R charges that Respondent gave false and/or intentionally misleading answers to questions on his appointment application to the Hospital in Sidney (the "Sidney application). Factual Allegations S and T charge that Respondent gave false and/or intentionally misleading answers to questions on his appointment application to Canton-Potsdam Hospital (the "Canton application").

FACTUAL ALLEGATIONS R.1 AND R.2

Initially, the Committee observes that Respondent's signature on the Sidney application is dated April 1, 2003. On that application, Respondent did not check either "Yes" or "No" in response to the question "Have you ever voluntarily or involuntarily terminated your medical staff membership at any other organization?". Instead, Respondent hand wrote "At the end of each contract" in answer to the question.

Factual Allegation R.1 is not sustained. "R.1" alleges that Respondent's response "At the end of each contract" was false and/or intentionally misleading because his employment contract with Finger Lakes Health and/or Geneva General Hospital ("Finger Lakes") was effective through June 30, 2003 and Respondent, in fact, resigned on May 8, 2002. The allegation stated that Respondent resigned only after being invited to do so because of his disruptive behavior and inappropriate demeanor in the clinical setting.

The Committee notes that Respondent's employment contract with Finger Lakes could be terminated without cause by either party and that Respondent signed a letter from Finger Lakes, which acknowledged that his resignation had been accepted, effective on May 8, 2002.

The Department presented hearsay testimony from Steven Hanks, M.D., Chief Medical Officer at Finger Lakes, concerning Respondent's allegedly disruptive behavior and inappropriate demeanor in the clinical setting. The Department failed to present any direct testimony concerning Respondent's alleged behavior. The Committee ultimately discounted Dr. Hanks' hearsay testimony, and gave greater weight to his testimony that Respondent resigned for reasons unrelated to clinical competency or allegations of sexual misconduct (T. 1458-1462). In weighing Dr. Hanks' overall testimony, the Committee did not believe it supported a conclusion that Respondent's behavior or demeanor in the clinical setting resulted in Respondent's invitation to resign.

The Department alleged in Factual Allegation R.2 that Respondent's response "At the end of each contract" was false and/or intentionally misleading because Respondent's temporary privileges and one year provisional status at Via Health of Wayne, New York had

been terminated in approximately August 2001 because of Via Health's investigation of Patient A's allegations against Respondent.

William Stroman, administrator of Via Health, testified that Respondent was employed by the Division of Rural Emergency Medicine ("DCREM"), and that Respondent, through that group, worked at the Via Health hospitals at Newark Wayne and Myers. The Committee concluded, on the basis of Mr. Stroman's testimony, that Via Health lacked the capability to terminate Respondent's employment because it did not directly employ Respondent (T. 1490-1491). While Via Health ultimately arranged through DCREM to remove Respondent from any scheduling at its facilities, Via Health could not terminate Respondent.

The Committee initially concluded, based on Mr. Stroman's testimony and the wording of Factual Allegation R.2, that it could not sustain the language in the second and third sentences of the allegation concerning Respondent's termination. However, on further reflection, the Committee concluded that the essential thrust of Factual Allegation R.2 was that Respondent had been terminated through Via Health's direction that DCREM not schedule Respondent to work at Via Health's facilities.

Nevertheless, the Committee does not sustain either Factual Allegation R.1 or R.2 because it does not find that Respondent's answers were intended to be either false or misleading. Respondent forthrightly filed a statement as part of his Sidney application detailing that he was investigated by OPMC in connection with various allegations (Dept's Ex. 13, hand numbered pgs. 16, 30). Logically, had Respondent intended to mislead by omitting his interactions with Finger Lakes and Via Health, he would not have detailed other past problems in his statement. In determining not to sustain these allegations, the Committee took into account that Respondent did not mention the incident with Patient A in

his statement. The Committee concluded that by referring to the other incidents described in his statement, Respondent effectively alerted Sidney that his past could be problematic. Respondent's statement may have been incomplete but was not misleading. The Committee did not believe Respondent intentionally gave a false answer. In light of Respondent's disclosures, the Committee declines to sustain Factual Allegations R.1 and R.2, and in any event would not find that his answers on the Sidney application rose to the level of moral unfitness.

FACTUAL ALLEGATION S.1

Factual Allegation S.1 charges that Respondent gave a false and/or intentionally misleading answer when he answered "No" to a question on the Canton application with regard to his prior hospital medical staff membership. The allegation charges that by answering "No" to the question "...has your membership, association, employment or practice ever been limited, suspended, revoked, not renewed, granted with stated limitations or voluntarily suspended?", Respondent intentionally misled by not disclosing his termination from Finger Lakes.

The Committee declines to sustain Factual Allegation S.1 because Respondent filed the Canton application on April 22, 2002. The allegation, itself, states that Respondent did not resign until May 8, 2002. The Committee, therefore, concludes that Respondent could not have intended to mislead on the Canton application with regard to the events at Finger Lakes by virtue of the fact that he had not yet resigned when the application was submitted.

FACTUAL ALLEGATION S.2

Factual Allegation S.2 charges that Respondent's answer "No" to the question on the Canton application "...has your membership, association, employment or practice ever been limited, suspended, revoked, not renewed, granted with stated limitations or

voluntarily suspended?" was false and/or intentionally misleading in that Respondent did not disclose his termination from Via Health, and that the termination occurred subsequent to Via Health's investigation of the Patient A allegations.

The Committee sustains Factual Allegation S.2 as factually true and distinguishes its conclusions from those which resulted in it not sustaining Factual Allegations R.1 and R..2. With regard to the Canton application, Respondent's statement concerning the OPMC investigations stated, "...my record is currently spotless. <u>There are no restrictions or censures recorded</u>." (Dept's Ex. 14, pg. 9, first paragraph). Additionally, Respondent checked "No" in response to the question, "Have you ever been refused membership on a hospital, medical or dental staff, association, employment, or practice at another facility, or has your membership, association, employment or practice ever been limited, suspended, revoked, not renewed, granted with stated limitations or voluntarily surrendered?" (Dept's Ex. 14, pg. 7, third question from top). The Committee did not believe Respondent was being truthful when he checked "No" in response to this question, or when he stated that his record was currently spotless without recorded restrictions or censures. The Committee notes that Respondent had entered into the Memorandum of Agreement at Albany Memorial Hospital and views that document as a recorded restriction, and the incident with Employee I as a mark on his record. Rather than believing that Respondent's statement of OPMC's investigation to Canton was an attempt to be forthcoming, the Committee felt that in this instance, it evidenced an intent to conceal. When the Committee weighed all of these considerations, it concluded that when Respondent answered "No" to the question set forth in Factual Allegation S, his answer was indeed false and/or intentionally misleading in that he did not disclose his termination from Via Health. The Committee, concludes that Respondent's answer "No" constituted an act evidencing moral unfitness to

practice medicine and the fraudulent practice of medicine. The Committee, also, concludes, in concurrence with the above, that by definition Respondent's answer "No" constituted the willful filing or making of a false report.

Additionally, the Committee concludes that Respondent's answer "No" constituted a violation of Public Health Law Section 2805-k(1)(b) in that he did not disclose the discontinuance of his employment at Via Health or the reasons for the discontinuance.

FACTUAL ALLEGATION T.1

Factual Allegation T.1 charges that Respondent also gave a false and/or intentionally misleading answer when he answered "No" in response to another question on the Canton application, "Have your privileges at any hospital ever been suspended, denied, diminished, revoked, not renewed, or voluntarily surrendered?". Factual Allegation T.1 alleges that Respondent intentionally misled by not disclosing his termination from Finger Lakes.

The Committee declines to sustain Factual Allegation T.1 based on the same reasoning upon which it declined to sustain Factual Allegation S.1. The Canton application was filed on April 22, 2002 while Respondent did not resign from Finger Lakes until May 8, 2002.

FACTUAL ALLEGATION T.2

Factual Allegation T.2 charges that Respondent gave a false and/or intentionally misleading answer when he answered "No" in response to the question on the Canton application, "Have your privileges at any hospital ever been suspended, denied, diminished, revoked, not renewed, or voluntarily surrendered?", when he did not disclose his termination from Via Health.

In contrast to Factual Allegation S.2, the Committee declines to sustain this allegation as being factually true. The question to which Respondent answered ""No" in Factual Allegation T.2 dealt with hospital privileges. The Committee concluded that Respondent could justifiably have answered "No" because no action was ever taken against his hospital privileges at Via Health (T. 1511), and accepted Respondent's testimony in which he distinguished between his employment through DCREM and his hospital privileges (T. 4205-4214). Notwithstanding the limitation on his employment at Via Health through DCREM, Respondent's attending privileges were unaffected and he could see his own patients in the emergency room. His privileges were undiminished.

FACTUAL ALLEGATION U

The Committee does not sustain the "U" allegations other than the first sentence in Factual Allegation U.3 which states that Respondent mentioned promotional opportunities or sent e-mails concerning promotional opportunities to Employees Q and R. The allegations essentially allege that Respondent made verbal sexual overtures to Employees Q and R and offered employment opportunities as a quid pro quo for sexual favors. Witnesses were presented by both the Department and Respondent with regard to the "U" allegations. Employees Q and R testified for the Department, and Respondent, Pam McLenon and Jenna Ponwitz testified for the defense. Ultimately, the Committee was confronted with conflicting accounts by the various witnesses for the Department and Respondent. The Committee was presented with a "He said, she said" type situation which did not provide a basis for finding a clear cut preponderance of evidence in either direction. Because the Department had the burden of proof, the Committee did not sustain the allegations.

FACTUAL ALLEGATION V

The "V" allegations allege that Respondent made certain sexually inappropriate remarks toward Employee S in the hospital setting, and that he unfastened her bra and exposed her breasts while listening to her chest. The Committee found Employee S' testimony credible and sustains the "V" allegations on that basis.

Factual Allegation V.1, charges that Respondent said to Employee S that "...you'll never want to leave" the vibrating chair. The Committee sustains "V.1" as true to the extent that Respondent made a remark to that effect at a meeting at which Employee S was present. However, the Committee notes from Employee S' testimony that Respondent's remark was addressed to everyone at the meeting and not specifically to Employee S.

Factual Allegation V.2 alleges that Respondent said to Employee S, "If you were the type of girl who fooled around with married men, you'd be my first choice." The "V.4" allegations charge that after advising Employee S who had a respiratory infection that he neded to listen to her lungs, Respondent unfastened Employee S' bra and lifted up her shirt and bra, exposing her breasts. The Committee concludes that Factual Allegations "V.2" and "V.4(i)" and "V.4(ii) all constitute acts evidencing moral unfitness in the practice of medicine, and references Dr. Braen's testimony in support of its conclusions (see Findings of Fact # 2-12). The Committee also sustains the V.4 allegations regarding the exposure of Employee S' breasts as the willful harassment, abuse or intimidation of a patient.

Factual Allegations V.1 and V.3 which also alleged inappropriate remarks by Respondent were not viewed by the Committee as rising to the level of moral unfitness.

FACTUAL ALLEGATION W

The Committee sustains as true Factual Allegation W which alleges that Respondent sent an e-mail to a Board member and to the acting CEO of the Hospital at Sidney in an

attempt to persuade them not to report the events at the hospital to the Committee for Physician's Health (CPH) or to OPMC. The e-mail which was entered into evidence speaks for itself when it states that Respondent "would also beg that none of the recent events be reported to CPH or OPMC or my license in gone." The Committee does not believe that Respondent's desire for due process at the hospital prompted him to request that the events not be reported. In fact, Respondent had already been terminated from the Hospital at Sidney when he sent the e-mail. After reading Public Health Law Section 230(11) regarding the reporting of information which may reasonably appear to show that a licensee is guilty of misconduct, the Committee concludes that Respondent's attempt to avoid having the events reported by the hospital administration constitutes both moral unfitness in the practice of medicine and the fraudulent practice of medicine.

SUMMARY

In addition to the Factual Allegations which the Committee sustains above, the Committee also sustains, on the basis of the Findings of Fact made above, the following introductory paragraphs contained in the Factual Allegations; A, A.6, B, C, D, D.7, E, F with regard to F.1, F.2 and their subparts and F.3 only with respect to F.3.d, G, I, I.1, J, J.1, J.2, K, M, N with regard to N.2 and N.3, P, Q, S with regard to S.2 and V and V.4.

The Committee ultimately sustained the following Specifications based on the sustained Factual Allegations listed below;

Conduct in the Practice of Medicine Evidencing Moral Unfitness to Practice Medicine

Specification 1- A and A.2 and A.3

Specification 6- F and F.2, F.2.a, f.2.b, F.2.c, F.2.d, F.3 and F.3.d

Specification 9- I and I.1, I.1.a , I.1.b and I.1.c

Specification 10- J and J.1, J.1a, J.1.b, J.2, J.2.a, J.2.b and J.2.c

Specification 14- N and N.1 and N.2

Specification 15- O

Specification 16- P and P.1, P.2, P.3 and P.4

Specification 19- S and S.2

Specification 22- V and V.2, V.4, V.4.(i) and V.4(ii)

Specification 23- W

HARRASSING OR ABUSING A PATIENT PHYSICALLY AND/OR VERBALLY

Specification 27- F and F.2, F.2.a, F.2.b, F.2.c, F.2.d

Specification 29- I and I.1, I.1.a, I.1.b and I.1.c

Specification 30- J and J.1, J.1.a and J.1.b

Specification 31- O

Specification 32- P and P.1, P.2 and P.3

Specification 33- V.4, V.4(i) and V.4(ii)

REVEALING INFORMATION WITHOUT CONSENT

Specification 34- D and D.2 and D.3

FRAUDULENT PRACTICE

Specification 39- S and S.2

Specification 42- W

NEGLIGENCE ON MORE THAN ONE OCCASION

Specification 43- A and A.6, A.6.a and A.6.b

Specification 45- C and C.4

WILLFULLY MAKING OR FILING A FALSE REPORT

Specification 50- S and S.2

FAILURE TO KEEP ACCURATE RECORDS

Specification 52- D, D.7 and D.7.a

VIOLATING THE PUBLIC HEALTH LAW

Specification 54- S and S.2

DETERMINATION AS TO PENALTY

The Committee determines that Respondent's license to practice medicine should be revoked. This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L §230-a, including:

> (1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license to a specified area or type of practice; (4) Revocation of the license; (5) Annulment of the license or registration; (6) Limitations on registration or the issuance of any further license; (7) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service, and (10) Probation.

The Committee considered whether therapy might enable Respondent to continue practicing and determined that Respondent's history demonstrates that therapy is not an effective option to prevent lapses in his behavior. The Committee observes, for example, that the incident with Employee/Patient S occurred notwithstanding Respondent's treatment with Dr. Land. The Committee believed that unlike drug testing, Dr. Land's proposal (T. 3508-3512) to monitor Respondent's behavior through feedback forms from anyone who has meaningful contact with him (i.e.,- staff, patients, family), was insufficient as a monitoring device unless routinely required, and was too unwieldy. Dr. Land's proposed therapeutic intervention was considered in the context of the sustained allegations and

specifications which occurred over an approximately 15 year period, including a period when the hearing was already in progress. In that context, Respondent's lack of awareness of his behavior and his inability to exercise discretion at an acceptable level do not bode well for the success of Dr. Land's proposed therapeutic intervention, nor does the proposed intervention allay the Committee's concern for patients and employees who may come in contact with Respondent. The treatment proposed does not provide a sufficient basis to allay the Committee's grave concerns that it would not adequately protect the public were Respondent permitted to continue practicing medicine.

After carefully reviewing all the penalties and options available, the Committee concludes that revocation is the only feasible result in this case. The Committee has no suggestions as to what Respondent might do to improve his status so as to resume his medical license. The Committee has no doubt concerning Respondent's desire to practice medicine but the lengthy litany of Respondent's behavioral issues are impossible to ignore, particularly in the face of multiple acknowledgements by Respondent himself of his behavior (i.e.- Memorandum of Agreement, Respondent's apologies). The Committee acknowledges the possibility that in the past some of the accusations may have indeed tended to unfairly victimize Respondent, but the length of time and consistency of the indiscretions give the Committee no other option except for revocation.

In the end, the possibility that Respondent could be assisted to change his behavior is severely discounted by the Committee for a number of reasons, including his unwillingness to be forthcoming with those who might assist (i.e.- colleagues, Dr. Land, CPH), and the fact that the Committee does not find Dr. Land's monitoring plan to have a credible chance of success. The duration of Respondent's indiscretions despite therapy

and practice constraints leads the Committee to be pessimistic about the possibility of remediation and restoration of Respondent's license to practice medicine.

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice medicine be and hereby is **REVOKED**; and
2. This **ORDER** shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

DATED: Eggertsville , New York
25 March , **2005**

Joel H. Paull, M.D., D.D.S.
Chairperson

Richard Lee, M.D.
Stephen E. Wear, PH.D.

TO: Cindy Fascia, Esq.
Bureau of Professional Medical Conduct – 25th Floor
Division of Legal Affairs
New York State Department of Health
Corning Tower Building
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Catherine Gale, Esq.
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7136 East Genesee Street
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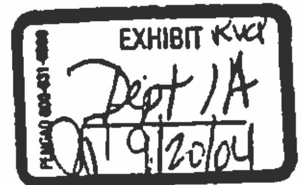
APPENDIX 1

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



IN THE MATTER OF GEORGE MICHAEL INNES, M.D.	AMENDED STATEMENT OF CHARGES

GEORGE MICHAEL INNES, M.D., Respondent, was authorized to practice medicine in New York State on February 16, 1988, by the issuance of license number 173637 by the New York State Education Department. Respondent is currently registered with the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, on or about June 29, 2001, provided medical treatment to Patient A, a then fifteen year old female, in the Emergency Department of Via Health/Newark Hospital in Newark, New York.

1. Respondent told the nurse that he wanted to speak to Patient A alone, and asked the nurse to leave, or words to such effect.
2. Respondent said to Patient A, "It's time to go under the covers", or words to such effect. Respondent then lifted the examination gown over Patient A's head, in such a manner that the gown was covering her face and exposing her breasts.
3. Respondent touched and/or cupped each of Patient A's breasts, which touching was not an appropriate part of the medical workup for Patient A and/or was not medically indicated and/or had no legitimate medical purpose.
4. Respondent asked Patient A if she ever gave oral sex, or words to such effect.
5. Respondent asked Patient A if she had ever had anal sex, or words to such effect.

6. Respondent did not document in Patient A's medical record:

   a. A breast examination.

   b. Any questioning conducted or information obtained from Patient A regarding sexual activity or sexual behavior.

7. Respondent asked Patient A questions regarding sexual activity and/or sexual behavior that were not within accepted standards of medical care and/or were medically inappropriate and/or had no legitimate medical purpose.

B. Respondent, on or about December 17, 2002, provided medical care to Patient B, a then fifteen year old female, in the Emergency Department of Canton-Potsdam Hospital. Patient B had been sent for evaluation after her school had notified Child Protective Services that Patient B had bruises on her arm.

1. Respondent performed the examination while Patient B was wearing her street clothing and/or without requesting that the patient be gowned.

2. Respondent tried to unfasten Patient B's bra, and had difficulty in attempting to do so. Respondent said, "I used to be good at this", or words to such effect.

3. Respondent, after Patient B's bra was removed, cupped and/or lifted each of Patient B's breasts from underneath and then dropped and/or released each one.

4. Respondent asked Patient B to drop and/or lower her skirt. Respondent then pushed the patient's thighs slightly apart.

5. Respondent said that Patient B "obviously [was] sexually active and promiscuous", or words to such effect.

6. Respondent said that Patient B dressed "dangerously" and "should not dress so provocatively", or words to such effect.

7. Respondent left the examination room and returned shortly. Respondent then said to Patient B's mother, who had been present for the examination, that Patient B dressed too dangerously and provocatively, or words to such effect.

8. Respondent asked questions and/or made statements regarding Patient B's mode of dress and/or sexual activity that were inappropriate and/or failed to meet accepted standards of care.

C. Respondent provided medical care to Patient C, a then twelve year old female, on or about January 12, 2003, in the Emergency Department of Canton-Potsdam Hospital.

1. Respondent told the nurse that he wanted to speak to Patient C alone, and asked the nurse to leave, or words to such effect.

2. Respondent asked Patient C if she had engaged in sexual intercourse and/or oral sex with her boyfriend and/or if she had touched her boyfriend's penis and/or if her boyfriend had ever put his fingers in her vagina, or words to such effect.

3. Respondent asked Patient C questions regarding sexual activity and/or sexual behavior that were not within accepted standards of medical care and/or were medically inappropriate and/or had no legitimate medical purpose.

4. Respondent did not document in Patient C's medical record any questioning conducted or information obtained regarding sexual activity or sexual behavior.

D. Respondent provided medical care to Patient D, a then twenty year old male, on or about November 11, 2002, in the Emergency Department of Canton-Potsdam Hospital.

1. Respondent made a diagnosis of gonorrhea, which diagnosis was not medically justified.

2. Patient D was accompanied to the hospital by a friend. Respondent walked into the room and, in the presence of Patient D's friend, told Patient D, "You've got the clap", or words to such effect.

3. Respondent did not ask Patient D if he wanted his friend to remain present before discussing his alleged diagnosis.

4. When Patient D questioned the diagnosis, saying that he only had one girlfriend and that she was "a good girl", or words to such effect, Respondent told Patient D, "maybe your girlfriend isn't such a good girl", or words to such effect.

5. Respondent prescribed antibiotic therapy which was inappropriate and/or which did not meet the standard of care.

6. Respondent failed to take and/or record an adequate and/or accurate history from Patient D.

7. Patient D's girlfriend called and spoke to Respondent on or about the evening of November 11, 2002, and told Respondent that Patient D, since taking the medication prescribed by Respondent, was vomiting and having uncontrollable diarrhea, or words to such effect.

    a. Respondent failed to document in Patient D's medical record this telephone conversation and/or Patient D's vomiting and uncontrollable diarrhea.

b. Respondent failed to advise that Patient D should either alter the medication regimen prescribed by Respondent or be re-evaluated in the Emergency Department.

8. Respondent wrote in Patient D's medical record that Patient D had a history of "clap" (gonorrhea), when in fact Patient D had no such history.

9. Respondent wrote in Patient D's medical record that Patient D was having discharge from his penis, when in fact Patient D made no such complaint and/or did not have any discharge.

E. Respondent provided medical care to Patient E, a then seventeen year old female, in the Emergency Department of Canton-Potsdam Hospital on or about September 10, 2002. Respondent diagnosed Patient E as having a lumbar contusion.

1. Respondent failed to adequately review the x-rays of Patient E and/or failed to diagnose Patient E's lumbar fracture.

2. Respondent failed to provide adequate and/or appropriate treatment for Patient E's lumbar fracture, and/or failed to consult an orthopedist and/or recommend that Patient E obtain such consultation and/or failed to notify Patient E's primary care physician.

3. Respondent, on or about September 10, 2002, subsequent to Patient E's discharge from the Emergency Department, had a telephone conversation with Patient E's mother. Respondent, in said telephone conversation, told Patient E's mother that Patient E in fact had a lumbar fracture. Respondent told Patient E's mother that the treatment for Patient E's lumbar fracture would be the same as for Respondent's previous diagnosis of lumbar contusion, or words to such effect.

4. Respondent failed to document in Patient E's medical record his telephone conversation with Patient E's mother and/or failed to document that the diagnosis of lumbar fracture was not made and/or not conveyed to Patient E and/or her mother until subsequent to Patient E's discharge from the Emergency Department.

5. Respondent's documentation in Patient E's medical record was not accurate and/or intentionally misleading with regard to when Patient E's lumbar fracture was diagnosed and/or when the patient and/or her family were informed of the diagnosis of lumbar fracture.

F. Respondent, on or about July 24, 1998, engaged in the following conduct toward Patient F, a then twenty-one year old female [illegible] in which Respondent's children participated. Respondent engaged in said conduct on the way to and during the course of a picnic at Respondent's residence to which Patient F and the other staff and participants in the [illegible]:

1. Respondent asked Patient F if she had a boyfriend and, upon learning that she had begun dating her boyfriend when she was sixteen, said Patient F would "need a Sugar Daddy in her life", or words to such effect.

2. Respondent mentioned that he was aware that Patient F had had a skin rash, and told Patient F that he had a light at his home that he could use to examine her skin, or words to such effect. Respondent took Patient F into the basement or ground floor area of his house to examine her and/or demonstrate the use of the light on her, and engaged in the following conduct:

   a. Respondent asked Patient F to turn her back to him. Respondent then pulled Patient F's shorts and bathing suit bottom away from her body, exposing her buttocks, which conduct had no legitimate medical purpose.

   b. Respondent, when Patient F turned around, grabbed the front of her shorts and bathing suit bottom and pulled them away from her body, exposing her pubic area, for no legitimate medical purpose.

   c. Respondent moved the light so that it shone on Patient F's groin area. Respondent said "There isn't even any bacteria down there", or words to such effect.

   d. Respondent grabbed the top of Patient F's bathing suit and exposed one breast, which conduct had no legitimate medical purpose.

3. Respondent, on or about July 24, 1998, subsequent to his bringing Patient F into his house to examine her, engaged in the following conduct toward Patient F:

   a. Respondent, after alcoholic beverages had been served, followed Patient F into the house when she went to use the bathroom, and asked her if she was too drunk to give him a kiss, or words to such effect.

   b. Respondent put his hand on Patient F's clothed buttocks and rubbed them.

   c. Respondent, when Patient F again went into the house to use the bathroom, followed Patient F upstairs.

   d. Respondent, in the presence of others, made suggestive remarks speculating on Patient F's skill in performing oral sex.

G. Respondent, on or about July 5, 1999, provided medical care to Patient G, a then thirty-one year old female, in the Emergency Department of Samaritan Medical Center, Watertown, New York. Patient G's complaint was severe headache with nausea and photophobia.

1. Respondent pulled up Patient G's bra, exposing her breasts, which conduct had no legitimate medical purpose.

2. Respondent touched Patient G's vaginal area, which conduct had no legitimate medical purpose.

3. Respondent touched Patient G's clitoris, which conduct had no legitimate medical purpose.

4. Respondent, upon learning that Patient G had made a complaint about Respondent to Samaritan Medical Center, disclosed to a mutual acquaintance that Patient G had been treated by Respondent and had filed a complaint against him. Respondent asked the mutual acquaintance to talk to Patient G and ask her to withdraw her complaint against Respondent.

H. Respondent, on various occasions between approximately November 1997 and March 1999 engaged in inappropriate conduct toward Employee H, who was then employed by Samaritan Medical Center [redacted]. Respondent was the Director of the Department of Emergency Medicine. Respondent's conduct included the following:

1. Respondent, when asked by Employee H in the course of her employment if he needed anything, said "what I really need is a blow job" or words to such effect.

2. Respondent, when asked by Employee H in the course of her employment if he needed anything, said "I need a blonde, 5 feet 4, with no morals", or words to such effect.

3. Respondent told Employee H: "I am the Director of the Department, and if I wanted to, I could close the door and tell you to drop down to your knees and give me a blow job and I would not need anyone in this hospital to give me permission" or words to such effect.

4. Respondent asked Employee H "what is the kinkiest sex you ever had?" or words to such effect.

5. Respondent told Employee H explicit details of his sexual encounters.

6. Respondent, if Employee H appeared to be in a good mood when she came in to work, said "You must have gotten something last night. I'm glad somebody did" or words to such effect.

7. Respondent told Employee H that his wife was making him sleep on the couch, or words to such effect, talked about how his career and his marriage were ruined, and said that he was thinking about committing suicide, or words to such effect. When Employee H offered sympathy to Respondent, Respondent then asked Employee H to perform oral sex on him or made other remarks of a sexual nature.

8. Respondent sent E-mails and/or computer messages to Employee H that contained sexual images and/or sexual content.

I. Respondent, on various occasions between 1990 and 1996, at Albany Memorial Hospital in Albany, New York, engaged in the following conduct toward Patient (Employee) I:

1. Respondent, during the course of an employee assessment/exam he was performing on Patient (Employee) I, engaged in the following conduct:

   a. Respondent unhooked Patient I's bra.

   b. Respondent lifted up Patient I's bra and exposed her breasts.

   c. Respondent, referring to Patient I, said that the person who usually performed the employee assessments/physicals had "missed a good one" or words to such effect.

J. Respondent, on various occasions, between 1990 and 1996 at Albany Memorial Hospital, offered back rubs to staff. Patient (Employee) J accepted Respondent's offer to help her back and/or neck pain.

1. Respondent, during the course of said treatment of Patient (Employee) J, engaged in the following conduct:

   a. Respondent touched or attempted to touch Patient J's breasts, which conduct had no legitimate medical purpose.

   b. Respondent touched or attempted to touch Patient J's vaginal area, which conduct had no legitimate medical purpose.

2. Respondent, during the course of a party for [redacted] staff at Respondent's residence in Clifton Park, New York, engaged in the following conduct toward Employee J:

   a. Respondent, while Employee J was in Respondent's swimming pool, tried to and/or did put his hand on Employee J's crotch.

   b. Respondent followed Employee J when she went upstairs to use the bathroom and tried to kiss her.

   c. Respondent put his hand on Employee J's buttocks.

K. Respondent, on various occasions between 1990 and 1996 at Albany Memorial Hospital, engaged in the following conduct toward Employee K:

1. Respondent, while Employee K was seated, put his foot or feet in Employee K's lap and/or on her hip.

2. Respondent asked Employee K to run away with him and have an affair with him, or words to such effect.

3. Respondent said to Employee K "Let's open a bordello and you can be our main whore", or words to such effect.

4. Respondent told Employee K "you don't know what a big penis is because you are married to an oriental", or words to such effect.

L. R[redacted]

[redacted]

a. [redacted]

b. [redacted]

c. [redacted]

[redacted]

2. [redacted]

3. [redacted]

a. [redacted]

b. [redacted]

4. [redacted]

5. [redacted]

6. [redacted]

a. [redacted]

b. [redacted]

M. Respondent, after Nurse L had told Nurse M about Respondent's conduct, and after Nurse M had reported said conduct to her supervisor, engaged in the following conduct toward Nurse M at Albany Memorial Hospital:

1. Respondent, when Nurse M was alone in the utility room and/or the medication room, came into the room and closed the door behind him and/or blocked Nurse M's exit.

2. Respondent said that Nurse M should "think about what this was doing to [Respondent's] wife and children", or words to such effect.

3. Respondent told Nurse M that he "knew a lot of things about her," that he "knew what hours she worked," that he "knew where her daughter went to school," and that he "knew when her daughter would be home alone", or words to such effect.

N. Respondent, on various occasions between 1988 and 1990 at St. Peter's Hospital, in Albany, New York, engaged in the following conduct toward Nurse N:

1. Respondent offered to pay money if Nurse N and another nurse went to a hotel room with Respondent, or words to such effect.

2. Respondent told Nurse N that he needed to speak with her in his office about a patient, or words to such effect. Respondent then brought Nurse N into his office and closed the door. Respondent then grabbed Nurse N and kissed her on the mouth, without Nurse N's consent.

3. Respondent put or attempted to put his tongue in Nurse N's mouth without her consent.

O. Respondent, on an occasion between 1988 and 1990 at St. Peter's Hospital, offered to treat Patient (Nurse) O's neck and/or back injury with a hot Keri Lotion treatment and/or massage. Respondent, during the course of said treatment, touched Patient O's breasts, which touching had no legitimate medical purpose.

P. Respondent, on an occasion between 1988 and 1990 at St. Peter's Hospital, when asked by Patient (Employee) P if he could help her sciatica, offered to treat Patient P's sciatica with a hot Keri Lotion treatment and/or massage. Respondent, during the course of said treatment, engaged in the following conduct:

1. Respondent removed Patient P's underpants, which conduct had no legitimate medical purpose.

2. Respondent touched Patient P's upper inner thigh and/or groin and/or pubic area, which conduct had no legitimate medical purpose.

3. Respondent told Patient P "your problem is that you need to get fucked more," or words to such effect.

4. Respondent, on one occasion subsequent to his treatment of Patient P, followed Patient P into the darkroom of the x-ray area. Respondent blocked Patient P's exit, and asked Patient P for a kiss and/or tried to kiss Patient P and/or told Patient P that if she gave him just one kiss he would let her leave, or words to such effect.

Q. Respondent, in July and August 1999, was evaluated by a psychiatrist employed by Respondent and/or Respondent's attorney to evaluate Respondent. The psychiatrist was to prepare a report to send to Respondent's attorney, which report could be forwarded to the Office of Professional Medical Conduct. Respondent understood this, and agreed to the evaluation. The psychiatrist prepared a report, which he submitted to Respondent's attorney, which report was in turn submitted by Respondent's attorney to the Office of Professional Medical Conduct.

1. Respondent, in the evaluation, told the psychiatrist that other than the incidents in Watertown in 1998-1999, there had been no other instances or allegations of misconduct against him. In fact, there had been other instances and/or allegations against Respondent, and Respondent knew such fact.

2. Respondent caused the psychiatrist to prepare an evaluation and recommendations which, in part, relied on Respondent's misrepresentation that other than the incidents in Watertown, he had no complaints against him of sexual harassment.

R. Respondent, on or about March 25, 2003 submitted an Application for Appointment to the Medical Staff to The Hospital in Sidney, New York. Respondent, in response to the application question **"Have you ever voluntarily or involuntarily terminated your medical staff membership at any other organization?"**, answered "At the end of each contract". Respondent's answer was false and/or intentionally misleading in that:

1. Respondent, on or about January 31, 2002, entered into an employment contract with Fingerlakes Health and/or Geneva General Hospital, in Geneva, New York, as an Emergency Department Physician. Said contract was to remain in full force and effect until June 30, 2003, unless earlier terminated as provided in the contract. Following administrative assessment of Respondent's allegedly disruptive behavior with Emergency Room nursing staff and his allegedly

inappropriate demeanor in the clinical setting, Fingerlakes Health and/or Geneva General Hospital decided to invite Respondent's resignation. Respondent resigned on or about May 8, 2002, pursuant to terms and conditions set forth in a letter agreement dated May 8, 2002.

2. Respondent, on or about October 2000, was granted temporary privileges and a one year provisional status at Via Health of Wayne, New York, which has hospitals in Newark, New York [Newark Hospital] and Sodus, New York [Myers Hospital]. Respondent's association with Via Health ended in approximately August 2001, when Respondent was terminated. Respondent's termination occurred subsequent to Via Health's investigation of Patient [illegible]'s allegations against Respondent.

S. Respondent, on or about April 22, 2002 submitted an Application for Appointment to the Medical Staff to Canton-Potsdam Hospital, Canton, New York. Respondent, in response to the application question: **"Has your membership [on a Hospital Medical Staff], Association, employment or practice ever been limited, suspended, revoked, not renewed, granted with stated limitations or voluntarily surrendered?"**, answered "No." Respondent's answer was false and/or intentionally misleading, in that:

1. Respondent, on or about January 31, 2002, entered into an employment contract with Fingerlakes Health and/or Geneva General Hospital, in Geneva, New York, as an Emergency Department Physician. Said contract was to remain in full force and effect until June 30, 2003, unless earlier terminated as provided in the contract. Following administrative assessment of Respondent's allegedly disruptive behavior with Emergency Room nursing staff and his allegedly inappropriate demeanor in the clinical setting, Fingerlakes Health and/or Geneva General Hospital decided to invite Respondent's resignation. Respondent resigned on or about May 8, 2002, pursuant to terms and conditions set forth in a letter agreement dated May 8, 2002.

2. Respondent, on or about October 2000, was granted temporary privileges and a one year provisional status at Via Health of Wayne, New York, which has hospitals in Newark, New York [Newark Hospital] and Sodus, New York [Myers Hospital]. Respondent's association with Via Health ended in approximately August 2001, when Respondent was terminated. Respondent's termination occurred subsequent to Via Health's investigation of Patient A's allegations against Respondent.

T. Respondent, in the Canton application, answered "No" to the question: **"Have your privileges at any hospital ever been suspended, denied, diminished, revoked, not renewed, or voluntarily surrendered?"** Respondent's answer was false and/or intentionally misleading, in that:

1. Respondent, on or about January 31, 2002, entered into an employment contract with Fingerlakes Health and/or Geneva General Hospital, in Geneva, New York, as an Emergency Department Physician. Said contract was to remain in full force

and effect until June 30, 2003, unless earlier terminated as provided in the contract. Following administrative assessment of Respondent's allegedly disruptive behavior with Emergency Room nursing staff and his allegedly inappropriate demeanor in the clinical setting, Fingerlakes Health and/or Geneva General Hospital decided to invite Respondent's resignation. Respondent resigned on or about May 8, 2002, pursuant to terms and conditions set forth in a letter agreement dated May 8, 2002.

2. Respondent, on or about October 2000, was granted temporary privileges and a one year provisional status at Via Health of Wayne, New York, which has hospitals in Newark, New York [Newark Hospital] and Sodus, New York [Myers Hospital]. Respondent's association with Via Health ended in approximately August 2001, when Respondent was terminated. Respondent's termination occurred subsequent to Via Health's investigation of Patient A's allegations against Respondent.

U. Respondent, on or about May 1, 2004, outside of The Community Lounge in Sidney, New York, said to Employee R and Employee Q, "You have a tongue ring and you don't. Why don't we get in my truck and you can both do me and I can compare", or words to such effect. Employee R and Employee Q refused. Respondent, after the May 1, 2004 incident, engaged in the following conduct toward Employee R and/or Employee Q at The Hospital in Sidney, New York:

1. Respondent said "You are all talk and no action", or words to such effect.

2. Respondent said "The offer is still open, my truck is parked outside", or words to such effect.

3. Respondent mentioned and/or sent e-mails regarding promotional opportunities in The Hospital to Employee R and/or Employee Q, and/or mentioned work re-assignments to work with their friends. Respondent, after mentioning said promotional opportunities to Employee R and/or Employee Q, would sometimes say at the end of such conversation and/or in close proximity to such conversation "Oh, by the way, the offer is still open, my truck is parked outside." or words to such effect.

V. Respondent engaged in the following conduct toward Patient (Employee) S at The Hospital in Sidney:

1. Respondent, in a meeting with Employee S and a sales representative and/or others regarding the purchase of equipment, said to Employee S, "We'll get you a heated, vibrating chair and you'll never want to leave", or words to such effect.

2. Respondent said to Employee S "If you were the type of girl who fooled around with married men, you'd be my first choice", or words to such effect.

3. Respondent, when Employee S was going on vacation, said to Employee S "at least bring me a picture of you in a bikini", or words to such effect.

4. Employee S was ill with a respiratory infection and/or other illness, and was treated in the Emergency Department of The Hospital. Respondent gave Employee S samples of an antibiotic. Thereafter, Respondent saw Employee S at work, and told her that he "needed to listen to her lungs to see if the antibiotics were working" or words to such effect. Respondent had Employee S step into his office, which is also a conference room, and engaged in the following conduct:

   (i) Respondent unfastened Employee S's bra.

   (ii) Respondent lifted up Employee S's shirt and bra and exposed her breasts.

W. Respondent, on or about August 7, 2004, sent an e-mail to a Board member and the acting CEO of The Hospital wherein Respondent attempted to persuade them to not report the events at The Hospital in Sidney to either the Committee for Physicians' Health (CPH) or the Office of Professional Medical Conduct (OPMC).

SPECIFICATION OF CHARGES

FIRST THROUGH TWENTY-THIRD SPECIFICATIONS
MORAL UNFITNESS

Respondent is charged with professional misconduct by reason of his committing conduct in the practice of medicine that 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 and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.7.
2. The facts in Paragraphs B and B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8.
3. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3.
4. The facts in Paragraphs D and D.2 and/or D. 4 and/or D.8 and/or D.9.
5. The facts in Paragraphs E and E.5.
6. The facts in Paragraphs F and F.1 and/or F.2 and F.2(a) and/or F.2(b) and/or F.2(c) and/or F.2(d) and/or F.3 and F.3(a) and/or F.3(b) and/or F.3(c) and/or F.3(d).
7. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3 and or G.4.
8. The facts in Paragraphs H and H.1 and/or H. 2 and/or H.3 and/or H.4 and/or H.5 and/or H.6 and/or H.7 and/or H.8.
9. The facts in Paragraphs I, I.1 and/or I.1(a) and/or I.1(b) and/or I.1c).
10. The facts in Paragraphs J, J.1 and/or J.1(a) and/or J.1(b); J.2 and J.2(a) and/or J.2(b) and/or J.2(c).
11. The facts in Paragraphs K and K.1 and/or K.2 and/or K.3 and/or K.4.
12. The facts in Paragraphs L, L.1 and L.1(a) and/or L.1(b) and/or L.1(c) and/or L.1(d) and/.or L.2; L.3 and L.3(a) and/or L.3(b); L.4 and/or L.5; L.6 and L.6(a) and/or L.6(b) and/or L.6(c).
13. The facts in Paragraphs M and M.1 and/or M.2 and/pr M.3.
14. The facts in Paragraph N and N.1 and/or N.2 and/or N.3.
15. The facts in Paragraph O.
16. The facts in Paragraphs P and P.1 and/or P.2 and/or P.3 and/or P.4.
17. The facts in Paragraphs Q and Q.1 and/or Q.2.
18. The facts in Paragraphs R and R.1 and/or R.2.

19. The facts in Paragraphs S and S.1 and/or S.2.

20. The facts in Paragraphs T and T.1 and/or T.2.

21. The facts in Paragraphs U and/or U.1 and/or U.2 and/or U.3.

22. The facts in Paragraphs V and/or V.1 and/or V.2 and/or V.3 and/or V.4.(i) and/or V.4(ii).

23. The facts in Paragraph W.

TWENTY-FOURTH THROUGH THIRTY-THIRD SPECIFICATIONS

HARASSING OR ABUSING A PATIENT PHYSICALLY AND/OR VERBALLY

Respondent is charged with professional misconduct by reason of his willfully harassing, abusing, or intimidating a patient either physically or verbally, in violation of New York Education Law §6530(31), in that Petitioner charges:

24. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.7.

25. The facts in Paragraphs B and B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8.

26. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3.

27. The facts in Paragraphs F and F.1 and/or F.2 and F.2(a) and/or F.2(b) and/or F.2(c) and/or F.2(d) and/or F.3 and F.3(a) and/or F.3(b) and/or F.3(c) and/or F.3(d).

28. The facts in Paragraphs G and G.1 and/or G.2 and/or G.2 and or G.4.

29. The facts in Paragraphs I, I.1 and I.1(a) and/or I.1(b) and/or I.1(c).

30. The facts in Paragraphs J, J.1 and/or J.1(a) and/or J.1(b).

31. The facts in Paragraph O.

32. The facts in Paragraphs P and P.1 and/or P.2 and/or P.3 and/or P.4.

33. The facts in Paragraphs V.4 and V.4(i) and/or V.4(ii).

THIRTY-FOURTH AND THIRTY-FIFTH SPECIFICATIONS
REVEALING INFORMATION WITHOUT CONSENT

Respondent is charged with professional misconduct by reason of his revealing personally identifiable facts or information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law, in violation of New York Education Law §6530(23), in that Petitioner charges:

34. The facts in Paragraphs D and D.2 and/or D.3.
35. The facts in Paragraphs G and G.4.

THIRTY-SIXTH THROUGH FORTY-SECOND SPECIFICATIONS
FRAUDULENT PRACTICE

Respondent is charged with professional misconduct by reason of his practicing medicine fraudulently in violation of New York Education Law § 6530(2), in that Petitioner charges:

36. The facts in Paragraphs D and D.8 and/or D.9.
37. The facts in Paragraphs E and E.5.
38. The facts in Paragraphs Q and Q.1 and/or Q.2.
39. The facts in Paragraphs R and R.1 and/or R.2.
40. The facts in Paragraphs S and S.1 and/or S.2.
41. The facts in Paragraphs T and T.1 and/or T.2.
42. The facts in Paragraph W.

FORTY-THIRD THROUGH FORTY-SEVENTH SPECIFICATIONS
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:

43. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6 and/or A.6(a) and/or A.6(b) and/or A.7.
44. The facts in Paragraph B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8.
45. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4.
46. The facts in Paragraphs D and D.1 and/or D.5 and/or D.6 and/or D.7 and 7(a) and/or 7(b).
47. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3 and/or E.4.

FORTY-EIGHTH THROUGH FIFTY-FIRST SPECIFICATIONS
WILLFULLY MAKING OR FILING A FALSE REPORT

Respondent is charged with professional misconduct by reason of his making or filing a false report, in violation of New York Education Law § 6530(21), in that Petitioner charges:

48. The facts in Paragraphs D and D.8 and/or D.9.
49. The facts in Paragraphs E and E.5.
50. The facts in Paragraphs S and S.1 and/or S.2.
51. The facts in Paragraphs T and T.1 and/or T.2.

FIFTY-SECOND AND FIFTY-THIRD SPECIFICATIONS
FAILURE TO KEEP ACCURATE RECORDS

Respondent is charged with professional misconduct by reason of his failure 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:

52. The facts in Paragraphs D, D.7 and D.7(a) and/or D.8 and/or D.9.

53. The facts in Paragraphs E and E.4 and/or E.5.

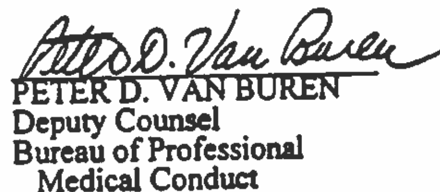
FIFTY-FOURTH AND FIFTY-FIFTH SPECIFICATIONS
VIOLATING PUBLIC HEALTH LAW

Respondent is charged with professional misconduct by reason of his violating section twenty-eight hundred and three-d or twenty-eight hundred and five-k of the public health law, in violation of New York Education Law § 6530(14), in that Petitioner charges:

54. The facts in Paragraphs S and S.1 and/or S.2.

55. The facts in Paragraphs T and T.1 and/or T.2.

DATED: September 17, 2004
Albany, New York



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Bureau of Professional
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